FARM WORKERS HEALTH SERVICE

ANNUAL REPORT 1969-70

California State Department of Public Health
2151 Berkeley Way, Berkeley, California 94704

Introduction

Highlights of the year 1969-70 in California for the Farm Labor population, centered on unionization strides, and legislative action in which there was considerable re-enforcement of endeavors on behalf of the farm worker, particularly with regard to his working conditions. These gains are reflected in the following items:

- -- The successful unionization of farm workers in the table grape industry. This was made possible not only through the local efforts of the United Farm Workers Organizing Committee but also through popular concern and support which resulted in an effective nationwide boycott. One of the benefits was the establishment of the Robert Kennedy Health Plan for union workers.

- -- Re-emphasis on the part of the California legislature concerning the enforcement of pesticide control, particularly with regard to hydro-carbons and organo-phosphate chemicals.

- -- The demonstrated increased attention on the part of the California Comprehensive Health Planning Council to the health needs in the rural areas.

- -- Passage of Senate Bill 681, which provides a mechanism for local enforcement of those sections of the Labor Code relating to labor camps. Local health departments would be encouraged to be designated by their governing boards as the enforcement agency.

- -- The additional farm labor housing units (in 1970, 2,080 units in 25 locations built through the auspices of Migrant Master Plan in the Department of Human Resources and Development and the trend towards improving clinic and day care facilities.

- -- The change in social welfare regulations which allowed for the inclusion of infants in group care facilities (and which was particularly aimed toward assisting migrant families with infants in the farm labor centers).

- -- The action spearheaded by the California Rural Legal Assistance in calling for effective enforcement of field crop sanitation laws.

- -- Broader educational programs for seasonal agricultural children ages 3-17 through the Compensatory Education Department and the Department of Education.

Individually, many of these items do not appear to have much effect on the needs of the seasonal agricultural worker (with the exception of the unionization efforts which have been underway for the last five years.) Collectively, these actions have indeed brought considerable attention to the various specific needs in social and health care of the rural population; and more specifically, the rural poor.

Yet despite these advances on behalf of the farm worker population, there is very little room for complacency with regard to meeting the needs of this population. Even though the Farm Workers Health Service general objectives have been met by at least 60% of the projects and there has been a consistent effort to maintain a meaningful outreach program in all areas of health services, the fact is that generally, the medical and dental care needs of more than 70% of the population are not being met. This is a very conservative estimate.

As in past years, the factors which contribute to the inability to provide a broader scope of service have been:

-- Indeterminate minimal funding for areas with chronic health care problems and very special geographic and community characteristics.

-- Distribution of services. Because of the minimun funding, projects tend to concentrate their services in farm labor centers where population is more easily accessible and concentration of services can be delivered in a more consistent pattern. This inevitably excludes the greatest portion of seasonal agricultural workers who reside within the general community or in outlying areas. These families are generally overlooked from year to year, and although contacted, may find it difficult because of the transportation problem to avail themselves of services.

-- The need to effectively utilize the manpower available to the rural areas. This problem encompasses not only the need for specialized training of professionals as well as paraprofessionals but also the ability to utilize optimally the services which each discipline can provide.

-- The unsuitability of facilities to assure quality of care. There has been an effort on the part of projects to expand and improve their facilities to be able to incorporate the diagnostic procedures so essential for better maintenance of health care.

In relation, both to the statewide trend and to the problems still prevalent, the Farm Workers Health Service staff, during the year 1969-70, concentrated on the following areas:

-- A general assessment and evaluation of all personal health care components. Consideration was given to administrative management, committment of the project as reflected in program development and innovations and expansion of services, the degree to which local projects were able to rally supportive services from other social and health agencies, the utilization of staff in relation to program objectives, and the potential of the project to develop and insure the establishment of a community advisory board.

-- The environmental health unit assumed major responsibility for planning, outlining, seeking legislative support, and assisting all agricultural counties, in addition to project counties, in developing a program of enforcement relating to field crop sanitation.

Environmental health consultation has also included the identification and work with potential groups of individuals to develop consumer advisory boards.

-- In personal health care projects, state staff has promoted the development of the nurse practitioner concept. Special training for nurses has been initiated in at least three of the major projects in California. It must also be added that this was done under major sacrifices to the local project since additional funding was not available either for training of the nurses or training of the health aides to assume nursing responsibilitiies. Time had to be allowed from other necessary activities to allow for this training.

-- Local projects have increasingly requested health education consultation and training as their programs expand and as this component services become more pronounced in their need. The idea of instituting a comprehensive program has become increasingly important in all areas.

-- The continued effort on the part of state consultants to work with RMP and CHP Boards and State agencies such as Department of Industrial Welfare, Department of Human Resources and Development (Workmen's Compensation and Disability Insurance) and State Department of Social Welfare and other state agencies engaged in services which also can render benefits to farm workers.

-- Established a cooperative working plan with some of the unit coordinators of migrant education programs.

-- Published the Glosario finally!

-- Seasonal Agricultural Advisory Committee was reconstituted on state level. The next meeting is to be held in Spring, 1971. Members of the new committee are:

Anita Alba	Consumer Advocate
Robley Berry	Calif. Congress of Parents and Teachers
Mary Delfin	Consumer Advocate
Elsa Fowler	Consumer Advocate
Toribio Fuentes	Consumer Advocate
Connie Garcia	Consumer Advocate
Edward Kimmelshue	Grower
Leon Mirviss, D.D.S.	Dentist
Franklin Murphy, M.D.	Physician
Antonio Orosco	Consumer Advocate
Miguel Ramos	Consumer Advocate
Israel Rodriguez	Consumer Advocate
Nancy Singh	Public Health Nurse
Stanley Skillicorn, M.D.	Physician
Florence Wyckoff	Member at large

MEDICAL AND DENTAL CARE SERVICES

Seventeen counties in California have developed a personal health care program consisting primarily of medical and preventive services. Most of the services were provided through clinic facilities and fee-for-service arrangements. Fee-for-service was employed primarily for specialist care, episodic care in situations when the clinic facility was not open for service and for dental care on a limited basis. The increase of patient load is related primarily to the increase of clinic sessions which has made it possible to sustain a more limited patient load with the exception of some sessions where 50 or 60 patients a session is still not uncommon.

Manpower

It was interesting to note that even though the shortage of manpower has always been chronic in the rural areas, expansion of medical care programs which resulted in additional sessions or additional clinic sites did not suffer from lack of sufficient manpower as anticipated. Few clinic sessions have failed to operate due to the lack of physicians. This is a particularly remarkable record to be sustained in rural areas where all physicians who work in the various clinics have already had a full day's work experience. All projects have attempted to improve their services by sustaining the same physicians to cover their clinic sessions so that there is not a turnover constantly for the patients. Even the rotation systems employed by some of the clinics, such as Santa Clara and San Joaquin County Medical Society, the assignment of physicians is on specific days where there can be followup by the patients to the same physician.

The physicians serving the rural areas seemed to express willingness to accept the concept of nurses engaging in screening services or assuming a role of the nurse practitioner. Support of this concept is certainly not shared by all of the physicians but in Stanislaus County for example, the value of the nurse as an evaluator for physician care has been nearly unanimously accepted by that society. The combination of screening plus followup services has been an educational experience for physicians who are working in migrant health projects and where effective followup is accomplished.

The exposure to the valuable work of paraprofessionals and the ability of professionals to accept the very special contribution of people from the community to be health workers, has also rendered a more effective use of physician and nursing manpower. There are some counties where the utilization of the health worker is still poor or unaccepted. Those projects that have poor inter-staff relationships and spotty coordination of services, usually reflect their insecurity through their attitudes in employment and utilization of health assistants in whatever field. As professionals are more secure and their contribution is recognized in the agency, they are more able then to extend themselves in accepting other personnel.

Unfortunately, there are still problems in the assimilation of the auxiliary workers with professional workers. It is difficult to overcome the hierarchy of institutions and the need to have supordinates rather than partners in provisions in services.

Facilities

As federal guidelines began to be more specific in terms of structuring minimum requirements which might provide a better quality of care for patients in the migrant projects, local projects have been increasingly more conscious of the inadequacies of their facilities. There have been general trends towards repairing and renovating the facilities to include compact laboratory units wherever this is possible and where laboratory technicians are available. Even those projects such as San Joaquin Medical Society that opposed using site laboratory facilities in favor of the referral of specimens to existing automated laboratory facilities, have felt differently once they have a unit which is specifically a clinic unit and is not used for other purposes during the day. Likewise, because of a strict law imposed by the Board of Pharmacy, more and more of the projects have needed to incorporate a pharmacist as part of their operational staff. Special storage space is to be designed then for pharmaceutical supplies. The Farm Workers Health Service staff has also emphasized the importance of adequate waiting room facilities as well as the assurance of privacy for each patient when receiving counselling by physicians or nurses. There are still a few projects with over-crowded and unattractive facilities but these are in the minority. At the Solano County project located in Dixon (funded through state resources for three years), a special clinic building will be constructed as a model of what might be accomplished in farm labor centers using the same materials that are available through the migrant master plan to make available a health center for the population in each farm labor area. These health centers could then be used at other times for health education purposes, counselling, group conferences and training.

Services Provided

Most of the clinics are currently providing care for acute conditions, routine screening for Tb, routine laboratory tests which consist usually of urinalysis, hemoglobin, or hematocrits. Preventive services such as immunizations, well child care, prenatal and postnatal care are also provided. Family planning services have expanded markedly and with federal funds now available for family planning services, consideration has to be given towards having this type of service funded through family planning funds rather than through migrant health funds. Thus, it would be possible to shift some of the funds into such needed service as restorative dental care.

This year Tb funds were cut back from many programs. This means that in the rural areas where Tb still has a high incidence, particularly in the large agricultural counties, migrant health projects may need to direct special emphasis to this service. As much as possible, local

projects are being encouraged to seek county support for the control of Tb since it is a communicable disease.

Public health nursing services are employed in the function of coordinating medical clinic services as well as providing public health nursing counselling during clinic hours. (Other public health nursing functions are discussed in the Nursing Section.) Supportive services include health aide services which consist of interpreting, assistance to physicians, and health education activities during clinic hours. They also assume most responsibility for case finding and followup services.

There is concern in state staff that the medical condition statistics do not reflect much prevalence of parasitic disease. One of the reasons is that our projects have not undertaken routine stool examinations. Furthermore, there is a particular skill, on the part of the lab technician, in identifying the organisms and not all laboratory technicians have had experience in areas where parasitic diseases are prevalent, so have not achieved this technique. Many specimens therefore are returned with negative findings. Because of this, many projects do not consider parasites to be a significant condition. Sutter County Hospital has been able to find a higher incidence of parasitic disease through their concentrated laboratory efforts.

Dental care services are still minimal. The U. C. Dental Mobile Unit was able to provide very good services to children under the migrant education program but again only those residing in Farm Labor Centers. San Luis Obispo project probably was the one project that provided broader dental care but limited the services due to lack of funds.

Current proposals indicate inclusion of dental services in most projects.

The services provided through the medical care components have shown that patients now are seeking preventive services such as physical examinations. Because of the patient loads, for acute care, not too many of these patients can be served.

Hospitals in the area have not had as many children with pneumonia, dehydration due to diarrheas and critical illnesses. Medical care is sought in early stages of illnesses.

Referrals

Referrals to the clinic although listed as 75% by family, friends or self may not be a true representation of the process of referral. A public health nurse may refer initially, for example, but the family must have time to test out referral on friends and family. If they encourage following through with referrals, the visit may be listed as family or friends instead of public health nurse.

The interstate referrals are being followed up but the delay imposed by mountainous paper - passing and referral rituals is a disservice to

patients. Another method for processing of migrant inter-state referrals will be resumed in the State Health Department beginning January 1, 1971.

Tabulating completed referrals on a local basis is still a problem for some projects. Reviews of the projects reflect that referrals as a rule are being completed and that coordinated followup methods are being more carefully instituted.

MEDICAL CLINIC AND FEE-FOR-SERVICE STATISTICS

Number of Patients

Migrant health service projects in California gave medical care to a substantially greater number of patients in 1969-70 than they did in 1968-69. The total patient population of the clinics and fee-for-service programs increased 44.6% from 18,016 in 1968-69, to 26,043 in 1969-70. There were 51,715 patient-visits in 1968-69, and 66,593 in 1969-70, representing an increase of 28.8%. The number of visits per patient remained about the same, going from 3.0 to 2.6.

There were a total of 1,875 clinic sessions held in 1969-70, as compared with 1,545 in 1968-69. Statewide, the average number of patients per clinic remained about the same, being 29.5 in 1968-69 and 31.0 in 1969-70. This does vary considerably among the different clinics, however, with a low in 1969-70 of about 10 patients per session and a high of about 53.

Demographic Characteristics

The demographic characterists of the patient population in 1969-70 were quite similar to those of the 1968-69 patients.

Most of the change that did occur was in migrancy status. The proportion of patients who were migrants increased to 47.0% in 1969-70 from 44.3% in 1968-69. There was also some change in the homebases of migrants. The proportion of migrants whose homebase was Mexico increased from 17.0% in 1968-69 to 19.9% in 1969-70. Most of this increase in Mexican homebases was balanced by the decrease in interstate migrancy. Of the 1969-70 migrants, 45.0% had interstate homebases, down from 48.1% in 1968-69. The porportion of migrants from California remained about the same as last year, with 34.6% having California homebases.

As was the case last year, the large majority of patients, 84.6%, were Caucasian-Mexican. About 12.8% were Caucasian-Anglo, and 1.5% were Negro. The age and sex distribution of patients also remained about the same. Children under fifteen years represented 49.1% of all patients, averaging 2.4 visits per patient. Adult males comprised 14.3% of the patients, also averaging 2.4 visits apiece, while adult females, 36.6% of all the patients, averaged 3.4 visits apiece.

Fee-for-service visits by age groups show a somewhat different pattern than do clinic visits. Males 15 years and over made 17.9% of fee-for-service visits, although they represent only 11.6% of clinic visits. Females 15 years and over made only 38.9% of fee-for-service visits while making 45.0% of clinic visits.

COMMENTARY

Upon conducting a review of the data we routinely collect, we have decided that some revisions are appropriate at this time - both in the data items themselves and in the processsing procedures. This should enable us to streamline our data collection procedures and cut down somewhat the number of items tabulated to put more emphasis on the analysis of available data, rather than on its collection.

We also plan to examine some different data items than those we have in the past. To begin with, we have changed the clinic form, omitting some items and adding others. (The new form is due to be initiated in the clinics on January 1, 1971.) We are omitting the item on "source of referral to clinic" for instance, as it has been tabulated for years and shows little change, and also because the accuracy of such information is somewhat doubtful.

We are also omitting the item on who the patient was seen by in the clinic, i.e., the nurse, doctor, both doctor and nurse, etc. In its stead will be a section concerning the "result of the clinic visit." This will include information on: whether the patient received all the care he needed; whether he received partial care and was to return to the clinic; whether he was referred out for further care or whether no other source of care was available to him. We hope that this information, analyzed in relation to factors such as primary conditions will give some indication of what proportion of patients' needs the clinics are able to meet and what needs for additional medical resources are not being met by the community-at-large.

We are expanding our ability to tabulate specific laboratory tests. In conjunction with this, we plan to do more analyses of the relationship between lab tests and other factors such as primary and/or referral condition.

Recognizing the value of patient-specific data rather than visit-specific data, we hope to do some special studies utilizing data from clinics which assign individual numbers to their patients. This would enable us to relate all lab tests, referrals and preventive care given specific patients, as these relate to the medical conditions for which they were seen. We are, at the same time, considering the possibility of a Statewide patient numbering system. This, of course, would enable us to relate the clinic data concerning migrant patients from all clinics whose services they utilized.

Table 1

COMPARISON OF MEDICAL CLINIC ATTENDANCE AND FEE-FOR-SERVICE STATISTICS
1968-69 / 1969-70

NAME OF PROJECT	PATIENTS New Admissions & 1st Visit This Year		Increase		VISITS		Increase		AVERAGE NUMBER OF VISITS PER PATIENT		NUMBER OF CLINIC SESSIONS		AVERAGE NUMBER OF PATIENTS PER CLINIC SESSION	
	1968-69	1969-70	Number	Percent	1968-69	1969-70	Number	Percent	1968-69	1969-70	1968-69	1969-70	1968-69	1969-70
BUTTE CO.														
Gridley Camp Clinic	482	666	184	38.2	1,067	1,812	745	69.8	2.2	2.7	19	34	56.2	53.3
Gridley Fee-for-Service	124	102	-22	-17.7	166	125	-41	-24.7	1.3	1.2	-	-	-	-
COLUSA CO.														
Fee-for-Service	115	151	36	31.3	180	224	44	24.4	1.5	1.8	-	-	-	-
FRESNO CO.														
Migrant Health Serv.,Parlier	1,542	2,675	1,133[a]	73.5	6,571	7,407	836	12.7	4.3	2.8	145	168	45.3	44.1
Westside Night Clinics (3)	1,727	2,489	762[a]	44.1	7,347	7,705	358	4.9	4.2	3.1	193	195	38.1	39.5
Fee-for-Service	-	na	-	-	-	na	-	-	-	na	-	-	-	-
KERN CO. MEDICAL SOCIETY														
Lamont Migrant Clinic	644	563	-81	-12.6	1,619	1,281	-338	-20.9	2.5	2.3	48	48	33.7	26.7
Wasco Migrant Clinic	154	484	330	214.3	198	938	740	373.7	1.3	1.9	8	33	24.8	28.4
MERCED CO.														
Planada Night Clinic	918	1,197	279	30.4	1,919	2,638	719	37.5	2.1	2.2	49	51	39.2	51.7
So.Dos Palos Night Clinic	1,165	1,152	-7	-0.1	2,414	2,580	166	6.9	2.1	2.2	51	50	47.3	51.6
Livingston Night Clinic[1]	-	746	-	-	-	1,413	-	-	-	1.9	-	36	-	39.2
Nursing Clinics (4)	180[b]	192[b]	12	6.7	661	981	320	48.4	b	b	141	187	4.7	5.2
Fee-for-Service	-	18[c]	-	-	-	25[c]	-	-	-	1.4	-	-	-	-
MONTEREY CO.														
Family Care Clinic	717	d	-	-	1,583	d	-	-	2.2	d	64	d	24.7	d
Gonzales Prenatal Clinic	88	142	54	61.4	451	479	28	6.2	5.1	3.3	50	50	9.0	9.5
SAN BENITO CO.														
Migrant Night Clinic[1]	-	169	55	28.1	-	242	-119	-22.2	-	1.6	-	21	-	12.5
Day-Drop In (Health Dept.)	196	82			535	174			1.7	2.1	-	-	-	-
SANTA BARBARA CO.														
Fee-for-Serv. - Santa Maria	82	146	64	78.0	99	255	156	157.6	1.2	1.8	-	-	-	-
Fee-for-Serv. - Carpinteria	-	35[e]	-	-	-	61[e]	-	-	-	1.8	-	-	-	-
SANTA CLARA CO.MED. SOCIETY														
So.Co.Fee-for-Serv.Clinic	788	683	-105	-13.3	1,720	1,698	-22	1.3	2.2	2.4	250	252	6.9[f]	6.7[f]
SANTA CRUZ CO.														
Pajaro Family Care Clinic	715	1,829[g]	1,154	161.4	1,590	3,960[g]	2,390	150.3	2.2	2.1	61	125	26.1	31.6
Fee-for-Service	-	84	-	-	-	159	-	-	-	1.8	-	-	-	-

Table 1 (cont.)

COMPARISON OF MEDICAL CLINIC ATTENDANCE AND FEE-FOR-SERVICE STATISTICS
1968-69 / 1969-70

NAME OF PROJECT	PATIENTS New Admissions & 1st Visit This Year		Increase		VISITS		Increase		AVERAGE NUMBER OF VISITS PER PATIENT		NUMBER OF CLINIC SESSIONS		AVERAGE NUMBER OF PATIENTS PER CLINIC SESSION	
	1968-69	1969-70	Number	Percent	1968-69	1969-70	Number	Percent	1968-69	1969-70	1968-69	1969-70	1968-69	1969-70
SAN JOAQUIN CO. MED. SOCIETY[2]														
Migrant Camp Clinics (2)	652	2,121	1,469	225.3	2,479	5,926	3,447	139.0	3.8	2.8	138	269	18.0	22.0
Mobile Clinics (5)	1,044	1,258	214	20.5	2,620	2,380	-240	-9.2	2.5	1.9	129	157	20.3	15.2
Fee-for-Service	na	414	-	-	713	631	-82	-11.5	na	1.5	-	-	-	-
SAN LUIS OBISPO CO.														
Nipomo Mig.Health Center	916	891	-25	-2.7	3,116	3,109	-7	-0.2	3.4	3.5	108	103	28.8	30.2
Fee-for-Service	132	203	71	53.8	279	351	72	25.8	2.1	1.7	-	-	-	-
RIVERSIDE CO.														
Coachella Valley Fee-for-Ser.	342	534	192	56.1	984	2,025	1,041	105.8	2.9	3.8	-	-	-	-
Palo Verde Valley FFS	209	226	17	8.1	769	749	-20	-2.6	3.7	3.3	-	-	-	-
SOLANO CO.														
Dixon Camp Clinic	410	646	236	57.6	902	1,335	433	48.0	2.2	2.1	29	40	31.1	33.4
STANISLAUS CO. MED. SOCIETY														
Offices of Health (3)	1,896	2,417[h]	521	27.5	4,955	6,083[h]	1,128	22.8	2.6	2.5	-	-	-	-
Med.& Dent.Fee-for-Service	1,035	1,109	74	7.1	2,460	2,564	104	4.2	2.4	2.3	-	-	-	-
SUTTER CO. HOSPITAL														
Hospital Migrant Clinic	1,214	1,291	77	6.3	3,393	4,575	1,182	34.8	2.8	3.5	129	156	26.9	29.3
Fee-for-Service	43	79	36	83.7	43	141	98	227.9	1.0	1.8	-	-	-	-
YOLO CO.-UNIVER.CALIF.,DAVIS														
Yolo Gen.Hosp.Migrant Clinic	233	517	284	121.9	431	1,142	711	165.0	1.8	2.2	41	50	10.5	22.8
Migrant Camp Clinics (4)	253	732	479	189.3	451	1,425	974	216.0	1.8	1.9	33	77	13.7	18.5
TOTAL	18,016	26,043[k]	8,027	44.6	51,715	66,593[i]	14,878	28.8	3.0	2.6	1,545[j]	1,875[j]	29.5	31.0

See footnotes next page

Footnotes to Table 1

[a] This increase is due mainly to better reporting of "First Visit This Year" type patients - a factor which also effects the average number of visits per patient.

[b] Figure represents only patients not seen at one of the migrant clinics prior to being seen at one of the nursing clinics and, hence, does not represent the total number of patients seen in the nursing clinics.

[c] Figure does not include 43 visits for which records were submitted too late for inclusion in this year's report. These visits will be included in the 1970-71 report.

[d] Beginning with July 1, 1969, the Monday night operation of the Pajaro Family Care Clinic operated theretofore by the Monterey Co. Health Dept. was taken over by the Santa Cruz Co. Health Department which now operates both the Monday and the Wednesday night clinics.

[e] Does not include 10 visits (dental) for which records were submitted too late for inclusion in this year's report.

[f] Figure indicates only the average number of migrants seen and paid for under Migrant Health monies and not the average number of patients per clinic session.

[g] Increase is due partially to the Santa Cruz Co. operation of the Monday night clinic operated until June 30, 1969 by Monterey Co.

[h] Does not include 153 visits for which records were submitted too late for inclusion in this year's report. These visits will be included in the 1970-71 report.

[i] Does not include 208 visits for which records were submitted too late for inclusion in this year's report.

[j] Excludes Merced Co. Nursing clinics. Because of reasons given under g above, the number of visits and number of clinic sessions were omitted from the calculation of average number of patients per clinic session.

[k] Includes 2009 fee-for-service patients most of whom were also seen at a migrant clinic prior to referral to fee-for-service sources.

[1] First year of operation.

[2] The 1968-69 figures for San Joaquin cover the camp clinics only from August to November while the 1969-70 figures cover the entire season April-November 1969.

TABLE 2

SELECTED FARM WORKERS CLINIC AND FEE-FOR-SERVICE DATA
CALIFORNIA MIGRANT HEALTH CLINICS AND FEE-FOR-SERVICE PROJECTS
July 1, 1969 - June 30, 1970

Patient and Service Information

a. Age, Sex and Number of Visits

AGE	Number of Patients			Number of Clinic Visits	Number of Fee-For-Serv. Visits
	Total	Male	Female		
TOTAL	24,034 (100.0%)[a]	9,365	14,664	53,200 (100.0%)	13,393 (100.0%)
Under 1 year	1,492 (6.2%)	749	743	3,128 (5.9%)	583 (4.4%)
1 - 4 years	3,971[b] (16.6%)	2,059	1,911	8,137 (15.3%)	2,394 (17.9%)
5 - 14 years	6,206[b] (25.8%)	3,034	3,171	10,458 (19.6%)	3,755 (28.0%)
15 - 44 years	10,085[c] (42.0%)	2,505	7,578	25,884 (48.6%)	5,120 (38.2%)
45 - 64 years	1,862[b] (7.7%)	824	1,037	4,595 (8.6%)	1,300 (9.7%)
65 years and older	160 (0.7%)	79	81	397 (0.7%)	134 (1.0%)
Age not reported	258 (1.1%)	115	143	601 (1.1%)	107 (0.8%)

[a] Includes 5 patients of unreported sex.
[b] Includes 1 patient of unreported sex.
[c] Includes 2 patients of unreported sex.
[e] Includes 1968 Santa Clara So. County Fee-for-Service clinic visits.

b. Migrancy Status

	Total Patients	Seasonal Agricultural Workers			Not Seasonal Agricultural Workers	Unknown if Seasonal Agric. Workers
		Local	Migrant	Unknown if Migrant		
Number	24,034	9,333	11,308	711	1,821	861
Percent	100.0%	38.8%	47.0%	3.0%	7.6%	3.6%

c. Referrals to Other Services

Type of Other Service	Number of Referrals		
	From Farm Workers Clinic Sessions	From Fee-For-Service Non-clinic projects	Total All Projects
	6,634 (100.0%)	5,648 (100.0%)	12,282 (100.0%)
Public Health Nurse	2,263 (34.1%)	-	2,263 (18.4%)
Hospital Out-Patient	1,639 (24.7%)	70 (1.2%)	1,709 (13.9%)
Private M.D.	917 (13.8%)	4,293 (76.0%)	5,210 (42.4%)
Health Department Clinic	695 (10.5%)	419 (7.4%)	1,114 (9.1%)
Private Dentist	335 (5.0%)	271 (4.8%)	606 (4.9%)
Other Migrant Clinic	264 (4.0%)	-	264 (2.1%)
Private Laboratory	165 (2.5%)	6 (0.1%)	171 (1.4%)
Hospital Admission	161 (2.4%)	87 (1.5%)	248 (2.0%)
Univ.Calif. Dental Unit	-	432 (7.6%)	432 (3.5%)
Other	195 (2.9%)	70 (1.2%)	265 (2.2%)

Table 3

TYPE OF PATIENT VISIT AND ATTENDANCE RATE BY MONTH

Clinic Name: California Migrant Health Projects

Time Period: July 1, 1969 - June 30, 1970

Month	Number of Sessions	Average Attendance	TOTAL	Percent	TYPE OF VISIT			
					New Admission	First Visit This Year	Revisit	Unknown
July 1969			9,162	13.8	2,664	2,195	4,130	173
August			8,121	12.2	2,269	1,214	4,460	178
September			7,205	10.8	1,793	920	4,372	120
October			5,478	8.2	1,280	580	3,570	48
November			3,438	5.2	711	388	2,311	28
December			3,234	4.8	682	358	2,175	19
January '70			3,715	5.6	820	701	2,174	20
February			3,508	5.3	749	379	2,343	37
March			3,988	6.0	806	387	2,747	48
April			4,327	6.5	1,005	386	2,889	47
May			6,727	10.1	2,000	783	3,896	48
June			7,690	11.5	2,192	781	4,615	102
TOTAL			66,591	100.0%	16,971	9,072	39,682	868
TYPE OF VISIT (Percent)				100.0%	25.5%	13.6%	59.6%	1.3%

Total number of patients = 26,044
Total number of visits = 66,593
Average number of visits per patient = 2.6

Table 4
AGE OF PATIENTS BY SEX

Clinic Name: California Migrant Health Projects

Months: July 1, 1969 - June 30, 1970

AGE GROUP	TOTAL		SEX		
	Number	Percent	Male	Female	Unknown
Under 1 year	3,711	5.6	1,878	1,832	1
1 - 4	10,531	15.8	5,551	4,978	2
5 - 9	8,667	13.0	4,291	4,372	4
10 - 14	5,546	8.3	2,685	2,860	1
15 - 19	5,788	8.7	1,227	4,558	3
20 - 24	7,703	11.6	877	6,825	1
25 - 29	6,045	9.1	866	5,176	3
30 - 34	4,478	6.7	934	3,544	-
35 - 39	3,719	5.6	909	2,809	1
40 - 44	3,271	4.9	837	2,433	1
45 - 49	2,312	3.5	843	1,468	1
50 - 54	1,494	2.2	569	924	1
55 - 59	1,157	1.7	418	739	-
60 - 64	932	1.4	384	548	-
65 and over	531	.8	273	256	2
Age not reported	708	1.1	295	401	12
TOTAL	66,593	100.0	22,837	43,723	33

	Number	Percent
Males, 15 years and over	8,137	12.4
Females, 15 years and over	29,280	44.4
Children, under 15 years	28,455	43.2
TOTAL*	65,872	100.0%

* Excludes 721 patient visits for which age and/or sex was not reported.

Table 5
SEASONAL AGRICULTURAL WORKERS AND MIGRANTS
(excluding revisits and unknown visits)

Clinic Name: California Migrant Health Projects

Months: July 1, 1969 - June 30, 1970

	Number	Percent
Local seasonal agricultural workers	9,333	38.8
Migrant seasonal agricultural workers	11,308	47.1
Seasonal agricultural workers, unknown if migrant	711	3.0
Total number of seasonal agricultural workers	21,352	88.8
Not seasonal agricultural workers	1,821	7.6
Unknown if seasonal agricultural workers	861	3.6
TOTAL	24,034[a]	100.0

[a]Excludes 2,009 Fee-For-Service patients that were seen at a migrant clinic or Office of Health prior to referral. Migrancy status as well as ethnic composition was recorded at that time.

TABLE 6

Homebase of Agricultural Migrants seen at California Farm Workers Medical Clinics and Fee-For-Service Projects

Homebase Grouped

July 1969 - June 1970

HOMEBASE			
	Number	Percent	California Percent
TOTAL	10,745	100.0%	
California	3,721	34.6	100.0%
Sacramento Valley	490	4.6	13.2
Northern Coast	34	0.3	0.9
San Joaquin Valley	1,581	14.7	42.5
Central Coast	265	2.5	7.1
Southern Coast	384	3.6	10.3
Desert[a]	856	8.0	23.0
County not given	111	1.0	3.0
Interstate	4,831	45.0	
Texas	3,639	33.9	
Arizona	711	6.6	
New Mexico	101	0.9	
Oregon	88	0.8	
Washington	54	0.5	
Arkansas	42	0.4	
Idaho	40	0.4	
Other States	156	1.4	
Foreign	2,162	20.1	
Mexico	2,142	19.9	
Other Foreign	20	0.2	
No Homebase	31	0.3	

Homebase Reported	10,745	95.0%
Homebase Not Reported	563	5.0%
Total Number of Migrants Seen	11,308	100.0%

[a] Desert, here, includes all of Riverside County whereas generally West Riverside and East Riverside are considered South Coast and Desert respectively.

Table 7

Homebase of Agricultural Migrants in California Reported by Location of Medical Interviews
(Thirty seven locations grouped by Standard Crop Areas)

Homebase Ungrouped

July 1, 1969 - June 30, 1970

Homebase	Farm Worker Clinic Location				
	Total	Sacramento Valley	Central and Southern Coast	San Joaquin Valley	Desert (Riverside)
Number of migrants seen at Farm Workers Clinics and Fee-for-Service Projects	11,308	2,478	1,938	6,132	760
Percent	100.0%	21.9%	17.1%	54.2%	6.7%
California Total	3,721	981	380	1,906	454
Riverside	467	47	47	158	215
Merced	419	14	8	393	4
Imperial	389	63	45	258	23
Fresno	287	39	17	202	29
Kern	236	34	20	123	59
Tulare	236	110	33	83	10
Los Angeles	218	47	25	141	5
San Joaquin	202	12	2	144	44
Stanislaus	120	8	5	100	7
Butte	111	98	3	5	5
Yolo	102	81	1	20	-
Santa Cruz	91	16	68	7	-
Yuba	85	71	1	7	6
Solano	75	73	-	2	-
Monterey	67	6	25	17	19
King	58	42	-	10	6
Sutter	56	47	3	5	1
Ventura	42	10	1	28	3
Sacramento	40	23	2	15	-
Santa Barbara	31	3	16	11	1
Santa Clara	31	2	2	23	4
San Luis Obispo	29	8	16	5	-
Alameda	28	21	-	7	-
San Diego	25	3	5	17	-
San Benito	20	-	3	14	3
San Bernardino	20	6	3	8	3
Madera	19	5	-	14	-
Orange	19	15	-	1	3
Sonoma	17	1	3	13	-
San Francisco	12	3	2	7	-
Colusa	8	6	-	1	1
Mendocino	8	4	-	4	-
San Mateo	8	1	-	7	-
Contra Costa	5	2	1	2	-
Glenn	4	-	-	4	-
Lake	4	2	-	2	-
Inyo	3	-	-	3	-

Homebase	Farm Worker Clinic Location				
	Total	Sacramento Valley	Central and Southern Coast	San Joaquin Valley	Desert (Riverside)
Marin	3	2	-	1	-
Napa	3	-	-	3	-
Placer	3	3	-	-	-
Humboldt	2	2	-	-	-
El Dorado	1	-	-	1	-
Modoc	1	1	-	-	-
Nevada	1	-	1	-	-
Shasta	1	-	-	1	-
Siskiyou	1	1	-	-	-
Tehama	1	-	-	1	-
Tuolumne	1	1	-	-	-
California county not stated	111	48	22	38	3
Out-of-state Total	4,831	669	855	3,053	254
Texas	3,639	434	588	2,467	150
Arizona	711	162	215	286	48
New Mexico	101	9	33	48	11
Oregon	88	18	3	57	10
Washington	54	5	4	35	10
Arkansas	42	5	-	35	2
Idaho	40	7	-	23	10
Florida	25	4	-	21	-
Oklahoma	25	6	3	16	-
Nebraska	13	4	2	7	-
Missouri	12	3	-	4	5
Colorado	10	1	-	9	-
Michigan	10	5	2	3	-
Kansas	7	-	-	7	-
Tenessee	7	-	-	7	-
Georgia	5	-	-	5	-
Illinois	5	-	-	5	-
New York	5	1	2	1	1
West Virginia	5	-	-	1	4
Alabama	4	-	-	4	-
Nevada	4	2	1	-	1
Utah	3	-	1	2	-
Other states	14	3	1	8	2
Foreign Total	2,162	555	592	1,012	3
Mexico	2,142	553	583	1,003	3
Other Foreign	20	2	9	9	-
No Homebase	31	4	-	8	19
Homebase not reported	563	269	111	153	30

Table 8
SOURCE OF REFERRALS TO CLINIC
(excluding revisits and unknown visits)[a]

Clinic Name: California Migrant Health Projects

Months: July 1, 1969 - June 30, 1970

	Number	Percent
Family or friends	9,947	48.5
Self	4,049	19.7
Nurse	3,307	16.1
M.D.	171	0.8
General Hospital	111	0.5
Health Department Clinic	257	1.2
Social Worker	68	0.3
Health Educator	33	0.2
Economic Opportunity Commission	9	0.1
Mass Media	196	1.0
Other	203	1.0
Not reported	767	3.7
Health Aide	1,407	6.8
TOTAL	20,525	100.0%

[a]Migrant Clinic patients only.

Table 9
RACE
(excluding revisits and unknown visits)

	Number	Percent
Caucasian, Mexican	20,345	84.6
Caucasian, Anglo	3,079	12.8
American Indian	84	0.3
Negro	352	1.5
Other	101	0.4
Not reported	73	0.3
TOTAL	24,034	100.0%

3422

Table 10
PATIENT SEEN BY

Clinic Name: California Migrant Health Medical Clinics[a]

Time Period: July 1, 1969 - June 30, 1970

	Number	Percent
M.D. and Nurse	40,687	76.5
M.D. only	2,424	4.6
Nurse only	9,023	17.0
M.D., Nurse and Social Worker	11	*
Left before being examined	536	1.0
Dentist (Yolo Hospital Migrant Clinic)	11	*
Not Reported	508	1.0
TOTAL	53,200	100.0%

*less than 0.05%
[a]Includes only migrant clinic visits

Table 11
SOURCE REFERRED TO
(from all projects)

	Number	Percent
Private M.D.	5,210	42.4
Public Health Nurse	2,263	18.4
Hospital-outpatient	1,709	13.9
Health Dept. Clinic	1,114	9.1
Private Dentist	606	4.9
University. Calif. Dental Unit	432	3.5
Other Migrant Clinic	264	2.1
Hospital-admission	248	2.0
Private Laboratory	171	1.4
Other	265	2.2
Total number of referrals	12,282	100.0%

PERCENT PATIENT VISITS
BY PRIMARY MEDICAL CONDITION BY PROJECT
July 1, 1969 - June 30, 1970

DIAGNOSIS OR CONDITION (I.C.D. Seventh Revision)	TOTAL VISITS		NAME OF CLINIC OR FEE-FOR-SERVICE PROJECT							
			Butte County	Colusa County	Fresno County	Kern County Medical Society	Merced County	Riverside County	San Benito County	San Joaquin Medical Society
TOTAL	(66,593)	100%*	(1937) 100%	(224) 100%	(15112) 100%	(2219) 100%	(7635) 100%	(2774) 100%	(416) 100%	(8937) 100%
Infective Parasitic Disease	(3,288)	4.9	2.9	5.8	4.0	2.7	5.9	4.7	6.7	4.0
Neoplasms	(206)	0.3	0.1	0.4	0.1	0.2	0.3	0.5	0.2	0.3
Allergic, Endocrine System, Metabolic and Nutritional	(2,473)	3.7	2.6	3.6	4.2	6.6	2.4	4.7	4.8	2.7
Disease of Blood and Blood Forming Organs	(781)	1.2	0.8	1.3	1.2	1.6	0.3	1.9	-	0.7
Mental Psychoneurotic Personality Disorders	(1,153)	1.7	0.8	-	2.7	1.6	0.6	1.7	1.4	1.0
Disease of Nervous System and Special Senses	(3,549)	5.3	6.5	5.4	3.7	6.2	3.3	6.8	3.8	6.2
Disease of Circulatory System	(1,440)	2.2	1.1	1.8	3.3	2.9	1.8	3.1	1.4	2.0
Disease of Respiratory System	(10,020)	15.0	21.3	20.5	17.1	18.2	9.1	27.8	13.0	12.9
Disease of Digestive System	(4,759)	7.1	6.9	6.3	4.4	9.1	3.5	11.1	8.7	6.8
Disease of Genitourinary System	(3,535)	5.3	3.9	1.3	6.8	6.1	3.1	8.9	2.6	3.9
Complications of Pregnancy	(178)	0.3	0.4	0.4	0.4	-	0.4	0.6	1.2	-
Disease of Skin and Cellular Tissue	(3,380)	5.1	4.7	4.5	4.3	7.1	3.1	4.4	9.1	5.7
Congenital Malformations	(117)	0.2	-	-	-	0.5	0.1	0.1	0.5	0.1
Certain Diseases of Early Infancy	(102)	0.2	0.1	-	-	-	0.1	0.2	-	-
Symptoms and Ill-defined Conditions	(1,978)	3.0	2.6	2.2	1.1	4.1	2.7	7.3	3.6	1.9
Injuries and Adverse effects	(2,473)	3.7	4.0	10.7	1.3	2.8	1.7	6.7	4.1	3.7
Pregnancy and Family Planning	(10,854)	16.3*	6.1	2.2	40.0	7.3	13.2	2.9	19.5	3.8
Surgical Procedures	(24)		-	-	-	-	-	-	-	-
Special Conditions and Examinations	(14,390)	21.6	32.3	33.0	3.5	16.2	46.6	2.8	14.7	41.5
Conditions not Reported	(343)	0.5	0.7	-	0.3	0.9	-	-	0.2	-
Disease of Bones and Organs of Movement	(1,550)	2.3	2.1	0.4	1.8	5.9	1.6	3.6	4.3	2.6

*Total includes (449) 100% Pregnancy and Family Planning for Monterey County.

PERCENT PATIENT VISITS
BY PRIMARY MEDICAL CONDITION BY PROJECT
July 1, 1969 - June 30, 1970

DIAGNOSIS OR CONDITION (I.C.D. Seventh Revision)	NAME OF CLINIC OR FEE-FOR-SERVICE PROJECT							
	San Luis Obispo County	Santa Barbara County	Santa Clara Medical Society	Santa Cruz County	Sutter County	Solano County	Stanislaus Medical Society	Yolo-U.C. Davis
TOTAL	(3460) 100%	(316) 100%	(1698) 100%	(4119) 100%	(4719) 100%	(1335) 100%	(8649) 100%	(2567) 100%
Infective Parasitic Disease	8.7	2.8	5.1	8.9	3.7	2.0	6.3	3.0
Neoplasms	0.6	0.9	0.1	0.2	0.5	-	0.5	0.4
Allergic, Endocrine System, Metabolic and Nutritional	5.6	4.1	6.4	1.9	6.1	3.0	2.8	3.7
Disease of Blood and Blood Forming Organs	2.1	-	0.5	2.2	0.6	-	1.6	2.3
Mental Psychoneurotic Personality Disorders	3.5	1.6	1.6	2.8	1.1	5.7	0.7	2.1
Disease of Nervous System and Special Senses	5.3	11.1	8.3	3.4	5.1	4.6	8.5	6.2
Disease of Circulatory System	2.2	2.5	2.6	2.1	2.3	1.4	0.7	1.8
Disease of Respiratory System	17.0	12.7	20.1	14.1	15.0	11.7	13.4	12.7
Disease of Digestive System	7.5	31.3	8.1	6.1	9.6	4.3	11.9	9.2
Disease of Genitourinary System	6.3	7.3	5.6	6.5	6.5	5.6	4.2	3.6
Complications of Pregnancy	0.2	0.3	0.3	0.3	-	0.1	0.3	-
Disease of Skin and Cellular Tissue	4.8	3.8	8.3	5.7	5.1	6.6	6.0	6.5
Congenital Malformations	0.6	-	0.1	0.4	0.1	-	0.2	0.3
Certain Diseases of Early Infancy	0.2	0.3	0.1	1.2	0.1	-	-	-
Symptoms and Ill-defined Conditions	2.2	4.1	3.7	1.7	5.7	2.2	5.5	2.7
Injuries and Adverse Effects	6.7	3.5	6.8	2.8	4.6	2.2	7.4	3.2
Pregnancy and Family Planning	10.6	2.5	10.1	22.0	15.0	22.0	3.7	3.5
Surgical Procedures	-	-	-	-	-	-	0.2	-
Special Conditions and Examinations	13.2	9.5	7.5	14.1	14.3	47.2	23.9	32.2
Conditions not Reported	1.2	0.3	1.5	0.1	0.7	-	1.0	2.9
Disease of Bones and Organs of Movement	1.3	1.3	3.1	3.4	3.4	1.6	1.4	3.4

NURSING

INTRODUCTION:

The nursing component of FWHS continues to provide the bulk of the direct personal health services to migrants and seasonal agricultural workers families in California. The nurse, as a member of the medical care team in the clinic setting, as the initiator of outreach services in the community, as the primary coordinator of referral and followup care, and as the teacher and trainer of aides, is the key contributor to the quantity and quality of health care to our population as a whole and to this disadvantaged population in particular.

The equivalent of 116.5 nursing and aide positions federally funded and 56 nursing and aide positions locally contributed provided services in 1,875 clinic sessions, 69,242 nursing field visits and processed a total of 24,932 referrals. There was an increase of only 10% nursing and aide positions from last year, but because of the improved documentation and effective utilization of aide personnel, nursing services reflected an increase of almost 300% in referrals and 160% in field visits.

This improved documentation of nursing services amply illustrates to what extent those services are being rendered. The over-all objective then, of improving personal health care to the target population was fulfilled.

OBJECTIVES:

The nursing objectives were reworded this year under Personal Health to conform with the national and state program objectives under the same headings. Hopefully, these are more specific and measureable:

1. To promote casefinding and assess personal health needs in 10% of the migrant population and 50% of families and single men in labor camps.

2. To improve documentation of public health nursing services in all projects.

3. To promote continuity of care--referral services in four projects.

4. To increase coordination of nursing and medical care services in two projects.

5. To promote and improve training of allied and professional personnel in two projects. (This was added objective.)

PERSONAL HEALTH NEEDS:

Casefinding and assessment of health needs was accomplished by 1) more effective outreach 2) better utilization of all personnel 3) optimum use of clinic facilities, 4) increased number of nurse-aide positions and lastly 5) by promoting the extended role of the nurse in selective counties.

Staffing patterns, for example, are being materially influenced by two developments. One is the changing role and functions of the nurse who is assuming more and more of the physician skills; i.e., the "Extended Role of the Nurse". The other is the utilization of aides to extend nursing services into the community by more effective outreach and in the clinic setting by bilingual interviewing, instruction, interpretation, and patient advocacy. We believe that these two developments must go hand in hand, if we are to effect the best utilization of our existing manpower.

The development of more health manpower to serve in rural areas is also crucial to the availability and assessment of personal health services. The placement of two masters level nursing students and five basic nursing students in three of our projects was successfully promoted. (See Yolo, Santa Cruz and Santa Barbara.)

Nurses, medical students, and aides were responsible for health screening of approximately 3,000 school-age children in Region II Migrant Education Project. Followup was done in the migrant clinics.

One question that arises with the utilization of aides by the professional is, how is it decided just who makes the followup contact? The usual answer was:

> The nurse and aide work as a team. By mutual agreement and daily conferences decision is made as to who is going to handle the case. The Public Health Nurse generally does the training and has ultimate responsibility for supervision. The nurse usually makes the initial visit or assessment of health needs, follows cases needing her specific nursing judgment and who respond to "her style". The aide may assist in assessment; carries families who, at her level of competence, need her specific skills in communication and teaching; in evaluating cultural barriers and attitudes; and who require supportive health supervision.
>
> From personal observation and site visits the quality of nursing services has been enhanced by this team approach.

In looking at optimum use of facilities we concluded that not only did we need to improve the use of existing facilities, but more importantly, we needed to construct a clinic facility that would be especially designed for the purpose. Moreover, we needed to design a multipurpose building--we are speaking of migrant labor camp facilities that could be utilized for other purposes such as recreation, education, and social gatherings. With the help of the sanitarians, the two nursing consultants designed floor plans for such a building, the materials to be obtained from the migrant housing project in Fresno. This will be constructed shortly in one of the counties. The goal is to remodel, or redesign facilities for all the 20 labor camps in California next year.

NURSING STATISTICS:

To improve documentation of nursing services we implemented a revised format for gathering statistics. This was done with the assistance of the CLND committee on records and the conscientious daily efforts at proper recording by the local project staffs. Wherever possible we compared this

years statistics with last year. These efforts at better documentation were obviously successful as the statistics show definite increases in services rendered. We tabulated 19 projects. (See appendix on Nursing Statistics.)

REFERRALS AND CONTINUITY OF CARE:

Continuity of care is basic to improvement of quality. It does no good to only identify needs if followup is not built into the system of care. We promoted continuity of care in all projects and established more adequate referral and followup procedures in four projects. The improved statistics bear out the efforts in these areas. In addition, the fee-for-service form has been used in all our counties. This is a combined referral, statistic, and cost accountability form all in one. We were assisted in the design of this form by five project Nursing Directors, who used this form on trial basis last year.

Intercounty referrals in California are not processed through the state: to expedite care, referrals are sent directly from county to county. The local annual reports include information on this. One procedure that has improved completion of referrals is the increased practice of giving the patient a copy of his records to carry with him to present to the next health care facility.

However, some interstate referrals are processed through the state, although more and more we encouraged direct referrals project to project with a copy to state registries in the case of Tuberculosis for example. FWHS processed approximately 100 Tb referrals to and from Texas mainly in 1969 and 100 in 1970. Altogether, from 1967 when interstate referrals were initiated to current year, December 1970: 320 referrals have been processed through the state.

COORDINATION OF NURSING AND MEDICAL CARE SERVICES:

Coordination of services was promoted by joint interagency nursing staff meetings. Program planning, procedure setting and appraisal of services, especially in areas of referrals were the content of these discussions. This resulted in better communication and understanding of each others efforts in behalf of the same population. In Sutter County, we promoted orientation of Hospital staff personnel to the community nursing services, by providing 1 week placement in the local health department. Increased efforts at collaboration were promoted between Migrant Education, UC Dental Services, and FWHS personnel at both the state and local levels in Regions I (Santa Clara, Santa Cruz), II (Yolo, Colusa, Sutter), III (Stanislaus, San Joaquin, Merced).

TRAINING OF ALLIED HEALTH AND PROFESSIONAL PERSONNEL:

Much of the training and supervision of aides--although initiated, planned and evaluated (and written up) in some counties by health educators, ends up being the responsibility of the primary professionals in the field, i.e., the sanitarian and the nurse. This is especially true for those agencies which do not have health educators. Thus in 18 projects out of

20, nursing has the primary responsibility for the on-the-job training of aides. Health education too is done in most instances, not by health educators, but by nurses and aides - either on a one to one basis or group. Our statistics reflect the utilization of aides by nurses. Aides made 27% of all home visits and provided 29 man-years of service.

In the majority of the projects, the aides have civil service positions with appropriate job descriptions, pay and fringe benefits. Several have planned organized training programs followed by periodic inservice education, participation in nurse staff meetings and in one instance the aides have their own staff meetings. Thus staff development both for the professional and aide is integrated into the whole program.

GENERAL APPRAISAL:

The most critical need is for adequate funding to augment elements in specific existing projects. But all the funds in the world do not provide non-existing manpower, therefore, manpower must be recruited, trained and placed in areas of need.

Next to the shortage of manpower in rural areas, the most glaring need is for facilities and lacking that, for a public transportation system to existing facilities.

The goal of comprehensive health services will never be reached unless these three elements are combined simultaneously: 1) manpower development and training 2) construction of new needed facilities and 3) transportation. This necessitates and assumes adequate funding to support the developments in all these areas. Coupled with funding, we must include community organization efforts to develop adequate consumer input and support.

The need is there and demonstrated, the resources are woefully inadequate and non-existent. We have a lot of manpower, but it is untrained, unaware, underutilized, poorly distributed. If the resources aren't there, no matter how much we attempt to re-distribute, to rob needy urban areas to pay poor rural ones, we cannot meet the need with the current existing development patchwork. No sooner do we fill a gap here, then there is another hole there--what we really need is a whole new garment: to put a system where none exists now. The burden for changing the delivery of health care should not be placed solely on the shoulders of the field staff--the line worker, but should also be required of administrative heads of agencies--agencies which resist any inroads on changing administrative policies and structures, towards truly well-balanced comprehensive services.

Appendix

NURSING STATISTICS

I. NURSING POSITIONS BY MAN-YEARS STATEWIDE:

	1968-69	1969-70
USPHS funded	38.0%	59.0%
Locally funded	64.0	56.0
State funded	4.0	1.5
	106.0	116.5

This shows an increase of 10%; our goal was to increase positions by 10%. These were mostly aide positions (increase from 8 to 24).

LOCAL CONTRIBUTION NURSING POSITIONS BY MAN-YEARS:

	1968-69	1969-70
Nursing Director	1.8%	2.1%
Supervisor	3.6	5.9
PHN	30.1	23.8
RN	11.4	7.1
LVN	4.4	2.0
Aide	4.4	5.9
Volunteers	8.2	9.6
	63.9 (64)	56.4

II. NURSING MAN-YEARS DISTRIBUTION BY ACTIVITIES:

	1968-69	1969-70
Visits to home and camps	38.0%	37.0%
Clinics	36.0	38.0
Supervision	8.0	8.0
Administration	NA	3.5
Records	8.0	9.5
Conferences	10.0	4.7
	100.0	100.7

III. REFERRALS:

1968-69	Sent	Rec'd	Completed
Within County	3,783	NA	Breakdown
Out of County	95	NA	not
Out of State	25	NA	available
	3,903	-	1,987

1969-70	Sent	Rec'd	Completed
Within County	13,342	10,182	7,112
Out of County	670	348	347
Out of State	101	289	277
	14,113	10,819	7,736

Above shows both better documentation and actual increase in services rendered of approximately 260 - 290%.

IV. INDIVIDUAL PATIENT COUNT BY NURSING DISTRICT OR CENSUS TRACT:

Seven counties reported services to 400 camps (or to 1/4 of the state total of 1,843 camps) for a total of 40,000 individuals served.

V. NURSING VISITS BY SERVICE PROGRAM (TOTALS ONLY):

1968-69	1969-70
26,367	69,242

This shows better reporting and increase of 163%. Aides made 27% of these visits.

NURSING VISITS BY SERVICE PROGRAM (%)

	1968-69	1969-70
Child Health	36.5	38.6
Maternity	15.4	19.2
Adult Health	3.4	11.9
Tuberculosis	23.0	8.6
Handicapped	10.4	7.4
Acute Illness	3.6	3.4
Mental Health	1.3	3.3
Venereal Disease	.5	1.2
Other	5.9	6.4

During the 1969-70 fiscal year, eleven of California's local health jurisdictions received migrant health act fund support for an environmental services component in a local project.

Environmental services are identified primarily as surveillance and maintenance of standards in farm labor camps, both private and public; in farm worker occupied housing outside a camp, and in the fields, orchards and vineyards where food crops are grown and harvested.

Of the 33.97 man years of total staff time identified as service to farm workers in the 11 jurisdictions, over 50% was locally funded. Local reports indicate the most significant increase was in manpower and efforts this year to bring about a greater degree of compliance with field sanitation standards (toilets, handwash facilities and drinking water).

In most projects, new and effective working relationships have been developed between the many state and local agencies involved and concerned with living and working conditions of farm workers and their families.

Worthy of mention are programs of routine visits to the local Housing Authority operated migrant housing centers where in addition to traditional routine surveillance of water supply, waste disposal, housing, etc., field Sanitarians and Aides are checking day care and infant care facilities with attendant food service operations, schoolrooms, camp laundry facilities, clinic operations, etc. Also begun in many projects was a program of inter-agency referrals and sharing of information on environmental problems and situations noted by field staff. All projects were involved in development of a local "County Agricultural Industry Committee".

Occupational health programs are developing in health departments in California and there is recognition on the part of project counties of the need for control of accidental injury to agricultural workers. The rate of injury in agricultural enterprise is approximately three times that found in industry as a whole. To assist in the implementation of these programs real consideration must be given to providing funds for activities related to the occupational health and safety of farm workers.

An increase in man years of administrative time is due for the most part to efforts to better coordinate programs with those agencies, groups and organizations who share the interests and have the responsibility for upgrading the farm workers living and working environment.

ENVIRONMENTAL HEALTH OBJECTIVES 1969-70

Development of effective local health department programs which will assure a clean, safe, healthful environment for the migrant farm worker and his family.

1. By June, 1971, all farm labor camps will be inventoried, assessed, and evaluated, (2 year objective).

2. Ninety percent of all camp water supply systems will meet the Pure Water Law.

LIVING ENVIRONMENT

There has been increased effort on the part of project staffs to link available funding resources, at all levels of government and industry, to meet long-standing housing needs of farm workers. This was particularly noticeable in the Fresno, Kern, Merced, Monterey and Santa Cruz projects. Undoubtedly, inspectional activities and resultant corrections have generated several hundred thousands of dollars in repair and replacement costs and have had a multiplier effect on the local economies. This is something that often overlooked in appraising the value of environmental health programs--their economic affect.

Farm labor camps continue to serve as temporary homes for most migrant farm worker families. Of the 1,843 labor camps with capacity for approximately 103,000 people in the 11 project counties, 814 are classified as camps for single persons. The 1,029 camps housing 8,555 families include 25 migrant family centers constructed since 1966 under the California OEO Migrant Housing Program. This program is now administered by the State Department of Human Resources Development. Presently, the migrant family centers provide about 20 percent of housing for migrant farm families in the project counties. An indication of migrant housing shortage in California is illustrated by the fact that in 1970 over 3,000 families will have been turned away at these 25 family centers. The farmers and growers have been very inactive in constructing or converting labor camps to meet the severe housing needs of migrant farm families.

There was continued effort on the part of project staff to improve the maintenance of existing family camps to provide a safe and sanitary environment. Unfortunately, the shortage of money available to improve migrant family housing nullified the gains that were made by projects in most counties. This is best shown by the fact that in 1968-69 there was a compliance factor of about 58% while in the 1969-70 period it declined to 55% for the 8,105 violations found in housing for farm workers. In 1969-70 there were 3,504 inspections of labor camps and 4,426 of housing other than labor camps where farm workers live.

The responsibility for enforcement of state laws and regulations relating to labor camps rests with the State Department of Housing and Community Development. State legislation effective in late 1970 provides that the Commission of Housing Community Development instead of the Department may promulgate rules and regulations relative to farm labor housing. It also provides that upon written notice to the Department that any city, county, or city and county may assume responsibility for the enforcement of provisions relating to labor camp housing. It requires annual inspection of all labor camps. This materially strengthens the existing law by allowing for local enforcement and annual inspections of labor camps.

Although the state objective of acceptable water supply systems in 90 percent of farm labor camps was not achieved, five of the eleven projects indicated they reached this level, while over 80 percent met acceptable standards in the eleven projects.

In the labor camps programs, public agency operated migrant housing centers were improved with replacement of several hundred old ply dome (kraft paper) shelters with new plywood structures. The 2,100 units in 25 such housing centers are far too few in most areas to meet the housing needs of migrant families.

In recent years, hundreds of dilapidated houses used by farm workers have been demolished under local housing programs. The federal government encouraged the demolition of these units, unfortunately there was little money available for their replacement. As a result, many local health departments concluded that before further effort is made to demolish dilapidated and substandard housing that there must be assurance that low-cost replacement housing would be available. As a result of this dilemma little progress has been possible.

One agency plan that may help alleviate the replacement housing problem is the low-cost housing and community facilities program of the Farmers Home Administration. They recently embarked a new loan application process which should serve to expedite low interest loans to low income families. Local health departments will be encouraged to look upon this program as an additional resource. This would be consistant with the focus of existing project activities, which is, locating and identifying substandard migrant housing with emphasis on rehabilitation or replacement rather than on strict enforcement of the State Housing Law. This policy change on the part of local health agencies has also resulted in a much closer relationship with the county housing authorities who in turn have developed an interest in meeting the housing needs of farm workers. Five years ago, they were more oriented to providing housing for low income groups than catering to the farm workers housing needs.

WORKING ENVIRONMENT

Increased concern, including that of California's Governor (see attached news release), resulted in significant efforts during the past year to bring about a greater degree of compliance with requirements for field toilets and handwashing facilities in food crop growing and harvesting operations.

Effective in November 1969, were amendments to the California Food Crop Growing and Harvesting Sanitation Law including the provision that facilities be provided for every food crop growing and harvesting operation.

In March 1970, representatives from more than 30 California local health departments, together with other county and state agencies concerned or involved in working conditions on farms, met at a Farm Workers Health Service sponsored Conference in Fresno. Reviewed were: the State's Food Crop Growing and Harvesting Sanitation Law and 1969 Amendments to the Law, current health department and other agency activities and programs; ways and means whereby better coordination of the programs of all agencies could be achieved.

With some eight million acres of California farm land devoted to the growing of food crops and more than 370,000 persons working in the fields at peak harvest time, a program of adequate surveillance of fields requires considerable manpower and the closely coordinated efforts of all concerned.

An outcome of this Conference was development by the State Health Department's Farm Worker Health Service and Bureau of Food and Drug of a guide and outline for a local health department Food Crop Growing and Harvesting Sanitation program. This was distributed to all local health departments together with suggested inspection forms and file records, and appropriate pamphlets, brochures and general information material in English and Spanish relating to the subject (see attachments).

During April 1970, in a letter signed by Directors of the Departments of Agriculture, Public Health, Industrial Relations, U.C. Agricultural Extension, and Farm Labor Service of the Department of Human Resources Development, local counties were urged and encouraged to establish "County Agricultural Industry Committees". The committees would direct their efforts to the improvement of farm working conditions and lend support and backing to the agencies responsible for enforcement of laws relating to farm safety and sanitation. By the summer of 1970, local committees had been organized in 48 of California's 58 counties.

Leading the way in development of more effective food crop sanitation programs were the 11 local health departments who receive migrant health act fund support for an environmental component in a project. In the reporting period, the 11 departments conducted over 9,000 field surveillance inspections, a 50% increase in the number of inspections reported by project counties in the previous year. This effort required some 8.76 man years of field staff time.

In the conduct of an adequate program, numerous problems, normally not found in traditional Environmental Health Programs, must be overcome. Excessive travel is difficult to avoid when attempting to locate field operations. Mechanization and large field crews often permit rapid harvesting in relatively short periods of time. It is not unusual for a harvesting operation to be completed before a re-inspection can be made on a previously noted violation.

The issuance of notice to comply in three days or seven days, or sometimes with 24 hours which is customary in many local enforcement programs, will not be effective in a food crop sanitation program.

Many public health officials believe that Sanitarians should be given authority of issue "citations", similar to those given for traffic offenses, to persistant and willful violators of the food crop sanitation law. Two local departments receiving fund support have inaugurated citation procedures.

There has been recognition in California that greater than the risk of disease to consumers of food crops which may be subject to fecal contamination during harvesting, is the threat of disease or infection to the field workers themselves, and the possibility of infection spreading into communities near farming operations, especially where flu is abundant. Equally important and recognized is the need for basic facilities to maintain the dignity of men, women and children working in the fields.

Spanish speaking Environmental Health Aides in five of the projects have contributed measurably to increasing success of local programs. Mainly through their contacts with workers in the fields and in camps, complaints by employers of worker abuse of facilities or their refusal to use facilities provided have been added to a number of local health departments in the past year.

It is anticipated that manpower needs for surveillance will decrease in the years ahead as employers of field workers more fully recognize and accept their responsibility for providing basic facilities in the working environment.

STATE CONSULTANTS

The primary role of the state project environmental consultant is the promoting of effective services; namely, in project funded local health departments, which will assure a clean, safe, healthful living and working environment for the farm worker and his family. Activities include assistance in identifying environmental problems and needs, establishing local and statewide objectives, developing services and evaluating quantity and quality of efforts.

In the past year, a number of forms for both office and field use were developed to record vital environmental data for effective program planning and evaluation. Most projects utilized the state's data processing services--in turn receiving semiannual printouts covering all field activity of sanitarians and aides. Developed and used is a standard and guide for support of an environmental component in a local project together with a system and method for evaluating and scoring a project.

Submitted to the State Personnel Section and New Careers Unit was a job description and duty statement for the position of Environmental Program Assistant (Aide) to be employed at the state level when funds become available.

Considerable time this year involved meeting and working with such agencies and groups as the State Departments of Agriculture, Industrial Relations and Agricultural Extension Service; State Office of Farm Labor Services, California Rural Legal Assistance, Regional groups of Directors of Sanitation and County Agricultural Industry Committees for the purpose of coordinating activities related to food crop growing and harvesting sanitation statewide.

Working with doctors, nurses, administrators, housing authority and the Migrant Housing Section of Farm Labor Service, plans were prepared for construction of needed clinic facilities in migrant housing centers. At least three such clinics are scheduled for construction in the coming year.

With federal fund support for the environmental consultant position in the state project, efforts will continue to obtain maximum return on the limited federal environmental dollars invested in local projects. Local projects will be encouraged to assume a greater share of services now supported by Migrant Health Act funds and to seek new and improved methods of operation to more effectively and efficiently conduct programs related to farm workers.

APPRAISAL OF PROGRAM

Progress in meeting a national and state goal of "a healthful, safe, living and working environment for the migrants wherever they are" is reported by all projects. The degree of attainment varied from project to project and program to program. Some measures of success are reflected in the accompanying environmental tables.

Most projects indicated the greatest gains this year were in the food crop growing and harvesting sanitation program where in as many as 90% of the fields, sanitary toilets and handwash facilities were provided for workers during the harvest periods.

There has been an increased effort to measure progress from a predetermined baseline. Fresno, Monterey, Santa Cruz and Yolo counties covered 100% of labor camps in their surveillance programs this year.

At the time of preparation of this report, federal policy calls for phasing out of continued fund support for environmental components in a number of projects. This must and will result in a cutback in environmental services effecting the farm workers.

A local Environmental Health Director of one of the more effective programs concluded his annual report with the statement, "If outside (federal) funds were not available, environmental health services for the farm worker would be relegated to a minimum activity". (Merced).

In the 1969 report of the Senate Subcommittee on Migratory Labor, the opening paragraph under "Housing" includes a statement, "Efforts should be continued by all concerned Federal agencies to encourage strong, effective enforcement of existing codes and the strengthening of state laws governing health, sanitation and environment of labor camps". How better can federal support be demonstrated than continued and expanded funding for worthwhile and needed environmental services.

Some of the areas suggested by local projects for expansion and/or possible development include:

1. Development of a specific model for a labor camp program in a local health department.

2. Develop occupational health and safety program element in environmental health components of state and local FWHS projects.

3. Further development of the role of Environmental Program Assistant (Aide) in migrant projects at both the local and state levels. Also develop a training manual.

4. Establishing a program model for the position and role of Environmental Advocate in Community Health Center projects operated by non-governmental agencies. This would be a direct service, non-enforcement type program.

5. Development of minimum standards for limited time camping for an increasing number of migrant families who have campers, trailers or mobile homes.

All of the above would appear to have national application.

TABLE # 1

LOCAL MIGRANT HEALTH PROJECT ENVIRONMENTAL PROGRAMS
--COMPARISONS AND OBSERVATIONS-- *

ITEM	1966-1967	1967-1968	1968-1969	1969-1970
Number of migrant health projects with a sanitation component receiving federal grant assistance.	13	13	11	11
Number of positions in budget supported by migrant health act funds:				
Sanitarians	12.75	13.75	12.62	11.17
Sanitation Aides	1	2	2.25	4.33
Clerical	1	1	1	1.00
Total	14.75	16.75	15.87	16.50
Budgeted positions filled	11.28	12.77	13.80	15.50
Total number of man years of sanitation division staff time in activity identified as relating to agricultural workers	21.44	21.61	26.03	33.97
Percent of local health department migrant related sanitation activity supported by federal funds	53%	59%	52%	45%
Man years of activity by type of service provided:				
Inspection of Labor Camps	7.41	6.12	6.94	6.39
Inspection of other farm worker housing	4.87	5.09	5.25	8.23
Inspection of fields & farms	6.10	5.30	6.50	8.76
Supervision-administration-misc.	3.06	5.10	7.34	10.59
Total	21.44	21.61	26.03	33.97
Number of farm labor camps reported in project counties	2,509	1,742	2,042	1,843
Approximate person capacity of labor camps	150,000	127,000	112,818	103,086
Percentage of labor camps inspected at least annually	61%	91%	70%	89%
Percentage of camps with water supply systems meeting acceptable public health standards	65%	80%	79%	80%
Total number of labor camps inspections	3,450	4,164	5,873	3,504
Total number of housing inspections other than labor camp housing	3,216	4,559	8,881	4,426
Total number of inspections of fields and farms (toilets, handwash facilities, drinking water)	3,369	5,035	6,366	9,175
Total - all inspectional activity	10,035	13,758	21,120	17,105
Average number of inspections per Sanitarian or Aide	546	833	1,130	731

*Based on data submitted in annual progress reports from local projects

TABLE #2

ENVIRONMENTAL PROGRAM STAFFING AND ACTIVITY*

1969 - 1970

County	Number of Positions			Staff Time - Farm Worker Related Activities (Man Years)					
	Total	Project Funded	Locally Funded	Labor Camp Insp.	Other Farm Worker Housing Insp.	Food, Crop Sanitation	Misc., Training, Conf., etc.	Supervision & Administration	Total
Colusa	0.17	0.17	-	.04	-	.07	-	.06	0.17
Fresno	4.40	2.00	2.40	.50	1.80	1.75	.05	.30	4.40
Kern	6.12	1.00	5.12	1.50	1.25	1.75	.12	1.50	6.12
Merced	3.40	1.00	2.40	.30	.80	.60	.75	.95	3.40
Monterey	3.14	2.00	1.14	.70	.93	.54	.15	.82	3.14
Riverside	5.28	1.00	4.28	1.00	1.61	2.00	.27	.40	5.28
San Benito	1.10	.90	0.20	.62	.12	.24	.06	.06	1.10
San Joaquin	5.80	4.00	1.80	.69	1.64	.53	.50	2.44	5.80
Santa Cruz	2.05	1.83	0.22	.62	.02	.45	.33	.63	2.05
Sutter-Yuba	0.95	0.60	0.35	.24	.05	.49	.02	.15	0.95
Yolo	1.56	1.00	0.56	.18	.01	.34	.62	.41	1.56
TOTAL	33.97	15.50	18.47	6.39	8.23	8.76	2.87	7.72	33.97
PERCENT	100%	45%	55%	18%	24%	26%	9%	23%	100%

*Based on data submitted in annual reports from local projects.

TABLE #3

INSPECTIONAL ACTIVITY*

1969 - 1970

County	Total Number Inspections Made	Farm Labor Camps			Housing Other Than Camp			Field Toilet Units		
		Number of Inspections	Violations or Defects		Number of Inspections	Violations or Defects		Number of Inspections	Violations or Defects	
			Noted	Corrected		Noted	Corrected		Noted	Corrected
Colusa	57	13	6	3	-	-	-	44	20	3
Fresno	5,901	455	573	443	2,615	3,228	1,326	1,326	581	389
Kern	2,332	557	50	7	23	-	-	1,752	187	168
Merced	1,237	143	381	354	507	1,467	953	587	59	51
Monterey	2,819	975	627	590	876	289	184	968	247	235
Riverside	972	80	-	-	246	-	-	646	355	193
San Benito	320	101	17	2	23	-	-	196	75	27
San Joaquin	1,194	333	509	303	63	41	10	798	420	202
Santa Cruz	1,229	382	247	89	19	16	3	828	250	158
Sutter-Yuba	540	184	169	114	30	80	15	326	1,200	900
Yolo	504	281	151	48	24	8	2	199	88	48
TOTAL	17,105	3,504	2,730	1,953	4,426	5,129	2,493	9,175	3,480	2,374

*Based on data submitted in annual reports from local projects.

TABLE #4

FARM LABOR CAMPS, TYPES AND CAPACITIES*

1969 - 1970

County	Total # of Camps	Total Camp Person Capacity	Camp Types, Number & Capacities				
			Accommodations for Single Persons		Accommodations for Families		
			No. Camps	Person Capacity	No. Camps	No. Fam. Living Units	Person Capacity
Colusa	64	1,591	41	516	23	241	1,075
Fresno	311	12,846	69	5,476	242	1,917	7,370
Kern	193	6,247	39	685	154	1,112	5,562
Merced	85	10,955	28	2,460	57	1,039	8,495
Monterey	123	8,776	60	2,772	63	876	6,004
Riverside	171	10,363	102	7,354	69	515	3,009
San Benito	46	3,299	5	535	41	408	2,764
San Joaquin	504	31,362	258	22,275	246	1,555	9,087
Santa Cruz	50	1,738	36	1,080	14	159	658
Sutter-Yuba	199	7,500	93	2,900	106	450	4,600
Yolo	97	8,409	83	7,244	14	283	1,165
TOTAL	1,843	103,086	814	53,297	1,029	8,555	49,789

*Based on data submitted in annual reports from local projects.

TABLE #5

FARM LABOR CAMPS ENVIRONMENTAL STATUS*

1969 - 1970

County	Number Farm Labor Camps	Percent of Camps Meeting Acceptable Public Health Standards				
		Water Supply	Sewage Disposal	Garbage & Refuse Disposal	Food Handling	Housing
Colusa	64	80	85	70	-	70
Fresno	311	77	80	48	81	73
Kern	193	98	98	90	95	85
Merced	85	89	82	76	72	85
Monterey	123	99	99	99	96	97
Riverside	171	100	100	-	-	-
San Benito	46	71	87	75	25	25
San Joaquin	504	38	90	86	-	-
Santa Cruz	50	85	94	89	77	88
Sutter-Yuba	199	94	91	77	90	86
Yolo	97	99	99	80	80	63
		Weighted average percent				
TOTAL	1,843	80%	85%	77%	83%	78%

*Based on data submitted in annual reports from local projects.

'Law Is Clear'

Clean Toilets, Farmers Told

YOSEMITE (UPI) — Governor Reagan Tuesday told California's agriculture industry to provide proper sanitation facilities for farm workers or face compulsory action by the state.

Speaking in this Sierra vacationland to the California Council of Growers 10th annual convention, the governor said the law is clear that clean restrooms are required for all hired hands.

He said some farmers have been charged with neglecting this law.

"Without commenting on the validity of the charges, which are being investigated, I want you to know exactly where I stand on this issue," Reagan said.

The governor told the growers that Californians expect their produce to reach them clean and undiseased. He said this is the reason for the law which requires clean toilets and washup facilities.

"The answer lies not alone with regulatory and enforcement powers of the state," he told growers. "It lies with you —the leaders of the world's most advanced, diversified and sophisticated agricultural industry."

"Don't let a vew violators give your fine industry a black eye," he added. "Help us and yourselves by self-policing and enforcing our farm sanitation laws."

Sacramento Bee

April, 1970

GUIDE AND OUTLINE

FOR A

LOCAL HEALTH DEPARTMENT

FOOD CROP GROWING AND HARVESTING SANITATION PROGRAM

NEED: The County of ______________ has approximately __________ acres of land devoted to the growing of food crops. At the peak of the harvest season, a work force of some ______ persons are engaged in field activities, readying these crops for the packers, processors, canneries, wholesale and retail agricultural markets.

Workers in fields, orchards and vineyards must be provided with adequate and conveniently located toilet and hand-washing facilities, and a safe, wholesome and potable supply of drinking water. This is necessary to protect their own health and that of their family and fellow workers; to have a basically decent working environment, to protect the nearby communities from unsanitary conditions in the fields, and finally, to avoid contamination of food crops with the possible spread of disease to consumers.

AUTHORITY & ORIGIN

California Health and Safety Code

Sections 3700 - 3704

Sections 5474.20 - 5474.31

California Administrative Code, Title 17

Sections 8000 - 8013

California Labor Code

Section 2441

GOAL

The required toilet, handwashing facilities and drinking water will be provided and facilities will be properly maintained and used.

SPECIFIC OBJECTIVES - By ______________, 197_

1. At least _____% of fields, farms, orchards and vineyards, subject to food crop growing and harvesting sanitation

laws and regulations, will be found upon routine surveillance and/or random sampling to have available to workers the facilities as required. The ___% in violation will meet requirements within 24 hours or at time of reinspection.

2. Improper or inadequate maintenance of required facilities will be noted on not more than ___% of inspections. Correction of violations or defects will be noted on ___% of follow-up inspections.

PROGRAM ELEMENTS AND ACTIVITIES

ADMINISTRATION

1. Staff time, both administrative and field, shall be committed to the program.

2. An inventory or listing shall be prepared of:-

   a) All fields, farms, orchards and vineyards
   b) Growers and farmers
   c) Companies renting, servicing and selling toilet units, and units available
   d) Grower and Farmer Groups
   e) Farm Labor service offices and managers
   f) Labor Law Enforcement offices and reps.
   g) Industrial Welfare offices and reps.
   h) Farm Labor Contractors
   i)
   j)

3. Plans for field surveillance shall be developed based upon anticipated work load. Suggested man power for field work -- number fields or farms X frequency of visits X time (in minutes) to inspect.

4. Develop suitable records and forms for both field and office (file) use.

5. Develop specific policies and procedures for conduct of program, including necessary steps to be taken for those who refuse or fail to comply and persistant violators.

6. Plan for training and supervision of those involved in program.

7. Prepare and distribute copies of law and regulations to growers, farmers, labor contractors, companies renting, servicing and selling toilet units and to farm workers. Develop and distribute informational material in both English and Spanish.

8. Maintain close liaison with all state and local agencies and groups concerned or involved with field sanitation.

9. Be prepared to include in annual report to State Department of Public Health, services and activities relating to field crop sanitation program including: number fields/farms subject to law and regulations, degree of coverage, number inspections made, types of violations found, actions taken, degree of compliance, attainment of objectives, etc...

10.

11.

OPERATIONS

1. Based on inventory, activity plan and location of field workers at a given time, etc., schedule routine or random sample visits.

2. Each inspection will be concluded with a written report of findings.

3. Original of all inspection reports will be retained by health department and copy given to responsible person (farmer - labor contractor or representative).

4. Complaints of violations will be investigated on day received if possible.

5. When reinspection necessary, such reinspection to be made within 24 hours or at other specific time.

6. Copies of inspection reports noting violations will be sent to Local Farm Labor Service office. When violations have been corrected, Farm Labor Service shall be so notified.

7. Inspection results will be sent to offices of Divisions of Labor Law Enforcement and Industrial Welfare.

8. Accept, process and record inspection results or findings of other enforcement agencies.

9. From field reports, maintain a history of inspection results for each field, farm orchard and vineyard.

10. Encourage installation of permanent type facilities for orchards and vineyards and grower ownership of mobile chemical toilets.

11.

______ COUNTY HEALTH DEPT.

DIVISION OF ENVIRONMENTAL HEALTH

ROUTINE INSPECTION ☐

REINSPECTION NO. ______

COMPLAINT INVEST. ☐

REPORT OF INSPECTION

FOOD CROP GROWING AND HARVESTING SANITATION

CROP DESTINATION ______

LOCATION CROP GROWING/HARVESTING OPERATION ______

NAME OF GROWER, ADDRESS & PHONE ______

IF LABOR CONTRACTOR EMPLOYER - NAME, ADDRESS & PHONE ______

TYPE OF CROP ______ ACREAGE ______

NUMBER FIELD WORKERS: MALE ______ FEMALE ______ TOTAL ______

TYPE TOILETS: ☐ CHEMICAL ☐ PRIVY ☐ WATER FLUSH

NUMBER: TOILETS ______ HANDWASH UNITS ______

IF RENTAL, NAME OF COMPANY ______ DATE LAST SERVICE ______

NOTICE

Results of inspection of Field Sanitary Facilities in the above Food Crop Growing/Harvesting operation are recorded below. Violations, indicated by a cross (x), must be corrected forthwith. Failure to comply by not later than ______ am-pm on ______ may be considered a willful or knowing violation subject to prosecution in accordance with Section 5474.31 of the law. Appropriate sections of the law and regulations relating thereto are reprinted on the back of this form.

OBSERVATIONS

VIOL.	CODE SECTION	VIOL.	CODE SECTION	VIOL.	CODE SECTION	VIOL.	CODE SECTION
	5474.23		8004 (a)		8006		8012 (a)
	5474.24		8004 (b)		8007		8012 (b)
	5474.25		8004 (c)		8008		8012 (c)
	5474.26		8004 (d)		8009		8012 (d)
	5474.27		8004 (e)		8010		8013
	5474.28		8005		8011		Other

EXPLANATION: ______

INVESTIGATOR ______ DATE ______ HOUR ______

RECEIPT OF NOTICE ACKNOWLEDGED BY: ______ TITLE ______

COPY TO: ☐ LABOR LAW ENFORCEMENT ☐ DISTRICT ATTORNEY ☐ FARM LABOR SERVICE

☐ INDUSTRIAL WELFARE ☐ OTHER

SDPH
F & D-FWHS
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5474.23. Every employer shall provide or cause to be provided toilet and handwashing facilities for every food crop growing and harvesting operation.

5474.24. Employees shall use the toilet and handwashing facilities provided.

5474.25. Toilet facilities shall provide privacy and shall be so designed as to keep human excreta from contaminating the crop and to keep flies away from the excreta. Toilet paper shall be provided. Toilet facilities shall be maintained in a clean and sanitary condition.

5474.26. Handwashing facilities shall be such as to afford an opportunity to wash hands in clean water using soap or other suitable cleansing agent and to dispose of used wash water without nuisance of contamination of food crop.

5474.27. One toilet and handwashing facility sha be provided and maintained for each forty (40) employees, or fraction thereof, engaged in a food crop growing and harvesting operation.

5474.28. Toilet and handwashing facilities for food crop harvesting operations shall be provided a convenient locations. For the purpose of this chapter "convenient" means within a five-minute wal of place of work.

When, because of layout of access roads, ground terrain, or other physical conditions, it is not possible to comply with the foregoing requirement, toilet and handwashing facilities shall be located at the point of vehicular access closest to the workers.

CALIFORNIA ADMINISTRATIVE CODE, TITLE 17, CHAPTER 5, SUBCHAPTER 1, GROUP 11
FOOD CROP & HARVESTING SANITATION

8004. General Standards. Toilet facilities shall meet the following standards:

(a) Toilet facilities shall provide sufficient space for comfortable use. A minimum area of eight (8) square feet, with a minimum width of two and one-half ($2\frac{1}{2}$) feet, shall be provided for each toilet seat. A minimum area of ten (10) square feet, with a minimum width of two and one-half ($2\frac{1}{2}$) feet, shall be required when a urinal is included. Sufficient additional space shall be included if handwashing facilities are within the facility.

(b) Toilets shall be designed, constructed, and maintained so as to prevent the access of flies to the excreta.

(c) Buildings housing toilet and handwashing facilities shall be rigidly constructed and shall provide privacy.

(d) Their inside surfaces shall be of durable nonabsorbent material, smooth, readily cleanable, and finished in a light color.

(e) They shall be ventilated and provided with self-closing doors, lockable from the inside.

8005. Chemical Toilet Standards. The tank for chemical toilets shall be constructed of durable, easily cleanable material. Tank size shall be sufficient to: 1) contain the initial chemical charge; 2) provide capacity for at least one day's use for forty persons. Size and construction shall be such as to prevent splashing on the occupant, field or road. A minimum tank capacity of forty gallons is recommended.

8006. Suitable Chemicals. Suitable chemicals, effective at all times in controlling odors and liquefying solids, shall be used for the chemical toilets.

8007. Disposal of Contents of Chemical Tanks. Contents of chemical tanks shall be disposed of by draining or pumping into a sanitary sewer, an approved septic tank of sufficient capacity to handle the wastes, a suitably sized and constructed holding tank, approved by the local health department, or by any other method approved by the local health department.

HEALTH & SAFETY CODE, DIV.5, PART 1, CHAPTER 1
COMMON DRINKING CUPS

3700. No person...shall provide or expose for common use,...or allow to be used in common, any cup, glass, or other receptacle used for drinking purposes.

8008. Cleansing. Each facility shall be thoroug cleaned and washed down as often as necessary and a least after each emptying of the chemical tank.

8009. Privies. Privies shall be moved to a new site or taken out of service when the pit is filled to within two feet of the adjacent ground surface. The pit contents shall be covered with at least twc feet of well-compacted dirt when the privy is moved

8010. Toilets. It shall be the responsibility c the employer to insure that toilets are serviced ar maintained in a clean, sanitary condition and kept good repair at all times.

8011. Toilet Paper. Toilet paper shall be provided within the unit, in a suitable holder.

8012. Standards. Handwashing facilities shall meet the following standards:

(a) Pure, wholesome, and potable water shall be available for handwashing.

(b) Suitable signs shall be posted, indicating th the water is for handwashing purposes only, and not for drinking.

(c) The water tank shall be of sufficient capacit to provide wash water for one day's use. A minimum capacity for forty gallons is recommended.

(d) Handwashing facilities shall be provided at unit or in the immediate vicinity. It is recommen that such facilities be placed on the outside of th unit in order to facilitate use of the toilets and assure better use of such handwashing facilities.

8013. Waste Wash Water. Waste wash water shall disposed of to the chemical toilet tank, if any, i which case the volume of waste tank should be doub to a specially constructed pit or sump, to a roads ditch or ravine, or to a furrow between crops, provided that no method of disposal shall be employed that results in a nuisance or contamination of the food crop.

LABOR CODE
DRINKING WATER

2441. Every employer of labor in this state sha without making and charge therefor, provide fresh pure drinking water to his employees during workin hours. Access to such drinking water shall be permitted at reasonable and convenient times & places

FOOD CROP GROWING AND HARVESTING

INFORMATION AND INSPECTION RECORD

FIELD/FARM LOCATION ____

____

NEAREST CROSS ROAD: __________ FT.-YD-MI. N.E.S.W.

LAND OWNER ☐ LEASEE ☐ NAME ____________________

____

CROP: FRUIT ☐ NUT ☐ VEGETABLE ☐

NUMBER CROP ACRES ______________________

TOILET INSTALLATION: PERM. ☐ TEMP. ☐

HAND WASH FAC: PERM ☐ TEMP. ☐

SERVICE FREQ: __________ TIMES PER MO.

OTHER: ____

____

LOCATION MAP

OTHER: ______________________

____

NAME/ADDRESS ____ I.D. No. ______________

Front of Card

SUGGESTED FOR CARD OR CARDEX FILE USE

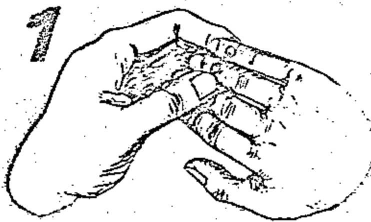
SDPH
F & D - FWHS 7/70

Back of Card

DATE	REASON FOR VISIT			EMPLOYER				NUMBER WORKERS		FIELD SANITATION STANDARDS Check (✓) if Viol. or Defects Noted Or Indicate Number as Appropriate														Inspector's Initials/No. and W.U.P.
										TOILETS						HAND WASH			DRINKING WATER				Common Cup Present	
										TYPE				DEFECTS			DEFECTS							
	Routine	Follow-Up	Compl'nt.	Owner	Leasee	L'Br. Contr'r.	Other	Male	Female	Water Flush	Chem.	Privy	Number Toilets	PHY.	OP.	Number Units	PHY.	OP.	None Available	Unsat. Cont. & Dispn'sr.	Unsatisf. Source	Sample Results M.P.N.		

DE LIMPIAR SUS MANOS

1



Mójese las manos con un poquito de agua, luego use el jabón hasta que haga espuma.

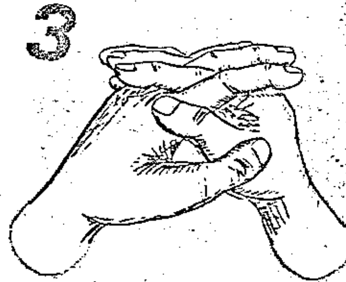
Junte los dedos de una mano y usando el pulgar de la otra mano restriéguese los dedos y las uñas.
Repita el proceso en la otra mano.

2

Usando el pulgar frótese la palma de cada mano.

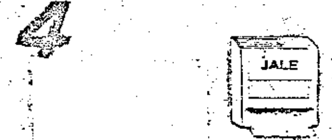
En esta posición use los otros dedos para restregarse el dorso de la mano.

3

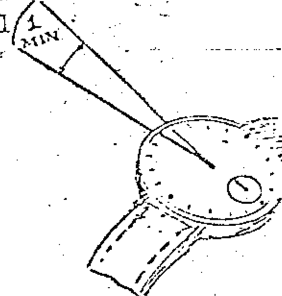


Ahora use un poco más de agua y frótese las manos bien.
Límpiese entre los dedos y también el dorso de las manos incluyendo las muñecas.
Ahora enjuáguese las manos con agua limpia hasta que desaparezca todo el jabón.

4



Deje que sus manos se sequen al aire o use una toalla de papel.



Toma a lo menos un minuto para lavarse bien las manos.

DEPARTMENT OF PUBLIC HEALTH

Farm Workers Health Service

Suggested for Decal or Placard use
with "De Limpiar Sus Manos" and Numbers
1, 2, 3 and 4 in Red over Yellow Background
Local Dept. Name at bottom

00287

HEALTH EDUCATION

What Were The Goals?

Broadly stated, the health education goals of the Farm Workers Health Service were to assist the farm worker to identify and articulate his own health needs and then to plan programs to motivate the worker and his family to seek health care services by providing adequate information in a meaningful, relevant and understandable manner. An extension of these goals was, and will continue to be, to assist the farm worker, as well as other members of the rural poor, to "work the system."

This extension of a goal will become even more important as services become more diversified and complex. In the event of national health insurance, even the more sophisticated consumer will need guidance and information helping him use the system to the maximum benefit of his health. Today, a migrant or another rural dweller with six or eight years of formal education, must decide which service resource to approach first when he needs help. Hopefully, health education has shared the responsibility of helping him make suitable choices. Health education should be a wedge with which to choose the resource, enter the system, and receive the necessary services on a continuing basis. (Nurses and social workers may be saying, "but that's our job." Yes, but health education has a role too.)

In order to achieve these rather broad goals, there have been operational objectives. These are quite simple:

1. To reach and communicate effectively with the rural poor.
    a. Through indigenous health workers.
    b. With culturally acceptable materials.
    c. Presented in health education programs jointly planned by health education, nursing, indigenous workers and the consumers of health services.
2. To provide training for indigenous workers.
3. To evaluate available materials and to plan new materials as needed.

What Has Been Accomplished?

The quantity and quality of health education provided in the nineteen local Farm Worker health projects have varied dramatically. One might assume that the health education activity within a project would depend heavily upon the absence or presence of a health educator on the agency's staff. In reviewing the progress reports of the individual projects, it

soon becomes apparent that the single factor of having a health educator as a staff member does not necessarily insure the project of an effective or productive health education program. Health education directors were employed in ten of the local health jurisdictions having a farm worker health program. However, less than half of them were actually involved in developing this component of the project. It appears that only when health educators were involved in the inception of the project did their input continue to be used in developing overall health education goals for the project.

All projects reported health educational activities, ranging from the one-to-one approach of providing health information, including the use of pamphlets, in home visits by nurses, aides, or a combination of both, both to producing and field testing original Spanish language materials. In four local projects, major responsibility for carrying out health education in home visits, migrant camps and in the community has been given to community health aides. In two of these, aide supervision has rested with the health educator, while nursing and environmental health staff usually supervise aide activities in all others.

While all of the projects report that most health education is done in the home or clinic on a one-to-one approach, eleven reported organizing community programs in schools, OEO camps and community recreation centers for from eight to 140 people. Community health education programs included Spanish language health films, film strips and discussion. One local reported holding an intensive in-service conversational Spanish course so that its professional staff would improve skills in communicating with Spanish-speaking clients.

In two counties where aides have primary responsibility for health education, more emphasis has been placed on working with the farm worker in developing his active responsibility for obtaining health services, as well as solving problems that ultimately affect his general well being.

Health Education Areas

Perhaps it should not be too surprising that all projects have emphasized family planning education. However, only one has attempted to evaluate how their efforts have been received. All projects incorporate family planning education into post partum visits, but five have attempted formal sessions in the community or in camps. For various reasons, these have not been too successful, and new methods of implementing this approach should be explored.

Infant care, prenatal care, nutrition, dental health, venereal disease, drug abuse and general health, in that order, have received the most attention. In citing unmet needs in health education, mental health was mentioned by staff twelve times.

One project discontinued a successful dental health education program because it stirred up a demand for needed dental services the project was unable to provide and to which the community refused to respond. It might be questioned as to whether or not such a program, no matter how frustrating the immediate response might ultimately lead to meeting the

demands. At present, most projects are reluctant to organize new health education programs if they cannot be assured that services will be available when interest is stimulated.

Roles of Aides In Health Education

The indigenous community health aide continued to add the important new and unique dimension to project outreach programs. Aides have served as the two-way interpreter, to the providers of services by explaining the farm workers' life style in terms of attitudes, values, survival needs, and knowledge; to the farm workers by helping them to understand and care for their personal health needs, and to integrate health values into their life style. In most communities, the aide is a trusted representative of the farm worker and his family, a catalyst and a liason between the farm worker and the agency providing services. Depending upon the various attitudes of the supervising profession, the aide has been an effective member of the planning team, a visiting nurse, a health educator, a community organizer, a clinic nurse, a clerical assistant, and a language interpreter. The most effective use of aides has been in projects where there is an atmosphere of trust and mutual respect.

Definite plans for transferring aide positions from project funds to general agency funds have been made in one county only. Other projects speak of this happening in a vaguely perceived future, while still others see no possibility of this occurring.

While aide training has varied from project to project, most feel that some uniform statewide curriculum for aides should be explored, including the creation of a definite career ladder, paid time off for attending classes, and salary steps within each position. All but five of the projects, aide training has been informal, on-the-job training by nurses or sanitarians. Health education has assisted on a varying basis. Most projects include aides in in-service training sessions for the public health nursing staff.