Report of a Comprehensive Primary Health Care Rapid Community Survey Among Hispanic Migrant Families in Charleston County, South Carolina

REPORT OF A COMPREHENSIVE PRIMARY HEALTH CARE RAPID COMMUNITY SURVEY AMONG HISPANIC MIGRANT FAMILIES IN CHARLESTON COUNTY, SOUTH CAROLINA

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INTRODUCTION

Literature Review

The Federal Office of Migrant Health estimates that there are 3,000,000 seasonal and migrant farm workers and dependents in the U.S.; of those, about 1,000,000 are migrants. The differences between migrant and seasonal workers are the following: a migrant farm worker is an individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months and who establishes for the purpose of such employment a temporary abode, while a seasonal farm worker is an individual who works cyclically but does not migrate.[1]

There are three major migrant "streams" in the U.S. The first stream originates in Florida and flows to the northern Atlantic states. The second originates in Texas and spreads to the plains states, Mid-West, and parts of the Rocky Mountains. The third, based in California and Arizona, covers the Western states. The eastern stream is the most ethnically heterogeneous; it includes African Americans, Mexican Americans, Mexicans, and an increasing number of Central Americans. An unknown but large number of migrant workers are undocumented; however, estimates are not available.[2]

The geographic mobility of these populations contribute to serious health risks. Poverty and substandard conditions of living aggravate health problems and encourage dependency on income derived from children.[3] Migration generates social and physical isolation, especially for wives who may find themselves without their familiar network that provided them social, emotional, and financial support. Male workers migrating alone have been found to have an increased risk of contracting HIV/AIDS and other sexually transmitted diseases. Specific health and behavioral problems, such as alcoholism and other substance abuse, have been also associated with migratory conditions.[4]

Language and socio-cultural differences contribute to the social isolation and create barriers to adequate health care; those barriers increase the likelihood that care will be sought from alternative sources, such as healers, or recourse to self-medication. Access and continuity of care is problematic. Despite the high prevalence of tuberculosis and other conditions, only 17% of migrant workers have access to or receive care at federally funded migrant health clinics.[5] The fluctuation of wages based on a piece rate system creates disincentives to health care; a visit to a health clinic may represent the loss of a day's worth of wages. Studies have indicated that the majority of migrants and seasonal workers and their families seek medical attention mainly for acute ailments, not for preventive care.[6] There are indications that many workers delay seeking care until they return to their countries of origin. Undocumented workers and those still pending legal decisions on residency status are the ones living in the worst conditions and the least likely to use the health

facilities. These conditions make it difficult not only to provide health care but also effective health education.[7]

Thus, the migrant condition can affect health in different ways: by increasing exposure to unhealthy living and working conditions and to specific health hazards; by leading to poor utilization of health care and to an overemphasis on acute care relative to routine or preventive care; and by fostering lack of awareness, lack of availability, and lack of access to adequate care.[8]

The leading causes of death for migrant and seasonal farm workers are similar to the rest of the U.S. population; that is, heart disease, cancer, and strokes; however, little is known about the prevalence, incidence or risk factors for these or other diseases among these seasonal workers. Reviews of health data from migrant health centers indicate that the most frequent diagnosis made, have been in order of frequency, upper respiratory infections, hypertension, obstetrical problems, diabetes mellitus, otitis media, dermatitis, trauma, urinary tract infection, anemia, obesity, gastroenteritis, family planning activities, and heart disease.[9]

Deficiencies of knowledge about migrant and seasonal populations:

- The exact numbers and the legal status of the migrant population is lacking at the state and federal levels.
- Basic demographic data are lacking at all levels.
- The health status of this population has not been well measured and the contributing factors for their health/disease profile are even less well documented.
- Data on migrant health is scant, including alcohol and other substance abuse and risk factors for STDs and HIV/AIDS.
- Estimates of the prevalence of HIV infection and other STDs in migrant and seasonal workers are limited.
- Information about HIV/AIDS related knowledge, attitudes, and behaviors is lacking.
- Cultural factors that could contribute to the success of interventions and facilitate changes in behaviors have not been studied.
- Knowledge is lacking on the modes of health education interventions that could have the most impact on the different groups of migrant workers.

THE STUDY

Background for the Study

The health of migrant farm workers is a very relevant issue in South Carolina since the majority of the state's agricultural labor (95%) is supplied by migrant and seasonal workers. According to the registry of the Employment Security Commission, approximately 20,500 migrant and seasonal laborers work in the state each year. However, it is estimated that the vast majority (93%) of all

agricultural labor is supplied by migrant rather than seasonal workers.[10]

The population of migrant farm workers of the Charleston county area is the second largest in the State of South Carolina. The main crops grown in the area are vegetables. Estimates indicate that about 2,000 registered individuals work in the area during the peak season in the spring, and about 450 in the fall.[11] According to the providers of services for the migrant population, the same individuals and families tend to return each year; most of them begin their journey in Florida and follow the same route year after year.[12]

During the fall season, most agricultural work is carried out by migrants who work in farms of Johns Island and vicinity areas of Charleston county. Johns Island is one of several coastal islands located to the south of the city of Charleston. The islands are separated from the city by the Ashley River and the Charleston Harbor and from each other by small rivers, narrow creeks, and broad expanses of marshlands. Until the early seventies this cluster of islands remained in semi-isolation. There is no public transportation on the islands except in the areas closer to the Ashley River, and some residences are only accessible by dirt roads or foot paths. There is no mass transit connecting the islands to the city of Charleston or to each other.[13]

The majority of migrant farm workers who come to this area are of Mexican origin. About half of them consist of families and the other half of single males ages 24 to 45; but the number of families has been decreasing steadily over the past years. The number of families remaining in the area was estimated to be 35-40 during the months of November-December 1993, when the study was carried out.[14] Some families live in the housing facilities of the 13 largest camps of the area but many prefer to rent houses from the local residents, when feasible.

The main organizations that provide services for the migrant population of the area are located on Johns Island. During 1993, Our Lady of Mercy, a Catholic charitable organization, provided food, clothing, and prescription money for 703 people. Rural Mission, an ecumenical non-profit organization, provided summer services for 90 families and winter services for 25 through its Headstart Program. The Chas. Co. School Migrant summer program served about 407 people in four schools and Chas. Co. School English Secondary Language served 45 students. The Sea Island Corporation Lab, located in Johns Island Clinic, served a total of 618 people. And the F.C. Fetter-Johns Island Clinic served an estimated 1,236 migrants of all ages. The clinic provided transportation from and to the camps when needed and so did Rural Mission using the Headstart bus. The Johns Island clinic is staffed with 2 full-time primary care physicians, 2 part-time pediatricians; 3 nurse practitioners, and 3 registered nurses; in addition to the laboratory and pharmacy staff. The regular office hours of the clinic are 8:00 am to 5:00 pm on Mondays, Tuesdays, Wednesdays, and Fridays; from 11:00 am to 8:00 pm on Thursdays; and

from 9:00 am to 1.00 pm on saturdays. The clinic offers the following services: general medical care, referrals, hospitalization, dental care, pharmacy, laboratory, X-rays, vaccination, family planning, WIC, health education, and case management. The clinic accepts Medicare and Medicaid patients.[15]

The only hospitals accessible to the Sea Islands West area are two private hospitals, a county funded hospital, and a state supported medical university/teaching hospital (all are located in downtown Charleston). The region has only two primary medical centers (located in Johns and Yonges Islands), considered satellite sites of the main center, also located in downtown Charleston. There is only one private practitioner in the Sea Island area who will accept Medicaid patients; there are no general practitioners, OB-GYN specialists, or pediatricians in the area who will accept Medicaid patients.[16]

The most common health problems identified at the clinic by the providers have been dermatological problems, including work related dermatitis and fungal infections, work related trauma, obstetrical consults, abdominal pain (non-specific), diabetes mellitus, and hypertension. Two cases of AIDS and several cases of venereal diseases were also mentioned, however there is no data available on the extent of these problems.

Purpose of the Study

The aim of this study was to collect population based information on health status, behavior, and knowledge of the Hispanic migrant families who remain/and or come to Johns Island and vicinity for the fall harvest. More specifically, the purpose of the study was to carry out a "rapid community survey" that would provide the information requested by two of the main health care providers of the area.

Rural Mission and Sea Island Comprehensive Health Care Corporation [17] perceived the necessity to have more detailed information about the health status, attitudes and knowledge of this particular population; the information was to be used to develop the most appropriate strategies to deliver the services needed by this particular population.

The questions addressed in this study were specifically designed to suit the needs of the providers. These included utilization of Headstart services, health status of children and adults, and health related knowledge and behavior of mothers with respect to reproductive health, immunizations, and STDs including HIV/AIDS.

Design and Methodology

Instrument

The instrument of the survey was a questionnaire elaborated in Spanish with the final version translated into English for the health providers. The questionnaire was pretested in the field with respondents of the intended target group. The language of the questions was modified and adapted to the local idioms. Both versions of the questionnaires are enclosed as Appendix 1 and 2.

The questionnaire had a total of 101 questions, that in addition to providing basic demographic data, also included the following primary health care topics: water and sanitation; access and satisfaction with health care services; prenatal care; breastfeeding; childhood diseases, including acute respiratory infections (ARI); family planning; immunization; growth monitoring and nutrition (under Headstart); accidents and injuries; chronic, non-communicable diseases; tuberculosis; and STDs and HIV/AIDS. The questionnaire was modeled after the Community Assessment of Primary Health Care Management Advancement Programme standard rapid surveys and adapted to the local circumstances and information needs of the providers of services.

Most of the questions were closed and precoded and only allowed one response per question. The multiple choice and continuous variable questions were recoded later, so they could be analyzed as dichotomous questions. All the answers were translated into numerical values for analytical purposes. To elicit some respondents' input, the last two questions were open ended. They asked the interviewee to name the main problems of the community and the possible actions that could be taken to solve them.

The investigator personally developed the questionnaire, pretested it, and modified it. The first version of the instrument was reviewed with the personnel of Sea Island Co. and Rural Mission to make sure that the questions were appropriate and addressed their expressed areas of concern.

Sampling

The target population were all women of Hispanic origin, of reproductive age (15-44), whose main livelihood depended at the present time on agricultural labor in Charleston County, South Carolina. Even though, as mentioned above, this was a multi-target survey, only females were chosen as respondents since they tend to be, with respect to health care, the main decision-makers of the family.[18]

The sample population was chosen among the Hispanic population of the Johns Island area and vicinity. The inclusion criteria were: Hispanic females, with children or pregnant, ages 15-44 whose main source of livelihood was derived from agricultural labor.

The sample of the population was not taken randomly. There was no certainty of the number of families living in the area at the time; estimates ranged from 25 to 40 according to the source--Rural Mission vs. Hispanic workers, for example. The size of the target population was very small. The current addresses of many of the families were not available. And above all, the personnel of Headstart program/Rural Mission for internal evaluation/planning purposes requested that I interviewed as many mothers with children in the program as feasible.

Data Collection

The method of data collection for this study consisted of formal interviews with members of this community.

All but one of the interviews were conducted in Spanish. On that occasion the interviewee was a Mayan speaker from Guatemala who could not speak Spanish; this interview was conducted in English, a language that she knew well. Most of the interviews were conducted in the interviewee's home or in a location where the interviewee felt comfortable. A period of time was spent before the interview explaining the purpose of the research and the precautions that would be taken to protect the identity of the informant. The interviews averaged half an hour in length. Only one person declined to be interviewed.

The investigator carried out all the interviews. However, since it was considered dangerous for a stranger to be in that area alone and it was believed that the families would not cooperate with strangers, even if they were Spanish speakers, the investigator was always accompanied and assisted by a member of Rural Mission or of the community who were familiar with the area and the families to be interviewed. The assistants made the introduction to the families and afterwards moved away discretely so the interviews could be carried out in privacy.

The data obtained by the survey was entered and processed by computer using the Statistical Package for the Social Sciences (SPSS). Chi-square test was used to measure the extent of the association between the variables. The cutoff point for the level of significance was set at .05.

RESULTS

Findings from survey:

Demographics:

Sex and Age of Interviewees: A total of 29 females were interviewed. Their ages ranged from 16 to 64; 69%[1] were below 31 years of age. Only one was 64 years old; she was interviewed because she was the keeper of her grandchildren after the death of their mothers.

Number of Children: Of the twenty-nine females interviewed, 5 were pregnant; two of them with their first child. One of the interviewees did not have children, although "she had been trying for a long time;" thus 10% of the sample did not have living children yet. Six (21%) had one; seven (25%) had two; another 7 had three; tree had 4; and another 3 mothers had 5 children. Which gives an average of 2.62 children/mother.

Age of Children: Thirteen (45%) respondents had no children under 2; thirteen had 1; and three had 2. Twelve (42%) had not children between 2-5; another 42% had 1; 14% (4) had 2; and one mother had three. Seventeen (59%) had no children older than 5; five (17%) had 1; one had 2; five had 3; and one had 4.

Size and Composition of Households: The average size of the households interviewed was 6.5 people, providing information for about a total of 185 people. Of those, 50 were adult males, 23 were children under 2 years of age, 33 were children aged from 2 to 5 years, and the rest consisted of children over 5 years of age and adult males and females over 45 years of age.

Country of Origin: Mexico was the country of origin of the majority (80%); followed by Guatemala (17%); only one interviewee identified herself as Mexican-American.

Level of Education: With respect to education, 21% of the interviewees had attended from 0 to 3 years of school; 55% had attended from 4 to 9 years; and 24.% had gone to an university; therefore only 21% can be considered illiterate in Spanish [19].

Proficiency in English: About 35% did not speak or understand English at all; 28% enough to communicate; and 38% could speak it and understand it. However, 41% could not read English at all; 28% some, and 31% said they could.

Occupation: The main occupation at the time of the interview of 59% of the sample was homemaker; 13% were working both as agricultural workers and housewives; 7% were currently working as maids; and 21% held different types of jobs.[20]

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[1] For the sake of simplicity and to facilitate readers review, all percentages have been rounded off to the closest whole number

Residence: Twenty-five of the respondents lived in Johns Island, 2 in Hollywood, and 2 on Edisto Island. The length of residence in the area varied: about 21% had spent up to 6 months in the area, 38% up to 11 months, and 42% 12 months. The majority (87%) of the respondents had worked/lived in the area before. Thirty-one percent were planning to go to Florida; 24% to remain in the area; 18% to go to Mexico and then return; 11% to another state; and 18% did not know.

Sanitation and Housing Conditions:

Nineteen interviewees lived in private houses and 10 (35%) in farm housing facilities. All the interviewees had full bathrooms and potable water in their houses. Only one did not have enough water to meet all the needs of her family. Most (93%) had adequate places to dispose of their garbage. In terms of heating, 42% of the households had central heating; 14% wood stoves; 7% a fireplace; and 38% had electric or gas heating portable units.

Transportation:

Except for 2 cases, the rest of the families had some form of private transportation--car, van, or truck.

Knowledge of Health Services Available:

The majority of the respondents knew about most of the services offered by the nearest health facility, in this particular case the health clinic, but for most the knowledge did not come spontaneously, proving was necessary. Very few mentioned WIC (women, infant, and children supplemental food program).

Distance to Nearest Health Care Facility: The distance to the nearest health service facility was over 3.13 miles (over an hour walking distance) for 23 (79.%) of the interviewees.

Satisfaction with Health Services: Sixty-nine percent expressed a general satisfaction with the health services available to the community. The 31% who were not satisfied gave the following reasons: 11% because of cultural/linguistic barriers; 7% because long waiting periods; 7% because they are too far away; 3.% because they did not have specialists; and the other 3% because of the cost.

Use of Headstart Facilities:

Twelve of the twenty-nine interviewees had children enrolled in the Migrant Headstart program administered by Rural Mission. The reasons that the other interviewees (10) with children under five gave for not having all/any of them there were that the child was perceived too young to go to school (3); the child got sick there (2); no need at the moment since she was not working (2); family member was taking care of child (1), the child did not like it (1), the children were treated poorly (1). Twenty-

one out of the twenty-two mothers thought the hours the center was open were convenient for their schedules/needs; the other one did not know the hours. None of them thought there was need to change the hours the center was open. Only one added that perhaps they were open too many hours already. None of the households had children with disabilities.

Health Behavior and Knowledge:

Prenatal Care: Only one mother had not received prenatal care during her last pregnancy. Some 69% sought prenatal care at the first trimester; 23% during the second; 4% during the third; and one did not remember. The total number of prenatal visits for one-third of the respondents ranged from 3 to 9; for a little more than half of them (54%) the range was 10 to 14 visits; and for 11% from 20 to 40 visits. A clinic and or a hospital was the place where all of them received the care. When asked whether they were planning to or used to breastfeed their children on third said no; and two-thirds said yes.

Family Planning: Over two-thirds of the sample (20) was using some form of family planning. Six were using pills; five had Norplant; four had had tubal ligation; two had been injected with Deproprovera; one was using rhythm method and two were using unspecified other methods. Twenty-five (86%) said they will use family planning in the future. The reasons given by the 9 women who were not using family planning at the moment were: were currently pregnant (5); wanted (more) children (2); husband did not want her to use contraception (1); and too old (1).

Childhood Immunizations: With regard to childhood immunizations, of the 28 interviewees with children; and after prompting, 75% knew about measles; 71% about polio; 61% about diphtheria; 61% about whooping cough; 68% about tetanus; and 46% about TB. All the mothers said that their youngest child under 2 years of age was vaccinated; and that the vaccinations took place in the hospital and the clinic. All of them were given a vaccination card.

STDs: Twenty of the respondents (69%) did not know what an STD was, even after probing by mentioning the better known (i.e., syphilis, gonorrhea, herpes). Of the 9 (31%) who knew, 1 did not know/did not remember how STDs are transmitted. But all 9 cases did mention how to prevent them. Their main source of information about the subject was pamphlets (3), school (2), radio/tv (2), and family/friends and health personnel.

HIV/AIDS: Seven of the interviewees (24%) could describe what HIV/AIDS was; nineteen (66%) had partial knowledge; and three (10%) flatly said they did not know. Four respondents (14%) knew all the different ways HIV is transmitted; eighteen (62%) had partial knowledge; and seven (24%) did not know/did not remember. Seven (24%) knew how to protect themselves against infection; fifteen partially; and seven did not know. Sixteen (55%) thought a pregnant mother could transmit the virus to her unborn child;

three (10%) did not think so; and ten (35%) did not know/remember. Nine said an infected mother should not breastfeed her child; five (17%) said she should; and fifteen (52%) did not know/remember. Eighteen of the respondents said there was no cure for AIDS; two said there was; and nine (31%) did not know/did not remember. The most frequent sources of information about AIDS mentioned were: tv/radio for fifteen of the interviewees (52%); pamphlets for seven (24%); health personnel for three; other source for three; and nursing school for one.

Health Status of Children and Adults:

Children: Only three of the mothers with children under 2 years of age reported their youngest having had diarrhea during the past month. One chose not to treat it; another treated it with pedialite; and the other used sugary water as remedy. As for ARI, eleven mothers (42%) reported their children having had problems during the past 2 weeks. Of those, nine (82%) gave the child some type of medication; one treated the child with some form of home remedy such a honey water, and the other one chose no treatment at all. A little less than one-third of the respondents (31%) reported their children having had another type of health problem in the past two weeks; which included 5 cases of otitis, and one case each of conjunctivitis, allergy, and asthma.

Adults: Four interviewees reported an accident involving an adult member of the household during the past year; two were work related; only one needed hospitalization/treatment. Four of the respondents (13.8 %) said one of the members of the household had diabetes and 2 did not know if there was any; in all four cases the person had been able to follow the treatment. Five cases of hypertension were reported, and one interviewee did not know; in all five cases the person had no problem following the treatment. There were five cases of anemia, and again one interviewee did not know; again the treatment was followed without difficulty. There was only one case of TB, and the treatment was followed. Seven respondents reported other diseases afflicting the adult members of the household: 3 cases of asthma; 1 of ovarian disorder; 1 of flu; 1 nerves/incapacity of concentration; 1 of vitamin deficiency; five of the seven adults were able to follow the treatment without problems; but one was having problems paying for her asthma treatment and the other (nerves) was too busy taking care of the family to visit a clinic.

Content of Open ended Questions--Major problems of the community and their solution:

Problems: Six respondents did not think the community had any major problems or had no opinion. The rest gave the following answers (some gave more than one): linguistic barriers (9), lack of transportation (4), lack of interpreters/bilingual personnel (3), alcohol abuse (3), confusion about clinic fees (2), need for more teachers for their children (2), need to legalize residence status (2), housing problems (1), fear to complain about headstart program (1), lack of support system between members of

community (1), and too much concern about other people's affairs (1).

Solutions: More English courses for adults (6), more bilingual personnel/interpreters (4), a system of transportation to key places (i.e., clinic, food stores) (2), organization of communal support system (1), report drunk's disorderly conduct to authorities (1), move to another area (1), stay away from people (1).

Description of Results of Bivariable Analysis:

A bivariable analysis looking at association of language and education variables with knowledge of health services indicated that those more able to speak/understand English were the ones who knew more about the services offered by the clinic. The school level of the interviewee did not seem to influence that knowledge.

Neither language proficiency nor level of education was a predictor of whether or not the interviewee was, in general, satisfied with the health services available to the community.

Language, more than level of education, appeared to influence positively the knowledge of which diseases can be prevented by immunization. However, neither education nor language proficiency appeared to influence the mothers knowledge about TB testing.

The correlation between the level of education of the person and their knowledge about venereal diseases was positive. But it was more so by language proficiency. However, there was no association between knowledge of how STDs are transmitted with either schooling and or proficiency in the English language of the interviewee.

With respect to HIV/AIDS, the school level of the respondent was correlated positively with the knowledge of the disease, its mode of transmission, prevention, and whether there was a cure or not. The association was not significant with regard to the knowledge of whether an infected pregnant mother can transmit the virus to the child, or if the mother should continue to breast feed. The respondents' proficiency in English in this particular case showed no correlation with their knowledge about any aspect of HIV/AIDS. These results seem to suggest that the respondents' knowledge about HIV/AIDS comes from Spanish written or speaking sources.

And, as could be expected, the level of education of the interviewee was positively correlated with their proficiency in the English language, particularly with respect to their ability to read in English.[21]

DISCUSSION and RECOMMENDATIONS

Due to sampling limitations substantive findings may be applicable only to this specific group. Any conclusions drawn from the analysis must be considered as guidelines only, given that the sample was not drawn randomly. In addition, the list of households that I interviewed was given to me by the Headstart personnel and the Mexican assistant, therefore the possibility that the interviewees share many characteristics in common not found among the rest can not be discarded. The presence of a employee of Headstart program might have influenced their answers with respect to their opinion about the program; the presence of a member of the community might have also influenced other answers, including those related to their perception of community problems and their solutions. The opinion and perception of the female respondents might not correspond to that of their husbands and or male heads of the family.

Furthermore, I was only able to collect information about the health status of 185 members of the community out of the estimated 450; those estimates might have underestimated the actual size of the population. An additional limitation of the study was that it was carried out during the fall season, when the population size is at its lowest point. Moreover, the characteristics of the families that remain/work in the area at this time of the year might differ considerably from those that come in the spring. Despite such limitations, I believe that the data collected by the study will provide general but useful information to the health providers of this area for this specific population.

Be that as it may, the study suggests that there are several areas that could be addressed to facilitate the delivery of services to this population, the most salient are: language and level of education deficiencies of the respondents, a certain degree of dissatisfaction with the health services available, mostly due to cultural and linguistic barriers and long waiting periods; need to encourage preventive care, and deficiencies in knowledge about childhood immunizations and sexually transmitted diseases including HIV/AIDS. Additional related areas of concern, expressed by more than one respondent, that could be addressed by the providers of services are lack of transportation, lack of interpreters/bilingual personnel, alcohol abuse, and confusion about clinic fees.[2]

Based on the findings, the following recommendations could be made:

Since approximately one-third of the mothers could not speak, understand, or read English, health educational and other materials should be developed in both languages.

About one-fifth of the sample are illiterate in Spanish, educational materials that suit their needs should be developed, in an oral or pictorial/representation form.

Full time bilingual personnel is needed, particularly at the clinic. The rules and regulations of the clinic, particularly the fees, and reasonable waiting periods should be delineated clearly and the information made available to the patients in a clear and understandable manner. These should be in a written and oral form in both Spanish and English.

Health education workshops could be organized at common gathering places such as the clinic and Rural Mission. Topics to be covered during the workshops should include areas where health knowledge has been documented to be deficient: WIC, prenatal care, children's immunization, and STDs, including HIV/AIDS. Ideally, these topics should be addressed by providers of services highly familiar with the culture, since the cultural norms that condition male/female sexual relationships among these Hispanic groups should be taken into consideration when designing appropriate talks, materials, and visual presentations.

Counseling/treatment for those who seek help for substance abuse should be readily available. Active educational efforts should be undertaken to address alcohol abuse among this particular group.

Providers should also seek the involvement of community members in the stages of development of those health education efforts, particularly in the design and implementation of informal teaching and outreach activities to assure that they are culturally sensitive.

Resources should be channelled to provide transportation to mothers/caretakers in regular basis, to facilitate access to the health services and to encourage visits to the clinic for routine or preventive care, including prenatal care.

Since the clinic is the nearest health facility for most interviewees, and the most frequently visited, information about health related issues should be available to them there. And the same could apply to the Headstart program premises. A list of services and of the various agencies that provide services for migrants should be developed and distributed to the providers for referral purposes. The providers of services should be encouraged to distribute this information, together with their own, to migrants who seek their services.

Further studies of the migrant/seasonal populations should be carried out in this area, particularly during the peak season in the spring.

Most of the findings of this study and the recommendations derived from the findings are consistent with other studies of migrant populations, including the need for educational materials in both Spanish and English, culturally sensitive, the need to involve the community in the development of health educational programs, the need of bilingual personnel, the need to address behavioral problems associated with isolation, such as alcohol

abuse, and the need to encourage preventive care visits, to improve access to the health services, to develop a resource directory, and to carry out further studies about migrant and seasonal populations.

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8. ibid

9. ibid

10. Jones, J et al. "HIV-Related Characteristics of Migrant Workers in Rural South Carolina." Southern Medical Journal. Vol 84, No.9 September 1991 pp. 1088-1090

11. Source: Rural Manpower Service. S.C. State Employment Service.

12.12. Sea Island Co. personnel, personal communication

13. Johns Island, Wadmlaw Island, Edisto Island and the Ravenel area comprise the region known as The Sea Islands West area. (See MAPS enclosed).

14. Source: Rural Mission and Sea Island Corporation records.

15. Sea Island Corporation, unpublished document. June 1993

16. Ibid

17. See enclosed brochures

18. This statement applies to most Spanish speaking populations. Source: Kjell I. Enge, PhD. Medical Anthropology; area of expertise: Latin America. Polly Harrison, PhD. Medical Anthropology; area of expertise: Latin America.

19. A person that has completed grade four in Mexico is supposed to know how to read and write. I asked those who said from 0-3 if, nevertheless, they knew how to read and write. They said no.

20. I was told by several interviewees that most of the females will work in the fields if there is work available.

21. See Appendix III

22. See Appendix IV

Name of interviewer #
Date of Interview __/__/__/

SECTION 1: IDENTIFICATION

Q1 Interview #

Q2 Province/Island #

Q3 Respondent's address
farm (1) private home (2)
trailer/mobile home (3) other (4)

Q4 Respondent's name _____
(#-- same as questionnaire#)

Q5 Sex: female (1) male (2)

Q6 How old are you? . . (years)

Q7 Were are you from?
Mexico (1) Guatemala (2) Other C.A. (3)
Puerto Rico (4) Mex/Am (5) Other (6)

Q8 Education/grade completed?
(if none, ask if able to read and write)
(10 = college/university)

Q9 Can you understand English?
yes (1) no (0) enough to manage/basics (2)

Q10 Can you speak English?
yes (1) no (0) enough to be understood/basics (2)

Q11 Can you read English?
yes (1) no (0) enough/basics (2)

Q12 Occupation (principal):
Housewife (1) Agri-worker (2)
Both (3) Maid (4) Other (5)

Q13 How long do you live/work in this area?
months __ weeks ___

Q14 Have you lived/worked in this area before?
yes (1) no (2) dk/dr (9)

Q15 Where do you plan to go when you leave the area?
country of origin (1) Florida (2)
other state (3) they remain here (4)
dk/dr (9)

Q16 Do you have your own means of transportation?
yes (1) no (0) other (2)

Q17 How many people live in this household?
total
males (adult)
'married' women of reproductive age (15-44)
currently pregnant women
women older than 44
children less than 24 months of age
children 2-5 years old
children over 5 years old

SECTION 2: WATER SUPPLY, AND SANITATION

Q20 Do you have indoor plumbing in your house?
yes (1) no (0)

Q21 Do you have enough running water all year/length of stay?
yes (1) no (0) not always (2) dk/dr (9)

Q22 What source of heating do you have?
central (1) none (0)
wood stove (2) portable unit (3)

Q23 What type of sanitary facility do you use?
water-seal, WC, laetrine __ (1)
open field, bucket __ (2)

Q24 Do you have special places to dispose of your garbage?
yes (1) no (0) dk/dr (9)

SECTION 3: HEALTH CARE SERVICES AVAILABILITY

Q30 How far away from your house is the nearest health service?
(3.13 miles = 1 hour walk)
Less than 60 min.walk (1)
More than 60min walk (2)
DK/NR (9)

Q31 Which health services are available there?

Maternal/child care	yes (1)	no (0)	DK/DR (9)
Family Planning	yes (1)	no (0)	DK/DR (9)
Immunization	yes (1)	no (0)	DK/DR (9)
Medical attention	yes (1)	no (0)	DK/DR (9)
Dental health	yes (1)	no (0)	DK/DR (9)
Mental health	yes (1)	no (0)	DK/DR (9)
Other	yes (1)	no (0)	DK/DR (9)

SECTION 4: ANTENATAL CARE

Q40 How many children do <u>you</u> have? total
less than 24 months of age
2-5 years old
older than 5
none **[go to Q100]**

Q41 Did you receive antenatal care during your last pregnancy?
yes (1) no (0) [go to Q50] DK/DR __ (9) [go to Q50]

Q42 How many months had you been pregnant before you got antenatal care?

3 mo.	(first trimester)	(1)
4-6 mo.	(second trimester)	(2)
7-9 mo.	(third trimester)	(3)
DK/DR		(9)

Q43 How many times did you get the care?
no.times ____ [if DK/DR enter 99]

Q44 Which is the principal place where you received antenatal care?

Hospital, clinic, doctor	(1)
Local TBA, healer, other	(2)
DK/DR	(9)

SECTION 5: BREAST FEEDING

Q50 Do you usually breast feed your babies?
yes (1) no (0) DK/DR (9)

SECTION 6 : DIARRHOEA DISEASE CONTROL

Q60 Has the oldest child under 2 had diarrhoea in the last month?
yes (1) no (0) **[Go Q70]** DK/DR (9) **[Go Q70]**

Q61 How did you treat him/her?
Medication (1) ORS (2) home made fluids (3)
pedialite (4) did not (0) DK/DR (9)
other (5)

SECTION 7: ACUTE RESPIRATORY INFECTIONS

Q70 Have any of your children been sick from a respiratory illness within the last 2 weeks? (flu, bronquitis)
yes (1) no (0) **[Go Q80]** DK/DR (9) **[Go Q80]**

Q71 Did you give him/her some type of treatment?
medicine (1) no (0) DK/DR (9)
other _____

SECTION 8: OTHER CHILDHOOD DISEASES

Q80 Has your child been sick of any other disease in the last month? (write down disease)
yes (1) no (0)

SECTION 9: CHILD IMMUNIZATION

Q90 Do you know which childhood diseases can be prevented by immunization?

Diphtheria	yes (1)	no (0)	DK/DR (9)
Measles	yes (1)	no (0)	DK/DR (9)
Tetanus	yes (1)	no (0)	DK/DR (9)
Whooping cough	yes (1)	no (0)	DK/DR (9)
Polio	yes (1)	no (0)	DK/DR (9)
Tuberculosis	yes (1)	no (0)	DK/DR (9)

Q91 Has your oldest child under 2 been immunized?
yes (1) no (0)**[Go Q100]** DK/DR (9)**[Go Q100]**

Q92 Where was he immunized?

doctor/clinic, hosp	(1)
health dept.	(2)
farm	(3)
other	(4)
DK/DR	(9)

Q93 Do you have the immunization card for this child?
yes (1) no (0)

SECTION 10: GROWTH MONITORING/NUTRITION: HEADSTART

Q100 Are all your children under 5 registered in the Headstart program?
yes (1) **[Go Q102]** no (0) DK/DR (9)**[Go Q104]**

Q101 Why not?
_____
_____

Q102 Are the center's hours convenient for you?
yes (1)**[Go Q104]** no (0)

Q103 Which hours would be more convenient for you?
hours _____

Q104 Do you have children with disabilities?
yes (1) no (0)

SECTION 11: FAMILY PLANNING (for all the respondents)

Q110 Are you or your husband currently using any family planning method?
yes (1) no (0)**[Go Q113]** DK/DR (9)**[Go Q113]**

Q131 Where you able to follow the prescribed treatment?
yes (1) no (0) DK/DR (9)

Hypertension

Q132 Have you or any household member ever been told by a health care provider that you have hypertension?
yes (1) no (0)**[Go Q134]** DK/DR (9) **[Go Q134]**

Q133 Where you able to follow the prescribed diet/medication?
yes (1) no (0) DK/DR (9)

Anaemia

Q134 Have you or any household member ever been told by a health care provider that you have anemia?
yes (1) no (0) **[Go Q136]** DK/DR (9) **[Go Q136]**

Q135 Where you able to follow the special diet or supplements prescribed?
yes (1) no (0) DK/DR (9)

Other

Q136 Any other disease that I have not mentioned?
yes (1) no (0) **[Go Q140]** DK/DR (9) **[Go Q140]**

Q137 Where you able to follow the diet/treatment prescribed?
yes (1) **[Go Q140]** no (0) DK/DR (9) **[Go Q140]**

Q138 Why not? (applies to all four questions)

	D	H	A	O
service unavailable	(1)	(1)	(1)	(1)
too costly	(2)	(2)	(2)	(2)
lack of transportation	(3)	(3)	(3)	(3)
too busy/child keeping	(4)	(4)	(4)	(4)
language barriers	(5)	(5)	(5)	(5)
bad personal treatment	(6)	(6)	(6)	(6)
poor quality services	(7)	(7)	(7)	(7)
long waiting periods	(8)	(8)	(8)	(8)
DK/DR	(99)	(99)	(99)	(99)
other	(10)	(10)	(10)	(10)

SECTION 14: TUBERCULOSIS

Q140 Have you or any family members ever been diagnosed TB?
yes (1) no (0) **[Go Q150]** DK/DR (9) **[Go Q150]**

Q141 Were you able to follow the treatment prescribed for the recommended period of time?
yes (1) **[Go Q150]** no (0) DK/DR __ (9) **[Go Q150]**

Q142 Why not?

service unavailable	(1)
too costly	(2)
lack of transportation	(3)
too busy/child keeping	(4)
language barriers	(5)
bad personal treatment	(6)
poor quality services	(7)
long waiting periods	(8)
DK/DR	(99)
other	(10)

SECTION 15-16: SEXUALLY TRANSMITTED DISEASES, HIV/AIDS

Q150 Do you know what is meant by a sexually transmitted disease? (ask for example)

yes (1) no (0) **[Go Q160]**

Q151 Do you know how people get STDs?

correct answer (1) DK/DR (9)
incorrect answer (2)

Q152 Do you know how to protect yourself against STDs?

correct answer (1) DK/DR (9)
incorrect answer (2)
partial knowledge (3)

Q153 Which is your primary source of STDs information?

friends/relatives	(1)
health personnel	(2)
radio/tv	(3)
magazines/news p.	(4)
pamphlets	(5)
other source	(6)
DK/DR	(7)

Q160 Do you know what HIV/AIDS is? (probe for explanation)

correct knowledge (1) DK/DR (9)
incorrect knowledge (2)
partially correct knowledge (3)

Q161 Do you know how people get HIV/AIDS?

correct knowledge (1) DK/DR __ (9)
incorrect knowledge (2)
partially correct knowledge (3)

Q162 Do you know how to protect yourself against HIV/AIDS?

correct knowledge (1) DK/DR __ (9)
incorrect knowledge (2)
partially correct knowledge (3)

Q163 Can a pregnant woman who is infected with HIV give the virus to her unborn child?
yes (1) no (0) DK/DR (9)

Q164 Should an HIV infected mother continue to breast feed?
yes (1) no (0) DK/DR (9)

Q165 Is there a cure for AIDS?
yes (1) no (0) DK/DR (9)

Q166 Which is your primary source of HIV/AIDS information?

friends/relatives	(1)
health personnel	(2)
radio/tv	(3)
magazines/news p.	(4)
pamphlets	(5)
other source	(6)
DK/DR	(7)

SECTION 17: SATISFACTION WITH HEALTH SERVICES

Q170 Are you satisfied with the health services provided to the community?
yes (1) no (0) no opinion (2)

Q171 Why not?

not enough/insufficient	(1)
too far away/lack of access	(2)
language/cultural barriers	(3)
poor quality of services	(4)
they don't treat us well	(5)
charges ($)	(6)
we have to wait a long time	(7)
other	(8)

In your opinion, what are the main problems of the migrant community in this area?

_____
_____
_____
_____

What do you think needs to be done to solve them?

_____
_____
_____
_____

THIS CONCLUDES THIS INTERVIEW, THANK YOU FOR TAKING THE TIME TO PARTICIPATE IN THIS SURVEY

APPENDIX III

Bivariable analysis of respondent variables with knowledge of health services:

Applicable number of cases: 29

Level of education by knowledge of **Maternal/Child care** services:

Variable:	Yes knows	No doesn't know	Level of Significance
Level of education	27	2	.26284

English proficiency by knowledge of **Maternal/Child care** services:

Variable	Yes knows	No does not know	Level of Significance
English understanding ability	27	2	.12993
English speaking ability	27	2	.12993
English reading ability	27	2	.21836

Level of education by knowledge of **Family Planning** services:

Variable:	Yes knows	No doesn't know	Level of Significance
Level of education	19	10	.42990

English proficiency by knowledge of **Family Planning** services:

Variable	Yes knows	No does not know	Level of Significance
English understanding ability	19	10	.05699.
English speaking ability	19	10	.05699
English reading ability	19	10	.03326

Level of education by knowledge of **Immunization** services:

Variable:	Yes knows	No doesn't know	Level of Significance
Level of education	28	1	.19641

English proficiency by knowledge of **Immunization** services:

Variable	Yes knows	No does not know	Level of Significance
English understanding ability	28	1	.37384
English speaking ability	28	1	.37384
English reading ability	28	1	.48016

Level of education by knowledge of **Medical attention** services:

Variable:	Yes knows	No doesn't know	Level of Significance
Level of education	29	0	.*

* = statistics cannot be computed when the number of non-empty rows or columns is one

English proficiency by knowledge of **Medical attention** services:

Variable	Yes knows	No does not know	Level of Significance
English understanding ability	29	0	.*
English speaking ability	29	0	.*
English reading ability	29	0	.*

* = statistics cannot be computed when the number of non-empty rows or columns is one

Level of education by knowledge of **Dental health** services:

Variable:	Yes knows	No doesn't know	Level of Significance
Level of education	26	3	.33847

English proficiency by knowledge of **Dental health** services:

Variable	Yes knows	No does not know	Level of Significance
English understanding ability	26	3	.49334
English speaking ability	26	3	.49334
English reading ability	26	3	.48482

Level of education by knowledge of **Mental health** services:

Variable:	Yes knows	No doesn't know	Level of Significance
Level of education	5	24	.04816

English proficiency by knowledge of **Mental health** services:

Variable	Yes knows	No does not know	Level of Significance
English understanding ability	5	24	.00522
English speaking ability	5	24	.00522
English reading ability	5	24	.01447

Level of education by knowledge of **other services:**

Variable:	Yes knows	No doesn't know	Level of Significance
Level of education	13	16	.24240

English proficiency by knowledge of **other services:**

Variable	Yes knows	No does not know	Level of Significance
English understanding ability	13	16	.00850
English speaking ability	13	16	.00850
English reading ability	13	16	.00879

Bivariable analysis of respondent variables with knowledge of childhood immunizations

Applicable number of cases: 28

Level of education by knowledge of vaccine against **diphtheria:**

Variable:	Yes knows	No doesn't know	Level of Significance
Level of education	17	11	.03408

English proficiency by knowledge of vaccine against **diphtheria:**

Variable	Yes knows	No does not know	Level of Significance
English understanding ability	17	11	.04507
English speaking ability	17	11	.04507
English reading ability	17	11	.20247

Level of education by knowledge of vaccine against **measles:**

Variable:	Yes knows	No doesn't know	Level of Significance
Level of education	21	7	.11329

English proficiency by knowledge of vaccine against **measles:**

Variable	Yes knows	No does not know	Level of Significance
English understanding ability	21	7	.03567
English speaking ability	21	7	.03567
English reading ability	21	7	.10837

Level of education by knowledge of vaccine against **tetanus:**

Variable:	Yes knows	No doesn't know	Level of Significance
Level of education	19	9	.03680

English proficiency by knowledge of vaccine against **tetanus:**

Variable	Yes knows	No does not know	Level of Significance
English understanding ability	19	9	.00319
English speaking ability	19	9	.00319
English reading ability	19	9	.02075

Level of education by knowledge of vaccine against **whooping cough:**

Variable:	Yes knows	No doesn't know	Level of Significance
Level of education	17	11	.73020

English proficiency by knowledge of vaccine against **whooping cough:**

Variable	Yes knows	No does not know	Level of Significance
English understanding ability	17	11	.03468
English speaking ability	17	11	.03468
English reading ability	17	11	.11989

Level of education by knowledge of vaccine against **polio:**

Variable:	Yes knows	No doesn't know	Level of Significance
Level of education	20	8	.02882

English proficiency by knowledge of vaccine against **polio:**

Variable	Yes knows	No does not know	Level of Significance
English understanding ability	20	8	.02302
English speaking ability	20	8	.02302
English reading ability	20	8	.09418

Level of education by knowledge of vaccine against **tuberculosis:**

Variable:	Yes knows	No doesn't know	Level of Significance
Level of education	13	15	.69174

English proficiency by knowledge of vaccine against **tuberculosis:**

Variable	Yes knows	No does not know	Level of Significance
English understanding ability	13	15	.07875
English speaking ability	13	15	.07875
English reading ability	13	15	.08707

Bivariable analysis of respondent variables with knowledge of Sexually Transmitted Diseases (STDs)

Applicable number of cases: 29
Level of education by knowledge of meaning of **STDs:**

Variable:	Yes knows	No doesn't know	Level of Significance
Level of education	9	20	.02955

English proficiency by knowledge of meaning of **STDs:**

Variable	Yes knows	No does not know	Level of Significance
English understanding ability	9	20	.01540
English speaking ability	9	20	.01540
English reading ability	9	20	.00724

Level of education by knowledge of STDs **means of transmission:**
Applicable number of cases: 9

Variable:	Yes knows	No doesn't know	Level of Significance
Level of education	8	1	.32465

English proficiency by knowledge of STDs **means of transmission:**
Applicable number of cases: 9

Variable	Yes knows	No does not know	Level of Significance
English understanding ability	8	1	.23568
English speaking ability	8	1	.23568
English reading ability	8	1	.23568

Bivariable analysis of respondent variables with knowledge of HIV/AIDS

Applicable number of cases: 29
Level of education by knowledge of meaning of **HIV/AIDS:**

Variable:	Yes knows	No doesn't know	Level of Significance
Level of education	7	22	.00482

English proficiency by knowledge of meaning of **HIV/AIDS:**

Variable	Yes knows	No does not know	Level of Significance
English understanding ability	7	22	.13374
English speaking ability	7	22	.13374
English reading ability	7	22	.26459

Level of education by knowledge of **mode of transmission** of HIV/AIDS:

Variable:	Yes knows	No doesn't know	Level of Significance
Level of education	4	25	.06367

English proficiency by knowledge of **mode of transmission** of HIV/AIDS:

Variable	Yes knows	No does not know	Level of Significance
English understanding ability	4	25	.13860
English speaking ability	4	25	.13860
English reading ability	4	25	.23848

Level of education by knowledge of **prevention** against HIV/AIDS:

Variable:	Yes knows	No doesn't know	Level of Significance
Level of education	7	22	.05271

English proficiency by knowledge of **prevention** against HIV/AIDS:

Variable	Yes knows	No does not know	Level of Significance
English understanding ability	7	22	.11548
English speaking ability	7	22	.11548
English reading ability	7	22	.09802

Level of education by knowledge of HIV transmission **pregnant mother to child:**

Variable:	Yes knows	No doesn't know	Level of Significance
Level of education	16	13	.15318

English proficiency by knowledge of HIV transmission **pregnant mother to child:**

Variable	Yes knows	No does not know	Level of Significance
English understanding ability	16	13	.99406
English speaking ability	16	13	.99406
English reading ability	16	13	.72024

Level of education by knowledge of appropriateness of HIV **infected mother breastfeeding** child:

Variable:	Yes knows	No doesn't know	Level of Significance
Level of education	5	24	.48929

English proficiency by knowledge of appropriateness of HIV **infected mother breastfeeding** child:

Variable	Yes knows	No does not know	Level of Significance
English understanding ability	5	24	.73832
English speaking ability	5	24	.73832
English reading ability	5	24	.57470

Level of education by knowledge of **cure** against HIV/AIDS:

Variable:	Yes knows	No doesn't know	Level of Significance
Level of education	2	27	.06738

English proficiency by knowledge of **cure** against HIV/AIDS:

Variable	Yes knows	No does not know	Level of Significance
English understanding ability	2	27	.43260
English speaking ability	2	27	.43260
English reading ability	2	27	.71675

Bivariable analysis of respondent variables with satisfaction with health services available to the community

Applicable number of cases: 29
Level of education by **satisfaction with health services** available to the community:

Variable:	Yes knows	No doesn't know	Level of Significance
Level of education	20	9	.98265

English proficiency by **satisfaction with health services** available to the community:

Variable	Yes knows	No does not know	Level of Significance
English understanding ability	20	9	.41195
English speaking ability	20	9	.41195
English reading ability	20	9	.14794

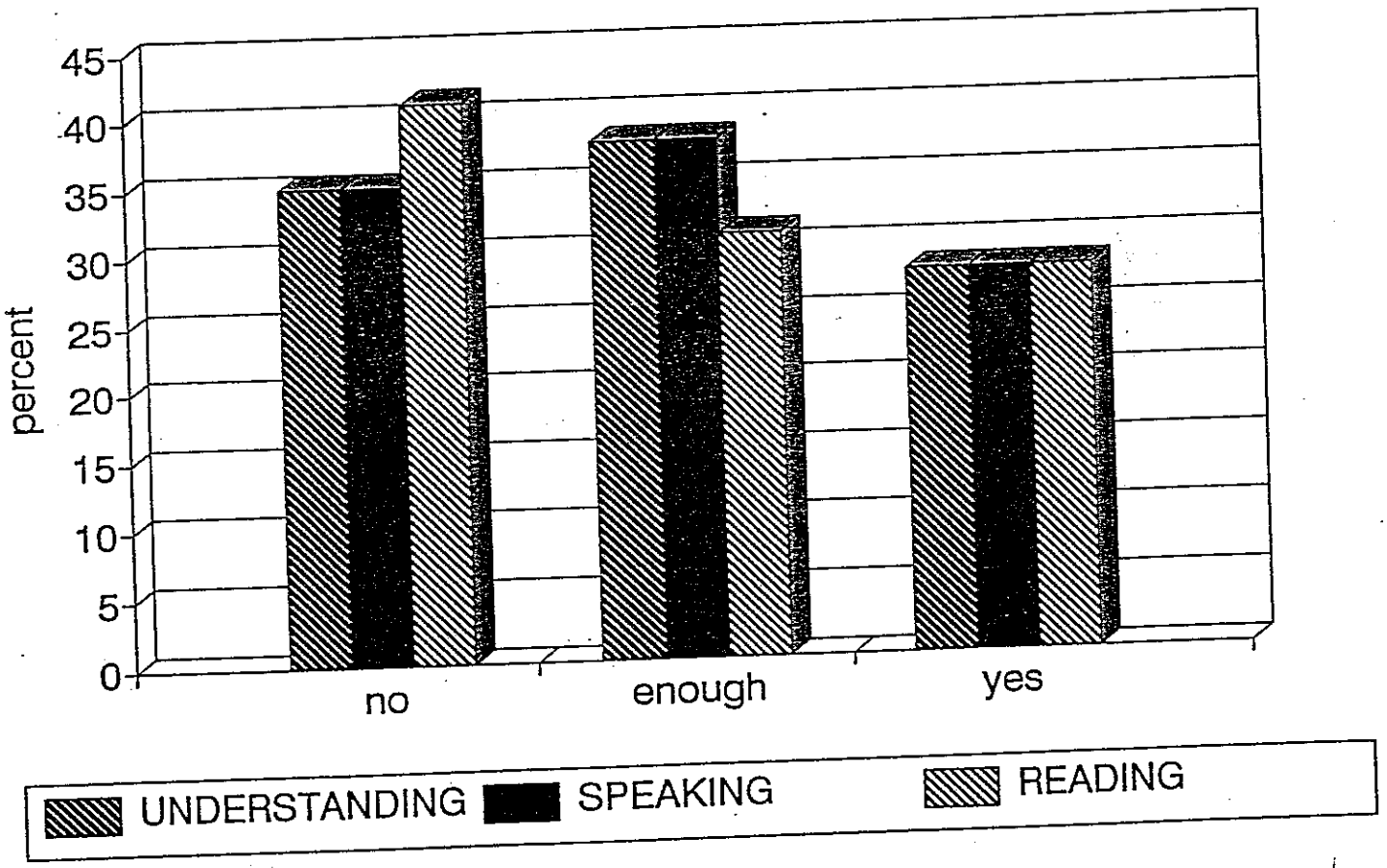
Bivariable analysis of respondent variables: level of education by English proficiency:

Applicable number of cases: 29
Significance levels:

Variable	Understanding	Speaking	Reading
Level of Education	.05129	.05129	.03262

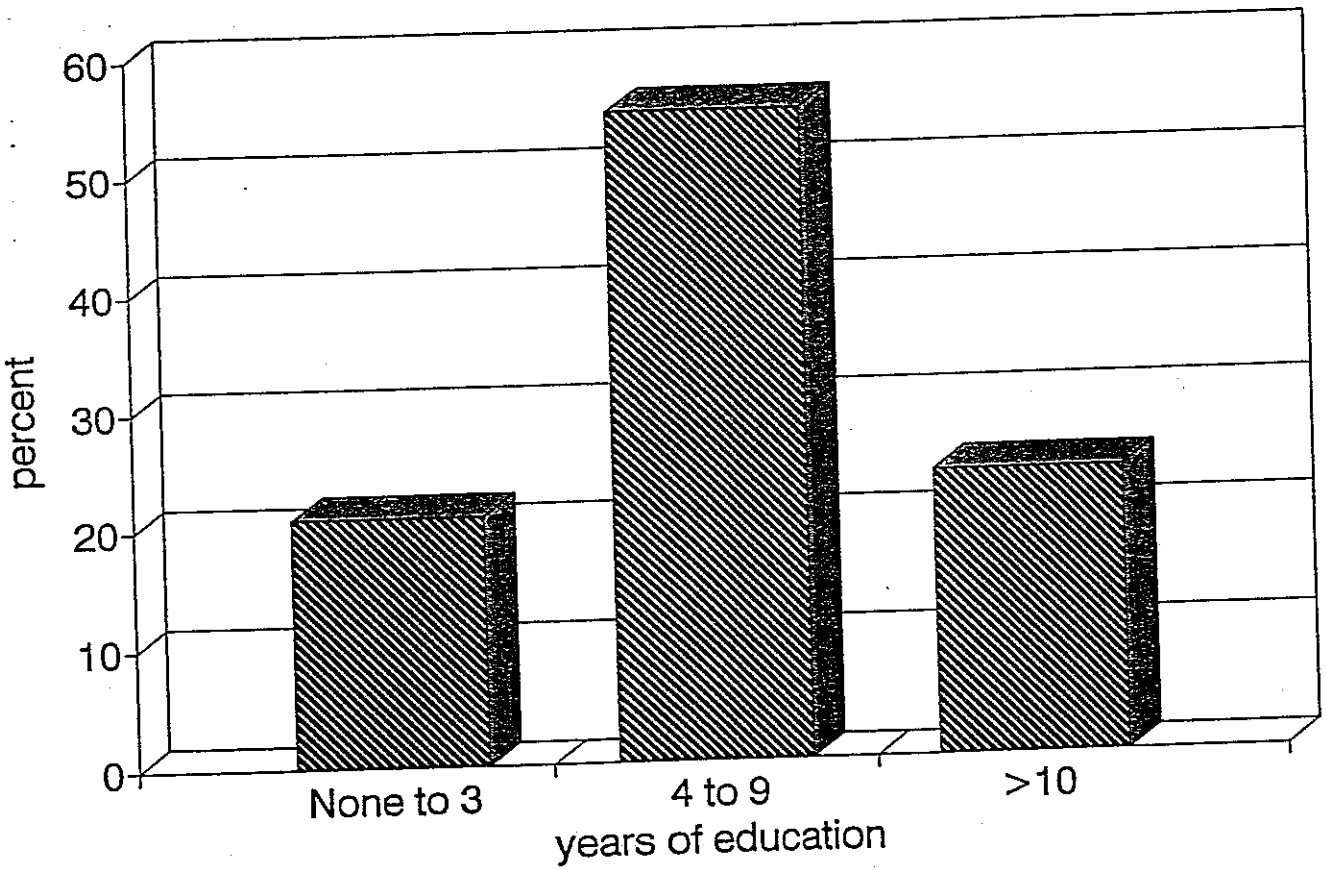
ENGLISH PROFICIENCY

n = 29



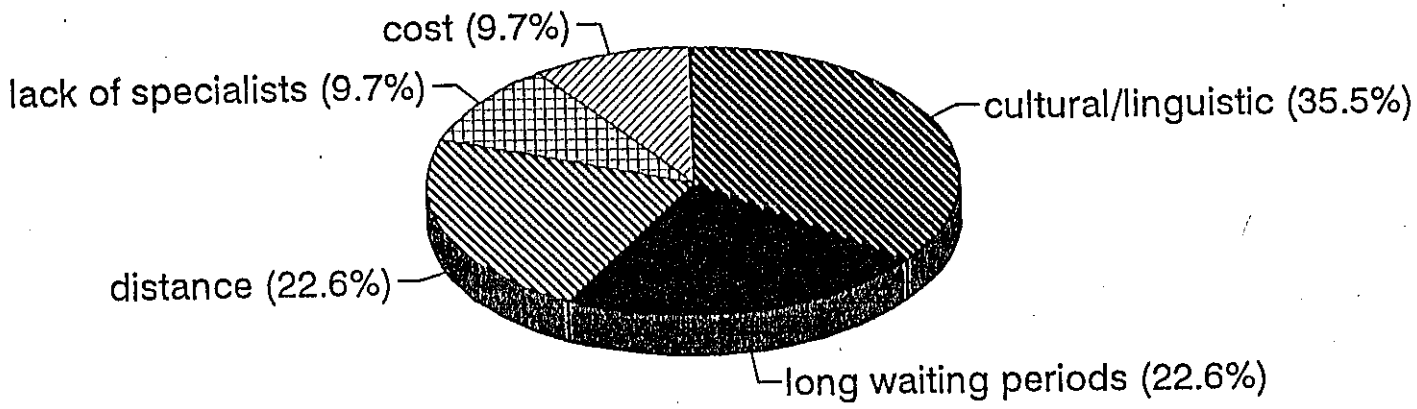
RESPONDENTS' EDUCATIONAL LEVEL

n = 29



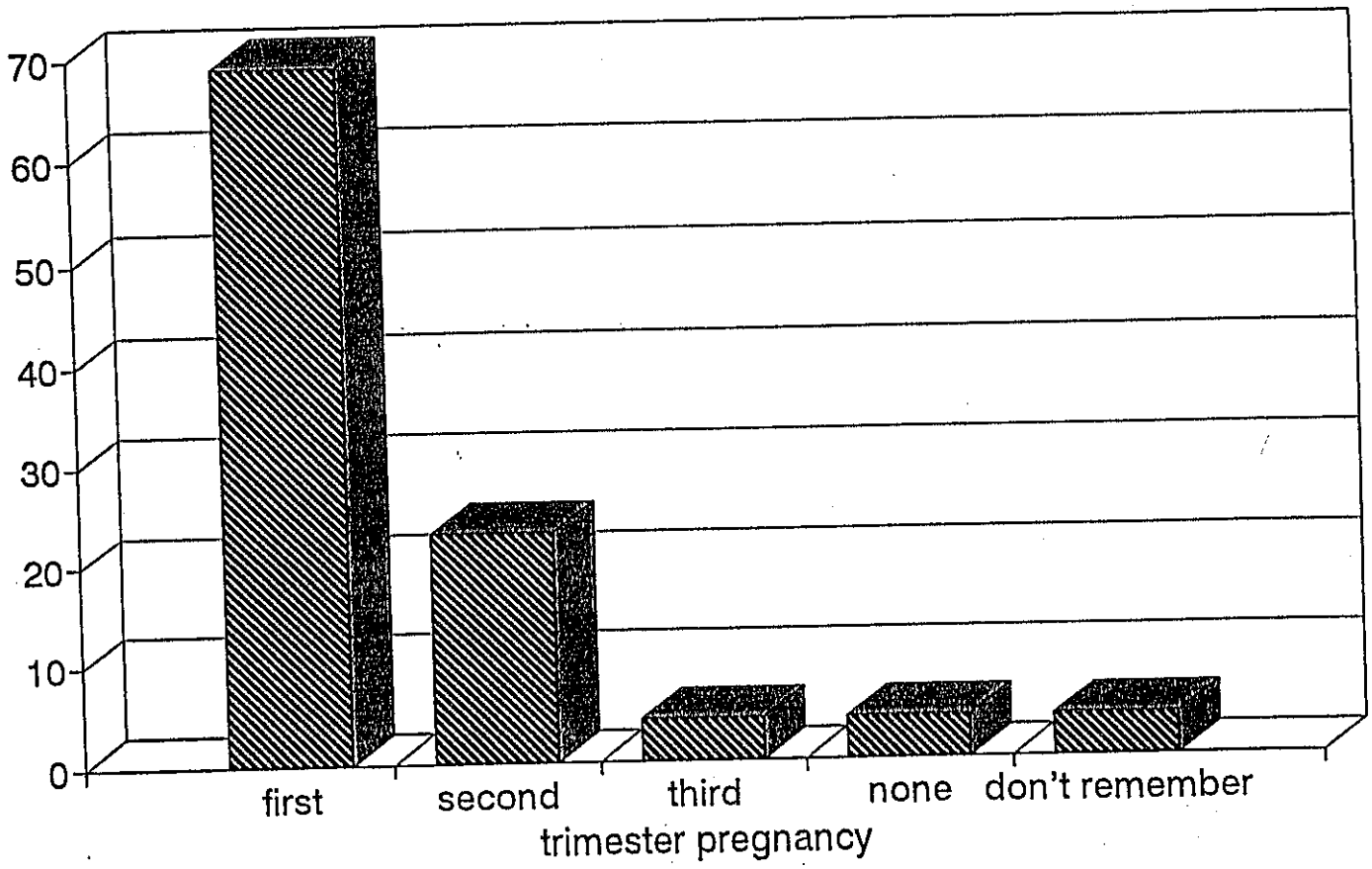
Disatisfaction with Health Services

n = 9 (33%)



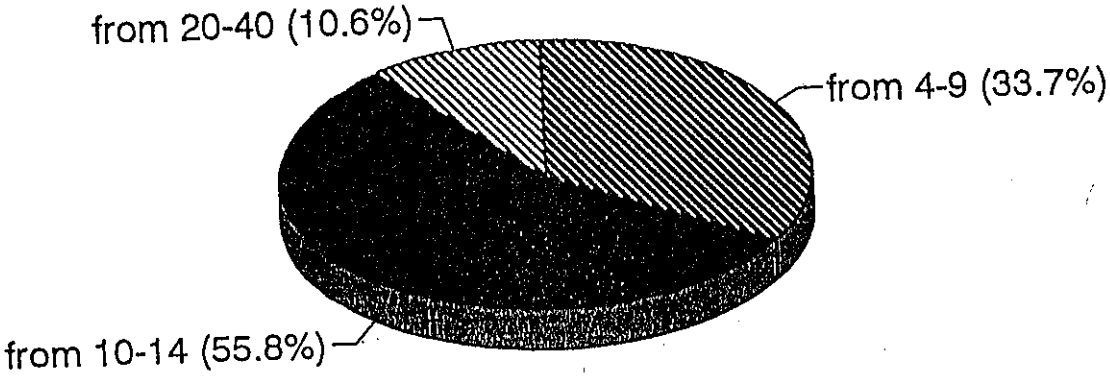
Prenatal Care

n = 27



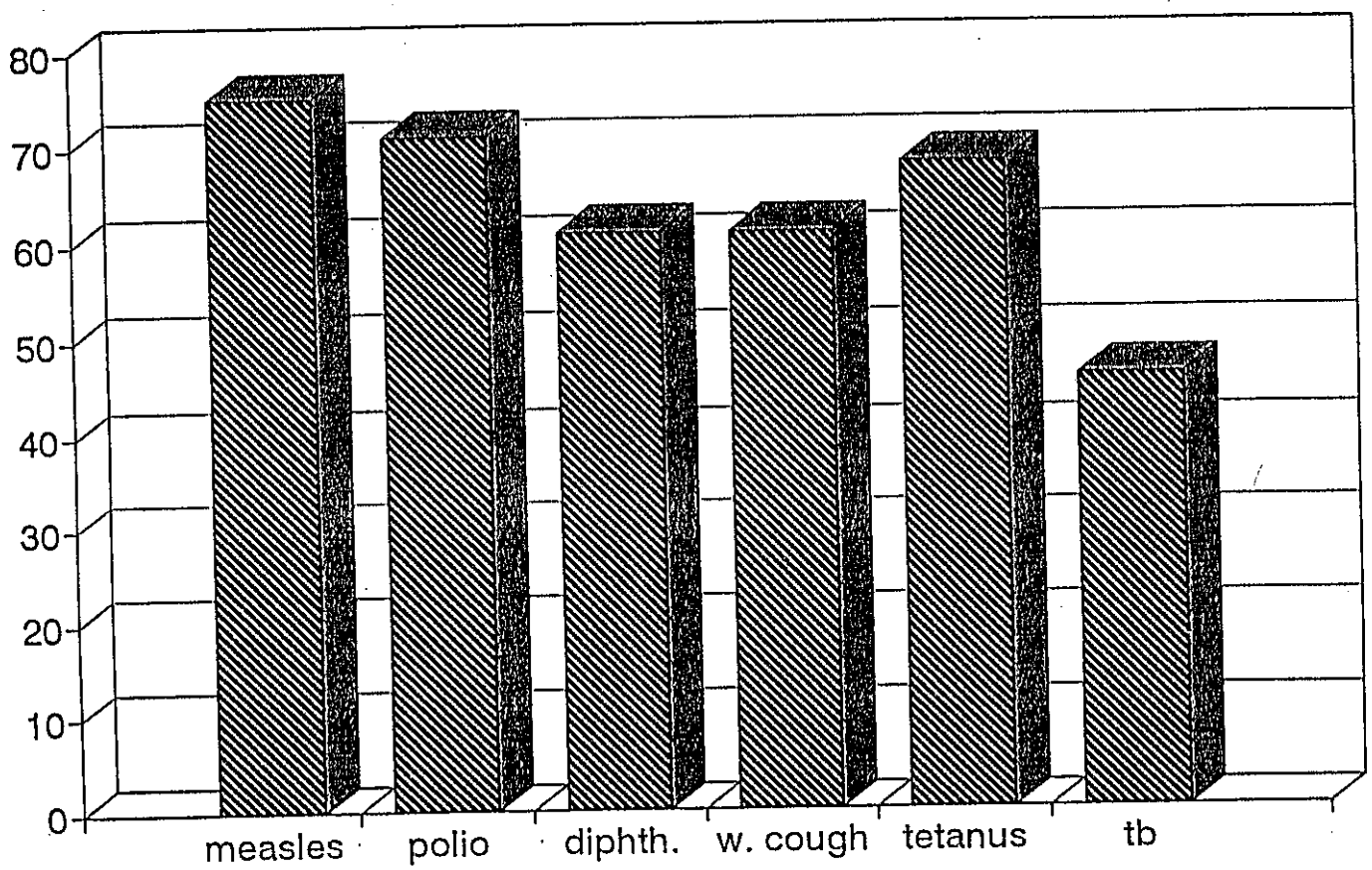
Prenatal Visits

n = 26



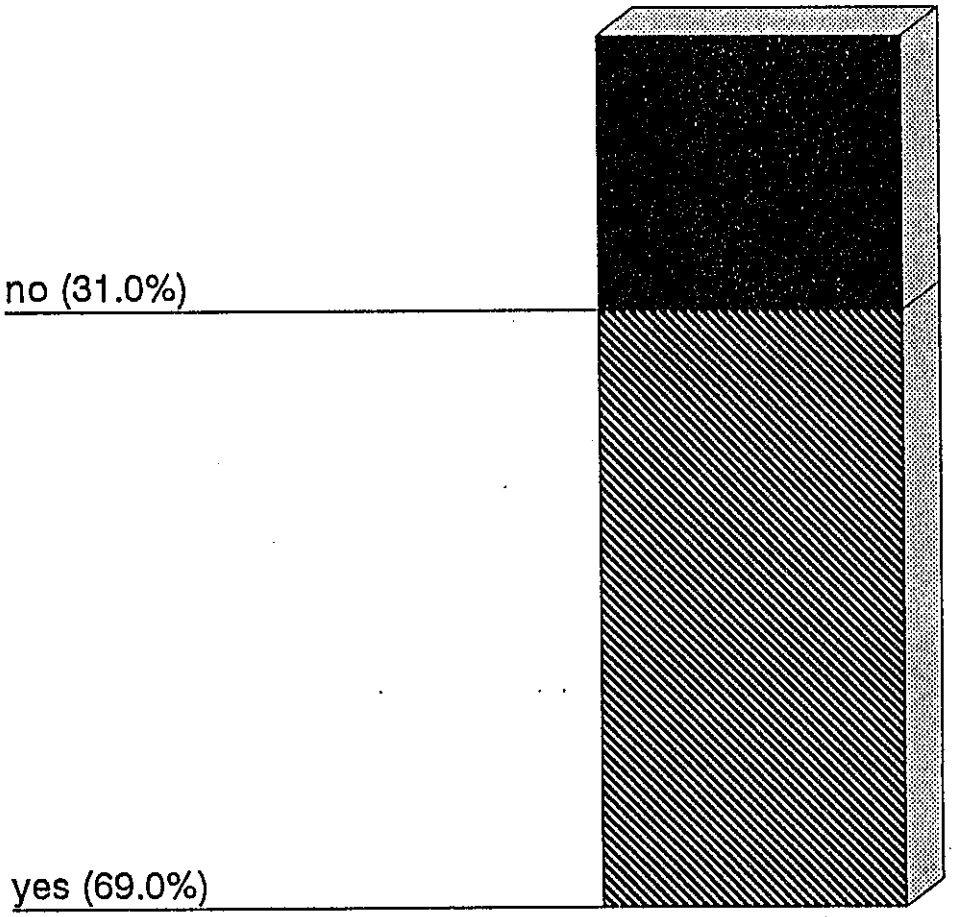
knowledge of childhood immunizations

n = 28



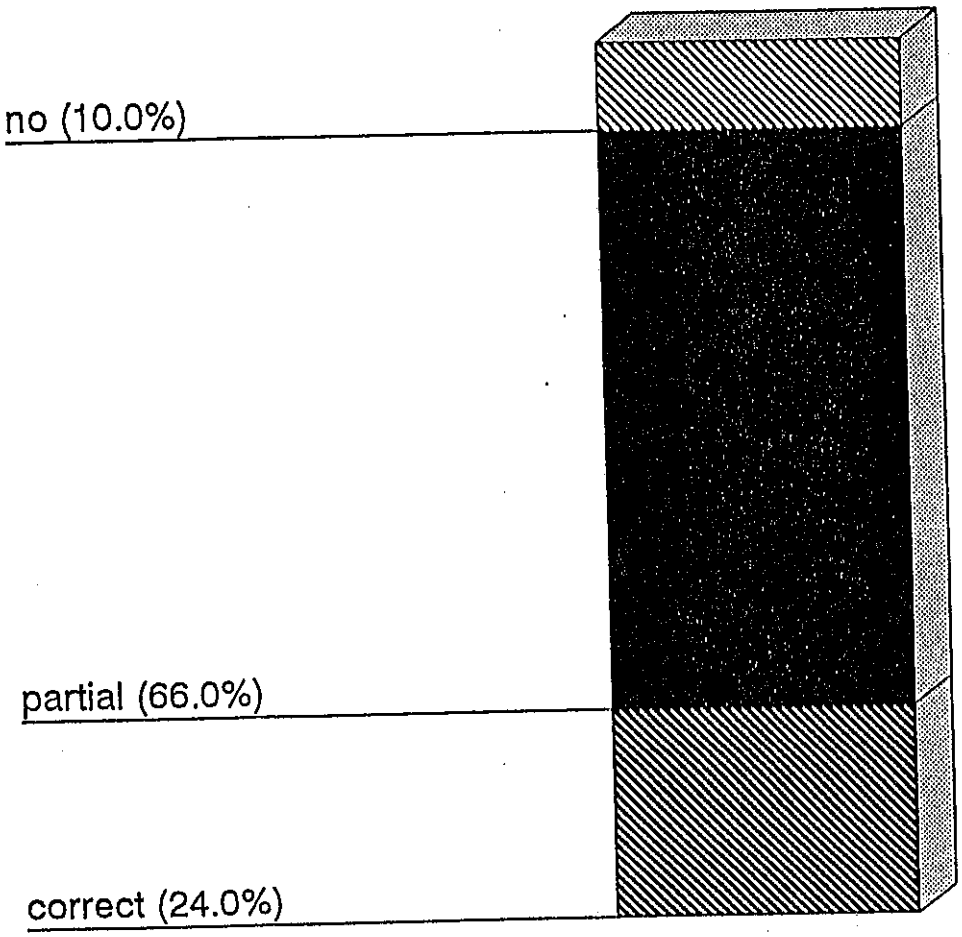
knowledge of STDs

n = 29



knowledge of HIV/AIDS

n = 29



Knowledge of HIV/AIDS

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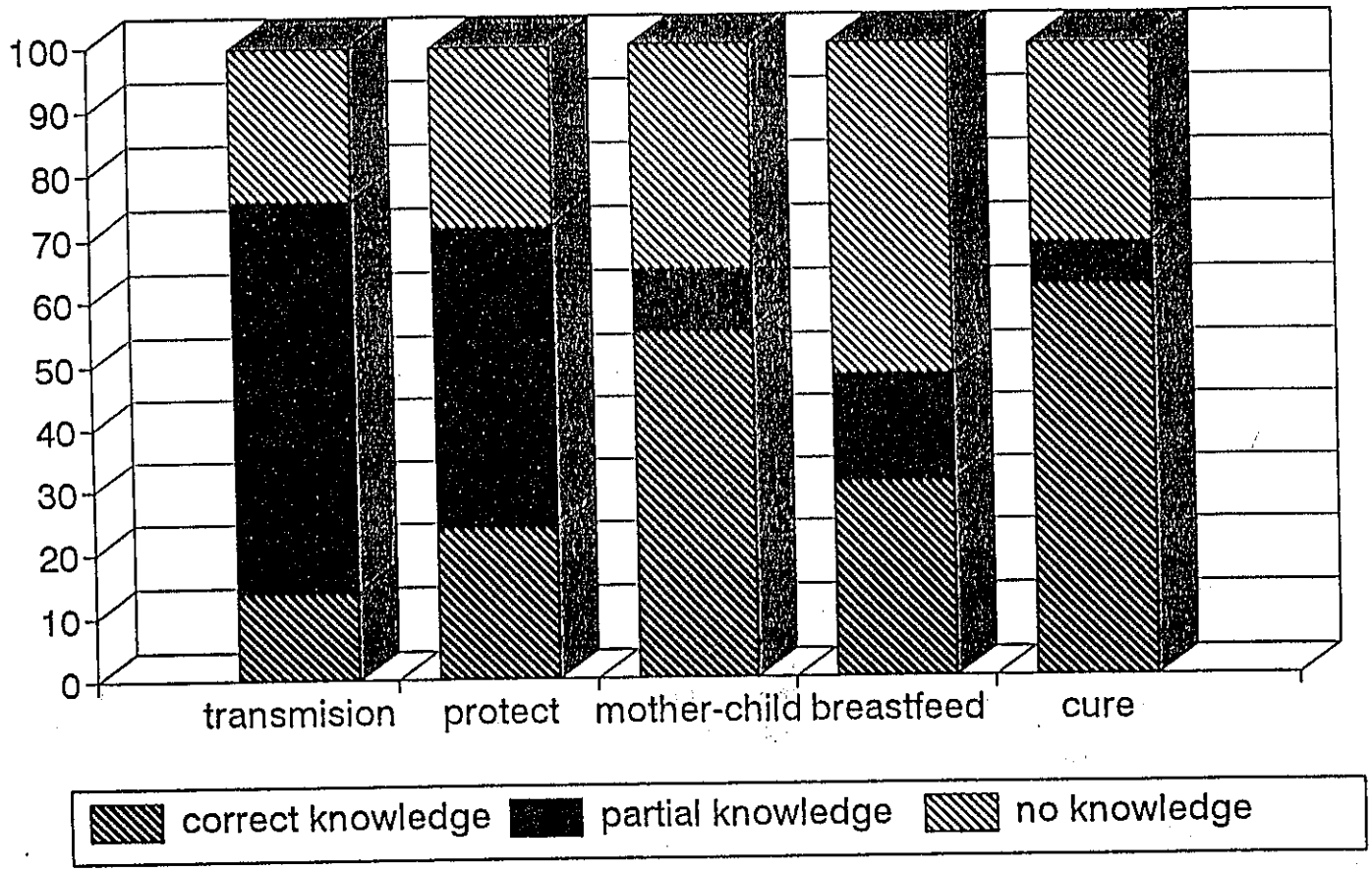
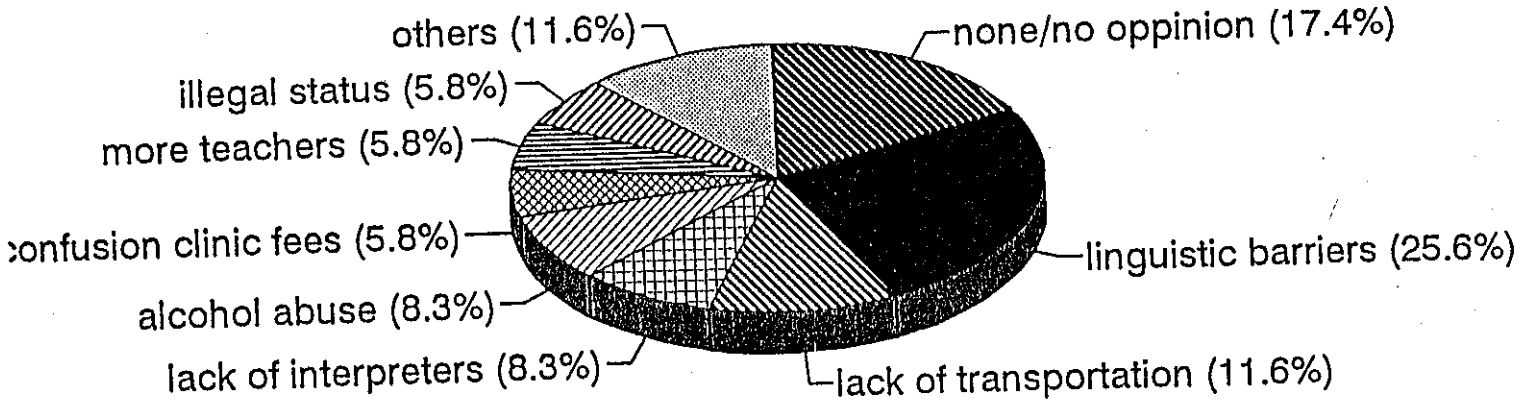


Main Community Problems

n = 29



MIGRANT SEASONAL FARM WORKERS EMPLOYED IN SOUTH CAROLINA - 1993

AREA OFFICE	COUNTIES	ACTIVITIES	ESTIMATED WORKERS	APPROX. DATES OF EMPLOYMENT
Aiken	Aiken Edgefield	1/ 2/ 6/	1,300	5/01-9/15/93
Barnwell	Barnwell	1/ 2/ 3/	150	5/15-7/15/93
Beaufort	Beaufort	2/	1,200	3/01-7/10/93
Bennettsville	Chesterfield	1/ 2/	150	1/15-8/01/93
Camden	Kershaw/Lee	2/ 3/ 6/	150	1/01-12/31/93
Charleston	Charleston	2/	2,000	3/01-7/15/93
Clinton	Laurens	5/	300	
Columbia	Lexington	1/ 2/	100	5/15-9/30/93
Conway	Horry	2/ 3/	500	5/01-8/30/93
Florence	Florence	2/ 3/	500	5/01-10/31/93
Gaffney	Cherokee	1/ 5/	240	4/15-10/05/93
Hampton	Allendale Hampton	1/ 2/ 4/	300	5/15-7/15/93
Hartsville	Darlington	2/ 3/	250	7/01-8/31/93
Kingstree	Williamsburg	2/ 3/ 6/	400	1/01-10/31/93
Lancaster	Lancaster	4/	50	7/01-8/15/93
Marion	Dillon/Marion	3/	600	5/01-10/31/93
Newberry	Saluda	1/ 2/	150	5/01-9/30/93
Orangeburg	Orangeburg	1/ 2/	200	6/01-10/01/93
Seneca	Oconee	5/	175	9/01-11/05/93
Spartanburg	Spartanburg	1/ 2/ 5/	1,900	4/15-10/05/93
Sumter	Clarendon Sumter	2/ 3/ 6	*3,500	1/01-10/30/93
Walterboro	Colleton	3/ 4/	100	7/01-8/30/93
			14,115	

*Total workers for spring and fall crops; approximately 75% of workers in spring harvest return for fall crop.

1/ Peaches
2/ Vegetables
3/ Tobacco
4/ Watermelon
5/ Apples
6/ Forestry

Rural Manpower Service
S. C. State Employment Service
1550 Gadsden Street
P. O. Box 1406
Columbia, South Carolina 29202

SEA ISLAND COMPREHENSIVE HEALTH CARE
MIGRANT POPULATIIONS
DECEMBER 1993

	AGES	PERSONS
OUR LADY OF MERCY - SERVED 1/193-11/30/93	ADULT	480
(FOOD, CLOTHING, PRESCRIPTION MONEY)	0-6 YRS	100
PRIMARILY JOHNS ISLAND	7-12 YRS	58
	13-18 YRS	65
CHAS.CO.SCHOOL MIGRANT SUMMER PROGRAM (NOT ACTUAL ATTENDANCE)		
JOHNS & WADMALAW ISLAND SCHOOLS	0-21 YRS	236
RAVENEL & EDISTO SCHOOLS	0-21 YRS	171
CHAS.CO.SCHOOL ENGLIGH SECONDARY LANGUAGE - SPANISH STUDENTS		
JOHNS ISLAND & WADMALAW SCHOOLS	0-21 YRS	41
RAVENEL & EDISTO SCHOOLS	0-21 YRS	4
RURAL MISSION HEADSTART PROGRAM		
WINTER SERVICES	ADULT	40
WINTER SERVICES	6WKS-5YRS	44
SUMMER SERVICES	ADULT	184
SUMMER SERVICES	6WKS-5YRS	200
SUMMER SERVICES - CHILDREN WAITING LIST	6WKS-5YRS	20
S.C. EMPLOYMENT BUREAU		
WINTER ESTIMATES - REGISTERED WORKERS	ADULT	450
SUMMER ESTIMATES - REGISTERED WORKERS	ADULT	2,000
SEA ISLAND LAB - JOHNS ISLAND CLINIC		
PATIENTS SERVED 1/1/93-11/30/93	ALL AGES	618
F.C.FETTER - JOHNS ISLAND CLINIC ESTIMATE BASED ON ABOVE		
PATIENTS SERVED 1/1/93-11/30/93	ALL AGES	1,236

PEDIATRIC HISTORY & IMMUNIZATION RECORD
(HISTORIA PEDIÁTRICA Y RECORD DE INMUNIZACIÓN)

Name: _____ (Nombre)
Clinic Number: _____ (Número de Clínica)
Date: _____ (Día)
Age: _____ (Edad)
Informant: _____ (Informador)
Interviewer: _____ (Entrevistador)

INMUNIZACIONES (Ponga las fechas)

DPT	_____	DT	_____
Tetanus Booster (tétano)	_____	Polio	_____
MMR	_____	Measles (sarampión)	_____
Mumps (paperas)	_____	Rubella (rubeola)	_____
TB Skin Test	_____	Typhoid Fever (tifoidea)	_____

BIRTH HISTORY (HISTORIA DE NACIMIENTO)

A. Birth weight of baby? (Peso de nacimiento del niño)_____
B. In what hospital was baby born? (En qué hospital nació el niño?
_____
C. How many days did he stay in the hospital? (Cuántos días permaneció el bebé en el hospital?_____
D. Were there any problems with the baby at birth or in the first month of life? If yes, specify. (Tuvo el bebé algún problema durante el nacimiento o primer mes de vida? SI NO
Si la respuesta es afirmativa, especifique. _____
_____

DEVELOPMENT (DESARROLLO)

A. At what age did your child walk alone? (A qué edad el niño comenzó a caminar solo? _____
B. At what age did your child start to say sentences like "I want water"? (A qué edad el niño comenzó a usar oraciones completas, por ejemplo "Yo quiero agua") _____
C. At what age was your child toilet trained during the day? A qué edad se entrenó el niño a usar el servicio durante el día?
_____
D. Does your child still wet the bed? (El niño todavía se orina en la cama? SI NO
E. Are there any problems in school i.e. failing grades, behavior, Etc. If yes. specify. (Tiene el niño problemas en la escuela, malas notas, mal comportamiento, ect.? (Si la respuesta es afirmativa, especifique. _____

NUTRITION (NUTRICION)

A. How much milk does your child drink in 24 hours? (Qué cantidad de leche toma el niño durante 24 horas? _____

B. Do you have problems getting your child to eat meat & vegetables? (Tiene usted problema con el niño haciéndole que coma carne y vegetales? SI NO

C. Does he snack on sweets and soft drinks frequently during meals? (Merienda el niño con dulces y sodas frecuentemente durante las comidas? SI NO

PAST MEDICAL HISTORY (HISTORIA MEDICA PASADA)

A. Has your child ever been hospitalized? If yes, give details, name of hospital, dates, reason. (Ha estado el niño hospitalizado? Si la respuesta es afirmativa, por favor escriba los detalles, nombre del hospital, fechas, y razón.) _____ SI NO

_____

_____

B. Has he had any serious injuries, i.e. head injuries, broken bones, lead poisoning, accidental poisonings? If yes, specify. (Ha tenido el niño heridas serias, como fracturas, envenenado accidentalmente, lesiones en la cabeza? Si la respuesta es afirmativa, especifique. _____ SI NO

C. Has he ever had any reactions to any drug or medications? (Ha tenido el niño reacciones serias a medicaciones? SI NO

D. Does he have more than three colds or ear infections per year? Durante el período de un año, ha tenido el niño más de tres resfriados o infecciones del oído?) SI NO

E. Has he ever had asthma or wheezing? (Ha sufrido de asma bronquial el niño?) SI NO

F. Have you ever been told your child has a heart murmur or had tests for heart trouble? (Alguna vez han diagnosticado que el niño tiene un murmullo en el corazón o en alguna ocasión le han examinado el corazón?) SI NO

G. Has he ever turned blue? (En alguna ocasión se ha tornado morado?) SI NO

H. Has he ever had swelling of the face, ankles, knees or other joints? (Alguna vez se le ha hinchado al niño la cara, el tobillo, las rodillas o cualquier otra coyuntura?) SI NO

I. Has he ever passed blood in his urine? (El niño alguna vez ha pasado sangre en el orine?) SI NO

J. Has he ever had a kidney or bladder infection? (Alguna vez ha tenido una infección en el riñon o vejiga?) SI NO

K. Has there ever been a discharge from the penis or vagina? Ha tenido el niño alguna infección en el pene o vagina? SI NO

L. Has he ever had convulsions or been unconscious after an injury? Ha tenido el niño convulsiones después de una caida o ha estado inconsciente después de una herida?) SI NO

M. Has he ever passed worms? If yes, was he treated by a doctor? (Ha tenido el niño parásitos? Si la respuesta es afirmativa, fué tratado por un doctor? SI NO

N. Has he ever had low blood? If yes, was he treated? Ha tenido la emoglobina baja? Fué tratado? SI NO

O. Has he ever eaten dirt, clay, plaster or paint? (En alguna ocasión el niño ha comido lodo, barro, yeso, o pintura?) SI NO

P. Has he ever tested for sicklem cell anemia? SI NO
If yes, results of test.

Q. Has your child ever taken drugs or smoked marijuana? En alguna ocasión el niño ha sido adicto a drogas, fumado mariguana?) SI NO

R. Has he had any other illnesses not metioned above? If yes, specify. (Ha tenido el niño algunas otras enfermedades además de las que hemos mencionado? Si la respuesta es afirmativa, especifique. _____ SI NO

S. Are there any other health or related problems you would like to discuss with the doctor? If yes, specify. (Tiene usted algunas otras preguntas o problemas que le gustaría discutir con el doctor?) SI NO

FAMILY HISTORY (HISTORIA DE LA FAMILIA)

A. Is either parent deceased? If yes, specify cause of death. (Uno de sus padres está fallecido? Si la respuesta es afirmativa, especifique la causa de muerte.) SI NO

_____

B. Are there any deceased brothers or sisters? If yes, specify. Tiene hermanos que han fallecido? Si la respuesta es afirmativa, especifique la causa de muerte.) SI NO

_____

C. Is there a family history of illnesses such as TB, diabetes, allergy, kidney disease, mental illness, cancer, heart diseases, high blood pressure, birth defects, venereal disease or any other serious illnesses? If yes, specify. (En su familia hay historia de tuberculosis, diabetes, alergias, alta presión, enfermedades mentales, o otras enfermedades graves? SI NO

_____

_____