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MIGRANT FAMILY HEALTH PROJECT - MG-29

ANNUAL REPORT

JANUARY 1, 1966 - DECEMBER 31, 1966

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Annual Report

January 1, 1966 - December 31, 1966

PAGES

Summary Progress Report .... 1 - 3

I Program Objectives .... 4 - 6

II Migrant Communities Served .... 7 - 19

1. Queen Creek Family Health Clinic
2. Guadalupe Family Health Clinic
3. Tanita Camp
4. Tanitas Family Health Clinic
5. Dysart Family Health Clinic
6. Tolleson Family Health Clinic
7. Avondale Family Health Clinic
8. Perryville Family Health Clinic
9. Buckeye Family Health Clinic
10. Harquahala Family Health Clinic

III Nursing Service in Migrant Program .... 20 - 26

IV Medical - The Maricopa County Migrant Health Program from a Clinician's Point of View .... 27 - 28

V Dental Health Program .... 29 - 32

VI Nutrition Services .... 33 - 36

VII Social Services .... 37 - 42

VIII Sanitation .... 43 - 48

IX Statistics .... 49 - 52

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SUMMARY PROGRESS REPORT

MG-29 January 1, 1966 - December 31, 1966

The Maricopa County Migrant Family Health Program has been operating since November, 1963. Some of the major factors involved in programming are:

1. Maricopa County comprises 9,200 square miles of land area.
2. Migrant families reside in Phoenix and surrounding rural communities in addition to 164 migrant labor camps.
3. There are short range medical and dental and social needs of migrant workers and their families that require our support and assistance.
4. There is the need to assist retraining programs for migrant men who are willing and able to avail themselves of this opportunity.
5. There are long range needs to assist migrant women by providing family planning and preventive services of prenatal care and cancer screening, as well as medical care for acute problems.
6. There is a need to meet the long range preventive and curative and rehabilitation needs of migrant men, women and children to enable them to have an opportunity to enjoy their maximum level of health, education and well being.
7. There are supporting resource services which must be brought to bear on the basic problems which face the migrant and his family as they attempt to adjust and enter the mainstream of the American way of life.
8. Many migrant families in Maricopa County are out migrants, yet there is still a great need to assist these families on a long term basis to effectively adapt to a stable way of life.
9. There is a need to develop a stable, practical and effective comprehensive medical care program in Maricopa County. This will aid to insure decentralized out-patient preventive and remedial medical services and health educational services which are more accessible to migrant workers and their families, on a long term basis.

The Maricopa County Health Department has actively pursued these goals over the past three years, providing consultations and supporting services to enhance the level of care provided by the Migrant Staff, and the community.

During this time, there has been rapid and steady progress in community development and comprehensive medical services in ten areas of the county. Seven of these areas now have permanent clinic sites; three labor camps, one in Avondale, one in Buckeye and one in Glendale are being served by the mobile trailer family clinic. Avondale and Tolleson are being served by the mobile trailer in addition to a permanent facility due to large clinic attendance. A new health center, which is a renovated church building, has been opened in Chandler, Arizona. This center is being used to serve county hospital out patients. It will also serve as a center for comprehensive county health services. The County Health Department began a joint out patient endeavor in the fall of 1966

at Mesa and Chandler. Guadalupe is planning on enlarging and expanding our clinic space at the Presbyterian Church grounds. This expansion will provide additional waiting space, to aid in health education efforts and provide additional conference rooms for privacy during interviews or counseling. This expansion was necessitated due to the increase of clinic load in all Guadalupe clinics.

Due to the expanded clinic attendance as well as the need to improve the level and quality of care, four of the ten Family Health Clinic areas are being served by the migrant clinician and a pediatrician and a public health trainee. This has aided the department to meet increasing total patient and total family needs in a single clinic setting. The pediatrician also serves on the county hospital staff and provides out patient clinic coverage one day a week, which aids in cementing relations with the county hospital staff to provide for continuity of care and avoidance of duplication of effort.

Transportation problems have been met through community participation and Office of Economic Opportunity (OEO) and migrant opportunity program personnel coordination in all areas served by the migrant teams.

The Family Health personnel have been coordinating with the Migrant Opportunity Program particularly regarding their Migrant Day Care Program. We have provided medical examinations; laboratory work for hemoglobin, urinalysis, Tuberculin skin tests; measle shots, and medical care for initial acute illness and continuity of medical care as needed for 240 migrant children. We are developing Day Care regulations and food handler courses to acquaint the Day Care Personnel with good public health preventive and remedial concepts.

Migrant Clinic Personnel cooperated with OEO and M.D.T.A. migrant retraining programs in the county for screening and examinations, treatment and follow up of 500 male trainees.

In 1966 the most accurate data we can obtain on migrants are those relative to labor camp occupants. Our statistical figures show 16,671 migrants living in 187 labor camps throughout the county. Even though the public health nurses are more aware of families who migrate out of the county during the summer, there are no valid figures on the total out migration. The reason being families may return to Maricopa County but they do not always return to the same town or fringe area location.

Our county Migrant Committee is a strong supporter of the health programs serving as a coordinating group to avoid duplication of effort and to provide for continuity of care. Personnel involved in new programs are encouraged to attend our monthly meetings to discuss their programs and to exchange information with personnel in other agencies and groups who are working with migrants.

The Maricopa County Health Staff is coordinating with state and other county staff to improve migrant services on a statewide basis. Plans are being developed to expand periodic migrant planning conferences for migrant project personnel throughout the state. A few out of state referrals have been received, served and replies to inquiries were coordinated through the State Health Department.

Our program sanitarian is on educational leave fulfilling his studies toward a M.P.H. degree. During his absence, district sanitarians have assumed responsibility for migrant labor camps within their respective districts and coordination is channeled through the district sanitation supervisors to a central migrant coordinator at the central office.

Community understanding and support have been maintained and strengthened in all migrant communities throughout the county. The County Migrant Committee has approved a sub-committee on Migrant Education to promote health education, day care and general educational efforts geared to improve the migrants' status. The committee also motivated the Avondale Farm Labor Office to renovate 29 bracero housing units for migrant use.

The Cross Roads Methodist Church has been working with the owner of Tanitas migrant camp north of Glendale, Arizona. The owner has provided a building for migrant clinics and day care classes to serve migrant families in that area.

Cooperation and coordination of medical, dental and sanitation programs with other agencies, Communicable Disease Center (C.D.C.), County Hospital and O.E.O. and school officials have enabled the staff to provide for a higher level and quality of care. The use of a multi-discipline team providing medical, dental, nursing, social work, nutrition, sanitation and clerical services has made an impact on the migrant and his health status.

Migrant Health Program Statistical Review

The comparative percentages shown on the chart are quite revealing.

There has been no increase in new admissions, however, return visits have averaged one additional visit per patient. This increase of 2,500, plus additional total services, bears out the fact we saw more patients with anemia, metabolic conditions, family planning, etc., which could be categorized in the preventive public health sphere.

Referrals to hospitals and private physicians reflect the increased effectiveness in this area of operation. We want to stress here again many of these patients are true migrants and not residents of Arizona.

The referrals to other health department services show 1,382 increase and a decrease in the dental referrals. This decrease in dental is due to the fact a large number of children seen in the dental clinic last year did not require previous medical attention; rather they were referred by the public health nurse directly to the dental clinic for follow up, without being screened again by the medical staff. The over-all number of dental patients seen in 1966 still is roughly comparable to 1965.

There is also a trend toward providing a higher quality of care for more patients.

I - PROGRAM OBJECTIVES

I - MIGRANT FAMILY HEALTH PROJECT - MG-29

Annual Report

This report covers the period of operation of the Maricopa County Migrant Family Health Project, January 1, 1966 through December 31, 1966.

A. PROJECT OBJECTIVES

The immediate objectives of the Mobile Health Clinic Project shall be:

1. To provide medical care (for ambulatory patients) to migratory workers and their families, to the extent possible by the limitation of facilities and staff. (Services will include diagnostic medical examinations, basic laboratory examinations, limited x-ray examinations, medical therapy (drug therapy), follow up between clinics by public health nursing personnel, and referrals for such diagnostic and therapeutic medical and surgical procedures which may be urgently needed but cannot be accomplished by the clinic).

2. The health clinic shall be working as a center for community organization for health services with the objectives of improving sanitary conditions in the communities and labor camps in the area, promoting health education of the migratory workers and families, promoting case finding, programs including skin testing and x-ray, and preventive services such as well child, maternity and immunization clinics.

3. The health clinic shall assess and evaluate the health needs of the migratory population in the county, with the ultimate objective of establishing such more permanent, community supported health services for which need has been found or demonstrated.

B. PROBLEMS AND EXPANDED ACTIVITIES FOR 1965-1966

1. The team has developed a "Basic Four" nutritional leaflet to aid in nutrition education.

2. We intend to expand health educational activities which will include: personal hygiene, sanitation, hand washing, immunizations, dental health, cancer, tuberculosis, menstrual physiology, family planning, etc.

3. To expand the Maricopa County Migrant Committee and bridge the gaps of lack of education and continuity of care among agencies and individuals working with migrants.

4. To strengthen agency support and coordination to provide for continuity of care and avoidance of duplication of effort.

5. To review existing clerical procedures in order to provide for improvement in record coding and filing and transferring to and from clinics.

6. To gather camp sanitation and housing data to compare with base-line data. This will help to define the number of migrants in the county and the amount of family housing needed.

7. To provide health education in camps to motivate migrants to maintain facilities and to appreciate grower efforts to improve housing.

8. To explore community unmet needs and attempt to promote services to meet these needs either through existing services or through new programs.

9. To promote a diarrhea survey with laboratory assistance of the Communicable Disease Center regional laboratory.

10. To cooperate and coordinate migrant program planning with the Arizona State Board of Health.

11. To survey migrant families to determine total family needs and to further stress family health during the next year.

12. To maintain an up-to-date map of Maricopa County showing migrant clinics and migrant camp sites.

13. To promote nursing in service education in the areas of nutrition and social services.

14. To orient all new personnel regarding migrant project objectives and the team approach.

15. To alert camp residents two days before clinic sessions so as to insure greater participation.

16. Housing is still a big problem and we hope to work closer with grower groups in an attempt to alleviate this problem.

17. Family planning services have received much support and there will be a great expansion in this program during the coming year if the present trend continues.

18. There is a need to stress coordination between Economic Opportunity Grant Programs and other local federal grant programs. This could be enhanced if federal coordinators acted as a catalyst to stimulate a better understanding of such gaps.

19. There is a need to strengthen ties with the County Hospital to facilitate the referral and follow up of patients between our respective agencies.

20. There is a need for more planning and aid to patients in the area of referral, transportation, and follow up to insure a smoother flow to and from agencies.

21. Transportation vehicles have been provided in Guadalupe, Glendale, Avondale, Buckeye, and Harquahala, but isolated specific needs still exist in areas not served by the Migrant Clinics.

22. Laboratory services need to be decentralized to better serve Guadalupe and Harquahala. Steps will be taken to remedy this situation this fall.

23. Campsites are lacking adequate toilet facilities and room space for registration of patients when the mobile trailer frequents camps in fringe areas.

24. Greater emphasis will be placed on medical problems of obesity, pica, hypertension, anemia, dental defects, and G.I. complaints during the coming year. The social worker will place greater emphasis on emotional problems including enuresis during the coming year. The social worker has been very effective in the area of family planning orientation and follow up.

II - MIGRANT COMMUNITIES SERVED

I. MIGRANT COMMUNITIES SERVED

QUEEN CREEK FAMILY HEALTH CLINIC
QUEEN CREEK, ARIZONA

The Queen Creek Family Health Clinic serves the indigent farm laborer in an area of 115 square miles. The area is composed of irrigated farming lands and citrus groves. The population of this area is approximately 6,000. Because of the location of the community of Queen Creek, which is situated only four miles from the Maricopa-Pinal county line, a portion of the patrons of the Queen Creek post office are residents of Pinal County. By special arrangements and in addition to the clinic services that are available to Maricopa County residents, these same services are offered to the migrants of Pinal County who live on the north side of Arizona Farms Road. These people consider themselves residents of the Queen Creek Community and almost always use Maricopa County facilities for shopping and recreation.

The indigent laborer of this area is mostly Mexican-American. There are many Anglos but almost no Negroes. Many of the Mexican-Americans are "out" migrants. The father and some of the older children will probably go to Washington, Idaho or Colorado for potato harvest or to California or Oregon for cherry picking. They often go to Buckeye, Avondale or Yuma to work in the lettuce fields when the season is over in this area. There is much shifting of jobs and places of residence within the area. This is much in evidence among the Anglos.

The area of living that has had to be neglected apparently is health care--especially preventive health care. The Family Health Clinic services in this area have given these people a chance for HEALTH in the broad concept and health is coming to mean more to them than just the absence of disease.

Many families are present and first generation immigrants from Mexico. They retain the Mexican family structure and culture. The husband usually can speak some English - the wife, none or almost none, and the children become bi-lingual after entering school.

Many cultural superstitions are retained by the Mexican-Americans. In Queen Creek there is a Mexican-American woman that is called "Doctor" by her patrons. Her services are used in conjunction with clinic services. For example - if it isn't clinic day and your 18 year old daughter has a side ache--you take her to the "Doctor". The "Doctor" takes a history - "Have you swallowed chewing gum?" "Yes" (As who has not). Diagnosis: "That is the trouble; the gum is stuck in your liver". Treatment: to wear around the abdomen a flannel band impregnated with ointment. In the same family there is a young boy with a growth failure problem and a younger daughter who suffers a skin allergy. The mother has been most responsible and reliable in seeing that the children keep the specialist and laboratory appointments in an effort to restore them to optimum health.

Before the establishment of the Queen Creek Family Health Clinic the nearest medical help was 20-50 miles away. For emergency, Maricopa County General Hospital, 50 miles away. The distance was costly in both time and money. The day it cost the wage earner to take himself or a

family member to County Hospital could be afforded only if the health problem was very critical. Also the family car could ill withstand the stress of a 100 mile trip - even if there was money for fuel. The nearest maternity and child health clinics were 20-25 miles away. As a result the mother saw a doctor for the first time at delivery and seldom returned for her postpartum examination. One-half or less of the infants never returned to a child health clinic for a six-week examination.

Before the Queen Creek Family Health Clinic was started, in July of 1965, unofficially, a Child Health survey was made. The only contacts were those families in the Queen Creek area that were open to some health department service. In 35 families that were open to some service there were 23 children under one year of age. Under six years there were 69 children. Of these children there were nine who were attending child health clinic in Chandler or Mesa, Arizona.

The problem of health care was complicated further by the fact that there is no school nurse in either Higley or Queen Creek schools which serve this area.

The need for medical services in this area was recognized. Under the initial sponsorship of the Farm Bureau the program was introduced to the community in November, 1965. There has now been one year of health services available in the area. Services offered are for the complete family and may include; Child Health, Maternity, Family Planning, Cancer Screening, Morbidity Care, Health Education, Nutrition Counseling, Referral and follow up.

The clinics were held in the First Baptist Church, Queen Creek until July, 1966. In September, 1966, the clinic moved to the Church of Jesus Christ of Latter Day Saints, Queen Creek. One all day clinic per month is held. Average registration is 63. Highest registration was 104; lowest was 51.

The church allows the clinic three locked cupboards for storage of drugs. Heating, cooling and electricity and part of the building are furnished by the church. The custodian of the church furnishes janitorial services for ten dollars per month.

One major health problem has been anemia among the children and adults. At present the average number of hemoglobins done per clinic is 20 - reduced from a high of seventy hemoglobins done in the February, 1966 clinic.

Many children have dental problems. Facilities for referral for dental care were available to the children for the first time this year through the service of the Family Health Mobile Dental Unit stationed at Guadalupe.

Through the extended services of the Family Health Clinic nutritional counseling is available.

Some possibilities to be explored for future improvement and to meet community needs: the need for group discussion and teaching in Family Planning and Maternity; the need for services of the Migrant Health Bus to

reach more remote areas - as Southeast of Chandler and Higley. The men especially are not being reached for needed health care; the need for more group presentations on sanitation and care and preservation of food; the need for orientation of residents of the communities to the goals and services of the Family Health Program.

The Family Health Clinic is held on a monthly schedule of one all day clinic per month. Staffing of clinic requires personnel as follows: two clinicians, two clinic nurses, one public health nurse, one nutritionist and three volunteers. The volunteers are residents of the community. They assist with initiation of records, assisting clinician where able. They also act as interpretors when necessary.

The average number of patients seen in one all day session is 72. The total number of patients receiving health care since December, 1965 is 749.

The Family Health Clinic in the Queen Creek, Higley, Chandler Heights area is helping to fill the health needs of the many migrant and rural poor and their families. As the immediate health problems subside, the family is becoming more oriented to preventive health care.

GUADALUPE FAMILY HEALTH CLINIC
GUADALUPE, ARIZONA

CLINIC	CLINIC SESSIONS PER MONTH	AVERAGE ATTENDANCE	PERSONNEL ASSIGNED	PROBLEMS
FAMILY HEALTH	2 All-Day Sessions	66	1 Public Health Nurse 1 Registered Nurse 1 Licensed Practical Nurse 1 or 2 Physicians 2 Health Aides 3 or 4 Volunteers Nutritionist	Inadequacy of facility in relation to waiting area, examining rooms, conferencing rooms; group health education area, and preparation room. Need for clerical assistance to facilitate record processing. Need for social worker.
** CHILD HEALTH	2 Half-Day Sessions	21	1 Public Health Nurse 1 Clinic Nurse 1 Physician 2 Health Aides 3 Volunteers Dental Hygienist, occasionally	Need for conference and group health education rooms; supervised play area for pre-school aged children

Patients who are medically indigent and have not had established residency in the county, have difficulty making arrangements for hospital delivery. The same applies to residents who are medically indigent, but do not qualify for admission to County Hospital for delivery.

** See Child Health. Initially, clinic was planned for children referred with special problems and on an appointment basis. Now the service is open to all children up to sixteen years of age, for acute as well as chronic problems. All children over three years of age in this clinic also have hearing screening tests.

No longer is Guadalupe a "slumbering community", resigned to a fate of hopelessness. It has found a voice which must be heard; a latent dignity which they insist be recognized; and the realization of the potential within themselves which they are applying aggressively toward improving their community. The impetus has come from the "Guadalupe Organization".

Education has had major emphasis. The G.O. Adult Education Classes had 41 students enrolled in day classes and 56 in night classes. Of these, 15 passed the G.E.D. Exams after four months of classes.

A Neighborhood Youth Corps Summer program with thirty boys and girls was designed to develop and promote leadership ability, display of initiative, and foster group cooperation.

One hundred and thirty six children participated in the Head Start Program.

Voter registration has been an on-going activity, and exercising the voter's privilege at the polls has had marked success. The people of the community have acquired a greater awareness of their responsibility as first class citizens, not only in their immediate community, but also their state and nation.

Striving for financial independence continues through provision of increased opportunities for employment. G. O. has an employment placement man and a representative from Mesa Employment Service interviews people for farm work. There are also plans to expand this farm placement to industrial training.

Savings in the Credit Union have greatly increased.

Also available in the community is commodities certification and distribution.

The people in the community display a greater understanding of the principles of good health practices and continue to increase their responsiveness to health services.

The Family Health Clinics attract a good part of the people in the community and attendance is consistently large.

Child Health and Maternity clinics also have consistently good attendance.

A pediatric clinic was added this year to provide special services for patients seen in family health clinics. This has shown marked growth within the past few months.

Nutrition counseling in the clinics and homes has resulted in improved nutrition practices in families, weight control in individuals who are obese, and contributed toward control of anemia in those with low hemoglobins.

The placement of the Dental Mobile bus for four months in Guadalupe has provided much needed dental care for children and some maternity patients.

The assistance provided by the G.O. Health Aides in clinics and the community has been of great value in getting patients to health and welfare resources. Transportation has been arranged or provided for those to whom it is not available. Emergency needs are met immediately. Appointments scheduled are being kept more consistently.

Outstanding prevailing needs are: Additional clinic space for Maricopa County Health Department so that personnel assigned can function in an environment more conducive to carrying out their assignment and so that patients have sufficient waiting room.

A survey conducted in Guadalupe revealed that out of 677 houses studied, 500 were sub-standard, 137 houses have inside toilets, 153 outside toilets and five with no facilities of any kind.

Two hundred eighty-seven homes have running water inside and one hundred sixty-eight have outside running water.

Housing is definitely a major need.

TANITA CAMP
GLENDALE, ARIZONA

Clinics were provided on a monthly basis, on the third Monday of the month, starting in October, and will continue for four or five months depending upon the need and the length of time the migrant laborers stay at this camp.

The clinics were provided through the mobile trailer and a new camp building used for registration of patients, nursing conferences and nutritional counseling.

Clinic hours were from 8:30 a.m. until all patients were seen, usually up till 3:00 p.m.

Clinics were staffed by the migrant clinician, one public health nurse, two clinic nurses, one nutritionist, one clerk, one social worker, five or six volunteers who assisted in registration and clinic duties.

See clinic diagnosis sheet for total patients seen per clinic site.

TANITAS FAMILY HEALTH CLINIC
GLENDALE, ARIZONA

Tanitas Family Health Clinic is held once a month during the season. Tanitas Camps offer homes and work to migrant field workers. Both Indian and Spanish speaking workers attend the trailer-clinic.

A larger, inside area was needed and this year a house was given by the camp owner for registration of patients and rooms for counseling by

the public health nurse, nutritionist, and dental hygienist.

The first clinic this fall was held in October and will continue until the workers leave camp to move north in the late spring.

The Service Guild of Crossroads Methodist Church volunteers continue to assist in the clinic. Volunteers hold "little school" for pre-schoolers three mornings a week, study hall for teen-agers, and Saturday evening social events for all. Notices of the clinic are announced over the Spanish radio station, fliers are distributed at the nearby camps, and the volunteers willingly go to the camp homes to remind patients to attend while the clinic is in session.

The migrant workers are willing to accept the clinic's services for illnesses and injuries. A program of education by public health nurses continues to help some workers overcome superstition and fear before accepting such services such as cancer screening, and other preventive and diagnostic programs.

Public health nurses visit in the worker's homes to explain clinic services and refer patients, offer counseling on health practices during pregnancy, and advice to new mothers. Follow-up visits are made on request from the clinician when a health problem may require continued supervision.

DYSART FAMILY HEALTH CLINIC
EL MIRAGE, ARIZONA

The clinic has continued to function in the Dysart Building every Tuesday. Dr. Dyson, assisted by one of the health department clinicians, a retired pharmacist, one public health nurse and clinic nurse staff the clinic. We are fortunate in having two volunteer registered nurses who work with the clinicians, as well as three volunteers who register and make out the patient's medical records. It is a busy area and noisy at times, but the future day care center is soon to be a reality as the adjacent land has been cleared for more buildings. A nutritionist and dental hygienist are scheduled at regular intervals so referrals can be made for these special services.

Clinic services include mainly morbidity, chronic conditions, physical examinations and some immunizations. Morbidity consists of upper respiratory illness and gastro-intestinal diseases. Chronic conditions seen are diabetes, epilepsy and arthritis, and some nervous conditions. Dietary problems which include obesity and anemia are ever present in this area.

The people of this area served by the clinic are farm workers, resident migrants and seasonal migrants from other areas or states. Services include: summer camp physicals on school children, examinations of school children sent to clinic for illness or accidents, Head Start Program referrals and follow-up care, referrals from C.A.P., and physical examinations on infants and pre-schoolers being admitted to the El Mirage Day Care Center; special arrangements have been made with Good Samaritan Hospital Out Patient clinic for performing tonsillectomies on those

children referred by Dr. Dyson. There is no charge for this service.

The clinic makes referrals to other agencies for more intensive follow-up care: Maricopa County General Hospital, Crippled Childrens Hospital, Maricopa County Health Department, special clinics and Dental Bus, Planned Parenthood Association, and Welfare Department. Clinic attendance usually fluctuates between 30 to 50 patients. The least number attending occurred on July 26 when 23 registered; the most patients seen were 66 on October 25, 1966. June and July are the lightest months and there is no clinic in August. In October, migrants from Texas, California, Nevada and the resident migrants began returning to the El Mirage area.

More and more multi-problem families are being seen in this clinic and the public health nursing follow-up visits have been increasing. The area served by this clinic is inhabited by a low-socio-economic group whose primary health care is received from the county medical services. The County Hospital medical facilities are from 15 to 40 miles away, making it difficult to attend because of transportation problems or fear of missing a day's work. Therefore, the clinic is of great advantage to the people in this area.

In November, 1966, the County Health Department initiated a family planning program to relieve planned parenthood of this responsibility and incorporate all health services under Maricopa County Health Department.

TOLLESON FAMILY HEALTH CLINIC
TOLLESON, ARIZONA

The Tolleson Family Health Clinic, because of growth in numbers and services offered, has developed into semi-monthly all day clinics. During the summer when many of the male workers migrate to other areas, 50 patients were registered for care. More and more the head of the household leaves the state during the summer months but his family remains in the community. Then when fall and cold weather approach, he returns to Arizona. The load, by November, had reached as high as 87 patients to be seen by the one clinician.

The staffing consisted of the clinician, district public health nurse, two clinic nurses, a clerk, and one volunteer. The nutritionist and social worker were available on an alternating basis.

In December the Grass Roots Program opened an office in Tolleson in the Tolleson Community Building. Some of these workers help in the clinics and have also provided transportation to the hospitals or other community resources, thus relieving the district public health nurse of this task, thereby allowing her to spend more time on health problems and their prevention. Also these workers have kept health literature available, posted clinic schedules, and provided interpreters for the public health nurse when needed.

However, a skilled volunteer is needed to assist the clinician. Since one cannot be found within the Tolleson area, it is necessary to transport one from the Glendale area to the clinic site. Having a paid trained aide or licensed practical nurse to assist the clinician would make for more efficient clinic service, as skilled volunteers are not always available. Also, in some areas, a few patients have objected

to having a volunteer from the community in the examining room during their examination.

Registration and conference space was provided in the Tolleson Community Building. The mobile trailer was used for the clinical area. The new clinic site scheduled for construction in February, 1966, has still not materialized. The original plans and bids far exceeded the budget set for the buildings which include City Hall Library and Jail in addition to the Health Department unit. New plans have finally been drawn and approved and are currently out for bid. Hopefully, construction will start in mid 1967.

The main medical problems during the summer season were impetigo and diarrhea. Through education, impetigo is becoming less of a problem, as the mothers have learned how to prevent it. However, in September when the field workers returned from California, there was an influx of impetigo cases. Many were severe with one requiring hospitalization because of kidney involvement. Because of the number of outside community-shared toilets and sub-standard housing, diarrhea continues to be a problem in spite of efforts to educate the people in this Spanish community.

In winter, upper respiratory infections remained the number one problem. The incidence of measles was high this spring with post measles pneumonia causing two deaths. Measles vaccine is available this winter.

Anemia in young children and pregnant women is a problem all year and contributes to the susceptibility of the children to upper respiratory infections. Low iron diets and too much milk in the diet are the main causes in the children while some of the mothers were run down from pregnancies too close together. Therapeutic supplements of iron are helping to correct this condition. Meanwhile, the nutritionist and public health nurse worked to educate the mothers regarding better nutrition with emphasis on high iron foods. A surplus food demonstration was presented to interested mothers - a joint effort of the Welfare Department and Health Department. The purpose was to show the mother how to better utilize the available surplus commodities and provide better nutrition for their families.

The number of women taking advantage of the family planning services offered continues to grow. These services have contributed to an improved physical and mental outlook on many women burdened down with repeated pregnancies.

More and more multi-problem families, living on the fringe of the economy, are finding their way to the Tolleson clinics. In some of the poor camps and courts where, in the past, one family might use Maricopa County Health Department facilities, now we find the majority of the people are coming into the clinics. The case load and clinics continue to grow as more and more people are reached.

AVONDALE FAMILY HEALTH CLINIC
AVONDALE, ARIZONA

The Avondale Clinic Building is the site for all clinics held in the Avondale area--because of the increase in clinic load, the migrant trailer is also used for the second clinician. The patient load has steadily been on the increase with a peak load of 107 patients on December 14. During the summer months when many of the families are out of the area, the registration varied from 30 to 60 patients per clinic session.

On the second and fourth Wednesday an all-day clinic is held and on the p.m. of the first and third Wednesday a pediatric clinic is held--of course if other members of the family need medical care on the day of the pediatric clinic they are given care. A pediatrician is assigned to this clinic. Because of the patient load it has been necessary to assign two clinicians to all four of these clinic sessions. With the increase in patient load and the addition of another clinician, the number of nursing staff remains the same.

The clinic building is rented by the health department and the City of Avondale assumes the responsibility for the utilities and cleaning of the building and grounds. The school grounds across the street are available for parking.

The staff, besides the two clinicians, consists of one public health nurse, two clinic nurses and a clerk. The nutritionist and social worker are present on a regular basis but not available for every clinic session.

Two volunteers are needed to work with the clinicians and one or two more are necessary to assist in carrying out the other clinic duties such as weighing and taking temperatures.

This clinic is an integrated part of the community. Some of the interplay evidenced has been:

MDTA - Those individuals attending the vocational school were given a complete physical including x-rays, diptheria tetanus, and follow up as indicated. For men with vision problems -- arrangements were made for an examination and glasses if indicated. The emotional needs of these men were evidenced by repeated clinic visits for physical complaints such as headaches, gastro-intestinal disturbances, and other evidences of anxiety.

CASHION DAY CARE CENTER - Patients were referred for acute morbidity -- upper respiratory infections, ear infections and diarrhea.

SCHOOLS - Many referrals were made by school nurses; they in turn read skin tests and assisted in follow up as recommended on these children

COMMUNITY ACTION AGENCY - This group is beginning to help to meet the vast problem of transportation of patients to different hospital and clinic facilities.

Interstate referrals have been received from the State of Washington and the patients have been followed in this clinic. Also patients are beginning to present Personal Health Records which were initiated in California. These help immeasurably in planning for the care of the family.

Health education is definitely showing progress in the areas of anemia, diarrhea, immunizations, prenatal care, and family planning. More and more women now are having a postpartum examination as they wish to plan their pregnancies.

PERRYVILLE FAMILY HEALTH CLINIC
PERRYVILLE, ARIZONA

In the spring of 1965 a clinic at this camp site was requested by volunteer workers from Avondale and by the Avondale District public health nurse. It was surveyed by the migrant staff but because of the small number of people at Perryville Camp a clinic was not started.

In April 1966 the Liberty school nurse, Buckeye District public health nurse and Avondale District public health nurse again requested a clinic to be held at Perryville. After a survey of the camp population it was decided to hold a monthly clinic for three consecutive months and offer a screening and preventive program.

On April 29, 1966, the first clinic session was held. Since there was no available facility for registration or conferencing this was done in the open area beside the mobile trailer. Volunteers were obtained from Perryville Camp itself, one from Buckeye which is over eight miles away and one from Avondale which is ten miles away.

Sixty-five patients attended this first clinic session. Of special note was 29 cases of lice. These children had been a problem in the school setting. Special instructions plus medication was given to try and eliminate this minor yet still serious problem. Serious because it interfered with the childrens' education as they were excluded from school until under treatment. One sixteen year old school girl referred by the school nurse was found to be pregnant. Six cancer screening examinations were done, one of which was found to be Class III Pap Smear. Twenty six children were started on immunizations. All patients received as part of their screening examinations a hemoglobin determination test. Out of the 65 only four had a hemoglobin lower than 10.5.

The clinic was staffed by the clinician, district public health nurse, two clinic nurses, volunteers, clerk, nutritionist, and social worker.

After the three monthly sessions the clinic was discontinued as by then most of the families had migrated elsewhere.

In September because the camp was beginning to fill up again, another clinic session was held. Twenty nine patients attended this session. At this time members of the clinic personnel inspected the camp area located behind the Perryville Tavern. There were no doors on the toilets, waste water was standing in puddles, garbage and trash was lying about on the ground.

There were garbage cans but these did not have lids and the cabins were in a very poor state of repair. This was reported to the district sanitarian. The camp was later closed as the owner did not wish to invest the money in the needed repairs to correct these unsanitary conditions.

The families moved to other camps in the Avondale and Buckeye area and are aware of clinic facilities in these locations. The final Perryville clinic session was held on November 30, 1966.

BUCKEYE FAMILY HEALTH CLINIC
COMPTON'S CAMP
BUCKEYE, ARIZONA

Clinics continued to be held at this migrant camp the first and third Fridays of each month. Hours were from 8:00 a.m. until all patients were seen, usually 2:00 p.m. to 4:00 p.m.

The space was provided through the use of the mobile trailer and a small dilapidated two-room cabin. The cabin is also used by the Migrant Ministry as a sewing room and for handcraft activities. This area is quite inadequate because of limited space and little or no heating or cooling. Part of the staff and most of the patients are exposed to the outside elements of heat in the summer and wind and cold in the winter. A better space must be found if effective service is to be provided to this area. Finding a new clinic site has so far been unsuccessful.

The staff consisted of the clinician, two public health nurses, one clinic nurse, clerk and two volunteers. Either the nutritionist or social worker were present at alternate clinic sessions.

The Vista workers, Migrant Ministry and Community Action Agency have helped in transporting patients to and from the clinic and to the Maricopa County General Hospital or other community resources.

A day care center was opened in the nearby Allenville area in January, 1966. Physical examinations and immunizations were provided for these pre-school children either at the family health clinic or the Buckeye Well Child Clinic--ill children are brought to the clinic for treatment.

Clinic attendance varied from 34 in August to 67 in November.

HARQUAHALA FAMILY HEALTH CLINIC
HARQUAHALA, ARIZONA

Clinic service has continued on a semi-monthly basis. The hours were 8:00 a.m. until all patients were seen--usually 1:30 p.m. to 2:00 p.m. Number of patients attending may vary from 30 to 56 per clinic session. Space is provided in an old school building.

Staffing consisted of the clinician, district public health nurse,

two clinic nurses, clerk and one to two volunteers--the nutritionist and social worker were present on an alternating basis.

This clinic continues to provide the entire scope of health department services to this remote rural ranch area. As previously mentioned, these families must drive at least 40 miles to the nearest rural town of Buckeye and for hospital or other clinic facilities, they must drive to Phoenix over 76 miles away.

Many of the families move frequently to California, Old Mexico and back to Arizona while some families work fairly permanently on farms within the area. Most families are Spanish speaking only, having received their education in Old Mexico, but they are intelligent, have an awareness of their problems, and try to help themselves.

Few men attend the clinic for preventive services. In fact, some Mexican men refuse to allow the family members to attend because of cultural beliefs and superstitions. Perhaps this is due to the fact some families are recent immigrants from Old Mexico.

Transportation continues to be a problem not only to the clinic site but for follow up on referrals to other facilities for further care. Also because of lack of transportation or money, many families wait until clinic day to be seen even though they may have been ill for several days.

The families are becoming increasingly aware of the services offered. Efforts continue to attempt and complete the immunization series before the families move on to another area. Most patients carry their Personal Health records or present records of any immunizations or care they may have received elsewhere.

III - NURSING SERVICE

III - NURSING SERVICE IN MIGRANT PROGRAM

I STAFF

The philosophy of the Maricopa County Health Department has always been to integrate a specialized program with generalized nursing service as quickly as feasible. In accordance with this philosophy, the public health nursing districts were sub-divided thereby allowing the district public health nurse time to function as the nursing team in the family health clinics. This has helped to improve service to the patient by reinforcing the continuity of care.

The nurse knows the patient whether he lives in the camps, cheap motels or other rentals in the district. Because she knows the family and his socio-economic surroundings, she can do a better job of conferencing in the clinic. She has a good knowledge of the clinic findings and physicians' recommendations to enable her to initiate follow up after clinic.

She also has a good knowledge of the community resources both local and county. The families know the nurse as a helping friend and are much more accepting of clinic care if they recognize a face among all the strange ones seen at a clinic setting. Also because of her knowledge of the home and needs of the patient, she can better interpret to the clinician what care it is possible to give in the home. Many seriously ill children could be cared for at home with the aid of modern medicine, but because of the poor crowded housing conditions of many of our families it is much wiser to refer them for hospitalization. The public health nurse knows the various areas of her district and the trend of migration. She knows when and to where the families migrate, and when they can be expected to return. When additional clinic hours are needed, she is able to make appropriate recommendations.

She knows the community leaders and is able to interpret the health department programs and needs of the families to them. Because of her knowledge and work with various community groups,she has been able to obtain through these groups some much needed volunteer help to assist in the operation of the clinic, to provide transportation, and assist in locating such necessities as emergency food and clothing. The district nurse and district sanitarian are housed in the same office. They work as a team in attempting to eliminate environmental conditions hazardous to health and to aid in the education of the grower, camp leader and families.

This has changed the Migrant Family Health Team from one specialized team to many community-centered teams with the clinician acting as the leader in all of the clinics.

In addition to the district public health nurse, clinic nurses also serve in all clinics. Their many duties include conferencing, laboratory procedures, assisting the clinician and training volunteers. They also keep all clinics adequately stocked with supplies.

A full-time Spanish speaking clerk works in the clinics on the west side of the county. This has been a great asset as she has an understand-

ing of the culture and language of many of the families. In Guadalupe the Guadalupe Organization pays the salary for a Spanish and Yaqui speaking aide who assists in interpreting in the clinics.

II TEAM MEETING OF CLINIC STAFF

A monthly team meeting is held in the Mesa District Office and in the Glendale District Office. These are attended by the clinician, all nurses and nursing supervisors who participate in the various migrant clinics, the nutritionist, social worker, and clerk. Other members of health department staff are invited to meetings as the situation may indicate.

The purpose of these meetings is to bring to the families served a better service both in the clinic setting and in their homes. This is brought about through the discussion of common problems, problems case, suggestions of staff and review of proposed changes in procedures and records.

III EDUCATION OF STAFF

This is carried on by case conferences by the team, clinician-nurse conference, supervisor-nurse conference, in-service education meetings, reading of material helpful in working with migrant families, and report of those attending outside meetings.

Eight of the Glendale district nurses, the social worker and nursing supervisor have been attending a weekly evening class in Spanish since September 1966. The class is taught by a volunteer public health nurse of Mexican descent who formerly worked with the Migrant Program of this health department. This added knowledge has increased rapport between the nurse and Spanish-speaking patients.

IV RECORDS

Adequate available records are essential in helping to give service to the patient and his family. Much effort and thought has been spent in trying to make the record system as simple, yet as efficient as possible. A control folder in which the entire families' records are encased has been developed. By a flagging system the person who reviews the records can tell at a glance, the date of return and reason for return of each individual. Also where and when the patient was referred for other service. This may be other health department services or any other community agency. In addition the control folder is flagged for reports pending.

The records are reviewed monthly. If the patient with an appointment has not returned to clinic, a letter of new appointment is sent for the next clinic session. This is done by the clerk. If reports or referrals have not been returned, she attempts to obtain these. For samples of control card, see Sample #1.

It was found essential to develop a portable index file which the clerk transports and uses at each clinic session. This index file prevents the duplication of records. If the patient presents himself to clinic for care and no record is available at that clinic site, the clerk checks the index file. The file will indicate whether the patient has attended

one of the other clinics.

If it indicates that he has a record at another clinic site or a closed record on file, a supplemental record is made and later combined with the original record, then filed in proper clinic box. This index card indicates the name of head of household and spouse, names and birth dates of those individuals admitted to service, the name of the clinic to which family was admitted and whether record is in the active or closed file. See Sample #2.

The Personal Health Record is now used as a common record by all clinics within the health department. This is a permanent record of service which the patient can present to any medical facility. See Sample #3.

Referrals have been received from other states. The patients were located, service initiated and a reply returned. Patients who have migrated to other states have written back to the clinician inquiring where they can receive the needed service in that state. Migrants upon return to Maricopa County readily seek care at the clinic in the area because of previous satisfactory service.

The only state effectively cooperating in interstate referrals is Oregon, and much needs to be done to rectify this problem.

V EDUCATION--INDIVIDUAL AND GROUP

The setting for individual and family education is both the home and the clinic. It starts with the patient or family's problem or need, and expands to other health areas as rapidly as the individual is ready. It may be verbal with aid of literature or actual demonstration.

It was found on home visits over the past three years: (1) that families did not understand that medication prescribed for one member of family should not be given to another ill member unless prescribed; (2) that it was necessary to complete antibiotic prescribed instead of stopping it just because the child was improved; (3) that parent, and not the child, should dictate whether or not a medication is taken.

When a nurse pinpointed for the mother the ways in which her child was improving, she was more understanding of why the diet prescribed and clinician's orders should be followed--example frequently used is the child with a low hemoglobin. The mother could see the actual change from a pale, fussy infant or child to an active, pink-cheeked one with a good appetite and a happier disposition.

Many of the families of Mexican descent do not start their infants on solid foods until they are almost a year old. Frequently it takes persuasion by an actual demonstration of spoon feeding to help the mother understand that the child will take solid foods when they are offered.

Group discussions with or without accompanying films are very desirable at the clinic setting, but because of the crowding and noise level of increased patient load, this is not always feasible. When possible, a group discussion is held, and educational efforts are being expanded.

Group education outside of clinic hours has been carried on successfully in some areas but this increases the workload of the district public health nurse. It would be better if she could work in consultant capacity to a Vista, OEO program or community worker.

VI COOPERATIVE WORK ON OEO PROGRAMS

Day Care Centers - Day care centers are established in Allenville, Cashion, Peoria, and El Mirage. Much nursing time is spent in consultation with the operator on suggested improvements of center, actual care given at center; individual infant or child problems, and community resources available. The nurse also helps the operator to plan for an educational program for aides and interested mothers.

In the past the physical examinations, immunizations and medical care has been given in the child health and family health clinics, or by a health department clinician and nurse at the center. The centers are using the Maricopa County Health Department Health Record. Since this is a record in triplicate, information regarding the child can be exchanged. See Sample #4.

Private physicians from local communities are now doing some of the physical examinations, and the ill children are referred to the family health clinics.

Measles Vaccine will be given to about 260 of these children.

MDTA Trainees - These individuals received their physical examinations at the Avondale Family Health Clinic. Clinician's recommendations were carried out by Nursing--further details are noted in the Avondale Family Health Clinic report.

Grass Roots Program - The district public health nurse oriented the community leader to the health department's program. The aides, using this knowledge, referred families to the clinics or other community resources. In some communities these aides assist in the clinics and provide transportation to other special facilities.

Vista Volunteers - These workers have a close working relationship with the district public health nurse. They have assisted in the clinics, transported patients to the clinics, assisted with or carried out recommended educational programs.

A Vista worker was assigned to the health department this past year. Since she was a retired Navy nurse with educational background in nutrition, she gave invaluable service to this program--she functioned in the migrant clinics in any capacity either as volunteer, nurse or nutritionist. Demonstration of the use of surplus commodities was one of the many educational services she performed.

Example of improvements brought about in one community by co-operative effort of district public health nurse, district sanitarian, Community Action Agency, Vista workers and Day Care Center--homes are cleaner, streets are graded, garbage is collected in cans and is later taken to dump by volunteer drives--and all garbage cans are covered. A library

and educational center has been added--a ball field has been cleared--streets have been named--new Star Route mail system has been established.

Evening classes are held where civics and other classes are taught. Group discussions have been started and various members of health department such as nurse, social worker, sanitarian, nutritionist, and sanitary engineer will participate as leader--see appendix C of social worker's report as an example of group discussion conducted.

G.O. - This group has been very active in the Guadalupe area. Local health department staff have acted as consultants and assisted in the education of the health aides. For further details, see the attached Guadalupe Family Health Clinic report.

VII PROPOSED CLINIC SITES

Allenville, Arizona - A monthly clinic will start January 30, 1967 in this very poor Negro community. The trailer will be used in conjunction with the Baptist Church. Volunteers will be obtained from the community.

Allenville is located about one mile south of Buckeye, Arizona. Both men and women serve as a farm labor pool when local growers need help.

Allenville has many problems but the biggest is the lack of water. They have a small well and a water tank with a capacity of 150 to 200 gallons serving about 200 families. This water does not meet standards because of chemical content. Water could be obtained from the neighboring town of Buckeye but the cost is prohibitive. The Day Care Center is frequently closed because of the lack of water.

The heat in the summer in the houses is almost intolerable because water is not available for the evaporative coolers.

In early January of 1966, this area was affected by the local floods. The district public health nurse was commended by the American Red Cross for her co-operative work in helping the distressed families.

Higley Area - This is a remote rural area in the southeastern part of the county. There are no physician or clinic facilities available. Some patients attend the Queen Creek Family Health Clinic when transportation is available.

Loma Land - This small group of families of Yaqui Indian and Mexican descent area are a lost group surrounded by the more affluent community of Scottsdale. No other health department facilities are available except in the Tempe or Phoenix area. Their income prohibits the use of available private physicians, and the distance and lack of transportation prohibits the use of other available health department facilities.

VIII UNMET NEEDS

Tuberculin skin testing - Routine skin testing is not a part of our program. It is only done on those individuals who complain of a chest

problem, or who appear to have symptoms of tuberculosis. This is due to the shortage of staff and the increased clinic load. Not only would staff be needed to give the test but they would have to return to the clinic site two days later to read the results.

Within the past year, two men who attended the family health clinic and did not have a skin test were admitted a few months later to the hospital with active tuberculosis.

Later a farm worker who lived in a truck and ate his meals with several different families was diagnosed as a case of active tuberculosis. He sought help from a private physician because he was no longer able to work. The physician referred him and his contacts to the health department.

The following ensued: His admission to a hospital, a skin testing and x-ray program of contacts, hospitalization of his youngest nephew in the State Tuberculosis Sanitorium, attendance of the other eight members of this family to the Diagnostic Chest Clinic as all had positive mantoux.

Two of his nieces had possible cardiac findings and are receiving diagnostic care--his sister was pregnant and is now attending the maternity clinic. Well child and family health care for the family is given at the local clinics. Arrangements were made with the school nurse for free lunches for the school-aged children.

The families also learned of the citizenship classes sponsored by the Community Action Agency.

In Allenville, a Youth Corps worker was diagnosed as having Far Advanced Pulmonary Tuberculosis. Her infant daughter was also diagnosed as having active Tuberculosis. Both were admitted to the hospital.

A skin testing program of that community is being conducted by the district public health nurse. The above mentioned tuberculosis patient not only had contact with other Youth Corps workers, but she also had helped in the Day Care Center. She was an unwed teenager who spent much time in many homes in the community. From this program, so far three converters have been discovered and are under medical care. One of these, a child under two, was admitted to the State Tuberculosis Sanatorium.

Arrangements have been made for the mobile x-ray trailer to work in these areas once or twice a year, but Tuberculosis still presents a problem because of mobility of migrant families.

Better Clinic Facilities - See the individual reports on the Buckeye and Guadalupe Family Health Clinics.

Shortage of Staff - Because of the heavy patient load, two clinicians function in the Avondale, Guadalupe and Dysart Family Health Clinics. The clinic nurse that assisted the clinician had to be assigned to assist with interviewing and aid in doing the laboratory procedures.

Volunteers had to be procured to function as assistants to the clinicians. Good reliable volunteers are difficult to obtain. At the last Avondale Clinic, there were no volunteers.

IX ADDITIONAL STAFF

A clerk, preferably Spanish speaking, is needed for the clinics on the east side of the county.

Two aides or licensed practical nurses are needed to assist the clinician, direct traffic in the clinic, check orders and see that clinic supplies are available and review records after clinic. These duties are now performed by either the public health nurse or the clinic nurse.

With the present patient load, these difficulties leave the nurses little time for adequate counseling and teaching.

NAME	B.D.	J	F	M	A	M	J	J	A	S	O	N	D	MCGH	PHN	DEN	SOC.S	OTHER	REPORTS PENDING
Christine [illegible]	3/30/28				110/7P														CSC 11/28/66
[illegible]	10/4/25																		
[illegible] Mae	3/28/59																		

CLINIC RECORD OUT: | | | | FOLDER REVIEWED BY: |
|---|---|---|---|---|---|
| PATIENT'S NAME | TO | REASON | DATE | SIGNATURE | DATE |
| | | | | [illegible] Baker | 12/2/66 |

- WHEN ADMITTED TO CLINIC, NOTE NAME AND BIRTH DATE. NOTE LAST NAME ALSO IF DIFFERENT FROM HOUSEHOLD NAME.
- NOTE IN PENCIL ON COLUMN OPPOSITE PATIENT'S NAME, THE SERVICE RETURN APPOINTMENT IS FOR – EXAMPLE: FP, CH, IMM., MORB., AP.
- FLAG WITH MAROON TAB THE MONTH OF RETURN APPOINTMENT – REMOVE FLAG AND ERASE AFTER APPOINTMENT IS KEPT.
- UNDER AREAS FOR REFERRAL, NOTE IN PENCIL DATE REFERRED.
- UNDER "OTHER" ALSO NOTE AGENCY TO WHICH PATIENT WAS REFERRED AND UNDER "REPORTS PENDING" NOTE DATE AND TYPE OF REPORT – EXAMPLE: CSC, STS, X-RAY. FLAG PINK (EXCEPTION: DENTAL, LIGHT GREEN; SOCIAL SERVICES, YELLOW).
- WHEN REFERRAL IS COMPLETED AND REPORTS RETURNED, ERASE DATE AND REMOVE FLAG.
- SIGN PATIENT'S RECORD OUT IN PENCIL, ERASE WHEN REFILED.
- ON MONTHLY REVIEW, IF PATIENT HAS FAILED APPOINTMENT, SEND LETTER OF APPOINTMENT.
- [illegible] PATIENT'S NAME IN APPROPRIATE COLUMN, NOTE IN PENCIL "L.S." MOVE MAROON FLAG TO THAT MONTH.

MCHD: MG 8
REV. 10/26/66:200

SAMPLE #1

1966

RAMIREZ, JOE & CONCEPTION D

Rosa 7-23-56
Conception 12-19-12

SAMPLE #2

RODRIQUEZ, JUAN & X H

Alvin 2-19-59

closed

SAMPLE #2

IV - MEDICAL

IV - MEDICAL

The Maricopa County Migrant Health Program from a Clinician's Point of View:

From a clinician's viewpoint, there is much that is gratifying in the present Migrant Health Program in Maricopa County. Before the current program was started three years ago, there was a virtual vacuum with respect to medical services for farm laborers. Now, however, this care is being provided to all outlying areas in the County, and in a manner which makes the service comparable to private care available elsewhere.

A real effort is being made to meet the needs of all patients seeking help. Since the beginning of the program not a single patient has been turned away from a clinic for any reason. Medical attention is available to any person who applies to the clinic for assistance, without restrictions, and much overtime work has been carried out in busy clinics in order that all applicants may be assured of service.

It has not been difficult to discern definite changes in the type of medicine which is being practiced. This is due, we feel, to the exposure the patients have had to the clinics and to the effects of health education, which is a vital part of the program. Those patients who are more or less stable residents and out migrants of the area are coming to the clinic for different reasons than three years ago. Whereas medical problems such as impetigo, diarrhea, malnutrition, anemia, and acute infections formerly were symptoms of poor eating habits, inadequate personal hygiene and poor sanitation, the patient population now is beginning to resemble more closely that of a typical medical practice. With the partial control of a number of acute conditions, patients are now seeking attention for more chronic complaints such as diabetes and cardiac problems, lung disease, hypertension and arthritis on a continuity basis.

A recent spot survey of farm labor camps throughout the county showed that the various clinics in the Migrant Program were well known, and many families interviewed declared their intention to use the clinics if and when medical problems arose.

The program is far from ideal, however, and a number of problems handicap it and prevent it from being as effective as it might be. Perhaps the main difficulty is the excessive crowding of most clinics. As clinic services have become better known, more and more families are making use of them. This problem has almost reached a crisis in certain areas. Most of our clinic settings are not adequate for the increasing demand which is being placed upon them, and more space is needed. The trailer clinic, while excellent as a temporary measure, presents many problems when a permanent site cannot be found to take over the job. There are many difficulties associated with moving and transporting large amounts of supplies, setting up and tearing down facilities.

It is our hope that the mechanisms for obtaining referrals and ancillary services like x-rays and laboratory tests may be improved in the future. At the present time, most of this work is done in conjunction with Maricopa County General Hospital, and since it is not under the direction of the health department, many problems have arisen when we have tried to work

cooperatively in the diagnosis and treatment of a particular patient. Private laboratory services have helped to meet this need.

Although we feel that we have obtained fairly good coverage of the female and child segments of the population, a source of disappointment to us is the percentage of male workers who apparently are coming to clinics for service. The natural male reticence and the problems of losing pay from field work during the day are probably the main reasons for this. In the near future, we hope to explore methods of dealing with this problem.

Comment

The most pressing need of the program seems to be expansion, if we really expect to do all that is required for this group. During the past few months, an additional physician has been assigned to our program from the U.S. Public Health Service, and this has halped greatly in relieving the burden in certain overcrowded clinics, and in allowing more time to be spent, when necessary, on problem cases. More personnel of all types are needed - physicians, nurses, aides, etc. It should be mentioned, however, that our efforts in the future should be directed not toward building the present clinics any larger, or staffing more personnel in the present clinics, but toward the establishment of more frequent clinics in the same location. Much better control and medical follow up is obtained if patients can come to the office twice a month, for example, rather than once a month.

The above goal can perhaps be facilitated by the new trailer clinic we have just obtained from Pinal County. This should make possible the penetration and coverage of new areas, and more complete service at our present locations.

Perhaps one of the most important points to be stressed is the comprehensive nature of the program. Medical service has not been fragmented; an entire family may come in at one time to receive a routine physical examination for the baby, immunizations for the young children, diagnosis and treatment of any morbidity which may be present, prenatal examination and counseling for the mother, Pap smears and other cancer screening services which are a part of the health department's program and family planning counseling for non-pregnant women who desire assistance. We feel that this is the direction in which we should continue to work in order to serve most effectively the farm workers in outlying areas of our county.

V - DENTAL HEALTH PROGRAM

V - MIGRANT DENTAL HEALTH PROGRAM

In March 1967, the dental portion of the migrant health program will be two years old. This report will summarize the over-all program and review the accomplishments for the period December 7, 1965 to December 22, 1966.

I BACKGROUND

The migrant dental health program began in March 1965 with the completion, equipping and staffing of a mobile dental trailer. This trailer is equipped with two dental units, radiographic, developing, sterilization, and storage facilities. It is staffed by a full-time dentist and two dental assistants and a hygienist.

The dental program, being a part of the over-all health services offered in the Migrant Health Program, has as its basic objective the provision of preventive, educational, and therapeutic services to children of migrant farm workers in the rural communities and migrant camps throughout Maricopa County.

Services were initiated in Avondale on March 10, 1965. Since this time the dental trailer has been in each of six communities where concentrations of migrant families are located. These communities are: Avondale, Buckeye, Tolleson, El Mirage, Glendale and Guadalupe. These six communities serve as a central point of service for surrounding areas as well as to cut down on travel of team members and permit more time for direct service.

Dental care for the migrant children in these outlying areas was almost non-existent, except for emergency treatment given at Maricopa County Hospital in Phoenix. Since transportation for these people is a big problem, the mobile dental trailer moving into these communities offers services, which otherwise would be very difficult for the people to obtain.

II ELIGIBILITY AND SERVICES

Priorities have been established for patients seen in the dental trailer. First priority is given to those children from migrant and farm worker families who are between the ages of three through eight years, and to maternity patients referred from the migrant health clinics. Indigent children with dental problems from the area schools are seen also when referred by the school nurses. The trailer remains in each of the communities three to five months and is open five days a week from 8:30 a.m. to 4:30 p.m. on an appointment basis, except for emergencies.

Most of the patients seen at the dental trailer have been referred from the migrant health clinics, after having first received a physical examination and/or treatment. In this way, the total health problems of the individual can be determined.

Therapeutic services rendered at the trailer include: oral examinations and charting, radiographs, prophylaxes and topical fluoride applications, pulpotomies, extractions, and emergency treatment.

The dental hygienist, in addition to giving prophylaxes and fluoride applications, was responsible for the dental health educational programs implemented in the schools of these communities.

Parents or guardians are requested to accompany the children to the trailer. The dental assistants talk with the parents about their children's individual problems and give instructions in home care, oral hygiene and diet. Those children not having a toothbrush are provided with a toothbrush kit at this time. One of the dental assistants is able to converse with the parents in Spanish.

In four of the communities the trailer is parked next to schools where water and sewage hook-ups are provided. The electricity is provided at no cost by the Arizona Public Service Company. The schools and school nurses have given excellent cooperation in helping the program achieve success. Broken appointments are filled by medically indigent children previously screened and who are awaiting appointments.

Two communities, Buckeye and Avondale, provide trailer space with utility hook-ups and parking space. At Buckeye, the trailer is parked next to the American Legion Building where health clinics are held.

Public health nurses, school nurses, and community volunteers have been extremely helpful in their cooperation with the dental team in providing referral and follow-up services. The volunteer workers in the community of Guadalupe have been especially helpful, since they visited homes to remind patients of appointments and provided transportation to the clinic when necessary.

III STATISTICS

The program strives to complete as many patients as possible, however, this is difficult because many patients move or become ill before treatment is completed. The following statistics include the period December 7, 1965, when the trailer arrived at El Mirage until December 22, 1966, when the trailer was completing its stay in Guadalupe:

EL MIRAGE AND PEORIA..........December 7, 1965 - April 11, 1966

Number Patient sittings	485
Examinations	139
Oral Prophylaxes	287
Radiographs	254
Crowns	44
Restorations	620
Pulpotomies	3

Extractions	190
Emergency treatments	52
Broken appointments	66
Patients completed	109
Not completed	30

GLENDALE.......................April 13, 1966 - July 1, 1966

Number Patient sittings	257
Examinations	96
Oral Prophylaxes	107
Radiographs	186
Crowns	20
Pulpotomies	12
Extractions	81
Broken appointments	28
Patients completed	69
Not completed	17

GUADALUPE......................July 11, 1966 - December 22, 1966

Number Patient sittings	451
Examinations	147
Prophylaxes	175
Radiographs	250
Crowns	51
Restorations	1,148
Pulpotomies	37
Extractions	254
Emergency treatments	62
Broken appointments	45
Patients completed	85

Not completed	30
Total Patient sittings	1,193

During the Arizona State Fair, November 4 - 13, 1966, the dental trailer was moved to the fair and "loaned" as an exhibit sponsored by the Arizona Dental Association and Maricopa County Health Department. The dental staff of the trailer and volunteers from the Central Arizona Dental Society and dental staff from the Maricopa County Health Department "manned" the trailer and gave dental health educational materials and instruction to the visitors, many of whom were school children.

The low number of broken appointments and the number of completed patients indicate that this program has been successful in helping to fill the needs of these people for dental services and is considered a vital part of the Migrant Family Health Program.

VI - NUTRITION SERVICES

VI NUTRITION SERVICES

The nutrition services in the Migrant Health program were curtailed during 1966 due to the lack of a nutritionist in the program from April 1, 1966 to September 12, 1966. A comprehensive report of the activities of the nutritionist to April 1, 1966, was presented by the former nutritionist.

Direct services to the following clinics have been given since September 12, 1966:

Avondale Child Health
Avondale Family Health
Avondale Maternity
Buckeye Child Health
Buckeye Family Health
Buckeye Maternity
Chandler Child Health
Chandler Maternity
Dysart Family Health
El Mirage Maternity
Gila Bend Family Health
Glendale Child Health
Guadalupe Family Health
Harquahala Family Health
Mesa Out Patient
Mesa Maternity
Perryville Family Health
Queen Creek Family Health
Tanitas Farms Family Health
Tolleson Family Health

Based on present figures available and estimating through December, approximately 1040 nutrition evaluations and instructions will be given involving 500 families. Each family is counseled in good normal nutrition practices with additional stress on particular problems. The types of counseling given and percentages instructed in each category are:

Category	%
Normal Nutrition	
Adolescent	3%
Adult	8%
Geriatric	1%
Infant	14%
Maternity	9%
Preschool	27%
School age child	11%
	73%
Therapeutic Nutrition	
Diabetic	1%
High Iron	13%
Low Calorie	10%
Low Sodium	2%
Other	1%
	27%
Total Family Nutrition Counseling	100%

With the limited data available, several conclusions can be drawn and problems noted. The preventive philosophy of public health is very evident in the nutritionist's work in the various health clinics. Whenever possible, nutrition counseling is given each patient attending any given clinic. In this way, good normal nutrition practices can be emphasized that will affect entire families. Such conseling is always based on individual family needs, economics, and food habits. Budgeting, use of surplus commodity foods, and food preparation are also discussed. The above figures show that 3/4 of the nutrition counseling given is primarily concerned with adequate normal nutrition. A Picture Guide to Good Eating is used to good advantage during these interviews.

The problems of feeding a family in the socio-economic group are many including: large families, lack of money, inadequate facilities, little knowledge, and lack of transportation. The nutritionist finds these people to be most receptive and eager for information. The areas which seem to need most emphasis are:

1. Breakfast - stressing the importance of this meal for all age levels.

2. Pre-school child - meeting the nutritional needs of this age level which has been found to be very poor and inadequate

3. Infant - adding solid foods, both kinds of foods and methods of addition.

4. Snacks - using snack foods to add to the over-all nutrition picture instead of the concentrated sweet foods now normally used.

5. Commodities - using these surplus foods to best advantage.

6. Budgeting - making better use of monies available.

7. Food preparation - using all foods for better nutrition, economy, and sanitation.

Therapeutic problems constitute approximately ¼ of the total number of patients counseled. These problems fall principally into two categories: anemia and obesity. The nutritionist counseled patients in the use of iron-rich foods, using The Iron Story pamphlet extensively. Pica is a problem among the anemic preschoolers. Nutrition conseling plus medication produced good results and elevation of hemoglobin levels.

The obese patient poses a problem requiring extensive counseling and follow up. All low calorie diets are based on the individual's eating habits making those adjustments needed to give a good level of nutrition with weight reduction. Of the 80 patients receiving low calorie instructions between September 12, 1966 and November 15, 1966, 19 have received initial follow-up with 12 losing at a good rate and seven making poor progress. These patients are receiving good support from all of the family health team and further follow-up is necessary before any conclusions can be made.

All therapeutic diets are based on modifications of each individual's eating pattern as this method has been found to be more effective. Specialty foods are rarely recommended. The acceptance and adherence to modified diets is good when the patient has been given adequate instruction by the nutritionist.

Direct services have been extended on home visits with various public health nurses. These home visits have been made in:

North Surprise
Guadalupe
Tanitas Farms
Glendale
Gila Bend
Queen Creek and other east county areas

Educational services extended throughout communities within Maricopa County are most important. To be effective in this area, community resources at all levels must be utilized and knowledge of the nutritionist's services made known. Orientation and exchange of information have been held with the following groups:

- Child Evaluation Center
- Home Management Aides and Case Workers of the State Welfare Department
- Grass Roots Organizations
- Day Care Centers in: Allenville
  - Cashion
  - El Mirage
  - Peoria
- Arizona State Public Health Nutritionists
- Arizona State Extension Department
- CAA organizations

The nutritionist has been included in several community programs. The first, a food demonstration and tasting party at the Tolleson Community building. This program evolved from interest generated by a similar program given in the spring by a group of student social workers. The public health nurse and a Vista worker enlisted the aid of the Welfare Department and the nutritionist. A very effective program resulted with preparation of two complete meals featuring surplus commodity foods and high iron foods. The group in attendance included: 14 local women, 21 children, two Vista workers from Allenville, three ASU Home Economics students, seven Home Management workers with the Welfare Department, and three case workers.

Food demonstration programs have been scheduled at the El Mirage Day Care Center, the Allenville Day Care Center, and the Gila Bend Community Action Agency. These demonstrations will be based on the use of commodity foods, budgeting the food dollar, and basic normal nutrition for the family.

The Day Care Center in El Mirage has asked for assistance in child feeding, menu planning, and food handling. Initial instructions have been given to the director of the center, and a series of classes are being scheduled.

VII - SOCIAL SERVICES

VII - SOCIAL SERVICES

The social work consultant of the Glendale District Office worked in the Migrant Family Health Clinics during the last eleven months. The social worker was available on a scheduled basis in each of the clinics (excluding Dysart) staffed by the personnel from the Glendale office. She offered four major services-direct casework, consultation, family life education, and family planning education.

CASEWORK:

The presenting problems of 301 families receiving casework were classified as follows:

Problem	Families
Financial Need	92
Need for Medical Care and Preparation for Hospitalization	39
Behavior and Emotional	38
Extreme Anziety	38
Marital Conflict	28
Parent-Child Conflict	27
Continued Service to Multi-Problem Families	16
Mental Retardation	9
Child Abuse or Neglect	8
Other	6
	301

Casework contacts were usually short-term ranging from one to four interviews. Approximately 33 families received long-term services which included home visits. Appendix A is a summary of a long-term service case and illustrates what can be accomplished through a direct service program.

CONSULTATION:

The frequency of case consultations has increased greatly. The public health nurses have refined their understanding of and use of social work consultation. A summary of a consultation case is included in Appendix B. Public health nurses are using the services of a consultant to improve the quality and depth of patient care. Other agencies such as schools and day care centers are seeking consultation services from Migrant Family Health Staff.

FAMILY LIFE EDUCATION:

Family life education groups were expanded to involve the Migrant Opportunity Programs (MOP) in Maricopa County. MOP operates four day care centers which offer service to farm workers and their families. The group program was initiated in the fall of 1966 at the Allenville Day Care Center and involved fourteen mothers from the community. Appendix C is an outline of the discussion. In camps and communities alike, the response to family life education groups has been positive. In the Spring a series of six programs were held in the Tolleson Community Building and included:

1) knowing the community, 2) budgeting and use of surplus foods, 3) understanding how and when to use the bank, 4) emotional and physical development of children, 5) home safety, 6) common sources of marital conflicts. Interesting results of the group meeting were the opening of savings account, use of library facilities, and interest in having a Head Start Program in the area.

FAMILY PLANNING:

During the last year, family planning has been a chief interest of the clinic staff. Different approaches to education for family planning and the use of birth control pills were tested. Both discussions and individual interviews were used. The effectiveness of each method seemed directly related to the staff member preference for individual or group teaching. The total area of planned parenthood is highly emotional and closely related to all areas of family relationships. As a result of prolonged contact with ladies interested in using an oral contraceptive, an information pamphlet was developed and printed in English and Spanish. A copy is attached in Appendix D.

Unless the social work staff in the program is increased, the social service program will stress group and consultative services. Limited staff automatically restricts extensive use of casework on an individual basis.

APPENDIX A

Patient's Name — L.L. 2/6/46 f/M
Tolleson, Arizona

Source of Referral: — Physician Tolleson Migrant Clinic

Presenting Problem: — Suspected Child Neglect

Opened: 10/15/65 — Closed to Social Services: 5/20/66

CASE SUMMARY: 5/20/66

REFERRAL: Mrs. L, her husband and four pre-school children lived in Tolleson, Arizona. Mr. L. was a migrant farm worker, and his family followed the crops with him. The L family usually spent the winter in Arizona and the summer in Idaho and California. The physician and district Public Health Nurse had encountered a family situation of (1) extremely low hemoglobin for all children; (2) failure to keep clinic appointments for all children; (3) possibility of mother's low I.Q.; (4) mother's inability to provide adequate care for the children; (5) need for basic education in child care; (6) budgeting; (7) mother's low ego concept and (8) apparent poor motivation. Public health nurse had been visiting in the home once a week but felt she was not making much progress and thought social services should come in. The doctor thought if there was no improvement within six weeks, he might want to consider foster home care for the children.

PLAN: Mrs. L was to be seen at home on a weekly basis. The social worker was to help her identify problems and support her in moving toward a solution of them. Mr. L would be seen with his wife as often as the work schedule allowed.

GOALS: (1) assess family strengths and weaknesses; (2) help to develop mother's self image; (3) better management of finances; motivate mother toward better care and understanding of children's physical and emotional needs; (4) to improve functioning of all family members; (5) better management of household, stressing sanitation and nutrition.

OUTCOME: The social worker worked closely with the public health nurse although the latter discontinued weekly home visits. Mrs. L came to see the value of the migrant clinics and attended them with her children. The children's hemoglobin improved and the quality of child care in the home improved. Mrs. L was able to involve herself somewhat passively with the Tolleson Family Life Education Group. Her interest in herself increased and she selected to try a reducing diet. While sanitation and nutrition remained problems, the home was cleaner (the kitchen was scrubbed and commodities stored in covered cans to combat cockroaches). As her self concept improved, Mrs. L learned to function better as a wife and mother. She continued to be slow in thought and movement and the worker was inclined to believe there was an I.Q. limitation. At the time the case was closed, Mrs. L actually smiled and took an interest in the care of her husband and children. The family left for Idaho in 6/66 and returned to Tolleson in 10/66. It is interesting to know that Mrs. L came to the clinic to tell the staff of the family's return and current address. She had lost twenty pounds and had continued her birth control pills while in Idaho and California.

APPENDIX B

Patient's Name: G.J.

Birthdate: 1/8/27

Opened: 5/23/66 Closed: 8/5/66

Source: Public Health Nurse

Presenting Problem: Emotional illness suspected

CASE SUMMARY: 8/5/66

The public health nurse requested consultation on this patient after she had interviewed her in the Avondale Family Health Clinic. The public health nurse related the patient had a previous record of hospitalization for mental illness. The patient had stated that at the time of previous hospitalization her diagnosis had been schizophrenia. At the current time the patient was living with her mother and five youngest children. She was five months pregnant. Her husband and older children had gone to another part of the

country to seek employment. Mrs. G was receiving welfare. She was depressed and lacked interest and expressed feelings of anxiety to the public health nurse. The patient was seen for one interview in Family Health Clinic on 5/23/66. A second conference with the public health nurse resulted in the following plan:

1. The public health nurse would visit with this patient in between clinic visits and would offer her as much support as possible.

2. The public health nurse would deal with specifics and attempt to keep the patient related to reality.

3. In order to help the patient relate more efficiently to reality, the public health nurse would help the patient plan for her own maternity care, for the care of her children, and for her delivery at the County Hospital.

4. Should the patient seem to become more depressed, the public health nurse would attempt to offer her some specific task to accomplish between clinic visits such as projected items needed for the new baby or planning adequate menus for her current family, etc.

The public health nurse continues to see this patient. She states that the patient seems to have improved not only in her emotional status but also in her physical appearance. The patient appears more out-going and more capable of maintaining relationships with public health department personnel and with members of her family. This case will be carried by the public health nurse on a routine basis until after the patient's delivery and six week check-up; at that time it will be re-evaluated. An additional consultation will be given if indicated.

Casework Interviews - 1
Consultation Interviews with Maricopa County Health Department Staff - 4

APPENDIX C

EDUCATIONAL PROGRAM FOR ALLENVILLE DAY CARE CENTER

The first of a series of group meeting was held at the Allenville Education Building on November 15, 1966. The meeting was attended by 15 center aides and mothers, the district public health nurse, and public health social worker, Mary Beth Ball. The discussion was moderated by the social worker and concerned the physical and emotional development of the child from birth to six years of age.

Discussion and group participation was good. The majority of the women were alert and interested. They indicated a desire to have additional educational programs and discussions and evidenced special interest in nutrition and preparation of budget foods.

The ladies requested help with the management of two problems of childhood. Discipline of children was explored. The general opinion seemed to be that the children didn't have adequate discipline at the Day Care Center. Most of the women favored limited physical punishment and consistent discipline for their own children at home.

The center aides agreed that sex play among young children presented a real problem. Different methods of reacting to the child's behavior were discussed along with possible causes of the behavior.

An outline of the information discussed is attached. A meeting is scheduled with the Center Director, Mrs. Harney, to discuss discipline of children and management of behavior problems.

PHYSICAL AND EMOTIONAL DEVELOPMENT OF YOUNG CHILDREN

I. Expression of Affection
   A. Hold the baby during feedings.
   B. Babies respond to stimulation--they shouldn't just lie in bed. They need to be played with and learn to play with toys and people.
   C. If children are to learn to love and to give to others, first they must be loved and given to. Their first experiences--good or bad--are with the mother or mother substitute.

II. What Happens to the Youngest Child When a New Baby is Born, and What Can You Do?
   A. Give extra time and attention to the older child.
   B. Give older child feeling that baby i theirs.
   C. Let older child help with care of baby.

III. Safety of Children
   A. Place all cleaners, knives, fire, medicine, poisons, etc., out of reach of children.
   B. Children need to be supervised in play.

IV. Discipline
   A. Above all else for good behavior and to help achild learn self-control, parents must be consistent in limits, demands, and discipline. If child is allowed to behave one way today, but is punished for same behavior tomorrow--he gets very confused.
   B. Children want limits and stable control because they feel more secure when they know what is expected. Also it shows them parents are concerned and care for them.
   C. If you use physical punishment such as spanking, you should never spank a child in anger because you may lose control and hurt the child.

V. Child Abuse
   A. I am sure you have all read or heard of cases of child abuse where a parent hurts his child such as a broken leg. Can any of you tell me of a situation of this type? Why do you think the parent

lost control? Do you think the parent meant to hurt the child? Immature adults often lose control when angered or under excessive stress. The child is convenient and is often used as an object to take their anger out on. Children always add to the complexity of living and place additional demands on the parents.

B. What can be done about this?
   1. Parent needs help and child needs protection.

VI. When Other Adults Take Advantage of Young Children
   A. What can you teach your children to help protect them?
      1. Not to talk with strangers
      2. Not to let boys or men undress them
      3. Not to go off without letting you know where they're going
      4. Explain but don't scare
      5. What have some of you told your little girls?

VII. Sex Play and Masturbation

VIII - SANITATION

VIII - SANITATION

Preliminary Program Report - May 1966

Preliminary figures from the spring survey show an increase in the number of persons living in labor camps in Maricopa County this year. In 1965, there were 14,252 persons living in 189 camps throughout the county. Since that tabulation, 16 camps were closed and 16 new camps were opened. The 1966 figures show 16,671 persons living in 189 camps in the county. This shows an increase in camp occupants of 2,419 persons.

There has been considerable improvements in camps. The major area of improvement has been in the replacing of privies with flush toilets, showers, and handwashing facilities. Installation of kitchen sinks with indoor running water is considered a second major area of improvement. Increased grower and migrant education by the team has resulted in improved camp supervision and a greater interest in camp conditions by both owners and occupants. Improved camp supervision and migrant education has resulted in lowering the damage to camp facilities.

Field sanitation has shown marked improvement. Approximately 99% of all field crews have some type of sanitary toilet available in the field. All field crews have a safe drinking water supply. The common drinking cup still remains a problem, although this is improving.

Crop rotation and increased salaries have improved the financial conditions of many migrants. Preliminary estimates indicate that approximately $750,000 has been invested in camp improvements in Maricopa County in the past two years by growers or camp operators.

A great degree of the improvements obtained are due to the growers' and owners' cooperation. These current improvements are very encouraging and we look forward to even greater strides in the future.

Sanitation Progress Report

Much time and effort has been expended in order to promote sanitation and bring about a noticeable improvement in the living conditions of the migrant in Maricopa County during the past few years. This has not been a dramatic change brought about by some miracle formula but rather a slow, at times barely perceptible change, where comparisons can only be made with other years rather than from month to month.

This slow evolvement received a real push with the change of programing which began in October 1964 and gradually gained momentum as personnel became more familiar with the task assigned and as the worker and the grower began to realize some of the benefits to be gained by cooperating with the sanitarian in his attempt to improve the environment of the migrant. By the end of 1965 a well-designed program had been initiated and definite progress was being made toward improving the conditions under which the migrant was living.

During the year 1966 it was possible for the sanitarian to devote more time to the correction of sanitation deficiencies and the education of the worker and grower in proper sanitation practices. More time was spent with the owners and operators in conferences on labor camp operation and facilities. Field sanitation was emphasized and growers were encouraged to provide adequate toilet facilities for field workers on the job. Special emphasis was placed on replacing privies with water flush toilets and including shower facilities.

Education aids were developed and special classes of instruction were given on sanitation. These classes were usually held in conjunction with nutrition lectures. Thirteen such classes were conducted throughout the year.

A total of 462 complete inspections were made in 1966 for the purpose of determining the sanitary condition of the various labor camps. These inspections covered housing, food, toilet facilities, water and general sanitation.

More than 550 camp visits in addition to those for inspection purposes were made. These represented follow-up visits for instruction and information as well as for survey purposes. One such survey conducted in December of 1966 was for the purpose of determining the amount and value of services received by single male migrants from various clinics established for the farm laborer in Maricopa County. A select number of camps, reasonably near clinic sites, and with a high population of single male workers was chosen for survey. The single workers were asked to answer a questionnaire regarding the availability and use of clinic services. This type of survey provides information for determining unmet needs and aids in planning for future programs.

Over 300 conferences with growers and workers were held throughout the year. Most of these were short conferences with individuals held during inspections of camps or while visiting camps or field operations for other special reasons. During these contacts with the workers or the camp owner or operator, the sanitarian had the opportunity to explain the sanitation reasons for requesting changes and improvements. These brief contacts served to create a better understanding between the sanitarian and those with whom he was attempting to work.

One of the special aims of the program for 1966 was the improvement of sanitary facilities in the fields where hundreds of people were often found working at one time with few or no toilet facilities available. Growers and labor contractors had to be contacted and convinced of the necessity for providing proper toilet facilities for the worker. Gradually through the year, after more than 50 field visits, most of the growers were providing at least a minimum number of toilets for field workers and some were providing other services for the worker for his convenience.

In addition to the above activities, the following was accomplished in the field of sanitation as part of the migrant program:

1. Eight vegetable packing sheds were inspected.
2. Over two hundred water samples were taken at camp sites for bacteriological determination. Several samples were taken for chemical analysis.

3. Twenty-two separate visits were made to camps for the purpose of checking individual sewage systems. Many of these visits included a complete inspection of a new system or an alteration.

4. Seventeen landfill site investigations were conducted. Some of these investigations were for the purpose of locating possible new sites.

5. Thirty-one citizens' complaints regarding sanitary or housing conditions at labor camps were investigated and appropriate action taken.

In October 1966 a change was made in the structure of the sanitation portion of the Migrant Family Health Program. The responsibility for labor camp sanitation was assigned to the district sanitarians to be handled as a regular part of their routine work.

A program sanitarian was chosen to coordinate the work of the district men and their supervisors on all matters pertaining to the Migrant Family Health Program and to work closely with other disciplines of the health department in the program.

As a result of the change in program structure twelve sanitarians, two supervising sanitarians and one program sanitarian became involved directly with sanitation in the migrant program, whereas previously the responsibility had been shared by two sanitarians.

With the increase in numbers involved in the program, it became possible to keep a larger percentage of camps under surveillance at any one time. The district sanitarian, working with the total sanitation program in a particular district can more easily time inspections and visits to coincide with the peak seasons of activity. New activities in each district are more readily detected by the district sanitarian, because his work is limited to a specific area. It should also be possible to keep a closer check on field sanitation with more personnel involved.

During the months of October and November 1966, a concerted effort was made to re-inspect all labor camps known to exist in Maricopa County. The twelve sanitarians involved were notified that information from the inspections would be needed for comparative purposes for the annual report, therefore if possible, all inspections should be completed by December 1, 1966. At the end of November inspection reports on 155 camps had been received in the central office and another 20 were received early in December. The following information was gathered from these inspections:

> Nine camps, not listed in a survey conducted in August 1966, were found to be in operation. Several camps, listed as operating or inactive in August, had been vacated and the buildings razed. Two locations formerly classed as labor camps were determined to be permanent housing with the tenants being permanently employed and not classified as migrant. Thirty camps were found to be inactive at the time of inspection.

The total number of camps reported for statistical purposes was 164 as against 187 in January 1966. Only camps included in the January 1966 and August 1966 surveys were included for comparative purposes. The difference in number of camps reported was the result of reclassification, closure and failure to receive an inspection.

See statistical report at the end of annual report.

Information gathered from the latest camp inspection forms indicated that 48 camps will require additional follow up for much needed sanitation improvement. Generally speaking these were camps with a past record of sanitation problems and in all cases the type of deficiencies noted were considered to be of a more serious nature such as improper waste and sewage disposal or inadequate sanitary facilities.

Future plans indicate that a greater percentage of time will be utilized in working to upgrade those camps where sanitation is poor. By reducing the number of visits to the well operated camps to a reasonable minimum, extra time can be provided for the closer surveillance of borderline or poorly operated camps, As the sanitarian becomes familiar with the camps in his district he will be able to plan his schedule so as to more effectively serve those locations where the need is the greatest.

A review of the table of deficiencies reveals that garbage storage and disposal, sewage disposal and toilet facilities head the list of deficiencies most often noted.

Even though much progress has been made toward inducing the camp supervisors and owners to provide for proper storage and disposal of garbage, open storage and burning are still prevalent in many camps. This, along with open waste, is one of the prime attractors for flies in the camp areas. Open top oil drums serve as both storage container and incinerator.

The privy is still being used in many camps throughout the county. Some are being kept in a reasonably clean and sanitary condition. Others are unscreened, unprotected against the entrance of flies and other vermin, malodorous and potential health hazard. Many have been noted in such a poor condition that effective repair is no longer possible. In all areas where privies have been found efforts have been made to have them replaced with a sanitary water carried sewage system. The addition of showers and hand washing facilities is always encouraged.

A special problem of note which can be overcome only by education and training is the refusal of persons from certain cultural backgrounds to accept and use modern toilet facilities when available. Even where the facilities are being used a serious sanitation problem frequently arises from failure to flush the toilet after each use. One particular case was noted where five toilets at one location were found to be full of human excrement. The situation was corrected simply by flushing each unit but the building was swarming with flies attracted by the existing conditions.

Open containers, used for the disposal of toilet paper, have been noted in the toilet facilities of many camps. This was true even where modern water flush toilets only were available. Such a condition provides an attractor for flies and creates a general unsanitary condition. Special

efforts are being made to eliminate this practice where noted. These include contacting the camp supervisor to enlist his aid and posting bi-lingual (Spanish and English) signs advising that the paper be flushed down the toilet.

A competent supervisor has been found to be the greatest single aid in obtaining and maintaining a high standard of sanitation in the labor camp. The sanitarian is able to accomplish much more if he can work through a person in authority who understands the migrant and has his respect. Continued effort is being made to encourage camp operators to provide competent supervision for their camps.

A major reason for the increase in camp deficiencies between the August and January inspections was the fact that some camps were still unoccupied due to late return of workers this season.

Throughout the year 1966 every effort was made to coordinate the work of the sanitarian with that of the public health nurse, the doctors, social workers and others to bring about a well balanced complete health program for the migrants. Joint classes in food nutrition and sanitation were presented wherever the facilities and an audience could be provided. Sanitarians worked jointly with others to locate sites for and establish clinics of various types. Day Care Centers for children of migrants received the guidance and services of the sanitarian along with that of the public health nurse, social workers, and others. At all times the sanitarian has been aware of the necessity for reporting any suspicions of infectious disease or other condition which might require the services of another discipline. This joint effort was further strengthened by frequent meetings through the year to discuss the various problems which had arisen and plan for future programs.

Several factors have arisen which could have a direct effect on the position of the migrant in Maricopa County in the near future, and on the operation of the Migrant Family Health Program.

Two new industries are locating in the centers of predominantly agricultural areas. One of these is a sugar processing plant and the other a meat packing plant. Both could possibly utilize at least some of the unskilled labor available. However, the greatest change in labor requirement might be brought about by the conversion of farm land to the production of sugar beets. Growing and harvesting conditions will be different than for those crops replaced and labor requirements will vary likewise.

The anticipated relocation of operations for one of the larger growers, if materialized will mean a change for a large number of laborers, and possibly create a depressed area where operations cease.

Many farm laborers have moved away from labor camp situations and are settling into a more permanent type of living, even to the point of owning their own homes. Even though the work performed is more or less transient, a home base is provided for the family with permanent ties such as school and church.

Hundreds of migrants may be found in the metropolitan area of Phoenix utilizing rooms in the older hotels, motels and even locating in some of the trailer courts. For the most part these are single males but family units are represented. As these migrants move to the more crowded urban areas and become a part of the community, changes in services might be required to best fit their needs.

Though many important improvements were made in 1966, relating to the sanitation and the health of the migrant, much is left for future effort by the sanitarian. The following projects are to be considered for special emphasis in 1967:

1. The improvement of all phases of field sanitation.

2. Removal of all privies considered to be unsanitary and hazardous to health and replacement with flush type toilets.

3. Continued work with camp owners in an effort to have competent supervisors placed in each labor camp.

4. Increased numbers of educational programs on sanitation and personal hygiene.

5. Continued cooperation with other disciplines of the Migrant Family Health Program in providing better services for the Migrant.

IX - STATISTICS

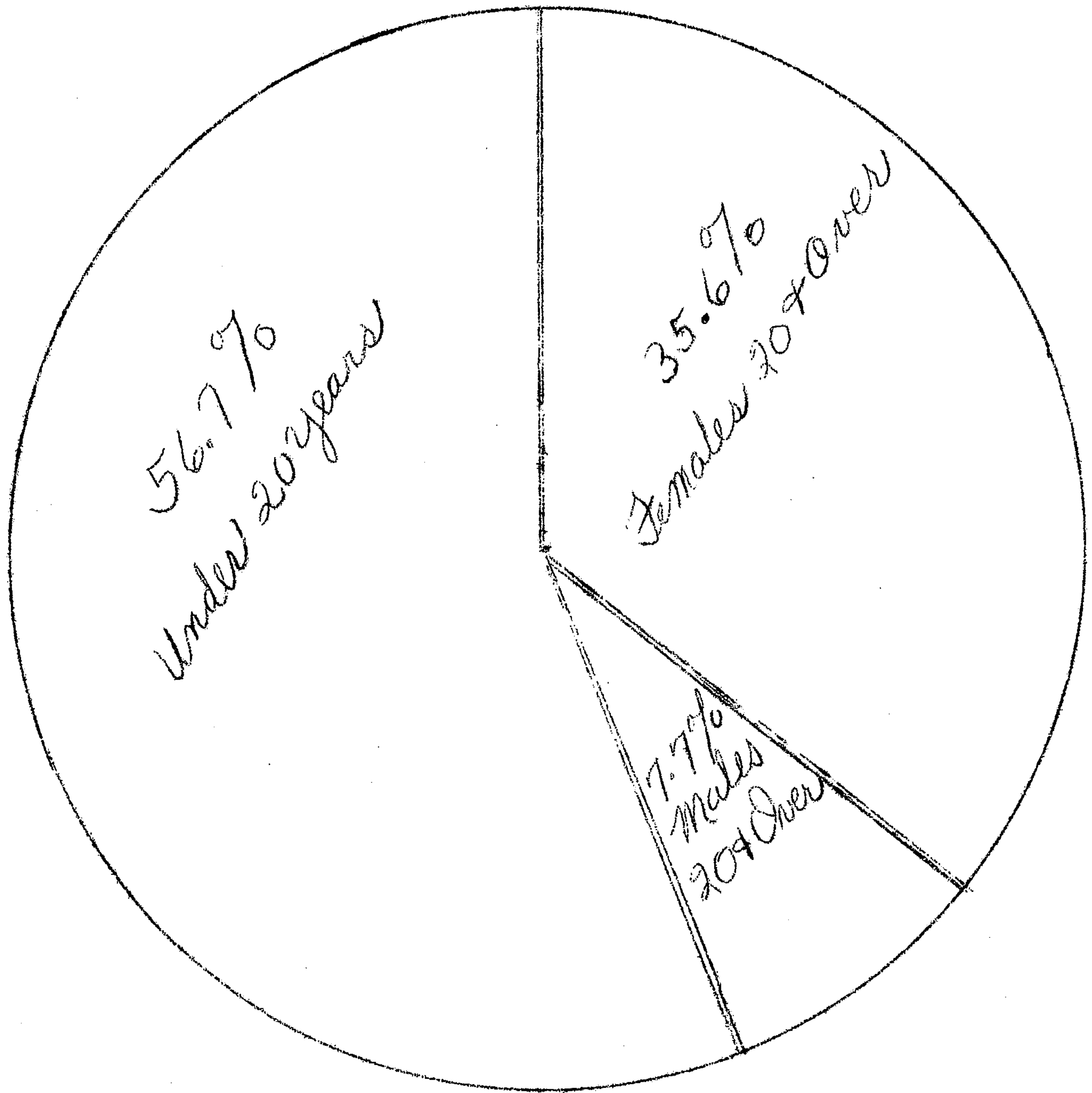
IX - STATISTICS

MIGRANT HEALTH PROGRAM

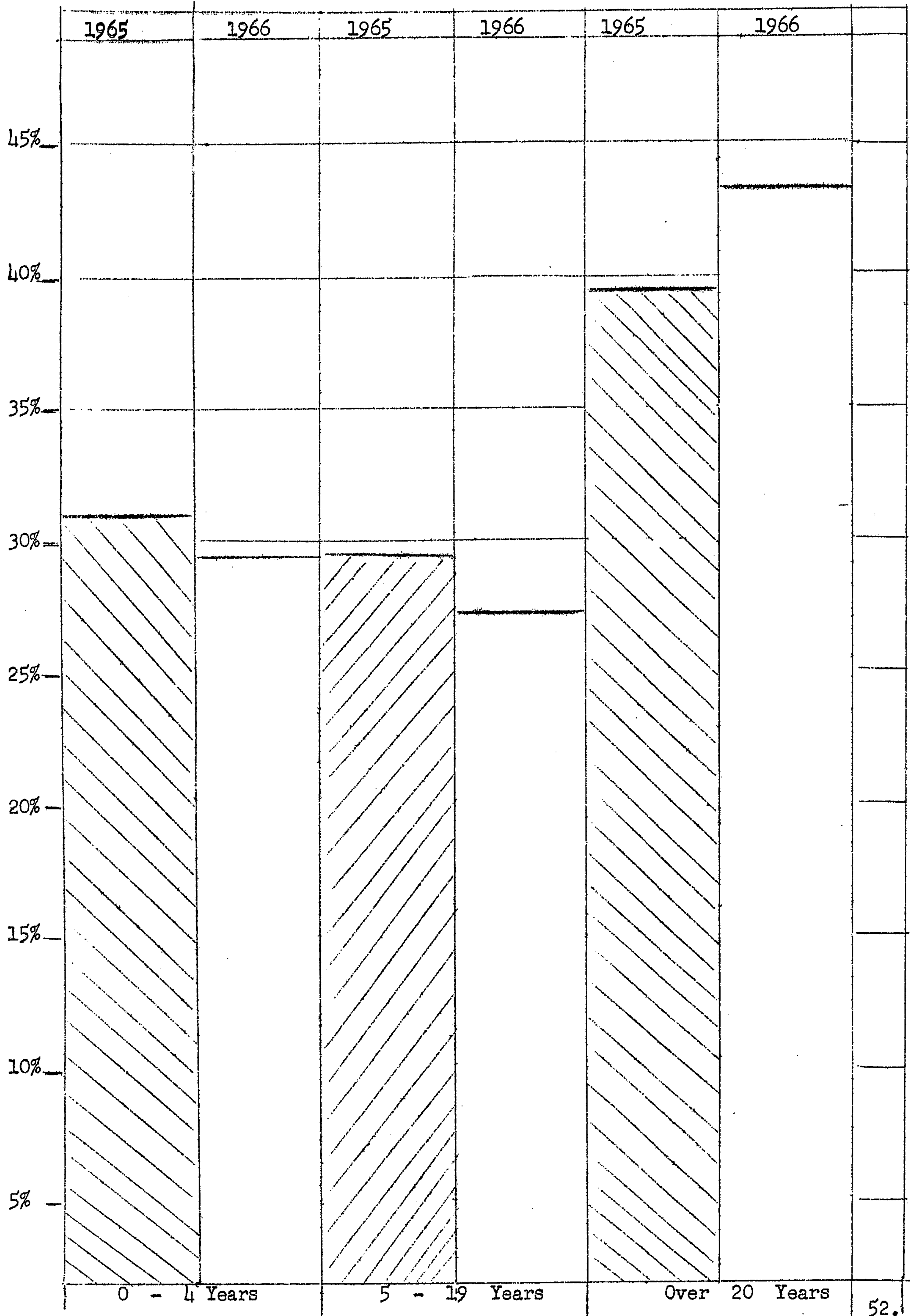
1966

CLINIC ATTENDANCE	1965	1966
New Admissions	3192	2895
Other Visits	4006	6859
Total Services	7198	9754
DIAGNOSIS		
TOTAL	100.0%	100.0%
Respiratory	24.9%	24.7%
Medical Examinations	10.1%	10.5%
Otitis	6.8%	4.3%
Diarrhea	3.4%	1.7%
Immunizations	4.0%	1.8%
Family Planning	5.1%	11.3%
Maternity	2.6%	1.8%
Anemia	3.0%	4.7%
Metabolic Diseases	2.9%	3.4%
Allergies	1.6%	1.4%
Accidents	1.2%	1.7%
Arthritis	1.5%	2.1%
Ill-Defined Conditions	11.2%	3.8%
Miscellaneous	21.7%	26.8%
TOTAL REFERRALS	433 --100.0%	835 --100.0%
To Other Agencies	171 -- 40.0%	211 -- 25.0%
Private Hospital	3.0%	5.5%
County Hospital	35.1%	15.0%
Indian Hospital	0.9%	0.4%
Crippled Children's Hospital	0.5%	3.6%
County Welfare	0.5%	--
Private Doctor	--	0.8%
To Other Health Department Services	262-- 60.0%	624 -- 75.0%
Mental Health Unit	0.2%	--
Diagnostic Chest Clinic	3.7%	2.5%
Dental Clinic	45.7%	9.5%
Maternity Clinic	4.4%	1.1%
Venereal Disease Clinic	0.9%	0.1%
Social Worker	--	3.6%
Well Child Clinic	--	2.4%
Public Health Nurse	--	6.0%
Nutritionist	--	47.9%
Miscellaneous	5.1%	1.7%
New Admission to Nursing Services	406	417
Total Nursing Visits	826	849

Race - Total	100.0%
White	24.2%
White/Mexican	69.0%
Indian	2.1%
Negro	4.7%


56.7%
Under 20 years
35.6%
Females 20 & Over
7.7%
Males
20 & Over

COMPARISON OF MIGRANT HEALTH ADMISSIONS BY SPECIFIC AGE GROUPS, 1965-1966



LABOR CAMP SANITARY DEFICIENCIES

THE FOLLOWING CHART SHOWS THE TOTAL NUMBER OF VIOLATIONS COUNTED IN ALL CAMPS AS OF EACH REPORTING DATE.

ANNUAL REPORT	JANUARY 1966	187 CAMPS REPORTED	85 ITEMS INSPECTED
SUMMER REPORT	AUGUST 1966	181 CAMPS REPORTED	85 ITEMS INSPECTED
ANNUAL REPORT	JANUARY 1967	164 CAMPS REPORTED	85 ITEMS INSPECTED

AREA INSPECTED	ITEM VIOLATED	NO. OF VIOLATIONS JAN. 1966	AUG. 1966	JAN. 1967
SITE	NOT LEVEL	2	0	0
	POOR DRAINAGE	11	2	6
	NOT CLEANABLE	0	0	0
	UNCLEAN	6	2	16
	POOR ACCESS TO MAIN ROAD	1	0	0
	NO CHILDREN'S PLAY AREA	2	0	0
	NO DAY CARE FACILITIES	0	0	0
WELL	UNSAFE	3	3	2
	POOR CONSTRUCTION	4	0	0
	OTHER	0	0	0
WATER	INADEQUATE	1	0	0
	SAMPLE - UNSAFE	7	1	1
	POOR PRESSURE	0	0	3
	CROSS CONNECTIONS			
	NOT PROTECTED FROM POL'N.	5	3	4
GARBAGE	INSUFFICIENT CANS	20	6	19
	UNPROTECTED	71	32	42
	METHOD DISPOSAL	54	11	5
SEWAGE INADEQUATE	SEPTIC TANK	2	0	0
	CESSPOOLS	15	5	15
	PRIVIES	26	8	8
	CHEMICAL	0	0	0
	OTHER	9	17	14
TOILETS	INADEQUATE, UNCLEAN, AND INCONVENIENT	31	23	25
	CENTRAL	1	0	2
	POOR REPAIR	30	23	27
	INDIVIDUAL	0	0	8
	GENDERS NOT SEPARATED	2	1	4
SHOWERS	INADEQUATE AND UNCLEAN	35	13	29
	NO HOT WATER	7	4	0
	GENDERS NOT SEPARATED	6	0	0
	POOR REPAIR	11	5	0
	CENTRAL	0	0	0
	INDIVIDUAL	0	0	0
LAVATORIES	INADEQUATE AND UNCLEAN	27	14	28
	CENTRAL	0	0	0
	NO HOT WATER	6	8	30
	POOR REPAIR	6	0	0
LAUNDRY	NO HOT WATER	2	2	0
	INADEQUATE	10	0	14
	POOR REPAIR	1	0	0

AREA INSPECTED	ITEM VIOLATED	NO. OF VIOLATIONS JAN. 1966	AUG. 1966	JAN. 1967
HOUSING FLOORS	POOR REPAIR	21	5	22
	DIRT	0	0	0
	OTHER	0	0	0
	POOR REPAIR	19	5	6
WALLS	POOR REPAIR	10	7	11
	UNCLEAN	4	0	0
HEATING	UNVENTED	3	3	9
	NOT APPROVED	4	3	0
	INADEQUATE		3	9
VENTILATION	INADEQUATE	2	2	3
LIGHTING	INADEQUATE	0	0	0
SLEEPING	INADEQUATE	1	9	5
	UNCLEAN	6	1	0
	NO VERMIN FREE	3	0	0
	OVERCROWDED	2	7	0
VECTOR CONTROL	FLIES	22	10	26
	MOSQUITOES	11	2	15
	ROACHES	2	1	8
	RODENTS	0	0	0
	SCREENING	10	2	0
	INADEQUATE	0	0	0
ELECTRICAL	INADEQUATE	3	0	0
	POOR REPAIR	3	0	0
	HAZARDOUS	0	0	0
FOOD	NOT COMPLY USPHS CODE	9	5	14
COOKING	FAMILY	1	0	1
	CENTRAL FEEDING	0	0	4
	REFRIGERATION PRO'D	0	0	0
	NO UTENSILS PROVIDED	0	0	0
	NO STORAGE PROVIDED	2	0	1
ANIMALS	IMPROPERLY HOUSED	1	0	0
UNOCCUPIED CAMP	INSANITARY	2	0	3
CONTROL	NO CAMP SUPERVISOR	4	2	9
	NO REG. ENFORCED	4	0	7
	NO OCCUPANTS KEEP OWN	7	0	1
	OTHER CONDITIONS	0	0	0
STORAGE	INADEQUATE	7	0	8
FIRE PROTECTION	HYDRANTS & HOSE	1	0	6
	CHEMICAL	1	0	7
	NONE	36	6	11
	OTHER	0	0	14
	TOTAL DEFICIENCIES	618	258	506

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