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ABSTRACT

In this 1969 annual report, 10 objectives of the Oregon Migrant Health Project--which served approximately 18,400 migrants during the project year--are listed. These objectives relate to providing for diagnostic and medical services, preventive medical services, and dental care, as well as promoting health awareness, education, and improved living conditions among the state's migrants. Medical and dental services, hospital services, nursing services, sanitation services, health education services, and a dental project are discussed in the general appraisal and are then broken down in terms of 12 specific county projects. The document is appended with the Oregon farm labor camp laws, the proposed revisions to the farm labor health code, and recommendations for improvements to farm labor camps. (AN)

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OREGON MIGRANT HEALTH PROJECT

ANNUAL PROGRESS REPORT

1969

UNITED STATES PUBLIC HEALTH SERVICE

PROJECT GRANT MG 05G (70)

RC005177

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ADMINISTRATIVE STAFF
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A. SUMMARY

I. GENERAL INFORMATION

a. The narrative report covers the period from November 30, 1968 to December 1, 1969.

STATE OF OREGON

Project Counties with migrant population   Non-project counties with migrant population

b. Objectives as listed in last approved project application are:

1. To provide diagnostic and needed medical services and in-patient short term hospitalization for migrant workers and their families.

2. To provide readily accessible preventive medical services for all migrant workers and their families.

3. To provide needed dental care through clinics and private dentists' offices for migrant workers and their families, with emphasis on children's dental needs.

4. To promote the use of personal medical records, and improved means of inter-state communication and to achieve maximum continuity of medical and public health services among migrant workers and their families.

5. To educate the migrant workers and their families to the value of and need for current personal medical and immunization records.

6. To promote improved sanitary conditions in farm labor camps and harvest fields through intensive inspection, education, and consultation.

7. To promote an increased community awareness and support for improved health care and environmental living conditions for migrant workers and their families.

8. To provide health education, home economics and family living training, and to achieve a better understanding of the value of good health practices with emphasis on nutrition.

9. To bring about a greater awareness of, and improved motivation for, the utilization of all community medical and preventive health services by the migrant workers and their families.

10. To work closely with all other agencies concerned with the health and welfare of the migrant workers and their families in order to achieve the health care objectives set forth.

c. The objectives listed (I. b.) remain unchanged for the coming project period. Changes have been made in procedures and methodologies in order to better attain the stated objectives. Such changes are described and evaluated within the reports on services.

d. This project year no changes of significance were evident in the migrant situation. Slight changes in the ethnic grouping percentages were recognized. In 1968, 51% of the families screened were Spanish speaking as compared with 55% in 1969. Twenty-seven percent of the families were new in the area in 1968 as opposed to approximately thirty percent in 1969. The trend of a few migrants "settling out" or "wintering over" continues in all the project counties.

II. Involvement of the community and the consumers, on the state level, in planning implementation, and financing of the Oregon Migrant Health Project has materialized through the years as a result of the project staff's efforts to obtain such. The table below is an attempt to illustrate the type and amount of involvement of a variety of agencies, groups and individuals associated with the project. Much of the project's accomplishment can be attributed to the involvement and support solicited from the consumers and the community.

INVOLVEMENT AND SUPPORT OF VARIOUS GROUPS AND INDIVIDUALS
IN ASPECTS OF THE MIGRANT HEALTH PROJECT - 1969

	Planning	Implementation	Financing (health services)	Supportive
Migrants	■	▲	■	▲
Farm Bureau	●	●	NA	●
Extension Service	●	●	NA	●
Department of Education	●	●	●	●
Tuberculosis & Health Assn.	■	■	■	▲
State Tuberculosis Hospital	●	●	●	●
U of O Medical School	●	●	●	●
U of O Dental School	●/■	●	■	●
Valley Migrant League	–			●
Department of Welfare	■		▲	▲
Employment Service	●	●	NA	●
Bureau of Labor	●			
Council of Churches		▲		●
Indian Health Service	■	■	■	■
Dental Auxiliary			■	■
Girl Scout Council				■
Department of Motor Vehicles			▲	
State Board of Health:				
Local Health Services	●	●		●
Epidemiology	●	▲		●
Maternal and Child Health	▲	▲	■	▲
Dental Health	–	■		–
Tuberculosis Control		●		●

● High
▲ Moderate
■ Low

III. Staff Orientation and Training

a. Provided by state project for local project staff:

1. May 15-16, 1969: Project Nurse and Community Health Aide Workshop
2. July 11, 1969: Migrant Health Project Nurse and Aide Meeting
3. October 22-23, 1969: Annual Migrant Health Seminar
4. October 24, 1969: Information Exchange Meeting
5. Individual training and problem solving on location

b. Provided by local project staff for staff:

1. Individual orientation on-the-job
2. Field application

MEDICAL AND DENTAL SERVICES

Review of the individual county migrant health project reports reflects significant improvement in health services provided migrant workers and their families within Oregon. An increased percentage of individuals seen for health screening have obtained medical care and we have been unable to document any acute medical problem that remained unmet, with the possible exception of an individual definitely refusing an offered service.

Year	Number seen	Receiving Out-patient care	Hospitalized	Health Counseling
1967	17,875	3,926	157	5,167
1968	16,782	4,576	291	2,728
1969	18,401	5,376	524*	9,846

*342 paid by project funds

In the majority of the counties, medical care is provided by private physicians in their individual offices, and with the good cooperation of the local medical community we feel the medical care provided is quite adequate. Three of the counties provided evening medical clinics as is shown in the separate reports. Table I shows the total number of conditions diagnosed by the International Classification of Diseases. In the 953 cases listed under Diseases of the Respiratory System, we note that 402 of these were for treatment of a common cold; 359 of these 402 were seen in the evening clinics in the three counties having such resources. In the counties without evening clinics, nurses worked more closely with the families in their home situations, helping in interpreting symptoms, and recommending certain procedures outlined by the health officer and the local medical society. See Exhibit One in attached packet. We note also that 150 cases of otitis media received treatment. We feel we have not done enough extensive case finding of school-age youngsters with hearing losses. Prior to the project, or in the beginning years of the project, many of the ear infections were not getting prompt treatment and it is hoped in the 1970 season we can do a much more complete hearing evaluation with follow-up on indicated care.

Nursing reports seem to reflect an increasing number of patients with ulcers, and we note that 46 were brought under treatment. As one nurse stated in a narrative report, "This year I am seeing fewer guitars and more ulcers in the camp. Isn't it a shame?" In talking about total health needs of a population, the reason for this is certainly something to be considered.

Four hundred eighty-nine patients were treated as a result of accidents, and 231 of these were from lacerations. This points out a problem that is discussed in more detail in the nursing narrative.

As noted in previous reports, the dental needs were of concern because resources were not readily available in the local communities. In cooperation with the University of Oregon Dental School this year, great strides were made toward dental prevention and in the provision of dental care. (See separate report.) It is hoped that this program will be continued and expanded in 1970. An increasing number of workers who come into the state are requesting dental services and we found an exciting response to the dental care programs held in the camps.

Emphasis has been on improving quality of medical care by making laboratory and X-ray facilities available, as well as on the provision of adequate medical manpower. One of the critical areas within the state is in the southern part of Marion County. The University of Oregon Medical School faculty and several interested medical students are working with the Marion County Health Department staff in planning a clinic for that area this coming season to provide clinical service 5 evenings a week. (See attached project application.)

The only project county not having an agreement with the local hospitals to provide hospital care for migrants has been Yamhill County. This past year an agreement was made with one of the local hospitals in Yamhill County to provide hospital care which was utilized

by an adjoing area of Marion County. It is hoped that Yamhill County will include mon its budget to make use of this facility.

TABLE I

Medical Conditions Found by Physicians among Out-patients

All Project Counties

	Condition	Count
I.	Infective and Parasitic Diseases	403
II.	Neoplasms	24
III.	Endocrine, Nutritional, and Metabolic	228
IV.	Diseases of the Blood and Blood Forming Organs	23
V.	Mental Disorders	76
VI.	Diseases of the Nervous System and Sense Organs	412
VII.	Diseases of the Circulatory System	75
VIII.	Diseases of the Respiratory System	953
IX.	Diseases of the Digestive System	640
X.	Diseases of the Genitourinary System	253
XI.	Complications of Pregnancy, Childbirth, and the Puerperium	99
XII.	Diseases of the Skin and Subcutaneous Tissue	469
XIII.	Diseases of the Musculoskeletal System and Connective Tissue	98
XIV.	Congenital Anomalies	14
XV.	Perinatal Morbidity and Mortality	2
XVI.	Symptoms and Ill-Defined Conditions	331
XVII.	Accidents, Poisonings, and Violence	489
	Prenatal	267
	Family Planning	310
		5166

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NURSING

Project nurses with their health aides make an effort to contact every family that comes into the area to do agricultural work. The family record is used as a tool to make a health assessment of the total family and the identification information recorded is an invaluable asset in the event the family moves on before medical care can be completed.

Please print and write on hard surface

FAMILY RECORD

(Use one record for each family)

Head of Family: [redacted] (Last Name) Francisco (First Name) (Middle Initial) (Nick Name) 50 (Age) M (Sex)

Home Address: [redacted] Ave. East (No. and Street) Abernathy (City) Texas (State) (Zip Code)

Local Address: [redacted] (Camp and Shelter No. or Farm) Linn (County) Oregon (State) (Zip Code)

Date of Arrival This Year 5-6-69 Arrival From Abernathy Next Destination Calif. or Abernathy

Did you work in Oregon last year No Where Owatonna, Minn. Other identifying family information:

Spanish (X) Indian ( ) Anglo ( ) Other (specify)

	Yes	No	Unk
Worked in area before?	( )	(X)	( )
Health insurance?	( )	(X)	( )
Social Sec. No. Husband [redacted] Wife			
Part of crew?	( )	(X)	( )
Leader			
Under Labor Contractor?	( )	(X)	( )
Contractor			

FAMILY COMPOSITION AND MEDICAL HISTORY

NAME	Relationship	Birth Date	Sex	Present Status: Working	Present Status: In School	Present Status: At Home	High Grade Comp.	English Spoken	Medical History (Serious Illness, Crip. Handicaps)	Immunization Record (Dates): Smallpox	DPT	DT	Polio	Other	X-Rays, Tests: Date	Results
	x x x x															
* Francisco	husb	4-2-19		✓			None		ok							
* Catarina	wife	4-30-31				✓	10th	yes	had cholecystectomy 3-27-69 umbilical hernia - hurts & burns							
* Rudalfo		5-25-51						yes	convulsions							
Maria Estela		1-23-53		✓	9th			yes	ok							
Maria Oralia		2-28-5[illegible]		✓	8th			yes	7-1 too [illegible] app.							
Francisca		4-12-56		✓	6th			yes	ok							
Francisco, Jr.		5-5-58		✓	5th			yes	ok							
Jose		7-21-59			2nd			yes	ok							
Rogelio		9-7-61			1st			yes	ok							
Jimmy		1-20-6[illegible]				✓		yes	ok							
Freddy		7-20-64				✓			ok							
Richard		3-31-66				✓			ok							
Michael		9-6-67				✓			ok							

Did Family Have Personal Health Records? Yes (X) No ( ) Were Personal Health Records Updated or Provided to Family? Yes ( ) No ( )

Linn County Health Department Prepared by Lupita Cavazos health aide Date 6-17-69

Form No. OH-46 Rev. 3-68 SP-7110
Oregon State Board of Health—Migrant Health Project

(Additional Data on Reverse Side)

Family Record as compiled by health aide

The nurse records on the nursing log the pertinent information that needs further attention and makes the necessary arrangements.

Name D. Park

NURSING SERVICE LOG -- REFERRALS & THEIR DISPOSITION

For Week Ending July 4, 1969

Office Copy

COUNTY Linn

Name (Please Print)	Sex	Age	Referred to nurse by:	Referred by nurse to	Condition ICD Code	LHS Coding Prog. code	LHS Coding No. visits	Arrangement for service	Outcome	Reason referral not carried out
Rudalfo XXXXXXX	M	18	mother	physician	Convulsions VI 345	25	8	inter-agency referral	hospitalized him routinely	
Francisco XXXXXXX	M	50	wife	physician	loss of hearing VI 38	51	2	inter-agency referral		
Catarina XXXXXXX	F	38	self	physician	copheritis chron. X 629	39	1	Inter-agency referral	referral rcd, given physician	
Catarina XXXXXXX	F	38	self	physician	PAP smear & exam X 629	39	4	7-14 made appt.	treated	
Jesus XXXXXXX	M	32	wife	physician	mental illness V 298	49	4	made appt. ment.hlth	pt. seen, given med.	
Martin XXXXX	M	2	mother	local hlth dept.	immunization Y 02	09	2	wrote out hrs./come	didn't get shots	
Jesse XXXXX	M	5	mother	self	cut w/glass, left foot XVII 892	19	3	cleansed wound. Soak Neosporin	healed	
Yolande XXXXX	F	11	mother	self	impetigo XII 684	09	3	cleansed w PHex, Neosp.	healed	
Celia XXXXXXX	F	15	mother	dentist	gums sore, teeth break XVII 528	19	3	appt. made 7/21 a.m.	pt. [illegible]ated	
Natividad XXXXXXX	F	31	aide	local hlth dept.	TB, need INH I 017	01	4	arranged to get medicine	me[illegible]cine received	
Alfundio XXXXXXX	M	66	aide	co.mental hlth.clinic	mental, paranoid V 297	49	3	phys.referral m.h.clinic	pt. treated, ok now	
Mercedes XXXXX	F	18	health educator	Linn-Benton Com.College	cont. edn. Y 04	59	3	made appt. w college	will attend comm.college	
Juanita XXXXXXX	F	35	self	lawyer	no drivers license Y 04	59	2	referred for legal aid	got drivers license	
Celestina XXXXX	F	48	aide	physician	bee sting or bite on eye VI 378	39	3	physician referred	pt. treated, ok now	
Dario XXXXXXX	M	11	mother	pharmacist	Poison Oak XII 709	19	2	Calomine & other pois. oak medicine	ok now	
Martina XXXXXXX	F	15	mother	self	Acne XII 709	19	2	cleanse face, diet planning, Neosporin	healed	

Totals:
No., physician-dental ref. 8 No., other ref. 9 No., phy.-dent. ref. completed 8 No., ref outcome unknown ____

Family Log as recorded by nurse

In the event the family moves on while undergoing treatment, or before definite diagnosis is confirmed, a referral is forwarded to their next destination -- or information is requested from place of previous residence.

DATE: September 17, 1969

INTER-AGENCY REFERRAL FORM
Oregon State Board of Health Migrant Project

TO:
Name: Carl F. Moore, M.D., Director
Agency: Texas State Health Department
Address: Austin, Texas

FROM:
Name: Gordon C. Edwards, M.D.
Agency: Oregon State Board of Health
Address: Portland, Oregon 97201

- - - - -

PATIENT

Name: [illegible], Rodolfo Sex: M Date of Birth: 5-5-51
Head of Household: Francisco Local Address: Lima
Home Address: 1012 Avenue E Albernathy, Texas
(Sufficient detail for location)
Name and Address of Person to notify in case of family emergency ______

Destination Address (if known): ______
Crew Leader's Name (if known): ______ Address: ______
Family Physician: ______ Address: ______
Racial Origin: Spanish-American Social Security No: ______
Conveyance: Make ______ (sedan, truck, color) ______ Year ______ License No. ______
Is Information on Personal Health Card current? Yes ______ No ______

- - - - -

REASON FOR REFERRAL

Diagnosis and/or Physician's order or recommendations:

Rodolfo was hospitalized in Oregon with a discharge diagnosis of "Status Epilepticus" and placed on Dilantin, Phenobarbital, and Furadantin. Prior to coming to Oregon to be with his family he had been in the U. S. Marine Corps and had received a discharge we understand.

(For immunizations and laboratory information refer to Personal Health Record.)

SERVICES REQUESTED

Nursing and medical supervision to see that Rodolfo continues his medication.

Reply requested: Yes X No ______ Signed: Hesther Poareo
- - - - - Supervising Nurse

Use this space for report to referring agency: Date: 10 - 8 - 69

10-16-69 reply received

"Rodolfo arrived in Abernathy on Sept. 1, 1969 with his family. He has had one seizure since being here. Was without drugs at this time but is on Dilantin and Phenobarbital at this time and has been encouraged to stay on drugs regularly."

Signed A. Morrison, PHN I

9-22-69 Referred by Dr. Bucker to Gerald W. Wagner, M.D., Director, Plainview-Hale Health Dist., Plainview, Texas.

Name of Worker: ______

1. Did migrant have Personal Health Card? Yes ______ No ______

OH-66 4/68 eg 10-16-69 Inf. to Lima Co.

Interstate Referral

An evidence of the acceptance of continuing medical care from one area to another is the more accurate information the family has been providing the project staff. It is noted that not as many false addresses are given as in previous years and it is believed this has been brought about by the families' understanding of the purpose of the information requested.

One of our objectives is "To provide readily accessible preventive medical services for all migrant workers and their families." This has been encouraged through health education. It is noted that the number of immunizations given this year have decreased. The project nurses noted in their reports that the level of immunization seemed to be higher and they put their available time into other activities. Immunizations were made available in all counties, however.

Another objective is "To promote the use of personal medical records, and improve means of interstate communication and to achieve maximum continuity of medical and public health services among migrant workers and their families." Closely allied with this is the objective, "To educate the migrant workers and their families to the value of and need for current personal medical and immunization records."

In evaluating the use of personal medical records it was felt that they were not being put to the most effective use and for some reason not enough pertinent information was being recorded on them, also the next nurse seeing the card was not having the benefit of knowing what had been done in planning with the family. A new family record is being devised for use this next season which will include space for a nursing plan and a copy of this record will be given the member of the family interviewed for them to carry with them. It is anticipated that this will provide much more comprehensive care while the family moves about within the State.

Since most of the project staff are seasonal, the state project nursing staff does a major part of the preseason planning. The supervising nurse works closely with other agencies and organizations with migrant programs. She has worked closely with the Migrant Education Section of the State Department of Education, particularly regarding the dental program and the health records required on the new Student Transfer Form.

As a result of the Department of Employment E & D Project, an informal interagency group began meeting in Malheur County. The supervising nurse has attended these meetings with representatives from Treasure Valley College, Department of Education, Welfare, Veteran's Administration, Apprenticeship & Training, U. S. Department of Labor, Department of Employment and local project staff. One of the problems brought in for discussion at the last meeting concerned the number of unpaid hospital bills resulting from highway accidents occurring with migrant families. This would seem to be a symptom rather than the problem. The next meeting will include representation from Motor Vehicle Department and State Police for discussion about the reasons why the workers are unable to get liability insurance, their accident rate, their difficulty in getting Oregon driver's licenses and it is hoped that something beneficial can be worked out.

The licensing of day care facilities was transferred to the Department of Welfare from the State Board of Health July 1, 1969 and we are presently working with the Welfare Division regarding indicated improvement of the seasonal day care services.

The State Nutrition Council was reactivated this season and following the Nutrition Survey in Polk County (see separate report) the state supervising nurse met with the Council and participated in the Nutrition Council Conference. She was also a member on a panel entitle "Quality and Distribution of Medical Care" at the Oregon Medical Association Annual Meeting.

As noted in the medical report, 231 of the accidents reported were lacerations. The majori of these lacerations were from children stepping on broken glass in the camp area. With th addition of our community health aides this year, many of the nurses did more in the area o camp and home safety in accident prevention programs. It is hoped to do an even more inten sive program in this area next year.

In discussion of problems at our annual seminar the major one common to all counties seemed to be transportation. It is said, "To make services available to migrants without making them accessible and acceptable is a waste of time, effort, and money." Acceptability is defined as "obtainable in a full set of variables such as geography, time, transportation procedures, and cost." In analysis of these quotations, we wonder if we really mean that we want to make the services accessible. The field project staff feel that in an increasing number of instances they are being looked upon as taxicab drivers rather than purveyors of a service. There seemed to be a consensus that if the potential patient recognized the value of good health, the need to be under medical supervision, the advantage of continuing medical care until the condition was alleviated, he would be more apt to find his way to the medical sources. Possibly then, it would be more advantageous to put the majority of professional time, nurses and community aides, in bringing this understanding about and then working on any barriers there might be in the individual being able to get to the medical source. This problem has been discussed on numerous occasions with Valley Migrant League staff, Migrant Ministry staff, and members of the working families. We are confident that lack of transportation need not be an insurmountable barrier to medical care.

HOSPITAL SERVICES

The hospital component of the Migrant Health Project has again helped defray expenses of migrants in 34 community hospitals. A portion of the cost for 342 hospitalizations (including newborns) was paid by migrant funds. In the reporting period, the sum of $39,388 was paid to participating hospitals. This represented a payment of 44% of the approximate $89,000 in total billing. While in some cases the migrant families are able to assume all or part of the unpaid balance, in the majority of cases the additional cost must be borne by the small community hospital. Limited to a 30-day billing, the average project payment per hospitalization amounted to $115.17. The average hospital stay was four days, with an average daily cost payment by the project of $29.59. Included as part of care was a total of 100 surgeries. A breakdown of final diagnoses and surgical procedures is shown in the accompanying tables. It is interesting to note a large number of hospitalizations were for delivery and mother and infant care. Under each county report is an age breakdown of the hospitalized patients.

Medical services available at the University of Oregon Medical School are still utilized. The actual number of patients receiving services is unknown since separate information on migrants is not kept. The Oregon State mental hospital, Crippled Children's Division, University State Tuberculosis Hospital, and Shriner's Hospital for Crippled Children readily accept and admit migrants needing their specialized services.

An example of the interest and cooperative effort of many people in providing needed care can be illustrated by the case of Mr. G. Mr. G. is a Mexican citizen who entered our country illegally in an effort to raise enough money for needed surgery for a young son in Mexico. He became acutely ill, was hospitalized in the community hospital and found to have active, infective tuberculosis and needed care in a tuberculosis hospital. Since he was in the country without visa, he had to be reported to the Immigration Service. The local Deputy District Director was very understanding of the problem and agreed to arrange a "postponement of action" in his case if Mr. G. could receive treatment here. The hospital was willing to accept him for treatment until he could be safely returned to his home. A necessary waiver of residency was obtained from the Director of the Tuberculosis and Chest Diseases Section, Oregon State Board of Health, and Mr. G. was admitted to the hospital. Mr. G. was understandably upset and worried about his family. After conferring with the local Mexican Consul, we were able to give Mr. G. some very practical suggestions as to where and how his family could receive needed follow-up and care in their home area. At reporting time Mr. G. is still hospitalized but making progress towards stabilizing his disease.

TABLE 2

HOSPITALIZATIONS - DECEMBER 1, 1968 - DECEMBER 1, 1969

For all project counties in which migrant project funds were used.
Total number of hospitalizations (including newborn) 342
Migrant project monies paid to community hospitals - $39,387.92

CLASSIFICATION OF DIAGNOSES BY SYSTEMS OR CATEGORIES (ICD)*

I. INFECTIVE & PARASITIC DISEASES - 8
- Tuberculosis (active 2, suspect 2) - 4
- Bacterial diseases (septicemia 1, scarlet fever 1) - 2
- Viral diseases (infectious hepatitis 1) - 1
- Venereal diseases (latent syphilis 1) - 1

II. NEOPLASMS - 4
- Malignant (lung 1, brain 1, cervix 1) - 3
- Benign (breast 1) - 1

III. ENDOCRINE, NUTRITIONAL, & METABOLIC DISEASES - 11
- Diseases of endocrine glands (diabetes mellitus 5) - 5
- Nutritional deficiency - 4
- Metabolic diseases (obesity not specified endocrine origin 2) - 2

IV. DISEASES OF BLOOD & BLOOD-FORMING ORGANS - 4
- Anemias - 4

V. MENTAL DISORDERS - 9
- Psychoses - 1
- Neuroses, personality disorders, 7 nonpsychotic mental disorders - 8

VI. DISEASES OF THE NERVOUS SYSTEM & SENSE ORGANS - 5
- Inflammatory diseases of central nervous system - 2
- Other diseases of central nervous system (epilepsy) - 2
- Diseases of the ear - 1

VII. DISEASES OF THE CIRCULATORY SYSTEM - 21
- Hypertensive disease - 3
- Ischemic heart disease - 14
- Diseases of arteries, arterioles, & capillaries - 2
- Diseases of veins, lymphatics, & other diseases of the circulatory system - 2

VIII. DISEASES OF THE RESPIRATORY SYSTEM - 29
- Acute respiratory infections - 10
- Pneumonia - 9
- Bronchitis, emphysema, & asthma - 3
- Other diseases of respiratory tract - 7

IX. DISEASES OF THE DIGESTIVE TRACT - 54
- Diseases of esophagus, stomach, & duodenum (ulcers 8) - 15
- Appendicitis - 9
- Hernias - 5
- Other diseases of intestine & peritoneum - 16
- Diseases of liver, gallbladder, & pancreas - 10

X. DISEASES OF THE GENITO-URINARY SYSTEM - 23
- Nephritis & nephrosis - 1
- Other diseases of urinary system - 10
- Diseases of male genital organs - 1
- Diseases of breast, ovary, fallopian tubes, & parametrium - 3
- Diseases of female genital organs - 8

XI. COMPLICATIONS OF PREGNANCY, CHILDBIRTH, & THE PUERPERIUM - 87
- Complications of pregnancy (ectopic pregnancy 1, false labor 5) - 6
- Urinary infections & toxemias of pregnancy - 1

*If more than one diagnosis is given, each condition is coded separately.

Abortion - 6
Delivery - 74
At term, (single delivery 63, twin delivery 1, stillborn twins 1) - 65
Cesarean Section, at term - 4
Premature, (single delivery 4, single stillborn 1) - 5

XII. DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE - 12
Infections of skin and subcutaneous tissue - 9
Other inflammatory conditions of skin and subcutaneous tissue - 3

XIII. DISEASES OF THE MUSCULOSKELETAL SYSTEM - 5
Arthritis & rheumatism - 2
Other diseases of bone & joint
Other diseases of musculoskeletal system - 1

XIV. CONGENITAL ANOMALIES - 1
Congenital anomalies of the respiratory system - 1

XVI. SYMPTOMS AND ILL-DEFINED CONDITIONS - 10
Symptoms referable to respiratory system - 1
Other general & ill-defined symptoms - 9

XVII. ACCIDENTS, POISONINGS, & VIOLENCE - 40
Fractures & dislocations - 13
Burns - 3
Lacerations, contusions, and concussions - 11
Sprains & strains - 4
Adverse effects of drugs & medicaments, etc. - 2
Accidental poisoning by drugs, medicaments, etc. - 7

CAUSES OF DEATH - 6
Malignant neoplasm of brain (metastis from lung) - 1
Infant deaths (prematurity 2, atelectasis & prematurity 1) - 3
Dehydration (secondary to diarrhea & upper respiratory infection) - 1
Pneumonia - 1

Surgical Procedures*

ICD Code #	Surgical & Non-Surgical Procedure	Total	Under 1 M	Under 1 F	1-4 M	1-4 F	5-14 M	5-14 F	15-44 M	15-44 F	45-64 M	45-64 F	65 & Older M	65 & Older F
	NEUROSURGERY													
01	Incision & excision of skull & intracranial structures	1						1						
	OPHTHALMOLOGY													
11	Operations on cornea & sclera	1				1								
	OTORHINOLARYNGOLOGY													
19	Operations on nose	1					1							
21.1	Tonsillectomy	5					1	1		3				
	VASCULAR & CARDIAC SURGERY													
24	Operations on peripheral blood vessels	1								1				
	ABDOMINAL SURGERY													
38	Repair of hernia	6	1						3		1	1		
41	Operations on appendix	15					2	2	6	4	1			
43.5	Cholecystectomy	4								2		1		1
46	Operations on stomach	3		1							2			
47	Incision, excision, resection & enterostomy of intestines	2							2					
	PROCTOLOGICAL SURGERY													
51	Operations on anus	2									1	1		
	UROLOGICAL SURGERY													
56	Operations on urinary bladder	1					1							
61.2	Circumcision	7	7											
61.9	Other operations on penis	1			1									
	GYNECOLOGICAL SURGERY													
67	Operations on ovary	1								1				
68.5	Ligation of fallopian tubes	12								12				
69	Hysterectomy	2								2				
70.3	Dilation & curettage of uterus (including diagnostic)	6								3		3		
71.3	Colporrhapy									2				
	OBSTETRICAL PROCEDURES													
75.9	Episiotomy	3								3				
77	Cesarean Section	3								3				
78.1	Dilation & curettage after delivery or abortion	5								5				
	ORTHOPEDIC SURGERY													
83	Reduction of fracture & fracture-dislocation of ankle & wrist	1												1
84	Reduction of other fracture & fracture-dislocation	4					1	2			1			
	PLASTIC SURGERY													
92	Incision of skin & subcutaneous tissue	3			1		1			1				
92.5	Suture of skin	2									1	1		
	BIOPSY													
A1.9	Biopsy of biliary tract	1								1				
A2.3	Biopsy of breast	1								1				
	OTHER NON-SURGICAL PROCEDURES													
A9.0	Intravenous pylogram	1						1						
R9.5	Spinal puncture	2	1				1							
R9.9	Cystoscopy	1										1		
	TOTAL	100												

*If more than one surgical procedure was performed, they are coded separately.

TABLE 3
INTERSTATE REFERRALS
December 1, 1968 - December 1, 1969

States	Individuals Referred from Other states	Individual Referrals from Oregon to Other States		
		Referred to	Responses from	Completed*
Arizona	6	12	9	5
Arkansas		3	2	2
California	1	45	27	24
Idaho		14	4	4
Kentucky		1	1	1
Missouri		2	2	
New Mexico		5	5	4
Oklahoma		4	3	2
Texas	16	66	45	35
Washington	2	20	11	7
Wyoming		1	1	1
Totals	25	173	110	85

*Indicates that the desired information was obtained or the person referred was located and plans made for continuity of care. Excludes those who could not be located or when the information desired was unknown.

INTRASTATE AND INTERSTATE REFERRALS

The use of some means of providing a continuity of care often means the difference between success or failure of medical treatment. In certain chronic diseases such as diabetes, epilepsy, or tuberculosis, continuous, periodic medical care and supervision are essential if optimum health is to be maintained for the individual. At the present time our system of intra- and interstate referrals seems to be the most workable means of providing this continuity of care both in and out of the state. While it has not been completely effective, it has helped migrant project nurses to provide more needed services.

During the reporting period a total of 259 individual referrals were processed through the state office. Of these, 173 were interstate referrals to 11 different states. (See Table 4). Replies received indicate that 85 or 49% of individual referrals were completed — completed in terms that the desired information was received or that the individual had been located and plans had been made for continuing care. Hopefully many more of these referrals can be completed during the winter while the families are at their "home base." Each referral was coded as to the referring condition. (See Table 3).

Again this year a large number of referrals were related to tuberculosis. Since our state Tuberculosis Control Section does not attempt to follow known tuberculosis migrants after they leave the state, we attempt to provide the medical supervision for them. A case file is maintained and prior to each harvest season a list of known cases is prepared. Each nurse and community health aide has a copy of this list. As families are screened, if the individual needs medical follow-up at that time, arrangements are made with local chest clinics, health departments, or physicians for the necessary care. We work closely with the Tuberculosis Control Section for mutual information and help in following these migrants.

TABLE 4

INTERSTATE AND INTRASTATE REFERRALS
(Total individuals 259)*
December 1, 1968 - December 1, 1969

DISEASE CONDITIONS REFERRED - AS CLASSIFIED BY CATEGORIES (ICD)

I. INFECTIVE AND PARASITIC DISEASE - 97
 Tuberculosis (known, suspected or contacts) - 55
  On prophylactic INH or needing repeat tuberculins or X-rays - 31
 Bacterial or viral infections - 4
 Venereal disease - 6
 Helminthiasis - 1

II. NEOPLASMS - 10
 Malignant neoplasms (pharynx 1, uterus 1, cervix 1) - 3
 Neoplasms, unspecified - 7

III. ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES - 19
 Thyrotoxicosis - 1
 Diabetes mellitus - 17
 Nutritional deficiency - 1

IV. MENTAL DISORDERS - 16
 Psychoses and Neuroses - 10
 Mental retardation - 6

V. DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS - 28
 Diseases of the central nervous system - 14
 Diseases and conditions of the eye - 5
 Diseases of the ear - 9

VI. DISEASES OF THE CIRCULATORY SYSTEM - 11
 Heart disease - 6
 Hypertensive disease and other diseases of circulatory system - 5

VII. DISEASES OF THE RESPIRATORY SYSTEM - 8
 Acute respiratory infections - 6
 Other diseases of respiratory tract - 2

VIII. DISEASES OF THE DIGESTIVE SYSTEM - 13
 Conditions of teeth or buccal cavity - 3
 Diseases of stomach - 4
 Hernias - 4
 Diseases of gallbladder - 2

IX. DISEASES OF THE GENITOURINARY SYSTEM - 8
 Diseases of urinary system - 3
 Diseases of female genital organs - 5

X. DISEASES OF SKIN AND SUBCUTANEOUS TISSUE - 2

XI. DISEASES OF MUSCULOSKETAL SYSTEM - 3

XII. CONGENITAL ANOMALIES - 1

XIII. SYMPTOMS AND ILL-DEFINED CONDITIONS - 9

XIV. ACCIDENTS - 9
 Fractures and dislocations - 7
 Burns - 1
 Poisoning - 1

SUPPLEMENTARY - 42
 Pre-natal or post-natal care - 25
 Family planning or counseling - 4
 Special tests (Pap and PKU) - 9
 Immunizations and medical information - 4

*From all project counties

Health Education

The health education component has strengthened the attainment of total project objectives. Achievements in health education, however slight they may be, are major breakthroughs in terms of project staff time, understanding and application. There is an increasing understanding, by the staff, of the health education approach (community organization - involvement), which is becoming more evident in programing and implementation. The Health Education Services report provides in detail a measurement of sub-objectives. In general, there was an increase in the utilization of indigenous aides; more in-service training for local project staff was provided; attempts to have migrant health advisory groups organized on the local level received negligible results; formation of a state migrant advisory committee is almost completed; and use and development of health information materials and educational techniques has improved. Much remains to be done in the area of health education, requiring continued state project staff support and guidance.

SANITATION

The following tables show a composite of the data available individually from the local project reports.

6. HOUSING ACCOMMODATIONS

a. CAMPS			b. OTHER HOUSING ACCOMMODATIONS		
MAXIMUM CAPACITY	NUMBER	OCCUPANCY (Peak)	LOCATION (Specify)	NUMBER	OCCUPANCY (Peak)
				368	3376
LESS THAN 10 PERSONS	197	1071			
10 - 25 PERSONS	245	3953			
26 - 50 PERSONS	329	4244			
51 - 100 PERSONS	84	5181			
MORE THAN 100 PERSONS	75	13093			
TOTAL	930	27542	TOTAL	368	3376

SURVEY OF HOUSING ACCOMMODATIONS

HOUSING ACCOMMODATIONS	TOTAL		COVERED BY PERMITS	
	NUMBER	MAXIMUM CAPACITY	NUMBER	MAXIMUM CAPACITY
CAMPS	930	27542		
OTHER LOCATIONS	368	3376		
HOUSING UNITS - Family:				
IN CAMPS	4403	25623		
IN OTHER LOCATIONS	375	2743		
HOUSING UNITS - Single				
IN CAMPS	288	1937		
IN OTHER LOCATIONS	51	615		

INSPECTION OF LIVING AND WORKING ENVIRONMENT OF MIGRANTS

ITEM	NUMBER OF LOCATIONS INSPECTED		TOTAL NUMBER OF INSPECTIONS		NUMBER OF DEFECTS FOUND		NUMBER OF CORRECTIONS MADE	
	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER
LIVING ENVIRONMENT:								
a. WATER	646	26	1594	52	100	2	62	2
b. SEWAGE	717	64	5554	48	728	4	381	2
c. GARBAGE AND REFUSE	722	26	3276	52	756	16	471	10
d. HOUSING	722	21	3128	44	849	2	480	-
e. SAFETY	485	21	1628	44	96	1	51	1
f. FOOD HANDLING	8	-	12	-	8	-	5	-
g. INSECTS AND RODENTS	722	21	1624	44	320	2	188	2
h. RECREATIONAL FACILITIES	39	-	174	-	1	-	1	-
WORKING ENVIRONMENT:								
a. WATER	xxxx	116	xxxx	148	xxxx	43	xxxx	7
b. TOILET FACILITIES	xxxx	114	xxxx	411	xxxx	106	xxxx	46
c. OTHER	xxxx	56	xxxx	55	xxxx	7	xxxx	3

Ninety-one percent of all farm labor camps in the state are now located in project areas. These 930 farm labor camps were capable of housing some 27,000 persons or about 87% of the total migrant population entering the state. The objective of this aspect of the program to assure that a healthy and safe environment is provided these farm workers. In order to achieve this objective it is necessary to correct defects in the camp and work environment.

Over this past season, some 100 defects were noted in the 646 individual water supplies in the farm labor camps. Of this number 62% were corrected. Seven hundred and twenty eight defects were noted in the disposal of sewage. This also included the provision and maintenance of toilet facilities. Fifty-two percent of these defects were corrected. Seven hundred and fifty-six defects were noted in the collection, storage and disposal of solid waste. Eighty-one percent of these were corrected during the season. One hundred and eighty-eight problems involving mosquitoes, flies, or rodents were observed and 59 percent of these were corrected. A majority of these defects observed and corrected were concerned with the maintenance of existing facilities, but new facilities are slowly being installed around the state, either replacing old and worn out facilities or providing new facilities where none previously existed. The emphasis placed on the camp environment has detracted from one very important aspect of the program. This is the provision and maintenance of the drinking water and toilet facilities at the places of employment. These problems involve not only the migrant or seasonal farm worker, but involve the resident wives and children from both the metropolitan and rural areas of the state. All though it is not required to provide drinking water for the workers in the field, the majority of employers do so. Out of 116 fields checked for potable water 43 supplies or 37 percent were contaminated. Only 7 or 16 percent of these were corrected. One hundred and fourteen fields were inspected for improperly constructed and/or maintained toilet facilities. One hundred and six individual toilets were found to be unsatisfactory. Of this number only 46 or 43 percent were corrected. There are a lot more agricultural fields, a lot more water supplies and a lot more toilet facilities throughout the state than were observed this season by the sanitarians. If the proportion of defects discovered is in direct ratio to the facilities inspected this season, the problem is extensive and serious. It is obvious that an insufficient amount of time is being spent on this very important area.

As is indicated in the Summary of the Sanitation Activities, revised rules and regulations have been adopted by the State Board of Health which will establish new standards for farm labor camp facilities and then maintenance. Just where the farm labor camps stand, at the present, in complying with the new standards is not known. What we do know is that approximately 140 camps throughout the state are sufficiently bad enough to close under the old standards, so there should be quite a bit of activity either in the improvement of existing camps or the closure of these substandard facilities.

This next season it is planned that all of the sanitation activities be conducted under the supervision of the local health departments and that the state supervisory staff restrict it's activities to surveillance, consultation, and the farm labor camp surveys within the project counties and throughout the remainder of the state. Whenever possible, project supported sanitation activities will be replaced by county sanitarians accomplishing the job they are responsible to do.

V. PLANS FOR CONTINUATION OF PROGRAM

Continued migrant health grant assistance is required in the provision of medical, dental and hospital services in the local project areas. The change in Welfare's residency requirements has opened another avenue of financing. However, the demand upon Welfare is far greater than the resources available. Therefore, a sharing of financial responsibility by various agencies and sources remains the most comprehensive method of financing medical, dental and hospital costs, with the migrant health grant assistance being the most substantial resource.

Oregon is one of the few states which does not provide state funds to local county health departments. As a result, it would be difficult for local governments to assume the costs of and meet the migrant health needs.

Comprehensive health planning efforts in Oregon have not progressed to the programing stage, and financing of such a program has not been considered. The inclusion of

migrant health services in a comprehensive health plan is not insured at this time. Experience has been that success is negligible in the utilization of Comprehensive Health funds (314-D) to fill gaps in community health services, due to the lack of such funds. Block grants have not materialized in sufficient amount to meet the community health needs; thus, categorical grants (such as migrant health grants) remain the most efficient means of providing services.

Progressive steps are being taken to meet the problem, for example:

a. The Migrant Health Project promotes efforts to capitalize on other resources for the provision and financing of quality medical and dental care:

   1. Real efforts have been made to integrate migrant health services with the community health services provided by local health departments;

   2. An experimental dental health program, utilizing dental students and emphasizing treatment and dental health education, materialized from a cooperative effort of three agencies and resulted in increased provision of and request for dental care;

   3. Plans are in progress to utilize medical students in a clinic and camp setting to improve medical care. This is a cooperative effort of the project, the University of Oregon Medical School and the Academy of General Practice.

b. The State Medical Association considers the medical needs of the rural population of prime importance and is in the process of studying the problems and possible solutions in terms of manpower available. Strong consideration is being given the possible use of para-medical personnel to provide services in the rural areas, with linking consultative support from available physicians.

STATISTICAL SUMMARY

Number of Migrants Receiving Care and Related Services:

County	Out Patient	Visits	Related Nursing Visits	Dental Care	Dental Visits	Health Counsel.	Hosp.	Other Hosp.	Health Screening
Linn	332	400	990	27	27	792	23	0	1842
Klamath	71	113	252	1	1	806	15	0	756
Washington	1096	1387	1592	26	40	1184	14	18	2221
Polk	169	239	243	45	64	148	8	3	1106
Clackamas	174	273	378	39	NA	904	3	13	1290
Umatilla	143	155	200	15	20	138	14	0	418
Marion	990	1373	885	114	140	592	70	0	3242
Tri-County	267	650	402	25	62	791	18	0	862
Jackson	331	400	402	34	45	736	24	9	731
Hood River	523	699	854	38	47	1813	69	0	1463
Malheur	555	1404	942	150	200	1750	84	125	2673
Yamhill	725	1236	373	72	76	192	0	14	1800
Total	5376	8329	7513	586	722	9846	342	161	18,404

NOTE: Reports for the following Sections are included in the preceding Summary:

B. Medical and Dental Services

C. Hospital Services

D. Nursing Services

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SANITATION

E. REVIEW AND EVALUATION

In the 1968 Annual Report, it was recommended by the State supervisory staff that "Reduced project support of sanitation services and shifting those funds to other areas of program needs" be accomplished. So as to accomplish this recommendation, the position of full-time Project Sanitarian for Polk and Linn Counties was abolished. It was planned that a half-time sanitarian from the Marion County Project would serve Polk County and that a sanitarian aide working under the supervision of county sanitarians would be employed on a seasonal basis in Linn County. As will be noted in the individual county reports, these plans did not materialize except that the abolition of the full-time sanitarian position was accomplished. Both the Linn and Polk County Health Departments indicated an inability to accomplish the job of camp inspections and surveillance with their existing staff. The supervisory sanitation staff of the project assumed the responsibility for providing these direct services out of the State Board of Health in Portland. Although the assumption of the responsibility for providing the direct services for the Tri-County project did not exactly come under the category of reduced sanitation support, it nevertheless amounted to the same thing. The funds approved for this position were directed to medical care items. As is indicated in the Tri-County Report, the beginning of the season found the local health department with only one sanitarian (where there had formerly been four) and no health officer. The ability of the sanitation supervisory staff at the Board of Health to extend their services to cover this need was found to be limited. In order to maintain the necessary contact with both the project and non-project counties throughout the State, to provide the necessary consultation and surveillance of the local programs, to accomplish the surveys of farm labor camp facilities, and to attend to the myriad of administrative tasks that arise, the direct service programs received only the minimum of time and attention required to do a proper job. As a result of these additional responsibilities the other tasks did not receive the attention they required. To complicate the matter further, the project sanitarians in Hood River and Malheur Counties resigned to accept positions elsewhere. Both positions have subsequently been filled, but there is always a loss of program continuity while the new sanitarians become accustomed to their positions. This left only six of the twelve project areas with anywhere near a stable sanitation program. In spite of these problems, accomplishments were made statewide as can be seen from the individual county reports.

In the winter of 1968 the Oregon State Employment Service requested that the State Board of Health enter into an agreement with them. This would have committed the county health departments to accomplish farm labor camp inspections under the U.S. Department of Labor standards for those growers wanting assistance in their out-of-state labor recruiting. The Board, acting on the advice of its attorneys, felt that it could not so commit the local health departments to make the inspections; and as a result the Employment Service was forced to make its own farm labor camp inspections. This proved rather interesting, as the counties were very willing to make the necessary inspections for the Employment Service. The Employment Service at that time would not, or could not, negotiate an agreement with anyone but the state health agency. Prior to this season, a Memorandum of Understanding was entered into by all of the local health departments having farm labor camps in their jurisdiction and this year the Department of Employment inspections were made by the county sanitarians.

It was noted in the last annual report that several bills were being prepared by legislative interim committees for consideration by the Legislature. Also Oregon State University had, at the request of the Governor, formed a task force to study migrant problems and come up with recommendations for their solutions. Two of the most controversial of their recommendations were a) that the State should adopt the U.S. Department of Labor standards and b) that all farm labor camps should meet standards prior to being occupied. This task force report was completed in sufficient time to give a copy to each legislator. During the legislative session a total of four bills were submitted, the first two bills listed having been prepared by the Interim Committee. These bills were concerned with a) the provision of hand washing facilities and drinking water in the fields; b) the provision of a tax incentive for farmers to improve their housing and camp facilities; c) removing the local health departments from administering the farm labor camp inspection program and transferring it to the State Board of Health; and d) the provision of an advisory committee to establish new farm labor camp standards. These bills were all actively supported by the Chicano groups, as

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well as the Valley Migrant League and the Oregon State Bureau of Labor. The State Board of Health supported those portions of each bill that would benefit the overall program and prove feasible to administer. The result of all this was naught. Nothing was passed by the Legislature, and the Task Force Report was for the most part ignored.

After it was determined that the Legislature was not going to make any changes in the existing laws, it was decided to amend the rules and regulations relating to farm labor camp sanitation and housing. These rules had not been amended since their adoption in 1959, the same year the existing statute was passed. At the time of their adoption the rules were, at best, a poor compromise between what constituted good camp housing and sanitation and what the farmers and camp operators felt they could comply with at the time. After writing the final draft of the proposed regulation changes, meetings were held throughout the State with various farm groups (arranged by the State Farm Bureau Federation) to learn the general feelings of the farmers toward these proposals. Although there were some objections to specific (but minor) changes in the regulations, most of the growers had very little to say in opposition to the proposals. After these meetings were held, arrangements were made to meet with representatives of migrant workers which included the Valley Migrant League, the United Farm Workers, and some OEO people. Although the proposals strengthened the regulations about as far as the statute would allow, the migrants felt that the Federal standards should be adopted as the baseline standards for farm labor camps. Because of the limitations imposed by the farm labor camp statute, the adoption of these standards would be impossible. If there is to be any appreciable increase in requirements in the future, it will take a legislative change of the existing statutes. These rules have now been adopted by the Oregon State Board of Health and a copy of them is to be found in the appendix of this report. Because of our inability to provide for certain areas of concern in the regulations, we have prepared a set of recommendations regarding space requirements, the provision of refrigeration, the installation in the living units of cold running water and a sink, the provision of electric lighting in all of common use facilities, the painting of the living units, and the provision of drinking water and hand washing facilities in the field. A copy of these recommendations is to be found with the changes in the regulations.

The farm labor camp surveys continued this year, but on a slightly reduced schedule. As has been indicated in past reports, the criteria for evaluating the farm labor camps have been their compliance with the farm labor camp statute and the administrative rules of the Oregon State Board of Health. The purpose for conducting these surveys has been and continues to be a) to obtain firsthand information on the conditions of the farm labor camps within the state, b) to provide a baseline of information from which the progress or lack thereof in the program can be determined, c) to establish priorities and objectives for accomplishment within the program, and d) to be able to provide accurate and reasonable program data to those requiring such information. Of the fifteen local health department jurisdictions, eight or a little over 50% have been resurveyed, but these counties contain over two-thirds of the total farm labor camps in the state. The following are the current results of these farm labor surveys:

A. An item-by-item comparison of the most significant sanitation problems encountered in the farm labor camps between the first survey and the resurvey. (Only those camps having been resurveyed are considered.)

Item	1964-1967 First Survey Total Camps-161 No. of Camps	% of Camps	1968-1969 Second Survey Total Camps-234 No. of Camps	% of Camps	Improvements In Percent
Unapproved Water Source	24	14.9	19	8.1	+ 6.8
Improper Sewage And Liquid Waste Disposal	33	20.5	27	11.5	+ 9.0
Poor Toilet Repair And Maintenance	82	50.9	65	27.8	+ 23.1
Improper Toilet Construction	90	55.9	58	24.8	+ 31.1
Improper Garbage Storage	87	54.0	74	31.6	+ 22.4
Improper Garbage Collection	24	14.9	16	6.8	+ 8.1
Improper Garbage Disposal	18	11.4	25	10.7	+ .7
Poor Camp Maintenance	71	44.2	76	32.5	+ 11.7

B. Comparison of the changes occurring in the general camp conditions and sanitation as indicated by the individual survey scores between the first and second surveys. Only those eight counties having been resurveyed are considered.

Rating	1964-1967 Original Survey No. of Camps	% of Camps	1968-1969 Resurvey No. of Camps	% of Camps	Difference
90 - 100*	30	18.6	135	57.7	+ 39.1
89 - 80	55	34.2	66	28.2	- 6.0
79 - below	76	47.2	33	14.1	-33.1

* A score of 90 - 100 is excellent to very good
80 - 89 is very good to fair and
79 - below is substandard to very poor.

This is the last season that the camps will be surveyed under the present standards. Unfortunately, the timing wasn't right so that the entire state could be resurveyed, but a first round of surveys will be accomplished next season using the new regulations and standards.

As will be noted from these tables, steady progress has been made within the program since the inception of the Migrant Health Project in 1964. Hopefully, this progress will continue and accelerate as the state begins to upgrade the standards for farm labor housing. Soon, the possibility exists for the passage of legislation which would enable the Board of Health to adopt standards which would take into account adequate living space, running water in the living units, refrigeration for food storage and protection, and the other important items contained in the present recommendations.

HEALTH EDUCATION

I. Health Education Services

A. Specific Objectives

The goal of the health education component of the Oregon Migrant Health Project is to motivate and establish constructive and effective action from all facets of the community which are involved in migrant health, such as migrants, growers, official and voluntary agencies, and interested groups and individuals, in an effort to improve the health practices, attitudes, knowledges, and beliefs of migrant agricultural workers and their families. Measurable objectives* developed to attain the goal are as follows:

1. To develop uniform community health aide programs in 83 percent of the local migrant health projects.
2. To establish migrant health advisory committees, composed of service providers, recipients and interested community members, in 50 percent of the local migrant health projects; and for the State migrant health project.
3. To aid the development and use of educational materials by staff in 100 percent of the local migrant health projects.
4. To provide educational materials and consultation on educational methods in the areas of personal and environmental health with special emphasis on dental health, personal hygiene, nutrition, pre-natal care, and camp maintenance in 100 percent of the local projects.
5. To promote community involvement and interagency and group cooperation in 100 percent of local migrant health projects.

B. Staff

1. Health Education Personnel

The State project staff includes one health educator (MPH) who serves as a consultant to 12 local migrant health projects and provides a limited amount of direct service, primarily as a method of in-service training for field staff. The consultant works with state and local project staffs to identify needs; and with the cooperation of the staff, sets priorities for program planning. Development of program varies according to the amount of staff and time available, interest level and orientation of staff (a majority of the consultant's efforts are devoted to affecting these factors). Coordination efforts constitute a priority in the consultant's work, as attempts are made to have a unified approach and a sharing of responsibilities among related organizations and programs; this requires a shift of emphasis by staff to involvement of the consumer and the community in programing. On the state level a special emphasis on developing closer working relationships with staff members of other agencies and organizations is resulting in what can only be termed as a productive togetherness in the area of health education. The extended awareness of and concern for the Migrant Health Project health education goal and objectives have brought continued and more active support this season from the:

a. Oregon Council of Churches (Migrant Ministry)

b. Valley Migrant League

c. Oregon Bureau of Labor

d. State Department of Education (Migrant Education Program)

e. Oregon Tuberculosis and Respiratory Disease Association

*For detailed analysis of extent of achievement see Section IV(a).

f. Columbia Girl Scout Council

g. Oregon Dairy Council

h. Oregon Dental Auxiliary

i. University of Oregon Dental School

j. Oregon Extension Service

The involvement of the above listed is primarily in the form of support through consultation from the state level to the local counterparts.

NOTE: Additional agencies and organizations involved in other aspects of the Oregon Migrant Health Project are not included in the above listing.

Involvement of other agencies and organizations on the local level is reported in more detail in the county project reports.

2. Other Project Personnel

All project staff, state and local, are involved in health education in some way. Inasmuch as local staffs do not have health education personnel, it is the local staffs' nursing, sanitation, community health aide, and sanitation aide personnel through which identification of needs, program planning, development, coordination and evaluation are carried out. The state project nursing staff has provided strong support in the implementation of health education activities on the local level. Nursing staff of local projects have been the primary implementors of health education services; as project nurses work directly with the consumers, are more involved in the community, and serve as supervisors of the community health aides who are employed as liason between the consumer and the project staff. The involvement of local project staff in health education activities in some instances has been curtailed due to local health department policies. For example, project nurses in two counties have had to limit their initiation of cooperative work with other agencies and their efforts in community involvement at the direction of local health department administration. This hindered but did not prevent such work.

Community Health Aides, (19 employed in 11 local projects) with the exception of one aide employed year-round, are hired generally for a period of three months, during the peak seasons. The short-term employment obviously restricts the aides' involvement in health education programing; however, many of the noticeable changes relating to health education can be attributed to the community health aides' presence on the staff, such as more awareness by the staff of the consumers' feelings and needs.

Sanitarian staff members generally restrict their concerns to working with growers, camp owners, and camp maintenance personnel, regarding camp sanitation improvements as required by Oregon State law. An outstanding exception to traditional practice this season was the efforts of one project sanitarian and two sanitation aides to work with the consumer in the area of health instruction. Due to the excellent local nurse and sanitarian staff cooperation and coordination, the sanitation aide staff moved into health instruction of patients attending evening clinics (this was done primarily through films and discussions). As reported by the project sanitarian, more involvement in health education services by sanitation personnel is indicated and planned, especially through health counseling within farm labor camps.

3. Migrants

Limited involvement on the state level of migrants has been primarily on an individual basis in the areas of identifying needs and evaluation. Involvement is elicited from ex-migrants and settled-out migrants who are generally more accessible and interested in contributing to the Migrant Health Project efforts. Their cooperation and involvement is requested and falls in the areas of identifying needs, program development, coordination and evaluation. An increase in

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the involvement of migrants and migrants' representatives will occur when the Advisory Committee to the Oregon Migrant Health Project is formed. All that remains in the formation process is the appointment of members by the State Health Officer. The list of possible candidates for members was compiled by soliciting suggested names from those agencies and groups related to and interested in migrant health needs.

NOTE: A copy of the organizational plan for the Advisory Committee is attached to the Annual Report.

C. Health Education Consultation or Other Assistance From Outside Project

This project year health education consultation from outside the project has not been adequate. Assistance, when requested, is received from the Director of the Health Education Section, Oregon State Board of Health. The available assistance is basically a provision of a sounding board for specific ideas developed by the project health educator. Even though limited, this type assistance is genuinely appreciated, as the state project health education component receives sole and soul direction from the project health education consultant, with the cooperation of the state project nursing and sanitation consultants. Other assistance when requested, has been received from individuals within the Oregon State Board of Health and from various agencies and groups, primarily in the areas of program development and coordination. The names of such correspond to the listing found in B-1. An addition to the list would be the Maternal and Child Health Section (School Health Program) and the Dental Health Section, Oregon State Board of Health.

In contrast, the project health education consultant provides assistance to persons outside the project staff, which indirectly benefits the project. For example, the consultant promoted and provided consultation to three local health departments regarding the establishment, justification, and responsibilities of a health education staff position.

In view of limited sources of outside consultative support to the State project in health education, it is felt that consultation from the U.S. Public Health Service is necessary and would be beneficial in evaluation and program planning.

D. Orientation And In-service Training in Health Education To Personnel

A two-day pre-season workshop was held for Community Health Aides and their supervising nurses, to:

1. Provide basic orientation to aide job responsibilities and to basic personal and environmental health practices.

2. Provide an opportunity for aides and their supervisors to become better acquainted prior to the peak season.

3. Provide an opportunity to share ideas and methods of aide utilization with other county projects, and to gain insight regarding the total program objectives.

The workshop, developed by the state project health education and nursing consultants, was in response to needs identified by the state staff and voiced by the local staffs. Preplanning for the workshop involved:

1. Cooperative planning with the Home Health Aide State Advisory Committee in order to conduct simultaneous but separate workshops with two joint sessions for the Community Health Aides and Home Health Aides (this resulted in free meeting rooms, in addition to other benefits).

2. Recruitment and orientation of county staff and project nurses and state peoject personnel for workshop staff.

Ten of the twelve local projects were represented at the workshop. At the time of the workshop eight local projects had completed aide recruitment, and even though not yet employed, the recruited aides participated in the workshop. Based upon verbal response from participants and observation, all objectives of the workshop were met. In view of the apparent success and value of this workshop it is felt that such a pre-season orientation should be provided annually for project staff (nurse, sanitarian and aide) with followup, intensive in-service education provided on the local level.

At the request of local nursing and aide staff, a mid-season followup meeting was provided. The format of the one-day meeting included a discussion of problems by discipline and a sharing of health education methods by the total group. Staff of seven local projects participated.

Varying degrees of orientation and in-service training in health education were provided by the state project health education consultant to 10 of the 12 local project staffs in their respective project areas. A majority of the efforts were directed to the nursing and community health aide staffs. The three direct service projects received the greatest amount of the consultant's time. The orientation and in-service concerned basically:

1. The acute need to move beyond health instruction to an active involvement of the migrant in an educational process (the following outline was developed from an adult basic education guide for use with staff in orientation, in-service and field demonstration).

YOU WILL HELP PEOPLE PRACTICE GOOD HEALTH HABITS

When you teach it will help if you

REMEMBER THAT...	ASK YOURSELF...
A. We learn to do BY DOING.	A. Am I helping him to practice what I'm teaching?
B. We learn better when we can SEE, HEAR, THINK and ACT.	B. Are there pictures, films, etc. that I can use to help him learn?
C. We learn when we are READY TO LEARN.	C. Does he want to hear what I have to say?
D. We act when our GAIN is WORTH the EFFORT SPENT.	D. Does he feel what I'm suggesting will be worthwhile for him?
E. We act when our behavior gains approval from people we respect.	E. Does he fear that his friends will think less of him if he does what is suggested?
F. We act when there is no supernatural or other fear about the results.	F. Do his beliefs tell him not to do what is suggested?
G. We learn when we can use the learning immediately to solve our problems.	G. Does he recognize the problem or is it a problem only in my eyes?

2. The effective use of visual aids as tools.
3. The practical application of suggested health education methods, such as ways to apply the suggested steps in the above outline.
4. The need for and methods of involving the community in the project, for example, making the community aware of particular migrant health problems (such as the need for more accessible abundant foods to meet emergencies) and enlisting their action in solving the problems.

The 1969 Annual Oregon Migrant Health Seminar, held in the fall of each year, as a total state and local project staff meeting, provided opportunities for program evaluation, planning and exchange of ideas. Following the two-day Seminar, a one-day Information Exchange Meeting was conducted which brought together a variety of

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agencies, groups and interested community members from across the state to discuss programs, problems and solutions in the areas of migrant education, social and economic welfare, and health. Obviously, time was not sufficient for complete exchange of information and adequate discussion of problems, however, benefits of bringing various groups together for consideration of common concerns were recognized. In response to evaluation questionnaires, local staff indicated that the Information Exchange Meeting was the most helpful to them of the three-day meeting. There were 108 persons in attendance, representing 12 county projects, 17 agencies and groups, and the Idaho and Washington State Migrant Health Projects. The meetings were planned and developed by state project staff with the cooperation of local project staffs. For the seminar program participants (panel members, moderators, and discussion leaders) were recruited from staffs of local county health departments and projects, the State Board of Health, University of Oregon Dental School, University of Oregon Medical School, Oregon Dairy Council, Portland State University.

II. Identified Needs and Problems

A. By Staff

1. Lack of local project staff time and understanding for needed pre-planning and implementation of health education.

2. Predominance of traditional concept of health education as just health instruction with heavy emphasis on films and pamphlets as entities unto themselves rather than as tools.

3. The need for community health aides to be employed on a year-round basis rather than on short-term basis during peak season, as short-term employment provides little vocational career benefits to the aide; does not allow aide time to develop and grow in the position to fulfill the health education needs of the projects as has been desired from an aide program.

4. The need to coordinate treatment measures with preventive measures.

5. The need to expand interests and concerns of staff beyond disciplines in order to affect a team approach.

6. The need to strengthen efforts to involve the consumer in programing and implementation.

7. The need for a community organization approach rather than "I'll do it myself," in order to achieve long-range benefits, such as needed community support and consumer involvement.

8. The need for better orientation and in-service training for old as well as new staff in areas such as aide utilization, aide guidance, and supervision, involvement of the consumer and the community, use of an educational approach, specific job responsibilities and suggested health education methods to employ.

9. The need for uniformity in health education emphasis in order to achieve continuity of efforts as migrants move from county to county.

10. The need to maintain the human element in project activities.

11. The need to rewrite project objectives in measurable terms.

B. By Migrants (and ex-migrants)

1. The need to inform the migrant of what camp conditions he should expect (by law).

2. The need for audiovisual aids applicable to the migrant population.

3. The need to expand project coverage to seasonal agricultural workers.

4. The need for working relationships between migrant representatives and project staffs.

5. The need for community health services for all segments of the community.

6. The need for more strict enforcement of farm labor camp sanitation requirements.

7. The need for better housing and sanitation.

C. By Others (Various agency and group representatives)

1. The need for staff understanding and willingness to respond to voiced needs of migrants and their representatives.

2. The need for cooperative efforts among agencies and groups working to meet the health needs of migrants.

3. The need for stronger legislation regarding farm labor camp sanitation.

III. Description of system of providing services and the services provided:

A. For the most part, the provision of services has been described elsewhere in the health education report. The table below represents categorical activities by state project staff (data on local projects is contained within the individual project reports). The major purposes of the table are to point out:

1. The amount of consultation provided to local staffs.

2. The amount of consultation involved with other agencies and groups to establish cooperative efforts in programing. Examples of such are noted within the Health Education and Nursing sections of this report.

Health Education Services (By type of service, personnel involved, and number of sessions).

PART V - HEALTH EDUCATION SERVICES (By type of service, personnel involved, and number of sessions.)

TYPE OF HEALTH EDUCATION SERVICE	NUMBER OF SESSIONS						
	HEALTH EDUCATION STAFF	PHYSICIANS	NURSES Supv	NURSES Asst	SANITARIANS *	AIDES (other than Health Ed.)	OTHER (Specify)
A. SERVICES TO MIGRANTS							
(1) Individual counselling	14		8				
(2) Group counselling	7		4				
B. SERVICES TO OTHER PROJECT STAFF							
(1) Consultation	339		226	206			
(2) Direct services	76		24	10			
C. SERVICES TO GROWERS:							
(1) Individual counselling	1						
(2) Group counselling	1						
D. SERVICES TO OTHER AGENCIES OR ORGANIZATIONS:							
(1) Consultation with individuals	219		126	90			
(2) Consultation with groups	13		110				
(3) Direct services				2			
(4) Program implementation				239			
E. HEALTH EDUCATION MEETINGS	696*		36	14			

*A portion of the information relating to health education services provided by state project sanitarians was not available, some of the data is included in the reports for Linn, Polk, and Tri-Counties.

**Total reflects some duplication of numbers from other categories within table.

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B. Involvement of Migrants in Health Education Activities

1. Method of identification of migrant leaders:

   There is not an overt effort to determine leadership in the migrant population, as most activity between project staff and migrants is on an individual family basis. In some cases, crew leaders, camp operators, or agency personnel housed in camps provide some leadership and can exert some influence. In working with migrant children, in camp settings it is much easier to determine leadership patterns and to recruit the support of those children in educational activities. Their support generally results in a greater participation by other children within the camp. Leadership among groups of settled-out migrants, primarily the Chicano group, is easily identified as presently there is much organizational activity of the Chicanos in Oregon. Due to cultural patterns, there are a variety of leaders, either true or self-appointed in the Chicano groups. In order to reach the entire group, many separate organizations must be recognized. The basic methods of leadership determination at this point are observation and cooperative group work.

   Leadership identification must not stand alone, as our real responsibility is to build on the identification of potential leaders in the migrant population with leadership development.

2. Ways in which migrants participated in health education activities:

   Involvement of migrants in health education activities is best described as reported by the local projects (see individual county project reports)

C. Activities

Activities* handled by the state project health education consultant at the request of other state and local project staffs are in the areas of:

1. Planning and developing workshops for in-service education
2. Providing advice, consultation and support regarding health education purpose, methods, and other components of the project.
3. Substituting at meetings in absence of the other project staff members.
4. Procurement and preparation of visual aids such as community service guides for specific localities.
5. Compilation of annual report.
6. Development and arrangements for annual seminar.
7. Preparation of information for mass media.
8. Correspondence regarding requests for information.

IV. Appraisal of Effectiveness of Educational Effort

The consultant's evaluation of the impact of health education planning and efforts is more in the realm of change exhibited in staff interest and performance relating to health education, as these factors determine the quality of health education services and the eventual consumer involvement in such services. The table for Health Education Services included in the 1969 Guidelines for the Annual Progress Report is viewed by the consultant as valuable, as the table directs attention to specific activities in the prevention area which previously were not considered (by some staff) as important as treatment activities. This season reflects inaccurate reporting by local project staff of health education services due to variances in the staffs' concept of health education, for instance, many persons do not interpret work with other agencies and groups as health education, consequently, this portion of the table would be left blank.

*See Health Education Services table for data regarding direct service to other project staff.

A. Extent to Which Proposed Objectives Were Achieved:

1. Uniform community health aide programs were developed in order to work effectively with the migrant population.

   (a) Of the local migrant projects 92 percent (11 of the 12 local projects) employed community health aides this project year as compared to 58 percent the previous project year.

   (b) To better prepare community health aides and their supervisors (project nurses) an orientation workshop was provided pre-season, in which community health aides in 58 percent of the local projects received orientation to general job responsibilities and basic health practices, and aide supervisors in 83 percent of the projects participated.

   (c) Of the local projects 92 percent indicate an increase in the numbers of persons screened, counseled, and receiving out-patient care as a direct result of employment of community health aides to screen families, explain health and community services, assist in utilization of services, and allow for more effective use of nursing time (see table below).

Individuals of Migrant Agricultural Families Served By Various Oregon County Migrant Health Projects, 1968 and 1969

Project Area	NUMBER OF INDIVIDUALS								
	SCREENED			COUNSELED			RECEIVING OUT-PATIENT CARE		
	1968 WOCHA*	1969 WCHA**	% Increase or Decrease	1968 WOCHA	1969 WCHA	% Increase or Decrease	1968 WOCHA	1969 WCHA	% Increase or Decrease
Hood River County	919	1463	+59.2	806	1813	+124.9	293	568	+ 93.9
Jackson County	374	731	+95.5	233	736	+215.9	56	331	+491.1
Klamath County	380	756	+98.9	--***	806	----	79	113	+ 43.0
Linn County	2286	1842	-19.4****	887	792	- 10.7	232	352	+ 51.7
Tri-County	654	800	+22.3	301	791	+162.8	47	267	+468.1

* WOCHA = Without Community Health Aides
** WCHA = With Community Health Aides
*** Not Reported
**** The Total Number of Migrants in The County Was Less in 1969 Than in 1968

2. The involvement of consumers and the community in programing and implementation would be increased via the establishment on the state and local levels of migrant health advisory committees, composed of service recipients, providers, and interested community members.

   (a) The formation of an Advisory Committee for the Oregon Migrant Health Project is in process, with the remaining step being the appointment of committee members by the State Health Officer.

   (b) Of the local projects 50 percent were encouraged to organize advisory committees; however, to date no such committees exist on the local level.

3. There was an increased understanding, use, and development of educational materials by project staff.

   (a) Of the local projects 100 percent were informed of and offered assistance in the selection, use and development of educational materials.

   (b) Of the 12 local projects 75 percent exhibited increased usage of educational materials, with 58 percent involved in the development of such materials.

4. The provision of educational materials and consultation regarding such to local projects in the areas of personal and environmental health increased from 41 percent of the projects in 1968 project year to 100 percent of the local projects in the 1969 project year. Among materials developed were community service guides for Linn, Polk, and Tri-Counties; bilingual posters regarding sanitation.

5. Community involvement and interagency and group cooperation were promoted in 92 percent of the local projects. The extent of increased activity in this category during the 1969 project year is difficult to measure as no evaluation tool has been available. The advent of the Health Education Services table will aid in the measurement and provide a basis for comparison in project years to come.

B. Problems Which Hindered Effectiveness of Health Education Efforts; Solutions and Methods:

An analysis of problems encountered in meeting stated objectives would be the most clear form of presentation.

1. Problems encountered in the community health aide program were primarily weaknesses in:

   (a) Aide acceptance by project staff.

   (b) Provision of aide supervision, guidance and direction.

   (c) Aide utilization.

   (d) Length of employment of aides.

The problems were restricted to approximately 16 percent of the local projects. The short-term employment of the aides during peak season did not allow sufficient time to overcome the above mentioned problems, however, the problems are indicators of:

   (a) The need to provide increased consultation and in-service training for aide supervisors.

   (b) The need to follow through with aide program planning done on a local level.

   (c) The need to supplement year-round aide programs based on a career lattice concept.

2. Basic problems involved in the promotion and establishment of migrant health advisory committees were - On the state level:

   (a) Fear of the unknown.

   (b) Slow acceptance of the idea.

   (c) Obtaining representation for all segments of the migrant population.

   (d) Ironing out the organizational details for a majority approval.

   (e) Lack of sufficient time to devote to the formation of the Advisory Committee.

   On the local level:

   (a) Lack of staff time and interest to obtain administrative support and become involved in formation of Advisory Committee.

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(b) The concern of adding another committee to the list of the many already in existence. The preference expressed in a few areas was to include migrant representation on existing boards, councils and advisory committees.

NOTE: This preference has merit and is possibly more sound than forming special migrant health advisory committees in the local project areas. Patience, persistence, state staff support and motivation through example should overcome the above problems.

3. Educational materials, especially audio-visual aids, continued to be used as the sole bearers of a message, rather than as a supportive tool, while other times no effort was made to clarify the verbal message with educational materials and aids. Increased consultation to local projects and field demonstrations aided in reducing these problems.

4. In the provision of educational materials and consultation on educational methods the greatest hindrances were:

   (a) Lack of materials applicable to the migrant population.

   (b) Lack of sufficient time to develop materials needed.

   (c) Lack of follow-through on plans to utilize educational methods.

5. In the promotion of community involvement and interagency and group cooperation the eternal barrier was the ease with which a job can be done by oneself without the difficulties of trying to involve others. The major problem is one of determining our real responsibility.

   Another problem is the failure to utilize the off-season for laying ground work in this area; project staff, especially when employed only during the peak season, find time lacking to devote to community involvement. Consultation regarding specific ways to involve the community and to get agency cooperation was the primary method employed to decrease this problem.

V. Specific Plans For The Future

A. As mentioned previously, the formation of an Advisory Committee to the Oregon Migrant Health Project is scheduled to be completed for the 1970 project year.

B. Changes in the community health aide programs would be desirable in order to better utilize the aide and to provide a secure employment opportunity. Such changes include:

   1. Possible joint funding of aide positions between the Migrant Health Project and the local health department, which would allow employment of a year-round aide to work jointly with the project and the general program of the health department. This idea is being considered in two counties.

   2. Subsequent provision of intensive on-going aide training in areas of communication, cultural factors, human behavior, job responsibilities....

C. The continued development of productive working relationships with related agencies and groups is deemed necessary.

D. The provision of more in-service education for staff members relating to involvement of the consumer and the community in programing and implementation.

G.

University of Oregon Dental School Project
MG 05G

Purpose of the Project

1. To assist County Health Departments in assessing the dental health of migrants and the children of migrants.
2. To identify dental care needs of migrants and the children of migrants.
3. To refer most urgent cases of dental care need to local dental practitioners.
4. To establish a dental prevention and dental health education program for migrants and migrant children.
5. To involve dental students in an area where there are unmet needs and likely to be greater emphasis in the future as outlined in "Highlights and Recommendations from Western Migrant Health Conference," Los Angeles, 1967 and Eastern States Migrant Health Conference, Orlando, Florida, 1968.

History of Dental Care for
Migrants in Oregon

The Migrant Health Act which was passed by the Federal Government in 1962 and extended in 1965 was intended to improve the health of migrant farm laborers whose average income in 1967 was about $2,000. Oregon's Migrant Health Program began in 1962 with a budget of $50,000 which has increased to $500,000 in 1969. Funds are entirely from Federal sources, there being no matching State funds.

In 1963 Malheur, Polk and Yamhill Counties budgeted for Migrant Health funds but did not include money for dental care. In their 1963 Migrant Health Report the following dental reports were noted:

Malheur

"Many of the children had dental caries that were visible while they were talking."

Polk

"There was no resource for dental care other than referral to private dentists in the area. The families stated they had no money."

1964

Additional counties conducted Migrant Health Projects but did not budget for dental funds. Annual reports contained the following comments about dental health:

Malheur

"Dental survey in summer migrant school by Dental Section of the State Board of Health revealed that 60 percent of the children were in need of dental care. Several of the needs were considered as emergency needs by the dentist, but there was no referral source except to private dentists and the families involved did not feel they could assume the cost."

Polk

"There was no referral source for dental care except by referral to private dentists. One of the Navajo women needed a tooth extraction and an extensive search was made for a dentist who would volunteer service since there was no money for dental care. The Director of the Dental Section of the State Board of Health contacted the dentist at Chemawa Indian School and asked if he would give emergency dental care. He would have been able to do so for any tribe except Navajo. The Chemawa School did not have a contract with the Navajo Indian tribe."

Washington

"There was no resource for dental care other than private dentists, and the cost was too great for the individuals involved."

The University of Oregon Associated Students became involved with a Migrant Health Project in which they did toothbrush demonstrations in Washington and Polk County schools.

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University of Oregon Dental School Project
MG 05G

1965

Migrant Health Projects continued. The following comments about dental care were noted in the annual report:

Malheur

"No dental care unless family was able to assume cost."

Polk

"A special fund had been included in this year's project budget to pay a dentist for dental services. This additional service was greatly appreciated by the people served. A dentist from the Dental Health Section of the State Board of Health carried out dental-oral screening at the summer migrant school; the project nurses conducted some dental screening in the camps; those seen with the more emergent dental problems were referred to the two participating dentists. The dentists were paid for a total of 58 hours and completed dental care on a total of 44 patients. Some of the patients were seen three and four times before their necessary dental work was completed.

Washington

"For the first time, the Migrant Project in the county had funds for emergency dental care. The table below details experience with this facet of the program.

No. of patients----------10
No. of visits------------12
Cost of service----------$93.50

"We are about to embark on a county-wide dental survey program which may be a preliminary to the development of dental service for indigent children. If this survey undertaking is a successful prelude to the initiation of clinic service, we may have available for migrant families dental care that will give a range of service we are not now able to provide within presently budgeted funds."

Marion (first year involvement in Migrant Health Project. Year end report included dental comment);

"No facilities were available for dental health."

1966

Oregon Migrant Health Objectives changes to include:

"To provide needed dental care through clinics and private dentists' offices to the migrant workers and their families with emphasis on children's dental needs."

Migrant Health Projects were conducted in seven counties, five of which had a dental component. Clackamas and Linn Counties, with new projects, did not include funds for dental care.

The following comments on dental health appeared in the Annual Reports:

Polk

"On May 26, the dental unit in the Polk County Health Department was available for use by the migrant dental program. One dentist used this facility 4-6 hours per week and a second dentist made his office available one afternoon per week. Ninety-eight visits were made by 76 patients. Much time was spent by the nursing staff in making appointments, checking back the day before the clinic, and finding people to fill the cancellations, and also with transportation. In pre-season planning, arrangement had been made with Valley Migrant League personnel for their assistance in the dental clinic but this did not work out satisfactorily. The dental program was again very popular with the families seen. Two families came back into the area to have dental work completed."

1968

All County Migrant Health Projects included funds for emergency dental care. Total dental budget all counties was $8,150.

1969

Total dental budget increased to $12,200 with an anticipation of some restorative dentistry for children.

In the Spring of 1969 the Department of Education which is eligible to receive funds under Title I Migrant Amendment for upgrading the education of migrants with emphasis on children was encouraged to include emergency dental care funds along with emergency dental care. A total budget for eight schools for medical and dental care combined was $9,400.

Author's Note: The idea that health, education, and welfare are inseparable in the growth and development of the child is an idea which is shared unanimously by professionals in education, welfare, and health. It should be noted that this concept is now incorporated in Oregon's approach to the war on poverty involving the migrant farm laborer and his family. The fact that this concept has been established is a tribute to those Oregon teachers and public health and welfare workers who have played prominent roles in developing Oregon's Migrant Programs.

By August 7, four of the eight schools had already used all of their budgeted dental funds.

PRELIMINARY PLANNING

In October, 1968, Drs. Porter, Bennett, and Castaldi submitted a major five year proposal for a United States Public Health Apprenticeship Training Grant to involve dental students and hygienists in community dental health projects in Albina, Good Samaritan Hospital, Nursing Homes, Migrant Farm Laborers, and Multnomah County Hospital.

On October 31 - November 1 Drs. Porter and Castaldi attended the 6th Annual Migrant Health Seminar sponsored by the State Board of Health in Portland. On the first day only Dr. Castaldi attended. Upon being introduced there was an immediate interest shown by nurses and medical health officers from a number of County Health Departments. Mrs. Nicely and Dr. Ragan from the Yamhill County wanted to be informed as soon as the above mentioned Apprenticeship Training Project was approved. The idea that students would be used for screening appealed to health departments for two reasons:

1. It was not possible to arrange for local dentists to screen migrants because of the uncertainty of the date of their arrival which is dependent on the interplay of weather and crop conditions.
2. Exposure of dental students to disadvantaged persons should help develop a future concern for neglected areas of dental care in the communities where they may practice dentistry.

In the Spring of 1969, Washington informed the University of Oregon Dental School that the Apprenticeship Training Program Grant Proposal was approved but not funded due to inadequate federal funds.

In May, 1969, Dr. Castaldi received word from Dr. Dave Witter, State Dental Health Director, and Mrs. Hesther Poareo, Supervising Nurse, Oregon's Migrant Health Program that some funds might become available from Migrant Health sources to provide stipends, travel funds, and per diem allowance for several dental students. Then followed meetings arranged by several County Health Departments with some local dentists, some of which were attended by Dr. Vincent and some by Dr. Castaldi. Since the project was a first-time venture, it was not possible to describe what would be done. Considerable concern about the project was expressed by dentists at the McMinnville meeting sponsored by the Yamhill County Health Department. Concern centered on a number of aspects of the project as follows:

1. Why were funds being provided for migrants when there were so many unmet needs among underprivileged permanent residents in the area?
2. Dental students should not be permitted to diagnose, treat, plan, and refer for dental care any patients.
3. The project would likely prove unnecessary because experience had shown that there are not likely any unmet dental needs among migrants in that area.
4. The use of mobile units or referral of migrants to the dental school (in both cases to have dental care done by students) was opposed.

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Subsequently a meeting of the Tri-County Dental Society was held at Salem. Dr. Witter and Dr. Castaldi attended and explained the nature of the project which was ultimately supported by the Society with no dissenting votes but with at least one member abstaining from voting.

Toward the end of May, Dr. Castaldi attended the Annual Migrant Educators' Meeting in Eugene where local and state migrant education problems were discussed. The announcement that the Dental School was to be involved in a project in the Migrant Summer School program was greeted with a great deal of enthusiasm by the teachers. The suggestion that mobile units be used was made by one teacher from an outlying area. Another suggested that children from a school near Portland be put on a bus and taken to the Dental School for care. When the merits of having the care done by local dentists was pointed out by Dr. Castaldi, the teachers agreed that every effort would be made to provide the care in this manner.

In June, Dr. Ruth, a 1969 graduate from University of Oregon Dental School; Mr. John Forsyth, an incoming fourth year student; Mr. John Nizic and Mr. Carl Hirtzel, both incoming third year students, were appointed to assist in the dental project. Dr. Castaldi met with Dr. Witter to plan the examining methods and recording procedures. The following aspects of oral health were to be assessed:

1. Decayed, missing, filled teeth (def. D.M.F. rates)
2. Oral hygiene index
3. Incidence and degree of fluorosis
4. Urgency of dental care need:
   - 0 = no care needed
   - +1 = early caries - pits, fissures by probing
   - +2 = moderate caries visible even without probing
   - +3 = gross caries but with no apical infection or history of pain
   - +4 = teeth decayed to the gum line, apical abscess or any other condition requiring immediate dental care.

UNIVERSITY OF OREGON DENTAL SCHOOL SUMMER PROJECT

Number of Children Examined:

		Number needing care by classification (3's & 4's)
Total children	995	
Migrant children	821	260
Head Start	44	18
Remedial	130	20

Number of the 260 migrant children receiving care--------137
Number of children receiving preventive fluoride treatment (Zircate Paste)---137

In addition, the dental school staff gave seven lectures to the schools' teaching staff which included 30 teachers' aides.

A considerable amount of time and effort was spent in working with the staff of the Department of Education in setting up the dental program, preparing budgets, scheduling appointments at the schools and making appointments with the local dentists. Special arrangements were made for several unusual and severe dental problems to receive care.

The program was thought to have been well coordinated with the total health program but tabulating the final results presented an unexpected difficulty. The summer migrant school budgets had included monies to pay for needed dental care for all the children enrolled and their reports gave the total amount spent for dental care which included children enrolled in remedial and Head Start classes. Some of the health departments had anticipated obtaining the final tally for the schools, and the school personnel had thought the health departments were keeping count of the number of migrant children receiving care. Consequently, a final accurate count of the total number of migrant children receiving dental care has been impossible to document accurately. It is known that some of the children received

care for less severe problems but the 137 children listed in the table were all that could be documented. The Director of the Dental School Project moved to Connecticut prior to completion of the statistics which was a further deterrent to tabulation of follow-up results.

The migrant staff of the State Department of Education and the supervising nurse of the state project have had several meetings this winter to determine what can be done to obtain the necessary statistical information -- as well as getting the needed dental care and it seems certain that a better recording system will be worked out for next season.

DENTAL HEALTH PROJECT
Conducted by University of Oregon Dental Students, Summer 1969
Dental Caries Experience of 44 Head Start Children, Ages 3-6

Age	No. Child.	"D" Teeth	"M" Teeth	"F" Teeth	Total DMF Teeth	F/DMF	"d" Teeth	"e" Teeth	"f" Teeth	Total def Teeth	f/def
3	8						0.87	-	-	0.87	-
4	9						2.11	-	-	2.11	-
5	15						2.00	-	0.40	2.40	16.7%
6	12	0.25	0.08	-	0.33	-	3.00	0.17	0.50	3.67	13.6%
Total	44										

DENTAL HEALTH PROJECT
Conducted by University of Oregon Dental Students, Summer 1969
Dental Caries Experience of 130 Remedial Children, Ages 4-11

Age	No. Child.	"D" Teeth	"M" Teeth	"F" Teeth	Total DMF Teeth	F/DMF	"d" Teeth	"e" Teeth	"f" Teeth	Total def Teeth	f/def
4	2						8.50	-	-	8.50	-
5	3						-	-	-	-	-
6	24	0.46	-	0.08	0.54	15.4%	1.79	0.08	1.67	3.54	47.1%
7	27	0.59	-	0.18	0.78	23.8%	2.18	-	3.00	5.18	57.9%
8	24	0.54	-	0.75	0.29	58.1%	1.50	-	2.54	4.04	62.9%
9	33	1.00	-	1.45	2.45	59.3%	1.82	-	2.73	4.54	60.0%
10	13	0.69	-	1.69	2.38	71.0%	0.69	-	2.85	3.54	80.4%
11	4	1.50	-	3.25	4.75	68.4%	0.50	-	0.50	1.00	50.0%
Total	130										

DENTAL HEALTH PROJECT
Conducted by University of Oregon Dental Students, Summer 1969
Dental Caries Experience of 821 Migrant Children, Ages 2-19 +

Age	No. Child.	"D" Teeth	"M" Teeth	"F" Teeth	Total DMF Teeth	F/DMF	:	"d" Teeth	"e" Teeth	"f" Teeth	Total def Teeth	f/def
2	23						:	-	-	-	-	-
3	28						:	1.93	-	0.04	1.96	1.8%
4	68						:	4.10	0.03	-	4.13	-
5	134						:	3.61	0.01	0.80	4.42	18.2%
6	131	0.39	-	0.04	0.43	10.5%	:	3.37	0.04	0.98	4.40	22.4%
7	113	0.69	-	0.15	0.84	17.9%	:	3.25	0.04	1.21	4.50	27.0%
8	72	1.22	0.01	0.24	1.51	15.6%	:	2.87	0.07	0.92	3.86	62.9%
9	71	1.32	0.01	0.41	1.75	23.4%	:	2.39	0.16	0.56	3.11	18.1%
10	41	1.15	0.22	0.24	1.61	15.2%	:	1.17	0.10	0.78	2.05	38.1%
11	32	1.69	-	0.31	2.00	15.6%	:	1.18	0.06	0.22	1.47	14.9%
12-18	85	2.09	-	0.12	2.21	5.3%	:	0.25	0.08	-	0.33	-
19+	23	4.13	0.09	0.39	4.61	8.5%	:					
Total	821											

DENTAL HEALTH PROJECT
Conducted by University of Oregon Dental Students, Summer 1969
DENTAL CARIES EXPERIENCE OF ALL PERSONS SEEN (995), AGES 2 - 19 + YEARS OLD

Age	No. Child	"D" Teeth	"M" Teeth	"F" Teeth	Total DMF Teeth	F/DMF	:	"d" Teeth	"e" Teeth	"f" Teeth	Total def Teeth	f/def
2	23						:	-	-	-	-	-
3	36						:	1.69	-	0.03	1.72	1.7%
4	79						:	3.99	0.02	-	4.01	-
5	152						:	3.38	0.01	0.75	4.14	18.1%
6	167	0.39	0.01	0.05	0.44	10.8%	:	3.11	0.06	1.05	4.22	24.8%
7	140	0.67	-	0.16	0.83	19.0%	:	3.04	0.03	1.56	4.63	33.6%
8	96	1.05	0.04	0.36	1.46	25.0%	:	2.53	0.05	1.32	3.91	33.9%
9	104	1.22	0.01	0.75	1.97	37.6%	:	2.21	0.11	1.25	3.57	35.0%
10	54	1.04	0.17	0.59	1.80	33.0%	:	1.06	0.07	1.28	2.41	53.1%
11	36	1.67	-	0.64	2.31	27.7%	:	1.11	0.06	0.25	1.42	17.6%
12-18	85	2.09	-	0.12	2.21	5.3%	:	1.42	0.08	-	0.33	-
19+	23	4.13	0.09	0.39	4.61	8.5%	:					
Total	995											

COMPARISON OF SELECT AGE GROUPS
AS RELATED TO URGENCY OF DENTAL CARE NEEDS

	Head Start							Remedial							Migrant						
Age	No.	0	%	1-2	%	3-4	%	No.	0	%	1-2	%	3-4	%	No.	0	%	1-2	%	3-4	%
2															23	23	100.0	0	-	0	-
3	8	6	75.0	2	25.0	0	-								28	13	46.5	9	32.1	6	21.4
4	9	4	44.5	3	33.3	2	22.2	2	0	-	1	50.0	1	50.0	68	36	52.9	12	17.7	20	29.4
5	15	7	46.6	4	26.7	4	26.7	3	3	100.0	0	-	0	-	134	25	18.7	78	58.2	31	23.1
6	12	5	41.7	5	41.7	2	16.6	24	8	33.3	10	41.7	6	25.0	131	24	18.3	63	48.1	44	33.6
7								27	5	18.5	16	59.3	6	22.2	113	14	12.4	60	53.1	39	34.5
8								24	3	12.5	20	83.3	1	4.2	72	13	18.1	24	33.3	35	48.6
9								33	5	15.0	23	70.0	5	15.0	71	17	23.9	30	42.3	24	33.8
10								13	2	15.4	11	84.6	0	-	41	15	36.6	10	24.4	16	39.0
11								4	1	25.0	2	50.0	1	25.0	32	9	28.1	12	37.5	11	34.4
12-18															85	24	28.2	39	45.9	22	25.9
19 +															23	3	13.0	8	34.8	12	25.2

COMPARISON OF SELECTED AGE GROUPS AS RELATED TO ORAL HYGIENE INDEX

Age	Migrant	Remedial	Head Start
5	1.46	1.00	1.43
6	1.53	1.48	1.33
7	1.64	1.54	
8	1.64	1.48	
9	1.68	1.51	
10	1.52	1.37	
11	1.58	1.45	
12-18	1.68		
19+	1.91		

COMPARISON OF SELECTED AGE GROUPS AS RELATED TO THE RATIO OF FILLED TEETH TO DECAYED, MISSING AND FILLED TEETH OF PERMANENT AND PRIMARY DENTITION EXPRESSED IN PERCENTAGES

AGE	Migrant Child. 1969		Remedial Child. 1969		Mon./Indep. Sch. 1959		Benton Co. 1968	
	F/DMF	f/def	F/DMF	f/def	F/DMF	f/def	F/DMF	f/def
5	-	18.2%	-	-	42.9%	56.7%		
6	10.5%	22.4%	15.4%	47.1%	13.9%	41.4%		
7	17.9%	27.0%	23.8%	57.9%	35.9%	49.1%		
8	15.6%	23.7%	58.1%	62.9%	29.0%	47.1%	54.9%	76.6%
9	23.4%	18.1%	59.3%	60.0%	38.1%	48.9%	62.6%	76.6%
10	15.2%	38.1%	71.0%	80.4%	48.9%	52.0%	70.4%	72.7%
11	15.6%	14.9%	68.4%	50.0%	38.6%	46.3%	64.9%	60.6%

UNIVERSITY OF OREGON DENTAL SCHOOL

611 S.W. Campus Drive
Portland, Oregon 97201

DEPARTMENT OF PEDODONTICS

Area Code 503 222-9781

July 31, 1969

Dr. Sumter S. Arnim, Dean
Graduate School of Biomedical Sciences at Houston
University of Texas
238 Hermann Professional Building
Houston, Texas 77025

Dear Doctor Arnim:

I have recently had correspondence from Dr. Pat Yeary about our mutual efforts at improving the dental health of migrant workers' children. A copy of my letter to Dr. Yeary which I would like you to read is enclosed.

We are now tabulating our findings from examinations on about 750 children, mostly Mexican-Americans. It will be no news to you that very few of these children have ever had any dental service. It is also a blessing that many have been born and raised in Texas where fluoride levels in water are adequate or even excessive because the decay rates would be much higher. We have observed quite a few cases of moderate fluorosis.

Our project was financed by a small federal grant ($4000) to employ four summer dental students. The purposes of our project was to identify those children in need of care, arrange for care for the most needy, and make some long term recommendations.

We learned that most of the migrant workers have as their home base Texas, Arizona, or California and that they are in these three states for the longest continuous period during the year, roughly three to four months.

In considering the availability of care for the migrant worker and his children, it seems to me that all of us in the dental profession must share in the responsibility. Since we know that the migrant remains in one area longer than others, then it seems reasonable to recommend that a program of care should be established in the home base areas. In other states where the migrants travel to work, follow up care can be arranged.

Why has so little care been done for the migrant? Is it because of lack of interest, unavailibility of dental services in areas where they live, or lack of funds to pay local dentists to do the treatment?

We have considered the possibility of using mobile dental units utilizing dental students and hygienists, but I am all too familiar with the inefficiency and necessary high cost per treatment of such an effort. Also, arranging for supervision by a faculty member is a particularly difficult problem when working with students in remote areas.

You will note that I have sent copies of this letter to an official in Health, Education, and Welfare and also to the Council on Dental Health of the A.D.A. Perhaps a national conference on the dental needs of migrant workers and our resources for providing care for these hard working, resourceful but disadvantaged people should be planned.

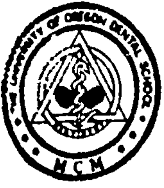
I am aware that the subject under discussion is not likely within your sphere of responsibility but would request any assistance that you can give me, even if it is nothing more than referring this letter to a dental public health authority in Texas. Thank you.

Yours sincerely,

C. R. Castaldi, M.S.D., D.D.S.
Professor of Pedodontics

CC:mc
Enclosure

ERIC



UNIVERSITY OF OREGON DENTAL SCHOOL

611 S.W. Campus Drive
Portland, Oregon 97201

DEPARTMENT OF PEDODONTICS

Area Code 503 222-9781

July 22, 1969

H. R. (Pat) Yeary, D.D.S.
P. O. Drawer 697
Cotulla, Texas 78014

Dear Doctor Yeary:

I was delighted to hear from you because we are involved in the same type of effort, and I appreciate the opportunity of exchanging experiences.

You are correct in assuming that many public health workers are not optimistic about any appreciable improvement in oral health through oral hygiene measures. On an individual basis, Dr. Arnim has certainly demonstrated long term improvement, but when it comes to large groups, the evidence is still pretty scarce.

I would agree with you that we must demonstrate success on a mass basis or else drop the whole matter. My approach has been first, to review the literature on oral hygiene and then set up a study based on past studies. My review of the literature leads me to these conclusions:

1. Pre-school children are incapable of wielding a tooth brush with any amount of success.
2. Parents of pre-school children most effectively brush their children's teeth by cross brushing rather than by a roll technique.
3. Brushing is more effectively taught to school children by the instructor brushing his or her own teeth while the child imitates; in other words, both brush together. This method is more effective than the use of a movie or on a model.
4. Removal of appreciable amounts of plaque may not be the sole criterion of the preventive effective of oral hygiene. Fluoride dentifrice studies in which no instruction on oral hygiene has been given have demonstrated caries increment reductions in six year old children who are very inadequate at wielding a tooth brush. It is possible that the mere introduction of a fluoride dentifrice into the mouth will exert a preventive effect.
5. Even fourth year dental students brush more effectively by cross brushing than by the roll method or the sulcular method.

Our preliminary findings showed one school of migrant and disadvantaged children which had very few toothbrushes and no formal oral hygiene instruction had as good an oral hygiene index (O.H.1 for 6 teeth was 9.44) as a comparable group of school children where the children had been given a toothbrush-dentifrice kit and instruction from the teachers (O.H.1. was 9.78).

With the above information as guides we set up our study. In two schools we gave instruction to all children as per #3 with dental students doing the instruction. We also gave each child a tooth brush. A description was given to all the teachers about what we were doing in order to solicit their assistance. Each child was required to keep his tooth brush at school and tooth brushing after the noon meal (provided by the school) was encouraged but not compulsory. Very few children failed to brush their teeth. The oral hygiene in the first school was checked one week after the first exam date on a Monday morning which would be after a week end when very few children even had a tooth brush at home. O. H. I. went from 9.44 to 8.93. Four days later, on a Friday when the children had brushed every day at noon after the second examination, the O. H. I. was down to 8.41. We then discovered that two of the classes who were housed in an isolated section of the building were mistakenly not given tooth brushes. Since I am writing this letter on the day we discovered this goof, I cannot tell you the final outcome of our study. We are going to re-examine the children one week from now and then run a statistical analysis of our data.

In the other school, we repeated what we did in school #1 but are not going to re-examine the children until July 29th.

Yours sincerely,

C. R. Castaldi, D.D.S., M.S.D.
Professor of Pedodontics

CC:mc
3 cc.
Enclosure

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February 19, 1969

Elton D Minkler, Supervisor
Migrant Education
Oregon Board of Education
Public Service Building
Salem, Oregon

Dear Mr. Minkler:

An extension of our dental care program is being planned for the 1969 season. We hope to have a dental student from the University of Oregon Dental School available to do dental screening in the summer migrant schools. The screening program will hopefully be part of an extensive dental health education program, and the migrant health project staff will be prepared to assist the school in any way they can in this dental health education and in the provision of dental care.

At the present time the program is being planned for the schools in the Willamette Valley, and we will keep you informed regarding progress.

Sincerely,

Hesther Poareo, P.H.N.
Nurse Consultant
Migrant Health Project
Environmental Health Section

HP:ah

Telephone: Area Code 503 — Days 226-2161 — After Hours 222-1500

OREGON
BOARD OF EDUCATION

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Deputy Superintendent and
Secretary of the Board

February 21, 1969

Mrs. Hesther Poareo
Migrant Health Project
Environmental Health Section
State Board of Health
Portland, Oregon

Dear Mrs. Poareo:

We were pleased to receive your letter anent the work your agency is doing to provide dental screening services for the migrant children in the Willamette Valley. Besides providing much needed services for the migrant children, your plan will give the Oregon Dental School students an opportunity to obtain valuable practical experience in their field.

A copy of your letter is being forwarded to all migrant summer school project directors. By receiving the information at this time they will have an opportunity to make provisions in their summer school plans and budgets to utilize this service.

Please keep us advised as to the progress of your planning so that we can keep our people advised.

Cordially,

Dale Parnell
Superintendent
Public Instruction

Elton D. Minkler, Supervisor
Migrant Education

EDM:jz

CLACKAMAS COUNTY

Clackamas County Migrant Health Project
Clackamas County Health Department
Hollister M. Stolte, M.D., Health Officer
1425 S. Kaen Road
Oregon City, Oregon 97045

POPULATION AND HOUSING DATA

FOR CLACKAMAS COUNTY.

GRANT NUMBER: MG 05G

5. POPULATION DATA - MIGRANTS (*Workers and dependents*)

a. NUMBER OF MIGRANTS BY MONTH

MONTH	TOTAL	IN-MIGRANTS	OUT-MIGRANTS
JAN.			
FEB.			
MAR.			
APRIL			
MAY			
JUNE			
JULY			
AUG.			
SEPT.			
OCT.			
NOV.			
DEC.			
TOTALS	1600-1700	1500-1600	100

b. NUMBER OF MIGRANTS DURING PEAK MONTH

	TOTAL	MALE	FEMALE
(1) OUT-MIGRANTS:			
TOTAL	24	14	10
UNDER 1 YEAR	2		2
1 - 4 YEARS	5	2	3
5 - 14 YEARS	7	6	1
15 - 44 YEARS	10	6	4
45 - 64 YEARS			
65 AND OLDER			
(2) IN-MIGRANTS:			
TOTAL	1266	624	639
UNDER 1 YEAR	43	19	25
1 - 4 YEARS	137	62	75
5 - 14 YEARS	448	232	216
15 - 44 YEARS	526	250	276
45 - 64 YEARS	95	56	39
65 AND OLDER	16	7	9

c. AVERAGE STAY OF MIGRANTS IN COUNTY

	NO. OF WEEKS	FROM (MO.)	THROUGH (MO.)
OUT-MIGRANTS	8 mo.	October	May
IN-MIGRANTS	6-8	June	September

6. HOUSING ACCOMMODATIONS

a. CAMPS

MAXIMUM CAPACITY	NUMBER	OCCUPANCY (*Peak*)
LESS THAN 10 PERSONS	6	50
10 - 25 PERSONS	11	220
26 - 50 PERSONS	17	648
51 - 100 PERSONS	7	475
MORE THAN 100 PERSONS	1	210
TOTAL*	42	1603

b. OTHER HOUSING ACCOMMODATIONS

LOCATION (*Specify*)	NUMBER	OCCUPANCY (*Peak*)
TOTAL*		

*NOTE: *The combined occupancy totals for "a" and "b" should equal approximately the total peak migrant population for the year.*

REMARKS

Information for 5a and 5b from family records and estimates of project nurse.

GRANT NUMBER	
MG 05G	CLACKAMAS COUNT
DATE SUBMITTED	

PART II - MEDICAL, DENTAL, AND HOSPITAL SERVICES

1. MIGRANTS RECEIVING MEDICAL SERVICES

a. TOTAL MIGRANTS RECEIVING MEDICAL SERVICES AT FAMILY HEALTH CLINICS, PHYSICIANS OFFICES, HOSPITAL EMERGENCY ROOMS, ETC.

AGE	NUMBER OF PATIENTS			NUMBER OF VISITS	
	TOTAL	MALE	FEMALE	MD.	PHN
TOTAL	174	65	109	273	378
UNDER 1 YEAR	16	5	11	24	37
1 - 4 YEARS	20	11	9	31	30
5 - 14 YEARS	48	27	21	72	122
15 - 44 YEARS	79	17	62	125	159
45 - 64 YEARS	10	5	5	20	28
65 AND OLDER					

No. of related nursing visits

b. OF TOTAL MIGRANTS RECEIVING MEDICAL SERVICES, HOW MANY WERE:

(1) SERVED IN FAMILY HEALTH SERVICE CLINIC*

(2) SERVED IN PHYSICIANS' OFFICE, ON FEE-FOR-SERVICE ARRANGEMENT (INCLUDE REFERRALS) 109

2. MIGRANTS RECEIVING DENTAL SERVICES

ITEM	TOTAL	UNDER 15	15 AND OLDER
a. NO. MIGRANTS EXAMINED-TOTAL	39	19	20
(1) NO. DECAYED, MISSING, FILLED TEETH			
(2) AVERAGE DMF PER PERSON			
b. INDIVIDUALS REQUIRING SERVICES - TOTAL	39	19	20
(1) CASES COMPLETED	) not available		
(2) CASES PARTIALLY COMPLETED	)		
(3) CASES NOT STARTED	2	1	1
c. SERVICES PROVIDED - TOTAL	77	37	40
(1) PREVENTIVE	1	1	
(2) CORRECTIVE-TOTAL			
(a) Extraction	38	14	24
(b) Other	38	22	16
d. PATIENT VISITS - TOTAL	not available		

3. MIGRANT HOSPITALIZATIONS

SOURCE OF PAYMENT	NO. PTS.	M	F	AGE GROUPING <1	1-4	5-14	15-44	45-64	65+	TOTAL HOSP. DAYS	AVE. HOSP. DAYS	PROJECT HOSPITAL COSTS	DOCTORS FEES PAID	TOTAL HOSPITAL BILLING
MIGRANT FUNDS	3	2	1			1	1		1	36	12	$1304.97	$600.10	$5354.55
OTHERS*	13	4	9		1	3	7	1	1	43	3			

*PAYMENT MADE BY PATIENT, INSURANCE, WELFARE, OR PROVIDED BY UNIVERSITY OF OREGON MEDICAL SCHOOL

4. IMMUNIZATIONS PROVIDED

TYPE	COMPLETED IMMUNIZATIONS, BY AGE: TOTAL	UNDER 1 YEAR	1 - 4	5 - 14	15 AND OLDER	INCOMPLETE SERIES	BOOSTERS, REVACCINATION
TOTAL - ALL TYPES							
SMALLPOX							
DIPHTHERIA							
PERTUSSIS							
TETANUS							
MEASLES							
TUBERCULIN SKIN TESTS							

No statistics available - services provided to migrants in regular Health Department clinics.

PART II (Continued) - 5. MEDICAL CONDITIONS TREATED BY PHYSICIANS IN FAMILY CLINICS, HOSPITAL OUTPATIENT DEPARTMENTS, AND PHYSICIANS' OFFICES.

MG 05G CLACKAMAS COUNTY

ICD CLASS	DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
I-XVII.	TOTAL ALL CONDITIONS	273	152	121
I.	INFECTIVE AND PARASITIC DISEASES: TOTAL	31	20	11
	TUBERCULOSIS			
	SYPHILIS			
	GONORRHEA AND OTHER VENEREAL DISEASES			
	INTESTINAL PARASITES			
	DIARRHEAL DISEASE (infectious or unknown origins):			
	Children under 1 year of age	2	2	
	All other			
	"CHILDHOOD DISEASES" – mumps, measles, chickenpox			
	FUNGUS INFECTIONS OF SKIN (Dermatophytoses)			
	OTHER INFECTIVE DISEASES (Give examples):			
	Strep throat	8	2	6
	Scabies	21	16	5
II.	NEOPLASMS: TOTAL	3	2	1
	MALIGNANT NEOPLASMS (give examples):			
	BENIGN NEOPLASMS	3	2	1
	NEOPLASMS of uncertain nature			
III.	ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES: TOTAL	6	4	2
	DISEASES OF THYROID GLAND			
	DIABETES MELLITUS	5	3	2
	DISEASES of Other Endoctine Glands			
	NUTRITIONAL DEFICIENCY	1	1	
	OBESITY			
	OTHER CONDITIONS			
IV.	DISEASES OF BLOOD AND BLOOD FORMING ORGANS: TOTAL	3	1	2
	IRON DEFICIENCY ANEMIA			
	OTHER CONDITIONS Nosebleeds	3	1	2
V.	MENTAL DISORDERS: TOTAL	3	2	1
	PSYCHOSES			
	NEUROSES and Personality Disorders	3	2	1
	ALCOHOLISM			
	MENTAL RETARDATION			
	OTHER CONDITIONS			
VI.	DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS: TOTAL	34	17	17
	PERIPHERAL NEURITIS	1	1	
	EPILEPSY	6	3	3
	CONJUNCTIVITIS and other Eye Infections	1	1	
	REFRACTIVE ERRORS of Vision	3	1	2
	OTITIS MEDIA	21	10	11
	OTHER CONDITIONS Migraine	2	1	1

PART II - 5. (Continued)

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ICD CLASS		DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
VII.		DISEASES OF THE CIRCULATORY SYSTEM: TOTAL	2	2	
		RHEUMATIC FEVER			
		ARTERIOSCLEROTIC and Degenerative Heart Disease			
		CEREBROVASCULAR DISEASE (Stroke)			
		OTHER DISEASES of the Heart	2	2	
		HYPERTENSION			
		VARICOSE VEINS			
		OTHER CONDITIONS			
VIII.		DISEASES OF THE RESPIRATORY SYSTEM: TOTAL	45	26	19
		ACUTE NASOPHARYNGITIS (Common Cold)	2	2	
		ACUTE PHARYNGITIS	4	2	2
		TONSILLITIS	14	7	7
		BRONCHITIS	8	5	3
		TRACHEITIS/LARYNGITIS			
		INFLUENZA	4	3	1
		PNEUMONIA	3	1	2
		ASTHMA, HAY FEVER	4	3	1
		CHRONIC LUNG DISEASE (Emphysema)	1	1	
		OTHER CONDITIONS	2	1	1
		Croup	3	1	2
IX.		DISEASES OF THE DIGESTIVE SYSTEM: TOTAL	15	4	11
		CARIES and Other Dental Problems			
		PEPTIC ULCER	8	2	6
		APPENDICITIS	3	1	2
		HERNIA			
		CHOLECYSTIC DISEASE			
		OTHER CONDITIONS	4	1	3
		DISEASES OF THE GENITOURINARY SYSTEM: TOTAL	24	11	13
		URINARY TRACT INFECTION (Pyelonephritis, Cystitis)	4	2	2
		DISEASES OF PROSTATE GLAND (excluding Carcinoma)			
		OTHER DISEASES of Male Genital Organs	1	1	
		DISORDERS of Menstruation	6	4	2
		MENOPAUSAL SYMPTOMS			
		OTHER DISEASES of Female Genital Organs	13	4	9
		OTHER CONDITIONS			
		COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM: TOTAL	4	2	2
		INFECTIONS of Genitourinary Tract during Pregnancy			
		TOXEMIAS of Pregnancy			
		SPONTANEOUS ABORTION	2	1	1
		REFERRED FOR DELIVERY			
		COMPLICATIONS of the Puerperium			
		OTHER CONDITIONS Threatened abortion	2	1	1
XII.		DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE: TOTAL	67	38	29
		SOFT TISSUE ABSCESS OR CELLULITIS	14	9	5
		IMPETIGO OR OTHER PYODERMA	36	20	16
		SEBORRHEIC DERMATITIS			
		ECZEMA, CONTACT DERMATITIS, OR NEURODERMATITIS	6	3	3
		ACNE			
		OTHER CONDITIONS # 695 #709 #700 #686	11	6	5

PART II - 5. *(Continued)*

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ICD CLASS	DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS
XIII.	DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE: TOTAL	3	2
	RHEUMATOID ARTHRITIS	2	1
	OSTEOARTHRITIS		
	ARTHRITIS, Unspecified		
	OTHER CONDITIONS Rheumatism	1	1
XIV.	CONGENITAL ANOMALIES: TOTAL	3	2
	CONGENITAL ANOMALIES of Circulatory System		
	OTHER CONDITIONS Birthmark	2	1
	Torticollis	1	1
XV.	CERTAIN CAUSES OF PERINATAL MORBIDITY AND MORTALITY: TOTAL		
	BIRTH INJURY		
	IMMATURITY		
	OTHER CONDITIONS		
XVI.	SYMPTOMS AND ILL-DEFINED CONDITIONS: TOTAL	7	4
	SYMPTOMS OF SENILITY		
	BACKACHE		
	OTHER SYMPTOMS REFERRABLE TO LIMBS AND JOINTS		
	HEADACHE	2	1
	OTHER CONDITIONS	5	3
XVII.	ACCIDENTS, POISONINGS, AND VIOLENCE: TOTAL	23	15
	LACERATIONS, ABRASIONS, and Other Soft Tissue Injuries	8	7
	BURNS		
	FRACTURES	7	3
	SPRAINS, STRAINS, DISLOCATIONS	4	3
	POISON INGESTION		
	OTHER CONDITIONS due to Accidents, Poisoning, or Violence	4	2

		NUMBER OF INDIVIDUALS
6.	SPECIAL CONDITIONS AND EXAMINATIONS WITHOUT SICKNESS: TOTAL	45
	FAMILY PLANNING SERVICES	13
	WELL CHILD CARE	4
	PRENATAL CARE	7
	POSTPARTUM CARE	4
	TUBERCULOSIS: Follow-up of inactive case	
	MEDICAL AND SURGICAL AFTERCARE	5
	GENERAL PHYSICAL EXAMINATION	
	PAPANICOLAOU SMEARS	10
	TUBERCULIN TESTING	
	SEROLOGY SCREENING	
	VISION SCREENING	
	AUDITORY SCREENING	
	SCREENING CHEST X-RAYS	
	GENERAL HEALTH COUNSELLING	
	OTHER SERVICES: (Specify) VD Follow-up	2

PART III - NURSING SERVICE

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TYPE OF SERVICE		NUMBER
1. NURSING CLINICS:		
a. NUMBER OF CLINICS		
b. NUMBER OF INDIVIDUALS SERVED - TOTAL		
2. FIELD NURSING:		
a. VISITS TO HOUSEHOLDS		819
b. TOTAL HOUSEHOLDS SERVED 257 families + 19 single men		273
c. TOTAL INDIVIDUALS SERVED IN HOUSEHOLDS		1290
d. VISITS TO SCHOOLS, DAY CARE CENTERS		
e. TOTAL INDIVIDUALS SERVED IN SCHOOLS AND DAY CARE CENTERS		
3. CONTINUITY OF CARE:		
a. REFERRALS MADE FOR MEDICAL CARE: TOTAL		249
(1) Within Area	239	
(Total Completed	177)	
(2) Out of Area	10	
(Total Completed	3)	
b. REFERRALS MADE FOR DENTAL CARE: TOTAL	53	53
(Total Completed	39)	
c. REFERRALS RECEIVED FOR MEDICAL OR DENTAL CARE FROM OUT OF AREA: TOTAL	5	5
(Total Completed	3)	
d. FOLLOW-UP SERVICES FOR MIGRANTS, not originally referred by project, WHO WERE TREATED IN PHYSICIANS' OFFICES (Fee-for-Service)		
e. MIGRANTS PROVIDED PRE-DISCHARGE PLANNING AND POST-HOSPITAL SERVICES	9	
f. MIGRANTS ASKED TO PRESENT HEALTH RECORD Form PMS-3652 or Similar Form) IN FIELD OR CLINIC: TOTAL	488	
(1) Number presenting health record	222	
(2) Number given health record	95	
4. OTHER ACTIVITIES (*Specify*):		
Camp visits	333	

REMARKS

PART IV - SANITATION SERVICES

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TABLE A. SURVEY OF HOUSING ACCOMMODATIONS

HOUSING ACCOMMODATIONS	TOTAL		COVERED BY PERMITS	
	NUMBER	MAXIMUM CAPACITY	NUMBER	MAXIMUM CAPACITY
CAMPS	42	1603		
OTHER LOCATIONS				
HOUSING UNITS - Family:				
IN CAMPS	324			
IN OTHER LOCATIONS				
HOUSING UNITS - Single				
IN CAMPS				
IN OTHER LOCATIONS				

TABLE B. INSPECTION OF LIVING AND WORKING ENVIRONMENT OF MIGRANTS

ITEM	NUMBER OF LOCATIONS INSPECTED*		TOTAL NUMBER OF INSPECTIONS		NUMBER OF DEFECTS FOUND		NUMBER OF CORRECTIONS MADE	
	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER
LIVING ENVIRONMENT:								
a. WATER	26		32		9		8	
b. SEWAGE	41		105		28		28	
c. GARBAGE AND REFUSE	41		107		20		20	
d. HOUSING	42		111		108		52	
e. SAFETY								
f. FOOD HANDLING								
g. INSECTS AND RODENTS	42		106		34		34	
h. RECREATIONAL FACILITIES								
WORKING ENVIRONMENT:								
a. WATER	XXXX		XXXX		XXXX		XXXX	
b. TOILET FACILITIES	XXXX		XXXX		XXXX		XXXX	
c. OTHER	XXXX		XXXX		XXXX		XXXX	

* *Locations — camps or other locations where migrants work or are housed.*

PART V - HEALTH EDUCATION SERVICES *(By type of service, personnel involved, and number of sessions.)*

TYPE OF HEALTH EDUCATION SERVICE	NUMBER OF SESSIONS					
	HEALTH EDUCATION STAFF	PHYSICIANS	NURSES	SANITARIANS	AIDES (other than Health Ed.)	OTHER (Specify)
A. SERVICES TO MIGRANTS.						
(1) Individual counselling			626		276	
(2) Group counselling					8	
B. SERVICES TO OTHER PROJECT STAFF						
(1) Consultation			20			
(2) Direct services						
C. SERVICES TO GROWERS:			Not Available			
(1) Individual counselling						
(2) Group counselling						
D. SERVICES TO OTHER AGENCIES OR ORGANIZATIONS:						
(1) Consultation with individuals			2			
(2) Consultation with groups			1			
(3) Direct services						
E. HEALTH EDUCATION MEETINGS			10		5	

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GENERAL INFORMATION

The current report deals with activities among the migrants from November 1, 1968 to November 1, 1969. The project nurse has continued her work throughout the entire year, assisted by a community health aide for three months during the summer. A part-time sanitarian was employed from March through October.

Our main objectives have continued the same as those for the state project as a whole.

Migrants were fewer in number again this year but began arriving earlier, since the strawberry harvest started nearly two weeks earlier. The peak of the season occurred during the raspberry season the first portion of July. Many of the people did not remain long in the area. Much rain in June damaged the berry crop and caused some of the migrants to leave the area and go to other crops in various places. There has been a slight increase in mechanization but this was not a significant factor this year.

In the Sandy area east of Oregon City, most of the migrants have customarily been Anglo and Indian with only a few Spanish-speaking people. This year there were a few more of the Spanish-speaking people in that area. In the Canby and Monitor areas south of Oregon City, the migrants have customarily been nearly all Mexican. This year there were fewer Mexicans in that area but more Anglos. It was reported that many of the families from Texas did not come this year because few beans were planted in our area.

Of migrants seen by the nurses, 83 families, or 30% of the migrants, were Spanish, 137 families or 48% were Anglos, 47 families or 18.2% were Indian, and 9 families or 3.5% were Negroes. A few Japanese from Portland lived in one camp for a brief time, but they were self-sufficient and did not care for or need nursing service.

The total number of migrants in this county has decreased the last two seasons. From 60 camps which operated the first year of the project, there were 42 which operated this year and they were not filled to capacity. Some came into the area and did not find housing near their work, so went to other places.

Since the project nurse and sanitarian had previously worked with the project, there was no need for orientation. However, they did participate in the annual Migrant Health Seminar. The project nurse attended an orientation conference in May for project aides. She and the community health aide attended a workshop for project personnel held in July. Other orientation and in-service training for the aide were provided by the project nurse and the health educator from the State Board of Health.

While it has not been possible to provide all service needed by migrants, the decreased number of migrants has made it possible to reach a greater proportion of them. Physicians and dentists in the area have continued to cooperate in providing services as needed. The East Multnomah-North Clackamas County Migrant Council has continued to work closely with us in attempting to meet needs of the people. They have helped meet emergency needs of the migrants as well as carrying on recreational activities in the camps.

The scattered geographical location of the camps makes it difficult to do optimum follow-up on health care and health teaching. Transportation to medical facilities continues to be a problem.

MEDICAL AND DENTAL SERVICES

The medical care for migrants in this county is provided in physicians' offices on a fee-for-service basis. The relatively small number of migrants scattered over a large geographical area have made it impractical to conduct special clinics. Usually the physicians will see these patients in their offices without prior appointments if there is urgent need and in most cases workers finish their field work in time to get to the

office during regular office hours. Physicians of the adjoining counties (Multnomah and Marion Counties) also cooperate in providing services to the migrants.

In 1.a of Part II it will be observed that of a total of 174 patients receiving medical care, 109 of these received care on a fee-for-service basis. The remaining 65 received care at the University of Oregon Medical School Outpatient Clinic or through the local health department. It was the policy for those patients who needed specialized care or extensive studies to be referred to the Medical School Outpatient Clinics. Women in late stages of pregnancy were generally referred to these clinics for prenatal care and delivery at the Multnomah County Hospital.

Dental service has been available again this year. Last year only emergent dental care was provided. This year considerable restorative work was also done. While the nurse referred 53 persons who complained of toothache or had other obvious evidence of dental needs, only 39 of these took advantage of the opportunity offered for care. Yet the general response to dental care seemed much greater this year than last.

In addition to the patients who received medical and dental care, there were 62 referrals which did not receive care while here. Many of these individuals left the area soon after referral and it is possible that they sought care at the next destination, but this is not definitely known. In some instances the condition improved without medical treatment.

In the analysis of diseases or conditions treated by physicians, it will be observed that there were 38 cases of impetigo and 16 of scabies. Twenty-six persons received treatment for respiratory disorders. Only two cases of diarrhea were treated, which is a record low for the project. Accidents accounted for 15 cases. Emphasis upon prenatal and postpartum care in addition to family planning services explains the fact that more women received medical services than did men.

While no special migrant clinics were held, migrants were invited to the Family Planning Clinic and the Immunization Clinics held at the Health Department at Oregon City. Thirteen women came to the Family Planning Clinic, and it is known that several families came to the Immunization Clinics, but separate statistics are not available to give a total number of immunizations.

HOSPITAL SERVICES

Though there were 13 patients hospitalized during the statistical year, only two of these had payment by the migrant project. Two patients delivered their babies at Multnomah County Hospital. One child was hospitalized at Doernbecher Hospital for excision of a buccal cyst, while another child was admitted to the same hospital for diagnostic studies for a seizure disorder. One lady had a hysterectomy at the University of Oregon Medical School Hospital. Another lady had a breast cyst excised at Emanuel Hospital under the Resident Program. Five migrants were hospitalized for one day each at Gresham Hospital after being involved in an automobile accident.

Nursing follow-up was provided to all the above mentioned hospitalized patients. While it was not possible to do pre-discharge planning in all of the cases, there was close coordination of efforts through contacts with the physicians, PHN coordinators at the hospitals and nursing staff. Patients were visited in the hospital when possible.

Relationships with the hospital personnel has been good. There has been prompt notification by the local hospitals when patients were admitted and cooperation in planning for their care.

NURSING SERVICES

Nursing services have been provided on a 12-month basis again this year. Though there are not a great number of migrants during the winter months, those who do remain seem to

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encounter a great number of problems requiring help from the nursing staff. Nursing activities are planned to implement the objectives as stated by the State Board of Health for the migrant project.

Based upon recommendations made at the close of last season, it was decided not to emphasize tuberculosis case finding but to provide tuberculosis follow-up.

Maternal and infant care was also given high priority.

The nursing staff for migrant health included services of a full-time migrant project nurse with some assistance during the summer months by one of the other public health nurses. In addition, a community health aide was employed from June through August. She worked very closely with the project nurse and made it possible to provide services to more people than would otherwise be possible.

The project nurse provided the orientation and daily consultation for the health aide. The supervising nurse was readily available when needed for consultation with the project nurse or aide. The state staff gave consultation concerning nursing care and health education as needed.

In an effort to provide nursing services to as many migrants as possible, the project nurse has kept in touch with the growers and explained our services where not already known by the grower. She has made contacts with the various physicians, dentists and druggists of the area in order to maintain good working relationships. Since there were no major changes in the project this year, efforts were directed at maintaining continuity of the program and providing follow-up on services rendered.

Early in the spring the project nurse sought out the migrants as they came into the area. Since most camps were not available for occupancy before the harvest season, those who came for pre-season work generally found their own housing. For that reason, it has been difficult to locate families, even though it was known that some had arrived in the area. Through the schools and local physicians' offices we learned of some of these families.

It has been the policy of the project nurse to visit each migrant family as soon as possible after arrival in the area in order to do a health screening and to explain to them the services available to them in the local area. Many of the families had been here before and knew of our services, but there are always new people. In order to help with total family needs rather than medical only, a leaflet was prepared indicating community resources for surplus foods, clothing, and other emergency help which might be needed. This was eagerly received and many needs were met through this pamphlet. It was impossible to compile any statistics on the number of people who found help by this means. However, it was noted that one afternoon the project nurse and the aide visited several camps and distributed these leaflets. They had occasion to visit the Migrant Clothing Center that evening and saw many people there who had received the pamphlets that very afternoon.

Because of the many camps, it was not possible to maintain a fixed schedule for camp visitation. However, the larger camps were visited on regular schedule once a week. The smaller ones were visited as frequently as possible. It was noted that occupancy varied a great deal. Families came and went. This made it very difficult to provide an effective follow-up plan.

No nursing clinic as such has been held. The nurse has attempted to visit each home in camps. Camp bosses in the larger camps have reported individuals in camp who had special needs. The standing orders formulated by the State Board of Health for migrant projects, with some modifications by the County Health Officer, have been utilized in meeting nursing needs. On several occasions children with suspicious skin lesions were brought to the Health Officer for diagnosis of impetigo or scabies. Treatment was then carried out under supervision of the project nurse.

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Again this year there were no migrant schools or day care centers in the county. Thus, no nursing service was rendered in institutions. The need for day care is a matter of real concern. In a number of instances, small babies were kept in a car adjacent to the fields while the mothers worked nearby. Attempts were made to caution the mothers of the dangers to the children, but the parents felt they had no other recourse.

Health education was conducted by the project nurse on a one-to-one basis. There were many opportunities to counsel on many different aspects of health care. The health aide was also able to devote time and effort toward health education. She conducted group classes on dental hygiene and nutrition. She did other health teaching on an individual basis.

The project nurse and aide traveled together a large share of the time. It was found that the aide could make family records, do some health teaching and some screening, while the nurse was able to devote more of her time to the finding and helping with actual health needs. At other times the aide was utilized to deliver appointments and do other errands. She sometimes visited camps alone, seeking out those people who most urgently needed the services of the nurse.

Three hundred, thirty-three camp visits were made by the project nurses and aide. This involved at least 819 home visits, though other homes were visited in which no specific nursing care was given.

A large amount of medical care was provided on a fee-for-service basis in the local physicians' offices. Migrants were given referral slips which they took to the physicians' offices. Usually the families made their own arrangements and provided their own transportation. On a few occasions transportation was arranged, though this is extremely difficult. A few migrants went directly to the physician's office without a referral slip. Then the health department was notified and could give verification of the migrant status. Follow-up was attempted on these referrals, but in many cases the families had moved on immediately and it was impossible to locate them for follow-up. Three families were not known previously and never located after referral, yet from all information given to us were bona fide migrants.

Since the health department now has a Family Planning Clinic, those women desiring such services were referred to it. Thirteen women received service, 10 of them having Pap smears done. Our services were explained to others. Many women who were contacted were already using birth control methods and did not need services at this time.

As in previous years, there were referrals to the Medical School Outpatient Department in Portland. For some of these, it was necessary for the nurse to arrange transportation or to take them herself.

It will be noted in Part III of the statistical report that of 239 referrals for medical care within the area, only 177 were completed. A few were still pending at the time of the report, so it is expected that a few more may be completed. The main reasons for non-completion are the fact that the family moved on before care could be given here and that there was delay in seeking treatment for non-acute conditions which in some cases did recover without treatment.

The nurse did not attempt thorough dental screening but noted urgent problems and referred these to dentists. In the Canby area, one dentist was extremely cooperative in providing care. He was able to do some restorative work in addition to the emergent needs. The nurse did follow-up as needed.

Since most of the hospitalizations were of short duration or were in Portland, it was difficult to do pre-discharge planning through actual visitation of the patient while hospitalized. However, contacts were made with physicians and hospital personnel, and it was felt that good follow-up care was accomplished. In the case of a child who broke his

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leg in May, he was hospitalized only one day, then sent home in a hip spica. The nurse helped set up a hospital bed with trapeze, provided other equipment, helped teach the family how to handle the patient and helped with other problems as they arose. She visited three times the first week, then at least once a week for three months until the cast was removed. Then she taught him crutch-walking and followed his progress until back to normal.

Ten referrals were made out of the local area, three of them out of state. Though only three answers were received to indicate completion, it is believed that the necessary care was obtained in other areas. Of those referrals received, three were completed. Two were not completed, as the patients had not returned to this area. One crew that worked in this county and went on to another county presented many health problems. The nurse made duplicate copies of family records and a report of the nursing referrals that had been made, with a listing of other problems encountered which might need further treatment while in that county. These were not included in the total number of referrals.

While one of our objectives this year was to provide good maternal and infant care, there were not many women seen in pregnancy. Seven women did receive prenatal medical care. The nurse was able to assist them in various ways. Through the Migrant Council, layettes were provided and made available to the nurse any time she saw a need. Of four postpartum patients, health counseling was given as well as provision for medical supervision. The nurse was also able to assist with health supervision of infants and small children.

Though a number of individuals were in need of immunizations, most were not sufficiently motivated to come to the clinic for immunizations. A number of Mexican families did come but very few Anglos came. There was insufficient interest to set up a special clinic in the camp areas, though there were attempts at health education.

Attempts were made to hire a community health aide from the migrant or low-income population. For various reasons, none was available. Therefore, a local resident was employed for the position. Since the project nurse speaks Spanish, there was no need for an interpreter; but it did mean that the aide could not communicate with many of the Spanish-speaking individuals. It is hoped that next season an aide can be secured from that population group.

Although our objective of making medical care available to all migrants has not been fully achieved yet, it was felt that we came closer to reaching the total group this year. This was partially due to a smaller number of migrants, but also to the fact that the community is aware of our services and helps apprise people not seen by the project nurse of the resources available to them.

It was a help to have our aide employed earlier this year, being employed the first of June. This allowed time for orientation and getting started early in the season. It is hoped that we can have an aide for the same three months next year.

Another recommendation for the coming year would be the utilization of other staff nurses during the harvest season in order that all camps may be visited frequently and that referrals and follow-up can be provided as necessary.

The migrant health project is well accepted in the community and has proven its value. The plan is to continue these services.

HEALTH EDUCATION SERVICES

It was the objective of the project nurse to give individual counseling and health teaching to migrants at every possible opportunity, with emphasis upon maternal and infant care, nutrition, and sanitation. It was felt that the community health aide could emphasize dental hygiene, personal hygiene, nutrition, and camp sanitation. The only group health

education classes were planned and held by the aide.

Members of the East Multnomah-North Clackamas County Migrant Council provided "Health kits" to the health department for use in health education classes. These contained toothbrush, toothpaste, soap, washcloth, Kleenex, and a comb. The aide conducted demonstrations on toothbrushing and personal grooming, then gave a kit to each child. Approximately 90 kits were given out in this manner.

Films were shown to groups of children. These were on nutrition, camp sanitation, and vector control. Interest was only fair.

Consultation was provided by the health educator from the State Board of Health. She was especially helpful to the aide as she planned her educational activities.

It was felt that possibly the most effective health teaching was done on an individual basis with those who felt needs and therefore had an interest in learning.

SANITATION SERVICES

The Migrant Sanitation Program for 1969 was carried on from the latter part of March on into October. One public health sanitarian was employed on a half-time basis for this purpose. There was a slight decrease in the number of camps in operation, forty-two compared to forty-five last year.

The specific objective was to improve the total environment of the farm worker and this consisted in the upgrading of housing, improved storage and disposal of garbage and refuse, in better sewage disposal, water supply, insect and rodent control.

By means of routine inspections before and during occupancy as well as follow-up visits and consultations, many of the goals were attained. In our consultations we emphasized that the purpose was not only to better the environment of the migrant worker, but that such improvement is beneficial to the public health of the whole community.

Good relationships and assistance from other agencies such as the County Extension Agent was also of value in promoting a true understanding and a positive attitude toward the migrant labor program.

As the need for guidance and consultation arose, such aid was always available from the Occupational Health Section of the State Board of Health as well as from the senior sanitarian and health officer of the local health department. Such consultation was mostly on legal and other technical matters.

All of the camps are the family type of which there are 324. Most of the units are individual cabins. However, there are some four and eight-plex structures and also former government housing.

There was about 90% response in notifying the local health officer prior to operating a camp, as required by law. However, some of these were late, such as one or two days prior to having the camp occupied. Inspections were made of those which had responded as well as those which had not. They were informed verbally and by letter to have corrections made and inform the local health department for approval before using the camp. Corrections were made with the exception of two operators. One decided not to use his camp. The other made some corrections in housing but operated a poorly maintained camp and closure was necessary. Others, on the verge of being closed, managed to make corrections in order to continue operation. Had the visits and inspections not been made previous to opening and followed up, very few or no improvements would have been made. The law requires notification prior to <u>operating</u>. It would be more practical, if a specified time before <u>any occupancy</u> were designated, when informing the health officer of intent to operate a camp.

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Water Supplies. For the most part water is supplied by drilled wells. Sampling for bacteriological analysis was made with about 21% not meeting the minimum standards. These were improved by obtaining proper chlorination as there are four supplies which are dug wells or springs and have chlorinators. Other improvements were disinfection temporarily until permanent corrections were brought about. There were two new wells drilled. One was to replace a dug well, while the other had formerly been using from his neighbor's supply. Three camps obtain their water from community supplies.

Sewage disposal. Most of the camps use pit privies. Three camps have flush toilets and septic tank systems. A total of 28 corrections were made which consisted of resetting the privies or making needed repairs.

Garbage disposal. In this regard most of the camps were maintained better this year. There was a total of 20 corrections made. This included proper cover on each container and replacing old or otherwise inadequate storage. A considerable number of the camps have collector service once per week. Otherwise the owner does it himself once or twice a week by hauling to a public dump.

Housing. Defects in housing continue to be a problem. Old construction which may have been classed as fairly good when built is not too easy to correct for permanent use. Fourteen units were repaired by covering knot holes, cracks, and broken wood with metal or wood in walls, floors, and roof. Four units were completely recovered with new roofing material. Five units were relined either with plywood or paneling. Eight units were painted on exterior or interior, three of them both interior and exterior. Various other minor repairs were made such as steps and entrances to eliminate hazards, etc.

Two new units were constructed at one camp. They were well constructed of wood and movable. Another camp of eleven units had a new shower building constructed with two shower heads for each sex.

One grower, who has depended upon bus transportation, etc., in the past, is planning to construct a new camp of twenty units for next year.

Insect and rodent control. This was accomplished by adequate storage and disposal of garbage and refuse, repairing or replacing broken screens, and proper mounding around the edges of pit privies. Thirty-four violations were found and corrected in this category.

There appeared to be more restlessness of the occupants this year. They did not stay at one place for very long. Camp owners did not know the reason, as they had formerly stayed during the season.

More operators used posters and other literature and indicated that it was of some value.

As to the carelessness of occupants in helping to maintain cleanliness, there are some owners who have actually not given specific instructions or regulations to follow during their stay. Few of the larger places have a "Camp Boss" whose responsibility is limited both by the situation and type of person he is. In other camps the occupants, apparently, are turned loose, so to speak. The owner in turn explains the poorly maintained camp by blaming them for the "Kind of Life" or the "Way" they live.

In future plans there are problems to be solved. One is the situation where a grower specifically states that he does not plan to operate a camp. Later the camp is partially occupied, as discovered by the project nurse, when occupants are in need of her services. The operator explains that these people just came in and needed housing.

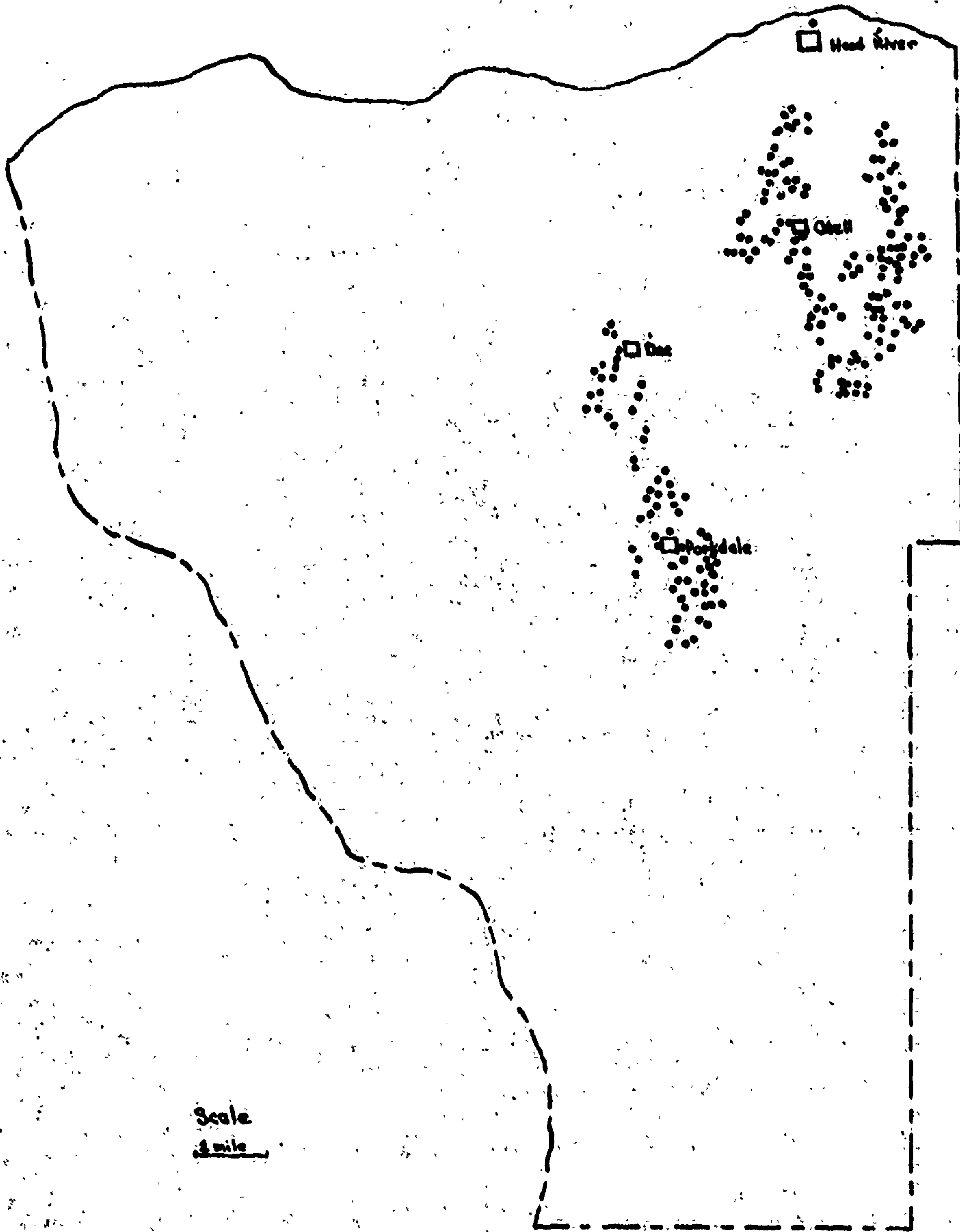
Another problem referred to earlier is the time at which operators are to notify the health officer. In the absence of a permit system, an attempt will be made to have the notification submitted at a specified time before any occupancy of the camp.

ERIC

If possible, more intensive and extensive direction will be made toward the occupants to help keep the camp orderly and clean. This will be partly accomplished by use of posters and literature available. Other means, such as films to promote a positive attitude of the worker, will be used.

At the larger camps the owner will be encouraged or directed to have an effective representative in charge of the camp.

HOOD RIVER COUNTY



Hood River County Migrant Health Project
Hood River County Health Department
L. L. Hoffman, M.D., Health Officer
Courthouse, Room 104
Hood River, Oregon 97031

POPULATION AND HOUSING DATA

FOR HOOD RIVER COUNTY.

GRANT NUMBER: MG 05G

5. POPULATION DATA - MIGRANTS *(Workers and dependents)*

a. NUMBER OF MIGRANTS BY MONTH

MONTH	TOTAL	IN-MIGRANTS	OUT-MIGRANTS
JAN.	70	30	40
FEB.	450	410	40
MAR.	450	410	40
APRIL	650	610	40
MAY	320	282	38
JUNE	200	192	8
JULY	150	142	8
AUG.	500	466	34
SEPT.	2300	2266	34
OCT.	160	126	34
NOV.	50	15	35
DEC.	70	30	40
TOTALS	5370	4979	391

b. NUMBER OF MIGRANTS DURING PEAK MONTH

	TOTAL	MALE	FEMALE
(1) OUT-MIGRANTS:			
TOTAL	34	22	9
UNDER 1 YEAR	1		1
1 - 4 YEARS	2	1	1
5 - 14 YEARS	7	4	3
15 - 44 YEARS	9	7	2
45 - 64 YEARS	13	11	2
65 AND OLDER	2	2	
(2) IN-MIGRANTS:			
TOTAL	2235	1712	523
UNDER 1 YEAR	40	15	25
1 - 4 YEARS	30	12	18
5 - 14 YEARS	210	130	80
15 - 44 YEARS	960	800	160
45 - 64 YEARS	515	400	115
65 AND OLDER	480	355	125

c. AVERAGE STAY OF MIGRANTS IN COUNTY

	NO. OF WEEKS	FROM (MO.)	THROUGH (MO.)
OUT-MIGRANTS	8	June	July
IN-MIGRANTS	8	June	July
	10	August	October

6. HOUSING ACCOMMODATIONS

a. CAMPS

MAXIMUM CAPACITY	NUMBER	OCCUPANCY *(Peak)*
LESS THAN 10 PERSONS	159	815
10 - 25 PERSONS	149	2390
26 - 50 PERSONS	228	924
51 - 100 PERSONS	5	368
MORE THAN 100 PERSONS	4	676
TOTAL*	345	5173

b. OTHER HOUSING ACCOMMODATIONS

LOCATION *(Specify)*	NUMBER	OCCUPANCY *(Peak)*
Roadside camping areas	19	Unknown
TOTAL*	19	

*NOTE: *The combined occupancy totals for "a" and "b" should equal approximately the total peak migrant population for the year.*

REMARKS:

Information for 5a was obtained from the Oregon State Employment Office.

Sex and age for 5b were derived on the basis of single men versus families and a determination of the size of an average family from health screening records.

GRANT NUMBER: MG 05G — HOOD RIVER COU

DATE SUBMITTED

PART II - MEDICAL, DENTAL, AND HOSPITAL SERVICES

1. MIGRANTS RECEIVING MEDICAL SERVICES

a. TOTAL MIGRANTS RECEIVING MEDICAL SERVICES AT FAMILY HEALTH CLINICS, PHYSICIANS OFFICES, HOSPITAL EMERGENCY ROOMS, ETC.

AGE	NUMBER OF PATIENTS			NUMBER OF VISITS
	TOTAL	MALE	FEMALE	
TOTAL				733
UNDER 1 YEAR	49	29	20	71
1 - 4 YEARS	49	22	27	57
5 - 14 YEARS	54	21	33	59
15 - 44 YEARS	210	105	105	386
45 - 64 YEARS	130	77	73	150
65 AND OLDER	6	5	1	10

No. of related nursing visits

b. OF TOTAL MIGRANTS RECEIVING MEDICAL SERVICES, HOW MANY WERE:

(1) SERVED IN FAMILY HEALTH SERVICE CLINIC? ____

(2) SERVED IN PHYSICIANS' OFFICE, ON FEE-FOR-SERVICE ARRANGEMENT (INCLUDE REFERRALS) 568

2. MIGRANTS RECEIVING DENTAL SERVICES

ITEM	TOTAL	UNDER 15	15 AND OLDER
a. NO. MIGRANTS EXAMINED-TOTAL	49	33	16
(1) NO. DECAYED, MISSING, FILLED TEETH	unknown		
(2) AVERAGE DMF PER PERSON			
b. INDIVIDUALS REQUIRING SERVICES-TOTAL	38	22	16
(1) CASES COMPLETED 38			
(2) CASES PARTIALLY COMPLETED			
(3) CASES NOT STARTED			
c. SERVICES PROVIDED - TOTAL	38	22	16
(1) PREVENTIVE			
(2) CORRECTIVE-TOTAL 47			
(a) Extraction 32			
(b) Other 15			
d. PATIENT VISITS - TOTAL	47	30	15

3. MIGRANT HOSPITALIZATIONS

SOURCE OF PAYMENT	NO. PTS.	M	F	AGE GROUPING <1	1-4	5-14	15-44	45-64	65+	TOTAL HOSP. DAYS	AVE. HOSP. DAYS	PROJECT HOSPITAL COSTS	DOCTORS FEES PAID	TOTAL HOSPITAL BILLING
MIGRANT FUNDS	69	28	41	15		8	28	18		232	3	$6436.58	$4452.00	$13039.25
OTHERS*														

*PAYMENT MADE BY PATIENT, INSURANCE, WELFARE, OR PROVIDED BY UNIVERSITY OF OREGON MEDICAL SCHOOL

4. IMMUNIZATIONS PROVIDED

TYPE	COMPLETED IMMUNIZATIONS, BY AGE: TOTAL	UNDER 1 YEAR	1 - 4	5 - 14	15 AND OLDER	INCOMPLETE SERIES	BOOSTERS, REVACCINATIONS
TOTAL-ALL TYPES	185	7	102	51	24		1
SMALLPOX	19	1	18				
DIPHTHERIA / PERTUSSIS	31	4	25	1			1
TETANUS / Polio	24	1	22	1			
MEASLES	13		13				
TUBERCULIN SKIN TESTS	98						

PART II (*Continued*) - 5. MEDICAL CONDITIONS TREATED BY PHYSICIANS IN FAMILY CLINICS, HOSPITAL OUTPATIENT DEPARTMENTS, AND PHYSICIANS' OFFICES.

MG 05G HOOD RIVER COUNTY

ICD CLASS	DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
I.-XVII.	TOTAL ALL CONDITIONS	689	446	243
I.	INFECTIVE AND PARASITIC DISEASES: TOTAL	74	40	34
	TUBERCULOSIS	3	3	
	SYPHILIS			
	GONORRHEA AND OTHER VENEREAL DISEASES	7	5	2
	INTESTINAL PARASITES	5	4	1
	DIARRHEAL DISEASE (infectious or unknown origins):			
	Children under 1 year of age			
	All other	2	1	1
	"CHILDHOOD DISEASES" – mumps, measles, chickenpox	4	3	1
	FUNGUS INFECTIONS OF SKIN (Dermatophytoses)			
	OTHER INFECTIVE DISEASES (*Give examples*):			
	Hepatitis	4	2	2
	Streptococcal Infections	43	17	26
II.	NEOPLASMS: TOTAL	11	4	7
	MALIGNANT NEOPLASMS (*give examples*):			
	Carcinoma of Lung	5	1	4
	Anal Cancer	4	1	3
	BENIGN NEOPLASMS	2	2	
	NEOPLASMS of uncertain nature			
III.	ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES: TOTAL	23	17	6
	DISEASES OF THYROID GLAND	2	2	
	DIABETES MELLITUS	15	11	4
	DISEASES of Other Endocrine Glands	3	2	1
	NUTRITIONAL DEFICIENCY	1	1	
	OBESITY			
	OTHER CONDITIONS	2	1	1
IV.	DISEASES OF BLOOD AND BLOOD FORMING ORGANS: TOTAL	8	5	3
	IRON DEFICIENCY ANEMIA	6	3	3
	OTHER CONDITIONS	2	2	
V.	MENTAL DISORDERS: TOTAL	7	5	2
	PSYCHOSES	1	1	
	NEUROSES and Personality Disorders			
	ALCOHOLISM	6	4	2
	MENTAL RETARDATION			
	OTHER CONDITIONS			
VI.	DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS: TOTAL	40	27	13
	PERIPHERAL NEURITIS	6	4	2
	EPILEPSY	4	1	3
	CONJUNCTIVITIS and other Eye Infections	10	8	2
	REFRACTIVE ERRORS of Vision			
	OTITIS MEDIA	16	11	5
	OTHER CONDITIONS	4	3	1

PART II - 5. *(Continued)*

MG 05G HOOD RIVER COUN

ICD CLASS		DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
VII.		DISEASES OF THE CIRCULATORY SYSTEM: TOTAL	10	7	3
		RHEUMATIC FEVER			
		ARTERIOSCLEROTIC and Degenerative Heart Disease	4	2	2
		CEREBROVASCULAR DISEASE (Stroke)			
		OTHER DISEASES of the Heart	2	1	1
		HYPERTENSION			
		VARICOSE VEINS			
		OTHER CONDITIONS	4	4	
VIII.		DISEASES OF THE RESPIRATORY SYSTEM: TOTAL	138	88	50
		ACUTE NASOPHARYNGITIS (Common Cold)	16	9	7
		ACUTE PHARYNGITIS	8	7	1
		TONSILLITIS	29	18	11
		BRONCHITIS	10	7	3
		TRACHEITIS/LARYNGITIS	3	1	2
		INFLUENZA	15	13	2
		PNEUMONIA	1	1	
		ASTHMA, HAY FEVER	14	7	7
		CHRONIC LUNG DISEASE (Emphysema)	2	2	
		OTHER CONDITIONS	40	23	17
IX.		DISEASES OF THE DIGESTIVE SYSTEM: TOTAL	80	56	24
		CARIES and Other Dental Problems	26	25	1
		PEPTIC ULCER	21	6	15
		APPENDICITIS	8	4	4
		HERNIA	1	1	
		CHOLECYSTIC DISEASE			
		OTHER CONDITIONS	24	20	4
X.		DISEASES OF THE GENITOURINARY SYSTEM: TOTAL	61	40	21
		URINARY TRACT INFECTION (Pyelonephritis, Cystitis)	24	16	8
		DISEASES OF PROSTATE GLAND (excluding Carcinoma)			
		OTHER DISEASES of Male Genital Organs	3	3	
		DISORDERS of Menstruation	10	7	3
		MENOPAUSAL SYMPTOMS	10	6	4
		OTHER DISEASES of Female Genital Organs	4	2	2
		OTHER CONDITIONS	10	6	4
XI.		COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM: TOTAL	7	5	2
		INFECTIONS of Genitourinary Tract during Pregnancy			
		TOXEMIAS of Pregnancy			
		SPONTANEOUS ABORTION	2	1	1
		REFERRED FOR DELIVERY	1	1	
		COMPLICATIONS of the Puerperium			
		OTHER CONDITIONS	4	3	1
XII.		DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE: TOTAL	73	47	26
		SOFT TISSUE ABSCESS OR CELLULITIS	11	9	2
		IMPETIGO OR OTHER PYODERMA	11	8	3
		SEBORRHEIC DERMATITIS			
		ECZEMA, CONTACT DERMATITIS, OR NEURODERMATITIS	5	5	
		ACNE			
		OTHER CONDITIONS	46	25	21

PART II - 5. (Continued)

MG 05G HOOD RIVER COUNTY

ICD CLASS		DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
XIII.		DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE: TOTAL	14	9	5
		RHEUMATOID ARTHRITIS	1	1	
		OSTEOARTHRITIS			
		ARTHRITIS, Unspecified	8	3	5
		OTHER CONDITIONS	5	5	
XIV.		CONGENITAL ANOMALIES: TOTAL			
		CONGENITAL ANOMALIES of Circulatory System			
		OTHER CONDITIONS			
XV.		CERTAIN CAUSES OF PERINATAL MORBIDITY AND MORTALITY: TOTAL			
		BIRTH INJURY			
		IMMATURITY			
		OTHER CONDITIONS			
XVI.		SYMPTOMS AND ILL-DEFINED CONDITIONS: TOTAL	53	39	14
		SYMPTOMS OF SENILITY			
		BACKACHE	5	3	2
		OTHER SYMPTOMS REFERRABLE TO LIMBS AND JOINTS	12	8	4
		HEADACHE	7	6	1
		OTHER CONDITIONS	29	21	8
XVII.		ACCIDENTS, POISONINGS, AND VIOLENCE: TOTAL	90	57	33
		LACERATIONS, ABRASIONS, and Other Soft Tissue Injuries	22	18	4
		BURNS	1	1	
		FRACTURES	35	17	18
		SPRAINS, STRAINS, DISLOCATIONS	8	3	5
		POISON INGESTION			
		OTHER CONDITIONS due to Accidents, Poisoning, or Violence	24	18	6

			NUMBER OF INDIVIDUALS
6.		SPECIAL CONDITIONS AND EXAMINATIONS WITHOUT SICKNESS: TOTAL	674
		FAMILY PLANNING SERVICES	49
		WELL CHILD CARE	12
		PRENATAL CARE	34
		POSTPARTUM CARE	33
		TUBERCULOSIS: Follow-up of inactive case	8
		MEDICAL AND SURGICAL AFTERCARE	67
		GENERAL PHYSICAL EXAMINATION	31
		PAPANICOLAOU SMEARS	32
		TUBERCULIN TESTING	98
		SEROLOGY SCREENING	35
		VISION SCREENING	47
		AUDITORY SCREENING	90
		SCREENING CHEST X-RAYS	24
		GENERAL HEALTH COUNSELLING	7
		OTHER SERVICES:	
		(Specify) Immunizations	107

PART III - NURSING SERVICE

MG 05G HOOD RIVER COUN

TYPE OF SERVICE	NUMBER
NURSING CLINICS:	
a. NUMBER OF CLINICS	5
b. NUMBER OF INDIVIDUALS SERVED - TOTAL	167
FIELD NURSING:	
a. VISITS TO HOUSEHOLDS	854
b. TOTAL HOUSEHOLDS SERVED	447
c. TOTAL INDIVIDUALS SERVED IN HOUSEHOLDS	1463
d. VISITS TO SCHOOLS, DAY CARE CENTERS	308
e. TOTAL INDIVIDUALS SERVED IN SCHOOLS AND DAY CARE CENTERS	423
CONTINUITY OF CARE:	
a. REFERRALS MADE FOR MEDICAL CARE: TOTAL	935
(1) Within Area	899
(Total Completed)	829
(2) Out of Area	36
(Total Completed)	24
b. REFERRALS MADE FOR DENTAL CARE: TOTAL	38
(Total Completed)	36
c. REFERRALS RECEIVED FOR MEDICAL OR DENTAL CARE FROM OUT OF AREA: TOTAL	11
(Total Completed)	11
d. FOLLOW-UP SERVICES FOR MIGRANTS, not originally referred by project, WHO WERE TREATED IN PHYSICIANS' OFFICES (Fee-for-Service)	1
e. MIGRANTS PROVIDED PRE-DISCHARGE PLANNING AND POST-HOSPITAL SERVICES	54
f. MIGRANTS ASKED TO PRESENT HEALTH RECORD (Form PMS-3652 or Similar Form) IN FIELD OR CLINIC: TOTAL	447
(1) Number presenting health record.	91
(2) Number given health record.	118
OTHER ACTIVITIES (Specify):	
Visits to camps	580

REMARKS

72

PART IV - SANITATION SERVICES

MG 05G HOOD RIVER COU

TABLE A. SURVEY OF HOUSING ACCOMMODATIONS

HOUSING ACCOMMODATIONS	TOTAL		COVERED BY PERMITS	
	NUMBER	MAXIMUM CAPACITY	NUMBER	MAXIMUM CAPACITY
CAMPS	345	5173		
OTHER LOCATIONS	19	unknown		
HOUSING UNITS - Family:				
IN CAMPS				
IN OTHER LOCATIONS				
HOUSING UNITS - Single				
IN CAMPS				
IN OTHER LOCATIONS				

TABLE B. INSPECTION OF LIVING AND WORKING ENVIRONMENT OF MIGRANTS

ITEM	NUMBER OF LOCATIONS INSPECTED*		TOTAL NUMBER OF INSPECTIONS		NUMBER OF DEFECTS FOUND		NUMBER OF CORRECTIONS MADE	
	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER
LIVING ENVIRONMENT:								
a. WATER	283		339		22		16	
b. SEWAGE	283		339		67		49	
c. GARBAGE AND REFUSE	283		339		154		123	
d. HOUSING	283		2545 units		496		322	
e. SAFETY	283		339		21		15	
f. FOOD HANDLING	1		1					
g. INSECTS AND RODENTS	283		339		188		101	
h. RECREATIONAL FACILITIES	1		1					
WORKING ENVIRONMENT:								
a. WATER	xxxx		xxxx		xxxx		xxxx	
b. TOILET FACILITIES	xxxx		xxxx		xxxx		xxxx	
c. OTHER	xxxx		xxxx		xxxx		xxxx	

Locations – camps or other locations where migrants work or are housed.

PART V – HEALTH EDUCATION SERVICES *(By type of service, personnel involved, and number of sessions.)*

TYPE OF HEALTH EDUCATION SERVICE	NUMBER OF SESSIONS					
	HEALTH EDUCATION STAFF	PHYSICIANS	NURSES	SANITARIANS	AIDES (other than Health Ed.)	OTHER (Sp
A. SERVICES TO MIGRANTS:						
(1) Individual counselling			1434	21	358	
(2) Group counselling			15		6	
B. SERVICES TO OTHER PROJECT STAFF.						
(1) Consultation		72	168	12	52	
(2) Direct services			24	17	5	
C. SERVICES TO GROWERS:						
(1) Individual counselling		15	348	196	87	
(2) Group counselling			1			
D. SERVICES TO OTHER AGENCIES OR ORGANIZATIONS:						
(1) Consultation with individuals			118	13	36	
(2) Consultation with groups			3			
(3) Direct services						
E. HEALTH EDUCATION MEETINGS			16		4	

Hood River County
MG 05G

NURSING NARRATIVE

The Hood River Valley is a climatic staircase approximately twenty-five miles long that descends from 3,500 feet in the upper valley to an elevation of 200 feet in the lower valley on the Columbia River. Because precipitation, temperature, and soil conditions vary in this tri-level valley, blossom time begins first in the lower region and moves into the middle and upper valleys at two week intervals.

Since fruit production is one of the two principal industries, the residents are very dependent on the migrant labor force. Community involvement and grower concern in behalf of the seasonal worker is increasing each year. There appears to be a closer relationship between the grower and the migrant in the Hood River Valley because most of the camps are small and are located very near the grower's residence. Before the Migrant Program growers often carried the cost of medical emergencies which was an emotional and financial burden. Now with medical and dental services provided they feel more freedom in their relationship with the migrant and his family. The need for transportation, clothing, etc. are often considered as minor problems which the grower is very willing to handle. In fact, this year one grower transported a person with active tuberculosis to the Oregon State Tuberculosis Hospital. Another acted as a godparent at 1:00 a.m. and still another paid over $700 for funeral expenses for one of his workers.

For more effective and efficient service the Migrant Program was made a part of the Health Department and all the personnel gave total community care. Nurses worked in specific areas and were able to cut down mileage and driving time. Community acceptance seemed to increase with this change.

Generally good weather, bumper crops, and good prices brought many migrants to the valley from Arizona, Texas, and California. Project staff averaged about one person to four hundred migrants so efforts were concentrated in the areas of pre-natal and post-natal care, family planning and child care.

A definite increase of Mexican single men and families was noted. Some crossed the border illegally and surveillance by the Border Patrol has been heavy. A great deal of controversy has arisen over their presence. Language differences brought about the formation of two classes: a Spanish class taught by an energetic Mexican woman, and an English class taught by our Spanish-speaking migrant sanitarian.

One of the main objectives of the program is to manage the acute and chronic medical problems of the migrant. However, before this is accomplished a great deal of time is spent solving other immediate problems. Here again community involvement has been important and will be listed as follows:

Upper Valley Day Care Program

The Center was open for eight weeks during strawberry harvest to provide child care for a large Mexican contract crew and other local children. One project nurse and aide worked out of the center screening and referring for medical care and acting as liaison between the center, family and physician.

Immunizations, TB testing, vision, hearing, dental and communicable disease screening were done under the direction of the program at the Center and the Health Department.

Health Education for the children and Center staff was provided and a great deal of counseling and instruction were given to staff and parents.

Lack of funds brought closure of the Center after strawberry harvest. Because of its valuable influence, the Health Department staff obtained TV coverage of its plight and through many joint efforts the Center reopened in October.

Council of Churches

Because of frequent needs for child care, transportation, etc., this group organized a FISH program which gave valuable assistance. They also published a resource book called "Where to Turn" and provided a small emergency fund to be used at the discretion of the Health Department.

Local people

The migrant aide was very adept at involving the community and through her efforts donations of clothing, cribs, bassinettes, walkers, toys, food, gas, tires, and a washing machine were made. Fifty-two migrant children were outfitted with clothing to start school. A great deal of community education was accomplished through her actions.

Volunteer Spanish-speaking migrants provided transportation and translation services.

Agencies

1. The County Extension Office newsletter carried current program plans to the grower and was a vehicle for locating migrants who needed medical attention.
2. Civil Defense loaned radios to facilitate communication for staff in the field.
3. Welfare, Juvenile, District Court and Employment Service all gave counseling and supportive help.

Schools

Additional classes were provided for the migrant children in the lower grades. Title I funds were used to provide pre-school and sport physicals and also provided money for entrance fees at the high school level.

Professionals

A local optometrist provided vision exams and glasses, at no cost to adult migrants. Children's vision needs were cared for by Lions' and Elks' programs.

All medical problems were routed through local physicians and migrants appreciated having a choice of doctors thus feeling they had a doctor of their own. Physicians were paid usual and customary fees, which increased their cooperation and interest in the patients.

One of the nine physicians, however, carried approximately eighty percent of the load, seeing patients without appointments and at a minimal fee. As the only Spanish-speaking doctor, he saw nearly all of the Mexican people. To aid with the increase in his patient load he employed a fourth year medical student from Pennsylvania.

All six dentists provided service on a rotating basis. Since the need for care far outweighed the available dentists' time, the services were limited. Fluoride tablets were provided by a local sorority as a back up in the dental program.

The State Migrant Project provided an excellent network for information exchange between counties and states.

Hospital

All regular admissions were cleared through the project and emergency problems were left to the doctor's discretion. Long term admissions were channeled to state institutions or placed under welfare services. Pre-discharge planning began as soon as staff were notified of admissions. The lack of funds for the use of the Emergency Room has caused some problems for the hospital and the seasonal worker.

Health education was often limited to instruction since basically education is not high on the list of migrant values. The process of learning is directly related to the need of the individual and on this premise we proceeded. We taught diaper care while the mother was

washing diapers. We did not use formal teaching. Our most effective teaching device was empathy. Gaining the confidence of an individual and making him feel that he had a friend often opened his mind to education and problem solving.

As the season closes a few families remain to establish permanent homes. Since the migrant medical funds are gone their medical care will be routed through the University of Oregon Medical School and supportive care will be given locally.

Planning for next year's program will begin soon with more emphasis on pre-season education for staff. Communication gaps between personnel will be analyzed and more opportunity for staff information exchange and case study evaluation will be considered.

SANITATION NARRATIVE

During the 1969 season, 79% of all migrant labor camps in Hood River County were inspected at least once. This figure represents the highest number of camps inspected in this county during any single year since the adoption of the program, despite the fact that the project's full-time sanitarian resigned during the middle of the season and the project was without a sanitarian for one full month before another was recruited.

The basic responsibility of the sanitation program is to assure compliance with the Farm Labor Health Code as promulgated by the Oregon State Board of Health. To this end, one full-time sanitarian works quite closely with local growers in a continuing program of education, inspection, and enforcement to maintain high standards in good camps and to upgrade those which need improvement.

To the incoming sanitarian, the most impressive facet of migrant labor housing in Hood River County is the amount of new construction in labor camps. Several growers have built new cement-block units resembling motels, with laundry rooms attached, complete with hot water, showers, flush toilets, and in some cases, electric heat. Several smaller growers have added shower/utility houses to camps which had previously not been provided with these facilities. One grower has installed cable TV service in his cabins (although migrants must provide their own TV sets). The better migrant camps of Hood River County were the subject of a feature article in the Sunday Oregonian (September 7, 1969).

The attitude of one grower apparently expresses the beliefs of many others. This gentleman stated that he is constrained by the pressures of the market place to provide better accommodations for his employees because, as a businessman, he is concerned with completing his harvest as soon as possible after its beginning. With better accommodations, he can hire the professional farm workers who can pick seven, eight, or ten bins of fruit apiece in a day. Before his new camp had been built, he found that the professional pickers were hired by his competitors and he had to make do with what he calls "the bin-and-a-half-a-day boys". And his harvest seemed to take forever.

Admittedly, not all camps in this county are showplaces. The present unofficial count of migrant labor camps in Hood River County stands at about 345 sites; not all of these boast admirable accommodations. However, it must be admitted that within the three years of the project's existence in this county overall facilities within the area have improved tremendously.

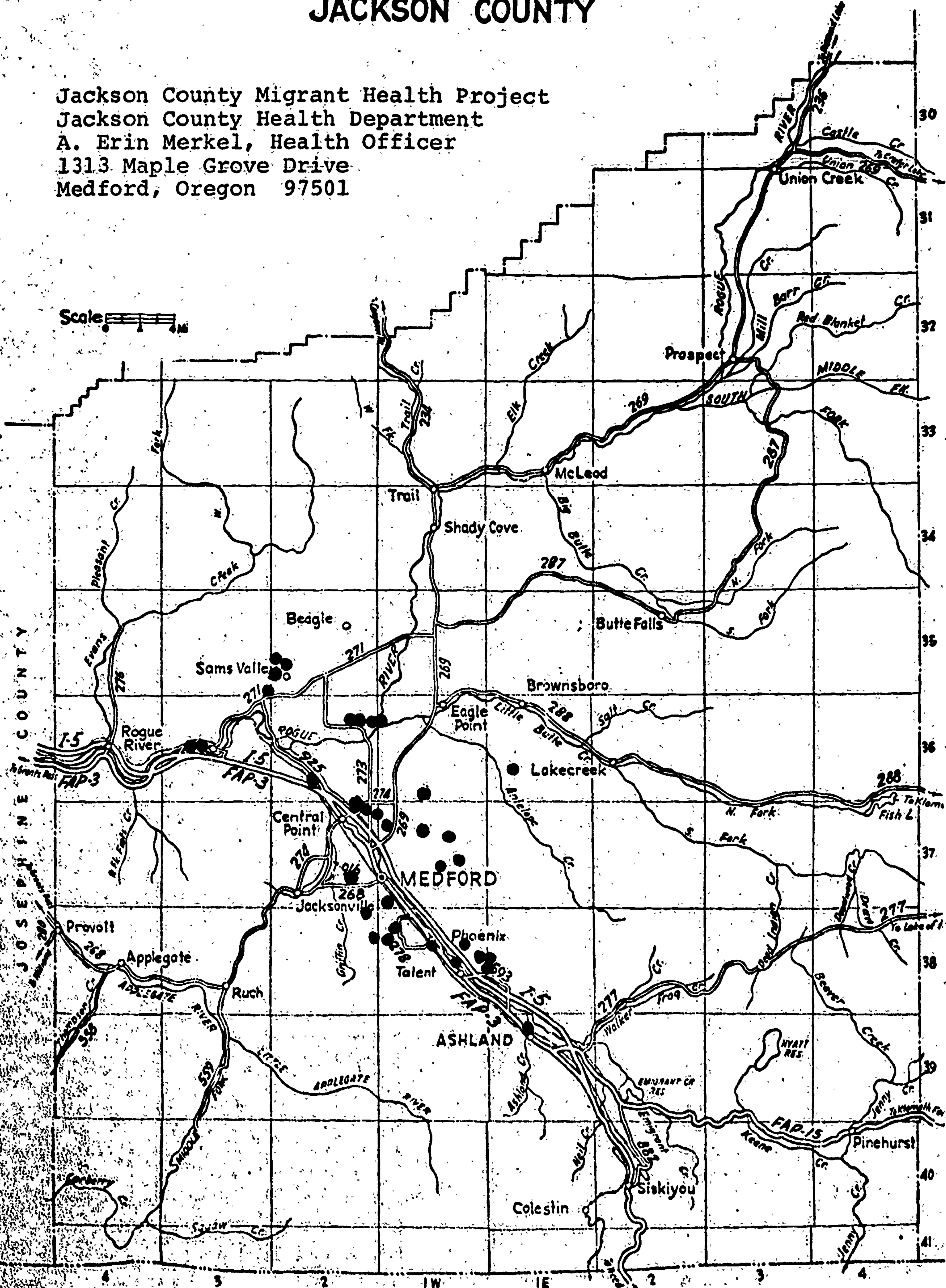
Specific problems in the field of migrant labor housing are those common to all counties: water supply, sewage disposal, solid waste, and so on. In this county we are fortunate that virtually all migrant camps are located where access to community water supplies is feasible, thereby removing one major problem from the area of consideration. Sewage disposal presents occasional problems, and whether the privy or the septic-tank-and-drainfield method is employed, these problems are dealt with as they arise. Happily, however, it is becoming apparent to growers that this office is willing to help in all phases of public health; we lay out one new drainfield each month for a migrant labor camp. Solid waste disposal continues to be something of a problem to all concerned (including the contracting hauler, who faces a 20-mile run to the upper parts of the valley). This situation has been eased considerably, however, by the passage of a garbage-disposal ordinance by the County of Hood

River within the past year. This ordinance facilitates enforcement of waste-disposal provisions of the state's health code for farm labor camps to a considerable degree. Additionally, it has been believed for some time that the establishment of a sanitary landfill operation in the southern part of the county would be a distinct asset; it is planned to investigate this possibility more fully in the future.

Considerable assistance has been provided by the Oregon State Employment Service, Hood River County Extension Service, the Occupational Health Section of the Oregon State Board of Health and by other staff members of the Hood River County Health Department.

JACKSON COUNTY

Jackson County Migrant Health Project
Jackson County Health Department
A. Erin Merkel, Health Officer
1313 Maple Grove Drive
Medford, Oregon 97501



POPULATION AND HOUSING DATA

FOR JACKSON COUNTY.

GRANT NUMBER: MG 05G

5. POPULATION DATA - MIGRANTS *(Workers and dependents)*

a. NUMBER OF MIGRANTS BY MONTH

MONTH	TOTAL	IN-MIGRANTS	OUT-MIGRANTS
JAN.			
FEB.			
MAR.			
APRIL			
MAY			
JUNE			
JULY	47	29	18
AUG.	714	696	18
SEPT.	840	822	18
OCT.	58	40	18
NOV.			
DEC.			
TOTALS			

b. NUMBER OF MIGRANTS DURING PEAK MONTH

	TOTAL	MALE	FEMALE
(1) OUT-MIGRANTS: TOTAL	18	13	5
UNDER 1 YEAR	1	1	
1 - 4 YEARS	2		2
5 - 14 YEARS	2		2
15 - 44 YEARS	11	10	1
45 - 64 YEARS	2	2	
65 AND OLDER			
(2) IN-MIGRANTS: TOTAL	459	324	135
UNDER 1 YEAR	6	1	5
1 - 4 YEARS	29	22	7
5 - 14 YEARS	96	52	44
15 - 44 YEARS	222	167	55
45 - 64 YEARS	103	80	23
65 AND OLDER	3	2	1

c. AVERAGE STAY OF MIGRANTS IN COUNTY

	NO. OF WEEKS	FROM (MO.)	THROUGH (MO.)
OUT-MIGRANTS	2	September	September
IN-MIGRANTS	8	August	September

6. HOUSING ACCOMMODATIONS

a. CAMPS

MAXIMUM CAPACITY	NUMBER	OCCUPANCY *(Peak)*
LESS THAN 10 PERSONS	3	
10 - 25 PERSONS	26	
26 - 50 PERSONS	5	
51 - 100 PERSONS		
MORE THAN 100 PERSONS	1	
TOTAL*	35	

b. OTHER HOUSING ACCOMMODATIONS

LOCATION *(Specify)*	NUMBER	OCCUPANCY *(Peak)*
TOTAL*		

NOTE: The combined occupancy totals for "a" and "b" should equal approximately the total peak migrant population for the year.

REMARKS

Information for 5a from health screening information, visits to orchards, and number of men at farm labor camp.

Total no. families screened by P.H.N.	Families in area first time		Ethnic Groups							
			Spanish		Anglo		Indian		Negro	
	No.	%	No.	%	No.	%	No.	%	No.	%
324	123	38	214	66	107	33	2	.7	1	.3

GRANT NUMBER MG 05G JACKSON COUNTY

DATE SUBMITTED

PART II - MEDICAL, DENTAL, AND HOSPITAL SERVICES

1. MIGRANTS RECEIVING MEDICAL SERVICES

a. TOTAL MIGRANTS RECEIVING MEDICAL SERVICES AT FAMILY HEALTH CLINICS, PHYSICIANS OFFICES, HOSPITAL EMERGENCY ROOMS, ETC.

AGE	NUMBER OF PATIENTS			NUMBER OF VISITS
	TOTAL	MALE	FEMALE	
TOTAL	177	93	84	332
UNDER 1 YEAR	15	9	6	21
1 - 4 YEARS	23	16	7	48
5 - 14 YEARS	32	16	16	16
15 - 44 YEARS	72	27	45	124
45 - 64 YEARS	34	24	10	71
65 AND OLDER	1	1		2

No. of related nursing visits

b. OF TOTAL MIGRANTS RECEIVING MEDICAL SERVICES, HOW MANY WERE:

(1) SERVED IN FAMILY HEALTH SERVICE CLINIC? 78

(2) SERVED IN PHYSICIANS' OFFICE ON FEE-FOR-SERVICE ARRANGEMENT (INCLUDE REFERRALS) 177 + 76* = 253

2. MIGRANTS RECEIVING DENTAL SERVICES

ITEM	TOTAL	UNDER 15	15 AND OLDER
a. NO. MIGRANTS EXAMINED-TOTAL	47	37	10
(1) NO. DECAYED, MISSING, FILLED TEETH			
(2) AVERAGE DMF PER PERSON			
b. INDIVIDUALS REQUIRING SERVICES-TOTAL	17	12	5
(1) CASES COMPLETED	8	7	1
(2) CASES PARTIALLY COMPLETED	6	3	3
(3) CASES NOT STARTED	3	2	1
c. SERVICES PROVIDED - TOTAL	18	13	5
(1) PREVENTIVE	12	11	1
(2) CORRECTIVE-TOTAL	1	1	
(a) Extraction			
(b) Other			
d. PATIENT VISITS - TOTAL	45	36	9

* The "76" number in 1b (2) were patients seen through orchardists' insurance coverage.

3. MIGRANT HOSPITALIZATIONS

SOURCE OF PAYMENT	NO. PTS.	M	F	AGE GROUPING <1	1-4	5-14	15-44	45-64	65+	TOTAL HOSP. DAYS	AVE. HOSP. DAYS	PROJECT HOSPITAL COSTS	DOCTORS FEES PAID	TOTAL HOSPITAL BILLING
MIGRANT FUNDS	24	14	10	3	3		10	8		114	5	$4666.74	$3153.00	$8797.87
OTHERS*	9	5	4							77	9			

*PAYMENT MADE BY PATIENT, INSURANCE, WELFARE, OR PROVIDED BY UNIVERSITY OF OREGON MEDICAL SCHOOL

4. IMMUNIZATIONS PROVIDED

TYPE	COMPLETED IMMUNIZATIONS, BY AGE: TOTAL	UNDER 1 YEAR	1 - 4	5 - 14	15 AND OLDER	IN-COMPLETE SERIES	BOOSTERS, REVACCINATIONS
TOTAL- ALL TYPES	110	17	35	38	20		
SMALLPOX	17		3	8	6		6
DIPHTHERIA	31	5	9	10	7		7
PERTUSSIS	23	5	9	9			
TETANUS	31	5	9	10	7		7
Polio	8	2	5	1			
MEASLES							
TUBERCULIN SKIN TESTS							

PART II (Continued) - 5. MEDICAL CONDITIONS TREATED BY PHYSICIANS IN FAMILY CLINICS, HOSPITAL OUTPATIENT DEPARTMENTS, AND PHYSICIANS' OFFICES.

MG 050 JACKSON COUNTY

ICD CLASS		DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
I-XVII		TOTAL ALL CONDITIONS	324	113	211
I.		INFECTIVE AND PARASITIC DISEASES: TOTAL	40	14	26
		TUBERCULOSIS	28	9	19
		SYPHILIS	2	1	1
		GONORRHEA AND OTHER VENEREAL DISEASES	3	1	2
		INTESTINAL PARASITES			
		DIARRHEAL DISEASE (infectious or unknown origins):			
		Children under 1 year of age			
		All other	2	1	1
		"CHILDHOOD DISEASES" — mumps, measles, chickenpox	1	1	
		FUNGUS INFECTIONS OF SKIN (Dermatophytoses)	4	1	3
		OTHER INFECTIVE DISEASES (Give examples):			
II.		NEOPLASMS: TOTAL			
		MALIGNANT NEOPLASMS (give examples):			
		BENIGN NEOPLASMS			
		NEOPLASMS of uncertain nature			
III.		ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES: TOTAL	13	4	9
		DISEASES OF THYROID GLAND			
		DIABETES MELLITUS	7	2	5
		DISEASES of Other Endocrine Glands			
		NUTRITIONAL DEFICIENCY	3	1	2
		OBESITY			
		OTHER CONDITIONS	3	1	2
IV.		DISEASES OF BLOOD AND BLOOD FORMING ORGANS: TOTAL	2		
		IRON DEFICIENCY ANEMIA	2	1	1
		OTHER CONDITIONS			
V.		MENTAL DISORDERS: TOTAL	20	5	15
		PSYCHOSES			
		NEUROSES and Personality Disorders	16	4	12
		ALCOHOLISM	4	1	3
		MENTAL RETARDATION			
		OTHER CONDITIONS			
VI.		DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS: TOTAL	19	6	13
		PERIPHERAL NEURITIS			
		EPILEPSY	3	1	2
		CONJUNCTIVITIS and other Eye Infections	6	2	4
		REFRACTIVE ERRORS of Vision			
		OTITIS MEDIA	3	1	2
		OTHER CONDITIONS	7	2	5

Jackson County
MG 05G

This year there was a noticeable increase in family groups in the valley.

Overall camp improvement this year has been satisfactory. The emphasis was on water supply and refuse disposal. In both instances there has been good progress. One of the problems encountered with refuse disposal has been the problem of emptying the garbage cans when full -- especially once the picking season got in full swing. One solution to this was getting many of the orchardists to subscribe to sanitary service pickup.

All but four of the water supply problems were corrected. Although attempts were made on three of the four systems they were not successful. The fourth one refused to correct the problem.

In most cases the orchardists have been very cooperative in improving their camps. Most of them feel that a better camp attracts a better type worker. This pays off in quality of work in the orchards and in taking care of the camp. Next year emphasis will be on the four bad water supplies, getting more to subscribe to sanitary pickup, and general camp improvement.

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PART II - 5. (Continued)

MG 05G JACKSON COUNT

ICD CLASS		DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
XIII.		DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE: TOTAL	3	1	2
		RHEUMATOID ARTHRITIS			
		OSTEOARTHRITIS			
		ARTHRITIS, Unspecified	3	1	2
		OTHER CONDITIONS			
XIV.		CONGENITAL ANOMALIES: TOTAL			
		CONGENITAL ANOMALIES of Circulatory System			
		OTHER CONDITIONS			
XV.		CERTAIN CAUSES OF PERINATAL MORBIDITY AND MORTALITY: TOTAL			
		BIRTH INJURY			
		IMMATURITY			
		OTHER CONDITIONS			
XVI.		SYMPTOMS AND ILL-DEFINED CONDITIONS: TOTAL	5	2	3
		SYMPTOMS OF SENILITY			
		BACKACHE			
		OTHER SYMPTOMS REFERRABLE TO LIMBS AND JOINTS			
		HEADACHE	5	2	3
		OTHER CONDITIONS			
XVII.		ACCIDENTS, POISONINGS, AND VIOLENCE: TOTAL	45	17	28
		LACERATIONS, ABRASIONS, and Other Soft Tissue Injuries	10	4	6
		BURNS			
		FRACTURES	10	3	7
		SPRAINS, STRAINS, DISLOCATIONS	11	4	7
		POISON INGESTION	6	3	3
		OTHER CONDITIONS due to Accidents, Poisoning, or Violence	8	3	5

			NUMBER OF INDIVIDUALS
6.		SPECIAL CONDITIONS AND EXAMINATIONS WITHOUT SICKNESS: TOTAL	
		FAMILY PLANNING SERVICES	18
		WELL CHILD CARE	5
		PRENATAL CARE	8
		POSTPARTUM CARE	4
		TUBERCULOSIS: Follow-up of inactive case	14
		MEDICAL AND SURGICAL AFTERCARE	12
		GENERAL PHYSICAL EXAMINATION	
		PAPANICOLAOU SMEARS	19
		TUBERCULIN TESTING	12
		SEROLOGY SCREENING	2
		VISION SCREENING	
		AUDITORY SCREENING	2
		SCREENING CHEST X-RAYS	29
		GENERAL HEALTH COUNSELLING	736
		OTHER SERVICES:	
		(Specify) Immunizations	25

PART III - NURSING SERVICE MG 05G JACKSON COUNTY

TYPE OF SERVICE	NUMBER
1 NURSING CLINICS: Migrants utilized regular facilities/community Family	
a. NUMBER OF CLINICS Planning Clinic, Chest X-ray, regular clinic days at	
b. NUMBER OF INDIVIDUALS SERVED - TOTAL Health Department	216
2 FIELD NURSING:	
a. VISITS TO HOUSEHOLDS	
b. TOTAL HOUSEHOLDS SERVED 246	
c. TOTAL INDIVIDUALS SERVED IN HOUSEHOLDS 731	
d. VISITS TO SCHOOLS, DAY CARE CENTERS 5	
e. TOTAL INDIVIDUALS SERVED IN SCHOOLS AND DAY CARE CENTERS 3	
3 CONTINUITY OF CARE:	
a. REFERRALS MADE FOR MEDICAL CARE: TOTAL	160
(1) Within Area	
(Total Completed 130)	
(2) Out of Area	
(Total Completed)	
b. REFERRALS MADE FOR DENTAL CARE: TOTAL	17
(Total Completed 14)	
c. REFERRALS RECEIVED FOR MEDICAL OR DENTAL CARE FROM OUT OF AREA: TOTAL	177
(Total Completed)	
d. FOLLOW-UP SERVICES FOR MIGRANTS, not originally referred by project, WHO WERE TREATED IN PHYSICIANS' OFFICES (Fee-for-Service) 76	
e. MIGRANTS PROVIDED PRE-DISCHARGE PLANNING AND POST-HOSPITAL SERVICES 8	
f. MIGRANTS ASKED TO PRESENT HEALTH RECORD Form PMS-3652 or Similar Form) IN FIELD OR CLINIC: TOTAL 728	
(1) Number presenting health record. 44	
(2) Number given health record. 573	
4 OTHER ACTIVITIES *(Specify)*:	

REMARKS

PART IV - SANITATION SERVICES

MG 05G JACKSON COU[illegible]

TABLE A. SURVEY OF HOUSING ACCOMMODATIONS

HOUSING ACCOMMODATIONS	TOTAL		COVERED BY PERMITS	
	NUMBER	MAXIMUM CAPACITY	NUMBER	MAXIMUM CAPACITY
CAMPS	36			
OTHER LOCATIONS				
HOUSING UNITS - Family:				
IN CAMPS	22			
IN OTHER LOCATIONS				
HOUSING UNITS - Single				
IN CAMPS	24			
IN OTHER LOCATIONS				

TABLE B. INSPECTION OF LIVING AND WORKING ENVIRONMENT OF MIGRANTS

ITEM	NUMBER OF LOCATIONS INSPECTED*		TOTAL NUMBER OF INSPECTIONS		NUMBER OF DEFECTS FOUND		NUMBER OF CORRECTIONS MADE	
	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER
LIVING ENVIRONMENT:								
a. WATER	31		77		11		6	
b. SEWAGE	36		50		4		4	
c. GARBAGE AND REFUSE	37		165		15		8	
d. HOUSING	37		224		9		6	
e. SAFETY								
f. FOOD HANDLING	2		2					
g. INSECTS AND RODENTS	37		45		8		6	
h. RECREATIONAL FACILITIES								
WORKING ENVIRONMENT:								
a. WATER	XXXX		XXXX		XXXX		XXXX	
b. TOILET FACILITIES	XXXX		XXXX		XXXX		XXXX	
c. OTHER	XXXX		XXXX		XXXX		XXXX	

* *Locations — camps or other locations where migrants work or are housed.*

PART V – HEALTH EDUCATION SERVICES *(By type of service, personnel involved, and number of sessions.)*

TYPE OF HEALTH EDUCATION SERVICE	NUMBER OF SESSIONS					
	HEALTH EDUCATION STAFF	PHYSICIANS	NURSES	SANITARIANS	AIDES (other than Health Ed.)	OTHER
A. SERVICES TO MIGRANTS:						
(1) Individual counselling			490	17	246	
(2) Group counselling			34		23	
B. SERVICES TO OTHER PROJECT STAFF.						
(1) Consultation		13	60			
(2) Direct services						
C. SERVICES TO GROWERS:						
(1) Individual counselling			21	15		
(2) Group counselling						
D. SERVICES TO OTHER AGENCIES OR ORGANIZATIONS:						
(1) Consultation with individuals			24	2		
(2) Consultation with groups			3			
(3) Direct services						
E. HEALTH EDUCATION MEETINGS						

ERIC

Jackson County
MG 05G

NURSING NARRATIVE

One public health nurse was employed from July 1, 1969 to October 31, 1969, and one community aide started mid July and worked until October 6, 1969. During the beginning and end of the season the aide worked four hours daily, but during the busy season it was full time. The working hours of both were such as to best accommodate the people -- usually the field work began around three o'clock and continued until eight or nine o'clock.

Orientation of the community aide began with the interview, continued with the migrant staff meeting held in Portland, and was carried on while on the job. The objectives, purpose, and job description were made available to her when she started work. After a limited framework of knowledge was presented to her, the aide worked closely with the public health nurse and was taught as situations and problems arose.

In the beginning of the season the doctors, dentists, and pharmacists were approached by letter concerning the continuation of the project, as well as inquiring as to their willingness to serve the migrants. Fifty medical doctors, 11 osteopathic doctors, 25 dentists and 24 pharmacists responded as willing. The interest and cooperation throughout the season was very good.

A letter was also sent to the Fruit Growers Association informing them of the project and the names of the persons involved in the work. Many of the growers and foremen were met at the orchards and further information was given as necessary. The four hospitals in the area were also contacted, and such matters as billing, notification of admission, and continuity of patient care were discussed. Discharge planning and out-patient care policies still need improvement.

The nurse also contacted various community agencies to inform them of the work, and to determine where migrants might receive needed help during their stay here. Some of the agencies that were utilized were Salvation Army, Good Will, Abundant Food, Office of Economic Opportunity, Welfare, and Gospel Mission. Since no school program was in operation, there was a problem of what to do with the children. The Office of Economic Opportunity Day Care Center offered its services but was utilized by very few families because of the time and transportation problem associated with it. (There are interested persons in the community who are planning to start up a school and pre-school program for the children.)

The public health nurse and aide visited orchards and downtown rental areas on a weekly basis. The county was divided into four sections, and each area was visited on a weekly schedule with one day to tie up loose ends. This system gave a basic plan and direction to the weekly activities, and thus contact could be made with the people shortly after they came to the area. Contacts with the migrants were usually made by visiting them. On occassion orchard foremen or others contacted the public health nurse. Health screening was usually done on the first visit, and necessary referrals made as soon as possible.

Medical referrals were made in various ways. The nurse often made the appointment if the family requested this; others made their own appointments, or just went to the emergency department at one of the hospitals. As a whole the migrant patients were treated by the private physician in his office -- usually an appointment could be set up for around four o'clock for those who worked, and as a whole the people kept their appointments, carried out orders, and returned for further care if necessary. Immunizations, minor infections, and other problems were often attended to by the local Health Officer. Also, the Family Planning Clinic was available to the migrant women. And free chest X-rays were made available through the Tuberculosis and Health Association.

Continuity of care is desirable for any patient including the migrant. More people carried their health record cards with them, but not enough. The importance of this record was re-emphasized to the people, and doctors were encouraged to use them. Several of the doctors sent reports with the patients if they needed further medical care. Also, several out-of-state referrals were sent. It was encouraging to receive prompt reply from one of

the health departments in California, on a newly diagnosed diabetic in her third prenatal trimester, through the State Project Office. Then, too, concerning weekend and evening services for the migrant: no facilities exist other than emergency care at one of the hospitals, or as has happened, the public health nurse or aide were contacted by telephone.

The transportation problem was solved by encouraging the migrants to assume responsibility by making appointments in the late afternoon, giving detailed information on office location, and follow-up visits by the nurse; and by providing transportation for those who needed it by utilizing the FISH organization and the aide. The aide was used in this capacity mainly in situations where she would be needed to act as an interpreter as well -- thus she performed a dual role.

Community interest in the migrant is growing! Other than what has already been mentioned, a group of local people, high school and college students and other interested adults accompanied the nurse and aide to the field to observe and participate. Sometimes one, sometimes two, three, or four would go at a time. They assisted in writing up forms, talking with the people, encouraging basic hygiene practices, playing games and reading to the children, etc.

A "Fiesta" was also held at the end of the season in which migrants and the locally interested people mingled together -- it is hoped that they will be the nucleus that will plan toward the future in this area. Also, at the Demoforum held in Jacksonville, November 8, 1969, problems of the migrant were discussed and plans proposed to establish a day care program that will take care of pre-school and school aged children, and in local assistance in helping families find adequate housing.

Recommendations for the coming year are:

1. To have a more active health education program.
2. For better coordination of patient care upon discharge.
3. To give support to community involvement, especially in utilizing the local youth.
4. To post a map in the camps with major resources and health services available in the community.
5. Acquiring dental kits for the migrant children.

SANITATION NARRATIVE

The migrant sanitation program began this year on June 19 and continued through August 29. Stanford Dew was the inspector again this year. There was regular communication between the inspector, the camp operators, the Employment Bureau, the Fruit Growers League, and the State Wage and Hour Inspector.

The objectives this year, basically, were to enact correction of any camp deficiencies and to upgrade, in general, each camp.

There are 36 camp locations - some having two or three separate camps. There are 43 separate camps in the county, although all were not used this year. The camps vary in type. Some are old houses used for a family or seven to ten men. Some camps are one or two room cabins built just for the purpose of migrant camps. We have two chicken houses converted to migrant housing. Some of the camps have trailer spaces as well as housing facilities. Two camps are for trailers or campers only. Most of the camps are used for either families or singles - although some of the orchardists prefer only singles.

Due to improved weather conditions, the crop this year was about two weeks ahead of last year. Also, this year there was a much heavier crop causing a greater number of migrants to come into the area. Many stay for the full season, returning south in October. This increase in picking force created some problems in housing facilities. Some housing was necessarily used at the last minute that had not been inspected prior to occupancy. Some, however, leave after the first picking and go north for other fruit.

Jackson County
MG 05G

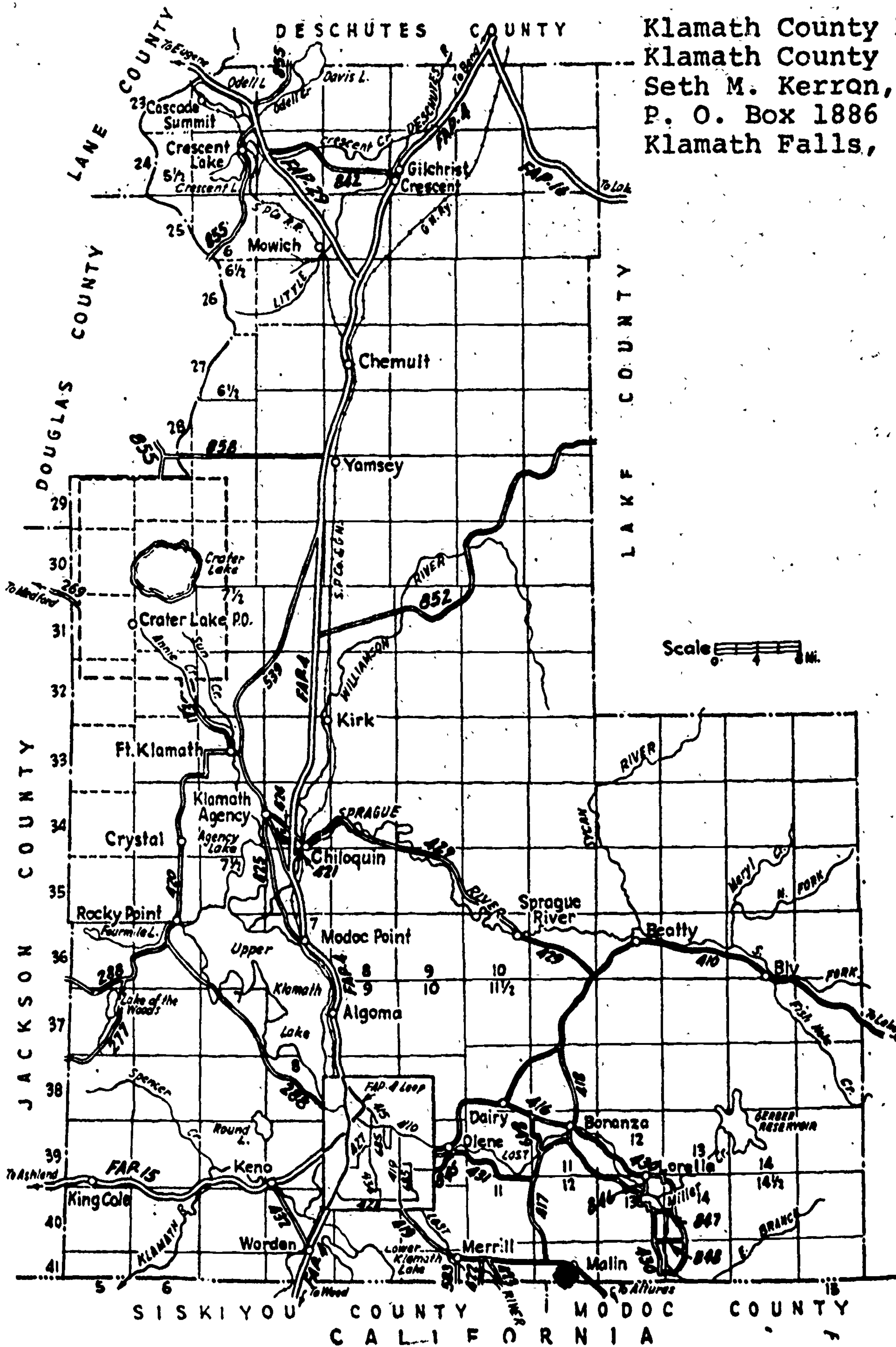
This year there was a noticeable increase in family groups in the valley.

Overall camp improvement this year has been satisfactory. The emphasis was on water supply and refuse disposal. In both instances there has been good progress. One of the problems encountered with refuse disposal has been the problem of emptying the garbage cans when full -- especially once the picking season got in full swing. One solution to this was getting many of the orchardists to subscribe to sanitary service pickup.

All but four of the water supply problems were corrected. Although attempts were made on three of the four systems they were not successful. The fourth one refused to correct the problem.

In most cases the orchardists have been very cooperative in improving their camps. Most of them feel that a better camp attracts a better type worker. This pays off in quality of work in the orchards and in taking care of the camp. Next year emphasis will be on the four bad water supplies, getting more to subscribe to sanitary pickup, and general camp improvement.

KLAMATH COUNTY



Klamath County Migrant Health Projec
Klamath County Health Department
Seth M. Kerron, M.D., Health Officer
P. O. Box 1886
Klamath Falls, Oregon 97601

POPULATION AND HOUSING DATA

FOR KLAMATH COUNTY.

GRANT NUMBER: MG 05G

5. POPULATION DATA - MIGRANTS (Workers and dependents)

a. NUMBER OF MIGRANTS BY MONTH

MONTH	TOTAL	IN-MIGRANTS	OUT-MIGRANTS
JAN.			
FEB.			
MAR.			
APRIL			
MAY			
JUNE			
JULY			
AUG.	60	39	21
SEPT.	205	184	21
OCT.	314	293	21
NOV.	177	156	21
DEC.			
TOTALS	756	672	84

b. NUMBER OF MIGRANTS DURING PEAK MONTH

	TOTAL	MALE	FEMALE
(1) OUT-MIGRANTS:	21	14	7
TOTAL			
UNDER 1 YEAR			
1 - 4 YEARS	2	2	
5 - 14 YEARS	11	7	4
15 - 44 YEARS	6	4	2
45 - 64 YEARS	2	1	1
65 AND OLDER			
(2) IN-MIGRANTS:			
TOTAL	293	157	136
UNDER 1 YEAR	3	3	
1 - 4 YEARS	37	17	20
5 - 14 YEARS	87	46	41
15 - 44 YEARS	123	66	57
45 - 64 YEARS	41	23	18
65 AND OLDER	2	2	

c. AVERAGE STAY OF MIGRANTS IN COUNTY

	NO. OF WEEKS	FROM (MO.)	THROUGH (MO.)
OUT-MIGRANTS	48	August	June
IN-MIGRANTS	6	September	October

6. HOUSING ACCOMMODATIONS

a. CAMPS

MAXIMUM CAPACITY	NUMBER	OCCUPANCY (Peak)
LESS THAN 10 PERSONS		
10 - 25 PERSONS		
26 - 50 PERSONS		
51 - 100 PERSONS		
MORE THAN 100 PERSONS	1	220
TOTAL*	1	220

b. OTHER HOUSING ACCOMMODATIONS

LOCATION (Specify)	NUMBER	OCCUPANCY (Peak)
Scattered housing in N. Calif.	9	44
Scattered housing in Oregon	8	50
TOTAL*	17	94

*NOTE: *The combined occupancy totals for "a" and "b" should equal approximately the total peak migrant population for the year.*

REMARKS

Information for 5a and 5b from family records.

GRANT NUMBER
MG 05G KLAMATH COUNTY
DATE SUBMITTED

PART II - MEDICAL, DENTAL, AND HOSPITAL SERVICES

1. MIGRANTS RECEIVING MEDICAL SERVICES

a. TOTAL MIGRANTS RECEIVING MEDICAL SERVICES AT FAMILY HEALTH CLINICS, PHYSICIANS OFFICES, HOSPITAL EMERGENCY ROOMS, ETC.

AGE	NUMBER OF PATIENTS			NUMBER OF VISITS
	TOTAL	MALE	FEMALE	
TOTAL	60	24	36	71
UNDER 1 YEAR				
1 - 4 YEARS	10	5	5	11
5 - 14 YEARS	17	9	8	19
15 - 44 YEARS	26	7	19	30
45 - 64 YEARS	10	7	3	11
65 AND OLDER				

No. of related nursing visits

b. OF TOTAL MIGRANTS RECEIVING MEDICAL SERVICES, HOW MANY WERE:

(1) SERVED IN FAMILY HEALTH SERVICE CLINIC? ____

(2) SERVED IN PHYSICIANS' OFFICE, ON FEE-FOR-SERVICE ARRANGEMENT (INCLUDE REFERRALS) 60

2. MIGRANTS RECEIVING DENTAL SERVICES

ITEM	TOTAL	UNDER 15	15 AND OLDER
a. NO. MIGRANTS EXAMINED-TOTAL			
(1) NO. DECAYED, MISSING, FILLED TEETH			
(2) AVERAGE DMF PER PERSON			
b. INDIVIDUALS REQUIRING SERVICES - TOTAL	6	2	4
(1) CASES COMPLETED			
(2) CASES PARTIALLY COMPLETED	1		1
(3) CASES NOT STARTED			
c. SERVICES PROVIDED - TOTAL	1		1
(1) PREVENTIVE			
(2) CORRECTIVE-TOTAL	1		1
(a) Extraction			
(b) Other			
d. PATIENT VISITS - TOTAL	1		1

3. MIGRANT HOSPITALIZATIONS

SOURCE OF PAYMENT	NO. PTS.	M	F	AGE GROUPING						TOTAL HOSP. DAYS	AVE. HOSP. DAYS	PROJECT HOSPITAL COSTS	DOCTORS FEES PAID	TOTAL HOSPITAL BILLING
				<1	1-4	5-14	15-44	45-64	65+					
MIGRANT FUNDS	15	2	13	5	1		7	2		65	4	$1931.39	$2060.50	$3698.70
OTHERS*														

*PAYMENT MADE BY PATIENT, INSURANCE, WELFARE, OR PROVIDED BY UNIVERSITY OF OREGON MEDICAL SCHOOL

4. IMMUNIZATIONS PROVIDED

TYPE	COMPLETED IMMUNIZATIONS, BY AGE					INCOMPLETE SERIES	BOOSTERS, REVACCINATIONS
	TOTAL	UNDER 1 YEAR	1 - 4	5 - 14	15 AND OLDER		
TOTAL - ALL TYPES	81	4	19	23	35	27	54
SMALLPOX							
DIPHTHERIA		1	5	8	17	10	21
PERTUSSIS		1	5	2		5	3
TETANUS		1	5	8	18	10	22
Polio		1	4	5		2	8
MEASLES							
TUBERCULIN SKIN TESTS							

II (Continued) · 5. MEDICAL CONDITIONS TREATED BY PHYSICIANS IN FAMILY CLINICS, HOSPITAL OUTPATIENT DEPARTMENTS, AND PHYSICIANS' OFFICES.

MG 05G KLAMATH COUNTY

DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
TOTAL ALL CONDITIONS	62	53	9
INFECTIVE AND PARASITIC DISEASES: TOTAL	2	2	
TUBERCULOSIS			
SYPHILIS			
GONORRHEA AND OTHER VENEREAL DISEASES			
INTESTINAL PARASITES			
DIARRHEAL DISEASE (infectious or unknown origins):			
Children under 1 year of age			
All other	1	1	
"CHILDHOOD DISEASES" – mumps, measles, chickenpox			
FUNGUS INFECTIONS OF SKIN (Dermatophytoses)			
OTHER INFECTIVE DISEASES *(Give examples)*:			
Intestinal helminthiasis	1	1	
NEOPLASMS: TOTAL	3	1	2
MALIGNANT NEOPLASMS *(give examples)*:			
BENIGN NEOPLASMS	3	1	2
NEOPLASMS of uncertain nature			
ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES: TOTAL	1	1	
DISEASES OF THYROID GLAND			
DIABETES MELLITUS	1	1	
DISEASES of Other Endocrine Glands			
NUTRITIONAL DEFICIENCY			
OBESITY			
OTHER CONDITIONS			
DISEASES OF BLOOD AND BLOOD FORMING ORGANS: TOTAL			
IRON DEFICIENCY ANEMIA			
OTHER CONDITIONS			
MENTAL DISORDERS: TOTAL	1	1	
PSYCHOSES			
NEUROSES and Personality Disorders			
ALCOHOLISM			
MENTAL RETARDATION			
OTHER CONDITIONS	1	1	
DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS: TOTAL	7	5	2
PERIPHERAL NEURITIS			
EPILEPSY			
CONJUNCTIVITIS and other Eye Infections	1	1	
REFRACTIVE ERRORS of Vision	2	2	
OTITIS MEDIA	4	2	
OTHER CONDITIONS			

PART II – 5. *(Continued)*

ICD CLASS		DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
VII.		DISEASES OF THE CIRCULATORY SYSTEM: TOTAL	3	2	1
		RHEUMATIC FEVER			
		ARTERIOSCLEROTIC and Degenerative Heart Disease			
		CEREBROVASCULAR DISEASE (Stroke)			
		OTHER DISEASES of the Heart	2	1	1
		HYPERTENSION	1	1	
		VARICOSE VEINS			
		OTHER CONDITIONS			
VIII.		DISEASES OF THE RESPIRATORY SYSTEM: TOTAL	20	19	1
		ACUTE NASOPHARYNGITIS (Common Cold)	7	7	
		ACUTE PHARYNGITIS	2	2	
		TONSILLITIS	6	6	
		BRONCHITIS	1	1	
		TRACHEITIS/LARYNGITIS			
		INFLUENZA			
		PNEUMONIA	2	1	1
		ASTHMA, HAY FEVER	1	1	
		CHRONIC LUNG DISEASE (Emphysema)	2	2	
		OTHER CONDITIONS			
IX.		DISEASES OF THE DIGESTIVE SYSTEM: TOTAL	8	8	
		CARIES and Other Dental Problems	2	2	
		PEPTIC ULCER			
		APPENDICITIS			
		HERNIA			
		CHOLECYSTIC DISEASE	1	1	
		OTHER CONDITIONS	5	5	
X.		DISEASES OF THE GENITOURINARY SYSTEM: TOTAL	7	5	2
		URINARY TRACT INFECTION (Pyelonephritis, Cystitis)	3	2	1
		DISEASES OF PROSTATE GLAND (excluding Carcinoma)			
		OTHER DISEASES of Male Genital Organs			
		DISORDERS of Menstruation	1	1	
		MENOPAUSAL SYMPTOMS	2	1	1
		OTHER DISEASES of Female Genital Organs	1	1	
		OTHER CONDITIONS			
XI.		COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM: TOTAL			
		INFECTIONS of Genitourinary Tract during Pregnancy			
		TOXEMIAS of Pregnancy			
		SPONTANEOUS ABORTION			
		REFERRED FOR DELIVERY			
		COMPLICATIONS of the Puerperium			
		OTHER CONDITIONS			
XII.		DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE: TOTAL	5	5	
		SOFT TISSUE ABSCESS OR CELLULITIS	4	4	
		IMPETIGO OR OTHER PYODERMA			
		SEBORRHEIC DERMATITIS			
		ECZEMA, CONTACT DERMATITIS, OR NEURODERMATITIS			
		ACNE			
		OTHER CONDITIONS	1	1	

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PART II - 5. *(Continued)*

ICD CLASS	DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
XIII.	DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE: TOTAL			
	RHEUMATOID ARTHRITIS			
	OSTEOARTHRITIS			
	ARTHRITIS, Unspecified			
	OTHER CONDITIONS			
XIV.	CONGENITAL ANOMALIES: TOTAL			
	CONGENITAL ANOMALIES of Circulatory System			
	OTHER CONDITIONS			
XV.	CERTAIN CAUSES OF PERINATAL MORBIDITY AND MORTALITY: TOTAL	1	1	
	BIRTH INJURY			
	IMMATURITY			
	OTHER CONDITIONS	1	1	
XVI.	SYMPTOMS AND ILL-DEFINED CONDITIONS: TOTAL	1	1	
	SYMPTOMS OF SENILITY			
	BACKACHE			
	OTHER SYMPTOMS REFERRABLE TO LIMBS AND JOINTS	1	1	
	HEADACHE			
	OTHER CONDITIONS			
XVII.	ACCIDENTS, POISONINGS, AND VIOLENCE TOTAL	4	3	1
	LACERATIONS, ABRASIONS, and Other Soft Tissue Injuries	1	1	
	BURNS	1	1	
	FRACTURES	2	1	1
	SPRAINS, STRAINS, DISLOCATIONS			
	POISON INGESTION			
	OTHER CONDITIONS due to Accidents, Poisoning, or Violence			

		NUMBER OF INDIVIDUALS
6.	SPECIAL CONDITIONS AND EXAMINATIONS WITHOUT SICKNESS: TOTAL	10
	FAMILY PLANNING SERVICES	1
	WELL CHILD CARE	1
	PRENATAL CARE	4
	POSTPARTUM CARE	
	TUBERCULOSIS: Follow-up of inactive case	
	MEDICAL AND SURGICAL AFTERCARE	
	GENERAL PHYSICAL EXAMINATION	
	PAPANICOLAOU SMEARS	1
	TUBERCULIN TESTING	
	SEROLOGY SCREENING	
	VISION SCREENING	
	AUDITORY SCREENING	
	SCREENING CHEST X-RAYS	
	GENERAL HEALTH COUNSELLING	
	OTHER SERVICES	
	(Specify) Refill prescription	1
	X-ray and lab	3

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PART III – NURSING SERVICE

MG 05G KLAMATH COUNTY

TYPE OF SERVICE	NUMBER
1. NURSING CLINICS:	
a. NUMBER OF CLINICS	
b. NUMBER OF INDIVIDUALS SERVED - TOTAL	
2. FIELD NURSING:	
a. VISITS TO HOUSEHOLDS	80
b. TOTAL HOUSEHOLDS SERVED	80
c. TOTAL INDIVIDUALS SERVED IN HOUSEHOLDS	319
d. VISITS TO SCHOOLS, DAY CARE CENTERS	30
e. TOTAL INDIVIDUALS SERVED IN SCHOOLS AND DAY CARE CENTERS	30
3. CONTINUITY OF CARE:	
a. REFERRALS MADE FOR MEDICAL CARE: TOTAL	62
(1) Within Area	62
(Total Completed)	54
(2) Out of Area	6
(Total Completed)	3
b. REFERRALS MADE FOR DENTAL CARE: TOTAL	6
(Total Completed)	1
c. REFERRALS RECEIVED FOR MEDICAL OR DENTAL CARE FROM OUT OF AREA: TOTAL	9
(Total Completed)	3
d. FOLLOW-UP SERVICES FOR MIGRANTS, not originally referred by project, WHO WERE TREATED IN PHYSICIANS' OFFICES (Fee-for-Service)	
e. MIGRANTS PROVIDED PRE-DISCHARGE PLANNING AND POST-HOSPITAL SERVICES	2
f. MIGRANTS ASKED TO PRESENT HEALTH RECORD Form PMS-3652 or Similar Form) IN FIELD OR CLINIC: TOTAL	319
(1) Number presenting health record.	83
(2) Number given health record.	77
4. OTHER ACTIVITIES *(Specify)*:	

REMARKS

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PART IV - SANITATION SERVICES

MG 05G KLAMATH COUNT'

TABLE A. SURVEY OF HOUSING ACCOMMODATIONS

HOUSING ACCOMMODATIONS	TOTAL		COVERED BY PERMITS	
	NUMBER	MAXIMUM CAPACITY	NUMBER	MAXIMUM CAPACITY
CAMPS	1	500		
OTHER LOCATIONS				
HOUSING UNITS - Family:				
IN CAMPS	71	500		
IN OTHER LOCATIONS	17	94		
HOUSING UNITS - Single				
IN CAMPS				
IN OTHER LOCATIONS				

TABLE B. INSPECTION OF LIVING AND WORKING ENVIRONMENT OF MIGRANTS

ITEM	NUMBER OF LOCATIONS INSPECTED*		TOTAL NUMBER OF INSPECTIONS		NUMBER OF DEFECTS POUND		NUMBER OF CORRECTIONS MADE	
	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER
LIVING ENVIRONMENT:								
a. WATER	1		1		1			
b. SEWAGE	1		1		2			
c. GARBAGE AND REFUSE	1		1					
d. HOUSING	1		1					
e. SAFETY	1		1					
f. FOOD HANDLING	1		1					
g. INSECTS AND RODENTS	1		1					
h. RECREATIONAL FACILITIES	1		1					
WORKING ENVIRONMENT:								
a. WATER	XXXX		XXXX		XXXX		XXXX	
b. TOILET FACILITIES	XXXX		XXXX		XXXX		XXXX	
c. OTHER	XXXX		XXXX		XXXX		XXXX	

* *Locations — camps or other locations where migrants work or are housed.*

PART V – HEALTH EDUCATION SERVICES *(By type of service, personnel involved, and number of sessions.)*

TYPE OF HEALTH EDUCATION SERVICE	NUMBER OF SESSIONS					
	HEALTH EDUCATION STAFF	PHYSICIANS	NURSES	SANITARIANS	AIDES *(other than Health Ed.)*	OTHER *(Specify)*
A. SERVICES TO MIGRANTS.						
(1) Individual counselling			484		382	
(2) Group counselling			3		3	
B. SERVICES TO OTHER PROJECT STAFF						
(1) Consultation			5			
(2) Direct services			2			
C. SERVICES TO GROWERS:						
(1) Individual counselling			3			
(2) Group counselling						
D. SERVICES TO OTHER AGENCIES OR ORGANIZATIONS:						
(1) Consultation with individuals			10		2	
(2) Consultation with groups			2			
(3) Direct services			2			
E. HEALTH EDUCATION MEETINGS			3		3	

Klamath County
MG 05G

NURSING NARRATIVE

August 21 to November 15 is the period of Klamath County's Migrant Health Project. Our objective in the past has been to provide complete health care to all migrants in the Klamath County area. This year we provided health care for northern Siskiyou and northern Modoc Counties in California in addition to Klamath County, as migrants in northern California had no health services available to them.

The number of migrants seen in this area was 175 less than the 500 seen last year. Part of the reason for decrease in migrants appears to be because of a later fruit season in the Northwest.

The potato and onion harvest started about the first of September and finished about the second week of November but the migrants moved on to California oranges at the end of October and the first of November. This year there were more than enough jobs available for the migrants who wanted to work. At one time, fifteen truck driving jobs were unfilled even though there were twenty migrant men not working but who were unwilling to work.

The growers in this area were unusually cooperative with the project nurse. There were, however, several occasions when a grower would not allow a migrant time off to see a doctor or dentist.

The Migrant Ministry was extremely helpful in providing food and clothing to all needy migrants. The community as a whole responded most generously with food staples and clothing. Many women gave their time to help with the pre-school program.

The entire staff at the Klamath County Health Department was very cooperative in time spent with the Migrant Health staff. Many hours were spent in orientation, paper work and suggestions.

The schools were very interested in the migrant children and worked closely with the project nurse in solving problems.

Medical needs for the migrants in this area were covered by two doctors in California and one doctor in Oregon about ten miles from the camp. For X-ray, dental and laboratory services, it was necessary for the migrant to travel thirty miles to Klamath Falls. If a dentist were closer to camp, more migrants would be able to receive dental care. Many of the migrants needing dental work refused to go to the dentist. Of the six referrals made, only one kept the appointment and had the dental work done. Both of the children refused to cooperate with the dentist. One adult left camp before his appointment and three adults failed to keep appointments. We had difficulty finding a dentist who would see migrants as they fail to keep dental appointments. Only a very few failed to keep doctor appointments.

During the season, one newborn expired 24 hours after delivery. The cause of death was atelectasis.

The project nurse from 1968 who is now employed at the Health Department will handle migrant health after the harvest season is over. Also, the Public Health Nurses will see those families who remain in the area.

Migrants in this area are hospitalized in the Presbyterian Intercommunity Hospital in Klamath Falls. Good relationships and communications between the project nurse and the hospital were established during the season. One of the weaknesses in the area of hospital services was establishing eligibility for welfare for the rest of the hospital bill. Many of the migrants could not get off work to go in to Welfare and some, because of their present earnings, could not qualify.

The Klamath County Migrant Project was staffed this year by a registered nurse and an aide. Better orientation is needed in the area of paper work for the registered nurse. The aide was very effective in her relationship with the migrants. The county Health Officer provided a wide variety of routine orders and sufficient equipment for the nurse to take care of minor

illnesses and accidents. The minor cases of medical need were taken care of in an office provided by the Migrant Ministry at the camp.

Many migrants left the area before interstate referrals could be completed.

More emphasis should be placed on the health record especially if migrants receive medical care in this area.

Sanitation services to the camp were provided by the county sanitarian. He made several visits to the camp and his comments and suggestions were very helpful.

The camp consists of 64 tents, 7 one-room cabins, and 64 trailer spaces. The upkeep of the camp this year has been excellent. The flies were bad only in September. The owners sprayed once but it seemed to alleviate the problem for only a few days. The recreational facilities were provided by the Migrant Ministry. They maintained a playground and have a building for the children to play in.

The main objective of the nurse and aide in health education was to present the migrants with as much health instruction as they could possibly absorb. Most of the education the migrants received was on an individual basis rather than in many group meetings. As migrant families were contacted for family records, the opportunity was taken to teach and answer questions. Tooth brushes and dental pamphlets offered a good method of dental instruction.

One of the volunteers that came to the camp every day to work in the day care center was a registered nurse. She saw and took many opportunities to teach health education; that is, washing hands, brushing teeth, clean clothes, clean floors, clean playground, etc.

The nurse talked to 484 migrants and the aide talked to 382 migrants on different health education topics.

The nurse and the aide held three group sessions. Two of the sessions were health education films. They were held after school and there were twenty present both times. We had one lesson on brushing teeth. There were only six as a group interested in listening. We had much more success on an individual basis. Very little interest was shown in attending group sessions of this sort.

KLAMATH COUNTY
MG 05C

From: KLAMATH BASIN MIGRANT MINISTRY COMMISSION (Supported and encouraged by but not limited to the Klamath Council of Churches)

TO: ALL KLAMATH COUNTY CHURCHMEN INTERESTED IN SERVING CHRIST BY SERVING A BROTHER IN NEED

It's harvest time again. And therefore, it's migrant season again. We will once more be running an activity and day care Center for the children of migrant workers at the Malin Migrant Labor Camp. The Center program will run from early September through the end of October.

We have hired a resident coordinator but he cannot run a program by himself. So WE NEED YOUR HELP!!! PLEASE volunteer any of the things listed below that you can (needed in this order):

1. YOUR TIME
   a. Working at the Center any day Monday thru Friday from 9 to 12 (two to three people each day): Semi-structured pre-school with games, stories, and creative art and music activities. 2:30 to 5:30 (four or five people each day): Organized activities such as outdoor games, sewing, movies, cooking and health education. THIS IS THE IMPORTANT TIME FOR WORKERS, since school-age children will be at the center then. It may be inconvenient for your children or husband once or twice, but it is important to the migrants and the success of the Center program that the hours serve them.
   b. Transporting volunteer workers to and from the camp.
   c. Transporting migrants to and from the doctor or dentist.
   d. Babysitting for volunteer workers' children. (Please note: This year we are having a telephone coordinator responsible for scheduling volunteer workers for each day of the week. To commit yourself for definite days and hours call the appropriate one(s) of the following: Mondays, Sally Renne, 4-7840; Tuesdays, Violet Koehn, 2-4549; Wednesdays, Gail Benson, 4-3067; Thursdays, Jan Heimann, 4-7584; Fridays, Ginny Champion, 4-9649. Call them any day; they are simply each responsible for scheduling volunteers on the days listed. Please tell them whether you'll come morning, afternoon, or both and whether you'll provide or need transportation. It would help to know which church or organization you are representing. If possible, volunteer for more than one day in a row or for a regular day each week by calling the appropriate coordinators. Tell other people you know about the program and ask them to volunteer, too. Don't let anyone miss this chance to put their faith to work.)
2. YOUR MONEY (Send to the Migrant Ministry Commission, Box 694, Klamath Falls)
   a. For resident's salary ($70 per week).
   b. For arts and crafts supplies.
   c. For emergency food for hungry families.
   d. For the Center lunch program.
3. YOUR FOOD
   a. Canned soup - any hearty meat base type.
   b. Soda or graham crackers.
   c. Staples (like flour, potatoes, beans, dry milk) or commercially canned vegetables or fruits.
   d. Home baked cookies (a real treat for the migrant children).
4. YOUR GOOD USED CLOTHING (not torn, worn out, or in need of repair).
   a. Sturdy work clothes (both men's and women's): jeans, shirts, sweatshirts, sox, good shoes, underwear.
   b. Baby clothes.
   c. Children's school clothes.
   d. Blankets.
   e. (NONE OF THESE: hats, fancy dresses, old shoes, lingerie)
5. LUNCH SUPPLIES: Styrofoam cups, plastic spoons, napkins, 5 oz. paper cups, paper towels.

6. ARTS AND CRAFTS SUPPLIES: colored paper, crayons, blunt-end scissors, masking tape, chalk, chalk-board erasers.
7. HEALTH AND GROOMING SUPPLIES: soap, combs, hair brushes, bobbie pins, clips, rollers, nail files, etc.
8. NICE BOOKS:
   a. Books below third grade level.
   b. Family magazines with pictures.
   c. Complete set of encyclopedias.
9. NICE TOYS AND GAMES.
10. YOUR INTEREST AND ENTHUSIASM. If you know of people who can offer one of the above, mention the need to them.

Items 3 thru 9 should be taken to Peace Memorial Presbyterian Church, 4431 South Sixth, 4-5057.

CONGRATULATIONS to the Girl Scouts, Troop #67. Thru a Reader's Digest grant, some hard work, and some volunteer help they have rejuvenated the Center building. They will run their traditional Saturday morning program of cooking, sewing, and health training. OTHER GROUPS are invited to plan additional Center activities for evenings or Saturday afternoons (parties, campfires, sing-alongs, etc.)

Last year's Migrant Ministry program at the Malin Camp was a real success under the leadership of Mrs. Levertta Moore and Mrs. Nancy Pederson. Many gave GENEROUSLY - soup, crackers, cookies, volunteer time and energy. Seventy-four people from nineteen churches (Malin, Merrill, Tulelake, Peach Memorial, Mt. Laki, and First Presbyterian Churches; St. Augustine, Holy Cross, Sacred Heart, and St. Pius X Catholic Churches; Hope, Zion, and Klamath Lutheran Churches; Church of the Brethren; Congregational-United Church of Christ; United Methodist Church; St. Paul's Episcopal Church; Tulelake Baptist Church; Kingsley Air Force Base Chapel; and Church Women United) gave joyfully of themselves during the five week program. Twenty-five to thirty families were served by the program and building. Between thirty and fifty children a day used the Center facilities - a warm place to play and find a friend.

This year's program should, we hope, be even better - WITH YOUR HELP. We have a strong, sensitive male resident, Mr. Eric Ranger, who will coordinate the Center's activities and attempt to establish lines of communication with the migrant families. There will be a full time county health nurse (Mrs. Emilee Montgomery) and a full time aide (Mrs. Esther Johnson). The two of them will cooperate in providing health care and training from 7:30 to 5:30 p.m.

Most of all we need people to volunteer their time. Instructions for volunteers will be very clear so you won't feel at loose ends. If you can volunteer a special talent, make it clear to your telephone coordinator(s) and we'll make sure supplies will be available.

One last thing: There is a great need among the migrants for literacy training. This fall we have an excellent opportunity to have a Laubach training course ("each one teach one") in Klamath Falls if there are at least twenty interested people. If you are interested in learning to teach migrant people some simple reading and writing skills, call Mrs. Violet Koehn, 2-4549.

WE ARE READY TO WORK AND WAITING FOR YOU TO HELP. If you have any further questions call me or my wife, Kit (2-1006).

George Range, Secretary

Klamath County
MG 05G

KLAMATH BASIN MIGRANT MINISTRY COMMISSION

NEWSLETTER

September 19, 1969

At last we have this year's program at the Malin Labor Camp well underway. Eric's relationship with many of the families at the camp is even better than we had hoped for. And great thanks is already due so many! Many people have been wonderful about contributing and collecting clothing, food, and money. Many stores have donated cases of food or given wholesale credit. Many individuals have donated checks, ranging from $1 to $25. The N.A.A.C.P. donated $70 and Beta Sigma Phi donated $25 for milk. Many businesses have made small donations of art and health supplies. And the involvement of all these individuals and groups is exactly what we need. Keep it going! All donations will be used. We do have a special need for two things: BLANKETS AND MONEY.

We had a very good meeting last Tuesday, September 16, at Mt. Laki Community Presbyterian Church, with 32 interested people present. The most important thing we did at that meeting was to locate some individuals to coordinate the various phases of our program this year. Here they are:

Coordinating Resident Director: Eric Ranger (723-2375)
Coordinator of master calendar of volunteer help: Sydney Ford (2-1884)
Coordinator of speakers' bureau: Ginny Champion (4-9649)
Coordinator of special events: Sister Irene (4-3366)
Collection coordinators for clothing and food donations:
Ann Steffenson (2-4852) -- 1409 McClellan Drive
Nancy Fletcher (2-6579) -- 5707 Denver

So, if you want to work at the camp (preferably in the afternoon), call Syd Ford. If you or your group want to plan a special program, call Sister Irene. If you have collected food or clothing, take them to Ann Steffenson's or Nancy Fletcher's. If you want to be a speaker or need someone to speak to a group about the program, call Ginny Champion. If you have collected money or wish to contribute some, send it to Klamath Basin Migrant Ministry Commission, Box 694, Klamath Falls. All donations should be reported to me (2-1006) to be recorded on a master list and officially acknowledged.

As of today only one church has contributed its share of the money we need to pay our Resident Coordinator ($70 a week) and the miscellaneous expenses which our program incurs (another $30 or so a week). CHURCHES, please give whatever you can ($25, $50, $100, $200).

Another activity we want to encourage is the transporting of people living in the Camp to Sunday church services in the vicinity. If you are concerned that the Camp residents learn more about the Christian message, then YOU must do something about it: Go out to the camp Sunday morning and take some people WITH YOU to church.

There is one very important thing to remember: Our purpose is not to give the people at the Malin Camp pity or charity. We are there to LOVE them, to show them that we are glad to welcome them to our community. Any giving we do must be out of love, and not with an air of sympathy or superiority or condescension. Christ would say to most of these people, "Come to me," and He would say to many of US, "Go away from me, you hypocrites."

The people we are ministering to are wonderful people. I hope you can get to know them, too. Our next meeting will give you that opportunity. It will be held in the headquarters building at the Malin Labor Camp, Tuesday, September 30, 7:30 p.m. PLEASE COME.

Very sincerely,

George W. Range, secretary

LINN COUNTY

Linn County Migrant Health Project
Linn County Health Department
John W. Guepe, M.D., Health Officer
Courthouse
Albany, Oregon 97321

POPULATION AND HOUSING DATA

FOR LINN COUNTY.

GRANT NUMBER: MG 05G

5. POPULATION DATA - MIGRANTS (*Workers and dependents*)

a. NUMBER OF MIGRANTS BY MONTH

MONTH	TOTAL	IN-MIGRANTS	OUT-MIGRANTS
JAN.			
FEB.			
MAR.			
APRIL			
MAY			
JUNE	492	492	
JULY	1583	1583	
AUG.	1842	1842	
SEPT.			
OCT.			
NOV.			
DEC.			
TOTALS			

b. NUMBER OF MIGRANTS DURING PEAK MONTH

	TOTAL	MALE	FEMALE
(1) OUT-MIGRANTS			
TOTAL			
UNDER 1 YEAR			
1 - 4 YEARS			
5 - 14 YEARS			
15 - 44 YEARS			
45 - 64 YEARS			
65 AND OLDER			
(2) IN-MIGRANTS			
TOTAL	1842	955	884
UNDER 1 YEAR	42	23	19
1 - 4 YEARS	191	93	98
5 - 14 YEARS	718	372	346
15 - 44 YEARS	768	393	375
45 - 64 YEARS	113	70	40
65 AND OLDER	10	4	6

c. AVERAGE STAY OF MIGRANTS IN COUNTY

	NO. OF WEEKS	FROM (MO.)	THROUGH (MO.)
OUT-MIGRANTS			
IN-MIGRANTS	10	June	August

6. HOUSING ACCOMMODATIONS

a. CAMPS

MAXIMUM CAPACITY	NUMBER	OCCUPANCY (Peak)
LESS THAN 10 PERSONS		
10 - 25 PERSONS		
26 - 50 PERSONS	3	116
51 - 100 PERSONS	6	435
MORE THAN 100 PERSONS	8	1250
TOTAL*	17	1801

b. OTHER HOUSING ACCOMMODATIONS

LOCATION (*Specify*)	NUMBER	OCCUPANCY (Peak)
Apartment	1	14
TOTAL*	1	14

*NOTE: *The combined occupancy totals for "a" and "b" should equal approximately the total peak migrant population for the year.*

REMARKS

Information for 5a from family records and for 5b from screening tally sheets

Families screened by P.H.N.	Families in area for first time		Ethnic Groups							
			Spanish		Anglo		Indian		Negro	
	No.	%	No.	%	No.	%	No.	%	No.	%
287	109	34	244	85.1	30	10.5	1	.3	12	4.1

GRANT NUMBER MG 05G LINN COUNTY

DATE SUBMITTED

PART II - MEDICAL, DENTAL, AND HOSPITAL SERVICES

1. MIGRANTS RECEIVING MEDICAL SERVICES

a. TOTAL MIGRANTS RECEIVING MEDICAL SERVICES AT FAMILY HEALTH CLINICS, PHYSICIANS OFFICES, HOSPITAL EMERGENCY ROOMS, ETC.

AGE	NUMBER OF PATIENTS			NUMBER OF VISITS
	TOTAL	MALE	FEMALE	
TOTAL	352	133	219	418
UNDER 1 YEAR	13	7	6	
1 - 4 YEARS	41	20	21	
5 - 14 YEARS	112	54	58	
15 - 44 YEARS	153	40	113	
45 - 64 YEARS	28	10	18	
65 AND OLDER	5	2	3	

No. of related nursing visits 990

b. OF TOTAL MIGRANTS RECEIVING MEDICAL SERVICES, HOW MANY WERE:

(1) SERVED IN FAMILY HEALTH SERVICE CLINIC?

(2) SERVED IN PHYSICIANS' OFFICE, ON FEE-FOR-SERVICE ARRANGEMENT (INCLUDE REFERRALS) 230

2. MIGRANTS RECEIVING DENTAL SERVICES

Dr. office and camp screening

ITEM (Estimates)	TOTAL	UNDER 15	15 AND OLDER
a. NO. MIGRANTS EXAMINED-TOTAL	162	150	12
(1) NO. DECAYED, MISSING, FILLED TEETH	Unable to determine		
(2) AVERAGE DMF PER PERSON	"	"	
b. INDIVIDUALS REQUIRING SERVICES-TOTAL	66	52	14
(1) CASES COMPLETED	5	3	2
(2) CASES PARTIALLY COMPLETED	25	19	6
(3) CASES NOT STARTED	39	32	7
c. SERVICES PROVIDED - TOTAL	162	150	12
(1) PREVENTIVE			
(2) CORRECTIVE-TOTAL	27		
(a) Extraction	10	6	4
(b) Other	17	14	3
d. PATIENT VISITS - TOTAL	30		

3. MIGRANT HOSPITALIZATIONS

SOURCE OF PAYMENT	NO. PTS.	M	F	AGE GROUPING <1	1-4	5-14	15-44	45-64	65+	TOTAL HOSP. DAYS	AVE. HOSP. DAYS	PROJECT HOSPITAL COSTS	DOCTORS FEES PAID	TOTAL HOSPITAL BILLING
MIGRANT FUNDS	23	7	16	6	2	1	12	2		83	4	$2271.83	$1425.00	$4678.44
OTHERS*														

*PAYMENT MADE BY PATIENT, INSURANCE, WELFARE, OR PROVIDED BY UNIVERSITY OF OREGON MEDICAL SCHOOL

4. IMMUNIZATIONS PROVIDED

TYPE	COMPLETED IMMUNIZATIONS, BY AGE: TOTAL	UNDER 1 YEAR	1 - 4	5 - 14	15 AND OLDER	INCOMPLETE SERIES	BOOSTERS, REVACCINATIONS
TOTAL-- ALL TYPES							
SMALLPOX		1				7	1
DIPHTHERIA, PERTUSSIS, TETANUS							
MEASLES							
TUBERCULIN SKIN TESTS							

1. No clinics in camps. 2. Difficulty with interpretation of health cards. 3. Higher level of immunization.

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PART II (Continued) - 5. MEDICAL CONDITIONS TREATED BY PHYSICIANS IN FAMILY CLINICS, HOSPITAL OUTPATIENT DEPARTMENTS, AND PHYSICIANS' OFFICES.

MG 050 LINN COUNTY

ICD CLASS	DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
I - XVII.	TOTAL ALL CONDITIONS	274	230	39
I.	INFECTIVE AND PARASITIC DISEASES TOTAL	15	11	4
	TUBERCULOSIS	5	2	3
	SYPHILIS			
	GONORRHEA AND OTHER VENEREAL DISEASES	2	1	1
	INTESTINAL PARASITES	5	5	
	DIARRHEAL DISEASE (infectious or unknown origins):			
	Children under 1 year of age	2	2	
	All other			
	"CHILDHOOD DISEASES" – mumps, measles, chickenpox	1	1	
	FUNGUS INFECTIONS OF SKIN (Dermatophytoses)			
	OTHER INFECTIVE DISEASES (Give examples):			
II.	NEOPLASMS: TOTAL	2	1	1
	MALIGNANT NEOPLASMS (give examples):			
	BENIGN NEOPLASMS			
	NEOPLASMS of uncertain nature	2	1	1
III.	ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES: TOTAL	11	6	5
	DISEASES OF THYROID GLAND			
	DIABETES MELLITUS	9	4	5
	DISEASES of Other Endocrine Glands			
	NUTRITIONAL DEFICIENCY			
	OBESITY	2	2	
	OTHER CONDITIONS			
IV.	DISEASES OF BLOOD AND BLOOD FORMING ORGANS: TOTAL	1	1	
	IRON DEFICIENCY ANEMIA	1	1	
	OTHER CONDITIONS			
V.	MENTAL DISORDERS: TOTAL	3	3	
	PSYCHOSES	1	1	
	NEUROSES and Personality Disorders	2	2	
	ALCOHOLISM			
	MENTAL RETARDATION			
	OTHER CONDITIONS			
VI.	DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS: TOTAL	29	28	1
	PERIPHERAL NEURITIS			
	EPILEPSY	3	3	
	CONJUNCTIVITIS and other Eye Infections	8	7	1
	REFRACTIVE ERRORS of Vision	8	8	
	OTITIS MEDIA	6	6	
	OTHER CONDITIONS	4	4	

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ICD CLASS		DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
VII.		DISEASES OF THE CIRCULATORY SYSTEM: TOTAL	8	8	
		RHEUMATIC FEVER	1	1	
		ARTERIOSCLEROTIC and Degenerative Heart Disease			
		CEREBROVASCULAR DISEASE (Stroke)			
		OTHER DISEASES of the Heart	1	1	
		HYPERTENSION	4	4	
		VARICOSE VEINS			
		OTHER CONDITIONS	2	2	
VIII.		DISEASES OF THE RESPIRATORY SYSTEM: TOTAL	45	39	6
		ACUTE NASOPHARYNGITIS (Common Cold)	11	11	
		ACUTE PHARYNGITIS	4	4	
		TONSILLITIS	8	8	
		BRONCHITIS	9	4	5
		TRACHEITIS/LARYNGITIS	1	1	
		INFLUENZA	4	4	
		PNEUMONIA	1	1	
		ASTHMA, HAY FEVER	3	3	
		CHRONIC LUNG DISEASE (Emphysema)			
		OTHER CONDITIONS	4	3	1
IX.		DISEASES OF THE DIGESTIVE SYSTEM: TOTAL	51	49	2
		CARIES and Other Dental Problems	42	40	2
		PEPTIC ULCER			
		APPENDICITIS			
		HERNIA	3	3	
		CHOLECYSTIC DISEASE	1	1	
		OTHER CONDITIONS	5	5	
X.		DISEASES OF THE GENITOURINARY SYSTEM: TOTAL	12	12	
		URINARY TRACT INFECTION (Pyelonephritis, Cystitis)	5	5	
		DISEASES OF PROSTATE GLAND (excluding Carcinoma)			
		OTHER DISEASES of Male Genital Organs	1	1	
		DISORDERS of Menstruation	3	3	
		MENOPAUSAL SYMPTOMS			
		OTHER DISEASES of Female Genital Organs			
		OTHER CONDITIONS	3	3	
XI.		COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM: TOTAL	5	5	
		INFECTIONS of Genitourinary Tract during Pregnancy			
		TOXEMIAS of Pregnancy			
		SPONTANEOUS ABORTION	1	1	
		REFERRED FOR DELIVERY	3	3	
		COMPLICATIONS of the Puerperium			
		OTHER CONDITIONS	1	1	
XII.		DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE: TOTAL	44	26	18
		SOFT TISSUE ABSCESS OR CELLULITIS	12	4	8
		IMPETIGO OR OTHER PYODERMA	21	11	10
		SEBORRHEIC DERMATITIS	1	1	
		ECZEMA, CONTACT DERMATITIS, OR NEURODERMATITIS	1	1	
		ACNE			
		OTHER CONDITIONS	9	9	

PART II - 5. (Continued)

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ICD CLASS		DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
XIII.		DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE: TOTAL	3	3	
		RHEUMATOID ARTHRITIS			
		OSTEOARTHRITIS			
		ARTHRITIS, Unspecified	3	3	
		OTHER CONDITIONS			
XIV.		CONGENITAL ANOMALIES: TOTAL	1	1	
		CONGENITAL ANOMALIES of Circulatory System	1	1	
		OTHER CONDITIONS			
XV.		CERTAIN CAUSES OF PERINATAL MORBIDITY AND MORTALITY: TOTAL			
		BIRTH INJURY			
		IMMATURITY			
		OTHER CONDITIONS			
XVI.		SYMPTOMS AND ILL-DEFINED CONDITIONS TOTAL	22	19	3
		SYMPTOMS OF SENILITY			
		BACKACHE	9	7	2
		OTHER SYMPTOMS REFERRABLE TO LIMBS AND JOINTS	5	4	1
		HEADACHE	3	3	
		OTHER CONDITIONS	5	5	
XVII.		ACCIDENTS, POISONINGS, AND VIOLENCE: TOTAL	22	18	4
		LACERATIONS, ABRASIONS, and Other Soft Tissue Injuries	8	8	
		BURNS	1	1	
		FRACTURES	8	4	4
		SPRAINS, STRAINS, DISLOCATIONS	4	4	
		POISON INGESTION			
		OTHER CONDITIONS due to Accidents, Poisoning, or Violence	1	1	

			NUMBER OF INDIVIDUALS
6.		SPECIAL CONDITIONS AND EXAMINATIONS WITHOUT SICKNESS: TOTAL	200
		FAMILY PLANNING SERVICES	10
		WELL CHILD CARE	3
		PRENATAL CARE	10
		POSTPARTUM CARE	4
		TUBERCULOSIS: Follow-up of inactive case	2
		MEDICAL AND SURGICAL AFTERCARE	3
		GENERAL PHYSICAL EXAMINATION	
		PAPANICOLAOU SMEARS	10
		TUBERCULIN TESTING	
		SEROLOGY SCREENING	
		VISION SCREENING	1
		AUDITORY SCREENING	
		SCREENING CHEST X-RAYS	2
		GENERAL HEALTH COUNSELLING	
		OTHER SERVICES: (Specify) Dental Screening	149
		Immunizations	6

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PART III - NURSING SERVICE MG 05G LINN COUNTY

TYPE OF SERVICE	NUMBER
NURSING CLINICS.	
a. NUMBER OF CLINICS	
b. NUMBER OF INDIVIDUALS SERVED - TOTAL	
FIELD NURSING:	
a. VISITS TO HOUSEHOLDS Estimate	1000
b. TOTAL HOUSEHOLDS SERVED	287
c. TOTAL INDIVIDUALS SERVED IN HOUSEHOLDS	1842
d. VISITS TO SCHOOLS, DAY CARE CENTERS	
e. TOTAL INDIVIDUALS SERVED IN SCHOOLS AND DAY CARE CENTERS	
CONTINUITY OF CARE:	
a. REFERRALS MADE FOR MEDICAL CARE: TOTAL	260
(1) Within Area	230
(Total Completed)	
(2) Out of Area	30
(Total Completed)	
b. REFERRALS MADE FOR DENTAL CARE: TOTAL	57
(Total Completed 40)	
c. REFERRALS RECEIVED FOR MEDICAL OR DENTAL CARE FROM OUT OF AREA: TOTAL	2
(Total Completed)	
d. FOLLOW-UP SERVICES FOR MIGRANTS, not originally referred by project, WHO WERE TREATED IN PHYSICIANS' OFFICES (Fee-for-Service) Estimate	10-15
e. MIGRANTS PROVIDED PRE-DISCHARGE PLANNING AND POST-HOSPITAL SERVICES	10
f. MIGRANTS ASKED TO PRESENT HEALTH RECORD Form PMS-3652 or Similar Form) IN FIELD OR CLINIC: TOTAL	287 families
(1) Number presenting health record.	51 families
(2) Number given health record	5 families
OTHER ACTIVITIES *(Specify)*:	

REMARKS

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PART IV - SANITATION SERVICES

TABLE A. SURVEY OF HOUSING ACCOMMODATIONS

HOUSING ACCOMMODATIONS	TOTAL		COVERED BY PERMITS	
	NUMBER	MAXIMUM CAPACITY	NUMBER	MAXIMUM CAPACIT
CAMPS	18			
OTHER LOCATIONS				
HOUSING UNITS - Family:				
IN CAMPS	356	1770		
IN OTHER LOCATIONS				
HOUSING UNITS - Single				
IN CAMPS				
IN OTHER LOCATIONS				

TABLE B. INSPECTION OF LIVING AND WORKING ENVIRONMENT OF MIGRANTS

ITEM	NUMBER OF LOCATIONS INSPECTED*		TOTAL NUMBER OF INSPECTIONS		NUMBER OF DEFECTS POUND		NUMBER OF CORRECTIONS MADE	
	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHE
LIVING ENVIRONMENT:								
a. WATER	17		17					
b. SEWAGE	17		45		39		32	
c. GARBAGE AND REFUSE	17		45		24		20	
d. HOUSING	17		45		9		7	
e. SAFETY	17		45		1		1	
f. FOOD HANDLING								
g. INSECTS AND RODENTS	17		45		6		3	
h. RECREATIONAL FACILITIES								
WORKING ENVIRONMENT:								
a. WATER	XXXX		XXXX		XXXX		XXXX	
b. TOILET FACILITIES	XXXX		XXXX		XXXX		XXXX	
c. OTHER	XXXX		XXXX		XXXX		XXXX	

* *Locations – camps or other locations where migrants work or are housed.*

PART V – HEALTH EDUCATION SERVICES *(By type of service, personnel involved, and number of sessions.)*

TYPE OF HEALTH EDUCATION SERVICE	NUMBER OF SESSIONS					
	HEALTH EDUCATION STAFF	PHYSICIANS	NURSES	SANITARIANS	AIDES *(other than Health Ed.)*	OTHER (Sp
A SERVICES TO MIGRANTS						
(1) Individual counselling			592	10	200	
(2) Group counselling			10	12	10	
B SERVICES TO OTHER PROJECT STAFF						
(1) Consultation			4	30	4	
(2) Direct services						
C. SERVICES TO GROWERS:						
(1) Individual counselling			3	36	2	
(2) Group counselling						
D. SERVICES TO OTHER AGENCIES OR ORGANIZATIONS:						
(1) Consultation with individuals			10		6	
(2) Consultation with groups						
(3) Direct services						
E. HEALTH EDUCATION MEETINGS			4	10	4	

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NURSING NARRATIVE

The Linn County Migrant Health staff for 1969 included one full-time project nurse, working from June to September, and one returning project nurse working in the month of July. Also giving invaluable assistance to the program this year were two Spanish-speaking aides, and a clerk.

This is the very first season that community health aides have been used in Linn County. Of special significance is the fact that they were migrant girls who spoke fluent Spanish. Thus, we were able to break communication barriers this year between the nurses and migrants, as well as between the migrants and the attending physician or dentist. There are certain other advantages too -- more accurate spelling of names, and more accuracy of information obtained.

There was a shortage of migrant workers in the county this year. In 1968 at the peak of the season there were 2,286 migrants in Linn County. This year there were only 1,842 workers here. This makes 444 fewer workers this year than last. This was partially attributed to last year's poor season. Also, the berry season in this area was cut short due to rain. The weather during most of the season was hot during the day and cold at night, which contributed to a high incidence of upper respiratory infections and tonsillitis among the camp residents.

For long term and emergency health problems, the migrant community was absorbed into the already heavy schedules of the County physicians and dentists. There seemed to be an increased acceptance of the program, and also an increased rapport between the doctors and dentists and the project staff. Perhaps this can be partially attributed to the use of our aides as interpreters, thus speeding up the office visits by eliminating much of the language barrier. Naturally, all was not smooth. One of the largest problems in the County seems to be transportation. Many of the migrant families come with a contractor and have no means of transportation once they reach Oregon. Another problem is the unwillingness of the migrant workers to take time from work to keep medical or dental appointments. These two factors are largely the cause of the seemingly high number of broken appointments.

The working relationship with the hospital was a smooth one. Hospitalizations were handled quickly and without difficulties. The hospitalization forms worked well, and in many instances we were able to pre-plan admissions with the hospital. There was rapid relay of information when any of the migrants required hospitalization, which enabled us to plan also for discharge care.

In the area of preventative medicine, we were able to offer the services of the County Immunization Clinics, the Mental Health Clinic, and the Family Planning services of Marion and Polk Counties. Many of the medical and dental referrals were in the nature of prevention. For instance, our increased stress on prenatal care is also in line with preventative health care.

There was a large emphasis in the County this year on dental care and dental education. We tried not only to deal with existing problems, but also to educate in the prevention of similar problems for the future. We were very fortunate to have the assistance of Dr. Castaldi from the University of Oregon Dental School, who with the help of four dental students, screened about 150 children in two camps for dental problems. From this screening, we were able to arrange for the immediate care of some of the children with the most emergent dental problems. Most of the children's dental care is far from complete, but at least it is started, and the parents know that the children's teeth need more attention. Most of the dental care was taken care of by the local dentists. One Corvallis dentist very cordially accepted to stay open later a couple of evenings to assist us in obtaining care for some of our children.

It is our feeling that the use of the Personal Health Records in this County is at a minimum. Most of the cards were blank. If immunizations were marked, it was next to impossible to

tell if they had a complete series of DPT or only one shot. This is because of the different way of marking in different areas. There were many times that the records seemed incomplete, only to have the mother say they received a series of shots either in school or in another state that were not recorded. We gave Personal Health Records only to those people we knew were going to a doctor or immunization clinic, since it seemed a waste to have people carry around blank cards.

As a whole, however, there seems to be an increased awareness of the need for immunizations, and we think there is a higher level of immunization among the migrants than in the past. We think perhaps the "hang-up" with the health cards is more with the interpretation of them than anything else.

The sanitarians from Portland checked the camps in the County many times. We saw improvements in many areas. Perhaps our best effort went into encouraging the inhabitants of the camps to clean up after themselves. We found the children to be most receptive. We feel that in this area there is a great deal more that could be done.

We were able to increase the community awareness of the program by using the local newspaper during our dental screening clinics. We were also able to involve several church organizations in the collection of clothing for the migrants. There were also volunteer church groups going out to camps to play with children and visit with migrants. Our rapport with the other social agencies in the community was very good, and we think brought about a greater awareness of what is being done for the migrant families. Many one-to-one contacts are the very best means of increasing awareness of the migrant health project. It makes one proud to have dispelled some of the stigmas attached to the work "migrant." Again we feel that our most effective method of health education this summer has been via one-to-one contacts. When one person takes the time to get involved in helping another, they both benefit. We were able to experiment with different methods of health education. Movies were an excellent method of attracting interest and conversation. Pamphlets are also helpful, and particularly "cartoony" ones for the children.

Again this year we were able to interest several young people into going on to college. Miss D. is enrolled at Linn-Benton Community College to begin her education toward being a speech therapist. Miss T. will begin her second year in prenursing at Linn-Benton. Miss G. will also be attending Linn-Benton Community College come fall. One fellow is going to be taking refresher courses to pass his GED exam, and then wants to apply for college to go into some sort of engineering.

All in all, this year has been a busy one, but one that has seen many "firsts" in Linn County. This has been the best year ever.

SANITATION NARRATIVE

Since the beginning of this program some three years ago, the sanitation services have been provided from the State Board of Health. This has been accomplished over the past two years by assigning the project sanitarian, employed by the Board of Health to work in Polk County, to spend at least two days a week in Linn County. This year, the position of project sanitarian in Polk County was abolished and it was planned that a sanitarian aide would be employed by the project, during the summer months, to maintain surveillance on the labor camps. He was to have been supervised by the registered sanitarians in the Linn County Health Department. The passage of a new Sanitarians Registration Act in the State appeared to preclude this type of arrangement (after all of the plans and budget had been approved) leaving the program, at the beginning of the season, with no one to implement it. The job fell to the supervisory sanitation staff of the Occupational Health Section, who by that time had already become responsible for accomplishing the Tri-County and the Polk County programs. Unfortunately, the season was upon us and only a few preseason inspections of the camps could be accomplished. The services provided by the Board of Health sanitation staff were inspection and follow-up visits to the camps, and consultations with the camp operators and growers.

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As in the Polk County program, it was our plan to do the best job that could be done with the time and personnel available. It was our hope rather than our objective to generally up-grade the camps in the areas of sewage disposal, the provision and maintenance of toilet facilities, improved solid waste storage and disposal, and general camp maintenance. The program emphasis was concentrated in these areas.

There are seventeen farm labor camps in Linn County, of which 13 are made up of individual cabins of frame construction. The balance of the camps are as follows: a converted school house, two converted barns, and one very old and dilapidated farm house. Interestingly enough, the converted school house served the purpose of farm labor housing quite well as there were inside lavatories and shower facilities. A privy provided the available toilet facilities, but this proved adequate. Some playground equipment was left at the old schoolhouse and this came the closest of any camp in the area to providing any recreational facility. The two converted barns were neither well appointed nor maintained and the ancient farm house, although containing inside plumbing, was a wreck and should not be used another year. The on-the-farm camps managed, for the most part, to meet the absolute minimum requirements of the law and regulations.

All seventeen farm labor camps had their own water supplies obtained from individual wells. The method of sewage disposal and the provision of toilet facilities was by the use of pit privies, with the exception of a malfunctioning septic tank and drainfield system at the old house. Poor drainage under the outside hydrants produced small swamps at strategic locations throughout many of the camps. Records indicate that 39 sewage disposal discrepencies were noted during the season in the seventeen camps, and sewage constituted one of the major problems. By and large the storage of garbage and refuse was accomplished in covered containers. There were, of course, exceptions in that certain growers insisted on using old hop baskets or whatever else was available. Some 24 discrepencies were noted in regard to garbage and trash storage and disposal. There was no centralized food service in any of the camps, and no refrigerators were provided in any of the living units.

A total of 45 camp inspections and follow-up visits were made to the seventeen camps during the season. Unfortunately this only totaled a little over two visits per camp, and actually the camps in the poorest shape were visited three and four times. As in Polk County, the season did produce its share of benefits for the program. Thirty-two of the 39 defects noted in the area of sewage disposal were corrected. Even though most of these concerned the maintenance of existing facilities, it is interesting to speculate on what the situation would have been like had there not been a program. Twenty of the 24 defects involving the storage and disposal of garbage and refuse were corrected. Seven improvements were made to living units (primarily repair of screens, doors, and windows) during the season, and the treatment and eradication of three rat infestations was accomplished.

The public health nurse had two community health aides assigned to her. These aides, in addition to assisting the nurses in their duties, worked with the migrant families in an attempt to improve their personal hygiene and general camp care and maintenance.

A persistent and rather tough approach had to be used to obtain some compliance and improvements. Along with this was a fear of what the consequences of a camp closure would do in disrupting the farm work. Surprisingly, in a few camps the farmer's wife put out extra effort to accomplish some of the camp maintenance.

As to the reasons for unsatisfactory progress, the principal one was that insufficient time was spent on the program. Aside from this, the same old reasons for lack of improvement to camp facilities come up. Heading up this list of farmers' complaints are a) the cost of improvement and b) the destruction or improper use of camp facilities. These of course come primarily from those very marginal camp operators and farmers and provide them with a comfortable excuse for not doing anything. Nevertheless, these statements are strongly believed by those farmers and camp operators voicing them. Every year these marginal camps are getting older and more run down, and hopefully, soon a good number of them will either go out of business or will be officially closed for occupancy.

With regard to the future of this program it is felt that the local responsibility for administration and service should be met by the county health department. If there is insufficient sanitation staff within the Linn County Health Department to tackle this additional job, assistance would be forthcoming from the Project. The past years of the project's administration from the State Board of Health have demonstrated that unless local interest and participation are forthcoming, not much of a lasting productive nature will occur.

COMMUNITY HEALTH AIDE

I really am not too good for writing annual reports cause I don't know where to start, but I guess the beginning is just the best place to start.

This summer was just full of excitment, along with encouragement, as well as with disappointments.

First, I will explain why I thought it was exciting.

I. I thought it was exciting because:

a) I had to get on the ball to get my drivers license to be able to drive the state car.
b) After I got my license I had to plan where I was going, ahead of time so that I wouldn't have to make a mistake.
c) After I knew where I was going I had to plan what I was going to do when I arrived.

After I had all the three steps put together, I was ready to go!

II. The encouragement part:

a) Have materials.
b) Have a set plan to where I was going.
c) What I was going to do once I got there.

But you know, that's kind of hard to follow. Once you get in a camp, no matter how well you plan your day, the families, the children, and sometimes the older boys will change your schedule.

I can remember the first day I went to one of the many camps we had to take care of -- Della and I had planned to show some films the following day, but instead we ended up showing the films that same day. This was at Folsom's camp and the bigger boys helped Della and I bring the equipment from the car to the place where we were going to show the films.

Some of the children would bring a table for me to set up the projector, while others helped Della put up the screen, still others would help me plug the projector, and set up the film, and the older girls would gather everyone for the so-called show. Before I started the "show", I would explain to them what the film was about and why I was showing it to them. Then I would start the film. After showing the film I would ask if they liked it and I would ask questions to see if they knew what it was all about.

In some camps this method really worked, but in others, it just didn't do any good. So we tried another method. We chose Bose Camp and Helms-Williams Camp for this method. Dr. Castaldi from Portland Dental School came down and helped. He brought some dental students to help out. They set up a dental clinic at both camps to make a dental screening. It worked out real well.

The day before we started our clinic, we had trained some teenage girls to help the small children to brush their teeth and to teach the older kids to brush correctly. We handed out toothbrushes and some tooth paste. They got to keep the toothbrushes, and they thought that was great. After we had this dental screening, Dr. Castaldi gave us a list of names of the persons who needed dental follow-up care. So after we had the names we made dental appointments and saw to it that these particular people kept their appointments.

Linn County
MG 05G

One of the problems we had was transportation. Some of the people had to be brought in for appointments because transportation was not available. But there were some who did go by themselves, which was a great help.

Aides Part

I thought by having Spanish-speaking aides this summer, it was quite helpful to the nurses and also for the families to understand each other better. I thought families appreciated the help available to them a little more. In my opinion, I saw that because we had been in migrant camps and by them knowing that Lupita and I had been in the same field they were, made them more confident, and helped us help them more. They were much more willing to share their problems as well as their sicknesses with us and the nurses. Many of the children were much more talkative than they had been before in other years. Many enjoyed playing the health game. By playing the games, many of them learned to keep their teeth clean, their hands clean, and tried to help pick up the trash.

There was a certain camp which I was really proud of and that was the Folsom Camp. While the families were there the children tried their best to pick up trash that was thrown around, tried not to throw any more than was necessary, and improved themselves by washing their hands even only with water.

I talked to some teenage fellows who were real friendly and willing to learn how to quit smoking. By showing them pamphlets, be telling them the diseases caused by smoking and also by telling them the results of smoking, many of them quit. Not only did I talk to the ones who wanted to quit, I also talked to the ones who wanted to start. Della was real good at explaining to them why smoking was so bad.

Our main purpose of the counseling, the films, the dental clinic was to prevent a sickness or disease before it started. Sonja gave Lupita, Marda, Della and I a list of things that we could consider while doing our health education, which helped quite a bit. These were things that would help us to prevent disease before it started.

I liked my job because, even though we didn't have a sanitarian to consult with, we consulted with the nurses. The nurse-aide relationship was wonderful. When we had a problem they would help us solve it instead of saying, "Well, do it this way." They would let us express our opinions and to try some of our own ideas, and it just worked out fine.

In our special county we had two public health nurses, but in the middle of the season one of our nurses quit and so Marda and I had to work out a certain way to work together so that it would work out. I would check the camps and then tell Marda where she was needed and she would go and see to it that the problems were taken care of, and if a doctors referral was needed or appointments were to be made, she would make it and deliver it. Some doctors also expressed the great help Lupita and I had been to them by helping out with the translation part. This way they knew exactly what was wrong with the patient and knew what to do because they had the correct information. Also the patient was not scared to go to see the doctor because we could translate for them.

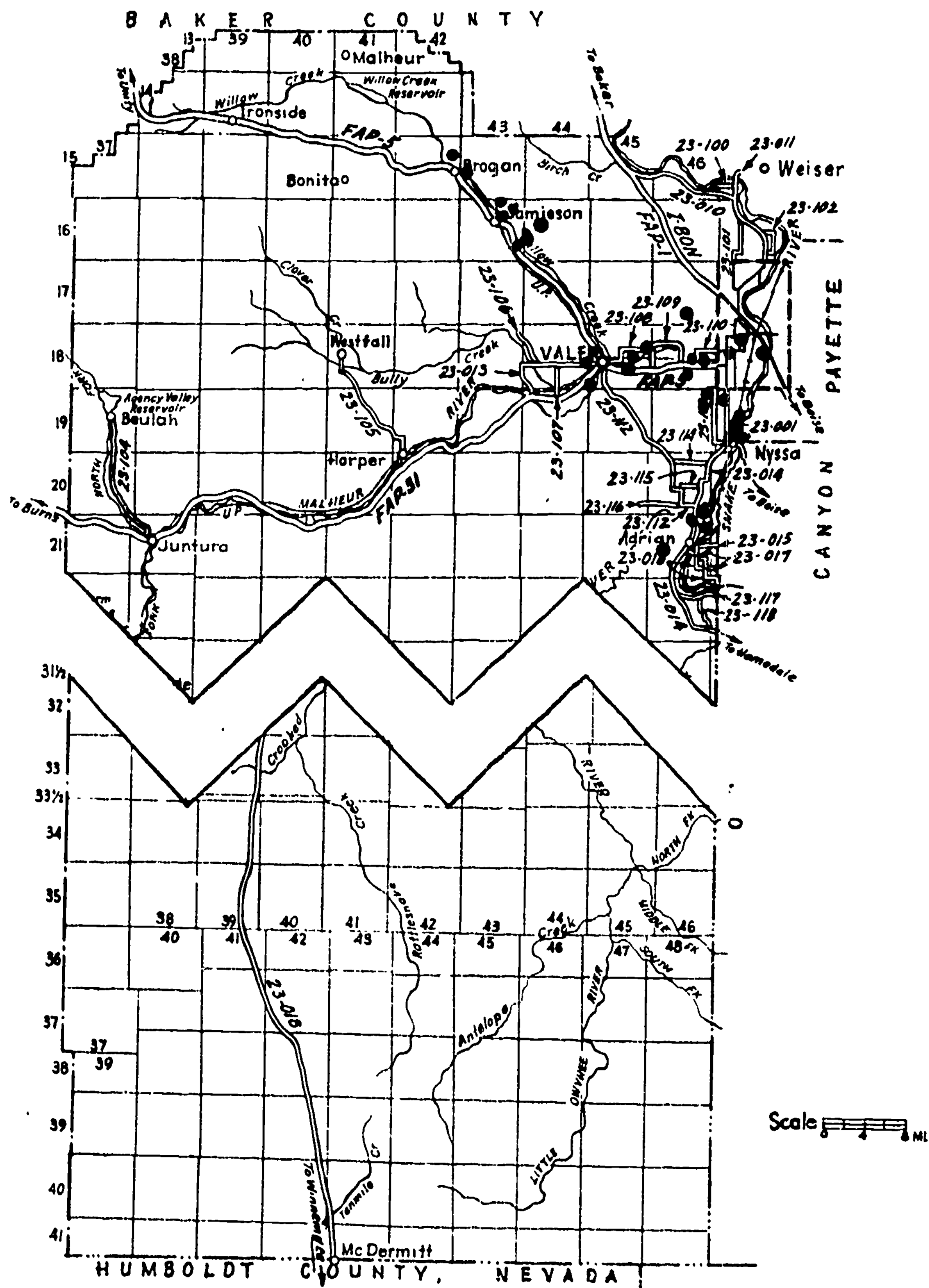
This year was a big experience, because coming from the migrant field into the field of helping ourselves and our own people, you might say, was a great one. We were accepted as though we were part of them and they were part of us. They shared with us and we shared with them our problems, and how we could help ourselves to solve them.

I sincerely hope that the day will come, when migrants won't have to migrate. That wages and the way of living will change so that they won't have to move so far away from home and from their loved ones.

Until next year, this is my report, expressing my feelings from deep inside and I am looking forward to working with you next year. Until then, May God Bless All.

MALHEUR COUNTY

Malheur County Migrant Health Project
Malheur County Health Department
Kenneth Pfaff, M.D., Health Officer
Courthouse
Vale, Oregon 97918



POPULATION AND HOUSING DATA

FOR MALHEUR COUNTY.

GRANT NUMBER MG 05G

5. POPULATION DATA - MIGRANTS (*Workers and dependents*)

a. NUMBER OF MIGRANTS BY MONTH

MONTH	TOTAL	IN-MIGRANTS	OUT-MIGRANTS
JAN.	1500	100	1400
FEB.	1500	100	1400
MAR.	1600	200	1400
APRIL	2800	1500	1300
MAY	2800	1500	1300
JUNE	1400	1200	200
JULY	3000	2800	200
AUG.	4000	2700	1300
SEPT.	4000	2700	1300
OCT.	2000	700	1300
NOV.	1500	100	1400
DEC.	1500	100	1400
TOTALS			

b. NUMBER OF MIGRANTS DURING PEAK MONTH

	TOTAL	MALE	FEMALE
(1) OUT-MIGRANTS: TOTAL	1500	820	680
UNDER 1 YEAR	92	44	48
1 - 4 YEARS	229	134	95
5 - 14 YEARS	380	200	180
15 - 44 YEARS	632	340	292
45 - 64 YEARS	140	90	50
65 AND OLDER	27	12	15
(2) IN-MIGRANTS: TOTAL	2573	1360	1213
UNDER 1 YEAR	50	19	31
1 - 4 YEARS	280	149	131
5 - 14 YEARS	980	542	438
15 - 44 YEARS	1024	507	517
45 - 64 YEARS	227	134	93
65 AND OLDER	12	9	3

c. AVERAGE STAY OF MIGRANTS IN COUNTY

	NO. OF WEEKS	FROM (MO.)	THROUGH (MO.)
OUT-MIGRANTS	44	September	June
IN-MIGRANTS	28	April	October

6. HOUSING ACCOMMODATIONS

a. CAMPS

MAXIMUM CAPACITY	NUMBER	OCCUPANCY (*Peak*)
LESS THAN 10 PERSONS	22	112
10 - 25 PERSONS	8	105
26 - 50 PERSONS	1	35
51 - 100 PERSONS	0	0
MORE THAN 100 PERSONS	5	1493
TOTAL*	36	1745

b. OTHER HOUSING ACCOMMODATIONS

LOCATION (*Specify*)	NUMBER	OCCUPANCY (*Peak*)
Rent homes (Vale, Ontario, Nyssa)	280	2250
TOTAL*	280	2250

*NOTE: *The combined occupancy totals for "a" and "b" should equal approximately the total peak migrant population for the year.*

REMARKS

Information for 5a and 5b from camp population, school enrollment, employment service figures and family records.

GRANT NUMBER	MG 05G MALHEUR COUNT
DATE SUBMITTED	

PART II - MEDICAL, DENTAL, AND HOSPITAL SERVICES

1. MIGRANTS RECEIVING MEDICAL SERVICES

a. TOTAL MIGRANTS RECEIVING MEDICAL SERVICES AT FAMILY HEALTH CLINICS, PHYSICIANS OFFICES, HOSPITAL EMERGENCY ROOMS, ETC.

AGE	NUMBER OF PATIENTS			NUMBER OF VISITS
	TOTAL	MALE	FEMALE	
TOTAL	555	231	324	1404
UNDER 1 YEAR	33	19	14	99
1 - 4 YEARS	104	63	41	260
5 - 14 YEARS	112	57	55	254
15 - 44 YEARS	239	67	172	613
45 - 64 YEARS	62	24	38	172
65 AND OLDER	5	1	4	6

No. of related nursing visits

b. OF TOTAL MIGRANTS RECEIVING MEDICAL SERVICES, HOW MANY WERE:

(1) SERVED IN FAMILY HEALTH SERVICE CLINIC? ______

(2) SERVED IN PHYSICIANS' OFFICE, ON FEE-FOR-SERVICE ARRANGEMENT (INCLUDE REFERRALS) 555 & unknown

2. MIGRANTS RECEIVING DENTAL SERVICES *

ITEM	TOTAL	UNDER 15	15 AND OLDER (partly cut off)
a. NO. MIGRANTS EXAMINED-TOTAL	422	371	51
(1) NO. DECAYED, MISSING, FILLED TEETH			
(2) AVERAGE DMF PER PERSON		4	6
b. INDIVIDUALS REQUIRING SERVICES-TOTAL	163	112	51
(1) CASES COMPLETED	72	51	21
(2) CASES PARTIALLY COMPLETED	78	61	17
(3) CASES NOT STARTED	2		2
c. SERVICES PROVIDED - TOTAL			
(1) PREVENTIVE			
(2) CORRECTIVE-TOTAL			93
(a) Extraction			49
(b) Other			2
d. PATIENT VISITS - TOTAL			105

* Report incomplete

3. MIGRANT HOSPITALIZATIONS

SOURCE OF PAYMENT	NO. PTS.	M	F	AGE GROUPING <1	1-4	5-14	15-44	45-64	65+	TOTAL HOSP. DAYS	AVE. HOSP. DAYS	PROJECT HOSPITAL COSTS	DOCTORS FEES PAID	TOTAL HOSPITAL BILLING
MIGRANT FUNDS	84	30	54	30	1	2	46	5		297	4	$10405.76	$6828.00	$19469.41
OTHERS*	125	35	90	5	6	9	86	13	6					

*PAYMENT MADE BY PATIENT, INSURANCE, WELFARE, OR PROVIDED BY UNIVERSITY OF OREGON MEDICAL SCHOOL

4. IMMUNIZATIONS PROVIDED

TYPE	COMPLETED IMMUNIZATIONS, BY AGE: TOTAL	UNDER 1 YEAR	1 - 4	5 - 14	15 AND OLDER	INCOMPLETE SERIES	BOOSTERS, REVACCINATION
TOTAL-- ALL TYPES	687	34	87	496	1	59	10
SMALLPOX	16		9	7			
DIPHTHERIA	46	8	6	10		18	4
PERTUSSIS	34	8	6	4		15	1
TETANUS	46	8	6	10		18	4
Polio	36	8	4	15		8	1
MEASLES	508	2	56	450			
Flu	1				1		
TUBERCULIN SKIN TESTS							

PART II (Continued) - 5. MEDICAL CONDITIONS TREATED BY PHYSICIANS IN FAMILY CLINICS, HOSPITAL OUTPATIENT DEPARTMENTS, AND PHYSICIANS' OFFICES.

MG 05G MALHEUR COUNTY

ICD CLASS	DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
I.-XVII.	TOTAL ALL CONDITIONS	1404		
I.	INFECTIVE AND PARASITIC DISEASES: TOTAL	113	34	79
	TUBERCULOSIS	33	6	27
	SYPHILIS	5	3	2
	GONORRHEA AND OTHER VENEREAL DISEASES			
	INTESTINAL PARASITES	8	4	4
	DIARRHEAL DISEASE (infectious or unknown origins):			
	Children under 1 year of age	6	1	5
	All other	30	7	23
	"CHILDHOOD DISEASES" – mumps, measles, chickenpox	4	2	2
	FUNGUS INFECTIONS OF SKIN (Dermatophytoses)			
	OTHER INFECTIVE DISEASES (Give examples):			
	Streptococcal Sore throat	2	1	1
	Pediculosis	17	7	10
	Vincent's angina	2	1	1
	Meningococcal	6	2	4
II.	NEOPLASMS: TOTAL	7	3	4
	MALIGNANT NEOPLASMS (give examples):			
	Follow-up Removal of breast	3	1	2
	BENIGN NEOPLASMS	2	1	1
	NEOPLASMS of uncertain nature	2	1	1
III.	ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES: TOTAL	117	40	77
	DISEASES OF THYROID GLAND			
	DIABETES MELLITUS	43	12	31
	DISEASES of Other Endocrine Glands			
	NUTRITIONAL DEFICIENCY	49	20	29
	OBESITY	16	6	10
	OTHER CONDITIONS	9	2	7
IV.	DISEASES OF BLOOD AND BLOOD FORMING ORGANS: TOTAL	4	1	3
	IRON DEFICIENCY ANEMIA	4	1	3
	OTHER CONDITIONS			
V.	MENTAL DISORDERS: TOTAL	23	5	18
	PSYCHOSES			
	NEUROSES and Personality Disorders	16	3	13
	ALCOHOLISM			
	MENTAL RETARDATION			
	OTHER CONDITIONS	7	2	5
VI.	DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS: TOTAL	48	17	31
	PERIPHERAL NEURITIS	6	1	5
	EPILEPSY			
	CONJUNCTIVITIS and other Eye Infections	25	10	15
	REFRACTIVE ERRORS of Vision	4	2	2
	OTITIS MEDIA	7	2	5
	OTHER CONDITIONS	6	2	4

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PART II - 5. (Continued)

MG 05G MALHEUR COUNTY

ICD CLASS		DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVIS
VII.		DISEASES OF THE CIRCULATORY SYSTEM: TOTAL	14	5	9
		RHEUMATIC FEVER			
		ARTERIOSCLEROTIC and Degenerative Heart Disease			
		CEREBROVASCULAR DISEASE (Stroke)			
		OTHER DISEASES of the Heart			
		HYPERTENSION	11	4	7
		VARICOSE VEINS	3	1	2
		OTHER CONDITIONS			
VIII.		DISEASES OF THE RESPIRATORY SYSTEM: TOTAL	208	88	120
		ACUTE NASOPHARYNGITIS (Common Cold)	8	4	4
		ACUTE PHARYNGITIS	14	7	7
		TONSILLITIS	6	4	2
		BRONCHITIS	26	16	10
		TRACHEITIS/LARYNGITIS	13	5	8
		INFLUENZA	118	47	71
		PNEUMONIA	20	4	16
		ASTHMA, HAY FEVER			
		CHRONIC LUNG DISEASE (Emphysema)			
		OTHER CONDITIONS	3	1	2
IX.		DISEASES OF THE DIGESTIVE SYSTEM: TOTAL	252	124	128
		CARIES and Other Dental Problems	130	77	53
		PEPTIC ULCER	13	4	9
		APPENDICITIS	14	6	8
		HERNIA	19	5	14
		CHOLECYSTIC DISEASE	19	9	10
		OTHER CONDITIONS	57	23	34
X.		DISEASES OF THE GENITOURINARY SYSTEM: TOTAL	50	21	29
		URINARY TRACT INFECTION (Pyelonephritis, Cystitis)	17	8	9
		DISEASES OF PROSTATE GLAND (excluding Carcinoma)			
		OTHER DISEASES of Male Genital Organs	6	2	4
		DISORDERS of Menstruation	10	4	6
		MENOPAUSAL SYMPTOMS			
		OTHER DISEASES of Female Genital Organs	14	5	9
		OTHER CONDITIONS	3	2	1
XI.		COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM: TOTAL	179	52	127
		INFECTIONS of Genitourinary Tract during Pregnancy			
		TOXEMIAS of Pregnancy			
		SPONTANEOUS ABORTION	9	3	6
		REFERRED FOR DELIVERY	101	26	75
		COMPLICATIONS of the Puerperium			
		OTHER CONDITIONS	69	23	46
XII.		DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE: TOTAL	158	46	112
		SOFT TISSUE ABSCESS OR CELLULITIS	4	1	3
		IMPETIGO OR OTHER PYODERMA	88	19	69
		SEBORRHEIC DERMATITIS			
		ECZEMA, CONTACT DERMATITIS, OR NEURODERMATITIS	15	4	11
		ACNE	7	2	5
		OTHER CONDITIONS	44	20	24

PART II - 5. *(Continued)*

MG 05G MALHEUR COUNTY

ICD CLASS	DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
XIII.	DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE: TOTAL	59	13	46
	RHEUMATOID ARTHRITIS	33	4	29
	OSTEOARTHRITIS			
	ARTHRITIS, Unspecified			
	OTHER CONDITIONS	26	9	17
XIV.	CONGENITAL ANOMALIES: TOTAL			
	CONGENITAL ANOMALIES of Circulatory System			
	OTHER CONDITIONS			
XV.	CERTAIN CAUSES OF PERINATAL MORBIDITY AND MORTALITY: TOTAL	6	1	5
	BIRTH INJURY			
	IMMATURITY			
	OTHER CONDITIONS	6	1	5
XVI.	SYMPTOMS AND ILL-DEFINED CONDITIONS: TOTAL	93	44	49
	SYMPTOMS OF SENILITY			
	BACKACHE			
	OTHER SYMPTOMS REFERRABLE TO LIMBS AND JOINTS	19	10	9
	HEADACHE	13	7	6
	OTHER CONDITIONS	61	27	34
XVII.	ACCIDENTS, POISONINGS, AND VIOLENCE: TOTAL	92	25	67
	LACERATIONS, ABRASIONS, and Other Soft Tissue Injuries	19	5	14
	BURNS	11	4	7
	FRACTURES	15	2	13
	SPRAINS, STRAINS, DISLOCATIONS	11	4	7
	POISON INGESTION	2	1	1
	OTHER CONDITIONS due to Accidents, Poisoning, or Violence	34	9	25

			NUMBER OF INDIVIDUALS
6.	SPECIAL CONDITIONS AND EXAMINATIONS WITHOUT SICKNESS: TOTAL		2011
	FAMILY PLANNING SERVICES	21	
	WELL CHILD CARE	25	
	PRENATAL CARE	35	
	POSTPARTUM CARE	26	
	TUBERCULOSIS: Follow-up of inactive case	28	
	MEDICAL AND SURGICAL AFTERCARE	524	
	GENERAL PHYSICAL EXAMINATION	5	
	PAPANICOLAOU SMEARS	3	
	TUBERCULIN TESTING	87	
	SEROLOGY SCREENING	4	
	VISION SCREENING		
	AUDITORY SCREENING		
	SCREENING CHEST X-RAYS	350	
	GENERAL HEALTH COUNSELLING	903	
	OTHER SERVICES. (Specify)		

120

PART III - NURSING SERVICE

MG 05G MALHEUR COU

TYPE OF SERVICE		NUMBER
1. NURSING CLINICS.		
a. NUMBER OF CLINICS		36
b. NUMBER OF INDIVIDUALS SERVED - TOTAL		610
2. FIELD NURSING:		
a. VISITS TO HOUSEHOLDS		2408
b. TOTAL HOUSEHOLDS SERVED		450
c. TOTAL INDIVIDUALS SERVED IN HOUSEHOLDS		2573
d. VISITS TO SCHOOLS, DAY CARE CENTERS		193
e. TOTAL INDIVIDUALS SERVED IN SCHOOLS AND DAY CARE CENTERS (Summer School only)		340
3. CONTINUITY OF CARE:		
a. REFERRALS MADE FOR MEDICAL CARE: TOTAL		596
(1) Within Area	592	
(Total Completed 537)		
(2) Out of Area	4	
(Total Completed 3)		
b. REFERRALS MADE FOR DENTAL CARE: TOTAL		182
(Total Completed)		
c. REFERRALS RECEIVED FOR MEDICAL OR DENTAL CARE FROM OUT OF AREA: TOTAL		1
(Total Completed 0)		
d. FOLLOW-UP SERVICES FOR MIGRANTS, not originally referred by project, WHO WERE TREATED IN PHYSICIANS' OFFICES (Fee-for-Service)	unknown	
e. MIGRANTS PROVIDED PRE-DISCHARGE PLANNING AND POST-HOSPITAL SERVICES	72	
f. MIGRANTS ASKED TO PRESENT HEALTH RECORD Form PMS-3652 or Similar Form) IN FIELD OR CLINIC: TOTAL		
(1) Number presenting health record.	125	
(2) Number given health record.	160	
4. OTHER ACTIVITIES *(Specify)*:		

REMARKS

PART IV - SANITATION SERVICES

MG 05G MALHEUR COUNTY

ABLE A. SURVEY OF HOUSING ACCOMMODATIONS

HOUSING ACCOMMODATIONS	TOTAL		COVERED BY PERMITS	
	NUMBER	MAXIMUM CAPACITY	NUMBER	MAXIMUM CAPACITY
AMPS	36	1745		
THER LOCATIONS	280	2250		
OUSING UNITS - Family:				
IN CAMPS	323	1602		
IN OTHER LOCATIONS	250	2000		
OUSING UNITS - Single	7	143		
IN CAMPS				
IN OTHER LOCATIONS	30	250		

ABLE B. INSPECTION OF LIVING AND WORKING ENVIRONMENT OF MIGRANTS

ITEM	NUMBER OF LOCATIONS INSPECTED*		TOTAL NUMBER OF INSPECTIONS		NUMBER OF DEFECTS POUND		NUMBER OF CORRECTIONS MADE	
	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER
IVING ENVIRONMENT:								
a. WATER	36	4	167	8	5	2	5	2
b. SEWAGE	36	4	171	8	98	1	47	
c. GARBAGE AND REFUSE	36	4	171	8	74	3	37	2
d. HOUSING	36	4	171	8	41		13	
e. SAFETY	36	4	171	8	3	1	3	1
f. FOOD HANDLING	1		2		8		5	
g. INSECTS AND RODENTS	36	4	171	8	17	2	10	2
h. RECREATIONAL FACILITIES	36		171					
ORKING ENVIRONMENT:								
a. WATER	XXXX	2	XXXX	2	XXXX		XXXX	
b. TOILET FACILITIES	XXXX	2	XXXX	2	XXXX	1	XXXX	1
c. OTHER	XXXX		XXXX		XXXX		XXXX	

Locations – camps or other locations where migrants work or are housed.

ART V – HEALTH EDUCATION SERVICES *(By type of service, personnel involved, and number of sessions.)*

TYPE OF HEALTH EDUCATION SERVICE	NUMBER OF SESSIONS					
	HEALTH EDUCATION STAFF	PHYSICIANS	NURSES	SANITARIANS	AIDES (other than Health Ed.)	OTHER (Specify)
SERVICES TO MIGRANTS.						
(1) Individual counselling			600	50	1150	
(2) Group counselling			385		609	
SERVICES TO OTHER PROJECT STAFF						
(1) Consultation			39		39	
(2) Direct services						
SERVICES TO GROWERS:						
(1) Individual counselling			1	50		
(2) Group counselling				4	3	
SERVICES TO OTHER AGENCIES OR ORGANIZATIONS:						
(1) Consultation with individuals			148	30	165	
(2) Consultation with groups			73	3	115	
(3) Direct services						
HEALTH EDUCATION MEETINGS			16		12	

NURSING NARRATIVE

This year's project nursing was done by one full time nurse. One full time interpreter assisted as a nurse aide. The project was supervised by the county nurse administrator. Both county nurses assisted many times when project staff was not available. Also, the health department secretary contributed many hours to our bookkeeping.

More than twenty new families stayed over this winter in the Nyssa area alone. Since the new non-resident welfare law was not yet in effect, this did create many problems. The cold weather was the biggest factor. Most of the people have no idea that it can get so cold. They never have enough warm clothes or blankets, and the houses, which are badly constructed, usually have poor heating facilities. These problems cause many health problems; surprisingly, we did not have any serious pneumonias (borderlines), but many URI's, sore throats and the ever present cold.

We did fewer immunizations this year because our clinic was changed to monthly, and then only held in the morning. We did have two large measles immunization clinics, made possible by the State Health Department sending over a physician. Our local physicians and hospitals continue to give great cooperation. We would like to mention and give credit to one local dentist, who gave us lower rates so more people could be treated.

This area was one chosen for the new Experimental and Development Program with the employment department. At first there was some misunderstanding between the families and our department, but we felt this was because the families arrived before the E and D counselors had begun working. Things were soon straightened out and we found the program workers very helpful. They made it possible for the staff to concentrate on other families. When their families needed health assistance, they would contact us and also for many that were not on their list. Different ones would go to them when they could not find us.

The E and D program was also responsible for our interagency meetings that were started this year. This includes all the agencies that are directly and some indirectly involved with the migrants. (There have been similar interagency meetings in Ontario but not solely for migrants). They have been most helpful and informative. This summer it seems that more cooperation was reached between all of us, or as it was so aptly stated, "Horse-trading"! One very good example was in our dental program. The Summer School paid for all the school children's dental care so we could use our dental monies on adults.

The summer has been busy or more appropriate "hectic". One big reason was the four to five weeks of unemployment because of rainy weather. People asked for assistance, who have never needed or asked for it in past years. When one reads reports from other counties, one gets very envious of their large staffs, clinics and health education programs. The project nurse has said, "Many a time I have wished for two or three of me and more like Mrs. Matones. For I know we are not reaching many, many families.

SANITATION NARRATIVE

The sanitation staff for Malneur County has remained unchanged for the past three years. The county sanitarian devotes 40% of his time to the Migrant Health Project. The State Bureau of Labor furnishes a representative to inspect conditions in the fields where women and children are employed during the months of June, July and August. He assists in maintaining water and sewage standards in the fields. He meets weekly with the sanitarian to discuss his findings and solutions to problems.

Objectives and duties of the sanitarian are to promote improved sanitary conditions in farm labor camps and harvest fields through intensive inspection, education, and consultation with growers. He promotes an increased community awareness and support for improved health care and environmental living and working conditions for migrant farm workers and their families to achieve the health care objectives set forth above.

Malheur County
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A close working relationship is maintained with individual growers, the Farm Labor Sponsor's Association, the State Bureau of Labor representative, and the Department of Employment. The sanitarian attends the monthly meeting of a Technical Action Committee consisting of representatives from the County Extension Agent, Farmers' Home Administration, Soil Conservation Service, Employment Service and other interested agencies.

Periodic consultations are held with the Farm Labor Health Consultant from the State Board of Health. Frequent consultations are held with the nursing staff.

The type of migrant housing available in Malheur County varies from single unit camps to one hundred sixty two units in the largest camp. The four large Farm Labor Sponsor's Association camps account for 273 units of the total 323 family units classed as camps. They are of concrete block apartment style and single unit wood-frame buildings. The wood-frame buildings are gradually being replaced with the new concrete block structures. Two camps are specifically for single male workers. One of these camps provide housing for approximately fifteen Phillipino workers who come from California each year to harvest asparagus. The other camp is a modern dormitory of six units housing approximately 128 Indians from a reservation in Arizona. A central cafeteria provides meals for these workers for a very reasonable charge. There are currently 21 individual unit farm houses in use by migrant workers which are classed as camps. Other small camps consisting of from two to seven cabins are providing another 23 units. Housing not classed as camps consists of older tourist courts licensed by cities and private rentals.

There is no permit system for migrant housing in Malheur County. However, persons intending to furnish housing for agricultural workers are required to notify the local health officer in writing of their intent so that it may be inspected. Standards are set by the Oregon Farm Labor Housing Code and enforced by the local health department. This sytem has provided a gradual improvement in housing conditions as borderline camps are eliminated and new housing is built to comply with the standards.

The domestic water supply for two of the thirty-six camps is from a municipal supply. The other camps have individual drilled wells. Inspection of the individual supplies are made to insure that the supply meets bacteriological standards and are protected from contamination. Twenty-two of the thirty-six camps are plumbed for inside flush toilets. The remainder are served by pit privies. Most discrepancies noted in the sewage disposal area continue to be in the construction and maintenance of pit privies. Garbage and refuse disposal continues to be a problem due to lids being left off the cans by tenants and the practice of burning mixed garbage and refuse in a barrel. Lack of refrigeration is a problem since the code does not require that refrigerators be furnished. Only one camp provides complete food service facilities and it meets with all requirements of the Sanitary Code for Eating and Drinking Establishments. Recreational facilities are furnished only in the large Farm Labor Sponsor's Association camps and at Skyline Farm's dormitory for single male workers. General cleanliness in the camps is considered satisfactory.

Regulations governing work environment remain unchanged since last year. Drinking water supplies are not presently required under the Code but if furnished the common drinking cup is prohibited. The majority of crews bring their own drinking water to the fields. Handwashing facilities in the fields are non-existent since this is not required under the present code. An attempt to amend this portion of the Code was defeated. The number of pit privies required in the field is covered by the Code. The Bureau of Labor representative has caused an increase in the number of privies furnished workers in the fields since last season.

Efforts in health education have been directed toward improvement of garbage disposal methods and sewage facilities. This has helped to some extent in elimination of breeding places for flies in the camps.

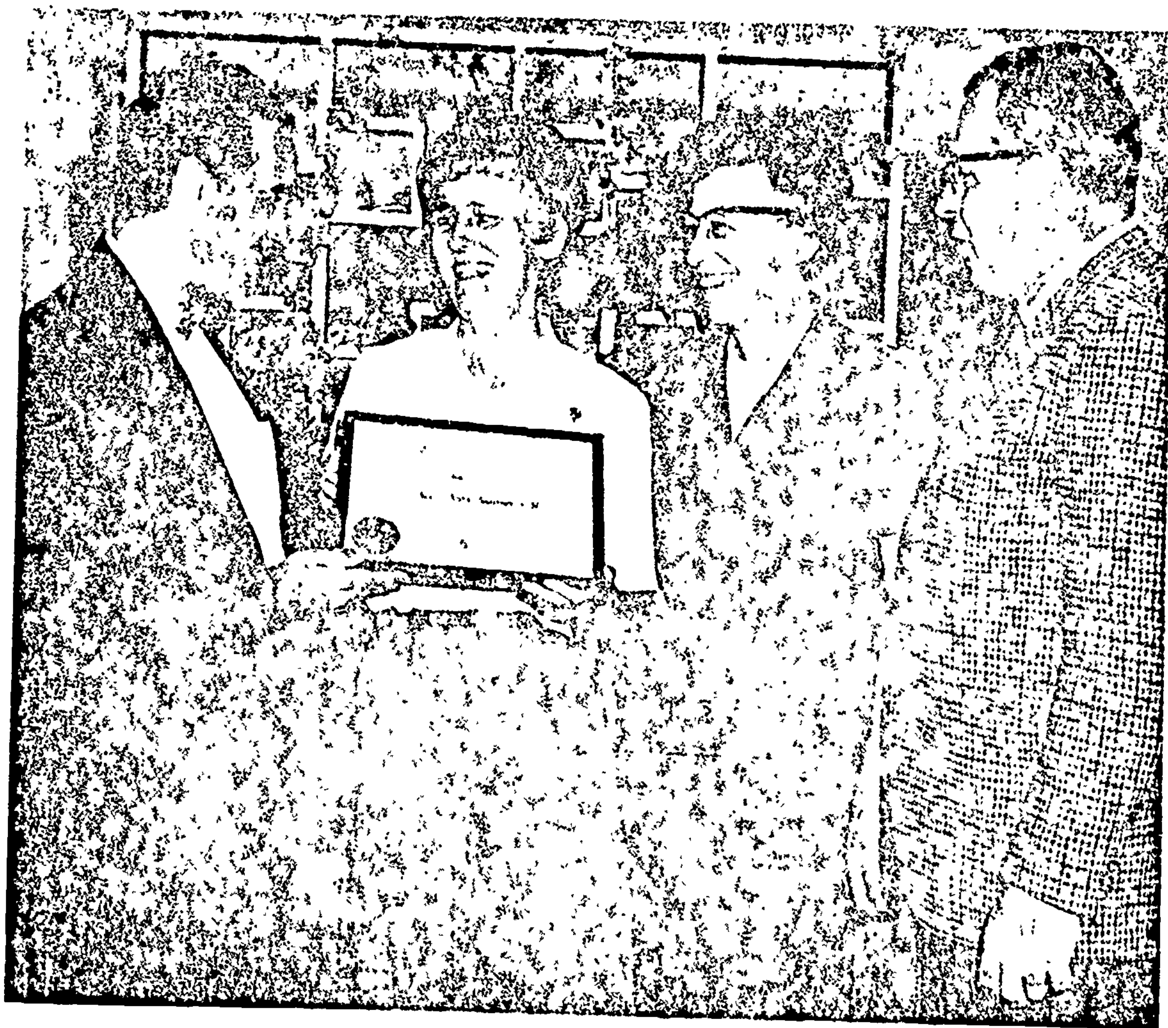
The sanitation program objectives to promote improved sanitary conditions in farm labor camps and harvest fields through intensive inspection, education and consultation has met with some measure of success. Community awareness and support for the program has contributed to the gradual improvement of conditions in the camps and in the fields. Only two closure notices were necessary during the season to correct deficiencies in the camp facilities.

Consultation with individual growers was the most successful method of maintaining satisfactory conditions both in the camps and in field working conditions.

Plans for the future have not been firmly decided since the sanitarian position was vacated on September 19, 1969 and a replacement has not been obtained at the time of this report.

- - - -

Fern Cramer, Migrant Project Nurse, Malheur County Health Department, has received a CITATION FOR COMMENDABLE ACHIEVEMENT from the Governor's Committee on Employment of the Handicapped. The award was presented to Mrs. Cramer during the 1969 Annual Oregon Migrant Health Seminar, by Joaquin Hernandez of the Oregon Employment Service. Mr. Hernandez cited Mrs. Cramer's excellent cooperation and assistance with the Employment Service's Experimental and Demonstration Project. The E & D Project's purpose in Malheur County is to provide comprehensive services needed by migrant families who were chosen to participate in the project.



Joaquin Hernandez, Counselor, Ontario Employment Division
Fern Cramer, Migrant Health Project Nurse, Malheur County Health Department
Hesther Poareo, Supervising Nurse, State Migrant Health Project
J. Nelson Miller, E and D Project Coordinator, Oregon State Employment Division

YAMHILL COUNTY
CLACKAMAS
COUNTY
POLK COUNTY
LINN COUNTY

St. Paul
Donald
Aurora
Hubbard
West Woodburn
Woodburn
Gervais
Monitor
Concomly
Waconda
Mt. Angel
Brooks
Hopmere
Quinaby
Scotts Mills
Keizer
Chemawa
Silverton
SALEM
Pratum
Liberty
Independence
Orville
Rosedale
Turner
Sublimity
Aumsville
Talbot
Jefferson
Mehama
Mill City
Gates
Niagara
Detroit
Idanha
Breitenbush

MARION COUNTY

Scale 0 2 4 Mi

April 1962

Marion County Migrant Health Project
Marion County Health Department
Peter J. Batten, M.D., Health Officer
2455 Franzen Street
Salem, Oregon 97301

POPULATION AND HOUSING DATA

FOR MARION COUNTY.

GRANT NUMBER: MG 05G

5. POPULATION DATA - MIGRANTS (*Workers and dependents*)

a. NUMBER OF MIGRANTS BY MONTH

MONTH	TOTAL	IN-MIGRANTS	OUT-MIGRANTS
JAN.	23	23	0
FEB.	40	40	0
MAR.	99	99	0
APRIL	216	200	16
MAY	395	379	16
JUNE	1978	1932	46
JULY	2807	2754	53
AUG.	1401	1356	45
SEPT.	1093	1048	45
OCT.	1091	1046	45
NOV.	1083	1041	42
DEC.	1083	1041	42
TOTALS	3221	3142	79

b. NUMBER OF MIGRANTS DURING PEAK MONTH

	TOTAL	MALE	FEMALE
(1) OUT-MIGRANTS:			
TOTAL	112	55	57
UNDER 1 YEAR			
1 - 4 YEARS	31	15	16
5 - 14 YEARS	35	15	20
15 - 44 YEARS	39	19	20
45 - 64 YEARS	7	6	1
65 AND OLDER	0	0	0
(2) IN-MIGRANTS:			
TOTAL	3130	1587	1543
UNDER 1 YEAR			
1 - 4 YEARS	494	271	223
5 - 14 YEARS	1024	525	499
15 - 44 YEARS	1381	642	739
45 - 64 YEARS	224	145	79
65 AND OLDER	7	4	3

c. AVERAGE STAY OF MIGRANTS IN COUNTY

	NO. OF WEEKS	FROM (MO.)	THROUGH (MO.)
OUT-MIGRANTS	8	June 1969	August 1969
IN-MIGRANTS	6 +	June 1969	August 1969

6. HOUSING ACCOMMODATIONS

a. CAMPS

MAXIMUM CAPACITY	NUMBER	OCCUPANCY (*Peak*)
LESS THAN 10 PERSONS	1	5
10 - 25 PERSONS	31	395
26 - 50 PERSONS	53	1500
51 - 100 PERSONS	43	2200
MORE THAN 100 PERSONS	30	3400
TOTAL*	158	7500

b. OTHER HOUSING ACCOMMODATIONS

LOCATION (*Specify*)	NUMBER	OCCUPANCY (*Peak*)
TOTAL*		

*NOTE: *The combined occupancy totals for "a" and "b" should equal approximately the total peak migrant population for the year.*

REMARKS

Source of information for 5a & 5b: migrant project family rosters

GRANT NUMBER MG 05G MARION COUNTY

DATE SUBMITTED

PART II - MEDICAL, DENTAL, AND HOSPITAL SERVICES

1. MIGRANTS RECEIVING MEDICAL SERVICES

a. TOTAL MIGRANTS RECEIVING MEDICAL SERVICES AT FAMILY HEALTH CLINICS, PHYSICIANS OFFICES, HOSPITAL EMERGENCY ROOMS, ETC.

AGE	NUMBER OF PATIENTS			NUMBER OF VISITS
	TOTAL	MALE	FEMALE	
TOTAL	990	358	632	1372
UNDER 1 YEAR	80			
1-4 YEARS	111			
5-14 YEARS	241			
15-44 YEARS	478			
45-64 YEARS	77			
65 AND OLDER	3			

b. of related nursing visits

c. OF TOTAL MIGRANTS RECEIVING MEDICAL SERVICES, HOW MANY WERE:

(1) SERVED IN FAMILY HEALTH SERVICE CLINIC? 805 migrants 1086 clinic visits

(2) SERVED IN PHYSICIANS' OFFICE, ON FEE-FOR-SERVICE ARRANGEMENT (INCLUDE REFERRALS) 148 migrants 240 total visits

(3) Served in hospital emergency 37 number visits 46

2. MIGRANTS RECEIVING DENTAL SERVICES

ITEM	TOTAL	UNDER 15	15 AND OLDER
a. NO. MIGRANTS EXAMINED-TOTAL	418	315	103
(1) NO. DECAYED, MISSING, FILLED TEETH		209	
(2) AVERAGE DMF PER PERSON		.91	
b. INDIVIDUALS REQUIRING SERVICES-TOTAL	227	146	81
(1) CASES COMPLETED		46	
(2) CASES PARTIALLY COMPLETED		5	
(3) CASES NOT STARTED		95	
c. SERVICES PROVIDED - TOTAL			
(1) PREVENTIVE		315	
(2) CORRECTIVE-TOTAL	109	68	41
(a) Extraction			
(b) Other			
d. PATIENT VISITS - TOTAL			87

3. MIGRANT HOSPITALIZATIONS

SOURCE OF PAYMENT	NO. PTS.	M	F	AGE GROUPING <1	1-4	5-14	15-44	45-64	65+	TOTAL HOSP. DAYS	AVE. HOSP. DAYS	PROJECT HOSPITAL COSTS	DOCTORS FEES PAID	TOTAL HOSPITAL BILLING
MIGRANT FUNDS	70	25	45	12	6	9	35	8		275	4	$9133.80	$3190.50	$19035.24
OTHERS*														

*PAYMENT MADE BY PATIENT, INSURANCE, WELFARE, OR PROVIDED BY UNIVERSITY OF OREGON MEDICAL SCHOOL

4. IMMUNIZATIONS PROVIDED

TYPE	COMPLETED IMMUNIZATIONS, BY AGE: TOTAL	UNDER 1 YEAR	1 - 4	5 - 14	15 AND OLDER	INCOMPLETE SERIES	BOOSTERS, REVACCINATIONS
TOTAL- ALL TYPES	170						
SMALLPOX							
DIPHTHERIA, PERTUSSIS, TETANUS	52	13	7	7	6		19
Polio	45	11	10	9		9	6
MEASLES	7	2	4	1			
TUBERCULIN SKIN TESTS	66	3	7	30	26		

(continued) 3. MEDICAL CONDITIONS TREATED BY PHYSICIANS IN FAMILY CLINICS, HOSPITAL OUTPATIENT DEPARTMENTS, AND PHYSICIANS' OFFICES.

ICD CLASS		DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
XVII.		TOTAL ALL CONDITIONS	1408	979	429
I.		INFECTIVE AND PARASITIC DISEASES: TOTAL	85	60	25
		TUBERCULOSIS	3	1	2
		SYPHILIS			
		GONORRHEA AND OTHER VENEREAL DISEASES	12	10	2
		INTESTINAL PARASITES	16	12	4
		DIARRHEAL DISEASE (infectious or unknown origins):			
		Children under 1 year of age	27	17	10
		All other			
		"CHILDHOOD DISEASES" – mumps, measles, chickenpox	22	18	4
		FUNGUS INFECTIONS OF SKIN (Dermatophytoses)			
		OTHER INFECTIVE DISEASES (Give examples):			
		Zoonotic Bacterial Disease	1		1
		Parasitic Diseases	4	2	2
II.		NEOPLASMS: TOTAL	10	6	4
		MALIGNANT NEOPLASMS (give examples):			
		Malignant of female genital organs	5	2	3
		BENIGN NEOPLASMS	5	4	1
		NEOPLASMS of uncertain nature			
III.		ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES: TOTAL	60	43	17
		DISEASES OF THYROID GLAND			
		DIABETES MELLITUS	31	22	9
		DISEASES of Other Endocrine Glands			
		NUTRITIONAL DEFICIENCY	21	14	7
		OBESITY	7	6	1
		OTHER CONDITIONS	1	1	
IV.		DISEASES OF BLOOD AND BLOOD FORMING ORGANS: TOTAL	7	5	2
		IRON DEFICIENCY ANEMIA	6	4	2
		OTHER CONDITIONS	1	1	
V.		MENTAL DISORDERS: TOTAL	10	6	4
		PSYCHOSES			
		NEUROSES and Personality Disorders	3	1	2
		ALCOHOLISM			
		MENTAL RETARDATION	1	1	
		OTHER CONDITIONS	6	4	2
VI.		DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS: TOTAL	131	102	29
		PERIPHERAL NEURITIS	2	1	1
		EPILEPSY	12	8	4
		CONJUNCTIVITIS and other Eye Infections	21	18	3
		REFRACTIVE ERRORS of Vision	11	9	2
		OTITIS MEDIA	48	37	11
		OTHER CONDITIONS of eye	35	28	7
		Other conditions of ears	2	1	1

PART II - 5. *(Continued)*

ICD CLASS		DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
VII.		DISEASES OF THE CIRCULATORY SYSTEM: TOTAL	17	11	6
		RHEUMATIC FEVER	1	1	
		ARTERIOSCLEROTIC and Degenerative Heart Disease	1	0	1
		CEREBROVASCULAR DISEASE (Stroke)	2	2	0
		OTHER DISEASES of the Heart	6	3	3
		HYPERTENSION	3	3	
		VARICOSE VEINS	2	1	1
		OTHER CONDITIONS	2	1	1
VIII.		DISEASES OF THE RESPIRATORY SYSTEM: TOTAL	246	179	67
		ACUTE NASOPHARYNGITIS (Common Cold)	98	74	24
		ACUTE PHARYNGITIS	43	36	7
		TONSILLITIS	23	18	5
		BRONCHITIS	21	13	8
		TRACHEITIS/LARYNGITIS	2	1	1
		INFLUENZA	19	12	7
		PNEUMONIA	2	2	0
		ASTHMA, HAY FEVER	11	8	3
		CHRONIC LUNG DISEASE (Emphysema)	2	2	0
		OTHER CONDITIONS	25	13	12
IX.		DISEASES OF THE DIGESTIVE SYSTEM. TOTAL	141	90	51
		CARIES and Other Dental Problems	103	74	29
		PEPTIC ULCER	6	4	2
		APPENDICITIS	1	1	0
		HERNIA	8	6	2
		CHOLECYSTIC DISEASE	22	4	18
		OTHER CONDITIONS	1	1	0
X.		DISEASES OF THE GENITOURINARY SYSTEM: TOTAL	55	38	17
		URINARY TRACT INFECTION (Pyelonephritis, Cystitis)	30	17	13
		DISEASES OF PROSTATE GLAND (excluding Carcinoma)			
		OTHER DISEASES of Male Genital Organs	1	0	1
		DISORDERS of Menstruation	17	15	2
		MENOPAUSAL SYMPTOMS	4	3	1
		OTHER DISEASES of Female Genital Organs	3	3	0
		OTHER CONDITIONS			
XI.		COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM: TOTAL	3	1	2
		INFECTIONS of Genitourinary Tract during Pregnancy			
		TOXEMIAS of Pregnancy			
		SPONTANEOUS ABORTION	3	1	2
		REFERRED FOR DELIVERY			
		COMPLICATIONS of the Puerperium			
		OTHER CONDITIONS			
XII.		DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE: TOTAL	129	93	36
		SOFT TISSUE ABSCESS OR CELLULITIS	58	41	17
		IMPETIGO OR OTHER PYODERMA	3	2	1
		SEBORRHEIC DERMATITIS			
		ECZEMA, CONTACT DERMATITIS, OR NEURODERMATITIS			
		ACNE			
		OTHER CONDITIONS	68	50	18

PART II - 5. *(Continued)*

ICD CLASS		DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
XIII.		DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE: TOTAL	10	5	5
		RHEUMATOID ARTHRITIS			
		OSTEOARTHRITIS			
		ARTHRITIS, Unspecified	7	4	3
		OTHER CONDITIONS	3	1	2
XIV.		CONGENITAL ANOMALIES: TOTAL	1	1	0
		CONGENITAL ANOMALIES of Circulatory System			
		OTHER CONDITIONS	1	1	0
XV.		CERTAIN CAUSES OF PERINATAL MORBIDITY AND MORTALITY: TOTAL			
		BIRTH INJURY			
		IMMATURITY			
		OTHER CONDITIONS			
XVI.		SYMPTOMS AND ILL-DEFINED CONDITIONS: TOTAL	197	129	68
		SYMPTOMS OF SENILITY	35	27	8
		BACKACHE			
		OTHER SYMPTOMS REFERRABLE TO LIMBS AND JOINTS	18	6	12
		HEADACHE			
		OTHER CONDITIONS	144	96	48
XVII.		ACCIDENTS, POISONINGS, AND VIOLENCE: TOTAL	306	210	96
		LACERATIONS, ABRASIONS, and Other Soft Tissue Injuries	231	159	72
		BURNS	6	5	1
		FRACTURES	11	5	6
		SPRAINS, STRAINS, DISLOCATIONS	44	31	13
		POISON INGESTION	5	3	2
		OTHER CONDITIONS due to Accidents, Poisoning, or Violence	9	7	2

				NUMBER OF INDIVIDUALS
6.		SPECIAL CONDITIONS AND EXAMINATIONS WITHOUT SICKNESS: TOTAL		449
		FAMILY PLANNING SERVICES	65	
		WELL CHILD CARE	17	
		PRENATAL CARE	38	
		POSTPARTUM CARE	1	
		TUBERCULOSIS: Follow-up of inactive case		
		MEDICAL AND SURGICAL AFTERCARE	9	
		GENERAL PHYSICAL EXAMINATION	37	
		PAPANICOLAOU SMEARS	59	
		TUBERCULIN TESTING	66	
		SEROLOGY SCREENING	101	
		VISION SCREENING	45	
		AUDITORY SCREENING	11	
		SCREENING CHEST X-RAYS		
		GENERAL HEALTH COUNSELLING		
		OTHER SERVICES: *(Specify)*		

CO MG 05G MARION COUNTY

PART III - NURSING SERVICE

TYPE OF SERVICE	NUMBER
RE	
URSING CLINICS:	
a. NUMBER OF CLINICS	
b. NUMBER OF INDIVIDUALS SERVED - TOTAL	
IELD NURSING:	
a. VISITS TO HOUSEHOLDS 832	
b. TOTAL HOUSEHOLDS SERVED approximately 600	
c. TOTAL INDIVIDUALS SERVED IN HOUSEHOLDS 587	
d. VISITS TO SCHOOLS, DAY CARE CENTERS 51	
e. TOTAL INDIVIDUALS SERVED IN SCHOOLS AND DAY CARE CENTERS Approximately 375 56 screenings	
CONTINUITY OF CARE:	
a. REFERRALS MADE FOR MEDICAL CARE: TOTAL 225	
(1) Within Area 173	
(Total Completed 148)	
(2) Out of Area 52 interstate	
(Total Completed)	
b. REFERRALS MADE FOR DENTAL CARE: TOTAL 81	
(Total Completed 58)	
c. REFERRALS RECEIVED FOR MEDICAL OR DENTAL CARE FROM OUT OF AREA: TOTAL 5	
(Total Completed 5)	
d. FOLLOW-UP SERVICES FOR MIGRANTS, not originally referred by project, WHO WERE TREATED IN PHYSICIANS' OFFICES (Fee-for-Service) 37	
e. MIGRANTS PROVIDED PRE-DISCHARGE PLANNING AND POST-HOSPITAL SERVICES Approximately 40	
f. MIGRANTS ASKED TO PRESENT HEALTH RECORD Form PMS-3652 or Similar Form) IN FIELD OR CLINIC: TOTAL Over 1000	
(1) Number presenting health record. 407 rosters Field visits 36	
(2) Number given health record. 886 391	
(3) Didn't have 224	
OTHER ACTIVITIES *(Specify)*:	

REMARKS

PART IV - SANITATION SERVICES

TABLE A. SURVEY OF HOUSING ACCOMMODATIONS

HOUSING ACCOMMODATIONS	TOTAL		COVERED BY PERMITS	
	NUMBER	MAXIMUM CAPACITY	NUMBER	MAXIMUM CAPACITY
CAMPS	158	9500		
OTHER LOCATIONS				
HOUSING UNITS - Family:				
IN CAMPS	1638	8170		
IN OTHER LOCATIONS				
HOUSING UNITS - Single				
IN CAMPS	276	1330		
IN OTHER LOCATIONS				

TABLE B. INSPECTION OF LIVING AND WORKING ENVIRONMENT OF MIGRANTS

ITEM	NUMBER OF LOCATIONS INSPECTED*		TOTAL NUMBER OF INSPECTIONS		NUMBER OF DEFECTS FOUND		NUMBER OF CORRECTIONS MADE	
	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER
LIVING ENVIRONMENT:								
a. WATER	158		616		22		6	
b. SEWAGE	158		616		113		89	
c. GARBAGE AND REFUSE	158		616		209		177	
d. HOUSING	158		616		69		51	
e. SAFETY	-		-		-		-	
f. FOOD HANDLING	-		-		-		-	
g. INSECTS AND RODENTS	158		616		11		6	
h. RECREATIONAL FACILITIES	--		-		-		-	
WORKING ENVIRONMENT:								
a. WATER	xxxx		xxxx		xxxx		xxxx	
b. TOILET FACILITIES	xxxx		xxxx		xxxx		xxxx	
c. OTHER	xxxx		xxxx		xxxx		xxxx	

* *Locations — camps or other locations where migrants work or are housed.*

PART V – HEALTH EDUCATION SERVICES *(By type of service, personnel involved, and number of sessions.)*

TYPE OF HEALTH EDUCATION SERVICE	NUMBER OF SESSIONS					
	HEALTH EDUCATION STAFF	PHYSICIANS	NURSES	SANITARIANS	AIDES (other than Health Ed.)	OTHER (Spec
A. SERVICES TO MIGRANTS:			PHN Aide			
(1) Individual counselling			592			
(2) Group counselling			16	14	18	
B. SERVICES TO OTHER PROJECT STAFF						
(1) Consultation			5	10	10	
(2) Direct services						
C. SERVICES TO GROWERS:						
(1) Individual counselling				125		
(2) Group counselling						
D. SERVICES TO OTHER AGENCIES OR ORGANIZATIONS:						
(1) Consultation with individuals						
(2) Consultation with groups						
(3) Direct services						
E. HEALTH EDUCATION MEETINGS			10	25	11	

Marion County
MG 05G

GENERAL INFORMATION

Marion County is located in the heart of the Willamette Valley of Western Oregon, midway between the Pacific coastline and the Cascade Mountains. Its politics are conservative and the largest single employer is the State of Oregon; although with farm marketings of $52 million dollars (the highest in Oregon) the economy is grounded in agriculturally related industry. Marion County administers a county health department, including a mental health unit, and a home health agency. The health department serves just under 1200 square miles and a population of 153,255 - up nearly 4,000 since the migrant project report of fall, 1968. During our peak migrant season an estimated 8,000 to 10,000 migratory workers help with the harvest of the area's major crops: strawberries, sweet cherries, and snap beans.

This report will cover a twelve month period from September 1, 1968 to September 1, 1969, however, our peak season extends from early June through August. This is the fifth consecutive season in which a specially funded migrant health project has been operating in our county.

Our overall goal is to assist the migrant farm worker to achieve a better state of health, while assisting our total community to upgrade the health and safety of the migrant's local environment.

Objectives for this 1969 year and past two years were:

1. To provide comprehensive medical care through:
    a. Local physicians in their offices.
    b. Neighborhood evening clinics staffed with physicians and nurses, including on-site laboratory services.
    c. Reimbursement of hospital and physicians for inpatient care.
    d. Distribution of, and reimbursement to pharmacists for, drugs ordered by a physician.
2. To provide emergency dental services through local dentists in their offices.
3. To provide generalized public health nursing services.
4. To provide generalized sanitation services.
5. To provide consultation services to growers and camp operators, in order to better obtain compliance with the law.
6. To provide consultation and information to other persons and agencies regarding health-related problems of the migrants.
7. To provide health education to migrants, their families and employers.

The changes from preceding project periods have been in depth of service or quality of care. We have:

1. Tried to improve the comprehensiveness of medical care, including hospital followup.
2. Moved further toward the prevention of disease, both medical and dental.
3. More effectively reached the migrant with public health nursing and sanitation by involvement of the migrants themselves.
4. Expanded consultation to growers and other involved with migrant workers, and actively assisted in coordination of services.
5. Evaluated health education functions and sought most effective methods.

The most significant change in the migrant population this crop season is in the total number estimated to be in our county. Our migrants tell us that last year's short season made many of their friends go elsewhere this year. It is difficult to validate this, although we have used several sources of information:

a. Our health screening records or family rosters,
b. Our sanitarians' estimates of living unit occupancy from visit to visit (counting six persons per unit), and
c. Bureau of labor estimates.

Marion County
MG 050

Many farm workers have settled in our county and no longer meet the definition of migrant as applied to this project. Others are now counted as out-migrants, with Marion County as home base. We have no accurate estimate of either group. They often are indeed the rural and city poor, often still unskilled and poorly equipped for year-round jobs in our county.

Our sanitarians feel again this year from observation, that the age distribution is similar to the general population, except in the teen-age group. Since our age breakdowns for statistical purposes have been 5-14 and 15-44, we have no readily available data from our one accurate source: our family roster records. We plan to add an age group from 15-20 during the next season. Another possibly significant change in our migrant population is in area of cultural background.

	1968	1969
Mexican-American	65%	59%
Anglo	30%	42%
Negro	5%	2%
Indian	-	1%

Mild spring weather this year produced record crops, especially in the tree fruits and berries. An all-time record sweet cherry crop brought out-standing prospects, only to be dashed by one week of solid rain and a second of drizzle. The heavy rain kept pickers from harvesting the ripe fruit which quickly split and was unmarketable. The strawberry crop faced a similar premature finale. The total yield was average to good for both crops, but one reason many migrants stay eight or more weeks in the Willamette Valley is that these early summer crops often run into the bean harvest with the cane berries providing a source of income between. The premature finish of strawberries and cherries and a somewhat late start for beans meant that many migrants were without income for three or more weeks. This is a critical time when migrants seek help not only for medical needs but for food, clothing, and transportation. This year seemed particularly difficult for many.

Although there has been prediction of increased mechanization in our harvesting for the last five or more years, the type of labor needed hasn't appreciably changed. For instance in 1966 Farm Bureau records show 27.7 thousand acres in pole beans, in 1967 29.6 thousand acres, and in 1968 30.5 thousand acres for the state.

This factor must be considered as we project future needs. Marion County will continue to employ farm workers. They may be employed in somewhat differing ways and their number somewhat reduced, but our economy is agricultural and production of quality table foods will continue in the Willamette Valley unless the land use is converted to residential. Emphasis on settling of migrants for the education, medical and social benefits continues, but this alone will not solve the many problems. Must we expand our definition so as not to discriminate against the migrant who has "left the stream"?

This year we made a greater effort to involve the migrant in program planning. The most successful example of this was in our health education component. (See health education section) We worked closely with the Valley Migrant League in its three major centers in the county. Selected migrants and crew leaders helped us in gauging the numbers likely to seek help from our in-medical clinics, and especially as the peak usage approached and again as the families moved on.

Specific planning was done with many growers early in the spring, both by sanitation and nursing personnel. A letter describing services and how obtained was mailed to all growers in May. They assisted us in many ways (follow-up, locating families, delivering messages regarding medical care, and occasionally helped arrange transportation).

Our home extension agents were involved in orienting our aides to food storage and cooking in a migrant camp - particularly with no refrigeration; demonstrating the use of abundant food items for maximum food value as well as for truly tasty meals. They also provided consultation in our health education programs.

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The change in residency requirements for welfare assistance was felt during our peak migrant season this year. Our communication with this agency is good and there were many referrals between the welfare and health departments. The greatest problems encountered were obtaining medical care for ex-migrants on marginal income settled in our community, and with no medical resource. A case history to this point is included at the end of part II. (Medical Services)

Many individuals and groups have contributed to the implementation of our health project. The Valley Migrant League has been mentioned previously. They were often a referral "clearing house", an interpreter, an emergency food or clothing resource, a place where a migrant went with a problem. The Migrant Ministry through our Council of Churches operated a day care center for children of migrant workers. Our doctor, dentist, pharmacists and hospital administrators were involved in planning this spring. Letters went to each doctor and dentist and discussions were planned with the in-medical and dental society. Our regular Health Department Citizens Volunteer Committees donated many hours of service in clinics, assistance with transportation and public relations.

Actual financial assistance not significant. Many resources available to the resident - such as our Lion's Clubs for assistance with eye examinations and glasses - are closed to the migrant. An outstanding exception to this was the summer migrant schools' financial contribution to the dental care needs of many children. A side benefit to the health department has been the schools' increased awareness of dental health - treatment and most effective means of preventing dental illness.

STAFF ORIENTATION AND TRAINING

Written guides from the State Board of Health were available for public health nurses. Similar guides were made last season for our community aides.

A planned orientation and practice session for all public health nursing staff in the early spring helped make continuity of care more realistic.

A workshop sponsored by Oregon State Board of Health in mid-May gave an excellent background of the program. At the workshop the public health nurses tried to draw up specific guides on how to collect data uniformly, how to code symptoms, etc. Consultation and assistance was readily available from our Migrant Health Section.

A second workshop at peak of season was helpful in exchanging ideas, but the press of need for follow-up from clinics made it difficult to place priority on this kind of exchange.

Our nursing service efforts were organized in a team approach. This proved to be an excellent way to use new and inexperienced nursing personnel and keep the aides close to their teammates and the families for whom they held responsibility.

Regular weekly staff meetings were held and included all project personnel. These served to further orient staff and were often a form of inservice training. Health education activities were planned at this time; we made a concerted effort to anticipate the migrant population and resultant clinic staffing needs. Our Mexican-American aides were invaluable and we sought their ideas in all aspects of the project.

Several inservice meetings were planned for the aides with community agencies and regarding medical conditions. They assisted in planning the weekly health education programs; gaining knowledge and developing skills in this area.

Our clerical staff was involved in the planning and organizing of our record keeping procedures. Changes in personnel in mid-season created some problems in continuity. We hope to develop a clerical manual for next season.

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GENERAL APPRAISAL OF 1969 ACTIVITIES

The depth of service and quality of care for migrant families can be better demonstrated this year, thus measuring the degree to which our objectives were met.

Documentation is included in the medical and dental services section and the nursing services section which shows:

a. An accurate DMF measure of the dental care needs of children attending the migrant summer schools.
b. An increase in number of repeat visits to doctor and dentists.
c. An increase in number of repeat clinic visits.
d. An increase in follow-up at clinics of patients seen at our hospitals both on in-patient and out-patient basis.
e. An increase in number of revisits to patients by nursing staff.
f. Laboratory services were readily available.

Though not so readily documented it was the feeling of the staff that our clinic services were delivered this year with less wait by the migrant and with more continuity of care and better communication with the clinic staff.

One of the strongest points in this general appraisal is that our aides (Mexican-Anglo) were excellent, and their selection is vital. Careful recruitment is essential. Our first aide was not hired until June 1st and the second on June 16. Two other aides joined the staff then also making group orientation possible before the peak season demand for services.

Our most constant frustration was and is in record keeping and the collection of meaningful statistics. We must avoid duplication, yet our figures at the end of a given period must be reliable.

The written orientation for aides was helpful, but the use of untrained persons means that all can't do the same things. Flexibility is the key in making the best use of persons from the migrant population and demands ingenuity on the part of the team.

Communications with hospital staff have been improved. Planning is needed to improve communications with doctor's office managers. We continue to seek ways to screen for tuberculosis and encourage immunizations.

We continue to have transportation problems. Even though we don't have huge numbers of migrants brought to the area in buses or trucks, we still find transportation to a far distant medical resource a problem.

GENERAL DESCRIPTION OF HEALTH EDUCATION SERVICES

Health education services were provided at medical clinics and in migrant camps during 1969 by both nursing and sanitation staff. Films were shown and group discussions were conducted involving migrants who were waiting for medical services. Cooking demonstrations using abundant foods were conducted during one clinic and at two camps. These sessions directly involved occupants of the camps and utilized their own homes and cooking facilities. In both clinic and camp situations, migrant involvement was stressed and sincere attempts were made to find out what subjects the people were interested in.

A. Specific methods used

1. Presentation of health education subjects of immediate concern to Marion County migrants.
2. Correlation of education materials presented with problems encountered during camp inspections.
3. Development of attractive presentations designed to increase acceptance of materials and staff members by the migrants.
4. Presentations geared to the language and customs of the migrants involved.

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5. Involvement of the migrants in the planning and presentation of demonstrations and programs.

B. Staff

Most of the presentations were made by nursing and sanitation aides with assistance from nurses and the project sanitarian. Initial planning was very general with specific needs being identified as the season went along. Weekly migrant staff meetings were held with all staff members participating. Future direction and needs were determined at these meetings. Migrants were involved in planning to the extent that materials to be used and subjects to be covered were determined by their desires as often as possible. They also took part in evaluating the different programs.

C. Consultation

Valuable information and support was immediately available from the Migrant Section of the Oregon State Board of Health. Health education personnel provided ideas on how best to approach the people. This service was invaluable due to the fact that no full time health education personnel were available. Our staff was aware of problems which required migrant cooperation and education was felt to be necessary. The methods of approach or stimulation of staff ideas were provided to a great extent by consultation received.

NEEDS AND PROBLEMS

Initial planning was conducted during meetings of the total migrant staff. Sanitation problems related to medical situations were the primary stimulus for our activities. Priority was given to convincing the migrants that certain habits related to living in unsanitary camps had a direct connection with their personal medical problems.

Language, acceptance of our efforts by the migrants, and contact with a significant part of the migrant population were the principal problems encountered.

Organized presentations were provided at eighteen sessions. Two sessions were held in migrant camps and sixteen at medical clinics. Approximately 650 people attended sessions at which about 80 films were shown. Clinic sessions lasted an average of 2½ hours. Camp sessions were used to conduct food preparation demonstrations using abundant foods. These demonstrations were very successful for two reasons. A very enthusiastic ADC mother conducted the demonstrations. Her vast experience with different methods of preparing these foods stimulated a great amount of interest. The subject being presented was of considerable interest to the people and was well accepted by women in the camps. Several women were first invited to come to a demonstration. Following this, they were able to help organize it in their own camp. This aspect has favorable side effects as shown in this case study.

Mrs. A. had moved into the camp early in the year. Her family had numerous small medical problems and she had many complaints of illness - most seemed related to tension and anxiety. After much "coaxing" she attended a cooking demonstration in a distant clinic. She found it to be helpful and was anxious to share the information with others. She was instrumental in arranging a similar program in her own camp. The program went well, but more significant for Mrs. A. was the fact that with a purpose and meaningful activity her complaints subsided and she felt well for the first time in ages.

We had attempted to identify migrant women known as good cooks to be our "leaders" since the subject was foods. We had some success, but found many obstacles:

1. Many of the women also worked in the field and growers had indicated their bonus would be paid only if they worked every day. This problem was not solved with growers due to press of time and other duties. We feel it would be readily solved in most cases.
2. We were often asking a mother to forfeit her earnings for the day. We felt in some cases a token payment at least would have solved the problem.

3. Several women were too shy or afraid to come into the courthouse where an initial demonstration was held. They were enthusiastic until they thought of going into what was also the jail and "big official building."

In general our health education effort got better as the season progressed. We were hampered by lack of personnel to assume responsibility for program planning, etc. The nurse and sanitarian had regular full-time assignments and our aides did not have the necessary background. Language was a real problem in one area and our Spanish speaking aides were necessarily involved in the medical aspects of the clinic. We tried to find some migrant teenage boys who could help, but had no luck. Our sanitarian aides were young college students and we felt the communication was good. We will retain this as a specific objective for next season.

The clinics were staffed by licensed physicians, 2-3 public health nurses, a registered nurse, community aides, and volunteer assistants from the community.

A migrant was likely to know of our clinics from an information sheet in his cabin, a 12" x 18" wooden sign in his camp, from his neighbors, camp boss, grower, community aide in the area, or the public health nurse. When he arrived at the school serving now as a medical clinic, he was seen first by our community aide or a volunteer who determined which members of his family wished to be seen. A check was made for records - this year's or ones from previous years containing medical history information. He was then asked to complete a medical history using the bilingual health form if he or family member to be seen had not previously done so. This is a lengthy form and although many areas chose not to use it, we attempted to make it meaningful by spending the time with the migrant to help interpret the questions or re-phrase them for a more accurate answer. We feel it was a good use of time except the migrant may deny a prior condition if he feels pressed for time, or chooses to, or forgets. Our community aides - Spanish speaking when indicated - gave assistance in this area as well as filling out the family roster. At this point the person's health card was discussed and he was given a number card to insure his being seen in turn.

After registration, the family was interviewed by a public health nurse and a brief description of the problem was written down for the physician. Based on symptoms discussed or observed, lab work might be requested, B/P taken, and height, weight and T.P.R. recorded. Waiting time was spent in a classroom where we had health education on-going throughout the evening. Both the health education and laboratory components of our evening clinics are discussed in detail in a later section of this report.

The medical care provided equated that of a general practice office including some minor surgery such as suturing small lacerations. In the south County, a family planning clinic functioned also, and although it was planned for one night per week, it expanded to be a regular clinic service as patients' needs demonstrated the importance of this. Limited family planning was provided in the Woodburn Clinic also. The main resource for these families, however was our county-wide family planning clinic at the health department office in Salem.

A second public health nurse was present in the doctor's office to make arrangements for any further treatment or evaluation and assist the physician as necessary. A post-exam interview was done when indicated. Our doctors could prescribe from medicines on hand (formulary attached) or use prescription blanks authorizing payment by the Migrant Drug Fund. In each clinic location arrangements were made with a nearby drug store to remain open during the clinic hours, although the prescription could be taken to any drugstore. Several times a call was made asking the druggist to please wait for a family who was on its way or would be there shortly.

The migrant probably spent 60 to 90 minutes in the clinic per visit. His total time was greatly influenced by the nature of his problem, need for lab work - or kind of lab test necessary, his personal interest in the health education program of the evening, and by the time he arrived at the clinic. We were concerned about this and will continue efforts to

keep this waiting time to a minimum.

If any of the migrant family were asked to return to clinic, the registration routine and interviewing time was much shorter. They usually saw the same physician and might see a film they had requested the week or two before.

Migrants prefering private care or needing care when a clinic was not available were given a referral slip by a public health nurse. Payment is not always the biggest problem, helping a migrant find a physician who could see him in his office was often a time consuming task. Often the only resource was to direct him to the hospital emergency rooms even though the symptoms shown were not of a medically emergent nature. The consolidation of Salem's two general hospitals may provide a partial solution to this difficult situation. Only one hospital will be handling emergencies in the future and will be staffed with a resident physician. Currently no physicians hold evening office hours and this does not seem likely in the near future.

The arrangements for phasing our migrant medical clinics in and out are to utilize the private physician as the demand for service indicates. This is frustrating in that early in the season many doctors seem to vacation, then when close to schools' opening, they are extra busy with the many entrance exams needed by students of all ages.

Currently Title XIX funds in our State are limited to those individuals who are receiving assistance under categorical grants from our public welfare department. Occasionally a child arriving in our community early enough in the spring may be enrolled in a Headstart Program and have medical and dental needs covered.

Health education on the one to one basis is the most widely used method and likely the most effective. A great deal of this occurred during clinic sessions since we were staffed to allow the public health nurse to spend this time with the patients. Group health education is discussed at length in that section of this report.

The statistical data in Part II of this report shows that most of the migrants receiving medical services were seen in our evening medical clinics. Nearly twice as many women were seen as men. Many of the problems treated were of an acute nature such as respiratory infection, injuries, and skin conditions. During our peak season we used the ICD codes but not the MH code requested in the report. We have adapted our data to the MH code as nearly as possible. In the last section (number 6) special conditions and examinations without sickness, our collection of data did not indicate if certain of these were done as part of medical service or as nursing service.

Although data from previous years is in a different format some comparisons are possible. Approximately 150 more medical visits were recorded this year. Fewer visits were made to the local hospital emergency rooms and private physicians offices and more were made in our evening clinics. Twice as many family planning medical services were provided. We feel the distribution of diagnosis is similar to previous years.

We have received the medical consultation needed primarily from our local medical society, our local hospitals, and the Oregon State Board of Health.

In general, we feel that the medical care received in Marion this year has been more comprehensive and that this has greatly strengthened our project. Probably our greatest weakness has been in making a system of tabulation work so this evaluation could be honest and reliable. Change of personnel and the numerous forms involved in the total project made it most difficult to itemize services in the many ways requested.

CHANGES IN FUTURE

Some migrants still may not be aware of how to get medical help. This presents a problem in the focus of our publicity because our county has many people in need of medical care who are poor, and who are farm laborers. With the encouragement from all sources to settle,

the migrant is faced with an even more difficult time finding care. A perfect case in point is that of Mrs. S. She and her family have been migrants but decided to settle in Salem. They have moved but not out of Marion County for three years now. They have received a little help from welfare on several occasions, but have been largely independent. She became ill and had no money for medical care. The public health nurse arranged a medical exam for her and the doctor felt that she should be evaluated for possible thyroid surgery. Our chief resource in this instance is our state medical school in Portland. They were unable to see her for six weeks and the referring doctor felt it must be done sooner. She developed emotional symptoms in character with her disease and felt she would die. She was unable to care for her husband and children. The public health nurse discussed the problem with our welfare department without a firm committal to pay for possible surgery; however, the internist associated with the referring doctor agreed to see her and write a letter to welfare describing her condition. Mrs. S. became more and more emotionally disturbed and couldn't talk directly with either physician because of language barriers. Eventually, due to the persistence and interest of the public health nurse, she was seen and begun on a medical regime rather than surgical which gradually began to control her symptoms and her anxiety slowly is subsiding. After all the delay and increased anxiety, surgery was deemed unnecessary as she responded favorably to medical treatment.

DENTAL PROGRAM

This year for the first time the health department and the schools cooperated with the University of Oregon Dental School in a program to provide additional dental care for migrant children attending summer schools.

Students at the University of Oregon Dental School with their faculty members evaluated the dental needs of students in five Marion County schools. The dental needs were classified from 1-4, classification four denoting the most urgent needs.

Arrangements were made with local dentists to treat the students needing care, starting with the most urgent and continuing as long as funds lasted. A detailed report of the number of students evaluated and types of treatment given is included for four of these schools. In some instances dental funds from the health department were used to supplement the school funds.

In the north end of the county, the public health nurse served as coordinator between schools and the dentists. She assisted in arranging appointments and instructing schools in getting permission slips and medical history from the parents of the children needing care. The school aides provided transportation often deciding which student kept a set appointment by the school attendance that day. Because one migrant school was held in the evening, the dentist arranged special office hours to accommodate these children. Thus, with careful planning the number of broken appointments was kept to a minimum. A real effort was made to arrange for parents to accompany their children to at least the initial visit with the dentist. The one dentist doing the bulk of the work was continually aware of the need for preventing traumatic experiences with dental care which might keep a child away from a dentist in years to come. The dental students instructed the children in proper dental care and applied topical fluorides. All children were provided with toothbrushes. The public health nurse was involved in making arrangements with the schools for the demonstrations and working with principals on notices sent to the parents.

During a camp visit several migrant children were proudly showing the public health nurse their dental work. When questioned about the proper method of teeth brushing they were able to explain this quite well, not only with words but by use of finger as a pretend toothbrush. During another camp visit the children did extremely well in identifying the foods good for teeth and the concept of detergent foods as nature's toothbrush. Follow-up of these same children next summer to determine their brushing and dental care needs would be an important aspect of this program.

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Adult migrants and non-school children with dental problems were referred by public health nurses for urgent dental work. A total of 81 patients were referred and of this number 63 received some treatment.

These statistics combined with the screening of children in school certainly document the need for dental care in our migrant population. This has been observed previously and our dental budget was increased this year by 100 percent. Even so this seems to be a small budget in relation to the apparent needs.

Due to the higher school enrollment in the northern area of our county more children were identified for treatment than in the southern area, where the migrant population is greater, the work season shorter, and the school enrollment smaller.

The school program identified 51 students with urgent dental care needs. Forty-six students received complete treatment and an additional five received partial care. Combining these figures we were able to provide dental care to 114 migrants this year.

Of the 23 people who needed emergency service but never received treatment we noted that over 75 percent were in our south county where the dentists feel hard pressed to serve even the resident population. The schools in the area found it necessary to seek dental care out of the community. We can only speculate that many of the migrants urgently in need of dental care may not find it locally even though they carried a referral slip to authorize payment. It is approximately 20 miles from the major concentration of migrant camps into Salem where some of the newer dentists in town were able to see patients quite readily during the daytime hours.

Dental treatment available in our evening clinics would be well used. A dentist arranging evening hours in the area would also be well used. Whether or not a dentist available 20 miles away would be kept busy is a question we hope to explore next season.

HOSPITAL SERVICES

A total of six hospitals were contracted to give both in-patient and out-patient service in the Marion County Migrant Project. Early in the migrant season, meetings were set up with representatives from each hospital and representatives from the project. An explanation of the project and the billing process were discussed. The system was continued whereby the hospitals assumed the responsibility for notifying (within 48 hours) the project staff of the admission of a migrant. During peak season the project migrant clerk called the various hospitals daily at specified times and talked with designated persons to determine migrants using hospital services. The public health nurse coordinator would then go to the hospital to verify the migrant's status as specified by the federal project definition. Attempts were made to do predischarge planning at this time.

There were very few problems with the pre-discharge and follow-up planning. The main problem seemed to be getting to the patient for verification before he left the hospital or the area. This is a difficult problem to solve, because of the mobility of these people. On the whole better follow-up was possible this year, because of the hospital coordinator. We were able to verify patients much more rapidly and accurately and "lost" a smaller number.

A total of 55 patients received in-patient services from the participating hospitals throughout the migrant season. Out-patient service was given to 34 patients in our participating hospitals. There were two accident victims hospitalized in Portland. Some migrants went to Multnomah County Hospital for delivery. They have been unable to give us the number of patients cared for in their hospital because this information is not recorded for ready recall. Almost one third of those in the local area were obstetrical patients. This fact points out the need for emphasis on maternal and child health services. An exploration of the value and use of prenatal and infant care classes should be undertaken next year.

Closely allied with the need for maternity services were the Family Planning Clinics. Family Planning Clinics were held once a week at one clinic site. Family planning clinic sessions averaged four patients. Each patient was counseled by the public health nurse regarding the various devices. The fathers were urged to attend, but this was not mandatory. A few fathers did attend. Following the patient's discussion with the nurse, she was seen by the doctor. A physical exam and Pap smear were done. The method the doctor and patient agreed on was prescribed by the doctor. A follow-up interview with the nurse was next to make sure the patient had no further questions.

The Pap smear tests were all Class I or II except three. Two were class 3+ and one class 4+. Of the two 3+ one left the area and an interstate referral was sent in an attempt to find her. The second patient was given her report before leaving the area with instructions to contact her family physician soon. The third patient was seen by a local physician with cancer diagnosed as in-situ. Surgery was performed on August 26th - just three weeks after the initial Pap test was done.

There was much diversification of conditions and age with our in-patient hospital care. There were three appendectomies some GI problems, several respiratory problems, and some skin problems.

Out-patients were cared for in the emergency rooms of the participating hospitals and in the local doctors' offices. There were 37 out-patients cared for in the emergency room with diagnosis ranging from broken bones and lacerations to measles and emphysema.

Most of the hospital patients were referred to the migrant medical clinic in their area for follow-up care on discharge. Over half of them were seen at least once at the evening medical clinics as well as by the project nurse. The Santiam area hospital felt a definite decrease in patients using their emergency room this year. This decrease probably was due to a lower migrant population and to the increase in the patients that were seen in Salem. It was stated by the nursing service director at the Santiam area hospital that the migrant evening clinics were greatly reducing the previous overload.

There were some migrant families who received some financial help from welfare for their medical care. (One family who was under welfare care in another state was unable to receive help because the welfare department did not help beyond a 50 mile radius.) Some migrants receive assistance under Crippled Children's Division. One is being followed in the Rubella follow-up clinic. One migrant family had insurance that covered their emergency room care. Attempts were made to help the migrant see his need for assuming responsibility for his medical care and medicines. In most instances these people were unable to assume this load. Arrangements for obtaining care were generally made by the project public health nurses.

The main problem with these people will always be their high rate of mobility. The evening medical clinics made case-finding and case follow-up more effective. Continued emphasis on maternal and child health services is a must with special emphasis on family planning, prenatal and post-natal care. Increased personnel could aid in earlier case-finding and more adequate follow-up. Through increased emphasis on health education we hope to decrease the number of acute cases needing treatment each year. Additional personnel should include a health educator.

The total project was aided in consultation by the medical doctors, hospital administrators, dentists, State Board of Health project consultants regarding the in-patient hospitalization, dental program, and health education programs to name a few. Early determination of the types of statistics needed would be most helpful in order for the projects to obtain more accurate workable statistics.

NURSING SERVICES

In harmony with the project objectives the nursing services were focused on comprehensive care. One objective we held to tenaciously was a thorough screening of all Marion County's

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160 labor camps - to try and acquaint the migrants with medical care resources in the area, and to encourage medical care early in an illness. We also hoped to concentrate on maternal child health care including prenatal, care of the newborn and family planning information.

Our staffing pattern changed this year as we moved to a team approach. As noted in previous sections our County divides somewhat naturally into two areas - North and South. The migrants are different in these areas - in length of stay, in ethnic background and in sheer numbers. The experienced public health nurse in each area acted as team leader and held responsibility for the evening clinics, follow-up, continued camp screening, and communications with the local community.

The total nursing staff had opportunity to offer service to migrants from September 1968 to May 1969 and the time spent was equal to or greater than two full time public health nurses. As our peak season approached we added staff as follows: project supervisor, three public health nurses, and four community aides on a full time basis from June to September. Two registered nurses were employed on a part-time basis and assisted with each evening clinic. A total of 62 volunteers assisted in our evening clinics.

In addition to weekly staff meetings, each team met briefly following each clinic to plan for follow-up services. The aides met for planned individual conferences with the project supervisor on at least two occasions and frequently on a less formal basis. The close working relationship of the team seemed to increase their confidence and help them identify their roles in a comfortable manner. The director of nursing and nursing supervisor met with the staff and migrant project supervisor regularly to insure good communications and continually evaluate our nursing service.

On a planned basis the nurses visited the Day Care Center, schools and Valley Migrant League office to further encourage communication and coordination of services.

Consultation was received primarily from the Oregon State Board of Health. Much related to record keeping and statistics gathering procedures. The rest was primarily related to continuity of patient care, for example, in planning for the discharge of a prematurely born infant who was still known to experience respiratory distress, we received consultation as to the best route for the family to take back to Texas so that medical help would be accessible.

We called upon our medical staff and migrant helpers in seeking consultation regarding specific medical problems. The combination of local resources and State Board of Health provided excellent consultation and most of our needs were met. We hope to continue to learn the customs and characteristics of our migrant population - both Spanish speaking and Anglo.

SERVICES PROVIDED TO MIGRANTS

Our general system for providing nursing services to migrants and families is through home visit, medical care clinics, Well Child Conferences, field visits to camps, schools and day care centers. Policies and procedures for these activities in our generalized nursing service as well as specifically for the migrant project are compiled in a manual; kept up to date in this case by a committee concerned year-round with migrant health. Each nurse has standing orders from our health officer approved by the local Medical Society.

In addition to the description of nursing service at our evening medical clinics contained in the Medical Services Section of this report, we offered a nursing clinic to the migrant families. A number of patients had an examination and conference with the nurse and were not necessarily seen by the doctor. We plan to keep an accurate count of this service next year because we feel it is an extremely valuable adjunct to home visits, field visits, etc.

Migrant families were seen throughout the year in well child, venereal disease, chest, and family planning clinics within the context of services provided to the total community.

Many of our out-migrants use these clinics and although a family is basically resident to our County it still moves to another state or area for a harvest season. It has been difficult to determine in many cases if a family is migrant by project definition or not. This means detailed interviewing regarding migrant status.

Our nursing philosopy is to help patients help themselves to better health. The following case histories describe families seen in camps, fields, schools, day care centers, clinics and combinations of all locations.

A middle-age, obese lady with severe pyorrhea was found in a camp by our aides. Along with this chronic problem, upper respiratory infections became a prevalent complaint. She was also identified in the family planning clinic for metrorrhagia and placed under treatment. Finally, arrangements were made by the end of the summer for a complete extraction of her teeth and denture replacement. Happily the patient saw the need for this treatment and was able to arrange for making payments on the majority of her bill.

Another interesting family included an Indian man with a broken hand who was tossing his knife against the wall because of the "meddling neighbors who send people to investigate us." His wife had a severe case of psoriasis, which the other migrants feared as being communicable. The public health nurse visited the family. Her action included listening, encouragement to the husband in having his fractured hand recast, and giving a referral for a doctor's diagnosis and treatment of the wife's skin condition. By the end of the visit, the family accepted the nurse's suggestions and went under the care of a private medical doctor.

Home calls were made to expectant mothers. One young mother was placed under the care of a private medical doctor for follow-up as she had been bleeding for several weeks. To further complicate matters she seemed emotionally upset. Several more visits were made in which the nurse allowed her to express her feelings towards her estranged husband, parents and the unwanted pregnancy. During this time, the need for medical care was stressed as well as dietary needs. An interstate referral was made to Alabama when she left Oregon.

We have had our multicatastrophe families as usual. One that comes quickly to mind contains a father with heart, lung, drinking, financial, and mental problems; a mother with mental, gynecological, and urinary complaints; children with recurrent upper respiratory infections and skin infections; a young brother who stole the family car; and a teenage friend who was without a stable family of his own. This acquired member of the household also had physical problems - recurrent skin infections, upper respiratory infections, increased size of lymph nodes and low white blood cell count. This young fellow finally left this area and went to California in search of his father. We had been able to contact his mother through welfare, public health, or the Juvenile Department in Phoenix for permission for a lymph node biopsy. This family has set up a permanent residence in Marion County. We have had continual follow-up as the father is disabled. They are currently receiving assistance from welfare, our well child clinic and in the school health program.

Some other nursing service given in the home has included injections of hypertetanus for persons with puncture wounds. These referrals were from the migrant medical clinics. (They had never had immunizations.) Other injections such as intramuscular penicillin, B12, and estrogen were given. Temperatures, both rectal and oral, were quite common procedures on young children especially with upper respiratory infections. This time was excellent for demonstrating procedures for the education of parents and children. For example, while a nurse was changing a dressing on a two-year-old girl in camp, a small crowd of children formed to watch. The nurse stressed the importance of handwashing and cleansing cuts with soap, scrubbing, and good rinse procedures with water. Phisohex was given to the family, too. Individual health education such as the above is a major emphasis in our project. The group methods are discussed later.

We have well defined channels for obtaining medical-dental and other care in our county and the surrounding area. Our plan for sending and receiving out-of-state referrals is also well defined. Shortage of available medical personnel in the area has been mentioned

previously, and even though the nurses knew and followed appropriate channels this may account for some of our incomplete local referrals. In addition we know that as was stated in Health is a Community Affair,* "persons with little education and low income, sometimes hampered by barriers of language, are too often apprehensive, confused, and overwhelmed by scattered facilities and the impersonal and institutionalized services with which they are frequently confronted." We sincerely hope that through our contacts with these people in their homes they will become comfortable with us and can ask for help before a crisis arises. Personal contact will increase trust and make communications more reliable.

The statistical data in Part III of the report shows that over 3,200 migrants were screened this year for health problems. This is approximately 500 more than in 1968. This figure is from our family roster forms and since we worked first with families presenting health problems, and then screened "well" families, many "well" families were not identified by roster. In actuality an estimated 4,500 migrants were personally contacted regarding health services.

The 225 referrals made for medical care were those in addition to our evening clinic services. The number referred for further care after a clinic visit is not available.

Many informal referrals and referrals sent to all Oregon Counties were received. However, the five written referrals for families known to be moving to Marion County are listed. These families were given the needed medical and nursing follow-up.

Comparison with previous years' statistics is difficult as different types of services have been recorded. An effort to obtain useful statistical data has resulted in a change in the format and the data collected each year. This limits the usefulness of such data for comparison of one year with another. Some stability in coding of disease classification and in the data collected is essential if meaningful data is to be collected and relevant.

Since over half of our staff were new to the summer migrant project at the beginning of the season, we found that the bulk of staff training and orientation had to be devoted to clerical and record keeping functions. Although orientation and inservice programs were specially planned for our aides and new public health nurses, weekly staff meetings were essential. Other members of the staff who continue to work with migrants are encouraged to attend the workshops and community planning meetings related to migrant health. We hope that problems of data collection can be reduced so that our staff time can be better used in the provision of comprehensive services to the families we serve.

In general we feel that our nursing services were well organized and were of excellent quality. We were able to employ an additional public health nurse this season to work closely with the six hospitals in our area and plan for follow-up care after discharge. This permitted the nurses in the two teams to spend more time in the field.

We feel that our nursing service in general was good, but it dealt primarily with the acute medical problems and could not include the more comprehensive activities necessary for quality nursing service to the many migrant families. We feel that if funds were available to allow assignment of an additional public health nurse and aide our objective for nursing services could be more nearly realized.

The major weakness this year was in providing quality service to all migrants. We feel our service was more comprehensive than in preceding years, and that the staff was prepared and able to deliver quality service when the migrant was reached. Another significant problem is due to staff tenure. Constant staff turnover means continuous - staff orientation and always an inexperienced staff. Mid-season changes in our clerical staff

*Health is a Community Affair - National Commission on Community Health Services, Harvard University Press: Cambridge, Massachusetts. 1966 (pg. 53)

did not seem to present too great a problem at the time, but in final collection of data and compilation of our report, it has created a serious problem.

FUTURE PLANS

We do not plan to modify our objective of quality comprehensive nursing service to migrant families because we feel professionally obligated to this goal. We feel that the team approach is good and should be continued. We do plan, however, several changes in procedure in light of this year's experience. Many relate to record keeping and data collection. Specifically, we plan to develop a clerical manual and add a concise summary of recording procedures to the public health nurse and aide manuals, and to the medical clinic guide. We plan to change the physical setup of our evening clinics slightly (by such things as purchase of additional lightweight screens) to provide more optimum interviewing and examining areas. We have gained valuable experience in health education this summer and employment of a full time health educator would be most appropriate. If funds do not permit this the nursing and sanitation staff will continue to provide as much meaningful health education as possible.

LABORATORY SERVICES

This year for the first time we offered on-site laboratory facilities to our migrant families attending the evening medical clinics. We did not do routine lab tests on each family member; however, we attempted to establish routine procedures for certain kinds of symptoms. We have discussed the possibility of obtaining a routine and urinalysis on each new patient during the next season.

As one would expect, white blood counts, differentials, urine exams, and hematocrits were by far the greatest number of procedures done. The mono-test, for infectious mononucleosis, was done only once and can probably be dispensed with next year. We feel that next year we should do more G.C. smears and change our routine OB lab work to include a type and RH determination. Possibly an antibody screen and the two minute slide determination for pregnancy should be used rather than the two hour test tube test as done this year.

We plan to spend time in the beginning of the 1970 peak season to familiarize the nurses with the lab tests available and the specific tests indicated for specific complaints. Our routine procedures will be written out and available to the nurse taking medical history.

LABORATORY TEST SUMMARY

Test	Number
WBC	84
Diff	84
HMCT	142
ESR	29
UA	124
Cult.	10
Pregnancy	5
Bld. Sug.	18
Occult Bld.	1
Ua Sug.	6
UDRL	2
GC Smear	3
SGO-T	1
Mono test	1

SANITATION NARRATIVE

I - Sanitation Services

Sanitation services in Marion County are provided by staff sanitarians, with the direct assistance of sanitation aides, support of clerical and supervisory staff and

are coordinated with related activities of the nursing staff. Activities include intensive camp inspections during occupancy, consultation with growers regarding necessary camp improvements, health education presentations at medical clinics, and a program of spraying camps with residual spray to combat insect vectors. Off season activities are directed toward work with growers on major camp improvements, presentation at meetings and preparation for future work.

(a) Specific Objectives

1. Periodic camp inspection as often as possible.
2. Closure of substandard camps.
3. Evaluation and improvement of water supplies.
4. Continued intensive garbage and fly control.
5. Grower and migrant education regarding camp sanitation responsibility.

(b) Staff

The sanitation staff consisted of one full-time Project Sanitarian I, one part-time Sanitarian II, two part-time Sanitation Aides, one Sanitation Director part-time, and one Clerk-Stenographer part-time. All staff members were paid employees.

The full-time project sanitarian directly supervised the part-time sanitarian and the aides during the migrant season. During the off season, the bulk of the project sanitarian's efforts were directed toward obtaining basic camp corrections. At times the project sanitarian was asked to make presentations before groups, testify at legislative committee meetings and accompany groups on camp tours.

The part-time sanitarian was assigned to the north half of the county and directly supervised the work of one sanitation aide. Due to illness during June, the part-time sanitarian did not work, and his duties were taken over by other staff sanitarians.

Each sanitation aide accompanied a sanitarian during camp inspections. They sprayed all privies, garbage cans, and other fly attractants, posted health signs, and talked to the occupants about keeping the area clean.

The Sanitation Division Director coordinated staff activities, and accompanied the project sanitarian to various meetings and legislative activities.

The clerk-stenographer maintained up-to-date individual files for each camp, and a card file of inspections, water samples taken, and notifications to operate received.

Other staff sanitarians assisted the project sanitarian at various times during the migrant season.

(c, d, e) Relations With Other Groups And Consultation

In order to promote corrections and improvements in migrant housing, close working relationships were maintained with growers, and grower oriented organizations such as the Oregon Farm Bureau. At times, advice on plumbing problems was needed, and valuable assistance was obtained from the State Plumbing Inspector, Oregon State Board of Health, and from the Marion County Building Department. In response to requests from the Valley Migrant League, twenty-six (26) homes were inspected for day care by staff sanitarians. The project sanitarian assisted with a camp tour for the Oregon Legislative Committee on Labor and Management.

(f) Statistical Information, Part IV

Fewer camps were used by a smaller migrant population during 1969, as compared to past years. Family housing units made up the bulk of the units provided and reflect the character of the migrant population. The total number of inspections made was somewhat lower than last year, due in part to unfamiliarity of those who filled in for the part-time sanitarian. Part of the drop was probably due to the

fact that maintenance and promptness of correction was very good, therefore, fewer revisits were necessary.

II General Description of Housing Conditions

Housing for migrants in Marion County has changed very little during the past few years. Conditions range from very good to barely acceptable. Maintenance is generally poor and conditions deteriorate each year, due to a considerable amount of abuse during occupancy.

(a) Type of Housing and Trends

Most of the housing is of wood frame construction with wood floors and asphalt roofing material. Most units have glass windows but some have been replaced by fiberglas or wooden shutters due to breakage. The majority of units have windows screened. Most of the newer units have concrete floors, single wall plywood construction with metal roofing. Built-in bunk arrangements for sleeping are most common, with a majority of the units partitioned for privacy. Heat and cooking are usually provided for with one stove unit. Wood fuel has been the most common, but more gas and electric units are appearing each year. Very few units have water inside. Convenient water outlets outside the cabins are provided in most camps.

There have been very few new units constructed in the past few years. The new units which have been built are for the most part excellent housing. Uncertainty as to crop conditions and prices, and the threat of farm union activities, have restricted improvement in housing. Unfavorable publicity has caused growers to make some improvements as a reaction to public opinion, but to a greater degree has made some resistant to all authority.

(b) Analysis Table A

During the 1969 season, 158 camps were operated with a peak capacity of about 9,500 persons. This is a decrease of about 10 percent as compared to 1968. This capacity easily handled the 1969 population, and indications are that even fewer camps will be used in the future.

(1) Authority For Permits

Oregon law requires operators of farm labor camps to notify the local health department prior to camp occupancy. Response to this requirement in Marion County has been fairly good. Those growers who failed to submit a notice prior to operation did not do so to evade inspection, but rather indicated a lack of understanding as to the importance of this notice to staff sanitarians. To our knowledge, only one camp was operated for any period of time without our knowledge during 1969, and that situation was corrected.

(2) Factors Contributing to Progress

Overall improvement in housing has been very slow. Uncertainty or lack of capital has made new construction or major improvement of existing camps rare. One exception has been in the West Stayton area. Prior to the 1969 season, several growers who had never provided shower washroom facilities did so, at the request of the Project Sanitarian. One grower, north of Salem, constructed a new six unit building which was to be used for rental housing in the off season.

The progress which has been made is a result of the establishment of a constructive relationship with most of the growers. It is characterized by a persistent approach toward gaining improvements, but sympathetic to the problems of both growers and migrants. If continued, more cooperation can be expected in the future. Factors outside the control of this department have restricted progress to some extent. Fear of unionization and unfavorable publicity have caused some growers to be increasingly antagonistic.

(c) Analysis of Table B

The 158 camps which were operated during 1969 were inspected 616 times, or about once a month for four months. Fewer violations were noted this year, and corrections were completed more rapidly than in the past.

(1) Water Supplies

Water supplies, in the majority of cases, are acceptable. The Aumsville area remains the most difficult to deal with. The occurrence of impure water seems to be a community problem, which is not restricted to farm labor camps. Accessibility of water at high water table or shallow depths, and unexplainable impure sources compound the problem. The problem demands continuing work due to the high population density at harvest time in this area.

Sewage Disposal

Sewage disposal in most of the camps is satisfactory. Some cases of drain-field failure and plugging of lines was noted this year. Additional drain lines or cleaning of lines solved most of these problems. In one instance, closure of the camp was necessary due to the complexity of the problem.

Garbage and Refuse Control

Garbage and refuse control was greatly improved over that of the 1968 season. More growers subscribed to garbage pickup services which removed the material, on the average, twice per week. The main problem is still to get the camp occupants to put the material in the containers provided. Only when camp occupants learn to take pride in keeping thei area clean, can garbage and refuse control lose its place as the major maintenance problem.

Refrigeration

Very few camps provide refrigeration for the occupants. Most of the refrigeration which exists is provided by the occupants themselves after they move in. In most cases this necessitates use of non-perishable foods, or buying small amounts which are used in a short period of time.

(2) Food Handling

No centralized food service facilities are provided in Marion County camps. Food service is mainly on a family basis in individual cabins. At least one camp has a small store where occupants may purchase food items, most of which require little preparation. Due to the nature of the work, camp occupants appear to spend as little time as possible preparing food.

Insect and Rodent Control

Between the supplemental activities of Sanitation Aides on insect control, assistance by sanitarians on rodent control and the activities of growers, control of insects and rodents is generally good. Poor food handling and disposal practices by the people contribute to the problem and makes continued control necessary.

Recreational Facilities

Very few camps provide recreational facilities. This situation has not changed in the past few years. Whatever areas are available, are generally utilized for the recreational activities which go on.

General Cleanliness

Cleanliness was improved in most camps during 1969. This was due for the most part to better temporary maintenance by the majority of growers and reflected a general attitude of better cooperation.

ERIC

III Work Environment

Inspection of the work environment in Marion County is done by representatives of the Oregon Bureau of Labor. In general conditions are acceptable and few complaints regarding sanitation problems are referred to staff sanitarians.

IV Health Education

A program of health education was developed between the sanitation and nursing staffs prior to the 1969 season. Initially the program was carried on at medical clinics conducted by the nursing staff. Sanitation aides provided most of the manpower and conducted most of the sessions. This program was seen by the sanitation staff as an opportunity to work with the migrants to obtain their cooperation in dealing with problems of camp maintenance and to give them advice concerning various problems related to health. In order to present these subjects with the most up-to-date information available, films were shown on such subjects as Family Planning, Camp Sanitation, Nutrition, Cancer, Venereal Disease, Rabies, Tooth Brushing, and Drug Abuse. Sanitation aides and the project sanitarian talked informally with the audiences about these subjects, and at times received assistance from public health nurses on medical subjects. An effort was made to find out what the migrants wanted to know about. Some of the subjects presented were done at the request of the migrants. Response was generally good, but some language problems were encountered at Woodburn due to some persons who only spoke Spanish. Sessions averaged about two hours, and audiences averaged about 40 persons. As many as 100 persons were in attendance, and as few as 10. Presentations were made at 16 clinics with about 80 film showings. A considerable amount of the effort was aimed at the children, with the hope that a lasting impression might be gained. It is hoped that the program might be expanded in future years and extended into the camps, manpower being the chief limitation.

V General Appraisal of Sanitation Program

Success in achieving goals during 1969 was better than expected. Major camp improvements were made with less effort than anticipated. A more efficient program of camp maintenance would be a great help to stopping the deterioration of existing housing. Factors both economic and public opinion wise will have to change before any great improvement in housing will come. Mechanization of camp production with the elimination of hand harvesting seems to be a more likely prospect. The corrections which were made during 1969 were made by growers who appreciated the approach of those asking improvement. They reacted to reasonable treatment and cooperated as best they could in most cases. The extent of cooperation received is reflected by the fact that less than half as many camps were closed during 1969 as compared to 1968.

VI Future Plans

In order to continue to obtain improvements, a close compatible relationship must be maintained with those people who provide camp facilities. Continued effort must also be made to gain the confidence of the people who live in the camps through education. In this connection it might be advisable to employ aides who speak languages spoken other than English. There is no replacement for intensive camp inspections to continually remind those affected of the importance of maintaining clean living areas. If we learn from the 1969 season, there is every reason to believe that we can expect even better cooperation.

POLK COUNTY

Polk County Migrant Health Project
Polk County Health Department
E. B. Bossatti, M.D., Health Officer
102 Courthouse
Dallas, Oregon 97338

POPULATION AND HOUSING DATA

FOR POLK COUNTY.

GRANT NUMBER MG 05G

5. POPULATION DATA - MIGRANTS (Workers and dependents)

a. NUMBER OF MIGRANTS BY MONTH

MONTH	TOTAL	IN-MIGRANTS	OUT-MIGRANTS
JAN.			182
FEB.			182
MAR.	186	4	182
APRIL	193	12	181
MAY	230	61	169
JUNE	431	376	55
JULY	871	751	120
AUG.	989	869	120
SEPT.	161	63	97
OCT.	134	-	134
NOV.			
DEC.			
TOTALS			

b. NUMBER OF MIGRANTS DURING PEAK MONTH

	TOTAL	MALE	FEMALE
(1) OUT-MIGRANTS:			
TOTAL	218	106	112
UNDER 1 YEAR	2	1	1
1 - 4 YEARS	16	7	9
5 - 14 YEARS	102	54	48
15 - 44 YEARS	87	37	50
45 - 64 YEARS	9	7	2
65 AND OLDER	2		2
(2) IN-MIGRANTS:			
TOTAL	888	458	430
UNDER 1 YEAR	21	11	10
1 - 4 YEARS	100	63	37
5 - 14 YEARS	314	145	169
15 - 44 YEARS	372	182	190
45 - 64 YEARS	76	52	24
65 AND OLDER	5	5	

c. AVERAGE STAY OF MIGRANTS IN COUNTY

	NO. OF WEEKS	FROM (MO.)	THROUGH (MO.)
OUT-MIGRANTS	48	January July	June September
IN-MIGRANTS	12	June	August

6. HOUSING ACCOMMODATIONS

a. CAMPS

MAXIMUM CAPACITY	NUMBER	OCCUPANCY (Peak)
LESS THAN 10 PERSONS		
10 - 25 PERSONS	10	195
26 - 50 PERSONS	7	295
51 - 100 PERSONS	8	615
MORE THAN 100 PERSONS	5	815
TOTAL*	30	1920

b. OTHER HOUSING ACCOMMODATIONS

LOCATION (Specify)	NUMBER	OCCUPANCY (Peak)
TOTAL*		

*NOTE: The combined occupancy totals for "a" and "b" should equal approximately the total peak migrant population for the year.

REMARKS

Information for 5a from family records, school records, and health aides.
Information for 5b from family records and special screening inspection tally sheet.

Total number of families screened by P.H.N.	Families in area first time	Ethnic Group			
		Spanish	Anglo	Indian	Negro
180	49	85	78	10	7

GRANT NUMBER	
MG 05G	POLK COUNTY
DATE SUBMITTED	

PART II - MEDICAL, DENTAL, AND HOSPITAL SERVICES

1. MIGRANTS RECEIVING MEDICAL SERVICES

a. TOTAL MIGRANTS RECEIVING MEDICAL SERVICES AT FAMILY HEALTH CLINICS, PHYSICIANS OFFICES, HOSPITAL EMERGENCY ROOMS, ETC.

AGE	NUMBER OF PATIENTS			NUMBER OF VISITS
	TOTAL	MALE	FEMALE	
TOTAL	165*			239*
UNDER 1 YEAR				
1 - 4 YEARS				
5 - 14 YEARS				
15 - 44 YEARS				
45 - 64 YEARS				
65 AND OLDER				

No. of related nursing visits

* Figures incomplete

b. OF TOTAL MIGRANTS RECEIVING MEDICAL SERVICES, HOW MANY WERE:

(1) SERVED IN FAMILY HEALTH SERVICE CLINIC? ______

(2) SERVED IN PHYSICIANS' OFFICE, ON FEE-FOR-SERVICE ARRANGEMENT (INCLUDE REFERRALS) 165

2. MIGRANTS RECEIVING DENTAL SERVICES

ITEM	TOTAL	UNDER 15	15 AND OLDER
a. NO. MIGRANTS EXAMINED-TOTAL	69	45	24
(1) NO. DECAYED, MISSING, FILLED TEETH	296	166	130
(2) AVERAGE DMF PER PERSON		3.7	5.4
b. INDIVIDUALS REQUIRING SERVICES-TOTAL	45	21	24
(1) CASES COMPLETED	25	9	16
(2) CASES PARTIALLY COMPLETED	12	7	5
(3) CASES NOT STARTED	8	5	3
c. SERVICES PROVIDED - TOTAL	173	43	130
(1) PREVENTIVE	5	2	3
(2) CORRECTIVE-TOTAL	168	41	127
(a) Extraction	117	15	102
(b) Other	51	26	25
d. PATIENT VISITS - TOTAL	64	35	29

3. MIGRANT HOSPITALIZATIONS

SOURCE OF PAYMENT	NO. PTS.	M	F	AGE GROUPING <1	1-4	5-14	15-44	45-64	65+	TOTAL HOSP. DAYS	AVE. HOSP. DAYS	PROJECT HOSPITAL COSTS	DOCTORS FEES PAID	TOTAL HOSPITAL BILLING
MIGRANT FUNDS	8	4	4	2			6			29	4	$921.13	$672.00	$2003.49
OTHERS*	3	3			1	2				229				

*PAYMENT MADE BY PATIENT, INSURANCE, WELFARE, OR PROVIDED BY UNIVERSITY OF OREGON MEDICAL SCHOOL

4. IMMUNIZATIONS PROVIDED

TYPE		COMPLETED IMMUNIZATIONS, BY AGE: TOTAL	UNDER 1 YEAR	1 - 4	5 - 14	15 AND OLDER	INCOMPLETE SERIES	BOOSTERS, REVACCINATIONS
TOTAL-ALL TYPES								
SMALLPOX	1	1			1		1	3-4
DIPHTHERIA	3						1	2
PERTUSSIS	2						1	3-4
TETANUS	3							2-4
Polio	3	1	1					
MEASLES	1			1				
TUBERCULIN SKIN TESTS		5						

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PART II (Continued) - 5. MEDICAL CONDITIONS TREATED BY PHYSICIANS IN FAMILY CLINICS, HOSPITAL OUTPATIENT DEPARTMENTS, AND PHYSICIANS' OFFICES.

MG 05G POLK COUNTY

ICD CLASS	DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
I-XVII.	TOTAL ALL CONDITIONS	239	165	84
I.	INFECTIVE AND PARASITIC DISEASES: TOTAL	14	14	
	TUBERCULOSIS			
	SYPHILIS			
	GONORRHEA AND OTHER VENEREAL DISEASES			
	INTESTINAL PARASITES			
	DIARRHEAL DISEASE (infectious or unknown origins):			
	Children under 1 year of age			
	All other			
	"CHILDHOOD DISEASES" – mumps, measles, chickenpox			
	FUNGUS INFECTIONS OF SKIN (Dermatophytoses)			
	OTHER INFECTIVE DISEASES (Give examples):			
	Parasitic	2	2	
	Pediculosis	6	6	
	Mumps	6	6	
II.	NEOPLASMS: TOTAL		1	
	MALIGNANT NEOPLASMS (give examples):			
	Receiving Cobalt treatment at University of Oregon	11	1	12
	BENIGN NEOPLASMS			
	NEOPLASMS of uncertain nature			
III.	ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES: TOTAL	7	2	5
	DISEASES OF THYROID GLAND			
	DIABETES MELLITUS	7	2	5
	DISEASES of Other Endocrine Glands			
	NUTRITIONAL DEFICIENCY			
	OBESITY			
	OTHER CONDITIONS			
IV.	DISEASES OF BLOOD AND BLOOD FORMING ORGANS: TOTAL			
	IRON DEFICIENCY ANEMIA			
	OTHER CONDITIONS			
V.	MENTAL DISORDERS: TOTAL	8	8	
	PSYCHOSES		1	
	NEUROSES and Personality Disorders		2	
	ALCOHOLISM		1	
	MENTAL RETARDATION		1	
	OTHER CONDITIONS		2	
	Emotional disturbance of childhood		1	
VI.	DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS: TOTAL	14	11	3
	PERIPHERAL NEURITIS			
	EPILEPSY		1	
	CONJUNCTIVITIS and other Eye Infections		2	
	REFRACTIVE ERRORS of Vision		4	
	OTITIS MEDIA		3	
	OTHER CONDITIONS Migraine		1	

PART II – 5. *(Continued)*

ICD CLASS		DIAGNOSIS OR CONDITION	MG 05G TOTAL VISITS	POLK COUNTY FIRST VISITS	REVISIT
VII.		DISEASES OF THE CIRCULATORY SYSTEM: TOTAL	6	2	4
		RHEUMATIC FEVER			
		ARTERIOSCLEROTIC and Degenerative Heart Disease			
		CEREBROVASCULAR DISEASE (Stroke)			
		OTHER DISEASES of the Heart 1			
		HYPERTENSION 1			
		VARICOSE VEINS			
		OTHER CONDITIONS			
VIII.		DISEASES OF THE RESPIRATORY SYSTEM: TOTAL	32	22	10
		ACUTE NASOPHARYNGITIS (Common Cold)		9	
		ACUTE PHARYNGITIS		3	
		TONSILLITIS		3	
		BRONCHITIS		2	
		TRACHEITIS/LARYNGITIS			
		INFLUENZA		1	
		PNEUMONIA		2	
		ASTHMA, HAY FEVER			
		CHRONIC LUNG DISEASE (Emphysema)		2	
		OTHER CONDITIONS			
IX.		DISEASES OF THE DIGESTIVE SYSTEM: TOTAL	89	64	25
		CARIES and Other Dental Problems		49	
		PEPTIC ULCER		1	
		APPENDICITIS			
		HERNIA		3	
		CHOLECYSTIC DISEASE		3	
		OTHER CONDITIONS Cirrhosis of liver Functional disorders of Intestine		8	
X.		DISEASES OF THE GENITOURINARY SYSTEM: TOTAL	17	10	7
		URINARY TRACT INFECTION (Pyelonephritis, Cystitis)		5	
		DISEASES OF PROSTATE GLAND (excluding Carcinoma)			
		OTHER DISEASES of Male Genital Organs			
		DISORDERS of Menstruation		1	
		MENOPAUSAL SYMPTOMS		1	
		OTHER DISEASES of Female Genital Organs		2	
		OTHER CONDITIONS Kidney infections		1	
XI.		COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM: TOTAL	7	3	4
		INFECTIONS of Genitourinary Tract during Pregnancy			
		TOXEMIAS of Pregnancy			
		SPONTANEOUS ABORTION			
		REFERRED FOR DELIVERY		2	
		COMPLICATIONS of the Puerperium			
		OTHER CONDITIONS Postpartum infection		1	
XII.		DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE: TOTAL	8	8	
		SOFT TISSUE ABSCESS OR CELLULITIS			
		IMPETIGO OR OTHER PYODERMA		2	
		SEBORRHEIC DERMATITIS			
		ECZEMA, CONTACT DERMATITIS, OR NEURODERMATITIS		5	
		ACNE		1	
		OTHER CONDITIONS			

PART II - 5. (Continued)

MG 05G POLK COUNTY

ICD CLASS		DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
XIII.		DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE: TOTAL	14	10	4
		RHEUMATOID ARTHRITIS		1	
		OSTEOARTHRITIS			
		ARTHRITIS, Unspecified		2	
		OTHER CONDITIONS		7	
XIV.		CONGENITAL ANOMALIES: TOTAL	4	1	2
		CONGENITAL ANOMALIES of Circulatory System			
		OTHER CONDITIONS Congenital hip		1	
XV.		CERTAIN CAUSES OF PERINATAL MORBIDITY AND MORTALITY: TOTAL			
		BIRTH INJURY			
		IMMATURITY			
		OTHER CONDITIONS			
XVI.		SYMPTOMS AND ILL-DEFINED CONDITIONS: TOTAL	5	3	2
		SYMPTOMS OF SENILITY			
		BACKACHE		1	
		OTHER SYMPTOMS REFERRABLE TO LIMBS AND JOINTS		1	
		HEADACHE		1	
		OTHER CONDITIONS			
XVII.		ACCIDENTS, POISONINGS, AND VIOLENCE: TOTAL	6	6	
		LACERATIONS, ABRASIONS, and Other Soft Tissue Injuries		4	
		BURNS			
		FRACTURES			
		SPRAINS, STRAINS, DISLOCATIONS		1	
		POISON INGESTION			
		OTHER CONDITIONS due to Accidents, Poisoning, or Violence		1	

				NUMBER OF INDIVIDUALS
6.		SPECIAL CONDITIONS AND EXAMINATIONS WITHOUT SICKNESS: TOTAL		291
		FAMILY PLANNING SERVICES	8	
		WELL CHILD CARE	1	
		PRENATAL CARE	9	
		POSTPARTUM CARE	1	
		TUBERCULOSIS: Follow-up of inactive case	5	
		MEDICAL AND SURGICAL AFTERCARE	3	
		GENERAL PHYSICAL EXAMINATION	1	
		PAPANICOLAOU SMEARS	2	
		TUBERCULIN TESTING	5	
		SEROLOGY SCREENING		
		VISION SCREENING	60	
		AUDITORY SCREENING	40	
		SCREENING CHEST X-RAYS	4	
		GENERAL HEALTH COUNSELLING	44	
		OTHER SERVICES: Dental screening	70	
		(Specify) Cardiac screening	39	

ERIC

PART III - NURSING SERVICE

MG 05G POLK COUNTY

TYPE OF SERVICE		NUMBER
1. NURSING CLINICS:		
a. NUMBER OF CLINICS		
b. NUMBER OF INDIVIDUALS SERVED - TOTAL		
2. FIELD NURSING:		
a. VISITS TO HOUSEHOLDS	399	
b. TOTAL HOUSEHOLDS SERVED	180	
c. TOTAL INDIVIDUALS SERVED IN HOUSEHOLDS	1106	
d. VISITS TO SCHOOLS, DAY CARE CENTERS	12	
e. TOTAL INDIVIDUALS SERVED IN SCHOOLS AND DAY CARE CENTERS	120	
3. CONTINUITY OF CARE:		
a. REFERRALS MADE FOR MEDICAL CARE: TOTAL		82
(1) Within Area	79	
(Total Completed 63)		
(2) Out of Area	3	
(Total Completed)		
b. REFERRALS MADE FOR DENTAL CARE: TOTAL		49
(Total Completed 41)		
c. REFERRALS RECEIVED FOR MEDICAL OR DENTAL CARE FROM OUT OF AREA: TOTAL		8
(Total Completed 2)		
d. FOLLOW-UP SERVICES FOR MIGRANTS, not originally referred by project, WHO WERE TREATED IN PHYSICIANS' OFFICES (Fee-for-Service)	24	
e. MIGRANTS PROVIDED PRE-DISCHARGE PLANNING AND POST-HOSPITAL SERVICES	8	
f. MIGRANTS ASKED TO PRESENT HEALTH RECORD Form PMS-3652 or Similar Form) IN FIELD OR CLINIC: TOTAL		180 Families
(1) Number presenting health record.	45	
(2) Number given health record.	13	
4. OTHER ACTIVITIES (*Specify*):		

REMARKS

Aide - 112 total households visited
School visits 16
Households served 134

PART IV - SANITATION SERVICES

MG 05G POLK COUNTY

TABLE A. SURVEY OF HOUSING ACCOMMODATIONS

HOUSING ACCOMMODATIONS	TOTAL		COVERED BY PERMIT	
	NUMBER	MAXIMUM CAPACITY	NUMBER	MAXIMUM CAPACITY
CAMPS	30	1890		
OTHER LOCATIONS				
HOUSING UNITS - Family:				
IN CAMPS	409	1890		
IN OTHER LOCATIONS				
HOUSING UNITS - Single				
IN CAMPS				
IN OTHER LOCATIONS				

TABLE B. INSPECTION OF LIVING AND WORKING ENVIRONMENT OF MIGRANTS

ITEM	NUMBER OF LOCATIONS INSPECTED*		TOTAL NUMBER OF INSPECTIONS		NUMBER OF DEFECTS FOUND		NUMBER CORRECTIONS MADE	
	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER
LIVING ENVIRONMENT:								
a. WATER	30		30		4		4	
b. SEWAGE	71		71		88		50	
c. GARBAGE AND REFUSE	71		71		45		20	
d. HOUSING	71		71		18		10	
e. SAFETY	71		71		2		2	
f. FOOD HANDLING								
g. INSECTS AND RODENTS	71		71		1		1	
h. RECREATIONAL FACILITIES								
WORKING ENVIRONMENT:								
a. WATER	xxxx		xxxx		xxxx		xxxx	
b. TOILET FACILITIES	xxxx		xxxx		xxxx		xxxx	
c. OTHER	xxxx		xxxx		xxxx		xxxx	

* *Locations — camps or other locations where migrants work or are housed.*

PART V – HEALTH EDUCATION SERVICES *(By type of service, personnel involved, and number of sessions.)*

TYPE OF HEALTH EDUCATION SERVICE	NUMBER OF SESSIONS					
	HEALTH EDUCATION STAFF	PHYSICIANS	NURSES	SANITARIANS	AIDES (other than Health Ed.)	OTHER
A. SERVICES TO MIGRANTS.						
(1) Individual counselling			53	8	95	
(2) Group counselling			2		2	
B. SERVICES TO OTHER PROJECT STAFF						
(1) Consultation			63	6	41	
(2) Direct services			17		2	
C. SERVICES TO GROWERS:						
(1) Individual counselling			18	50	3	
(2) Group counselling			1			
D. SERVICES TO OTHER AGENCIES OR ORGANIZATIONS:						
(1) Consultation with individuals			20		3	
(2) Consultation with groups			45	1	7	
(3) Direct services			100		16	
E. HEALTH EDUCATION MEETINGS			59	12	59	

Polk County
MG 05G

NURSING NARRATIVE

Approximately 36 migrant families remained in Polk County in 1968 and made it their home base for 1969. Additional families began arriving in March with the largest number coming into the county August 8, 1969. There were about 75 less families this season than last season.

There are sixteen migrant labor camps near Independence, but only ten were open for occupancy this year. The cherry camps were filled for about a week and then about two-thirds of a bumper sweet cherry crop was destroyed by the rain; and as the pie cherry crop was harvested by machine, the cherry pickers had to move on. Most of the workers went to Washington State, returning for the bean harvest in July.

The strawberry harvest started on May 28 but was considerably shortened by damage from rain. The families remaining in the area worked in the caneberries and money was short as there were many workers for the amount of picking to be done. Some of the farm labor camps in the bean area were not utilized as bush beans were planted rather than pole beans. The pear harvest lasted approximately one week; and as children were not allowed to participate, many of the families left for Washington, Idaho, and eastern Oregon by the end of August. Some of the prune crop was harvested by machine for the first time in the county. The families remaining in the area harvested the filbert crops and hoped to remain in the area for the winter but rental housing is very limited. There was not enough work for any of the families in the county this season.

The one project nurse was assisted during the summer by a Mexican-American girl who served very effectively as a community health aide. She had lived in two of the camps in the area and knew many of the people through her church, school, Valley Migrant League and community Action Program attendance. The aide made camp visits, assisted in making family records, reminded patients of medical and dental appointments, often providing transportation when necessary.

A nutritional survey was conducted in the summer migrant school and much of the preparation, survey work and follow-up was done by the project nurse and aide. (See following nutritional survey report.) The aide assisted the families in filling out the diet intake summaries and child development records, and following the survey counseled families regarding their diet needs. She also showed some films in the school on vision and dental health.

The dental students from the University of Oregon Dental School conducted a dental survey and follow-up dental prevention program as well as care program, and the project staff assisted in this. All of the children in the school who had dental needs (34) were seen at least once in a private dentist's office for follow-up care.

The project nurse and aide attended a two-day in-service training workshop at the beginning of the season and a one-day workshop in July. They also were able to attend several health department staff meetings.

The doctors in the area were again receptive to seeing migrant patients in their offices; so no clinics were held. Mental Health, Planned Parenthood, Well-Child, Child Development and Mobile Chest Clinics were also available to the migrant population. Two of the local dentists gave generously of their time in providing dental care. The three local hospitals with agreements with the project kept their doors open to migrants, and patients also received treatment at the University of Oregon Medical School, Shriner's Hospital, and the State Crippled Children's Division.

It is believed that all seasonal farm laborers in need of medical care received it with the exception of mental health referrals. Mental health referral follow-ups are a problem due to patients' short stay in the county. Transportation continued to be the number one problem with patient motivation a close second. Adequate low rental housing is a problem for those wishing to remain in the area.

Polk County
MG 050

Nutritional Survey

Problem: It has been generally stated that persons in the poverty group are subject to malnutrition. Often accompanying this condition is a variety of health factors such as vision problems, hearing problems, birth defects, cardiac disorders, dental needs, etc. At the present time no detailed or specific information is available to actually determine whether this problem and the accompanying health conditions exist among the children of migrant families in Polk County.

Objectives: To definitively determine the nutritional status of children from 20 former migrant families, 20 Mexican-American migrant work force families, and from 20 migrant families from other ethnic groups.

To determine the health problems associated with malnutrition.

Methods: Children, taken from families as specified above, will be multiphasically screened. This screening will include: (1) physical examination, (2) psychological evaluation, (3) dental examination, (4) vision testing, (5) audiometric examination, (6) biochemical examination of blood for Vitamins A and C, (7) urinalysis, (8) dietary intake summary, and (9) cardiac scanning.

This work will be accomplished by dental students from the University of Oregon Dental School; a child psychiatrist; an audiometrist and a nutritionist from the Board of Health; a technician from the Oregon Heart Association; public health nurses; and community health aides. This survey will be done on July 22 and 23 in the summer migrant school in Polk County.

Evaluation: From the evaluation of the information obtained from the multiphasic screening, the nutritional status can be determined as well as the health conditions associated with malnutrition. If indicated, a nutritional program for the migrant agricultural workers will be implemented. Children who are found in the survey with health defects will be referred for medical care and necessary follow-up.

Procedure: The Polk County Migrant Project Nurse and her Mexican-American aide conducted interviews to obtain the food records. An effort was made to obtain information regarding prepared foods. For example, if tortillas were listed on the record, the family was asked if the tortilla was made with flour or corn meal. The records were kept on days when the children were not attending school to get a more accurate picture of the usual pattern of eating.

Each record was evaluated by a nutritionist of the Oregon State Board of Health for calories, protein, carbohydrate, fat, Vitamins A and C. Recommendations for improvement were given when indicated.

Dietary intakes were evaluated by comparison to the Recommended Daily Allowance for age and sex. Laboratory values for Vitamins A, C, hemoglobin and hematocrit were rated "low" when below the following:

Hemoglobin	11 gm./100 ml.
Hematocrit	31 ml./100 ml.
Vitamin A	20 mcg./100 ml.
Ascorbic Acid	0.3 mg./100 ml.

Discussion

The study was not comprehensive enough in scope to "determine the nutritional status of children in the study" as planned. However, the findings were of major importance and clearly indicate the need of nutritional as well as medical follow-up.

Height.

When compared to the University of Iowa standards, 36% of the children were below normal in height for age and sex. This developmental lag in height was most marked in the preschool girl group but was characteristic of one-third of all the boys as well. It is impossible to determine on the basis of available evidence how much of the difference was attributable to genetic variation and how much to undernutrition. There was no control group.

Weight.

Judged by the same standards - the Iowa Growth Charts - 14.5% were below normal in weight for age and sex. These findings are similar to results of other researchers (Dr. Arnold Schaefer, Dr. Owens, Dr. Foman) who are doing nutrition studies on low income groups of U.S. children in 1969. They report that height is a more valid indicator of poor nutrition than weight.

Vitamin A.

Blood levels of Vitamin A were critically low (below 20 micrograms per 100 ml.) in 38% of the study population. Intake of Vitamin A foods correlated closely with the low blood levels seen. Forty-five of the 55 children who kept records had a vitamin intake less than the Recommended Daily Allowances for their age group. The school-age girls had the highest percentage (46%) of low Vitamin A blood levels and 12 of 14 girls this age had lower than recommended intakes.

Sources of Vitamin A are not expensive. Deep green leafy and deep yellow vegetables such as carrots, spinach, winter squash, sweet potatoes as well as egg yolk, liver, cantaloupe and other deep yellow fruits are good sources of this vitamin.

Vitamin C.

Vitamin C blood levels were less than adequate for good health in 17% of the children examined. However, none of the school-age boys (22) had blood Vitamin C levels under 0.3 mg./100 ml. Approximately one-third of the girls and the preschool boys had blood levels lower than 0.3 mg%.

The dietary findings regarding Vitamin C supported the biochemical results for the most part although seven of the ex-migrant and five of the resident school-age boys had low intakes which were not reflected in seriously low levels of this vitamin.

Good sources of Vitamin C include citrus fruit, tomatoes, cabbage as well as cantaloupe and strawberries. The last two are more expensive out of season but available locally in season in Oregon.

Protein, Hemoglobin and Hematocrit Values.

Only one child (a resident six year-old boy) had a hemoglobin less than 11.0 gm%. The same child had a hematocrit value of 31 ml.%. Another child (a resident school-age boy) had a low protein intake (lower than Recommended Daily Allowance for age).

Calories.

Preschool children met caloric requirements for age better than older boys and girls. Fifty percent of the school-age children consumed diets inadequate in calories. These data support the findings on height and weight.

ERIC

Clinical Appraisal.

Of the 55 children examined by the same physician in this study, 2 were rated poor, 3 fairly poor, 11 fair, 7 fairly good, 24 good - making a total of 47. Of the others, 8 were rated obese (4 boys and 4 girls were in this category), 1 skinny and 2 "OK." One of the children rated OK had a question concerning anemia. He did not have either a low hemoglobin or hematocrit however.

The preschool group were those in most need of care. At the time of examination there were a number with upper respiratory infections. Several children had scarring of ear drums and a few had current ear infections.

It is recognized that there are difficulties encountered by the families in preparing adequate diets for their families which include:

1. Limited income with the resulting inability to buy meat and other fresh foods.
2. Lack of space to carry any quantity of food with them such as canned goods.
3. Almost no refrigeration available in camps.
4. Inadequate ccooking facilities. Almost none of the stoves have ovens and the size of the cooking area is quite small.
5. Cooking utensils are not furnished in the camp and it is almost impossible for a mobile family traveling in one car to have any storage space to carry any utensils with them except a very limited number.
6. The long working hours do not offer opportunity to prepare a variety of foods or food that takes considerable time in preparation.

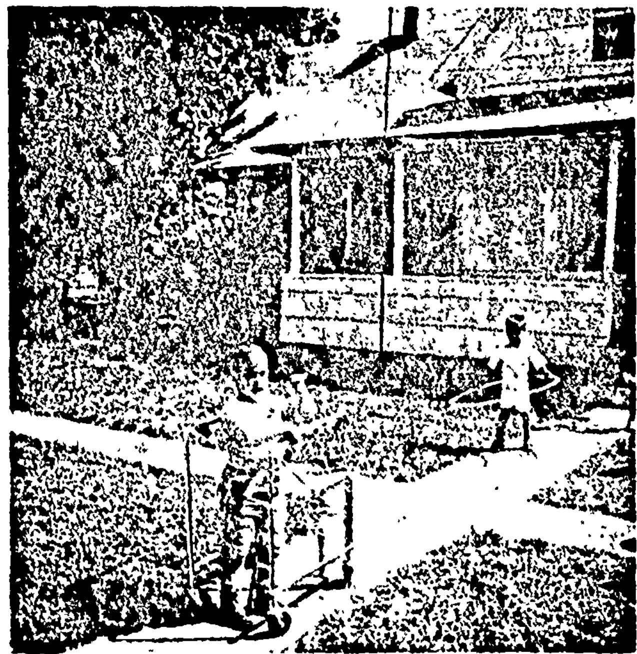
Recommendations to meet the nutritional deficiencies are made so as not to change the eating pattern of the migrant family, but rather to supplement their diets with the needed foods, for example:

1. Adding yellow and green leafy vegetables to the diets, and
2. Using yellow cornmeal rather than white flour in tortillas, as sources of Vitamin A.

* * * *

REMEMBER ROBERTO?

1967



February 1969

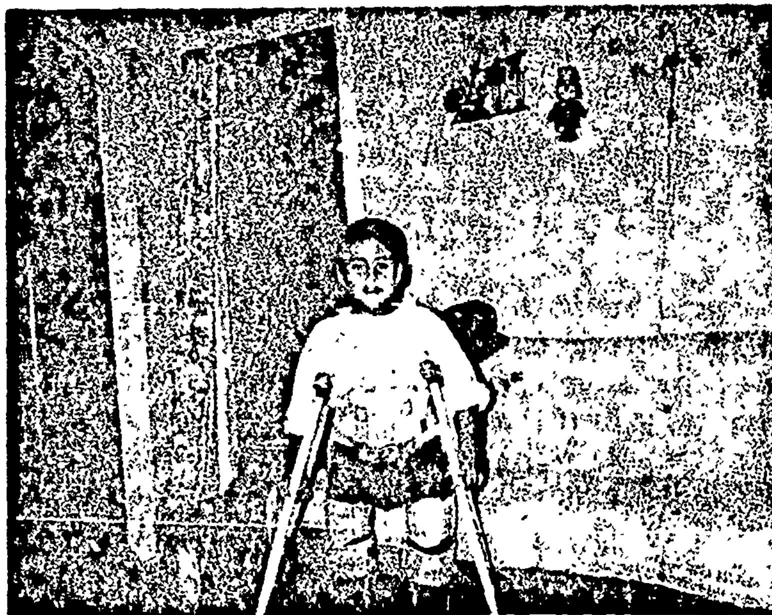
Polk County
MG 05G

Born February 18, 1964 with a spina bifida, he has been a paraplegic since he was nine months old. A project nurse first saw Roberto in a Well-Child Clinic in March 1965 and the 1965 report told the story as we knew it then. The family has made their home base in Polk County for the past two years in order for Roberto to have the necessary care.

A considerable amount of nursing time has been spent with the G. family in supportive assistance for Roberto's care. The hope of seeing Roberto on his feet has given his family the strength and courage to continue the difficult task of keeping him clean and free from sores.

When the G. family left the area for the potato harvest this fall, Roberto was kept in Shriner's Hospital for more training in crutch walking. They had hoped to take him with them, but the housing in the potato harvest camp was not adequate for a small boy on crutches.

The family is together again and one of the local teachers is beginning some home tutoring this winter. Plans are under way for Roberto to be able to go to school with the other children next fall when he will be six years old.



Roberto, December 1969

SANITATION NARRATIVE

As has been the case over the past six years, the sanitation services have been provided by the Oregon State Board of Health. This year it was anticipated that the services would be provided by a half-time sanitarian from the Marion County Migrant Health Project, but as it happened, this was not possible. The Marion County Health Department was unable at the last minute to obtain sufficient additional money to provide the other half of the sanitarian's salary. This left only the project supervising staff of the State Board of Health to provide the program services. These services consisted of surveys and inspections of the farm labor camps and consultations with the farmers and camp operators. Because of the unanticipated and immediate nature of the Board of Health's involvement in this program, definite program objectives were not established. It was determined that the best that could be provided would be one preseason inspection of each farm labor camp, and, hopefully, two inspections during the period of occupancy. Time was of the essence, and since this was not a new program to the area, we decided to operate on the following

basis:

a) An initial inspection of the camp facilities would be made prior to occupancy, recommendations for improvements made to the operator, and
b) After each subsequent inspection made during camp occupancy, the defects explained to the operator and a deadline given for completion of the necessary work.

As stated above the actual staff consisted of the supervising and assistant supervising sanitarians from the Occupational Health Section of the Oregon State Board of Health. Relationships had already been established with the local County Extension Agent, the State Department of Employment, the local Farm Bureau Organization, and the Technical Action Panel (comprised of a variety of federal and local agencies, headed by the representative from the Farm Home Administration). Because this was an "in-and-out" type of program this year, contact was maintained with these groups, but no cooperative type of programs was initiated. No inspections of farm labor camps were accomplished under the federal standards.

Seventy-one inspections were made of the thirty farm labor camps in the county. These camps varied in size from two units to fifty-three units, and all migrant workers were housed in on-the-farm camps. During the course of the season, four contaminated water supplied were found. There were eighty-eight violations discovered relating to the disposal of sewage and provision and maintenance of toilet facilities. A large percentage of these were due to lack of toilet maintenance and disposal of waste water from underneath water hydrants. Forty-five discrepancies were noted in the area of solid waste. These were concerned mostly with garbage storage, and one camp had located its garbage dump less than fifty feet behind the camp. Eighteen cabins failed to meet minimum standards required, mostly with regard to screening and lack of repair to doors and windows. One rat infestation was found which was caused primarily by poor garbage storage and poor camp maintenance. Only two camps provided refrigeration for storage and preservation of food.

Of the thirty farm labor camps in Polk County, twenty-three are short-term occupancy camps used to house cherry pickers. Four of these cherry camps housed the workers in tents; two provided travel trailer parking spaces with a central utility and toilet facilities; while another, in addition to providing trailer spaces, used an old hop barn which had been converted into living units. The balance of the cherry camps consisted of cabins. The remaining seven camps were large, long-term occupancy camps for the row crop farms. Six of these camps consisted of frame cabins, and five of the six were quite old. The largest percentage of problems were found in these six camps and an inordinate amount of pressure had to be exerted to obtain their owners' cooperation. The last (seventh) camp had dormitory facilities.

This year the cherry crop was one of the heaviest in many years. Everything looked "rosey" for the cherry grower, but this didn't last long. No sooner did the picking begin than an unseasonable and heavy rain began that lasted for over a week. Most of the cherries in this area are processed into maraschino cherries, but any flaws in the cherries make them unsuitable for processing. Needless to say, the heavy rain split the cherries and the workers left to find employment elsewhere.

In generally appraising the accomplishments of this season's activities, it is worth noting that of the four contaminated water supplies existing at the beginning of the season, there were none at the end of the season. Of the eighty-eight violations noted in the area of sewage disposal and provision and maintenance of toilet facilities, fifty or sixty-five percent were brought up to standards. Of the forty-five problems involving garbage and refuse disposal, twenty or forty-five percent were corrected, and ten living units were screened and/or generally repaired. There was little time for the sanitarians to spend with the migrants themselves, but the public health nurse had an assigned community health aide to assist her and the aide also worked with the migrant families in the areas of personal hygiene and better camp care.

Polk County
MG 05G

There were no camp closures in Polk County this year, but in three of the poorer camps, the threat of imminent closure was a continuing presence. The basic camp facilities were so meager that maintenance was the only saving grace and when this slipped, immediate action was required.

We hear rumors from representatives of agriculture that it is only a matter of time before all labor camps on row crop farms will be phased out in this part of the State. If we are to believe that this will occur when a satisfactory bush bean is developed for the institutional market, or when drive-out or platoon labor can be substituted for seasonal farm workers, then the "feet dragging" by most of the farmers with camps in this area is understandable. On the other hand, these same statements have been coming out of agriculture for the past eight years and there has been little phasing out so far.

All things being considered, this was a fairly productive year. The farmers are cognizant of the program's existence and have felt a slightly heavier and more insistent hand pushing for more improvements and better maintenance. But, it is obvious that this program, although not requiring a full-time sanitarian, should be administered out of the local county health department. This would allow for more frequent inspections and call backs, allow for a local identification with the project, and should increase the local or community support of the program.

DESCHUTES COUNTY

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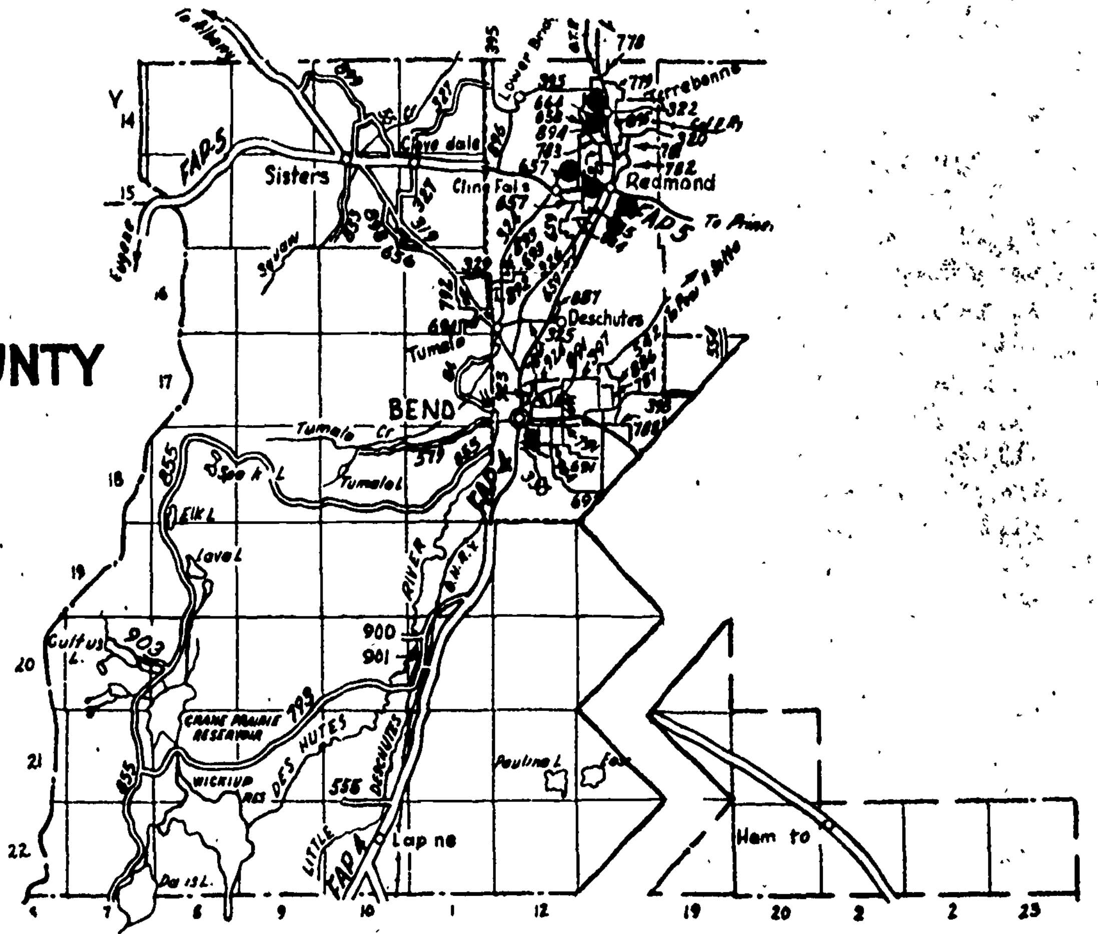
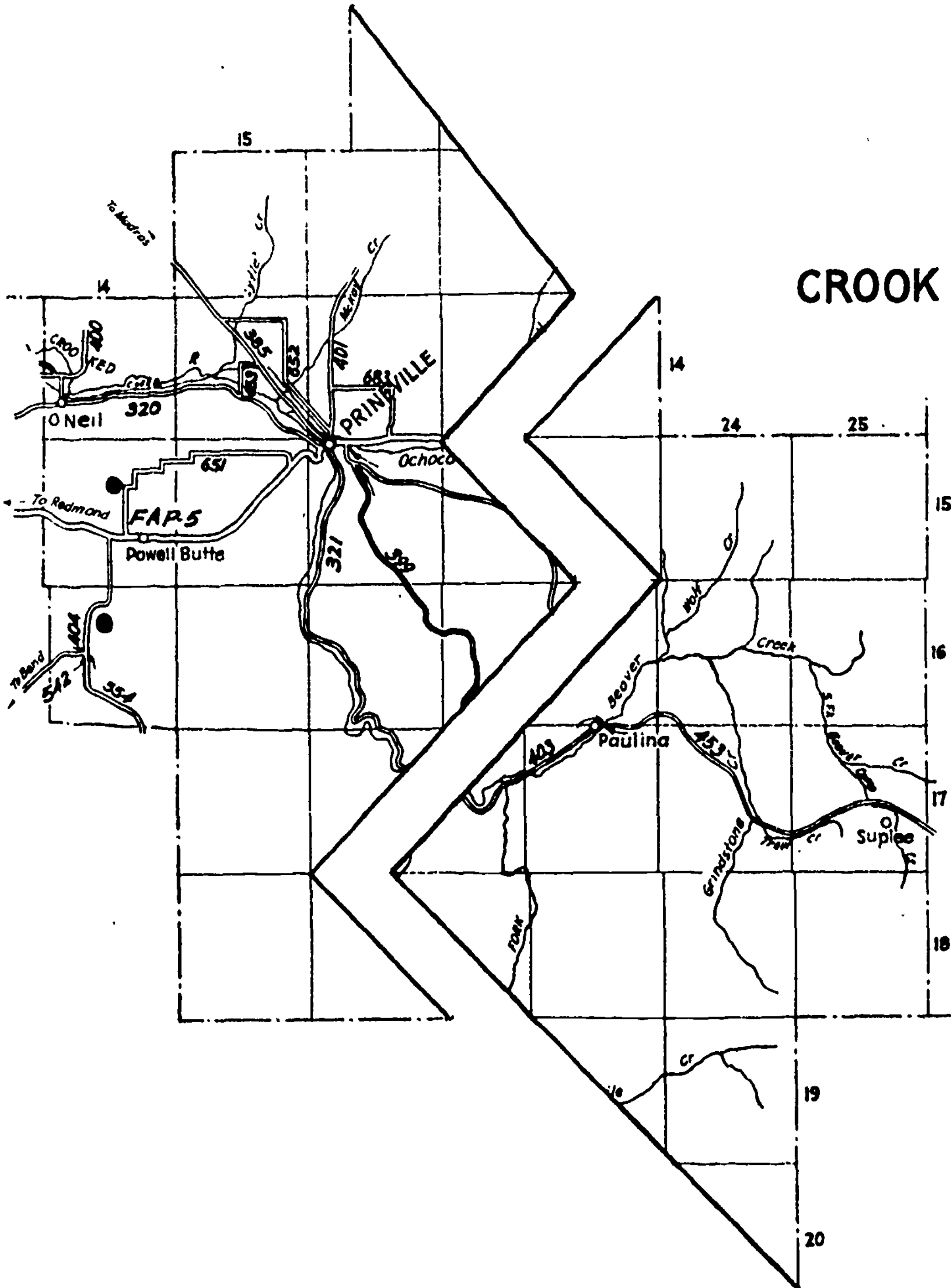
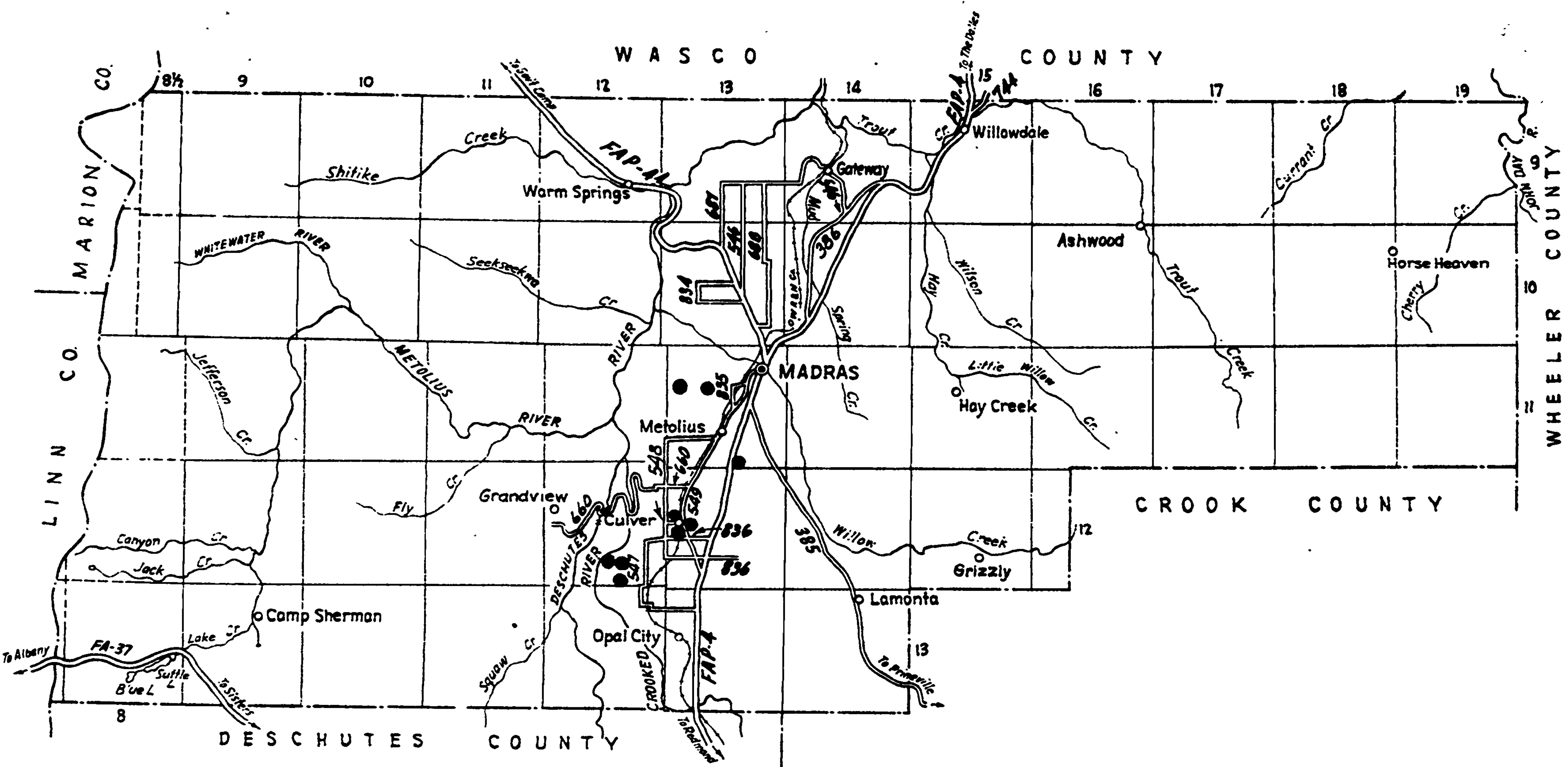


CROOK COUNTY

Scale mi.





JEFFERSON COUNTY

Tri-County Migrant Health Project
Tri-County Health Department
A. Ben King, M.D., Health Officer
Courthouse
Bend, Oregon 97701

POPULATION AND HOUSING DATA

FOR TRI COUNTY.

GRANT NUMBER MG 05G

5. POPULATION DATA - MIGRANTS (*Workers and dependents*)

a. NUMBER OF MIGRANTS BY MONTH

MONTH	TOTAL	IN-MIGRANTS	OUT-MIGRANTS
JAN.			
FEB.			
MAR.			
APRIL			
MAY			
JUNE			
JULY			
AUG.	34		
SEPT.	322		
OCT.	505		
NOV.	18		
DEC.			
TOTALS			

c. AVERAGE STAY OF MIGRANTS IN COUNTY

	NO. OF WEEKS	FROM (MO.)	THROUGH (MO.)
OUT-MIGRANTS	12	September	November
IN-MIGRANTS	8	September	October

b. NUMBER OF MIGRANTS DURING PEAK MONTH.

	TOTAL	MALE	FEMALE
(1) OUT-MIGRANTS:			
TOTAL	10	7	3
UNDER 1 YEAR	1		
1 - 4 YEARS	1		
5 - 14 YEARS	5		
15 - 44 YEARS	3		
45 - 64 YEARS			
65 AND OLDER			
(2) IN-MIGRANTS:			
TOTAL	862	427	435
UNDER 1 YEAR	21	10	11
1 - 4 YEARS	115	52	63
5 - 14 YEARS	283	137	146
15 - 44 YEARS	376	187	189
45 - 64 YEARS	65	39	26
65 AND OLDER	2	2	

6. HOUSING ACCOMMODATIONS

a. CAMPS

MAXIMUM CAPACITY	NUMBER	OCCUPANCY (*Peak*)
LESS THAN 10 PERSONS		
10 - 25 PERSONS	4	79
26 - 50 PERSONS	1	45
51 - 100 PERSONS		
MORE THAN 100 PERSONS	1	250
TOTAL*	6	374

b. OTHER HOUSING ACCOMMODATIONS

LOCATION (*Specify*)	NUMBER	OCCUPANCY (*Peak*)
Motels - Apts	20	125
TOTAL*	20	125

*NOTE: *The combined occupancy totals for "a" and "b" should equal approximately the total peak migrant population for the year.*

REMARKS

Information for 5a and 5b from family records.

GRANT NUMBER MG 05G TRI-COUNTY

DATE SUBMITTED

PART II - MEDICAL, DENTAL, AND HOSPITAL SERVICES

1. MIGRANTS RECEIVING MEDICAL SERVICES

a. TOTAL MIGRANTS RECEIVING MEDICAL SERVICES AT FAMILY HEALTH CLINICS, PHYSICIANS OFFICES, HOSPITAL EMERGENCY ROOMS, ETC.

AGE	NUMBER OF PATIENTS			NUMBER OF VISITS
	TOTAL	MALE	FEMALE	
TOTAL	267	63	102	
UNDER 1 YEAR	14	9	5	
1 - 4 YEARS	26	14	12	
5 - 14 YEARS	27	14	13	
15 - 44 YEARS	87	22	65	
45 - 64 YEARS	10	3	7	
65 AND OLDER				

No. of related nursing visits

b. OF TOTAL MIGRANTS RECEIVING MEDICAL SERVICES, HOW MANY WERE:

(1) SERVED IN FAMILY HEALTH SERVICE CLINIC? ______

(2) SERVED IN PHYSICIANS' OFFICE. ON FEE-FOR-SERVICE ARRANGEMENT (INCLUDE REFERRALS) 267

2. MIGRANTS RECEIVING DENTAL SERVICES

ITEM	TOTAL	UNDER 15	15 AND OLDER
a. NO. MIGRANTS EXAMINED-TOTAL	25		
(1) NO. DECAYED, MISSING, FILLED TEETH 60			
(2) AVERAGE DMF PER PERSON		2	
b. INDIVIDUALS REQUIRING SERVICES-TOTAL	25		
(1) CASES COMPLETED 20			
(2) CASES PARTIALLY COMPLETED 5			
(3) CASES NOT STARTED 2			
c. SERVICES PROVIDED - TOTAL	25		
(1) PREVENTIVE 12			
(2) CORRECTIVE-TOTAL 18			
(a) Extraction		5	7
(b) Other		2	11
d. PATIENT VISITS - TOTAL 62			

3. MIGRANT HOSPITALIZATIONS

SOURCE OF PAYMENT	NO. PTS.	M	F	AGE GROUPING <1	1-4	5-14	15-44	45-64	65+	TOTAL HOSP. DAYS	AVE. HOSP. DAYS	PROJECT HOSPITAL COSTS	DOCTORS FEES PAID	TOTAL HOSPITAL BILLING
MIGRANT FUNDS	18	10	8	5	1	2	6	4		74	4	$2542.52	$910.00	$4166.70
OTHERS*														

*PAYMENT MADE BY PATIENT, INSURANCE, WELFARE, OR PROVIDED BY UNIVERSITY OF OREGON MEDICAL SCHOOL

4. IMMUNIZATIONS PROVIDED

TYPE	COMPLETED IMMUNIZATIONS, BY AGE: TOTAL	UNDER 1 YEAR	1 - 4	5 - 14	15 AND OLDER	INCOMPLETE SERIES	BOOSTERS, REVACCINATION
TOTAL-- ALL TYPES	42	12	12	14	1	29	1
SMALLPOX							
DIPHTHERIA							
PERTUSSIS							
TETANUS							
MEASLES							
TUBERCULIN SKIN TESTS	16						

PART II *(Continued)* - 5. MEDICAL CONDITIONS TREATED BY PHYSICIANS IN FAMILY CLINICS, HOSPITAL OUTPATIENT DEPARTMENTS, AND PHYSICIANS' OFFICES.

MG 05G TRI COUNTY

ICD CLASS		DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
I.-XVII.		TOTAL ALL CONDITIONS		210	
I.		INFECTIVE AND PARASITIC DISEASES: TOTAL		26	
		TUBERCULOSIS			
		SYPHILIS			
		GONORRHEA AND OTHER VENEREAL DISEASES			
		INTESTINAL PARASITES		1	
		DIARRHEAL DISEASE (infectious or unknown origins):			
		Children under 1 year of age		12	
		All other		6	
		"CHILDHOOD DISEASES" - mumps, measles, chickenpox		2	
		FUNGUS INFECTIONS OF SKIN (Dermatophytoses)			
		OTHER INFECTIVE DISEASES *(Give examples):*			
		Herpes		1	
		Pediculosis		2	
II.		NEOPLASMS: TOTAL	1	1	
		MALIGNANT NEOPLASMS *(give examples):*			
		Metastasis following hysterectomy		1	
		BENIGN NEOPLASMS			
		NEOPLASMS of uncertain nature			
III.		ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES: TOTAL	8	8	
		DISEASES OF THYROID GLAND	2	2	
		DIABETES MELLITUS	3	3	
		DISEASES of Other Endocrine Glands			
		NUTRITIONAL DEFICIENCY			
		OBESITY	3	3	
		OTHER CONDITIONS			
IV.		DISEASES OF BLOOD AND BLOOD FORMING ORGANS: TOTAL	2	2	
		IRON DEFICIENCY ANEMIA	2	2	
		OTHER CONDITIONS			
V.		MENTAL DISORDERS: TOTAL	4	4	
		PSYCHOSES			
		NEUROSES and Personality Disorders	4	4	
		ALCOHOLISM			
		MENTAL RETARDATION			
		OTHER CONDITIONS			
VI.		DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS: TOTAL	18	18	
		PERIPHERAL NEURITIS			
		EPILEPSY			
		CONJUNCTIVITIS and other Eye Infections			
		REFRACTIVE ERRORS of Vision	2	2	
		OTITIS MEDIA	13	13	
		OTHER CONDITIONS	3	3	

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PART II - 5. *(Continued)*

MG 05G TRI COUNTY

ICD CLASS		DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
VII.		DISEASES OF THE CIRCULATORY SYSTEM: TOTAL		3	
		RHEUMATIC FEVER			
		ARTERIOSCLEROTIC and Degenerative Heart Disease		1	
		CEREBROVASCULAR DISEASE (Stroke)			
		OTHER DISEASES of the Heart			
		HYPERTENSION		1	
		VARICOSE VEINS		1	
		OTHER CONDITIONS			
VIII.		DISEASES OF THE RESPIRATORY SYSTEM: TOTAL		74	
		ACUTE NASOPHARYNGITIS (Common Cold)		41	
		ACUTE PHARYNGITIS		2	
		TONSILLITIS		8	
		BRONCHITIS		7	
		TRACHEITIS/LARYNGITIS			
		INFLUENZA		5	
		PNEUMONIA		4	
		ASTHMA, HAY FEVER		1	
		CHRONIC LUNG DISEASE (Emphysema)			
		OTHER CONDITIONS		6	
IX.		DISEASES OF THE DIGESTIVE SYSTEM: TOTAL		12	
		CARIES and Other Dental Problems		6	
		PEPTIC ULCER		2	
		APPENDICITIS			
		HERNIA		1	
		CHOLECYSTIC DISEASE			
		OTHER CONDITIONS		1	
		Gastritis		2	
X.		DISEASES OF THE GENITOURINARY SYSTEM: TOTAL	8	8	
		URINARY TRACT INFECTION (Pyelonephritis, Cystitis)			
		DISEASES OF PROSTATE GLAND (excluding Carcinoma)		1	
		OTHER DISEASES of Male Genital Organs		1	
		DISORDERS of Menstruation		3	
		MENOPAUSAL SYMPTOMS			
		OTHER DISEASES of Female Genital Organs		3	
		OTHER CONDITIONS			
XI.		COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM: TOTAL			
		INFECTIONS of Genitourinary Tract during Pregnancy			
		TOXEMIAS of Pregnancy			
		SPONTANEOUS ABORTION			
		REFERRED FOR DELIVERY			
		COMPLICATIONS of the Puerperium			
		OTHER CONDITIONS			
XII.		DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE: TOTAL		18	
		SOFT TISSUE ABSCESS OR CELLULITIS		3	
		IMPETIGO OR OTHER PYODERMA		9	
		SEBORRHEIC DERMATITIS			
		ECZEMA, CONTACT DERMATITIS, OR NEURODERMATITIS		3	
		ACNE			
		OTHER CONDITIONS		3	

PART II - 5. *(Continued)*

MG 05G TRI COUNTY

ICD CLASS		DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
XIII.		DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE: TOTAL		8	
		RHEUMATOID ARTHRITIS		1	
		OSTEOARTHRITIS			
		ARTHRITIS, Unspecified		3	
		OTHER CONDITIONS		4	
XIV.		CONGENITAL ANOMALIES: TOTAL			
		CONGENITAL ANOMALIES of Circulatory System			
		OTHER CONDITIONS			
XV.		CERTAIN CAUSES OF PERINATAL MORBIDITY AND MORTALITY: TOTAL			
		BIRTH INJURY			
		IMMATURITY			
		OTHER CONDITIONS			
XVI.		SYMPTOMS AND ILL-DEF IED CONDITIONS: TOTAL		12	
		SYMPTOMS OF SENILITY			
		BACKACHE		3	
		OTHER SYMPTOMS REFERRABLE TO LIMBS AND JOINTS		1	
		HEADACHE		5	
		OTHER CONDITIONS		3	
XVII.		ACCIDENTS, POISONINGS, AND VIOLENCE: TOTAL		16	
		LACERATIONS, ABRASIONS, and Other Soft Tissue Injuries		3	
		BURNS		2	
		FRACTURES		3	
		SPRAINS, STRAINS, DISLOCATIONS		6	
		POISON INGESTION			
		OTHER CONDITIONS due to Accidents, Poisoning, or Violence		2	

				NUMBER OF INDIVIDUALS
6.		SPECIAL CONDITIONS AND EXAMINATIONS WITHOUT SICKNESS: TOTAL		322
		FAMILY PLANNING SERVICES	50	
		WELL CHILD CARE	50	
		PRENATAL CARE	16	
		POSTPARTUM CARE	6	
		TUBERCULOSIS: Follow-up of inactive case	1	
		MEDICAL AND SURGICAL AFTERCARE	4	
		GENERAL PHYSICAL EXAMINATION	12	
		PAPANICOLAOU SMEARS	6	
		TUBERCULIN TESTING	14	
		SEROLOGY SCREENING	4	
		VISION SCREENING	6	
		AUDITORY SCREENING	1	
		SCREENING CHEST X-RAYS	2	
		GENERAL HEALTH COUNSELLING	190	
		OTHER SERVICES:		
		(Specify)		

PART III - NURSING SERVICE

MG 05G TRI COUNTY

TYPE OF SERVICE		NUMBER
NURSING CLINICS.		
a. NUMBER OF CLINICS		
b. NUMBER OF INDIVIDUALS SERVED - TOTAL		500
FIELD NURSING:		
a. VISITS TO HOUSEHOLDS	800	
b. TOTAL HOUSEHOLDS SERVED	188	
c. TOTAL INDIVIDUALS SERVED IN HOUSEHOLDS	862	
d. VISITS TO SCHOOLS, DAY CARE CENTERS	20	
e. TOTAL INDIVIDUALS SERVED IN SCHOOLS AND DAY CARE CENTERS	100	
CONTINUITY OF CARE:		
a. REFERRALS MADE FOR MEDICAL CARE: TOTAL		72
(1) Within Area		
(Total Completed 72)		
(2) Out of Area 2		
(Total Completed)		
b. REFERRALS MADE FOR DENTAL CARE: TOTAL		27
(Total Completed 20)		
c. REFERRALS RECEIVED FOR MEDICAL OR DENTAL CARE FROM OUT OF AREA: TOTAL		4
(Total Completed 1)		
d. FOLLOW-UP SERVICES FOR MIGRANTS, not originally referred by project, WHO WERE TREATED IN PHYSICIANS' OFFICES (Fee-for-Service) 80		
e. MIGRANTS PROVIDED PRE-DISCHARGE PLANNING AND POST-HOSPITAL SERVICES 2		
f. MIGRANTS ASKED TO PRESENT HEALTH RECORD Form PMS-3652 or Similar Form) IN FIELD OR CLINIC: TOTAL		180
(1) Number presenting health record. 71		
(2) Number given health record 38		
OTHER ACTIVITIES *(Specify)*:		

REMARKS

PART IV - SANITATION SERVICES

MG 05G TRI-COUNTY

TABLE A. SURVEY OF HOUSING ACCOMMODATIONS

HOUSING ACCOMMODATIONS	TOTAL		COVERED BY PERMITS	
	NUMBER	MAXIMUM CAPACITY	NUMBER	MAXIMUM CAPACITY
CAMPS	6	407		
OTHER LOCATIONS	20	215		
HOUSING UNITS - Family:				
IN CAMPS	74	383		
IN OTHER LOCATIONS	45	225		
HOUSING UNITS - Single				
IN CAMPS	1	14		
IN OTHER LOCATIONS				

TABLE B. INSPECTION OF LIVING AND WORKING ENVIRONMENT OF MIGRANTS

ITEM	NUMBER OF LOCATIONS INSPECTED*		TOTAL NUMBER OF INSPECTIONS		NUMBER OF DEFECTS POUND		NUMBER OF CORRECTIONS MADE	
	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER
LIVING ENVIRONMENT								
a. WATER	6.	16	24	44	5		5	
b. SEWAGE	15	11	60	36	9	2	5	1
c. GARBAGE AND REFUSE	15	11	60	36	22	8	11	4
d. HOUSING	15	11	60	36	9	2	5	1
e. SAFETY	15	11	60	36	1		1	
f. FOOD HANDLING								
g. INSECTS AND RODENTS	15	11	60	36	3		2	
h. RECREATIONAL FACILITIES	1				1		1	
WORKING ENVIRONMENT:								
a. WATER	xxxx		xxxx		xxxx		xxxx	
b. TOILET FACILITIES	xxxx		xxxx		xxxx		xxxx	
c. OTHER	xxxx		xxxx		xxxx		xxxx	

** Locations – camps or other locations where migrants work or are housed.*

PART V – HEALTH EDUCATION SERVICES *(By type of service, personnel involved, and number of sessions.)*

TYPE OF HEALTH EDUCATION SERVICE	NUMBER OF SESSIONS					
	HEALTH EDUCATION STAFF	PHYSICIANS	NURSES	SANITARIANS	AIDES (other than Health Ed.)	OTHER (Specify)
A. SERVICES TO MIGRANTS			PHN-CHA			
(1) Individual counselling			231	4		
(2) Group counselling						
B. SERVICES TO OTHER PROJECT STAFF						
(1) Consultation		5	6	32	3	
(2) Direct services						
C. SERVICES TO GROWERS						
(1) Individual counselling	2		2	68		
(2) Group counselling						
D. SERVICES TO OTHER AGENCIES OR ORGANIZATIONS:						
(1) Consultation with individuals			12	3		
(2) Consultation with groups	1		2	3		
(3) Direct services			6			
E. HEALTH EDUCATION MEETINGS	1	1	6	10	6	

ERIC

Tri-County
MG 05G

TRI-COUNTY SANITATION

This year, a series of circumstances left the Tri-County Health Department with only one sanitarian and no health officer at the beginning of the migrant season. Because of this, the sanitation services were provided directly by the State Board of Health. These services consisted of inspections and surveys of the camp facilities, and consultation with the camp owners and operators.

The specific objectives to be achieved this season were as follows:

1. To evaluate all of the individual water systems and to obtain corrections to all of those found defective.
2. To obtain compliance with the state laws and regulations with regard to the provision and maintenance of toilet and lavatory facilities.
3. To obtain correction to those defects in farm labor camp sanitation involving the storage, collection, and disposal of garbage and solid waste.
4. To effectively inform the growers and camp operators of the need for providing and maintaining good camp facilities.
5. To effectively inform the migrant agricultural worker and his family of the need for properly utilizing these facilities.

The sanitation staff consisted of the supervising and the assistant supervising sanitarians from the Occupational Health Section who made a total of four inspection trips to the area. Camp inspections were accomplished both prior to and during camp occupancy.

Working relationships with personnel from the Oregon State Department of Employment, the Central Oregon Potato Growers Association, and the Tri-County Health Department were for the most part already established last year. This year, all local health departments negotiated agreements with the Department of Employment to provide inspections of farm labor camps, under the federal standards, for those growers wanting employment service assistance in their out-of-state labor recruitment. As it happened, no farm labor camp in the Tri-County area could meet the U. S. Department of Labor standards. Although the State Board of Health provided the bulk of sanitation services, the Tri-County Health Department was called upon to collect water samples, and the Department became actively involved when it appeared that two camps were to be closed.

There has been and continues to be a shortage of good farm labor housing in this area. The housing that is presently available consists of one large central farm labor camp, several groups of small cabins and stationary house trailers located on the farms, two facilities containing apartment type units, various motels, and several shacks. During the 1969 season, six farm labor camps and 20 other locations were used to house the farm laborers and their families.

In the Tri-County area, 1969 was far from being an ideal farming year. Late spring rains leached out the commercial fertilizer, early fall freezes produced frozen potatoes and irregular harvest contributed to generally poor crop yield. The poor crops accompanied by 8° to 15°F temperatures in the area made the housing situation quite uncomfortable for many of the families. Even though there are usually some provisions for heating the living units they were not adequate for this type of weather condition.

In the Madras, Round Butte, Metolius, and Culver areas the water supply is provided by a central water district supplied from Opal Springs. No problem exists with this system. However, in the Redmond and Powell Butte areas two camps obtained their water from irrigation ditches. The water from the irrigation system is diverted into cisterns - unfiltered but chlorinated. This practice, which is a particularly poor one, is general for the rural population in these areas.

The method of sewage disposal for this particular area of the State has been accomplished by another unique process. Wells (dry) are drilled into the porous Basalt, which underlies the entire area, until a volcanic lava tube, a void, or an ash bed is located. Into these holes the sewage has been dumped with or without benefit of septic tank. Only

this year has this practice been stopped and the installation of septic tanks and drain fields been required. Eighty percent of the toilet facilities provided were flush toilets while only 20 percent were privies. One camp provided no toilet facilities at all until a Notice of Camp Closure was prepared and ready for the State Health Officers signature.

Garbage and solid waste storage, collection, and disposal practices presented no particular problem in those living units in or adjacent to the communities because of the commercial garbage pickup services. The farm camps though, presented a different problem. Several of the growers and camp operators felt that the farm labor contractor should be responsible for removing the garbage and solid waste. Until their legal responsibility was clearly explained to the camp operators, garbage remained a problem. The burning of garbage in 55 gallon drums did little to help the problem at a few of the camps.

As there were no central food service facilities in any of the camps, workers had to store, prepare, and eat their food with and in the facilities provided. All of the units had a stove (of some type for cooking and heating), but refrigeration and food storage facilities were almost non-existent.

The time for digging potatoes extends from September through October which coincides with the heaviest fly season for central and eastern Oregon. Although at night and in the morning the temperature may fall well below freezing; the late morning and afternoon sun can and often does raise the temperature well above the 70°F mark. In the on-the-farm camps the lack of refrigeration and food storage facilities, and in several camps improper garbage practices and poorly constructed privies did little to alleviate the fly problem. The large central labor camp at Culver sprayed with diazonon with good success.

Growers and camp operators in this area have not as yet responded too well in meeting their responsibilities of providing adequate housing and meeting camp sanitation standards. A "Notice of Intent to Operate a Farm Labor Camp" (to be sent to the County Health Officer) is required of each grower or camp operator. In the Tri-County area these notifications were obtained by going to each farmer and camp operator and having him sign it.

In spite of what was an apparently not too fruitful season, actually the 54 camp inspections paid off. The first two inspections were conducted prior to the occupancy of the camp. These did little to generate interest or progress toward getting the camps ready for occupancy, but it did set the stage for what was later to follow. By the time the camps were ready to open the sanitarians were no strangers to the growers and they were pretty well aware of what was required before the camp could be occupied. During the course of the season, five defective water supplies were noted and five supplies corrected. Eleven sewage disposal violations were discovered and six of these corrected which amounted to a 55 percent improvement. Thirty violations were noted in the area of garbage storage, collection, or disposal and 15 or 50 percent of these were corrected. Eleven unsatisfactory dwelling units were found and of these, six were either improved or in the case of the Culver Labor Camp, three units were phased out because of their poor structural condition.

The factors contributing to what improvements were achieved were primarily a) pressure from the sanitarians to upgrade the conditions, b) familiarity by the farmers and camp operators of the requirements, c) the threatened closure of several camps, and d) better management at Culver Labor Camp. In addition to these factors there was the nurse and the community health aide that did much while working with the farm workers to achieve better personal hygiene and camp care by the migrant workers themselves. Unfortunately, public opinion in this area has not centered on this particular problem and apparently there is little being done by the Office of Economic Opportunity groups toward improving the situation.

In looking forward to next year, it is quite apparent that this program should be administered by the local health department. A locally administered program should increase the local interest in the program, and allow for more frequent camp visits by the sanitarians throughout the entire year to keep things continually moving.

Tri-County
MG 05G

The program has begun, some progress has been made and now it should be up to the local health department to assume the responsibility, which has been delegated to them by law, for the administration of this program.

NURSING NARRATIVE

This was Tri-County's second year to have a Migrant Health Project. One project nurse and a health aide began work in August and terminated in November.

The migrant families began moving into the area in September before field work was available. Because of rain, the potato harvest was slow in starting. Many of the families were given referral slips for abundant food. The Dorcus Society, Care and Share, and various thrift shops in the area assisted in providing clothing, especially for the school children. A Madras slaughterhouse donated approximately 75 pounds of meat to the needy families.

Before the majority of the migrants started moving in, pharmacies and doctors were contacted in Jefferson, Deschutes, and Crook counties. The program was explained to pharmacies in Crook County since this county didn't help us last year. Self-addressed cards were mailed out to physicians and dentists in the three counties signifying whether or not the physicians and dentists would assist us. The reponse was rapid with only one dentist in Crook County telling us he would be "too filled up" for the entire time the migrants would be here.

Less migrants than we anticipated arrived here. Most of them told of having financial troubles because of poor crops. We logged 180 families with a total of 880 people. The ethnic groups included Spanish, Anglos, Indians, and one Negro. The largest numbers of families came from Texas, Washington, and Eastern Oregon.

This year saw many young men and women working on the combines as more and more farmers in the Tri-County area are converting to machinery. A year ago the frequent comment was that the migrants would never adjust to working on the combines because they can't make enough money.

The season was slow in starting and was slowed further because of the rain and frost. The yield was poor with low tonnage.

We heard many comments from migrants to the effect that it won't pay to return to Jefferson County any more because of increasing mechanization. Many farmers had difficulty getting their potatoes out because there was a lack of people to make up crews on combines.

This year we had a case of a 15 year old boy who hurt his hand while working on a combine. The camp manager was dressing the wound until she encouraged the boy to see a doctor. I notified the employment agency of the boy's age and circumstances and they in turn notified the Department of Labor. There were other incidences of on-the-job injuries in which several farmers tried to get the project to pay.

The migrant seems to look on the farmer with suspicion, expecting to "be taken" with each encounter. The farmers in turn were unhappy over the fact that if the yield was poor or the potatoes very small, the crew would quit and go to another contractor and work. Another farmer was busy disinterring empty potato sacks that had been buried by some of the pickers. He discovered 30 sacks, and, I am told, the practice is common.

The health aide started work in August and proved valuable in filling out family logs, making family contracts, transporting migrants to doctor's offices and participating in health education.

We were able to see more migrants this year than last but because of the large area involved, I felt we could have seen more people if we had possessed a second aide. Much of our time was spent in listening to the many problems involved. There seemed to be more

cases of intoxication and marital problems which might account for the many broken appointments. The nurse would tell the parents she could be at their home at a certain time to immunize their children, they would agree to be there but would not keep the appointment.

There were no evening clinics this year as local physicians were co-operative in seeing patients in their offices. Many of the physicians and the dentists would call me to discuss a particular patient's progress or prognosis. Many families who had been in the area before sought medical care without referral slips. The nurses were notified of the visits and follow-up visitations in most cases were made in the homes.

Some difficulty was encountered in one of the local hospitals concerning notifying the project nurse when migrants were admitted. At times, the migrants were discharged after three days with no local address or other helpful information obtained.

The principal of the Culver High School was very helpful in meeting for consultation on school children in need of dental care or glasses. The Culver Grade School provides two special classes for migrant children. We feel that this is helpful in a way, however, it segregates the children too, and so they are not exposed to the English language as they would be if they attended a mixed class.

Skin infections were prevalent again this year and the project nurse and the aide provided the families with phisohex soap and packets of neosporin ointment. This treatment was effective, but in many instances it took several nursing visits to encourage the family in continuing care. Several of the families stopped using the neosporin ointment and instead took their children to the doctor for treatment.

Health education was done by individual contact. The manager of the Culver Camp came to the project nurse to enlist her help in cutting down vandalism in the toilet facilities. Much time was spent talking to the families about keeping their areas clean and not allowing their children to use the bathrooms as a play area. Posters were placed on the walls listing camp rules, doctors' addresses, and phone numbers. Several small posters were set up in the women's bathrooms in regard to adequate disposal of paper, sanitary napkins, etc. All the posters were left undisturbed and there was marked improvement in the bathrooms.

Children were being left alone in the cabins. The mothers or an older sister would call us and after the public health nurse would get to the cabin, she would discover a sick child alone. Too much time was being spent in the doctor's offices and transporting patients to allow much time for counseling, so posters were put up telling the people sick children were their responsibility and they were not to leave them alone or in the day care center. The prevalence of impetigo and hair lice in the day care center was down compared to last year. The nurse encouraged many mothers to buy medication for the removal of lice and nits and also gave them medication when there was a need.

Too many children stayed out of school to work and babysit. In Redmond, a teacher told the public health nurse that last year there were forty-four children attending school, this year there were four. This is due to the decreased number of migrants in Deschutes County and also to the fact that not enough parents seemed concerned enough over education. Since the majority came from Texas, they all spoke of a school program where special classes are held for migrant children where they can catch up to their grade level. Most of the children talked to did not like school -- mostly from the third grade up. It is disheartening to see 10 and 12 year olds come in from working in the fields, covered with dust and dropping tiredly on the bed. They are robbed of their childhood. How can parents see this and tolerate it? How can potato growers and contractors and school officials know and maybe see this and not do something about it?

The public health nurse talked to the juvenile officer about the many children at the camp not attending school. He made a few visits but because he speaks no Spanish, made little headway. The migrants who do not wish to discuss something seem to lose their English speaking ability. It is hard to imagine any other children from another culture being allowed to stay out of school without someone noticing and putting a stop to it.

The project nurse could meet with more individuals if she had an office or a place where she could set up an office at each major camp to talk to the migrants and also give immunizations at the patient's convenience. The immunizations were disappointingly low because too many mothers could not recall where the records were. Education in this is necessary. The mothers should have a good idea of the number of immunizations and also what they protect against. Many, many mothers did not have any idea of what the injections were for.

Supervision in the area of recreation is needed in the camps. That would cut down on the vandalism.

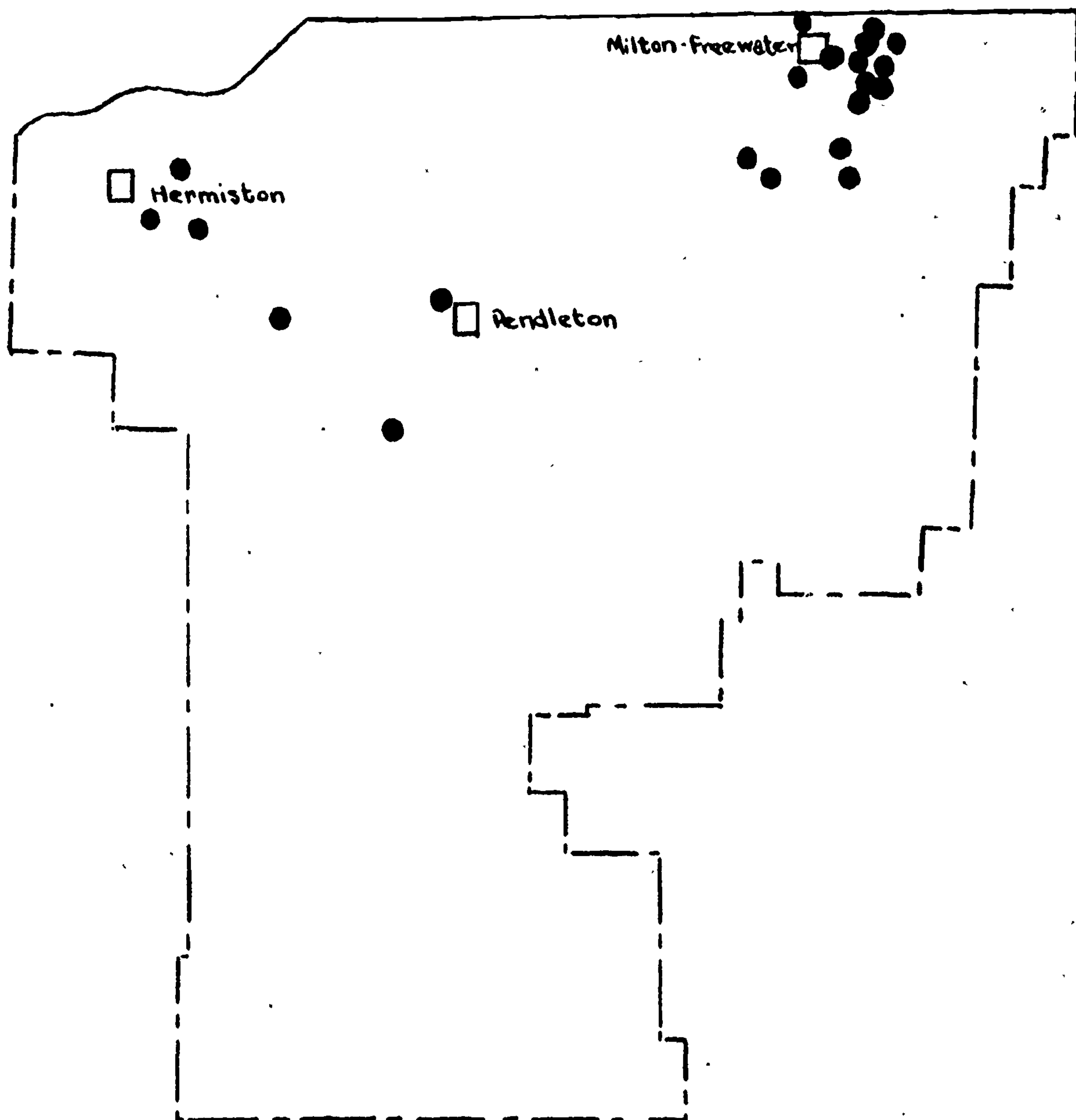
Perhaps next year some doctor in the Tri-County area would be willing to keep his office open during the evening hours. This would eliminate using the emergency room as a clinic.

CASE HISTORY--NURSING

The young mother with her three month-old daughter and her parents came to the Lone Pine area in Crook County from Texas. They seemed a closely knit, loving family, obviously doting on the infant.

During the family interview the baby started cooing and laughing and, naturally, everyone admired and played with the baby. The mother asked many questions concerning child care, diet, rate of development, etc. The grandmother, throughout the conversation, kept looking at the project nurses with what could only be termed suspicion. When the interview was over the grandmother called us back at the door saying, "Here, you better hold the baby or else I'd have to spend a lot of time looking for you. You know "mal de ojo." We complied by holding the baby for a few seconds. Apparently when we admire something about another person, we, in effect, put a hex on him. The child will become ill with elevated temp, vomiting, sometimes convulsions, unless the person doing the admiring cancels out the "hex" by touching or holding the admiree! The nurses and the aides learned to touch any child about whom they were discussing, if possible. The majority of the migrants always re-assure the nurses that they do not really believe they are capable of having the evil eye, but, just in case, the nurses touch.

UMATILLA COUNTY



Umatilla County Migrant Health Project
Umatilla County Health Department
Alton L. Alderman, M.D., Health Officer
P. O. Box 8
Pendleton, Oregon 97801

POPULATION AND HOUSING DATA

FOR UMATILLA COUNTY.

GRANT NUMBER MG 050

POPULATION DATA - MIGRANTS *(Workers and dependents)*

a. NUMBER OF MIGRANTS BY MONTH

MONTH	TOTAL	IN-MIGRANTS	OUT-MIGRANTS
JAN.			
FEB.			
MAR.			
APRIL			
MAY			
JUNE			
JULY			
AUG.			
SEPT.			
OCT.			
NOV.			
DEC.			
TOTALS			

b. NUMBER OF MIGRANTS DURING PEAK MONTH

	TOTAL	MALE	FEMALE
(1) OUT-MIGRANTS:			
TOTAL			
UNDER 1 YEAR			
1 - 4 YEARS			
5 - 14 YEARS			
15 - 44 YEARS			
45 - 64 YEARS			
65 AND OLDER			
(2) IN-MIGRANTS:			
TOTAL	420	184	236
UNDER 1 YEAR	18	8	10
1 - 4 YEARS	103	32	71
5 - 14 YEARS	105	50	55
15 - 44 YEARS	167	77	90
45 - 64 YEARS	22	14	8
65 AND OLDER	5	3	2

c. AVERAGE STAY OF MIGRANTS IN COUNTY

	NO. OF WEEKS	FROM (MO.)	THROUGH (MO.)
OUT-MIGRANTS			
IN-MIGRANTS	2	March	October

6. HOUSING ACCOMMODATIONS

a. CAMPS

MAXIMUM CAPACITY	NUMBER	OCCUPANCY *(Peak)*
LESS THAN 10 PERSONS	5	60
10 - 25 PERSONS	3	70
26 - 50 PERSONS	2	95
51 - 100 PERSONS	1	75
MORE THAN 100 PERSONS	2	500
TOTAL*	13	800

b. OTHER HOUSING ACCOMMODATIONS

LOCATION *(Specify)*	NUMBER	OCCUPANCY *(Peak)*
Milton-Freewater - travel trailers parked on state and private property		
TOTAL*		

*NOTE: *The combined occupancy totals for "a" and "b" should equal approximately the total peak migrant population for the year.*

REMARKS

Source of information for 5b: family records.

GRANT NUMBER	
MG 05G	UMATILLA COUNTY
DATE SUBMITTED	

PART II - MEDICAL, DENTAL, AND HOSPITAL SERVICES

1. MIGRANTS RECEIVING MEDICAL SERVICES

a. TOTAL MIGRANTS RECEIVING MEDICAL SERVICES AT FAMILY HEALTH CLINICS, PHYSICIANS OFFICES, HOSPITAL EMERGENCY ROOMS, ETC.

AGE	NUMBER OF PATIENTS			NUMBER OF VISITS
	TOTAL	MALE	FEMALE	
TOTAL	143			155
UNDER 1 YEAR	6			
1 - 4 YEARS	50			
5 - 14 YEARS	29			
15 - 44 YEARS	52			
45 - 64 YEARS	5			
65 AND OLDER	1			

No. of related nursing visits

b. OF TOTAL MIGRANTS RECEIVING MEDICAL SERVICES, HOW MANY WERE:

(1) SERVED IN FAMILY HEALTH SERVICE CLINIC? 39

(2) SERVED IN PHYSICIANS' OFFICE, ON FEE-FOR-SERVICE ARRANGEMENT (INCLUDE REFERRALS) 137

2. MIGRANTS RECEIVING DENTAL SERVICES

ITEM	TOTAL	UNDER 15	15 AND OLDER
a. NO. MIGRANTS EXAMINED-TOTAL	55	55	
(1) NO. DECAYED, MISSING, FILLED TEETH			
(2) AVERAGE DMF PER PERSON			
b. INDIVIDUALS REQUIRING SERVICES-TOTAL	21	21	9
(1) CASES COMPLETED	15	9	6
(2) CASES PARTIALLY COMPLETED	15	9	6
(3) CASES NOT STARTED	2	2	2
c. SERVICES PROVIDED - TOTAL			
(1) PREVENTIVE	0	0	0
(2) CORRECTIVE-TOTAL			
(a) Extraction			
(b) Other			
d. PATIENT VISITS - TOTAL			

3. MIGRANT HOSPITALIZATIONS

SOURCE OF PAYMENT	NO. PTS.	M	F	AGE GROUPING						TOTAL HOSP. DAYS	AVE. HOSP. DAYS	PROJECT HOSPITAL COSTS	DOCTORS FEES PAID	TOTAL HOSPITAL BILLING
				<1	1-4	5-14	15-44	45-64	65+					
MIGRANT FUNDS	14	6	8	3	1		10			51	4	$1716.40	$1014.00	$3706.34
OTHERS*														

*PAYMENT MADE BY PATIENT, INSURANCE, WELFARE, OR PROVIDED BY UNIVERSITY OF OREGON MEDICAL SCHOOL

4. IMMUNIZATIONS PROVIDED

TYPE	COMPLETED IMMUNIZATIONS, BY AGE					INCOMPLETE SERIES	BOOSTERS, REVACCINATION
	TOTAL	UNDER 1 YEAR	1 - 4	5 - 14	15 AND OLDER		
TOTAL-- ALL TYPES							
SMALLPOX	4		1	3			
DIPHTHERIA	7		7			16	2
PERTUSSIS	7		7			16	2
TETANUS	7		7			16	2
Polio	12	1	10	1		18	
MEASLES							
TUBERCULIN SKIN TESTS							

RT II (Continued) - 5. MEDICAL CONDITIONS TREATED BY PHYSICIANS IN FAMILY CLINICS, HOSPITAL OUTPATIENT DEPARTMENTS, AND PHYSICIANS' OFFICES.

MG 05G UMATILLA COUNTY

ICD CLASS		DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
II.		TOTAL ALL CONDITIONS		69	
		INFECTIVE AND PARASITIC DISEASES: TOTAL	33	14	1
		TUBERCULOSIS	27	9	
		SYPHILIS			
		GONORRHEA AND OTHER VENEREAL DISEASES			
		INTESTINAL PARASITES			
		DIARRHEAL DISEASE (infectious or unknown origins):			
		Children under 1 year of age	4	4	
		All other			
		"CHILDHOOD DISEASES" - mumps, measles, chickenpox			
		FUNGUS INFECTIONS OF SKIN (Dermatophytoses)	2	1	1
		OTHER INFECTIVE DISEASES *(Give examples)*:			
I.		NEOPLASMS: TOTAL			
		MALIGNANT NEOPLASMS *(give examples)*:			
		BENIGN NEOPLASMS			
		NEOPLASMS of uncertain nature			
II.		ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES: TOTAL	22	12	10
		DISEASES OF THYROID GLAND	2	1	1
		DIABETES MELLITUS	5	3	2
		DISEASES of Other Endocrine Glands			
		NUTRITIONAL DEFICIENCY	10	5	5
		OBESITY	5	3	2
		OTHER CONDITIONS			
IV.		DISEASES OF BLOOD AND BLOOD FORMING ORGANS: TOTAL			
		IRON DEFICIENCY ANEMIA			
		OTHER CONDITIONS			
V.		MENTAL DISORDERS: TOTAL			
		PSYCHOSES			
		NEUROSES and Personality Disorders			
		ALCOHOLISM			
		MENTAL RETARDATION			
		OTHER CONDITIONS			
VI.		DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS: TOTAL	20	7	13
		PERIPHERAL NEURITIS	2	1	1
		EPILEPSY	3	1	2
		CONJUNCTIVITIS and other Eye Infections			
		REFRACTIVE ERRORS of Vision			
		OTITIS MEDIA	14	4	10
		OTHER CONDITIONS Deviant eye	1	1	

PART II - 5. *(Continued)*

MG 05G UMATILLA COUNTY

ICD CLASS		DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
VII.		DISEASES OF THE CIRCULATORY SYSTEM: TOTAL			
		RHEUMATIC FEVER			
		ARTERIOSCLEROTIC and Degenerative Heart Disease			
		CEREBROVASCULAR DISEASE (Stroke)			
		OTHER DISEASES of the Heart			
		HYPERTENSION			
		VARICOSE VEINS			
		OTHER CONDITIONS			
VIII.		DISEASES OF THE RESPIRATORY SYSTEM: TOTAL	13	3	10
		ACUTE NASOPHARYNGITIS (Common Cold)			
		ACUTE PHARYNGITIS			
		TONSILLITIS			
		BRONCHITIS			
		TRACHEITIS/LARYNGITIS			
		INFLUENZA			
		PNEUMONIA	9	1	8
		ASTHMA, HAY FEVER	2	1	1
		CHRONIC LUNG DISEASE (Emphysema)	2	1	1
		OTHER CONDITIONS			
IX.		DISEASES OF THE DIGESTIVE SYSTEM: TOTAL	15	3	12
		CARIES and Other Dental Problems			
		PEPTIC ULCER	11	1	10
		APPENDICITIS			
		HERNIA	4	2	2
		CHOLECYSTIC DISEASE			
		OTHER CONDITIONS			
X.		DISEASES OF THE GENITOURINARY SYSTEM: TOTAL	8	3	5
		URINARY TRACT INFECTION (Pyelonephritis, Cystitis)	4	2	2
		DISEASES OF PROSTATE GLAND (excluding Carcinoma)			
		OTHER DISEASES of Male Genital Organs			
		DISORDERS of Menstruation			
		MENOPAUSAL SYMPTOMS			
		OTHER DISEASES of Female Genital Organs	4	1	3
		OTHER CONDITIONS			
XI.		COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM: TOTAL		10	
		INFECTIONS of Genitourinary Tract during Pregnancy			
		TOXEMIAS of Pregnancy			
		SPONTANEOUS ABORTION			
		REFERRED FOR DELIVERY		10	
		COMPLICATIONS of the Puerperium			
		OTHER CONDITIONS			
XII.		DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE: TOTAL	28	10	18
		SOFT TISSUE ABSCESS OR CELLULITIS			
		IMPETIGO OR OTHER PYODERMA			
		SEBORRHEIC DERMATITIS			
		ECZEMA, CONTACT DERMATITIS, OR NEURODERMATITIS			
		Scabies	15	5	10
		OTHER CONDITIONS Infected mosquito bites	12	4	8
		In Hermiston too	1	1	0

II • 5. *(Continued)*

DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE: TOTAL	3	1	2
RHEUMATOID ARTHRITIS			
OSTEOARTHRITIS			
ARTHRITIS, Unspecified	3	1	2
OTHER CONDITIONS			
CONGENITAL ANOMALIES: TOTAL			
CONGENITAL ANOMALIES of Circulatory System			
OTHER CONDITIONS			
CERTAIN CAUSES OF PERINATAL MORBIDITY AND MORTALITY: TOTAL			
BIRTH INJURY			
IMMATURITY			
OTHER CONDITIONS			
SYMPTOMS AND ILL-DEFINED CONDITIONS: TOTAL	13	5	8
SYMPTOMS OF SENILITY			
BACKACHE	9	3	6
OTHER SYMPTOMS REFERRABLE TO LIMBS AND JOINTS			
HEADACHE	4	2	2
OTHER CONDITIONS			
ACCIDENTS, POISONINGS, AND VIOLENCE: TOTAL		1	1
LACERATIONS, ABRASIONS, and Other Soft Tissue Injuries		1	1
BURNS			
FRACTURES			
SPRAINS, STRAINS, DISLOCATIONS			
POISON INGESTION			
OTHER CONDITIONS due to Accidents, Poisoning, or Violence			

	NUMBER OF INDIVIDUALS
SPECIAL CONDITIONS AND EXAMINATIONS WITHOUT SICKNESS: TOTAL	170
FAMILY PLANNING SERVICES	14
WELL CHILD CARE	39
PRENATAL CARE	10
POSTPARTUM CARE	3
TUBERCULOSIS: Follow-up of inactive case	11
MEDICAL AND SURGICAL AFTERCARE	1
GENERAL PHYSICAL EXAMINATION	6
PAPANICOLAOU SMEARS	26
TUBERCULIN TESTING	
SEROLOGY SCREENING	
VISION SCREENING	20
AUDITORY SCREENING	20
SCREENING CHEST X-RAYS	
GENERAL HEALTH COUNSELLING	
OTHER SERVICES:	
(Specify) Speech screening	20

ERIC

PART III - NURSING SERVICE

TYPE OF SERVICE		NUMBER
1. NURSING CLINICS:		
a. NUMBER OF CLINICS		
b. NUMBER OF INDIVIDUALS SERVED - TOTAL		
2. FIELD NURSING:		
a. VISITS TO HOUSEHOLDS		200
b. TOTAL HOUSEHOLDS SERVED		86
c. TOTAL INDIVIDUALS SERVED IN HOUSEHOLDS		418
d. VISITS TO SCHOOLS, DAY CARE CENTERS		96
e. TOTAL INDIVIDUALS SERVED IN SCHOOLS AND DAY CARE CENTERS		80
3. CONTINUITY OF CARE:		
a. REFERRALS MADE FOR MEDICAL CARE: TOTAL		200
(1) Within Area	200	
(Total Completed	176)	
(2) Out of Area		
(Total Completed	)	
b. REFERRALS MADE FOR DENTAL CARE: TOTAL		20
(Total Completed	15)	
c. REFERRALS RECEIVED FOR MEDICAL OR DENTAL CARE FROM OUT OF AREA: T.B. TOTAL		10
(Total Completed	8)	
d. FOLLOW-UP SERVICES FOR MIGRANTS, not originally referred by project, WHO WERE TREATED IN PHYSICIANS' OFFICES (Fee-for-Service)	30	
e. MIGRANTS PROVIDED PRE-DISCHARGE PLANNING AND POST-HOSPITAL SERVICES	24	
f. MIGRANTS ASKED TO PRESENT HEALTH RECORD Form PMS-3652 or Similar Form) IN FIELD OR CLINIC: TOTAL		400
(1) Number presenting health record.	42 families	
(2) Number given health record.	28 families	
4. OTHER ACTIVITIES *(Specify)*:		

REMARKS

Our records will be more complete next year.

PART IV - SANITATION SERVICES

TABLE A. SURVEY OF HOUSING ACCOMMODATIONS

HOUSING ACCOMMODATIONS	TOTAL		COVERED BY PERMITS	
	NUMBER	MAXIMUM CAPACITY	NUMBER	MAXIMUM CAPACITY
CAMPS	13	800		
OTHER LOCATIONS	2	120		
HOUSING UNITS - Family:				
IN CAMPS	165	570		
IN OTHER LOCATIONS	30	120		
HOUSING UNITS - Single				
IN CAMPS	2	230		
IN OTHER LOCATIONS				

TABLE B. INSPECTION OF LIVING AND WORKING ENVIRONMENT OF MIGRANTS

ITEM	NUMBER OF LOCATIONS INSPECTED*		TOTAL NUMBER OF INSPECTIONS		NUMBER OF DEFECTS FOUND		NUMBER OF CORRECTIONS MADE	
	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER
LIVING ENVIRONMENT:								
a. WATER	9		15		4		1	
b. SEWAGE	9	3	18	4	1	1	0	1
c. GARBAGE AND REFUSE	13	5	27	8	7	5	5	4
d. HOUSING	13		31		3		2	
e. SAFETY	13		13		2		2	
f. FOOD HANDLING	2		5					
g. INSECTS AND RODENTS	13		14		2		2	
h. RECREATIONAL FACILITIES								
WORKING ENVIRONMENT:								
a. WATER	XXXX		XXXX		XXXX		XXXX	
b. TOILET FACILITIES	XXXX		XXXX		XXXX		XXXX	
c. OTHER	XXXX		XXXX		XXXX		XXXX	

Locations — camps or other locations where migrants work or are housed.

PART V - HEALTH EDUCATION SERVICES *(By type of service, personnel involved, and number of sessions.)*

TYPE OF HEALTH EDUCATION SERVICE	NUMBER OF SESSIONS					
	HEALTH EDUCATION STAFF	PHYSICIANS	NURSES	SANITARIANS	AIDES *(other than Health Ed.)*	OTHER *(Specify)*
A. SERVICES TO MIGRANTS.						
(1) Individual counselling			138	3	8	
(2) Group counselling				14		
B. SERVICES TO OTHER PROJECT STAFF						
(1) Consultation				25		
(2) Direct services				1		
C. SERVICES TO GROWERS:						
(1) Individual counselling						
(2) Group counselling						
D. SERVICES TO OTHER AGENCIES OR ORGANIZATIONS:						
(1) Consultation with individuals				49		
(2) Consultation with groups				1	1	
(3) Direct services				10		
E. HEALTH EDUCATION MEETINGS						

Umatilla County
MG 05G

NURSING NARRATIVE

This report is concerned with the nursing aspects of Umatilla County's Migrant Health Project, April 15, 1969 to November 1st. There was no project nurse November 1968 to April, 1969.

Because of complete failure of cherry and prune crops, there were fewer migrants this year than last, but because of the heavy asparagus harvest there was more stoop labor, mostly Mexican-American. Ninety percent of the families were new to this area. In the new situation many even fairly well-educated and intelligent migrants could not independently handle their medical-dental needs, and welcomed assistance. There were exceptions. A migrant member of EBONY's editorial staff neither needed nor wanted help. Another family, while extremely appreciative of the nurse's interest, felt no need for her services. They enjoyed their migrant life and reported earning as high as $150 a day. When prospects for income in an area were less, they left.

The primary purpose of the project nurse is counseling, guiding and providing or arranging for preventive and corrective services to help migrant families improve their health.

Objectives of the local project are essentially those listed in the Oregon Migrant Health Nursing Service Guide. This report is built around those objectives. Medical service was provided by doctors in Walla Walla, Milton-Freewater, Hermiston, Umatilla, and Pendleton, who were cooperative and understanding in spite of already heavy overloads. Contracts with Walla Walla General, St. Mary's, St. Anthony, Good Shepherd and Umatilla Hospitals are in effect. We know of no cases of non-acceptance of migrant patients by any doctor or hospital in this area. Unfortunately there was a problem of migrants failing to keep appointments.

Efforts were directed to providing readily available preventive medical services, making migrants more aware and encouraging utilization of Community Health Services. Except for giving gamma globulin provided by the Red Cross to 33 residents of Hermiston Farms because of a case of Infectious Hepatitis, special clinics for migrants were not held. Families were informed of and urged to participate in local clinics. Schedules for Well Child and Immunization Clinics in Milton-Freewater were changed to times more convenient for migrant families. Acceptance of service for children (39 attended Well Child Clinic) was gratifying. One family, all loaded up and ready to go, delayed departure from camp until after their child attended clinic at 8:30 P.M. We were less successful in efforts to induce adults to have tuberculin tests or chest X-rays.

Emphasis on Dental care was in meeting most urgent demands. The project nurse assisted in a survey of children at the Migrant School, Head Start and Day Care Center, conducted by a team from the University of Oregon Dental School. Unfortunately, this coincided with the end of asparagus and pea harvest and many families left without obtaining recommended treatment. Earlier all remaining 1968-69 dental funds were designated to start treatment of a dentally crippled nine year old girl (see letter). Because of a dispute with the Camp Manager over problems associated with continuously quartering dogs in their cabin, this family left before the funds were expended. July 1st arrived before the released funds could be reassigned. While the Migrant School was in operation they provided dental care for their enrollees, while we concentrated on others.

To promote use of personal health records and help achieve continuity of health services, we demonstrated their importance to us. The nurse requested the records on her first visit. At clinics they were again requested and updated and parents advised to be sure to show them next time. Forty-two families brought personal records with them. In 26 of these, additional health services were provided and records updated. New personal health records were started for 28 families who came without any.

As a single unit in a composite of services, we attempted by coordinating our efforts with those of others to provide needed services with minimum duplication. Consequently, we provided transportation only when it was important for the nurse to be present when the

Umatilla County
MG 05G

patient was seen. Some examples were: (1) A child with a deviant eye, so we would know and understand the doctor's advice and could work effectively with the family. (2) A 45 year old woman who said she had never been to a doctor and agreed to go only on condition that the nurse stay with her. (3) A child with a foreign body in a posterior cleft of the palate, referred by the Health Officer to a local doctor for emergency removal because of danger of choking.

Transportation when needed was provided by OEO, CAP, Community Representative. Space for Well Child and Immunization Clinics was provided in the Neighborhood Center. Local churches helped by providing food and clothing, but ran out of layettes due to heavy turn over. Work was coordinated with the Welfare and local office of the State Employment Service. A migrant had a hernia repaired and another was treated for a back injury when under Workmen's Compensation. Local pharmacists were helpful, although there were problems in getting them to identify drugs in their billing. One pharmacist informed the nurse of duplicate prescriptions in a migrant family that was flitting from doctor to doctor.

Migrant families were visited by the nurse as soon as possible after arrival. She learned where they were from Day Care Center employees, Camp Manager, Employment Office and Health Department sanitarians. Families were screened to ascertain needs, help to make appointments, and arrange for care. Several visits were sometimes required. For example, the children in one family were afraid of dentists. Although Milton-Freewater Farm Labor Camp was seldom full, due in part to high rents of $20 a week, it was the temporary home for most migrant families who were visited.

Although there were unresolved problems, we feel that in the nursing part of the program strengths far outweighed weaknesses. Many of the problems were associated with administrative details. For example, hospitals occasionally failed to notify us of admission of migrant patients. A two pound-six ounce baby, born the day after the family arrived, was in the hospital for three months. We were notified after the infant's discharge and then we were not told they were migrants. Before we could visit, the family returned to Kansas. In billing, the specific services or drugs were too often not specified. On the positive side was acceptance by the migrants and the community of the project nurse. She was truly interested in each family and able to convey her interest. The appended letters demonstrate the migrants' response.

Special plans for the future:

1. Give attention to migrant families leaving the area comparable to that given to those coming in.
2. Encourage them to let us know where they are going and to keep data on when they go.
3. Establish policies which will encourage staying with the same doctor for a given illness.
4. Provide more information to the project nurse on the amount of funds available, and expended, for various aspects of the fee-for-service programs.
5. Establish and distribute more definitive guide lines on what migrant health funds do or do not cover.
6. Establish rates and procedures for prompt submission of bills.

For next year we hope for no crop failures, no rain at harvest peak and more employment and economic security for migrant workers and their families.

The project nurse integrated health education on a one-to-one basis into each of her contacts. Sometimes individual conferences spontaneously developed into group meetings. One young mother invited six friends to share in a family planning conference. The Mexican-American migrants were very interested in family planning but not for long.

In nutrition and diet counseling, the Health Department nutritionist assisted the nurse. Nutritionally significant conditions of patients with whom they worked included:

Umatilla County
MG 05G

Diabetics 2, gout 1, bleeding gastric ulcer 1, anemia 3, obesity 3, pregnancy 4, and at least 7 mothers of malnourished children. A CAP sponsored cooking class at Neighborhood Center which emphasized using surplus foods for better nutrition was conducted by Home Extension Service independently of the health project.

Health Education is never a one-way process. From the migrants we gained a little understanding of the influence of their social values and cultural concepts on health practices.

SANITATION NARRATIVE

A sanitarian aide was employed early in the year in order to conduct sanitary surveys to determine deficiencies in migrant housing, water systems, solid waste storage and disposal, rodent and insect control, sewage disposal, housing, safety in the environment relating to health of the community, and to obtain compliance before occupancy.

The initial visits revealed that not more than 13 camps would be opened this year. The reduction in the number of camps was for three reasons: (1) a late freeze destroying the soft fruit crops, (2) continued automation in the green pea industry and, (3) the camp operator's inability to meet the minimum standards for migrant housing. The correction of 1 water system and 1 housing deficiency was the result of the early visits.

The migrant housing is of wood frame except for two camps which are of block construction. The structures are in good condition and in general have not required a great deal of upkeep; this attributable to the original sound construction. There continues to be an increase in the use of travel trailers among the migrants. Few of the travel units are used by the Spanish-American migrants.

The lack of travel trailer facilities is our biggest problem. It was hoped to have facilities available this season. However, because of state regulations requiring certain licensed professions to perform the construction, additional monies for their employment were not available. Interest in reorganizing to construct the needed facilities has not been generated.

Hundreds of acres of land have been put into asparagus and potato production. This year in the west end plans are for hundreds more acres next year, which will require additional laborers for harvest. The two existing camps are not of sufficient size to house the increase of workers. It is planned to use motels in the area for housing purposes.

One of the camps was posted for closure because of sewage and solid waste violations. The migrants did not want to move, so took it upon themselves to make the corrections since the camp operator was not interested. After the camp complied with the minimum standards, the migrants moved out.

Harvest did not begin until the latter part of the summer due to the lack of early fruits. Employment for tomato and cucumber harvest was short; therefore, the camps were not occupied much of the time until apple harvest. The lag provided additional time for the operators to continue improvements of the camps.

Public opinion and interest of those furnishing housing has helped a great deal in providing acceptable housing. Farmer associations and cooperatives in the past have aided in improving housing. Of the thirteen camps open this year, only 6 have their own water and sanitary disposal systems. The remaining 7 are connected to public facilities.

Of the 6 camps with individual water systems, 1 chlorinates the supply. Two camp supplies have to chlorinate to obtain acceptability. A water source that does not require chlorination would be more desirable. However, economically, the required depth of the wells to obtain a potable source is almost out of the question. If the recommendations of the county comprehensive water and sewer plan are realized, public water would be available.

Umatilla County
MG 05G

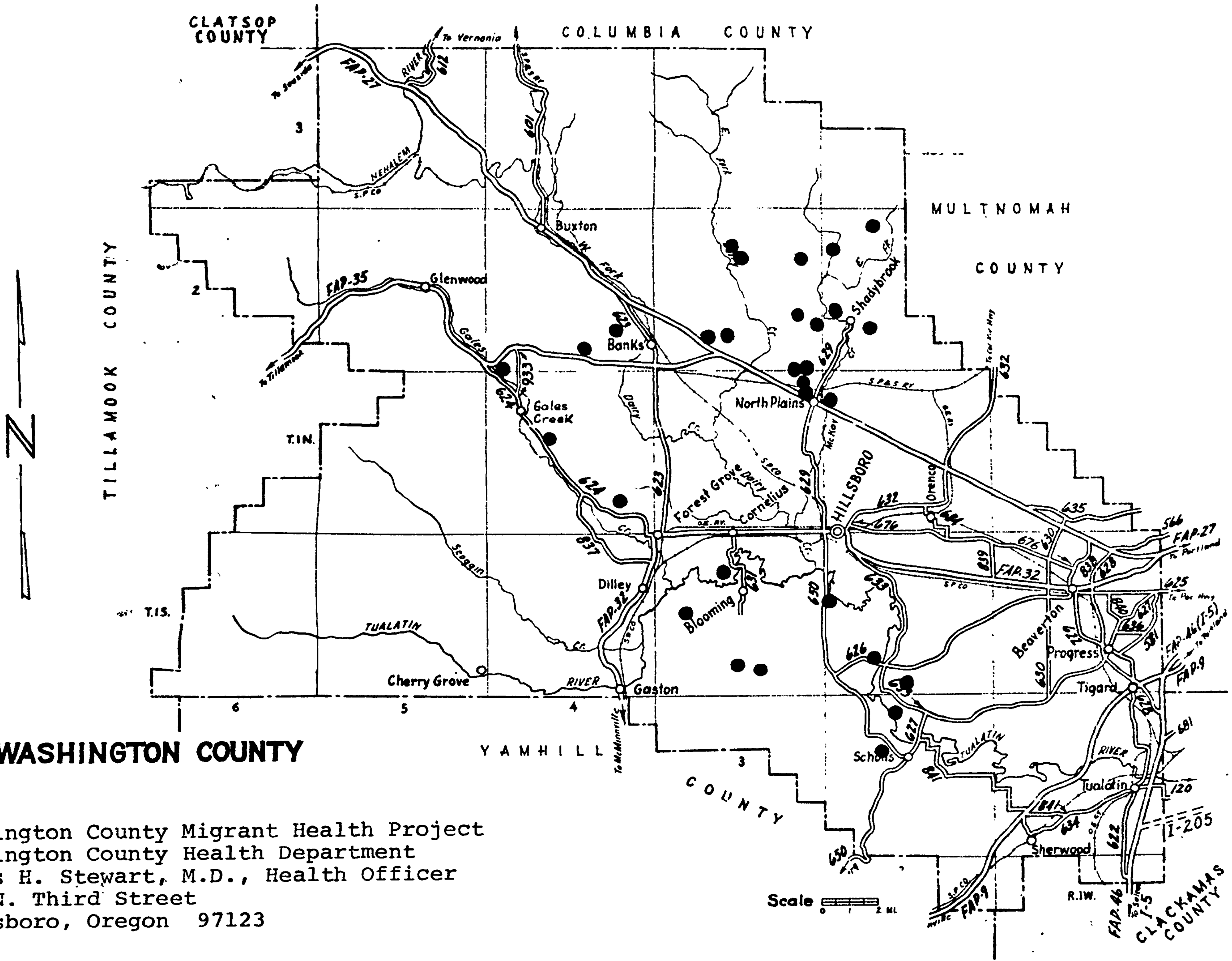
Solid waste storage and collections at the camps were acceptable. Eight of the 13 camps use contract services for solid waste collection.

Refrigeration is provided in all eleven family camps. This is an improvement over last year as of the 11 that were open, 9 camps had refrigerators. Public food service was available at one dormitory migrant camp. The sanitary surveys made of the facility indicated acceptability. The comprehensive plan for reconstruction of the camp includes the construction of a new kitchen.

Health education has exclusively been provided only for camp operators. A general meeting of farmers from Umatilla and Morrow counties, sponsored by the employment service, provided opportunity to discuss migrant housing. Acceptance of the program was good.

The objectives for next year's program are:

1. To improve solid waste storage problems at two camps.
2. To provide potable water at all camps.
3. To upgrade existing housing, including travel trailer facilities.
4. To upgrade environmental conditions in the camps.
5. To provide a field sanitation program.
6. To provide health education to the migrants.



WASHINGTON COUNTY

Washington County Migrant Health Project
Washington County Health Department
James H. Stewart, M.D., Health Officer
150 N. Third Street
Hillsboro, Oregon 97123

POPULATION AND HOUSING DATA

FOR WASHINGTON COUNTY.

GRANT NUMBER MG 05G

5. POPULATION DATA - MIGRANTS (*Workers and dependents*)

a. NUMBER OF MIGRANTS BY MONTH

MONTH	TOTAL	IN-MIGRANTS	OUT-MIGRANTS
JAN.			
FEB.			
MAR.			
APRIL	85	85	
MAY	376	376	
JUNE	1446	1446	
JULY	340	340	
AUG.	182	182	
SEPT.			
OCT.			
NOV.			
DEC.			
TOTALS	2429	2429	

b. NUMBER OF MIGRANTS DURING PEAK MONTH

	TOTAL	MALE	FEMALE
(1) OUT-MIGRANTS:			
TOTAL			
UNDER 1 YEAR			
1 - 4 YEARS			
5 - 14 YEARS			
15 - 44 YEARS			
45 - 64 YEARS			
65 AND OLDER			
(2) IN-MIGRANTS:			
TOTAL	1446	729	717
UNDER 1 YEAR	15	8	7
1 - 4 YEARS	148	69	79
5 - 14 YEARS	617	314	303
15 - 44 YEARS	594	293	301
45 - 64 YEARS	70	44	26
65 AND OLDER	2	1	1

c. AVERAGE STAY OF MIGRANTS IN COUNTY

	NO. OF WEEKS	FROM (MO.)	THROUGH (MO.)
OUT-MIGRANTS			
IN-MIGRANTS			

6. HOUSING ACCOMMODATIONS

a. CAMPS

MAXIMUM CAPACITY	NUMBER	OCCUPANCY (*Peak*)
LESS THAN 10 PERSONS	0	-
10 - 25 PERSONS	7	139
26 - 50 PERSONS	9	303
51 - 100 PERSONS	6	433
MORE THAN 100 PERSONS	10	1497
TOTAL*	32	2372

b. OTHER HOUSING ACCOMMODATIONS

LOCATION (*Specify*)	NUMBER	OCCUPANCY (*Peak*)
TOTAL*		

**NOTE:* *The combined occupancy totals for "a" and "b" should equal approximately the total peak migrant population for the year.*

REMARKS

Information from family rosters given in 5a and 5b.

GRANT NUMBER
MG 05G WASHINGTON COUNTY
DATE SUBMITTED

PART II - MEDICAL, DENTAL, AND HOSPITAL SERVICES

1. MIGRANTS RECEIVING MEDICAL SERVICES

a. TOTAL MIGRANTS RECEIVING MEDICAL SERVICES AT FAMILY HEALTH CLINICS, PHYSICIANS OFFICES, HOSPITAL EMERGENCY ROOMS, ETC.

AGE	NUMBER OF PATIENTS			NUMBER OF VISITS
	TOTAL	MALE	FEMALE	
TOTAL	NOT AVAILABLE			
UNDER 1 YEAR				
1 - 4 YEARS				
5 - 14 YEARS				
15 - 44 YEARS				
45 - 64 YEARS				
65 AND OLDER				

No. of related nursing visits

b. OF TOTAL MIGRANTS RECEIVING MEDICAL SERVICES, HOW MANY WERE:

(1) SERVED IN FAMILY HEALTH SERVICE CLINIC* 273

(2) SERVED IN PHYSICIANS' OFFICE, ON FEE-FOR-SERVICE ARRANGEMENT (INCLUDE REFERRALS) 823

2. MIGRANTS RECEIVING DENTAL SERVICES

ITEM	TOTAL	UNDER 15	15 AND OLDER
a. NO. MIGRANTS EXAMINED-TOTAL	167	114	53
(1) NO. DECAYED, MISSING, FILLED TEETH			
(2) AVERAGE DMF PER PERSON			
b. INDIVIDUALS REQUIRING SERVICES-TOTAL	134	81	53
(1) CASES COMPLETED			
(2) CASES PARTIALLY COMPLETED			
(3) CASES NOT STARTED			
c. SERVICES PROVIDED - TOTAL	402		
(1) PREVENTIVE 15			
(2) CORRECTIVE-TOTAL 387			
(a) Extraction 149			
(b) Other 238*			
d. PATIENT VISITS - TOTAL			

* Including 15 unknown services

3. MIGRANT HOSPITALIZATIONS

SOURCE OF PAYMENT	NO. PTS.	M	F	AGE GROUPING <1	1-4	5-14	15-44	45-64	65+	TOTAL HOSP. DAYS	AVE. HOSP. DAYS	PROJECT HOSPITAL COSTS	DOCTORS FEES PAID	TOTAL HOSPITAL BILLING
MIGRANT FUNDS	14	3	11	2	3	9				75	5	$2256.71	$2041.00	$5046.65
OTHERS*	18													

*PAYMENT MADE BY PATIENT, INSURANCE, WELFARE, OR PROVIDED BY UNIVERSITY OF OREGON MEDICAL SCHOOL

4. IMMUNIZATIONS PROVIDED

TYPE	COMPLETED IMMUNIZATIONS, BY AGE: TOTAL	UNDER 1 YEAR	1 - 4	5 - 14	15 AND OLDER	INCOMPLETE SERIES	BOOSTERS, REVACCINATIONS
TOTAL-- ALL TYPES	NOT AVAILABLE						
SMALLPOX							
DIPHTHERIA							
PERTUSSIS							
TETANUS							
MEASLES							
TUBERCULIN SKIN TESTS							

(Continued) - 5. MEDICAL CONDITIONS TREATED BY PHYSICIANS IN FAMILY CLINICS, HOSPITAL OUTPATIENT DEPARTMENTS, AND PHYSICIANS' OFFICES.

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DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
TOTAL ALL CONDITIONS	1037	809	228
INFECTIVE AND PARASITIC DISEASES: TOTAL	141	130	11
TUBERCULOSIS	8	8	
SYPHILIS	0	0	
GONORRHEA AND OTHER VENEREAL DISEASES	4	2	2
INTESTINAL PARASITES	0	0	
DIARRHEAL DISEASE (infectious or unknown origins):			
Children under 1 year of age			
All other	10	7	3
"CHILDHOOD DISEASES" – mumps, measles, chickenpox	3	3	
FUNGUS INFECTIONS OF SKIN (Dermatophytoses)	0	0	
OTHER INFECTIVE DISEASES (Give examples):			
Pediculosis	114	108	6
Thrush	2	2	
NEOPLASMS: TOTAL	2	2	
MALIGNANT NEOPLASMS (give examples):			
BENIGN NEOPLASMS	2	2	
NEOPLASMS of uncertain nature			
ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES: TOTAL	30	16	14
DISEASES OF THYROID GLAND	2	2	
DIABETES MELLITUS	27	13	14
DISEASES of Other Endocrine Glands			
NUTRITIONAL DEFICIENCY			
OBESITY	1	1	
OTHER CONDITIONS			
DISEASES OF BLOOD AND BLOOD FORMING ORGANS: TOTAL	8	4	4
IRON DEFICIENCY ANEMIA	4	2	2
OTHER CONDITIONS	4	2	2
MENTAL DISORDERS: TOTAL	8	8	
PSYCHOSES			
NEUROSES and Personality Disorders	2	2	
ALCOHOLISM			
MENTAL RETARDATION			
OTHER CONDITIONS	6	6	
DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS: TOTAL	116	69	47
PERIPHERAL NEURITIS	1	1	
EPILEPSY	16	5	11
CONJUNCTIVITIS and other Eye Infections	22	14	8
REFRACTIVE ERRORS of Vision	28	19	9
OTITIS MEDIA	34	24	10
OTHER CONDITIONS	15	6	9

PART II - 5. *(Continued)*

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ICD CLASS		DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
VII.		DISEASES OF THE CIRCULATORY SYSTEM: TOTAL	27	12	15
		RHEUMATIC FEVER	6	2	4
		ARTERIOSCLEROTIC and Degenerative Heart Disease	1	1	
		CEREBROVASCULAR DISEASE (Stroke)			
		OTHER DISEASES of the Heart	3	1	2
		HYPERTENSION	1	1	
		VARICOSE VEINS	1	1	
		OTHER CONDITIONS	15	6	9
VIII.		DISEASES OF THE RESPIRATORY SYSTEM: TOTAL	154	147	7
		ACUTE NASOPHARYNGITIS (Common Cold)	69	67	2
		ACUTE PHARYNGITIS	9	7	2
		TONSILLITIS	34	32	2
		BRONCHITIS	11	11	
		TRACHEITIS/LARYNGITIS			
		INFLUENZA	6	6	
		PNEUMONIA	1	1	
		ASTHMA, HAY FEVER	20	19	1
		CHRONIC LUNG DISEASE (Emphysema)			
		OTHER CONDITIONS	4	4	
IX.		DISEASES OF THE DIGESTIVE SYSTEM: TOTAL	247	182	65
		CARIES and Other Dental Problems	202	139	63
		PEPTIC ULCER	4	4	
		APPENDICITIS	3	2	1
		HERNIA	1	1	
		CHOLECYSTIC DISEASE	7	7	
		OTHER CONDITIONS	30	29	1
X.		DISEASES OF THE GENITOURINARY SYSTEM: TOTAL	68	54	14
		URINARY TRACT INFECTION (Pyelonephritis, Cystitis)	35	29	6
		DISEASES OF PROSTATE GLAND (excluding Carcinoma)			
		OTHER DISEASES of Male Genital Organs	1	1	
		DISORDERS of Menstruation	5	5	
		MENOPAUSAL SYMPTOMS	6	5	1
		OTHER DISEASES of Female Genital Organs	18	12	6
		OTHER CONDITIONS	3	2	1
XI.		COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM: TOTAL	13	9	4
		INFECTIONS of Genitourinary Tract during Pregnancy			
		TOXEMIAS of Pregnancy			
		SPONTANEOUS ABORTION	1	1	
		REFERRED FOR DELIVERY			
		COMPLICATIONS of the Puerperium	1	1	
		OTHER CONDITIONS	11	7	4
XII.		DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE: TOTAL	74	64	10
		SOFT TISSUE ABSCESS OR CELLULITIS	38	31	7
		IMPETIGO OR OTHER PYODERMA	4	4	
		SEBORRHEIC DERMATITIS			
		ECZEMA, CONTACT DERMATITIS, OR NEURODERMATITIS	14	14	
		ACNE	1	1	
		OTHER CONDITIONS	10	7	3
		Poison Oak	7	7	

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PART II - 5. *(Continued)*

ICD CLASS		DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
XIII.		DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE TOTAL	25	19	6
		RHEUMATOID ARTHRITIS	1	1	
		OSTEOARTHRITIS	1	1	
		ARTHRITIS, Unspecified	8	8	
		OTHER CONDITIONS	15	9	6
XIV.		CONGENITAL ANOMALIES: TOTAL	7	7	
		CONGENITAL ANOMALIES of Circulatory System			
		OTHER CONDITIONS	7	7	
XV.		CERTAIN CAUSES OF PERINATAL MORBIDITY AND MORTALITY: TOTAL			
		BIRTH INJURY			
		IMMATURITY			
		OTHER CONDITIONS			
XVI.		SYMPTOMS AND ILL-DEFINED CONDITIONS: TOTAL	62	53	9
		SYMPTOMS OF SENILITY	4	2	2
		BACKACHE	16	12	4
		OTHER SYMPTOMS REFERRABLE TO LIMBS AND JOINTS	15	13	2
		HEADACHE	8	7	1
		OTHER CONDITIONS	19	19	
XVII.		ACCIDENTS, POISONINGS, AND VIOLENCE: TOTAL	47	25	22
		LACERATIONS, ABRASIONS, and Other Soft Tissue Injuries	20	9	11
		BURNS	2	1	1
		FRACTURES	18	9	9
		SPRAINS, STRAINS, DISLOCATIONS	5	4	1
		POISON INGESTION			
		OTHER CONDITIONS due to Accidents, Poisoning, or Violence	2	2	

				NUMBER OF INDIVIDUALS
6.		SPECIAL CONDITIONS AND EXAMINATIONS WITHOUT SICKNESS: TOTAL		171
		FAMILY PLANNING SERVICES	28	
		WELL CHILD CARE	13	
		PRENATAL CARE	31	
		POSTPARTUM CARE	8	
		TUBERCULOSIS: Follow-up of inactive case	0	
		MEDICAL AND SURGICAL AFTERCARE	2	
		GENERAL PHYSICAL EXAMINATION	2	
		PAPANICOLAOU SMEARS	12	
		TUBERCULIN TESTING	0	
		SEROLOGY SCREENING	1	
		VISION SCREENING	1	
		AUDITORY SCREENING	1	
		SCREENING CHEST X-RAYS	0	
		GENERAL HEALTH COUNSELLING	0	
		OTHER SERVICES:		
		(Specify) Abundant food	40	
		CAP	4	
		PKU	2	
		Welfare	22	
		Immuniz	4	

PART III - NURSING SERVICE

TYPE OF SERVICE		NUMBER
1. NURSING CLINICS:		
a. NUMBER OF CLINICS		29
b. NUMBER OF INDIVIDUALS SERVED - TOTAL		273
2. FIELD NURSING:		
a. VISITS TO ~~HOUSEHOLDS~~ Families	1592	
b. TOTAL ~~HOUSEHOLDS~~ Families SERVED	378	
c. TOTAL INDIVIDUALS SERVED IN HOUSEHOLDS	2221	
d. VISITS TO SCHOOLS, DAY CARE CENTERS	55	
e. TOTAL INDIVIDUALS SERVED IN SCHOOLS AND DAY CARE CENTERS	187	
3. CONTINUITY OF CARE:		
a. REFERRALS MADE FOR MEDICAL CARE: TOTAL		826
(1) Within Area	692	
(Total Completed 648)		
(2) Out of Area		
(Total Completed)		
b. REFERRALS MADE FOR DENTAL CARE: TOTAL		
(Total Completed)		
c. REFERRALS RECEIVED FOR MEDICAL OR DENTAL CARE FROM OUT OF AREA: TOTAL	134	
(Total Completed 134)		
d. FOLLOW-UP SERVICES FOR MIGRANTS, not originally referred by project, WHO WERE TREATED IN PHYSICIANS' OFFICES (Fee-for-Service)	44	
e. MIGRANTS PROVIDED PRE-DISCHARGE PLANNING AND POST-HOSPITAL SERVICES	Locally 11	
f. MIGRANTS ASKED TO PRESENT HEALTH RECORD Form PMS-3652 or Similar Form) IN FIELD OR CLINIC: TOTAL		
(1) Number presenting health record.	Not Available	
(2) Number given health record.		
4. OTHER ACTIVITIES *(Specify)*:		
Visits to Camps (Multiple Families)	741	
Unduplic. count of individual	2221	
Unduplic. count of family	378	

REMARKS

PART IV - SANITATION SERVICES

TABLE A. SURVEY OF HOUSING ACCOMMODATIONS

HOUSING ACCOMMODATIONS	TOTAL		COVERED BY PERMITS	
	NUMBER	MAXIMUM CAPACITY	NUMBER	MAXIMUM CAPACITY
CAMPS	32	2680		
OTHER LOCATIONS	--	--		
HOUSING UNITS - Family:				
IN CAMPS	536	2680		
IN OTHER LOCATIONS	---	--		
HOUSING UNITS - Single				
IN CAMPS				
IN OTHER LOCATIONS				

TABLE B. INSPECTION OF LIVING AND WORKING ENVIRONMENT OF MIGRANTS

ITEM	NUMBER OF LOCATIONS INSPECTED*		TOTAL NUMBER OF INSPECTIONS		NUMBER OF DEFECTS FOUND		NUMBER OF CORRECTIONS MADE	
	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER
LIVING ENVIRONMENT:								
a. WATER	32		217		2			
b. SEWAGE	32		4053		274		72	
c. GARBAGE AND REFUSE	32		1585		156		30	
d. HOUSING	32		1311		75		8	
e. SAFETY	32		866		53		17	
f. FOOD HANDLING	32		1					
g. INSECTS AND RODENTS	32		54		9		2	
h. RECREATIONAL FACILITIES	32							
WORKING ENVIRONMENT:								
a. WATER	xxxx	60	xxxx	73	xxxx	39	xxxx	3
b. TOILET FACILITIES	xxxx	57	xxxx	189	xxxx	50	xxxx	4
c. OTHER	xxxx	56	xxxx	55	xxxx	7	xxxx	3

* Locations – camps or other locations where migrants work or are housed.

PART V – HEALTH EDUCATION SERVICES *(By type of service, personnel involved, and number of sessions.)*

TYPE OF HEALTH EDUCATION SERVICE	NUMBER OF SESSIONS					
	HEALTH EDUCATION STAFF	PHYSICIANS	NURSES	SANITARIANS	*AIDES (other than Health Ed.)	OTHER (Spec
A. SERVICES TO MIGRANTS:						
(1) Individual counselling			782	9	393	
(2) Group counselling			33		29	
B. SERVICES TO OTHER PROJECT STAFF						
(1) Consultation						
(2) Direct services						
C. SERVICES TO GROWERS:						
(1) Individual counselling			62	65	97	
(2) Group counselling						
D. SERVICES TO OTHER AGENCIES OR ORGANIZATIONS:						
(1) Consultation with individuals				3		
(2) Consultation with groups			2	4		
(3) Direct services						
E. HEALTH EDUCATION MEETINGS			50			

* Includes Sanitation & Nursing Aids

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MEDICAL, DENTAL, HOSPITAL, AND NURSING SERVICES

Migrant medical, dental and nursing is a year round project in Washington County. In the off season the settled out migrant is assimilated into the Public Health Nurse's schedule as part of her responsibility in rendering health services to the community at large.

During the in-season (April through September) the role of the Public Health Nurse changes. For all practical purposes she is a "migrant nurse". She gives a high priority to the health problems of the migrant, for she knows he will be here only a short time. She is often frustrated, works overtime, often is over-rushed, and after it is over, chastises herself for not finding the time to do things better.

This year a Public Health Nurse with two years experience in the migrant program was appointed Project Nurse. She served as a coordinator of nursing activities, and also gave nursing services to the three Day Care Centers serving migrant children.

There were six staff Public Health Nurses; three were new to the Project. Nurses were assigned a geographical location (see 1968 report). The nursing staff was supplemented by an "Anglo" college student aide assigned for transportation duties. She also assisted in compiling statistical data. Two Spanish-American aides, residents of the county, were also hired as student aides for the nursing program. One aide was assigned to each team of three nurses and a system of communications was developed so that the student aide would never be without a professional staff member who could give supervision and advice. The Spanish-American aides were capable and intelligent workers who made a contribution to the program; however, next year we plan a different method of selecting and using migrant personnel as aides (see objectives #2 and #5). A job description was developed for the aides which in essence outlined duties of a subprofessional. She was allowed to refer patients to the Health Department Clinic Nurse for screening and further service. She was discouraged from diagnosing or identifying herself as a nurse. Public Health Nurses referred patients directly to doctors and clinics.

Patients were offered a wide variety of means for medical services. Most of these were on a fee-for-service basis. Appointments were made during regular office hours. Lack of appointment space was the only reason encountered with physicians' offices for refusing to see a migrant patient. Only one physician presented any difficulty and this was due to a misunderstanding and not because the patient was a migrant. Local physicians referred patients to the local hospital laboratory when further studies were needed. In cases requiring more sophisticated procedures, they furnished medical histories in order to have the patient hospitalized at the University of Oregon Medical School Hospital. Private physicians contacted the Public Health Nurse when patients failed to return or when a specific condition required health supervision.

Four evening clinics were held at the Health Department. The goals were: medical treatment, laboratory studies, X-rays, immunizations and a medical history. A Spanish-American doctor offered his services at these clinics. He was also available for telephone consultation when unusual problems arose. He furnished literature appropriate to specific diseases written in Spanish. He also translated letters received from Mexican doctors, as it was found that our Spanish-American aides were unfamiliar with the translation of medical terminology.

The evening clinics were staffed by the Project Nurse and two staff Public Health Nurses, one Spanish-American aide, two volunteer Registered Nurses, one volunteer laboratory technician, and two non-medical volunteers. The County X-ray Survey Center was open for three of the clinics; however, chest X-rays were abandoned as a routine because the degree of usage was not enough to justify keeping the technician on standby.

Patients were routed through four stations: registrar, vital signs, laboratory, and the doctor. The receptionist usually was the Spanish-American aide but one evening this duty was performed by a staff secretary. She felt the language barrier was no obstacle as other bilingual patients were always more than willing to help.

Patients were weighed, measured, and vital signs taken. A urinalysis and hematocrit were done. Of ninety-four patients, all had normal hematocrit. Four had traces of urine sugar. Two were known diabetics, and referred to the Public Health Nurse for supervision and further follow up. The other two were checked in the camp by the Public Health Nurse who did repeat clini-tests. After medical consultation, no further studies were indicated, but these two patients received health education and an interstate referral was initiated on a precautionary basis.

A medical questionnaire written in English and Spanish was attempted by our medical student but created some embarrassing problems when the individual could not read. Other patients appeared more interested in seeing the doctor than answering questions.

Review of personal migrant health records indicated the immunization level of the migrant is generally satisfactory. Consequently, few immunizations were required.

The doctor at station four examined the patient and gave the nurse orders for any follow-up or further treatment that might be indicated.

A third year medical student was assigned to the Health Department this summer. His identification of himself in his written report was as a "cultural anthropologist rather than a physician". His contribution to health services was obscured by other interests, although he participated in clinics and had the opportunity to broaden his education as a physician.

Overlapping the evening clinics, a private physician volunteered to keep his own office open one evening a week. By the time the Health Department clinics were phased out, another physician was also keeping office hours for migrants one evening a week. This was on a fee-for-service basis. The medical student participated in these clinics which was a better arrangement, as he worked directly with the private physician. The Health Department provided a staff Spanish-American aide for these clinics. The physician in each instance arranged for his office nurse to assist him during the special migrant hours.

Patients were also seen at the University of Oregon Medical School clinics and were referred there via one of the above-mentioned local clinical services, or were on occasion referred directly by the Public Health Nurse.

Family Planning Clinics are a regular function of the Health Department. Twenty-three migrant patients were seen in the ten clinics held during the migrant season.

Public Health Nurses played a vital role in screening patients for referral to medical care, and also were responsible for supervision in follow-up care and health education.

Patients were hospitalized at the University of Oregon or the local community hospital. Patients were hospitalized either on referral from a private physician, on direct emergency admission after an accident, or by the Public Health Nurse's referral to the University of Oregon.

One infant was transferred to a non-participating Portland hospital from a participating local hospital. Arrangements at the state level were initiated immediately to sign a contract with the Portland hospital for this one patient. Unfortunately the infant died in the emergency room. However, had the infant lived, the eighteen year old parents could conceivably have had an enormous bill without the prompt resolution of participating status. It is normally to the University of Oregon that we try to direct such cases in order to spare the family such expenses and still not compromise quality medical care. We feel that consideration must include not only the patient's immediate medical problem but also the impact his illness or hospitalization will have upon him, his family, his life and his expenses.

The University of Oregon has Public Health Nurse Coordinators who serve as a liaison between the hospital and community. Hospital admissions, discharge planning, and follow-up present few problems. One consistent problem was failure of hospital personnel to have the patients

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sign the operative permit at a time we had arranged for a translator to be there. In previous years children needing tonsillectomies were usually gone from the county by the time their turn came up on a waiting list. This year children were seen on specific days and scheduled immediately. Thus our Public Health Nurse was able to inform the family of the day and time immediately upon identification of this problem. She was still required, however, to verify to the University of Oregon that the patient was coming in.

The relationship with our local hospitals was beyond reproach. The Project Nurse was notified immediately of hospitalizations; also of patients who came in or failed to come in for scheduled X-ray or laboratory procedures. Many of the hospital staff, medical and non-medical, became concerned with the migrant and called to discuss his problems. . .problems not necessarily related to his immediate illness.

It should be interjected that this type of community interest and concern for the migrant has been growing in our county and one can trace its development through the migrant reports submitted in previous years and the efforts made during those years. Consequently, in 1969, we enjoy better communication; doctors and hospitals are recognizing more and more that the Health Department nursing staff can and should be utilized in rendering health services not only to the migrant but to the entire community.

Again, there were few problems with admissions, discharge planning and follow-up care from hospitalizations. Both hospitals used by our project were most cooperative. Friday hospital discharges were delayed when it was felt unwise to change the patient's environment over a weekend without Public Health Nurse visits, such as in the case of an eleven year old child with a compound comminuted skull fracture. This child was seen by the nurse daily for a period of time and then several times a week thereafter, and is still under medical care. Hospital discharges were also delayed until the nurse could line up proper equipment, such as a hard mattress or crutches.

Besides the nursing services expected of any migrant nurse, which it is redundant to repeat year after year, nurses received more requests for hospital discharge follow-ups this year. This was due to the nature of the cases and better utilization of Public Health Nurses and aides. One such case was that of a brain tumor requiring passive exercises. Another case was that of a four year old child with a deformed hand who underwent plastic surgery and Public Health Nurse follow-up supervision to be sure that physical therapy recommendations were followed. Another area of nursing consideration is PKU testing for migrant infants born in another state where history and mobility makes it doubtful that this testing has been done. One such case was found with an elevated PKU.

Dental care was provided by private dentists on a fee-for-service basis. The definition of "emergency" was occasionally stretched because of the serious need. In one case (non-emergent but serious) the patient volunteered to pay half. We agreed when the dentist called to see if we would pay the other half. The migrant grapevine (nothing to do with the boycott) is one of our best means of communication. Soon others called in with the same proposal and it was felt their concern was greater when they shared part of the financial responsibility. By comparison (see 1968 and 1969 statistics) the migrant seems to have more initiative in seeking dental care than medical care. Perhaps the reason for this is that medically we tell him he is sick even when he doesn't believe it or know it; we bribe him with promises of personalized taxi service and pay his bill; rarely does anyone look in his mouth except himself.

Migrant Dental Screening was done at North Plains School by Dr. David Witter of Oregon State Board of Health and the dental students from University of Oregon Dental School. Eighty-one children were screened, ranging in age from two to twelve. The language barriers were overcome by use of bilingual teaching staff and aides. Twenty-six children were found to need emergency care. Twenty-two actually received treatment, but the other four had left the area and could not be found after the screening clinic. The parents were contacted for permission and the children were given appointments to see local dentists. The school provided transportation as the parents were working. The children were seen by dentists in Hillsboro, Forest Grove, and Beaverton. After emergency care had been completed, a few children with

less urgent problems received additional care. The cost of the treatment was shared by the funds from the Health Department and Dental Health funds from the school at North Plains. The clinic was interesting for the dental students. They saw many acute conditions such as gingivitis due to calculus, rampant caries, abcesses and mottling.

Changes to be considered in the future are in the employment of aides, transportation, and need for referrals to doctors or clinics.

Statistically we are able to establish that the majority of patient referrals for medical care were originated by the Health Department Clinic Nurse. Their arrival at the Health Department is the result of the work of Public Health Nurses and aides in the camp. A bilingual aide is needed in the Health Department to work afternoons and to help in special evening clinics. Her role will be as interpreter, health educator, and nursing assistant. She will not be assigned to work in the camps. This position should be filled by a qualified Spanish-American county resident who is familiar with community resources.

Statistics can be used to support the fact that a number of patients referred to doctors are questionable in their need to see a doctor. They might have benefited as much by Public Health Nurse health education. Doctors also question the value of their spending time on all the "common colds" and other self-limited minor conditions they see.

We are also concerned about possibly too liberal a use of transportation furnished by the Health Department. One aide was hired for transportation. It was our goal to screen the need for this service. Our Spanish-American aides were not to be used in this capacity except in rare cases.

Three of our eleven patients hospitalized locally were accident cases. The others, with the exception of one, found their way to the hospital without Health Department transportation. This was also true in a number of cases when patients were in pain, had minor fractures, etc.

Transportation services en masse are now suspect, based on three years experience, of having evolved into a luxurious convenience; and it is questioned whether it reaches those who really need it. A typical case and not without humor: A family came to the Health Department on the day they had an appointment at the University of Oregon Medical School. They wanted transportation services from our aide who had already returned to college. They agreed to keep their appointment (but didn't), and the Public Health Nurse drew them a map of how to reach the Clinic. This family responded by drawing her a map of newly constructed roads recently opened and much shorter.

We feel our county does a good job in delivering health services to the migrant but we should not lose sight of the fact that our statistics reflect work accomplished. It does not reflect those we missed, or those where we failed to break through the cultural barriers and/or ignorance or whatever it is; barriers of a husband who will not permit treatment of his aborted wife with possible retained placenta; barriers where an infant child died of dehydration through parental neglect; barriers such as a husband who denies birth control methods for his over-burdened wife. How might we have reached them?

OBJECTIVES - - - 1970

1. No transportation en masse. Transportation to be arranged based upon professional judgment of nurse that the patient's condition is serious and he will not receive medical care without her intervention.

2. Clinic aide, bilingual, assigned to the Health Department and for special evening clinics. She will not transport or work in camps.

3. Public Health Nurse will attempt more health education in minor illnesses but will not deny anyone who insists upon seeing a doctor.

4. A primary physician and secondary physician for each camp, but with freedom of choice for patients who for a valid reason wish to see a different doctor.

ADVANTAGES: A. Less confusion in arranging doctor appointments.

B. More acquaintance with doctor, ergo, more confidence and more continuity of care.

C. Budget, billing and statistics will be easier for the accountant.

D. Immediate knowledge of any pending epidemic.

E. Knowledge of total health picture in a given camp which will give useful information to sanitation department or for nursing programs.

F. Less danger of over treatment and of doctor shopping.

5. A liaison person (center of influence) to be selected from the migrant group within each major camp, probably to be paid on a part-time basis, to act as a communication center and clearing point for all matters of health in the camp.

6. Camp physicians (Objective #4) and camp aides (Objective #5) to be formed into an Advisory Board which will also include camp operators and other interested community people.

ENVIRONMENTAL SANITATION SERVICES

The Sanitation Section of the Washington County Department of Public Health conducts a continuing program designed to up-grade the environment of the migrant worker during his stay in Washington County. The Sanitation Migrant Project Staff includes one full-time Project Sanitarian who is responsible to the supervisor of Environmental Health Services. All the sanitarians on the staff are involved in the program and are under the direction of the Project Sanitarian.

This season three student aides were employed to work with our project. These well qualified aides were responsible to the Project Sanitarian. All had experience in the health field. One had worked with the project several years ago during its initial stages. Another aide, a medical student from the University of Oregon, was with our sanitation section last season. The third aide, a graduate student at a local university, is a sanitarian with the Health Department in Washington State. These aides were employed full time and played an important part in the overall project.

Each sanitarian and aide were assigned specific camps. This type of organization provided a good overall surveillance of the camps and made possible good working relationships with the grower.

There were 32 operating camps in the county this season. The major problem was that of sewage, especially privy maintenance and repair. Garbage disposal and storage was also a troublesome problem. Next season we hope to have the latter difficulty largely solved, since franchised operators under a new County Ordinance will be providing pickup service which can be utilized by camp operators who have not worked out an otherwise acceptable method of garbage and trash disposal.

The majority of migrant housing in this county consists of single room cabins of frame type construction. Sleeping and cooking facilities are provided within these cabins.

Lavatory facilities are usually community type located in the center of the camp. As new construction is added within the camps, there is a trend to supply self-contained family units with individual lavatory facilities.

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A Notification of Intent to Operate a Farm Labor Camp is required of all operators prior to utilization of their housing facilities. The majority of growers have cooperated with us in this permit-type system.

The overall housing condition this season improved over the previous season; however, housing conditions still tend to be a problem. This problem is magnified in the smaller camps where the economics of operation are border line. It may be that a trend toward larger and better maintained camps will result as enforcement tightens and a firmer definition of proper standards is developed.

The number of water samples collected is indicated under living environment in Table B. The sources of water within the camp vary, but the majority are of the drilled well type. When untreated water does not conform, the operator is required to maintain a chlorinator on a continuous basis.

The number of inspections under sewage in Table B reflects both privy and flush toilet inspections. This tends to be one of our major problems in some camps, due to the deterioration of the privy condition through the period of camp occupancy (caused by the inadequate maintenance of camp facilities and irregular schedules of cleaning).

The number of garbage defects reflects improper storage, collection and disposal of the garbage. Improper disposal of the garbage (being a major problem) is due to the inadequate means of landfill operations developed by the camp owners. As mentioned before, we expect to have this problem solved next year with the county-wide garbage franchise program in effect.

Refrigeration is not required to be supplied by the grower; however, several farmers have refrigeration provided within their cabins. All the camps participated in the Vector Control Program that we conducted. The sanitarian aides sprayed all the camps, privies and washrooms with insecticide. Incidentally, use of DDT as an insecticide will be completely phased out in the next season.

In the majority of the camps there are very few recreational facilities provided. We hope to improve this problem by emphasizing to the grower the importance of such facilities and their place in the migrant camp.

Cleanliness within the camps seems to be correlated with the size of the camp. The smaller camps seem to have more maintenance problems for they generally do not have a camp manager who is responsible for such duties.

There are generally no hand washing facilities or mobile food service units provided for the people in the working environment (fields). Toilet facilities consist of portable privy accommodations. Drinking water is usually provided in the fields and presents a problem because the sources of these supplies are varied. Storage facilities for field water supplies are not always of approved construction.

The majority of health education efforts on behalf of sanitation consisted of individual counseling sessions with the growers by the Sanitarians and Sanitarian aides as they worked within the camps and fields. This counseling involved discussions of well construction and water distribution, abatement of common drinking cup violations, vector control, refuse disposal, and related health problems. Aides also carried out a program of posting placards throughout the camps illustrating the proper method of camp usage and personal hygiene.

Each of the sanitation objectives was accomplished with some measure of success. Objectives 1, 2, and 7 should be achieved each year and more emphasis placed on the remaining objectives to improve the degree of accomplishment.

Each grower was notified at the end of the previous season of the problems encountered in his camp during the summer. This year in a summary letter to the grower, we plan to include, as stated before in our objectives, specific interpretations of the Health Code. The growers

ERIC

will be expected to adhere to these specific requirements in the forthcoming season. These will be proposed in such a fashion as to increase the farmer's awareness of his responsibility for maintaining basic sanitation standards if he expects to operate a camp for migrant workers.

Below are some tentative examples of the specific standards which we are developing in order that the vague, broad standards in state law and regulations may become more definite and enforceable.

FOR GARBAGE & RUBBISH:

1. All garbage cans will be provided with attached lids and shall be provided one for every two cabins. It is necessary that new cans and/or lids be provided whenever a container rusts through or is no longer vector proof.

2. These cans shall be emptied as often as necessary to prevent overflow or spillage of garbage on the ground.

3. If any landfill operation is to be used for the disposal of garbage, it shall be located at least 200 feet from any living unit and covered with earth at least once a week.

4. If any labor camp lies within a solid waste franchise area, pick up of garbage and other solid wastes in the camp shall be contracted with the franchised operator.

FOR SEWAGE DISPOSAL:

1. If privies are provided they must be:

   a. Fly-tight at all times.

   b. Cleaned daily.

   c. Provided with toilet seats and lids which completely cover and occlude the privy hole when it is not in use.

   d. All privies should be limed regularly and no less often than twice weekly.

   e. All screens must be maintained in a fly-tight condition throughout the season.

   f. Privies must be relocated every two years or sooner if the pit is filled or surface erosion or other factors require it.

SUMMARY

The statistics compiled for this report cover approximately one year from September, 1968 to September, 1969. The objectives indicated in the last report are listed below:

1. Nursing Objectives

   1. To provide dental care beyond emergency requests.

   2. To maintain evening clinics primarily as screening centers or ports of entry into the mainstream of medical services.

   3. To expand use of Spanish aides.

   4. To develop a job description and plan for closer supervision of student aides.

   5. To organize an advisory group, including physicians, migrant workers and other interested individuals to explore local resources and avoid duplication of services.

Washington County
MG 05G

Four of the five nursing objectives were accomplished this year. The fifth is included again in our 1970 objectives in a broader form.

Objective #2 was modified with the advent of clinics in private physicians' offices, as the need for screening was less. The migrant patient received the same care in private practice as the residents of the county and probably enjoy better health than the rural poor of this state who do not have as liberal choices of health services as do the migrants.

2. Sanitation Objectives

 1. To obtain 100% compliance with all water supplies in both camps and fields.
 2. To eliminate all common drinking cup violations.
 3. To effect an 85% improvement in the required owner's facilities.
 4. To obtain 90% grower participation in up-grading the insect and rodent control program.
 5. To improve garbage and refuse disposal by 20%.
 6. To establish 20% more recreation facilities for children in the camps.
 7. To obtain 100% compliance with requirements for growers to notify the Health Department of their intent to operate a farm labor camp.

We feel that sanitarian objectives such as 1, 2, 5, and 7 should be met each season. The other objectives are also important and more emphasis will be placed on them in the forthcoming season.

We would like to stipulate an additional objective. This objective would be to make the grower realize he carries primary responsibility for all environmental living conditions in his camp. The Health Department expects to make camp operators responsible for maintaining legal sanitation standards at all times in any camp where migrant agricultural workers are living. One of the problems involved in accomplishing this objective is the general terms in which the state statutes and regulations are presented. These terms are difficult to apply and enforce without specific definition of criteria. Our staff is working on specific standards for each of the general requirements of the law. These standards will be used to determine whether the camp is in compliance with adopted laws and regulations. Examples of such specific standards are stated on page 208. A copy of the completed specific standards with an explanation of how they will be applied will be sent to each camp operator, along with his annual letter detailing specific corrections necessary before occupancy next season. A more uniform level of sanitation will be attainable with the expectations and standards clearly defined through step-by-step definition of the law. Substantial deviation from these specific standards will be grounds for closure of a facility.

It appears that statistical requirements for the Oregon Migrant Program are becoming top-heavy. It is urgently suggested that the tabular and narrative reporting requirements for 1970 be streamlined, perhaps utilizing local workers along with state representatives to devise a simplified reporting format which will not burden the staff in a way that seriously interferes with delivery of health service.

The migrant population this season was estimated at about 3,000 with most of the people originating from New Mexico and Texas.

Strawberries are one of the major crops of this area. Because of weather conditions this season, the strawberry crop was early thus creating a shortage of available help. Because of this condition and a change in the weather, many farmers did not complete their crop harvest of what could have been an excellent yield. This shortage of labor also caused some bad feeling between the growers who were competing for the available help. This also created problems with migrants needing medical care as nurses experienced much difficulty in "relocating" patients.

The appraisal of nursing objectives is incorporated within the nursing report.

ERIC

Washington County
MG 05G

The sanitation objectives 1, 2, 5 and 7 met with the greatest degree of completion.

All water supplies in the camps were checked prior to occupancy and all raised to state bacteriological standards except one. The samples from the field varied much more than those in the camp. Only two common drinking cup violations were cited, and all growers submitted Notifications of Intent to Operate forms.

The other objectives were met with varying degrees of satisfaction. All the objectives will be worked for again in the coming season with more emphasis placed on those not completely obtained.

A reliance will also be made on our specific interpretation of the Health Code as a standard within the camps.

YAMHILL COUNTY

Yamhill County Migrant Health Project
Yamhill County Health Department
Lloyd E. Ragan, M.D., Health Officer
Courthouse
McMinnville, Oregon 97128

POPULATION AND HOUSING DATA

FOR YAMHILL COUNTY.

GRANT NUMBER MG 05G

5. POPULATION DATA - MIGRANTS (*Workers and dependents*)

a. NUMBER OF MIGRANTS BY MONTH

MONTH	TOTAL	IN-MIGRANTS	OUT-MIGRANTS
JAN.	720		
FEB.	720		
MAR.	616		
APRIL	560		
MAY	1576		
JUNE	3500		
JULY	2500		
AUG.	2300		
SEPT.	800		
OCT.	750		
NOV.	1400		
DEC.	720		
TOTALS	15412		

b. NUMBER OF MIGRANTS DURING PEAK MONTH

	TOTAL	MALE	FEMALE
(1) OUT-MIGRANTS:			
TOTAL	1648	824	824
UNDER 1 YEAR			
1 - 4 YEARS			
5 - 14 YEARS			
15 - 44 YEARS			
45 - 64 YEARS			
65 AND OLDER			
(2) IN-MIGRANTS:			
TOTAL	3500	1750	1750
UNDER 1 YEAR			
1 - 4 YEARS			
5 - 14 YEARS			
15 - 44 YEARS			
45 - 64 YEARS			
65 AND OLDER			

c. AVERAGE STAY OF MIGRANTS IN COUNTY

	NO. OF WEEKS	FROM (MO.)	THROUGH (MO.)
OUT-MIGRANTS	22	November	March
IN-MIGRANTS	14	May 23	September

6. HOUSING ACCOMMODATIONS

a. CAMPS

MAXIMUM CAPACITY	NUMBER	OCCUPANCY (*Peak*)
LESS THAN 10 PERSONS		
10 - 25 PERSONS	2	42
26 - 50 PERSONS	2	68
51 - 100 PERSONS	6	440
MORE THAN 100 PERSONS	7	2277
TOTAL*	17	2827

b. OTHER HOUSING ACCOMMODATIONS

LOCATION (*Specify*)	NUMBER	OCCUPANCY (*Peak*)
Pri. Rent Accom.		
10-25	1	12
26-50	4	165
51-100	1	100
TOTAL*	6	277

*NOTE: *The combined occupancy totals for "a" and "b" should equal approximately the total peak migrant population for the year.*

REMARKS

GRANT NUMBER	
MG 05G	YAMHILL COUNTY
DATE SUBMITTED	

PART II - MEDICAL, DENTAL, AND HOSPITAL SERVICES

IGRANTS RECEIVING MEDICAL SERVICES

TOTAL MIGRANTS RECEIVING MEDICAL SERVICES AT FAMILY HEALTH CLINICS, PHYSICIANS OFFICES, HOSPITAL EMERGENCY ROOMS, ETC.

AGE	NUMBER OF PATIENTS			NUMBER OF VISITS
	TOTAL	MALE	FEMALE	
AL	1236	538	698	
DER 1 YEAR	104	50	54	
4 YEARS	207	90	117	
14 YEARS	366	199	167	
44 YEARS	414	143	271	
64 YEARS	142	53	89	
AND OLDER	3	3		

. of related
rsing visits

OF TOTAL MIGRANTS RECEIVING MEDICAL SERVICES, HOW MANY WERE:

(1) SERVED IN FAMILY HEALTH SERVICE CLINIC?	669
(2) SERVED IN PHYSICIANS' OFFICE, ON FEE-FOR-SERVICE ARRANGEMENT (INCLUDE REFERRALS)	56

2. MIGRANTS RECEIVING DENTAL SERVICES

ITEM	TOTAL	UNDER 15	15 AND OLDER
a. NO. MIGRANTS EXAMINED-TOTAL	198	80	118
(1) NO. DECAYED, MISSING, FILLED TEETH			
(2) AVERAGE DMF PER PERSON			
b. INDIVIDUALS REQUIRING SERVICES - TOTAL	196	79	117
(1) CASES COMPLETED	4	4	
(2) CASES PARTIALLY COMPLETED	68	25	43
(3) CASES NOT STARTED			
c. SERVICES PROVIDED - TOTAL	4		
(1) PREVENTIVE	4		
(2) CORRECTIVE-TOTAL			
(a) Extraction			
(b) Other			
d. PATIENT VISITS - TOTAL	76	33	43

3. MIGRANT HOSPITALIZATIONS

SOURCE OF PAYMENT	NO. PTS.	M	F	AGE GROUPING <1	1-4	5-14	15-44	45-64	65+	TOTAL HOSP. DAYS	AVE. HOSP. DAYS	PROJECT HOSPITAL COSTS	DOCTORS FEES PAID	TOTAL HOSPITAL BILLING
MIGRANT FUNDS														
OTHERS*	14				1	6	7			63				

*PAYMENT MADE BY PATIENT, INSURANCE, WELFARE, OR PROVIDED BY UNIVERSITY OF OREGON MEDICAL SCHOOL

IMMUNIZATIONS PROVIDED

TYPE	COMPLETED IMMUNIZATIONS, BY AGE: TOTAL	UNDER 1 YEAR	1-4	5-14	15 AND OLDER	INCOMPLETE SERIES	BOOSTERS, REVACCINATIONS
OTAL-ALL TYPES	205	96	62	24	6	9	23
SMALLPOX	8		5		3		
DIPHTHERIA	43	21	9	5	1	3	9
PERTUSSIS	39	21	9	5	1	3	5
TETANUS	43	21	9	5	1	3	9
Polio	58	33	19	6			
MEASLES	14		11	3			
TUBERCULIN SKIN TESTS	206						

PART II (*Continued*) - 5. MEDICAL CONDITIONS TREATED BY PHYSICIANS IN FAMILY CLINICS, HOSPITAL OUTPATIENT DEPARTMENTS, AND PHYSICIANS' OFFICES.

MG 05G YAMHILL COUN

ICD CLASS		DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISI
I.-XVII.		TOTAL ALL CONDITIONS			
I.		INFECTIVE AND PARASITIC DISEASES: TOTAL	52		
		TUBERCULOSIS	2		
		SYPHILIS			
		GONORRHEA AND OTHER VENEREAL DISEASES	8		
		INTESTINAL PARASITES			
		DIARRHEAL DISEASE (infectious or unknown origins):			
		Children under 1 year of age			
		All other	10		
		"CHILDHOOD DISEASES" - mumps, measles, chickenpox	2		
		FUNGUS INFECTIONS OF SKIN (Dermatophytoses)			
		OTHER INFECTIVE DISEASES *(Give examples)*:			
			12		
		Infectious Hepatitis	13		
		Shigella	5		
II.		NEOPLASMS: TOTAL	4		
		MALIGNANT NEOPLASMS *(give examples)*:			
			3		
		BENIGN NEOPLASMS	1		
		NEOPLASMS of uncertain nature			
III.		ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES: TOTAL	69		
		DISEASES OF THYROID GLAND			
		DIABETES MELLITUS	21		
		DISEASES of Other Endocrine Glands	28		
		NUTRITIONAL DEFICIENCY	1		
		OBESITY			
		OTHER CONDITIONS	19		
IV.		DISEASES OF BLOOD AND BLOOD FORMING ORGANS: TOTAL	3		
		IRON DEFICIENCY ANEMIA	3		
		OTHER CONDITIONS			
V.		MENTAL DISORDERS: TOTAL	29		
		PSYCHOSES			
		NEUROSES and Personality Disorders	24		
		ALCOHOLISM			
		MENTAL RETARDATION	5		
		OTHER CONDITIONS			
VI.		DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS: TOTAL	104		
		PERIPHERAL NEURITIS			
		EPILEPSY	12		
		CONJUNCTIVITIS and other Eye Infections	29		
		REFRACTIVE ERRORS of Vision			
		OTITIS MEDIA	58		
		OTHER CONDITIONS	5		

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PART II - 5. *(Continued)*

MG 05G YAMHILL COUNTY

ICD CLASS		DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
VII.		DISEASES OF THE CIRCULATORY SYSTEM: TOTAL	20		
		RHEUMATIC FEVER			
		ARTERIOSCLEROTIC and Degenerative Heart Disease	10		
		CEREBROVASCULAR DISEASE (Stroke)			
		OTHER DISEASES of the Heart	10		
		HYPERTENSION			
		VARICOSE VEINS			
		OTHER CONDITIONS			
VIII.		DISEASES OF THE RESPIRATORY SYSTEM: TOTAL	261		
		ACUTE NASOPHARYNGITIS (Common Cold)			
		ACUTE PHARYNGITIS			
		TONSILLITIS			
		BRONCHITIS	41		
		TRACHEITIS/LARYNGITIS			
		INFLUENZA	2		
		PNEUMONIA			
		ASTHMA, HAY FEVER			
		CHRONIC LUNG DISEASE (Emphysema)			
		OTHER CONDITIONS	218		
IX.		DISEASES OF THE DIGESTIVE SYSTEM: TOTAL	96		
		CARIES and Other Dental Problems	10		
		PEPTIC ULCER	15		
		APPENDICITIS			
		HERNIA			
		CHOLECYSTIC DISEASE			
		OTHER CONDITIONS	71		
X.		DISEASES OF THE GENITOURINARY SYSTEM: TOTAL	47		
		URINARY TRACT INFECTION (Pyelonephritis, Cystitis)	22		
		DISEASES OF PROSTATE GLAND (excluding Carcinoma)			
		OTHER DISEASES of Male Genital Organs			
		DISORDERS of Menstruation			
		MENOPAUSAL SYMPTOMS			
		OTHER DISEASES of Female Genital Organs			
		OTHER CONDITIONS	25		
XI.		COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM: TOTAL			
		INFECTIONS of Genitourinary Tract during Pregnancy			
		TOXEMIAS of Pregnancy			
		SPONTANEOUS ABORTION			
		REFERRED FOR DELIVERY			
		COMPLICATIONS of the Puerperium			
		OTHER CONDITIONS			
XII.		DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE: TOTAL	99		
		SOFT TISSUE ABSCESS OR CELLULITIS			
		IMPETIGO OR OTHER PYODERMA	14		
		SEBORRHEIC DERMATITIS			
		ECZEMA, CONTACT DERMATITIS, OR NEURODERMATITIS			
		ACNE			
		OTHER CONDITIONS	85		

PART II - 5. (Continued)

MG 05G YAMHILL COUNT[illegible]

ICD CLASS		DIAGNOSIS OR CONDITION	TOTAL VISITS	FIRST VISITS	REVISITS
XIII.		DISEASES OF THE MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE: TOTAL	27		
		RHEUMATOID ARTHRITIS	10		
		OSTEOARTHRITIS	4		
		ARTHRITIS, Unspecified			
		OTHER CONDITIONS	13		
XIV.		CONGENITAL ANOMALIES: TOTAL	2		
		CONGENITAL ANOMALIES of Circulatory System			
		OTHER CONDITIONS	2		
XV.		CERTAIN CAUSES OF PERINATAL MORBIDITY AND MORTALITY: TOTAL			
		BIRTH INJURY			
		IMMATURITY			
		OTHER CONDITIONS			
XVI.		SYMPTOMS AND ILL-DEFINED CONDITIONS: TOTAL	17		
		SYMPTOMS OF SENILITY			
		BACKACHE			
		OTHER SYMPTOMS REFERRABLE TO LIMBS AND JOINTS			
		HEADACHE			
		OTHER CONDITIONS	17		
XVII.		ACCIDENTS, POISONINGS, AND VIOLENCE: TOTAL	95		
		LACERATIONS, ABRASIONS, and Other Soft Tissue Injuries			
		BURNS			
		FRACTURES			
		SPRAINS, STRAINS, DISLOCATIONS			
		POISON INGESTION			
		OTHER CONDITIONS due to Accidents, Poisoning, or Violence	95		

				NUMBER OF INDIVIDUALS
6.		SPECIAL CONDITIONS AND EXAMINATIONS WITHOUT SICKNESS: TOTAL		311
		FAMILY PLANNING SERVICES	29	
		WELL CHILD CARE		
		PRENATAL CARE } POSTPARTUM CARE }	74	
		TUBERCULOSIS: Follow-up of inactive case		
		MEDICAL AND SURGICAL AFTERCARE		
		GENERAL PHYSICAL EXAMINATION	202	
		PAPANICOLAOU SMEARS		
		TUBERCULIN TESTING		
		SEROLOGY SCREENING		
		VISION SCREENING	1	
		AUDITORY SCREENING	5	
		SCREENING CHEST X-RAYS		
		GENERAL HEALTH COUNSELLING		
		OTHER SERVICES: (Specify)		

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PART III.- NURSING SERVICE

MG 05G YAMHILL COUNTY

TYPE OF SERVICE		NUMBER
1. NURSING CLINICS:		
a. NUMBER OF CLINICS		
b. NUMBER OF INDIVIDUALS SERVED - TOTAL		662
2. FIELD NURSING:		
a. VISITS TO HOUSEHOLDS		1850
b. TOTAL HOUSEHOLDS SERVED		365
c. TOTAL INDIVIDUALS SERVED IN HOUSEHOLDS		
d. VISITS TO SCHOOLS, DAY CARE CENTERS		220
e. TOTAL INDIVIDUALS SERVED IN SCHOOLS AND DAY CARE CENTERS		
3. CONTINUITY OF CARE:		
a. REFERRALS MADE FOR MEDICAL CARE: TOTAL		752
(1) Within Area	703	
(Total Completed 666)		
(2) Out of Area	36	
(Total Completed 13)		
b. REFERRALS MADE FOR DENTAL CARE: TOTAL		167
(Total Completed 72)		
c. REFERRALS RECEIVED FOR MEDICAL OR DENTAL CARE FROM OUT OF AREA: TOTAL		4
(Total Completed 2)		
d. FOLLOW-UP SERVICES FOR MIGRANTS, not originally referred by project, WHO WERE TREATED IN PHYSICIANS' OFFICES (Fee-for-Service)		
e. MIGRANTS PROVIDED PRE-DISCHARGE PLANNING AND POST-HOSPITAL SERVICES		
f. MIGRANTS ASKED TO PRESENT HEALTH RECORD Form PMS-3652 or Similar Form) IN FIELD OR CLINIC: TOTAL		709
(1) Number presenting health record.	40	
(2) Number given health record	669	
4. OTHER ACTIVITIES *(Specify)*:		

REMARKS

PART IV - SANITATION SERVICES

MG 05G YAMHILL COUNTY

TABLE A. SURVEY OF HOUSING ACCOMMODATIONS

HOUSING ACCOMMODATIONS	TOTAL		COVERED BY PERMITS	
	NUMBER	MAXIMUM CAPACITY	NUMBER	MAXIMUM CAPACITY
CAMPS	17	2827		
OTHER LOCATIONS	6	277		
HOUSING UNITS - Family:				
IN CAMPS	408	2827		
IN OTHER LOCATIONS	33	277		
HOUSING UNITS - Single				
IN CAMPS				
IN OTHER LOCATIONS				

TABLE B. INSPECTION OF LIVING AND WORKING ENVIRONMENT OF MIGRANTS

ITEM	NUMBER OF LOCATIONS INSPECTED*		TOTAL NUMBER OF INSPECTIONS		NUMBER OF DEFECTS POUND		NUMBER OF CORRECTIONS MADE	
	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER	CAMPS	OTHER
LIVING ENVIRONMENT:								
a. WATER	17	6	59		15		11	
b. SEWAGE	17	6	25		5		5	
c. GARBAGE AND REFUSE	17	6	89		30		20	
d. HOUSING	17	6	148		12		4	
e. SAFETY	17	6	62		13		10	
f. FOOD HANDLING								
g. INSECTS AND RODENTS	17	6	102		41		21	
h. RECREATIONAL FACILITIES								
WORKING ENVIRONMENT:								
a. WATER	xxxx	54	xxxx	73	xxxx	4	xxxx	4
b. TOILET FACILITIES	xxxx	54	xxxx	220	xxxx	55	xxxx	41
c. OTHER	xxxx		xxxx		xxxx		xxxx	

Locations — camps or other locations where migrants work or are housed.

PART V - HEALTH EDUCATION SERVICES *(By type of service, personnel involved, and number of sessions.)*

TYPE OF HEALTH EDUCATION SERVICE	NUMBER OF SESSIONS					
	HEALTH EDUCATION STAFF	PHYSICIANS	NURSES	SANITARIANS	AIDES (other than Health Ed.)	OTHER (Spec.) Psy.Soc
A. SERVICES TO MIGRANTS:						
(1) Individual counselling			176	16		
(2) Group counselling					12	3
B. SERVICES TO OTHER PROJECT STAFF						
(1) Consultation		3	2	12		1
(2) Direct services				9		
C. SERVICES TO GROWERS:						
(1) Individual counselling			27	67	15	
(2) Group counselling				11		
D. SERVICES TO OTHER AGENCIES OR ORGANIZATIONS:						
(1) Consultation with individuals		13	6	8		
(2) Consultation with groups		10	25	7		4
(3) Direct services			6	21		
E. HEALTH EDUCATION MEETINGS		11	62	7	13	34

Yamhill County
MG 05G

NURSING NARRATIVE

The following summary covers the 1969 Migrant season -- primarily from April through November. The objective remains providing the most comprehensive health service possible in this situation with the highest quality care to the migrant population in the county. It would be desirable to offer this type service on a year-around basis due to the number of migrants making Yamhill County their home base.

As in past years the migrant population served in the county are of both Spanish-American and Anglo origin. (See page 235) The number of individuals increased over last year due to higher expectations of good crops. Strawberries ripened earlier than anticipated with a shortage of pickers and extremely high pay for the families who arrived early. Shortly after the majority of families settled in, cherries were ready so that the shortage of pickers continued. Again pay was high to compete with strawberries. After approximately a week, heavy rains occurred destroying much of the cherry crop and ruining the remaining strawberries. Cherry picking machines were used more extensively this year, with some orchards using machines completely and others following the hand-picking of lower branches with machines for the treetops.

Two new crops were introduced this year, rhubard and broccoli. Most of the migrants were unfamiliar with this type of picking and felt they could not work fast enough to make sufficient wages. Blackcaps, red raspberries, and caneberries required pickers during the long lull before beans. Most of the families who came for the summer remained, as expectations for the pole bean crop were high. Growers began limited bean picking early in an effort to keep pickers. This seemed to discourage the migrants who did not pick their usual expected weights. The canneries had somewhat higher standards so that those individuals who did pick for weight received docks. The cucumber harvest was good and due to disillusion in the bean fields, many pickers turned to cucumbers. Though more growers are looking toward mechanization it is anticipated that manual picking will be utilized for a number of years. The need for migrants in cannery work continues.

All of the community agencies working with migrants in the past continued or expanded their services. Home Extension offered classes in sewing and cooking on a weekly basis at Eola. The Adult Education Center and the newly created Migrant Education Office in Salem offered evening education classes to both children and adults in migrant camps. In April and May several meetings were held with agency representatives to coordinate services offered to migrants and prevent competition over prime evening hours. As a result, all group activities had increased migrant attendance.

On March 18 an orientation session was held in the Health Department for all members of the staff who would be involved with migrants. Weekly during the season the members of all disciplines met to organize, channel, and clarify the program. This included looking at strengths and weaknesses. It is felt that this contributed greatly to the unity of the staff and to the real teamwork provided in supplying service. Members of the staff attended and participated in workshops sponsored by the Oregon State Board of Health in regard to migrants.

It is felt that this has been one of the most productive seasons. The morale of the staff remained high and preventive services were continued throughout the season despite the press of numbers. It would be imperative to continue the Clinic if any type of comprehensive care is to remain available to the migrant population in Yamhill County. We are investigating other grants to be utilized conjointly to expand to rural poor population. It is extremely doubtful that the Clinic could operate without federal assistance. The population it serves could not afford to pay sufficiently to operate Eola Clinic, and the more affluent are able to utilize the "non-system" medical and dental care offered locally. Taxpayers are in a state of unrest and local tax monies are limited.

Medical and dental services were offered in the manner described in previous reports. The teamwork approach was utilized to an even greater extent due to the additional aide time and necessary coordination. Forty-one medical clinic sessions were held in which residents

from the University of Oregon Medical School rotated through their particular specialty. The schedule was: Pediatric on Monday, Tuesday, and Thursday; Internal Medicine on Monday and Thursday, and OB-GYN on Tuesday of each week. ENT Clinic was held once a month on Wednesday. Preventive screening procedures such as tuberculin testing, routine urinalysis, etc. are planned for each patient on the first visit. Dental services were provided by four local dentists in their offices. Screening was done at Eola Clinic and appointments were made by the Public Health Nurse. An effort was made to make appointments for late afternoons. If there were additional funds for dental services, many more patients could have been cared for. (Part II)

During June, before laboratory equipment became available, we utilized the laboratory at a local hospital under a contract price of $1 per test. After July 1, a limited laboratory was available in the Clinic room at Eola Clinic. Although this caused much crowding and limited the privacy of patients, the service was well utilized with 370 laboratory procedures carried out. The hospital laboratory continued to do the requested procedures not available at the Clinic and in total performed 358 tests. An additional 102 tests, serology, sputum, and stool specimens were sent to the State Board of Health laboratory. Having laboratory facilities present seemed to increase the demand for laboratory procedures. We found that funds were quite inadequate to mee' the demands, but that the demands were consistent with the quality of medical care we wish to offer. Seventy-five X-rays were taken at the local hospital, 41 in connection with the tuberculosis program.

Prior to Clinic opening date, camps were visited, signs were posted and growers notified regarding Clinic service. During the 1969 season the local radio station offered an evening program in Spanish and announcements of Clinic service were made through this media. Phasing out service at the end of Clinic sessions is more difficult. Notices are posted in the Clinic indicating that patients should discuss plans for follow-up service with the Public Health Nurse before leaving the area. Many patients took advantage of this; however, others moved to another area on a more spontaneous decision. Signs are also placed in the Clinic giving closing dates and referring individuals to the Health Department after the Clinic closes. Much of this information is spread by word of mouth. Each year has brought increased demands for service after the Clinic has closed. The Health Department clinic nurse continues to screen and refer migrants to appropriate help. Public Health Nurses carry home base families in their case loads when the families move back to this area. Eola Village receives weekly public health nursing service the year-around. Long term care is referred to University of Oregon Medical School emergency room or out-patient clinic. If the project was year-around both opening and phasing out would be eliminated.

The project funds provide nearly all support for medical and dental care. A sign is posted stating "Medication--Dental appointments--50¢--your credit is good". Patients are reminded when dental appointments are given but no real effort is made to collect funds. It is noted that appointments are usually kept if this amount is paid. This also gives pride to those individuals who consider the Clinic a charity, and allows the patient to participate more actively in his own care. In past seasons we have received some assistance from Welfare when patients were hospitalized locally in emergency situations. This season no such situation occurred. Title XIX has had no effect in our state in regard to migrants. Changes in Welfare policy brought assistance to families in the area during the slack picking times. Most of these families continued to use Clinic services for medical care. At present we have no arrangements for billing for funds for any service.

This year meetings were arranged with participating physicians both before Clinic opened and after it closed. The doctors said the Clinic was a learning experience for them incidental to care provided the migrants.

The number of patients receiving medical care was 669, making a total of 1236 visits, an increase over last year and a decrease from the all time high in 1967. One hundred ten skin conditions were seen in the Clinic. Fifteen percent of referrals for more specialized care at University of Oregon Medical School were to Dermatology Clinic. These statistics plus discussion with attending physicians makes us consider the addition of a dermatologist on a once-a-month basis as one way of improving service. Twenty percent of additional referrals are made to the emergency room at University of Oregon Medical School for service which is

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too extensive for the Clinic to handle--25% are OB patients who need one visit there prior to delivery at University of Oregon School--these referrals probably cannot be improved on a local level.

The general appraisal of project services is that we are coming nearer our goals and objectives. Health services are limited by space and the short duration for which Clinic service is available. Space greatly limits health education activities which can be carried out at the Clinic. Limited waiting room space adds to discomfort of patients seeking care. Due to the number of skin conditions seen, the number of referrals to Dermatology Clinic and requests by physicians, we might consider having a dermatologist service available once a month. Consideration should be given to having Clinic service available once a week on a year-around basis. Continued emphasis needs to be kept on teaching how to get needed follow-up care.

Maybe some project funds for eye examinations and glasses should be considered. This year we utilized local service clubs for a number who had no resources for this care. It was kept minimal, of necessity. The number of patients receiving dental care could be increased with more funds. More coordination of team effort and communication can be done, although cooperation has been and continues to be good.

One difficulty was expressed by pediatricians in regard to communications when their patients were seen on standing orders by the Psychiatric Social Worker. It is difficult to tell if this communication problem was valid, as all had previously been introduced to the Psychiatric Social Worker and the Psychologist and regularly talked with them over coffee in the Clinic setting.

Nursing service was increased during the 1969 season with more emphasis on using the most appropriate personnel to provide the service. One Public Health Nurse was available at the Clinic from 1:00 until the Clinic closed; another was available to small camps during the same hours. A third nurse worked two evenings a week at Eola making home visits. A fourth helped cover small camps one evening a week. The Public Health Nurse, who was placed in Migrant Summer School and day care 3 days a week, was able to make a limited number of home visits to families where one parent remained home. A registered nurse functioned as Clinic Nurse during all Clinic sessions. This year we had one full time female Community Health Aide, two part time Community Health Aides and one part time male Community Health Aide. The Public Health Nurse in the Clinic was responsible for coordination of all other personnel on the project staff. For the most part this worked well and is certainly necessary to keep functioning smoothly. At the beginning of the season the male Community Health Aide was assigned specifically to Mental Health; however, he was unable to function as needed when the patient was female, and it was necessary to utilize a female Community Health Aide from nursing. During the later part of the season when he worked more directly under the Public Health Nurse coordinator assignments went more smoothly.

Several times during the summer, consultants visited Eola Clinic from the State Board of Health and U. S. Public Health Service. We enjoy having these visitors observe our Clinic and utilize the knowledge they may bring us if possible.

Nursing service offered through the Clinic is varied. Outreach accounts for about one-half of the Community Health Aide visits and one-third of nursing visits. The majority of outreach service is designed to help migrants recognize their health needs and to obtain needed service. We attempt to visit every migrant family in the area to explain the service we offer so that it may be utilized. This year with increased utilization of aides we contacted 80% of the migrant families passing through our area.

Obtaining adequate follow-up for medical care is felt to be nearly as great a problem as receiving initial care. Because of this need for follow-up medical care, supportive visits endorsing this philosophy are made by both Public Health Nurse and Community Health Aides. It is one aspect as likely to be overlooked by a general population as by a migrant population. Where chronic conditions occur, both the patient and family gain from home visits that combine demonstration and give support. In Clinic situations the nursing interpersonal relationships often become stronger because nursing and aide personnel are staple throughout

the season. Three hundred seventy-three nursing visits were made by the Public Health Nurse in the Clinic setting. Nursing vists (Part III) this year are more comparable to the visits in a generalized program, but reflect the concerns needed and utilized by this special population. Visits for acute conditions topped the count, followed by dental, tuberculosis, family planning, mental and emotional, and antepartum. At the low end of the curve were accident prevention, rheumatic fever, stroke, drug abuse, and multiple sclerosis. The number of accident patients seen in the Clinic shows a need to increase preventive efforts in this area. The age and activity of migrants indicate that while strokes rate high in a generalized program, this problem is rare among migrants. The success of nursing visits is not necessarily shown in the nursing statistics but is reflected in the reported statistics by such numbers as request dental care, the numbers requiring physical examinations, and the number of family planning patients. The smaller amount of communicable disease seen over a few years ago we feel gives an indication of the success of migrant projects throughout the country, particularly in relationship to immunizations. The number of nursing visits was greatly increased by the utilization of more aides.

Inasmuch as possible aide and nursing assignments were made so that the level of particular visits met the needs of personnel as well as patients. Delivering appointments, transportation, and teaching the importance of health cards were almost exclusively aide duties with occasional visits of this type made by the Public Health Nurse. Demonstrating nursing care, supervising health needs in school and day care centers, and high level counseling was done almost exclusively by the Public Health Nurse. The bulk of visits which fell between these extremes were made by either nurses or aides as they seemed appropriat. ith emphasis on smooth communication and continuity of care. It is an accepted principa. that each individual had a unique contribution to make to the total care needed.

There is an operating manual specifically for Yamhill County Migrant Project which contains such items as job descriptions, policies, procedures and standing orders for all disciplines. Though it was written and is being revised by changes on the local level, it reflects opinions and desires offered to us by the migrant population using the services, the local Farm Workers' Association of settled or settling Out Migrants, and volunteer organizations such as Migrant Ministry which involves local citizens as well as professionals giving health care. It also incorporates state and federal philosophies and forms. Personnel employed in a particular position write job descriptions and help define the roles in which they serve. The importance of this is reflected by the project teamwork.

Health Education is an integral part of all services since one goal is to better prepare families to utilize "non system medical services" generally available. It is a part of every home visit, every clinic experience and group and individual counseling. This year we had opportunity to utilize the Neighborhood Disease Control Self Help Kit from National Communicable Disease Center. The use of this kit was assigned to one lady community health aide who utilized it primarily in the small camps. Twenty-four showings of film strips were done in cabins of migrants with 15-20 persons viewing each strip. The aide felt that she got good participation because she was familiar with the material and she began by telling the initial part of the strip in story form, then obtained group participation by asking the audience to pick up additional details. The mothers expressed favorable reactions to parts on personal hygiene. The strips on tuberculosis and childhood diseases were most often requested by migrants and elicited the most questions. The kit was also used to train personnel for day care centers. It would be helpful to have more health education materials such as this available particularly on subjects such as accident prevention, care of an ill child, and dental hygiene. We could have utilized this type of group health education more by familiarizing the male community health aide with the kit earlier in the season and utilizing homes in Eola Village in the same manner as we utilized homes in the small camps. If the kit continues to be available to us we plan to do so. Attempts to have group health education activities at the clinic are limited by space, and on occasions when we tried it this summer, it was necessary to move out on the lawn due to the number of migrants attending. This area of service needs continued thought and creativity in action. We were impressed especially with the participation of local dentists and their dental assistants in bringing a dental hygiene demonstration to Eola.

Local referrals for care are made primarily to the Clinic during the summer and to private

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medical doctors on fee-for-service basis or to University of Oregon Medical School during the rest of the year. This year nursing referrals were 72% successful. The rate of referrals receiving medical care is somewhat higher than for dental care; however, there was a higher percentage of follow-through with initial requests for dental care. Moving and improvement of the condition are the reasons most often given for not following through. Transportation problems and lack of understanding are occasionally given as reasons for not following through with the indicated care.

Each year more interstate referrals have been made. Reviewing these, it appears that we are receiving more information regarding the completed referrals. The type of referral has changed from those expecting large amounts of care to a request for more limited care, as more knowledge has become available about other projects. The current referrals are probably more realistic but don't truly represent need. We do have concern regarding quality of care and its effect on the individual. An example of this was a diabetic patient being evaluated with only a urine test rather than a blood sugar or glucose tolerance test. When she was running no sugar, she rejected the diagnosis for further need for care. Incomplete referrals which are reported seem to result from inaccurate addresses being given by migrants. Since over half of the referrals are not reported back it is difficult to further evaluate the reasons they were not completed.

Nurses working on the Migrant Project are primarily the Local Health Department staff and have a familiarity with both program and local resources. An in-service interdisciplinary meeting is held in March. Nurses are urged to attend all workshops, etc. involving migrant health and related subjects. Orientation is mandatory for nursing personnel on the project.

Aides receive individual and group orientation by the Public Health Nurse on beginning employment. This year orientation was not as effective since aides did not begin work on the same date. If we are to continue to use aides who are moving in the migrant stream, this is a reality we must accept. The in-service coordination meeting held mid-season by the Psychiatric Social Worker and coordinating Public Health Nurse helped, but should have been instituted earlier in the season. Orientation procedure needs more thought and some revision. Aides felt that workshops held by State personnel were helpful and should be continued even though they occurred during the busy season.

On the whole, we feel nursing service improved, both in quality and quantity. Weaknesses pointed out in the narrative will receive thought and attention. Nursing service needs to be broadened during the winter months as do medical and dental services.

Health education services have been described in part earlier in this report. They suffer due to lack of personnel directly for this purpose. The Health Education Consultant from the State Board of Health is helpful in suggesting broad general ideas, but local implementation is left to local personnel who feel limited by other assigned commitments and lack of specific knowledge. The community health aides were very willing to share information about their culture which would enhance health education, and they used great initiative and creativity in using materials available. The lack of materials is a large problem. Comic books could provide an excellent vehicle of communication, if more health subjects were available in this form. Another method used was health-centered pictures to color with crayons, for children waiting in the Clinic. If more space were available, film strips and movies on health topics could also be shown in the waiting room during Clinics.

Members of the staff are involved with local organizations such as Migrant Ministry and Farm Workers' Association. On occasion we speak regarding the project to other civic organizations.

Though all the programs involved in the Migrant Project were somewhat more successful this year we must strive to come nearer our goals. It appears that becoming a year-around project plus implementing changes discussed in the narrative must be our next steps.

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SANITATION NARRATIVE

The 1969 pre-season activities primarily involved farm labor housing improvements. A large, badly run down group of cabins was closed for the entire season. A previously licensed camp was further improved to meet the 1968 Federal Regulations. Also meeting federal housing requirements were the "house type" facilities at Eola Village. A brand new camp, designed to fulfill the Federal Housing Regulations, was built.

A 27 unit group of old tourist-court type cabins used by migrants was closed this season. Practically every rule and regulation of the Travelers and Tourists Code was violated. The violations involved sewage disposal, garbage and refuse disposal, rodent control, fire prevention, plumbing and electrical codes, and the furniture and bedding codes. In this particular case we felt we had more authority to close these facilities via the Travelers and Tourists Regulations as a "tourist accommodation" rather than through the Farm Labor Housing Regulations as a Farm Labor Camp. One camp was further improved to more fully meet the new federal regulations. The improvements involved fire prevention - providing a second story exit for fire escape and installing fire resistant surfaces in the cooking areas; and vector control - all mattresses were replaced with new or fumigated mattresses. And the house units of Eola Village met the Federal Regulations. The 47 houses at Eola are 2 bedroom, 1 story, wood frame, with individual cooking and toilet facilities. By providing screening for the front doors and bathroom windows, these facilities meet the federal requirements. A new camp was specifically designed and built to meet all the requirements of the Federal Regulations. The housing consists of two five-plex apartment wings at right angles to each other. Each unit includes a large sleeping room, a combination nook and living area, and a kitchen with hot and cold running water, electric stove, and refrigerator. All of the aluminum windows are screened including a front screen door. A bath house is located near the center of the apartment wings. This facility consists of showers, flush toilets, lavatories, and laundry facilities.

Many of our camp operators were making improvements to meet the new federal regulations on farm labor housing. The addition of this new camp and the improvement of existing camps resulted in ten new living units and sixty-three units all meeting federal requirements providing quality housing for 546 migrants. The closure of the camp which had poor facilities was the result of several months of continual inspection, enforcement, and personally conversing with the camp owner. This resulted in a reduction of total housing units, but showed an increase in quality housing with fewer violations being issued. (See Table B). This process of improving the housing condition could not have been realized without the consultations and cooperation of the Yamhill County Housing Authority, Bureau of Labor and Oregon Employment Service, State Fire Marshal, State Electrical and Plumbing inspectors and the State Board of Health Furniture and Bedding Section.

The majority of the housing provided in the county are cabins of frame, single wall construction. The largest is Eola Village operated by the Yamhill County Housing Authority. There is a total of 17 camps covered by permits, including the before mentioned camps, offering 408 family units and a maximum capacity of 2827 migrants. Along with the camps are six other locations primarily consisting of 33 privately rented family units offering housing for a maximum capacity of 277 migrants. (See Table A).

This season, 17 licensed farm labor camps and 6 unlicensed workers' quarters provided housing for migratory agricultural workers. The sanitation section in cooperation with all the other disciplines within the Health Department, perfected a map locating farm workers' housing in Yamhill County. (See Map). In conjunction with locating housing, medical care availability was shown, including distances in miles between them. The numbered symbols correspond with a numbered index, providing an easy-to-read and understand map. The map was designed to be used by the nurses, nurses aides, community health aides, sanitarian aide, and migrants. The map eliminated much confusion by enabling the health personnel to locate the migrants and enabling the migrants to acquire adequate housing and medical aid. The use of this type of visual, educational aid was a tremendous improvement providing a meaningful communication for the users.

The Project staff consists of one sanitarian, working three-fourths time throughout the year

on farm labor camp sanitation. The sanitarian's responsibilities are to make frequent visits to farm labor camps for purposes of inspection, consultation on a variety of environmental problems, education, and if necessary, enforcement of laws and regulations. He was assisted during the summer months by a full time sanitarian aide. The same personnel, including the summer aide of the 1968 Migrant Season, was a definite advantage and a time-saver for our staff. As a result he was accepted by the growers and very few second follow-up violations were issued. We cannot overestimate the value of having the same summer aide for three consecutive summers. His acquired knowledge from the previous season was invaluable. And most important his previous acquaintance with the local growers and camp managers made evaluations more understandable and accurate.

The most frequently found defect in camps this season was that of insects and rodents. Of 41 unsatisfactory conditions found, 21 were satisfactorily corrected. This problem was partly the result of improper storage and disposal of garbage and refuse. Of 30 unsatisfactory conditions found, 20 were satisfactorily corrected. Substantial effort was made to assist the growers in eliminating this problem, first by improving the garbage situation and then by setting out bait stations to poison the rats. Possibly next year a Vector (mosquito and fly) Control District will be functioning in the Northeast and Southeast portions of the county. Most of the labor camps are located in this area and will benefit by the efforts of the Yamhill-Marion-Polk Vector Control District.

Water supplies are primarily derived from wells. There were 15 defective sources because of improper construction or poor maintenance. Eleven were brought into satisfactory compliance by proper sealing, batch chlorination, or other means.

Sewage disposal which has previously been by means of privies is changing to flush toilets. Newer camps are going this route and the growers' apprehension that the migrants would improperly use this type of facility is being dispelled.

Considerable time and effort was spent on field sanitation in the working environment. There were 73 inspections made of the field water supplies. Four were unsatisfactory, all of which were subsequently improved. There were 220 field toilet facilities inspected; 55 were unsatisfactory, and 41 were improved. Field toilet problems encountered were mostly related to maintenance and cleaning. (See Table B).

The sanitarian section hopes to maintain our positive relationships with the growers, camp managers and other interested groups of Yamhill County. Only by year-around contact with the growers and camp managers can this bond be secured. Therefore, the pre-season activities are an essential part in determining the total effectiveness of the migrant program. Progress continued this year at a more rapid rate than previously, due to the pre-season housing improvement, the improved communication via the housing map and aide training, and increased effectiveness of the sanitarian aide in performing his duties. By continuing the before mentioned activities and with the addition of new innovations, i.e., the Vector Control District, the ultimate achievement of the project goals and objectives will be realized.

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MIGRANT MENTAL HEALTH SERVICES

Continued growth of the Mental Health program over the six years since it was introduced as part of the comprehensive health services in this project is viewed as reaffirmation of the migrant population's need for and desire to use this type of help to resolve intrapsychic and inter-personal conflict and enhance day-to-day functioning. The goals of the program remain unchanged: to provide a diagnostic and treatment facility of high quality at a time and place where it is readily available. It is housed with the medical clinic in the largest migrant camp in the county, and the late afternoon and evening hours are geared to the harvesters' schedules.

Our experience this year indicates that the changing social philosophy in this country is bringing about a heightening of internal and external stress to an impoverished, mixed-ethnic population. The impact of federal and local program offering economic opportunities, heretofore beyond the fantasies of many of these people, is taking a cruel toll in some families. Years of poverty and ethnic minority status have resulted in low self-esteem, but at the same time provided a safety valve for the expression of their rage: curse the government the fates, society; no one will help; "there's nothing you can do about it."

Now, with the proliferation of "help yourself" programs, large numbers of these people, including Mexican males propel"ed by their more aggressively upward-striving wives, are coming to see these "opportunities" as no more than confrontations. "Opportunity" for what? To demonstrate one's feared inadequacy? As they cling tenaciously to the known way of life, discontented wives become contemptuous, and older children, growing up in a cross-cultural conflict in an era of unprecedented social change, become increasingly resistive to laboring in the fields and turning their earnings over to the family.

Many of these fathers take flight, sometimes literally, but more often into the beer bottle, passivity, or illness. Such was the plight of at least nine of the families seen this year. Implications for family life deterioration and disorganization are manifest.

It is to these concerns, we believe, that the mental health professionals and sub-professionals need to address themselves if "opportunity" is not to become the bellwether for the forces destructive to family life for large numbers of approximately one million people in the migrant stream. This staff is committed to the philosophy that the stresses attendant upon the expression of innate human drive toward growth and self-actualization are amenable to therapeutic intervention by a creative mental health approach.

In line with our practice of encouraging flexibility in use of personnel to promote the testing of innovative ideas for service delivery, each of the "helping people" was given freedom to choose methods and modes of interacting with the "consumer," the migrant client or potential client. This latitude to select activities geared to optimal use of individual expertise was thought to produce excellent results; but it did not, unfortunately, lend itself to uniform statistical reporting. Each discipline's activity, therefore, will be reported individually.

The clinical psychologist, who worked part-time one night a week, chose to focus on six psychodiagnostic evaluations requested by the coordinating public health nurse and the social workers; intensive work with three families and one individual, for a total of 112 interviews; consultation and informal contacts with other professional staff for a total of 7 hours. The psychologist provided 45 hours of direct service to clients.

The nurses' and community aides' mental health contacts will be reported in another section because their statistics were kept separately.

The project psychiatric social worker, whose services were augmented by a well-qualified friend who volunteered one night a week for the last half of the summer, elected to use the considerable referral resources of the medical clinic, an alert and capable team of public health nurses, and the four indigenous community aides, the latter being in or recently out of the migrant stream. Without exception, the referrals were appropriate and were supported by referring personnel on an ongoing basis through their contacts in other aspects of their clinic roles.

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The 1969 caseload for the social workers numbered 48 individuals from 32 families comprising 206 members. Ten were reopenings from previous contacts. Fewer than half a dozen people who accepted new referrals failed to keep their initial appointments. There were 147 hours of direct treatment provided. Although 12 patients had only one interview, 11 had five or more and the maximum was 11 with one woman, 10 of them conjointly with her husband.

This indicates a favorable growth trend from the modest beginning in 1964 when six families were seen for a total of 38 hours. It is believed that referrals would have been heavier this year if the treatment staff's schedules had not been filled by mid-season.

Characteristics of the 1969 patient caseload are identified in the table entitled "Social Workers' Reporting of Mental Health Patient Load 1969".

The flow of intake paralleled that of previous years with the peak during July. The month of June, when the migrants were just moving into the county, produced 15 cases, with 22 in July and 11 in August. Categories of care, as reflected in the forementioned table, were as follows: adult psychiatric, 19; child guidance, 9; family counseling, 7; marital counseling, 8; mental hospital follow-up, 4; and mental retardation, 1.

As in past years, it was the staff's impression that the Anglo patients evidenced a greater degree of interference with their functioning, were less motivated to engage in treatment, and were more inclined to use flight as a defense against internal and external stress. One such case was that of Mr. and Mrs. X, the course of which was as follows:

Mr. X was referred to Mental Health by a clinic physician because of complaints such as insomnia, headache and nervousness. His wife had informed the doctor that he also drank excessively.

Mr. X said apologetically that his need was past, that he simply had had a frightening experience. After drinking beer, wine, and vodka for several days, he underwent his customary hangover, but did not regain strength as rapidly as in the past. Two weeks after terminating this binge, Mr. X became hallucinatory and delusional. He was convinced that people were calling his wife and children "Japs", she being a Japanese whom he married while stationed with the army in Japan. He believed that there were people outside intending bodily harm to his family. Apparently he armed himself. His wife became fearful that he would do damage either to the family or to some innocent bystander and brought him to the clinic immediately following the acute phase of this episode.

His history indicates that he is the ninth of 14 children of a southwest farm labor family who were moonshiners. Mr. X has been drinking since he was a small child and has admitted for several years that he has a problem with drinking. His work as a heavy equipment operator is interrupted frequently for these binges, which his wife said had in the past been no more than his lying abed and howling meaningless phrases for two or three days and nights. She said this upset her and their four children, but it had never been this bad before.

As other aspects of their life style were gingerly touched upon, both Mr. and Mrs. X became reticent. Both readily accepted another appointment, but did not keep it. Mr. X gives more than a little evidence of schizophrenia, paranoid type. It is thought that Mrs. X's ambivalence toward treatment stems from some awareness of his pathology and the fear that he might be removed from the family, leaving them with a very uncertain future in a strange culture.

* * *

Among the adult Mexican patients, gross stress reactions, varying degrees of depression and marital conflict were common. Although physical ailments were most often the presenting symptoms, they were able to move quite quickly into meaningful discussions of their conflicts. Typical of the stress reaction was Mrs. A, whose course in four interviews was as follows:

She was referred because of depression, chronic tiredness and strange sensations of the head and extremities. A youthful-looking 34-year-old mother of six, she said the way things were, it was no wonder she was going funny in the head. She rejects the life style of the migrant

SOCIAL WORKERS' REPORTING OF MENTAL HEALTH PATIENT LOAD 1969

Age	Anglo Male	Mexican Male	Anglo Female	Mexican Female	Other Female (Japanese)	Primary Type of Service	
0 - 10	1	3		2		Child Guidance	6
11 - 20			1	5		Child Guidance	3
						Marriage Counseling	1
						Mental Hospital Follow-up	1
						Mental Retardation	1
21 - 30		1	2	8		Adult Psychiatric	3
						Marital Counseling	5
						Mental Hospital Follow-up	3
31 - 40	1	3	2	6	1	Adult Psychiatric	9
						Family Counseling	3
						Marital Counseling	1
41 - 50	2	2	2	4		Adult Psychiatric	5
						Family Counseling	4
						Marital Counseling	1
51 - 30		1		1		Adult Psychiatric	2
Totals	4	10	7	26	1		

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labor stream. Her parental family settled out three years after coming to this country from Mexico when she was 13. At 17 she married her present husband, five years her senior, a life-long farm laborer. Things were bad enough in the early years, but now that the children are older they resist working in the fields, and she is tired of spending half the year living in shacks, depending on uncertain crops to keep their bills paid and looking forward to a bleak future when she doubts they can make a living this way. It is all so unnecessary. She has for years pleaded with her husband to get a steady job and settle somewhere, not necessarily in Texas where they finally managed to buy a house. He has said he would, but he does not. With the offering of training opportunities, she has exerted increasing pressure on him until he said finally, a year ago, "I couldn't make it." Since that reluctant admission, he has become more fearful of everything--the children's well-being, getting lost in traffic or having an accident, choosing the wrong crop to follow--and has pretty well abdicated his role, forcing her to make the main decisions for the family, blaming her when things go wrong, and trying to seduce the children to his side during their many arguments. She thought he had grown lazy.

During four hours of interviews, Mrs. A was able to develop a bit more compassion to dilute her contempt for Mr. A. He was to have joined us for the last interview, but refused angrily when she insisted that he shower and change clothes.

* * *

Quite the reverse of this picture is presented by Mr. and Mrs. B, whose situation is described in the following:

Both born in Mexico, non-English-speaking and without formal education, they are 38 and 35 respectively. They are the parents of 10 children ranging in age from 16 to 6, and have been in the migrant stream all their lives. He has made several abortive attempts to settle out in the last four years.

Originally Mrs. B was referred to Mental Health because of uncontrolled psychomotor seizures, a volatile temper, and many physical complaints without physiological basis. She appeared alone for the first interview, an immature, narcissistic woman in spangled silver evening pajamas. Through the Spanish-speaking aide, she reported that all her trouble was with her husband. He no longer treated her like a husband should. He would not take her to town when she wanted to go, or take the family to restaurants, or take her dancing. She dated his changed behavior from four years ago when her seizures became more frequent and he had to give up the best job he ever had to stay with her while the children went to school per the insistence of the local authorities. He has been mad at her ever since. The aide co-therapist helped her to describe her need to have her husband pay lots of attention to her to prove that he loved her. Mrs. B said, coyly, that she did not have as many of these seizures when he was taking her out like he should.

It was agreed to have her husband join us for subsequent interviews, and obviously considering the co-therapists her allies, she was delighted with the idea.

He entered the next interview with hat in hand and head bowed. Appraised of our interest in his family, he stated his case without defensiveness: he has a large family, and it takes a lot of money to take care of them. When the family was smaller, he could take them to restaurants a lot, and he took his wife to nightclubs to dance whenever she wanted to go. Now it was not possible. Since he must stay with his wife all the time because of the seizures, he must get training as an automotive mechanic, a trade in which he already has considerable skill, so he can be certified to operate a shop adjacent to his home. In order to do this, he must have savings to carry the family during his training. His efforts to do this, so far, have been thwarted by her extravagant demands. She said he was a tightwad. He said he had to hold onto what money they made so he could take care of his family.

An appointment was made to discuss this further, but it was not kept. Mrs. B did not like the direction the last interview had taken, the aide co-therapist reported after a home contact, but Mr. B. thought it was helpful to him.

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(The aide co-therapist diagnosed Mrs. B as an irresponsible nut, which fits well with the social worker's impression of sociopathic personality disturbance, dyssocial behavior. Supporting evidence came later when a relative in close association reported to the aide a long history of Mrs. B's narcissistic exploitation of her husband, periodic gross neglect of her children, and a pattern of "taking off to the nearest beer hall" to associate at least informally with other men during periods of pique with her husband's real or fancied slights.)

* * *

Classic among the problems of the Mexican families trying to settle out of the migrant stream into the community was that of the C family. The Migrant Summer School reported that 5½ year-old Junior was much too immature to enter first grade in the fall. Having already had a year of kindergarten, he was unable to count beyond five when age-peers without school were going beyond 30; he would not do anything he did not choose to do and either responded by standing defiantly challenging the teacher's authority or by crawling under tables. He was also inclined to act out violently against peers. The faculty doubted that the parents could be involved because they knew them as being totally invested in settling in the community and striving toward unrealistic standards of upward mobility in the local social systems. The father either attended some class or was tutored five nights a week in addition to working at a full-time factory job. The mother worked whenever she could, including laboring with the older children in the fields. Junior, the youngest of the four, came to light when the kindergarten he had attended recommended that he be delayed in entering the first grade, and the Summer School confirmed this opinion. Junior finally got referred, and a description of the action follows:

Referral to Mental Health was effected by the coordinating public health nurse who seized the opportunity of Junior's humiliating temper tantrum in pediatrics clinic as a vehicle for referral, to which Mrs. C was at that point in time vulnerable.

Although the intake appointment was for both parents, only Mr. C appeared, bringing Junior. He did not understand the complaints because his boy was no trouble at home, and he did not agree with the schools that Junior was not ready to enter first grade. He agreed to a short-term evaluation series with his child, making it clear that he, himself, could be available only if it were absolutely necessary. His wife managed the discipline of the children anyhow, he said, and in response to an inquiry, said she had not accompanied him "Because she had something else to do."

An hour with Junior delineated the problem: as youngest in the family, he did not have to do anything he did not want to do, he was free to pick fights and lash out at older siblings because they were not permitted to fight back, and he was reaping the benefits of his family's recently-found economic success by demanding and getting anything he wanted. He acknowledged specified instances of behavior in school but thought it would not get him into trouble because "Father won't do anything about it." It was suggested that he and his father meet again to talk about what was going on in school, and he said he didn't care.

Father and son were seen together. A few of the problems as they were reported to us were described, and Mr. C did not seem uncomfortable until he turned to his son, who was standing in the middle of the room, and said, "Junior, what do you have to say about that?" Junior stood, hands in pockets, feet spread, lower lip protruding, mute and defiant. We said we were worried that he might not succeed in first grade because, after a year in kindergarten, he was counting only to five when others without prior school could count many more times than that. Junior was offered as many pieces of candy as he could count. He maintained his silence and defiant stance; Mr. C was coming to believe the complaints of the schools. He still hoped he would not have to involve himself in dealing with it.

"Count, Junior," he commanded. No response. "Junior," he said with increasing anger, "COUNT!" No response. "If you don't start counting right now, you're not going out to play any more," he shouted, "You'll just stay in the house all the time counting and making your name!" No response. Mr. C's agony came through in the heightened coloring of his face and neck, the perspiration now pouring off his body. "Junior," he yelled, "You're not going to do any more what you want to do! You're going to do what the teachers tell you!" No response. His

voice dropped to a plea. "Junior, you start talking, or you're not going to get any more candies any more." Silence.

Mr. C had experienced the problem, and there was no point in continuing the demonstration. Junior was excused from the interview.

It was suggested that Mr. and Mrs. C decide whether to place Junior in kindergarten or first grade, and return for an interview.

Mr. C came back. He could not face having his child retained and would rather have him repeat first grade than "kindy", because "he has to study." He refused a referral to the regular Mental Health Clinic because "we don't need it." However, he welcomed the offer of social work contact through the school Junior enters.

The outlook for Junior, we believe, is fairly hopeful because they are remaining in a community where comprehensive public health services are available.

* * *

Another source of stress on this population is the lack of basic knowledge and understanding of the operation of the social systems in which they exist. If they have questions or complaints about what is happening to them, they most usually do not know where to ask questions or register complaints effectively. Authority on all levels appears to them to be remote and disinterested, if not overtly hostile toward them. While this appears to be true broadly for both Anglo and Mexican populations, the latter are particularly susceptible to the role of the victimized.

Unsophisticated, inarticulate and somewhat fearful of the nebulous entity called "government" they have, in a variety of transactions, sought the help of lawyers who have told them, "There's nothing you can do about it." In more than one instance that proved to be remote from the truth. Patients under stress mentioned these situations as contributing to their distress, and several times well-directed letters of inquiry brought results in a short time. One such case evolved as follows:

Mr. and Mrs. L referred themselves to the social worker because of anxiety provoked by their indecision about moving from their southwestern home to the northwest, where they felt that better opportunities existed for rearing their eight children remaining at home. Mr. L favored the move, citing the fact that his $42.00 weekly income in the winter was insufficient for the family's needs. She was ambivalent, saying they had so many bills for past living that she did not see how they could move. She produced the bills, most of them for emergency medical care. The most pressing was a physician's charge incurred nine months earlier when one of the L children was seriously injured in a traffic accident. The operator of the vehicle was a minor whose father had agreed, in the presence of investigating officers, to pay all medical expenses involved, and the young operator was cited for law violation. The hospital had been paid, but the liable father had simply ignored the doctor bill. Mr. and Mrs. L had visited a Mexican attorney who told them there was nothing they could do about it.

The social worker helped them to direct letters that were sent by certified mail to the state police and the liable father, setting forth the facts of the situation. The police forwarded the inquiry to the department of financial responsibility, which sent a demand to the offending father. Within a few days he arranged to pay and sent the L's a waiver of future claims, which they signed, completing the transaction.

One stress, at least, was lifted from this overburdened family.

* * *

Another major emphasis of the Mental Health personnel's work this year was the participation in consultation, in-service training, and case conferences. Some 123 sessions under these categories involved 189 persons at various times; for the most part, the same people who comprised the Migrant Clinic, Day Care, and Summer School staffs. The categories for reporting

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these activities were somewhat ambiguous. Identifiable exclusively as in-service training would be didactically-presented sessions with the nursery personnel and the Project's community aides. The other sessions were case-related discussions that offered teaching opportunities. The arbitrary breakdown was as follows: 39 sessions involving 65 people in consultations; 31 sessions involving 69 people in in-service training; 53 sessions involving 55 people in case conferences.

In line with these activities, our concept of "team approach" is articulated in the way it was presented during the aide training sessions:

The idea of a "helping team" is to bring together several kinds of knowledge in such a way as to offer the patient or client all of the kinds of service we have available in this clinic in a way that the client can get the most good out of them. This means that each person on the team-- the community health aides, the nurses, the doctors, the psychologist, the social workers, the consultants to whom we have access from the downtown Mental Health Clinic, and the schools -- has a particular talent or skill to give that is his or her specialty, and each of these talents is of equal importance if we are to achieve a "fit" in a pattern of skills that will get the job done. The problems of the people whom we meet may have too many sides for any one professional discipline to meet the needs completely, and no one of us can master the task if he tries to cut the other team members out of the action. Because of our conviction, this philosophy operates in practice as well as in principle.

The nurses, all of whom are accustomed to working collaboratively with Mental Health personnel, were not only the primary source of referrals, but also used consultation extensively. The physicians varied in their use of the service according to personal preference seemingly related to prior experience.

Interaction with the Summer School faculty was highly productive and was structured somewhat differently this year in that the guidance committee which was comprised of the principal, four or five teachers, the school nurse and the social worker met weekly but did not confine its interest to consultation regarding individual children's problems or instances of problem behavior exclusively. In addition, the group participated in a "total millieu push" for children who were known to the clinic. Behavior viewed in the light of family dynamics and environmental conditions often seemed less inappropriate and more amenable to modification in the school setting, and reports from faculty tended to support the social worker's assessment of the progress of clinical treatment.

A third aspect of work with the school was the use of various opportunities to discuss common problems of the disadvantaged child in the school setting. Attention was focused on the unsocialized, the withdrawn, and the unmotivated child as well as on the perceptual distortions of children who project their intrapsychic conflicts and sociocultural orientation into the environment. One such opportunity derived from the showing of "Hansel and Gretel" which was described by three children between the ages of four and a half and five and a half as follows:

Maria, an extremely deprived child whose environment held little meaning for her, reported the show as "Handsome and Gretel." According to her, "The witch put Handsome in the oven and everything turned out all right."

Johnny, an anxiety-ridden little boy whose feelings of isolation and fears of abandonment led him to fantasies of omnipotence, said, "That ol' witch took the boy out in the middle of a great big field and left him there all by himself. I ain't going to put up with that ol' witch!"

Junior, an acting-out child given to violence toward his peers, described the show as, "An old-fashioned movie. Nothing happened. It would have been better with guns and shooting."

It would seem that these children rather dramatically made the case for perceptual distortion as it affects the learning process.

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New this year was an expanded concept of the community aides' role in mental health activities. In the past they have primarily served as Spanish-English interpreters, the "water boys" of the team. Their more direct involvement in the treatment process was seen as an appropriate use of their time and talents.

It is, of course, axiomatic that people who are not informed of the philosophy, principles, and techniques of a discipline become frustrated when they are expected to carry them out in practice. The obvious was overlooked by the Project social worker in the initial orientation sessions, and midway in the season it became apparent that some remedial activities were indicated if we were to make our new concept work. Inasmuch as we were nearing the peak of the season and time was at a premium, we were forced to limit our formal training sessions to four hours, and the aides were paid their regular salaries to attend.

The lecture-discussion method was used with the social worker structuring the program and team-teaching with the coordinating public health nurse, who was able to take the mental health concepts presented and broaden their application to other activities in which the aides were involved. We found this to be a valuable approach, and the aides' response was strongly positive.

Content was narrowed to include the concept of team, elemental dynamics of interviewing, basic concepts and principles of working with people, and selected aspects of the professional relationship. In defiance of those who hold that these are esoteric concepts ill-suited for transmission to high school level or less formally educated bodies, we found that the aides grasped the material readily, made immediate application of it, and reflected increased involvement and effectiveness as well as a notable reduction in anxiety that had been provoked by their not knowing why we were doing what we were doing, or what was expected of them. Our evaluation was supported by the nurses and physicians who remarked on the change.

Convinced of the necessity of this kind of in-service training, staff's plan is for an ongoing program throughout the next Project year. Not only did it free the aides to contribute more to the process and thereby help us to do a better job; but also we believe that this will enable us to continue the expansion of the aide role in the areas of case finding, utilization of the interaction between patient and aide in the home and during the time they are traveling to and from the clinic, funneling of additional pertinent information into the interviews, and follow-up contacts in the community with those who do not, for one reason or another, follow through on treatment plans.

Least satisfactory was an attempt at in-service training with the day-care nursery staff, a group of girls in their late teens. They reflected elaborate disinterest in the emotional growth needs of a child from birth to 4 years of age, and finally made it explicit that they regarded their charges as "just a job for the summer." Only one indicated any intention of ever working with children in the future.

Follow-up contacts were possible for 26 of the families seen in previous years. Nurses saw 16 and obtained information from relatives concerning four others. The social worker saw five, and the psychologist saw one. Of the five families seen by the social worker, ten individuals received additional treatment this summer. It was apparent that these people would have benefited from continuing care as a choice over the short-term contacts necessarily offered in the Project. However, one Anglo family seen in 1965 reported sustained gains in the ability to cope and required no further service. A large multi-problem Anglo family seen in 1964 maintained its maladaptive behavior and refused further care. Mrs. S, a Mexican woman seen in 1966 because of acute pains and peculiar sensations, has had no further treatment and has deteriorated markedly. She has separated from her husband and presented herself this year as near-psychotic. She was suspicious of further interviews and terminated after two sessions.

Of great concern at this point in time are those 120 - 140 families who are trying to settle out of the migrant stream into this community. Many of them are Mexican families midway in their child-rearing years, and the problems of adaptation frequently become overwhelming. They are entering a sociocultural milieu that is Anglo-oriented and not always friendly

toward them. They are either entering formal training, apprenticed to jobs, or undertaking a work pattern unfamiliar to them; almost universally having some doubt that they can "make it," they are under gross stress. The children enter over-crowded schools with the probability of cultural and educational lag according to local standards. Housing is scarce, exorbitantly priced and more often than not, inadequate. Even the climate is different. They are no longer following the sun, and the severity of some winters is more than they were prepared for either materially, physically, or emotionally.

Superimpose the average population's problems of marital adjustment, child-rearing, and interpersonal or intrapsychic conflict on the foregoing set of "givens" and the probability for maladaption becomes formidable. These are not people whose orientation leads them to seek public care facilities, and they consequently become known at times of crisis. An energetic reaching-out program, comprehensive in scope, affords the only opportunity for preventive intervention.

We advocate the employment of three full-time persons year-around to provide appropriate services to these families who choose to settle in this area. The team should include an indigenous community aide, a public health nurse, and a psychiatric social worker.

SUMMARY

Our six years of experience in providing mental health services to migrants confirm our belief that this population needs, wants and has the internal resources to invest in social-emotional growth in a favorable treatment climate. Demand for the service is ever-increasing and news of it is being spread by word among the migrants themselves, many of whom insist on having the social worker's name, address, and telephone number on a paper to carry with them. One woman called long-distance at a time of acute stress a few weeks after she left here.

Help needs to be available at times and places where it is useful and is best provided from a medical facility. Most of the emotional problems are presented as physical symptoms, and medical personnel's collaboration is essential to both referrals and ongoing treatment. The team approach is most economical and most effective, and brings to bear a variety of services in a short time. The use of indigenous aides has enormous potential if they are supported by an ongoing training program.

At the present time, the adult Mexican female seems most inclined to seek Mental Health services, although we are encouraged by the number of Mexican men who were here in interviews conjointly with their wives or total families this year.

We believe that the rapid pace of social change in this country is underlining family structural weaknesses that might not have become explicit under the aegis of the "nothing you can do about it" philosophy. With rare exception, the migrant parents with whom we have talked during this six-year project have avowed the determination that their children will be educated so that they will not have to live as the parents do. With the offering of adult job training opportunities, youth now challenges the parent generation: YOU do not have to live this way. Some do. They have neither the internal resources nor realistic opportunities to improve their situation. Others who have greater internal and external resources still may not be able to capitalize on these opportunities because of inhibiting intrapsychic or interpersonal conflict. It is to these people that we owe supportive services.

It is not now and never has been our goal to settle everyone who comes to our attention out of the migrant stream and into the community. For those 120 to 140 families whose free choice it has been to settle in this area, however, provision of reaching-out physical and mental health services is essential to the well-being of the entire community.

Yamhill County
MG 05G

MIGRANT FAMILIES ATTENDING FAMILY HEALTH SERVICES

Spanish-American

Spent Winter	
Arizona	17
California	48
Colorado	1
Idaho	14
New Mexico	3
Oregon	36
Texas	81
Washington	17
Unknown	10
Total	227
Previous Visits	70
No Previous Visits	157

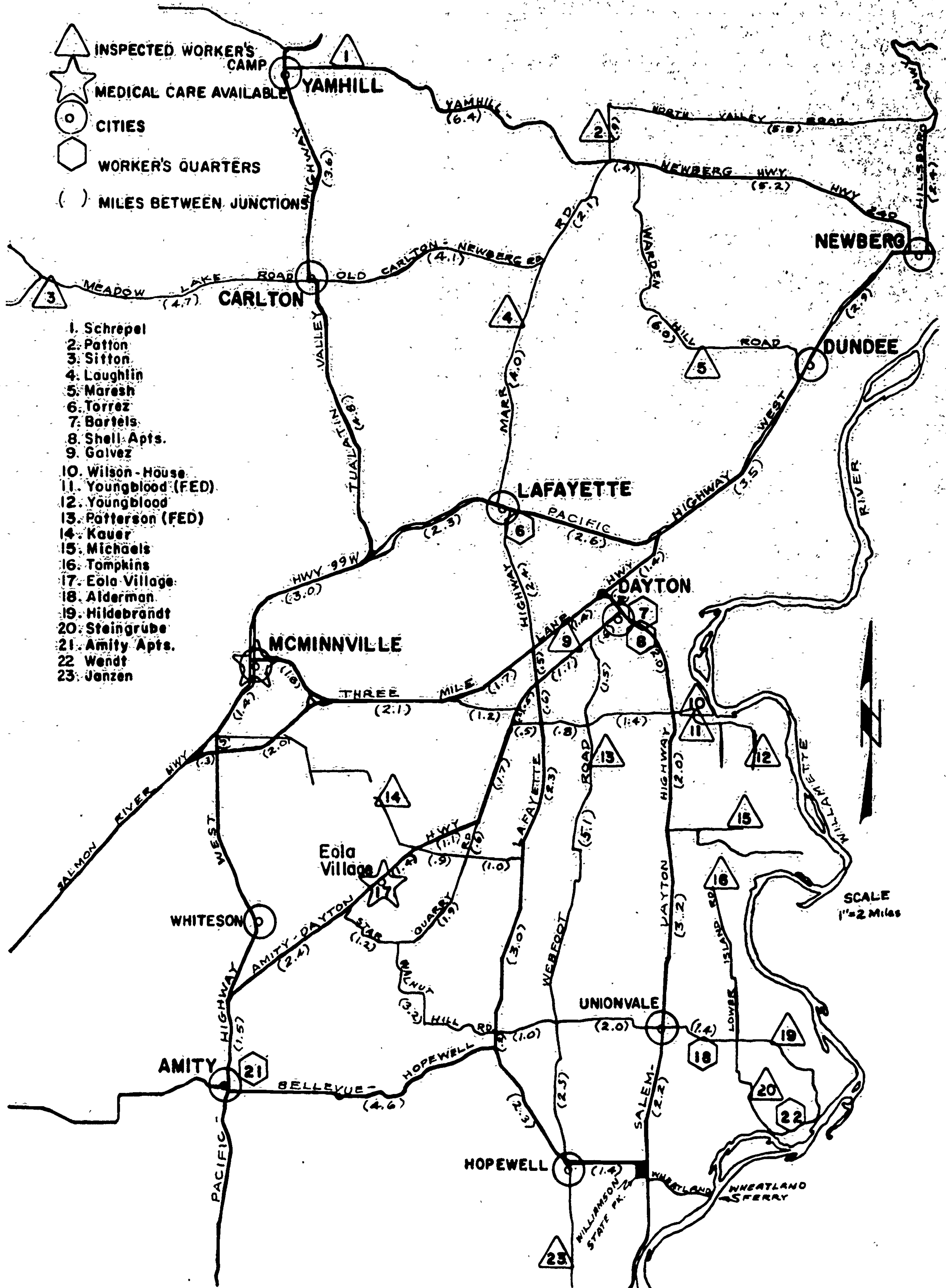
Anglo-American

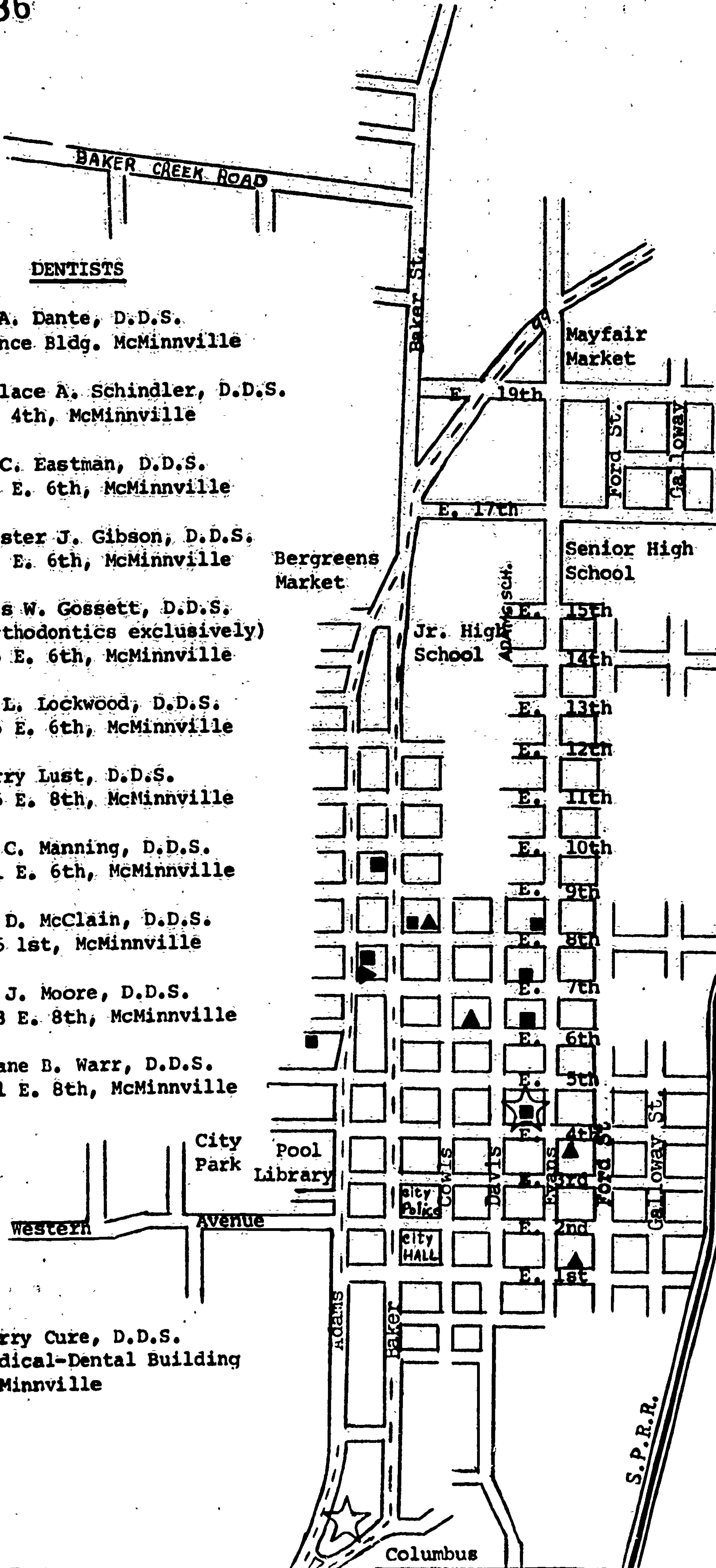
Spent Winter	
Arizona	11
Arkansas	2
California	29
Idaho	2
Kansas	2
Missouri	2
Oklahoma	4
Oregon	20
Texas	2
Washington	4
Unknown	4
Total	82
Previous Visits	30
No Previous Visits	52

COMPARISON BETWEEN SERVICE

	1964	1969
Clinic sessions	23.5	41
Hours of medical service	104	208
Patients receiving medical care	589	725
Public Health Nurse office visits	227	373
Public Health Nurse home visits	322	453
Public Health Nurse day care visits	23	220
Individuals given dental care	0	72
Individuals receiving mental health services	16	47
Community Health Aide home visits	not tabulated	1024
Community Health Aides employed from Migrant stream	1	4

FARM WORKERS HOUSING IN YAMHILL COUNTY





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MEDICAL HELP IN
MC MINNVILLE, OREGON

☆ HOSPITAL
■ DOCTOR
▲ DENTIST

APPENDIX . . . .

Oregon Farm Labor Camp Law

Farm Labor Health Code

Recommendations for improvements
to farm labor camps

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FARM LABOR CAMPS

446.510 Definitions for ORS 446.510 to 446.660. As used in ORS 446.510 to 446.660 and subsections (4) and (5) of 446.990, unless the context requires otherwise:

(1) "Board" means the State Board of Health.

(2) "Farm labor camp" means any place, area or piece of land where sleeping places or camping grounds are owned or maintained:

(a) By a person engaged in the business of providing sleeping places or camping grounds for employes or prospective employes of another person if the employes or prospective employes are or will be engaged in agricultural work; or

(b) In connection with any work or place where agricultural work is being performed, whether the sleeping places or camping grounds are owned or maintained by the employer or by another person.

(3) "Local health officer" means the health officer appointed under ORS 431.418. In case a farm labor camp is located in more than one county or in a city and county, the health officer within whose area the larger portion of the farm labor camp is located shall act.

(4) "Operator" means a person holding legal title to the land on which a farm labor camp is located. However, if the legal title and the right to possession are in different persons, "operator" means a person having the lawful control or supervision over the farm labor camp under a lease or otherwise.

(5) "Place of employment" means a location where one or more persons are actually performing agricultural work.

(6) "Sleeping place" means any room, structure, shelter, tent, trailer house, vehicle or other place where one or more persons are housed.

(7) "Facility" means a sleeping place, drinking water installation, toilet installation, sewage disposal installation, food handling installation or other installation which if in unsatisfactory sanitary condition would be a serious menace to public health.
[1959 c.314 §1, 1961 c.610 §16]

446.520 Water supply. (1) An ample supply of safe and potable drinking water shall be provided in every farm labor camp for drinking, hand washing, bathing and domestic purposes. This water shall be available from convenient outlets, which may include portable water containers, that comply with standards of the board relating to location, construction, operation and quality.

(2) Adequate hand washing facilities shall be provided either adjacent to all toilet facilities or adjacent to the living facilities in a farm labor camp.

(3) Any container used in common for drinking purposes is prohibited.

(4) If drinking fountains are provided at a farm labor camp, they shall be of an angle jet type with adequate water pressure at all times.
[1959 c.314 §2]

446.530 Toilet facilities. (1) In every farm labor camp there shall be at least one toilet or the equivalent thereof for every 15 employes or fractional part thereof of each sex housed in the farm labor camp. When a total of seven or less persons of both sexes are housed only one toilet need be provided. These toilets shall be readily accessible, be properly marked and conform to standards in the code relating to location, construction, operation and cleanliness.

(2) Adequate toilet facilities shall be provided at all places of employment. If drinking water is provided at the place of employment it shall be safe and potable and available from outlets, which may include portable water containers, that comply with standards of the board relating to location, construction, operation and quality.
[1959 c.314 §3]

446.540 Sewage disposal; plumbing. (1) Sewage disposal in a farm labor camp shall be effected by means of a connection to a community sewer system, a septic tank with subsurface disposal of the effluent, pit type privies or other sanitary means conforming to ORS 447.140 and rules of the board relating to sewage disposal.

(2) All plumbing in a farm labor camp shall be installed in compliance with ORS 447.010 to 447.140 and rules of the board relating to plumbing and water supply.
[1959 c.314 §4]

446.550 Refuse and trash. (1) All refuse in a farm labor camp, including garbage and kitchen waste, shall be stored in durable

watertight containers, so constructed as to exclude flies and rodents. These containers shall be maintained in a clean condition and in good repair.

(2) All refuse and trash shall be removed from a farm labor camp at least once each week and disposed of in a manner that will not endanger human health.
[1959 c.314 §5]

446.560 Prevention of breeding of animal or insect pests. Measures shall be taken in each farm labor camp to prevent the breeding of rodents, flies, mosquitoes, bedbugs and any other animal or insect vectors or parasites.
[1959 c.314 §6]

446.570 Sleeping places. (1) All sleeping places in a farm labor camp shall be maintained in good structural condition and constructed in a substantial manner so as to provide shelter for the occupants against the elements and to exclude, structurally or otherwise, rodents and insects.

(2) All sleeping places except tents, vehicles and trailer houses that are owned by the occupants, shall have, in addition to a door, an opening that can be used as an exit in case of fire.
[1959 c.314 §7]

446.580 Food and meals. In a farm labor camp where food or meals are prepared or served by the operator or by a concessionaire, the facilities for and practices of preparation and serving shall comply with ORS 624.010 to 624.120 and the rules of the board relating to eating and drinking establishments.
[1959 c.314 §8]

446.590 Reporting communicable diseases and unusual prevalence of illness. (1) The operator of a farm labor camp shall cause a report to be made to the local health officer immediately if an individual housed in the camp is known to have or is suspected of having any communicable disease or illness. This report shall include the name and address of the individual.

(2) If an outbreak of suspected food poisoning occurs in a farm labor camp, or an unusual prevalence of any illness in which fever, diarrhea, sore throat, vomiting or jaundice is a prominent symptom, the operator of the camp shall immediately report the outbreak or unusual prevalence to the local health officer.
[1959 c.314 §9]

446.600 Rules covering ORS 446.510 to 446.590 to be embodied in health code. The board shall make and enforce reasonable rules to carry out ORS 446.510 to 446.590. These rules shall be embodied in a health code for farm labor camps.
[1959 c.314 §10]

446.610 Adoption and amendment of health code for farm labor camps. (1) Before formulating a draft of the health code, the board shall invite the participation of interested state agencies and representative business, farm, labor and health organizations. These groups may make suggestions relating to the minimum standards to be embodied in the health code which shall be considered by the board. The board shall then prepare a tentative draft of the health code.

(2) Upon the fixing of a time and place for a hearing or hearings to consider the tentative draft, the board shall cause a notice of the hearing to be published in one or more daily newspapers of general circulation published and circulated in the City of Portland and in such other daily or weekly newspapers of general circulation in various affected areas in this state as will give wide notice of the hearing. Any individuals or groups may participate in the hearing, and submit their comments and suggestions relating to the minimum standards embodied in the tentative draft.

(3) Notice of the adoption and issuance of the health code shall be given in the same manner as notice of the hearing.

(4) The board shall cause copies of the health code and amendments thereto to be distributed to interested persons and state agencies.

(5) The board may amend the health code at any time upon its own motion or upon complaint by an individual or group, in the same manner as the health code was prepared, adopted and distributed under subsections (1) to (4) of this section.

(6) No defect or inaccuracy in a notice or in the publication thereof shall invalidate

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the health code or any amendment thereto adopted and issued by the board.
[1959 c.314 §§11, 12, 13, 14]

446.620 Closing facility that is not in accordance with health code. (1) Any facility of a farm labor camp that violates any provision of the health code hereby is declared a public nuisance. The local health officer, the Commissioner of the Bureau of Labor or the Director of the Oregon State Employment Service, or his representative, may, 24 hours after posting written notice, close such a facility if in accordance with the health code he considers it to be a serious menace to public health. The official taking this action shall prepare a closing order on forms prescribed by the board. The notice and the closing order shall specify the items which constitute the serious menace to public health. This closing order shall be posted conspicuously at or near the closed facility, and copies of the order shall immediately be sent to the local health officer and to the operator of the farm labor camp. The official closing the facility may after contacting the local health officer reopen it when the condition causing the closure has been corrected.

(2) The local health officer shall review the closing order within 24 hours after it was issued, and shall within that time rescind the order if he finds that it was erroneously issued or that the facility has been brought into compliance with the health code. The operator of the farm labor camp affected by the closing order shall be given an opportunity to show that the order was erroneously issued or that the facility has been brought into compliance with the health code. If the local health officer does not rescind the order within 24 hours after it was issued, he is considered to have confirmed the order.

(3) If the local health officer confirms a closing order, the operator of the farm labor camp may at any time thereafter demand, orally or in writing, that the facility closed by the order be reinspected. The local health officer shall reinspect the facility within 24 hours after receipt of the demand. If the closing order was erroneously issued or if the facility has been brought into compliance with the health code, the local health officer shall immediately rescind the order.

(4) If the local health officer considers an entire labor camp or place of employment to be a serious menace to public health, he may close it 24 hours after posting written notice. The local health officer taking this action shall prepare a closing order on forms prescribed by the board. The notice and the closing order shall specify the items which constitute the serious menace to public health. This closing order shall be posted conspicuously at or near the closed facility and copies of the order shall immediately be sent to the operator of the farm labor camp.

(5) If the position of local health officer is vacant or the local health officer refuses to act or is otherwise unable to act, the State Health Officer or his authorized representative shall perform the duties required of a local health officer by this section. The provisions of ORS 446.630 shall apply to the State Health Officer or his representative in those instances where the State Health Officer or his representative performs the duties required of a local health officer by this section.
[1959 c.314 §15; 1963 c.170 §1]

446.630 Appeal to circuit court. Any person aggrieved by a closing order issued under ORS 446.620, or by a failure on the part of a local health officer to cause a prompt reinspection to be made under ORS 446.620 after receiving a demand, may appeal to the circuit court of the county in which the farm labor camp, or the larger portion thereof, is located. This appeal must be made within 30 days after the date on which the county health officer confirmed the closing order. However, the closing order continues in effect while the appeal is pending and thereafter unless the court orders it suspended or rescinded.
[1959 c.314 §16]

446.635 Notice to local health officer prior to operation of camp. (1) A farm labor camp operator shall notify the local health officer in writing prior to operating a farm labor camp for the current year. He shall furnish his name and address, the address and location of the camp, the number and type of housing units providing sleeping places and the approximate date of maximum occupancy.

(2) Forms of the notice required under subsection (1) of this section shall be provided by the State Board of Health and shall

be made available to operators by the State Board of Health, and the local health officer, through local offices of state agencies, including the Oregon State Employment Service.
[1967 c.598 §2]

446.640 Supplying information and assistance to operators of camps. (1) The board shall conduct an educational campaign to inform all operators of farm labor camps and the persons housed therein of the provisions of ORS 446.510 to 446.660 and subsections (4) and (5) of 446.990 and of the health code, and shall encourage the continued improvement of health and sanitation.

(2) The Oregon State Employment Service shall cooperate in the formation of employers' committees and assist them in establishing their own system of inspection, improvement and maintenance of farm labor camps. This system is in addition to the procedures under ORS 446.510 to 446.660.
[1959 c.314 §17]

446.650 Cooperation with and assistance from United States. The board may, in carrying out ORS 446.510 to 446.660 and subsections (4) and (5) of 446.990, contract or cooperate with and receive aid or assistance from the United States or any agency thereof.
[1959 c.314 §18]

446.660 Applicability of Administrative Procedures Act; procedural rules. (1) In addition to the health code, the board may make procedural rules necessary to carry out ORS 446.510 to 446.660 and subsections (4) and (5) of 446.990.

(2) Except as otherwise specifically provided in ORS 446.610, the health code and all other rules of the board under ORS 446.510 to 446.660 and subsections (4) and (5) of 446.990 shall be adopted and issued under ORS 183.310 to 183.510.

(3) Except as otherwise specifically provided in ORS 446.620 and 446.630, proceedings relating to a closing order are subject to ORS 183.310 to 183.510.
[1959 c.314 §19]

PENALTIES

(4) Continued operation by the operator of a farm labor camp of a facility after it has been closed by a closing order under ORS 446.620, or wilful violation of any provision of ORS 446.510 to 446.660 or of the health code, is a misdemeanor; except that wilful failure to notify, as required by ORS 446.635, is punishable, upon conviction, by a fine of not more than $100, or by imprisonment in the county jail for not more than 30 days, or both.

(5) Wilful misuse, damage or destruction by any person housed in a farm labor camp of any facility required under the health code to protect the health of persons housed in the farm labor camp, or the health of the public, is a misdemeanor, and said person shall be liable for any wilful misuse, damage or destruction.

OREGON STATE BOARD OF HEALTH

PROPOSED REVISIONS TO THE
FARM LABOR HEALTH CODE

[Bracketed portions are deleted]

Underlined portions are inserted

OAR Chapter 333, Section 22-120 is amended to read as follows:

22-120 DEFINITIONS. (1) "Board" means the State Board of Health.

(2) "Farm labor camp" means any place, area or piece of land where sleeping places or camping grounds are owned or maintained:

(a) By a person engaged in the business of providing sleeping places or camping grounds for employes or prospective employes of another person if the employes or prospective employes are or will be engaged in agricultural work; or

(b) In connection with any work or place where agricultural work is being performed, whether the sleeping places or camping grounds are owned or maintained by the employer or by another person.

(3) "Local health officer" means the health officer under [ORS 431.410] ORS 431.418 for the county or city in which a farm labor camp, or the larger portion thereof, is located.

(4) "Operator" means a person holding legal title to the land on which a farm labor camp is located. However, if the legal title and the right to possession are in different persons, "operator" means a person having the lawful control or supervision over the farm labor camp under a lease or otherwise.

(5) "Place of employment" means a location where one or more persons are actually performing agricultural work.

(6) "Sleeping place" means any room, structure, shelter, tent, trailer house, vehicle or other place where one or more persons are housed.

(7) "Facility" means a sleeping place, drinking water installation, toilet installation, sewage disposal installation, food handling installation or other installation which, if in an unsatisfactory sanitary condition, would be a serious menace to public health.

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OAR Chapter 333, Section 22-122 is amended to read as follows:

22-122 CAMP [AREA] SITE

(1) The grounds of a farm labor camp shall be maintained in a clean, sanitary condition, free from waste water, sewage, garbage, [and other putrescible material.] litter or debris. During the period of camp occupancy, grass, weeds, and brush shall be kept cut.

(2) All Farm Labor Camps shall be located on well-drained ground and the sites shall be graded, ditched, or rendered free from depressions in which water [may] can stand. Measures shall be taken so as to adequately dispose of the waste water and spillage underneath outside water hydrants.

(3) [Except where permission is granted otherwise by the local health officer or the Board,] Provisions shall be taken to prevent or control the breeding of mosquitoes, flies, and rodents in the immediate camp area and in the barns, pens, feed yards, or similar [quarters of] livestock or poultry areas within 200 feet of any farm labor camp facility owned or under lawful control or supervision of camp operator.

(4) The operator of a farm labor camp shall be responsible for the maintenance and operation of camp and facilities.

(5) All toxic materials shall be stored in a safe place, inaccessible to the camp occupants. No empty containers such as drums, bags, cans, or bottles which contained toxic materials shall be left in the immediate camp area or disposed of in such a manner so as to endanger the camp occupants.

(6) No poultry or livestock shall be kept in the immediate camp area during the period of camp occupancy.

OAR Chapter 333, Section 22-124 is amended to read as follows:

22-124 WATER SUPPLY

(1) All water furnished at farm labor camps [and at places of employment] shall be from a source approved by the [board] local health officer and shall conform to the required [bacteriological] standards for purity accepted by [of] the Board.

(2) Except where the drinking water is obtained from a public water supply, the local health officer will submit a water sample from each drinking water system to the Board for bacteriological analysis prior to the occupancy of the camp, and as often thereafter as may be necessary to assure a potable water supply.

[(2)] (3) An ample supply of safe and potable water shall be provided in every farm labor camp for drinking, handwashing, bathing and domestic purposes. [This water shall be available from convenient outlets.] Water for drinking and domestic purposes shall be available within 100 feet of each sleeping place. An ample supply shall be construed as not less than 35 gallons of water per day per camp occupant.

(4) The water supply storage and distribution facilities shall be arranged, constructed, and if necessary, periodically disinfected to satisfactorily protect the water from contamination.

[(3) Except where the domestic water is obtained from a public water supply, the operator of a farm labor camp shall submit a water sample from each drinking water system for bacteriological analysis to the Board one month prior to occupancy of the camp, and as often thereafter as may be required by the local health officer. Water samples shall be collected in bottles supplied by the local health officer or the Board.]

[(4) Portable water containers equipped with spigots and tight-fitting covers may be used for field drinking water providing the containers shall be constructed of impervious non-toxic material which will protect the water from contamination. Containers such as barrels, pails or tanks, from which the water must be dipped or poured are prohibited.]

(5) Cups, dippers or other utensils used in common for drinking purposes are prohibited.

(6) If drinking fountains are provided at a farm labor camp they shall be of an angle-jet type with adequate water pressure at all times.

[(7) An adequate supply of hot water shall be available for bathing and laundry purposes at all farm labor camps. Adequate facilities for heating water may be substituted in lieu of actually providing hot water where the farm labor camp is occupied for less than two weeks or where less than 50 people are housed.]

[(8)] (7) Where water, unsafe for drinking purposes [intended for irrigation, fire protection or other purposes] is accessible, this water shall be posted as "Unsafe for drinking". These signs shall be printed in English and in Spanish. [Employees shall be notified that such water supply is not safe for drinking.]

[(9)] (8) There shall be no cross connection between a system furnishing water for drinking purposes and a [system furnishing water for other purposes, unless the water for the latter is from a source approved by the Board for drinking.] non-potable supply.

[(10) The water supply source, storage facilities, and distrubution facilities shall be arranged and constructed to satisfactorily protect the water from contamination.]

OAR Chapter 333, Section 22-126 is amended to read as follows:

22-126 TOILET, HANDWASHING, BATHING AND LAUNDRY FACILITIES

(1) [Adequate toilet facilities shall be provided at all farm labor camps and at all places of employment.] An adequate supply of hot and cold water shall be available for bathing and laundry purposes at all farm labor camps.

(2) In every farm labor camp there shall be at least one toilet or the equivalent thereof for every 15 employees or fractional part thereof of each sex housed in the farm labor camp. When a total of 7 or less persons of both sexes are housed, only one toilet need be provided. In installations containing laundry and bathing facilities, the floors and walls shall be of readily cleanabl finish and impervious to moisture. Floors shall be sloped to drain and not made of slippery materials. Floor drains shall be provided in all shower baths, showe rooms, or laundry rooms to remove waste water and facilitate cleaning. The walls and partitions of shower rooms shall be smooth and impervious to moisture.

(3) At places of field employment, one toilet shall be provided for every 25 employees of each sex. In fields where the duration of employment is less than five hours per day, the toilet ratio may be reduced to one toilet for every 40 employees of each sex. When a total of ten or less persons are employed only one toilet need be provided. All laundry and bathing facilities shall be maintained in a clean and sanitary condition.

(4) Toilet facilities in farm labor camps shall be readily accessible. When constructing new facilities, toilets shall not be more than 200 feet from the living quarters they serve. In every farm labor camp there shall be at least one handwashing basin for every 15 employees of the camp. These handwashing faciliti shall be provided either adjacent to all toilet facilities or adjacent to the sleeping places in a farm labor camp. Twenty-four inches of sink with an individ faucet shall be considered equal to one basin. Handwashing facilities shall be maintained in a clean and sanitary condition.

(5) Toilet or shower facilities provided for each sex shall be distinctly marked for "men" and for "women" by signs printed in English and in the native language of the persons occupying the camp where necessary. In every farm labor camp there shall be at least one shower head provided for every 15 employees of each sex. A plumbed in bathtub may be substituted for a shower head. When a total of 7 or less persons of both sexes are housed, only one shower need be provided.

(6) Adequate handwashing facilities shall be provided either adjacent to all toilet facilities or adjacent to the living facilities in a farm labor camp. In every farm labor camp there shall be at least one toilet for every 15 employees or fractional part thereof for each sex housed in the farm labor camp. When a total of seven or less persons of both sexes are housed, only one toilet need be provided. These toilet facilities shall be maintained in a clean and sanitary condition.

(7) In every farm labor camp there shall be at least one handwashing basin or equivalent for every 15 occupants of the camp. Portable handwashing basins at the ratio of one for each family shall be considered satisfactory. Toilet and bathing facilities provided for each sex shall be distinctly marked for "men" and "women" by signs printed in English and in Spanish.

(8) In every farm labor camp there shall be at least one shower provided with hot water supply for every 25 occupants of each sex. Where the farm labor camp is occupied for less than two weeks or where less than 50 people are housed, two galvanized #3 wash tubs may be substituted for one shower facility. When a total of seven or less persons are housed, only one bathing facility need be provided. Toilet facilities in farm labor camps shall be no more than 200 feet from the sleeping place that they serve and privies shall not be closer than 50 feet from any sleeping place or any facility where food is prepared or served.

(9) Privies shall conform to the regulations of the Board with regard to their construction and location and they shall be maintained in good repair and in a clean and sanitary condition.

(10) If urinals are used in the toilet facility and where three or more toilets are required for men, one urinal may be substituted for one toilet, up to a maximum of one-third of the total toilets required.

(11) Urinals shall be constructed of non-absorbent, non-corrosive materials with a smooth and cleanable finish.

OAR Chapter 333, Section 22-128 is amended to read as follows:

22-128 SEWAGE DISPOSAL AND PLUMBING

(1) Sewage disposal in a farm labor camp shall be effected by means of a connection to a community sewer system, a septic tank with sub-surface disposal of the effluent, pit type privies or other sanitary means conforming to ORS 447.140 and rules of the Board relating to sewage disposal.

(2) All plumbing in a farm labor camp shall be installed in compliance with ORS 447.010 to 447.140 and rules of the Board relating to plumbing and water supply and any applicable county or city plumbing code.

OAR Chapter 333, Section 22-130 is amended to read as follows:

22-130 GARBAGE AND REFUSE DISPOSAL

(1) All refuse in a farm labor camp including garbage and kitchen wastes, shall be stored in durable, water-tight containers so constructed as to exclude flies and rodents. These containers shall be maintained in a clean and sanitary condition and in good repair.

(2) All garbage and refuse [and trash] shall be removed from a farm labor camp at least once each week. [, and disposed of in a manner that will not endanger human health.]

(3) All garbage cans shall be kept covered and the garbage storage area shall be kept clean and free of flies and rodents.

(4) The garbage and refuse shall be disposed of in accordance with the rules of the Board relating to solid waste disposal.

OAR Chapter 333, Section 22-132 is amended to read as follows:

22-132 HOUSING

(1) All sleeping places in a farm labor camp shall be maintained in good structural condition and constructed in a substantial manner so as to provide shelter for the occupants against the elements and to exclude structurally or otherwise rodents and insects. [All sleeping places except tents, vehicles and trailer houses that are owned by the occupants shall have in addition to a door, an opening that can be used as an exit in case of fire.]

(2) Screens of not less than 16 mesh shall be provided on the doors and windows of the sleeping places when flies and mosquitoes are present. All doors with screens shall be tight fitting, in good repair, and self closing. No screens will be required if adequate control measures are employed to effectively eliminate flies or mosquitoes.

(3) The walls and roof of the permanently constructed sleeping places shall be tight and solid; the floors shall be constructed of a rigid and durable material, and shall be of a smooth and cleanable finish. If these sleeping places are used other than during the summer months of the year, they shall be constructed with a double wall or, if of single wall construction, they shall be provided with a safe heating device capable of maintaining a temperature of 68° F in all rooms.

(4) If tents are used for sleeping places, the tent body and screens shall be sound; the tent shall be treated with an effective waterproofing material as often as is necessary to assure the tent's being waterproof, and the tents shall be adequately screened to effectively keep out flies and mosquitoes. If tents are used other than during the summer months of the year, they must be provided with a safe and effective heating device capable of maintaining a temperature of 68° F in the tent at all times.

[(2)] (5) In every farm labor camp all [living quarters] sleeping places shall be swept, cleaned, and be free from rodents, insects and animal parasites before occupancy.

(6) All sleeping places except tents, vehicles, and trailer houses that are owned by the occupants shall have, in addition to a door, an opening that can be used as an exit in case of fire.

[(3)] (7) If mattresses are furnished they shall be clean, in good repair, and free from insects and animal parasites before being used by occupants. After each season, all mattresses shall be treated with an effective insecticide or fumigated and stored in a clean, dry place.

OAR Chapter 333, Section 22-138 is repealed and there is adopted in lieu thereof the following provisions:

22-138 FIELD SANITATION

(1) Drinking water furnished at places of employment shall be from a source approved by the local health officer and shall conform to the required standards of the Board.

(2) Portable water containers equipped with spigots and tight-fitting lids may be used for providing and storing field drinking water. These containers shall be constructed of impervious, non-toxic materials which protect the water from contamination and shall be washed with soap or detergent and sanitized with a suitable sanitizer at least every 7 days.

(3) Containers such as barrels, pails or tanks from which the water must be dipped or poured are prohibited.

(4) At places of field employment, one toilet shall be provided for every 25 employees of each sex. In fields where the duration of employment is less than five hours per day, the toilet ratio may be reduced to one toilet for every 40 employees of each sex. When a total of ten or less persons are employed only one toilet need be provided.

(5) Privies provided at places of employment shall conform to the regulations of the Board relating to sewage disposal with regard to construction and location, and be maintained in good repair and in a clean and sanitary condition.

(6) Toilet facilities provided for each sex shall be distinctly marked for "men" and "women" by signs printed in English and Spanish.

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Recommendations for improvements to farm labor camps: (in addition to the proposed regulation changes)

1. Space Requirements:

   a) Living units that are used for sleeping purposes only should provide a minimum of 50 square feet of floor space per occupant.

   b) For sleeping spaces in dormitories using double bunk beds, there should be a minimum of 40 square feet of floor space per occupant.

   c) In living units in which the occupants cook, eat, and sleep, there should be a minimum of 60 square feet per occupant.

   d) One half of the floor area should have a ceiling height of 7 feet and no floor area having a ceiling height of less than 5 feet should be taken into account when considering the provision of living space.

Space requirements are recommended to reduce as much as possible and practical, the close personal contact within the living group. Minimal living space is necessary to afford an adequate level of cleanliness in the unit. It reduces the transmission of upper respiratory diseases as well as other conditions resulting from overcrowding.

2. Plumbing and Running Water in the Unit:

   a) Each living unit in which the occupants cook, eat, and sleep should be provided with cold water (under pressure) and a sink.

This recommendation, although it entails the installation of a liquid waste disposal system, provides a method for the disposal of the waste water from the units (which is presently being thrown out of the front door), promotes better personal hygiene by making more water available for individual use, and allows a better level of general cleanliness and sanitation within the living units.

3. The provision of mechanical refrigeration and food storage:

   a) It is recommended that each unit be provided with a mechanical

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refrigerator capable of maintaining a temperature below 45° F and a storage area for foods.

Many of the foods that are available for consumption today spoil readily without refrigeration. Also, the conditions found in the labor camps often allow the food to become contaminated. This food, if it is not refrigerated, incubates and deteriorates allowing for the transmission of food-borne diseases. Other foods which do not require refrigeration should be stored in enclosed shelves protected from flies and other insects.

4. Painting the living units:

   a) It is recommended that the exterior of all frame living units be either painted or stained.

Unpainted housing units soon weather and dry out, the wood cracks and shrinks, and the units deteriorate rapidly. Also, much of the comment on the farm labor camps which is uncomplimentary arises from the unpleasant appearance of cabins.

5. It is recommended that electric lighting be provided for the general camp area, the wash houses, the shower, and the toilet facilities.

Lighting is recommended for the camp areas as many of the facilities must be located and used after dark. Minimal lighting of this type allows more effective control over the camp area and reduces camp accidents. Lighting in the showers, wash houses, and toilet facilities allows for a better level of maintenance. It is hard to clean what you can't see and conversely, the lighting should provide a better utilization of the facilities by the camp occupants.

6. The provision of drinking water in the harvest fields.

   a) It is recommended that drinking water be provided in all of the fields.

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All other industries and employers are required to provide drinking water for their employees and it seems that agriculture should be required to do the same to assure a potable supply of water on the job.

7. The provision of hand washing or hand cleaning facilities at the places of employment.
   a) Hand washing or cleaning facilities should be provided adjacent to the toilet facilities in the fields.

If we are to expect a better level of personal hygiene from the agricultural work force we must provide the method of accomplishing this improvement. Washing the hands after using the toilet facilities (especially before eating) is essential. Several of the products harvested go straight from the fields to the retail outlets and can be purchased and consumed by the public without washing or preparation. There is a potential threat that communicable diseases can be transmitted to the general public in this manner.

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