MARYLAND STATE DEPARTMENT OF HEALTH MONTHLY BULLETIN

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FROM 2411 NORTH CHARLES STREET BALTIMORE 18, MARYLAND

MARYLAND TB-VD HEALTH PROGRAM AMONG AGRICULTURAL MIGRANTS

A Cooperative Project

MARYLAND STATE DEPARTMENT OF HEALTH
MARYLAND TUBERCULOSIS ASSOCIATION

MARYLAND DEPARTMENT OF EMPLOYMENT SECURITY
COUNTY HEALTH DEPARTMENTS

C. REED CORBIN,
Project Director

78260

Dear Sir:

We have been advised by the Farm Placement Supervisor of the Maryland Department of Employment Security that you are scheduled to bring migrant farm workers into Maryland this season.

Maryland realizes the importance of the farm workers to its economy. As a protection to this valuable labor force the State and County Departments of Health, the Tuberculosis Association, and the State Department of Employment Security will offer blood tests and chest x-rays to all local and migratory farm workers.

The above letter points up the cooperative nature of a special health project, which is being carried out in the nine Eastern Shore Counties this summer, to control tuberculosis and venereal diseases among migrant farm workers.

During the height of the agricultural season the Eastern Shore of Maryland experiences the influx of about 7,000 migrant agricultural laborers. As in other states, this seasonal labor force is highly important to the economy of Maryland, but it also presents public health problems. The high prevalence of tuberculosis and syphilis in this group concerns all states depending on migrant labor. In addition, those having tuberculosis and syphilis in infectious stages constitute a communicable disease hazard to the local residents.

The States of Maryland, Delaware, and Virginia have jointly developed a cooperative plan to find and treat tuberculosis and syphilis among the migrants working in these three states. Another important objective of the project is to set a pattern for a smoother working relationship among the states in the East Coast Migrant Labor Stream. In the past many health programs for migrants have been hampered by the numerous prob-

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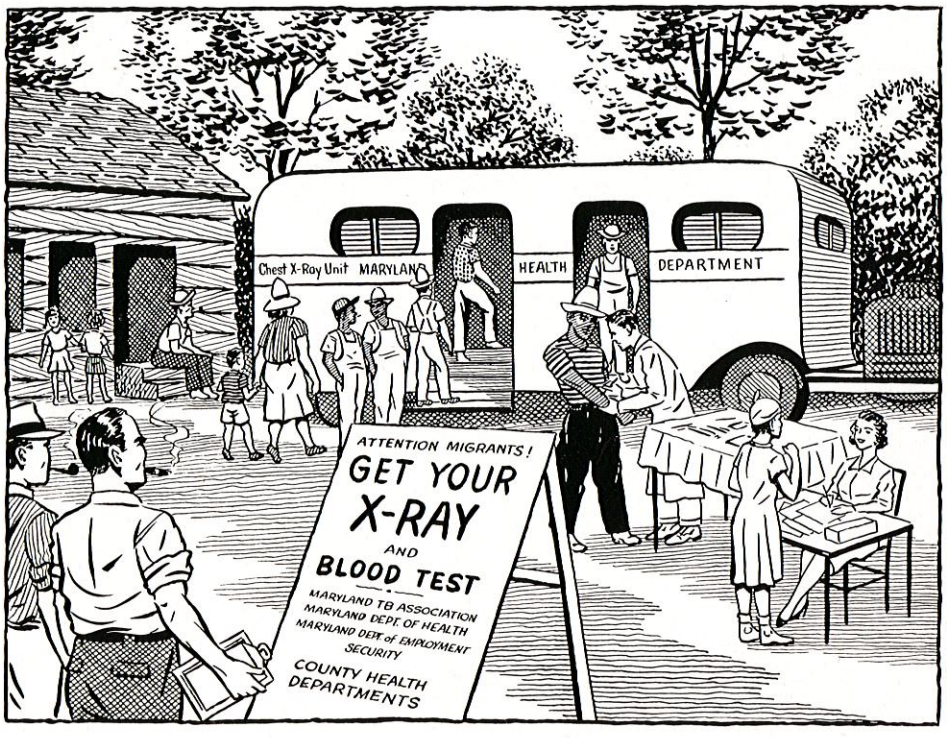

Maryland's TB-VD Health Program Among Agricultural Migrants

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lems resulting from the transient nature and non-resident status of migrants.

The Importance of Agricultural Migrants

The agricultural economy of the states in the East Coast Migrant Labor Stream depends heavily on the availability of seasonal labor forces. The local labor supply is inadequate to meet the fluctuating demands for manpower during the harvesting seasons. Mechanical harvesting devices are unsatisfactory for most truck crops since a machine has not yet been devised to select the right fruit for picking and to permit the immature fruit to remain on the vines. Sufficient labor at the right times enables the farmer to reap several premium harvests from the same crop.

The migrant labor stream is a result of this need for a seasonal labor supply. The difference in crops and seasons from the southern to the northern extremes of the east coast enables a crew of laborers to travel from area to area and be available in many different localities during the height of the agricultural season. By working the winter crops in Florida, year round work is available for a large number of workers.

Most farmers look to their state employment office to obtain workers. In Maryland the State Department of Employment Security maintains a trained staff of representatives who devote full time to the procurement and management of migrant farm workers. The number of workers needed for each farm is determined by a farm survey conducted by the Department of Employment Security through the farmers' and growers' associations. After the necessary information has been gathered, the procurement officers contact crew leaders in Florida to make arrangements for bringing labor crews into Maryland.

The crew leaders are private operators in the business of providing migrant laborers to the farmers. After the crew leaders make their commitments through the procurement officers, they bargain with individual migrants to encourage workers to join their crews. The crew leaders are responsible for providing transportation, lodging, and employment for the workers. They may collect fees for these services as well as carry on a business of selling soft drinks, lunches, and other products to the workers. However, most of their profit comes from a commission on the earnings of their crew of laborers. Individual workers are paid an hourly wage or a set fee for each container of fruit or vegetables they harvest.

In addition to organized crews, many people known as "free wheelers" follow the labor stream and deal directly with the farmers. These workers usually seek the most profitable work possible and will change from farm to farm during the season as the various harvests reach their peaks.

A number of local people wanting farm work will either deal directly with the farmers or will join a crew of migrants. Some crew leaders depend upon local people to complete their complement of workers. This arrangement is usually successful since many of the local people do not work until the migrants arrive, even though they could obtain work prior to that time.

The farmers and crew leaders are not the lone benefactors from the presence of migrants in the State. As a rule, the migrants enter the State with little money and leave with about the same amount. With the exception of that which is carried out in the pockets of crew leaders, the money is spent in the same locality where it is earned. Seven thousand wage earners spending most of their earnings in the local stores provide profits and jobs for many local people not connected with farming.

Where Migrants Come From

The majority of migrants in the East Coast Stream are non-white natives of the southeast. Most of them have previously earned a meager living by sharecropping sub-marginal farms. Although their basic needs were usually cared for, they seldom received regular wages for their labor. Due to a lack of education or initiative their opportunities for seeking another means of livelihood are very slight. These are the people who are attracted to the migrant labor streams, largely through the incentive of regular wages and frequently because it is their only source of income.

By joining a crew in their own area, or traveling to Florida where some 80,000 migrants headquarter, they become members of the migrant labor stream. Usually they discover their wages are inadequate to support a family back home, but by putting their wives and older children to work with them they can fare much better. Quite often this involves bringing along parents, grandparents, and other old people to stay in the camps to care for the younger children.

By becoming migrants their condition is seldom improved. Although they have some money in their pockets, they have sacrificed many advantages they previously had. Because of their constant travel they can no longer claim residence in a particular state, and in many states they find themselves ineligible for such benefits as welfare assistance and free medical or hospital care. It is not uncommon for weather conditions such as droughts, freezes, and storms to put them out of work for months, and as non-residents they have no place to turn for financial aid during these long periods of idleness.

The members of the migrant stream are constantly changing. Many leave after a season to go back home, but there are always others to replace them. Some drop off along the way and eventually settle down in the state where they were scheduled to work for a few months. Usually there are local people in the same state who join the crew and remain in the stream.

Most of the migrants coming to Maryland give Florida as their home address. An appreciable number list North Caro-

lina, and a few come from other southeastern states. There are a number of Maryland natives who join crews going South to work the winter crops in Florida.

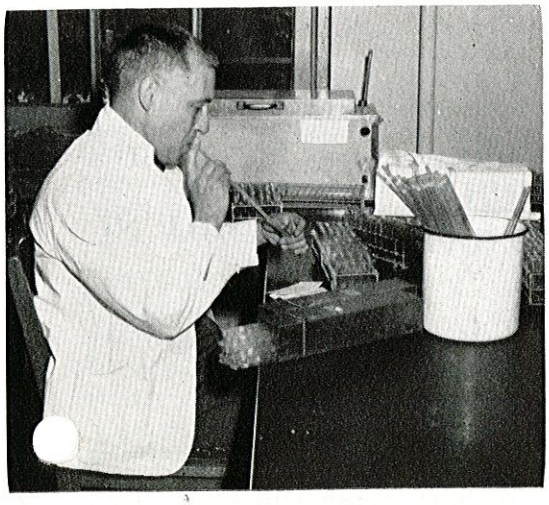
Health Problems Among Migrants

Those who become migrants usually have never had adequate medical attention. Partly because of their poverty, they avoid seeking medical attention. However, equally responsible is an ignorance and an apathy toward personal hygiene and basic health principles. The Florida State Board of Health is presently initiating studies to determine factors involved in the migrant's frequent failure to take advantage of the medical resources which are available free of charge to non-resident migrants.

Upon joining the migrant labor stream, both the healthy and the diseased must constantly live and travel together, thus multiplying individual health problems into a potential public health hazard. Of 3,415 migrants tested for syphilis in Maryland in 1958 over 12 per cent were found positive and at least 185 had never been treated for their infection.

Tuberculosis is also prevalent among migrants. This is supported by the experience of the neighboring State of Delaware where a combined tuberculosis and syphilis casefinding program was conducted in 1958. Chest x-ray examination of 4,117 migrants revealed 39 tuberculosis suspects. Follow-up of the 35 who could be located led to the diagnosis of active pulmonary tuberculosis in 8 individuals, a rate of 2 active cases per 1,000 examinations.

The Central Laboratory of the State Health Department is cooperating by providing rapid tests for syphilis.



Procedure of Syphilis Casefinding Among Migrants in Maryland

On several occasions in the past few years the Maryland State Department of Health has conducted syphilis casefinding programs among its migrant laborers. The last program was during the 1958 agricultural season when there was a combined effort to screen both migrants and residents. The figures presented here reflect only the migrant labor phase of the program.

Funds and personnel to operate the program came from the State Department of Health and the United States Public Health Service. A team consisting of a project administrator and two venereal disease investigators was organized and hired temporary personnel. The first step in setting up that screening program was to contact simultaneously the local health departments and the Department of Employment Security. From both agencies excellent cooperation was obtained. The Department of Employment Security supplied a list of all crew leaders recruited, the farms where each crew would reside and work, and the approximate arrival and departure dates of each crew.

The health officer was consulted in each county where migrant testing was anticipated, since in each county the program was sponsored by the local health department and under the overall direction of the county health officer. In most cases the county health officer sought and received the approval and support of the local medical society.

Upon final approval of the county health departments, both the crew leaders and the farmers were contacted by letter advising them of the program and soliciting their support. A personal visit was then made to the farmers, and arrangements were completed for the time and place of testing the labor force. In most cases testing was performed when the laborers returned from the fields to the labor camps so that no time was lost from work. A team of locally hired nurses or venereal disease investigators collected the specimens in disposable Sheppard Tubes. A locally hired clerk obtained the necessary identifying information from the workers at the time the blood specimens were taken. With the support of the crew leaders and the farmers 100 per cent participation could be anticipated. A small number presented current identification cards from other states indicating they had been previously tested within the year. These cards were always honored.

Specimens were sent via bus to Baltimore for testing in the Central State Health Department Laboratory. Results were then passed on to the Division of Epidemiology and Communicable Disease Control of the State Health Department where all information was reviewed and records prepared including individual identification cards. The information was forwarded immediately to the project director who gave identification cards of negative reactors to crew leaders for distribution. Positive reactors were notified by the crew leader to report to a convenient special clinic where they received diagnosis and appropriate treatment if needed. Prior to diagnosis, histories were taken from each patient with close attention directed toward possible previous treatment. In a few instances clinics were set up at the labor camps themselves, as a last resort to process patients who had failed to report to other clinics and were scheduled to move to another locality.

It is obvious that the volume of this project would have imposed a great burden on the local health department staff. Therefore, temporary workers were hired and in several counties patients were referred to private physicians who were supplied medicine and paid a fee from project funds. Although the project was supported by Federal funds, the local health department staff made invaluable contributions without which the program could not have succeeded.

Syphilis Survey of Migrants in Maryland, 1958

	Number	*Per-cent*
Estimate of Migrants in Area	5,000	
Blood specimens collected	3,415	
Number positive reactors	419	12

Results of Follow-up of 419 Positive Reactors

Brought to treatment first time for this infection	185	44
Returned to treatment, previous treatment inadequate	8	2
Previous adequate treatment	130	31
Other disposition and lost to follow-up	96	23
	419	

The Delmarva Conference and Later Developments

Increasing interest is being focused on the problems created by the migratory labor stream along the Eastern Seaboard. Numerous conferences of the Seaboard States have highlighted problems of duplication of effort, poor communication on health problems, uncertain jurisdiction, legal residence, and a host of others.

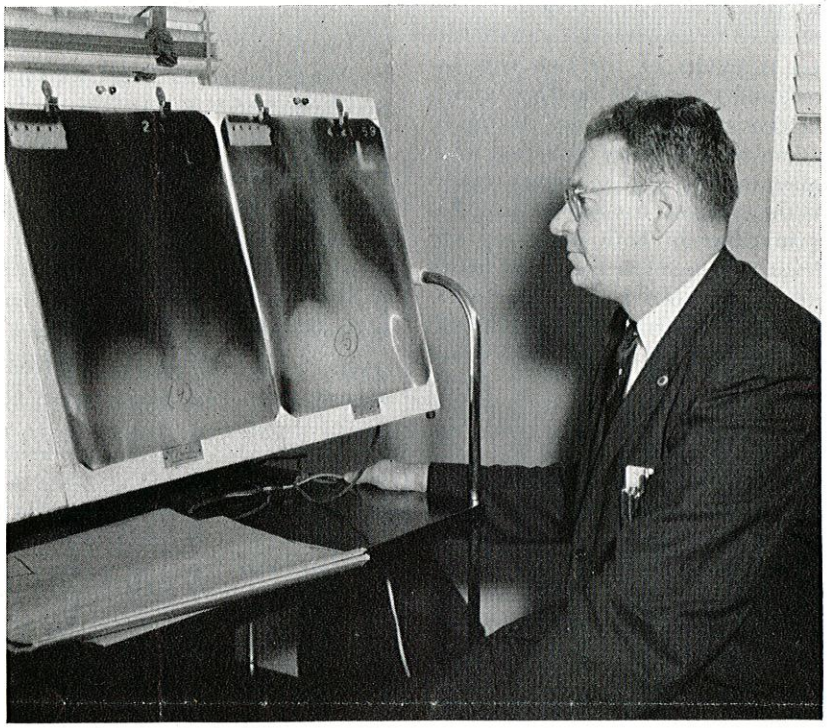
The three States of Maryland, Delaware and Virginia (Delmarva) have had two meetings to discuss a joint or cooperative project for combined tuberculosis and venereal disease control which would hopefully set a pattern for smoother working relationship among the states. Representatives of both the State Health Departments and the Tuberculosis Associations have attended these meetings.

The first such tri-state conference was held in Salisbury, Maryland, June 12, 1958. The idea was proposed to try to carry out a joint tri-state screening activity for tuberculosis and syphilis at the Kiptopeake-Norfolk Ferry where about 7,400 migrants come through each year from May 7 to October 1.

At the second conference in Norfolk, Virginia, October 5 and 6, it was unanimously concluded that for the present this approach was both impractical and too expensive, and instead it was agreed that the three states would carry out a coordinated effort along the lines employed in Delaware last summer.

The chief points of this coordinated program of tuberculosis and venereal disease casefinding were summarized as follows:

1. In each state the effort would be carried out by partnership between the Health Department and the Tuberculosis Association.
2. Virginia, Delaware, and Maryland Departments of Health agreed to coordinate carefully their efforts in tuberculosis and venereal disease casefinding and other health services to migrant farm workers during the 1959 season.
3. Each state would design its own program along the lines already developed by Delaware and would describe this briefly in a written plan.
4. These plans would be circulated between states together with current lists of local health officers, phones and addresses, and forms which would be used.
5. All three states agreed to use a card identical in content and color to the wallet sized one now used in Delaware. The color is important because it is changed each year (orange 1957, blue 1958, pink 1959). The three states also agreed to honor this record and not to repeat tests which may have been done in one of the other states during the year.
6. It was agreed that follow-up attempts would be made by direct referral to the local health department where the migrant was thought to have gone, rather than to route referrals through the State office.
7. It was further agreed that a resume of activities in Delaware, Maryland, and Virginia, together with the sample wallet sized card, would be sent to states farther to the north; e.g., Pennsylvania, New Jersey, and New York, requesting that x-rays and blood tests not be repeated if the migrant had been checked in 1959.
8. Requests for assistance from the United States Public Health Service would be submitted separately by each state. The Public Health Service Regional Offices would be supplied with information and asked to inform other States. Data from each of the three states would be analyzed and compiled in a tri-state report at the end of the season.



A medical specialist at Pinebluff State Tuberculosis Hospital reads chest x-rays daily and immediately forwards results.

Following the Delmarva Conference in Norfolk, the three states proceeded with their individual plans. The Maryland project officially got underway at a January meeting in Queen Anne's County's new health center at Centerville. Attending the meeting were eight of the nine county health officers from the Eastern Shore, representatives from the State Health Department, the Tuberculosis Association, the State Department of Employment Security, and the Johns Hopkins University School of Hygiene. Special guests included representatives from the Delaware State Board of Health and the Delaware Tuberculosis Association who described the 1958 Delaware project. The project was discussed in detail and such problems as financing, hospitalization, and many others appeared to be solved.

In addition to being a cooperative project between the three States, the Maryland program includes four participating agencies: the State Health Department, the Tuberculosis Association, the county health departments, and the State Department of Employment Security. Because of their enthusiastic support and interest in the project, the Department of Employment Security was asked to join as a full partner.

The project proposed by the Delmarva Conference was presented and endorsed by the Eastern Seaboard Migrant Labor Conference in Washington, D. C., on October 9-10. Other states were urged to follow the example set by Delaware, Maryland, and Virginia, and it has recently been reported that Florida will use an identification card identical to that adopted at the Delmarva Conference.

The 1959 Maryland Project

The Maryland project will be patterned after the 1958 syphilis casefinding program with the addition of tuberculosis screening along with serologic screening for syphilis. The Maryland Tuberculosis

Association is a joint participant with the Maryland Department of Health, the local health departments, and the Department of Employment Security. Funds and personnel for both tuberculosis and syphilis screening and syphilis follow-up will be provided by the Tuberculosis Association, the State Department of Health, and the Public Health Service. The follow-up of tuberculosis suspects will be the responsibility of the county health departments and the State Health Department.

The combination of the two programs will promote efficiency, curtail costs, and provide better services. X-ray technicians and venereal disease investigators will visit large labor camps and farms to give as many migrants as possible the opportunity to receive a blood test and x-ray at the same time. Identification cards will be issued to non-reactive participants as soon as results of the two tests are received, and to positive reactors following diagnosis and adequate treatment. Arrangements will be made to read small films immediately and to report results before the migrant has moved on. Reactors to either or both the x-ray and blood test will be referred to local health departments or special clinics for additional testing. Treatment for syphilis will be arranged as in 1958 with funds available for contracting with private physicians in those areas where it is advisable or necessary.

Once a tuberculosis suspect has been referred to the local health department for a large film, the local health department will process the individual in the same manner as with any other such patient. If hospitalization is required the Bureau of Tuberculosis will make arrangements to return the patient to the state of residence as is presently done, according to cooperative agreements of the Association of State Tuberculosis Directors.

It is believed that this tri-state project presents a real opportunity to end the interminable shifting of responsibility which has characterized this public health problem. Maryland and its two neighbors, Delaware and Virginia, will be setting an example for other states to follow which should be a solid contribution to a most difficult and frustrating problem.

This article was prepared by Charles D. Bird of the Division of Epidemiology and Communciable Disease Control, Maryland State Department of Health.

Polio Alert - 1959

Once more the Health Department is joining the nation-wide appeal to parents and young adults to be wise and ACT NOW before the polio season begins in July. All parents, who have not done so, should take the responsibility of protecting their children against polio.

CONSULT YOUR PHYSICIAN IMMEDIATELY. Remember that it takes several months for an appreciable degree of immunity to develop. The first and second inoculations are given one month apart. The third follows the second at least seven months later.

Health authorities everywhere are concerned over an increase of paralytic cases of poliomyelitis. The total of such cases in 1958 in the United States was 3,083 as compared to 2,499 in 1957, and figures for the first few months of 1959 show an increase over 1958.

Of special concern is the fact that over half of these cases have occurred in infants and preschool children. This was true in Maryland as well as the rest of the country. In the Detroit outbreak 61.4 per cent of the cases occurred in children under five years of age. None of the 22 persons who died had received three doses of vaccine. Sample studies show that this special risk group of very young children is not as thoroughly protected as the school aged child. Remember that inoculations should start in the first half year of life. This protection against polio as well as other inoculations for diphtheria, tetanus, whooping cough and smallpox is a priceless lifetime gift you owe to your child. These inoculations are safe — they are effective. The best time to start is NOW.

We will be Moving

June 24 to June 28th, 1959

BEGINNING JUNE 29th, 1959, THE OFFICES OF THE MARYLAND STATE DEPARTMENT OF HEALTH

WILL BE LOCATED AT:

301 WEST PRESTON STREET
BALTIMORE 1, MARYLAND

HOWEVER, THE BUREAU OF LABORATORIES OF THE DEPARTMENT OF HEALTH

WILL REMAIN AT:

16-20 East 23rd Street
BALTIMORE 18, MARYLAND

(All mail and specimens for this Bureau should be sent to the 23rd Street address.)

TELEPHONE NUMBERS FOR ALL OFFICES WILL BE:
VErnon 7-9000