

streamline

The Migrant Health News Source

National Summit of Clinicians for Healthcare Justice

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For the first time ever, frontline primary care clinicians and leaders from 13 national and regional clinical networks, who provide the safety net health care for the nation's uninsured and underinsured populations, came together to address the US healthcare crisis. These clinicians, who advocate for quality healthcare for all, gathered in Washington, DC for two days in October for the National Summit of Clinicians for Healthcare Justice.

The Summit was a first-of-a-kind event of clinicians, students and advocates from all over the country who came to celebrate, acknowledge and highlight the work frontline clinicians do to serve disenfranchised populations in need of health care. These doctors, nurses, physician assistants, nurse practitioners and midwives, pharmacists, dentists, psychologists, health educators and *promotoras de salud* work in small, isolated rural communities and inner-city neighborhoods. They work with the uninsured and underserved, serving migrant farmworkers, the homeless and working people who simply cannot afford basic health care. The Summit allowed these clinicians to raise their collective voice to bring health care and better health outcomes with dignity to all.

The historic event began with a call to action from six former US Surgeons General, the current acting US Surgeon General and the only three state Surgeons General. All have seen first hand the effects of healthcare inequality. Their discussion underscored the current crisis of childhood obesity. The Summit continued with plenary sessions led by champions of healthcare justice and breakout sessions facilitated by best practice experts on topics of interest to clinicians working for and serving the underserved. The sessions represented the full spectrum of knowledge and skills, including clinical practice, health policy, and community health improvement. We closed our meeting with inspiring comments from Dr. Jack Geiger, a Nobel Peace laureate



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Acting US Surgeon General Rear Admiral Steven K Galson, MD, MPH and six of his predecessors opened the National Summit for Healthcare Justice in October 2008. Pictured from left to right are Drs. Audrey Forbes Manley (Former Acting Surgeon General), Kenneth P. Moritsugu (Former Acting Surgeon General), David Satcher (16th Surgeon General), Steven K. Galson, Richard H. Carmona (17th Surgeon General), C. Everett Koop (13th Surgeon General), Antonia Novello (14th Surgeon General).

and the father of the community health center movement in the United States, and Dr. Gloria Wilder, president/CEO of Core Health and founder of Justice Speaks. Summit participants left with renewed vigor to continue the movement toward healthcare equity.

This Summit was the realization of a dream of leaders working for decades in primary care in underserved settings. It came together through strong partnership and the planning efforts of national organizations such as the Migrant Clinicians Network, the Association of Clinicians for the Underserved, National Association of Community Health Centers, Association for Asian and Pacific Island Community Health Centers, and the National Healthcare for the Homeless Council. Morehouse School of Medicine's National Center for Primary Care provided a strong academic partner and a conduit for funding from the Agency for Healthcare Research and

Quality and the Centers for Disease Control and Prevention. The Clinical Regional Advisory Network played a central role in the planning process, which also included regional clinician networks from the Northeast, Midwest, Mid-Atlantic, South, and West.

The Summit offered an extraordinary opportunity to network, collaborate and learn from one another. Together we voiced the need to eliminate health disparities and improve health for all. The Summit organizers, speaking for the 13 clinical networks that represent thousands of "frontline" primary care providers, developed a consensus platform for a pre-conference Capitol Hill staff briefing that featured former US Surgeon General Dr. David Satcher, and for all Summit participants to use in their efforts to bring an end to healthcare injustice. We realize that working together and

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Dr. Ed Zuroweste and Dr. Satcher
at Capital Hill Briefing

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presenting one voice on healthcare justice is much more powerful than doing so individually. The consensus platform is included in this issue of *Streamline*. It is time for all of us, who serve the millions of individuals in our country who continue to suffer from healthcare injustice, to step forward and demand significant change in US healthcare policy to allow for equal and quality healthcare for ALL! ■

PLATFORM

National Summit of Clinicians for Healthcare Justice

Health Care is a Human Right.

Every human being is mortal and is subject to painful, debilitating, disabling and fatal illnesses and injuries. Bodies of knowledge and techniques to prevent and combat illnesses and injuries, developed over millennia by the human community, are the shared heritage of all humanity.

The Universal Declaration of Human Rights, like other international documents, expresses the world's judgment: "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services..." (The General Assembly of the United Nations, 1948, Article 25)

Health care services, however, are not readily and equitably available in the United States. In particular, lack of health insurance and the inability to pay for services restricts access to even the most basic care for millions of Americans, with dire personal and societal consequences.

We Call for Healthcare Justice.

- Everyone must have ready access to health care, regardless of any individual's ability to pay for services.
- Healthcare services must be of equal quality for everyone, regardless of anyone's economic circumstances.
- The burden of paying for health care should be borne by society broadly.
- Market forces and private interests cannot be allowed to restrict service access to disenfranchised and marginalized groups.
- Individuals must be able to choose their healthcare providers.
- The primary healthcare work force must be dramatically expanded to provide care for everyone.
- Healthcare providers and consumers must be accountable for efficient operation of healthcare systems and effective utilization of healthcare resources.

Indicators of Healthcare Injustice

The grim figures below reflect long-standing healthcare injustices that clinicians observe in our patients everyday. A deteriorating economy threatens to worsen these conditions, and urgent national action to establish healthcare justice is required.

Health Insurance: The number of people without health insurance coverage was 45.7 million (15.3 percent) in 2007.¹ This was an increase of 22% since 2000. Uninsured persons are 60% more likely to die from cancer.² Uninsured diabetics are 50% more likely to undergo amputation.³ Uninsured pregnant women are 30% more likely to give birth to an infant who dies, or is born with severe illness or complications.⁴ Thirty-seven thousand people died from 2000 through 2006 because they lacked health insurance, including 22,000 people in 2006.⁵

Health Disparities: Racial and ethnic minorities, compared to whites, often have less access to health care, receive lower-quality health care, and have higher rates of illness, injury, and premature death. Among adults, death rates for African-Americans are approximately 55 percent higher than they are for whites. African-American women have the highest death rates from heart disease, breast and lung cancer, stroke, and pregnancy among women of all racial and ethnic back-

grounds. In 2001, Asian Americans and Pacific Islanders had the highest tuberculosis case rate of all racial and ethnic populations in the United States. Although they made up only 26 percent of the U.S. population in 2001, African-Americans and Latinos accounted for 67 percent of newly reported AIDS cases. Compared to the general U.S. population, American Indians are 400 percent more likely to contract tuberculosis, 291 percent more likely to suffer from diabetes, 67 percent more likely to have pneumonia or influenza, and 20 percent more likely to suffer from heart disease.⁶ Among pre-school children who are poor, nearly 30 percent have untreated cavities, compared to only 6 percent among children from middle class families.⁷ Despite an array of effective known treatments, the majority of those with mental disorders do not receive treatment.⁸

Special Populations: Immigrants, seasonal and migrant farmworkers, and homeless persons are disproportionately excluded from health care, on account of much higher rates of uninsurance and other economic, social and cultural factors. Homeless persons are three to four times more likely to die than are housed persons.⁹ Migrant and seasonal farmworkers are often in poor health, at elevated risk for injuries and illnesses due to the nature of their jobs, yet in 2000 only 20 percent reported

using any healthcare services in the preceding two years.¹⁰ Nearly 50 percent of foreign-born noncitizens were uninsured in 2003.¹¹ ■

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Update on *Hombres Unidos contra la Violencia Familiar*

Karin Hopkins, MPH, Migrant Clinicians Network

Last summer in *Streamline* we shared the good news about our project to prevent sexual and intimate partner violence by working with Hispanic migrant men. MCN's *Hombres Unidos Contra la Violencia Familiar* has now completed two highly successful seasons working in collaboration with Keystone Health Center in Pennsylvania, the Center for Multicultural Wellness and Prevention in Florida and Community Health Partnership of Illinois. For this coming year we are adding two new sites: Campesinos sin Fronteras in Somerton, Arizona and the South Texas Colonia Initiative, Inc. in Corpus Christi, Texas.

Our intervention strategy consists of a course facilitated by two male promotores that engages groups of 9-15 men for five sessions that last two hours each. At this point, 169 migrant men have completed all five sessions. We are still analyzing our second year results, but we expect them to be comparable or better than the first year results. Our pre- and post-tests of participants' knowledge and attitudes showed an overall positive change in responses with very striking improvements for some of the questions. The education was very effective in helping the participants understand facts about the definition and causes of rape and abuse and in dismantling myths. The education helped the participants understand that insults and verbal assaults are part of the abuse definition. Before the intervention, 74% believed this and after the education 94% of the participants understood. Prior to the education, 64% of the participants thought that drunkenness causes men to hit their partners, decreasing to 48% after the training. There was also an important change in attitude regarding the perception that women who report rape are telling the truth. Before the education, 52% of the men believed women reporting were telling the truth, increasing to 72% after the education. At the end of the educational sessions, 83% of the participants understood what to say if they saw someone being violent towards another person, versus 50% prior.

The participants had a lot to say after completing the course. (See Comments from the Participants). There was much importance placed on men's roles in their families, being a good role model and training younger men to avoid making the same mistakes. Younger unmarried men mentioned that they felt like they were better prepared for marriage and would have an idea of how they're supposed to act when they find a

wife. It was also mentioned that men did not want their daughters to be in an abusive relationship when they grow up. In all three sites the men said that they now had "the language" to talk about these things. Violence in their environment was something they were aware of, but they didn't know how to articulate it or open a conversation on these issues.

The *Hombres Unidos* project will continue for at least two more years with CDC funding. MCN expects to release the curriculum that we are developing over four years of pilot testing in 2009. The key to our successful intervention has been recruiting good competent facilitators who are known and trusted in their communities. MCN would like to acknowledge the hard work of our 2008 facilitators: Gabriel Fuentes, Noe Quiroz, Esteban Moya, Miguel Vasquez-Antunez, Felipe Fana and Omar Fana Tavarez. We would also like to send a special thanks to Emiliano Diaz de Leon, our Leadership Consortium member who has become our principal trainer for the project.

Some of our general recommendations for sexual and intimate violence prevention work with Latino migrant men are:

- Use appropriate language and low literacy materials
- Offer alternatives to violence, not accusations
- Use culturally appropriate images, scenarios, role plays, etc.
- Provide enabling factors to allow migrant

workers to participate in courses (flexible schedule, location, etc.)

- Provide food and give out certificates and prizes
- Good facilitators are natural leaders with
 - Dedication to the program goals and principles
 - Cultural and linguistic competence
 - A positive reputation in their communities
 - Courage to speak out against violence

For more information on this or other projects in MCN's Family Violence Initiative, visit www.migrantclinician.org/clinical_topics/family-violence. ■

Comments from the Participants

"This program needs to continue, you can't abandon it. It is a fundamental theme in society; every family is affected. Family violence is an ongoing problem; it needs ongoing support to change."

"Working together we can unite the community."

"I never had the language to talk about this before."

"I like what I have learned; I can be a better person in my family."

"Older men can help teach younger men."

"Now that we know better, we can't do nothing."

"You don't always think that [emotional abuse] it hurts people, but it can be worse than physical abuse."

"A man is a man, but a man should behave himself and know how to act."

"Boys must be taught how to act so they can stop the cycle of violence."

"The way that parents raise kids determines the way that society will be. The family is the cell of society."

"The more people who think that it's bad, the more they will try to change. Societal pressure is the greatest force for change."



Donate to MCN

Please join Migrant Clinicians Network as a force for justice in health care for the mobile poor. Support from you allows us to continue offering educational programs that develop excellence in practice, clinical leadership and models of best practices. Please make a financial contribution to MCN at www.migrantclinician.org. Thank you!

Fatal Injuries among Landscape Services Workers

Editor's Note: The following is excerpted from the National Institute for Occupational Safety and Health, Fact Sheet: *Fatal Injuries among Landscape Services Workers*, October 2008, and is available from <http://www.cdc.gov/niosh/docs/2008-144/pdfs/2008-144.pdf>. We highlight the dangers of this industry as 41% of landscapers in 2006 were Hispanic. This industry reflects the rapidly changing demographics of the US workforce and the occupational transience of the migrant farm-worker population.

Overview

An average of 197 landscape services workers¹ died from on-the-job injuries each year between 2003 and 2006². The fatality rate for the landscape services industry, about 25 deaths per 100,000 workers, is similar to that for more recognized high-risk industries such as agriculture and mining. Although landscape services workers make up 0.8% of the U.S. workforce, they experienced 3.5% of the total occupational fatalities.

Landscape services workers complete jobs such as landscape and irrigation installation, lawn care, tree removal, general landscape maintenance and snow removal.

Workforce

Landscape services workers numbered slightly more than 1 million workers in the U.S in 2006. The Bureau of Labor Statistics (BLS), U.S. Department of Labor, estimated over 924,000 landscaping and groundskeeping workers plus 110,000 first-line supervisors for those workers across all industries. The landscape services industry employed approximately 680,000 workers in 2006. The remaining 300,000+ landscape services workers were employed in other industries such as golf courses, resorts, public parks, and schools. Forty-one percent of landscape services workers in 2006 were Hispanic or



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Latino in comparison with 16% of the total U.S. workforce. www.bls.gov/cps/cpsaat11.pdf

Occupational Fatalities

BLS Census of Fatal Occupational Injuries (CFOI) identified 789 deaths due to traumatic injuries among landscape services workers and their first-line supervisors between 2003 and 2006. In each of these years, 25 to 30% of these workers who died were identified as self-employed. About 56% of the fatalities occurred among white workers, 29% among Hispanic and Latino workers and 11% among Black or African American workers. <http://www.bls.gov/iif/oshcfoi1.htm> Nearly 80% of the landscape services worker fatalities occurred in the landscape services industry.

The most common event resulting in landscape services worker fatalities was transportation incidents (Figure 1). About 33% of all landscape worker fatalities were due to transportation incidents in comparison with 43% for all U.S. industry. Landscape services workers were more likely to die due to falls to lower level, struck by falling objects, and electrocutions (22%, 17%, and 9.8%, respectively) than the overall U.S. workforce (12%, 6.3%, and 4.4% respectively).

Landscape services workers were engaged in a range of activities at the time of the occupational fatalities (Table 1). Using tools or machinery during tree trimming or removal activities was particularly hazardous. Fatalities during tree trimming or removal activities were caused by falls from heights, being struck by falling objects and electrocutions. Information is not available to determine if the workers trimming or removing trees were employed by tree services companies or other landscaping services companies. Most landscape services worker fatalities occurred on private property with the largest proportion at private residences.

Table 1. Activities at the Time of Landscape Services Worker Fatalities, 2003 - 2006

Activity	Fatalities
Using/Operating Tools or Machinery (during trimming or removing trees)	355 (288)
Vehicle or Transportation Operations	241
Constructing, Repairing, Cleaning	103
Physical Activity, n.e.c.	46
Other Activities	44

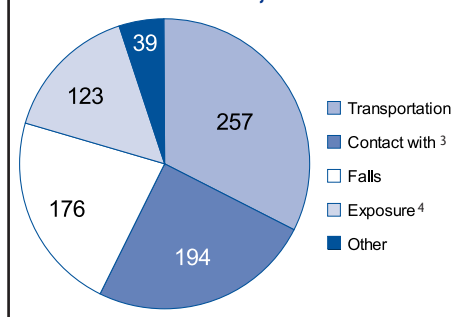
Decentralized job sites, like those listed for these fatalities, are associated with reduced organizational and infrastructure support for safe and healthful work practices.

Transportation-related fatalities for landscape services workers and their first-line supervisors for 2003 – 2006 are compared with total fatalities by month. The numbers of total and transportation related fatalities were generally greater in May through September than in the remaining months. ■

Endnotes

1. Landscape services workers includes these Standard Occupational Classifications: Landscaping and Groundskeeping Workers (37-3011), Tree Trimmers and Pruners (37-3013), Grounds Maintenance Workers, All Other (37-3019), and First-Line Supervisors/Managers of Landscaping, Lawn Service, and Groundskeeping Workers (37-1012).
2. The Census of Fatal Occupational Injuries preliminary data for 2006 were used for the analysis included in this document. The final 2006 data identified four more landscape services worker fatalities.
3. Contact with objects or equipment includes struck by, struck against, and caught in or compressed by objects or equipment.
4. Exposure includes temperature extremes, contact with electric current, exposures to substances including animal venoms, and oxygen deficiencies, e.g., drowning.

Figure 1. Events associated with Landscape Services Worker Fatalities, 2003 - 2006



Illnesses and Injuries Related to Total Release Foggers — Eight States, 2001—2006

Editor's Note: *The following is excerpted from the CDC's Morbidity and Mortality Weekly Report, October 17, 2008 / 57(41):1125-1129 and is available from <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5741a3.htm>. We bring this to your attention as structural pesticide use is common in migrant housing and reflects an important potential source of pesticide exposure for workers and their families.*

Total release foggers (TRFs), sometimes called "bug bombs," are pesticide products designed to fill an area with insecticide and often are used in homes and workplaces to kill cockroaches, fleas, and flying insects. Most TRFs contain pyrethroid, pyrethrin, or both as active ingredients. TRFs also contain flammable aerosol propellants that can cause fires or explosions. The magnitude and range of acute health problems associated with TRF usage has not been described previously. This report summarizes illnesses and injuries that were associated with exposures to TRFs during 2001–2006 in eight states (California, Florida, Louisiana, Michigan, New York, Oregon, Texas, and Washington) and were investigated by the California Department of Pesticide Regulation (CDPR) and state health departments participating in the SENSOR-Pesticides program.* During 2001–2006, a total of 466 TRF-related illnesses or injuries were identified. These illnesses or injuries often resulted from inability or failure to vacate before the TRF discharged, reentry into the treated space too soon after the TRF was discharged, excessive use of TRFs for the space being treated, and failure to notify others nearby. The findings indicate that TRFs pose a risk for acute, usually temporary health effects among users and bystanders. To reduce the risk for TRF-related health effects, integrated pest management control strategies that prevent pests' access to food, water, and shelter need to be promoted and adopted. In addition, awareness of the hazards and proper use of TRFs need to be better communicated on TRF labels and in public media campaigns.

States participating in the SENSOR-Pesticides program and CDPR conduct surveillance on pesticide poisoning. In addition, the New York City Department of Health and Mental Hygiene through the New York City Poison Control Center (NYCPCC) has access to data on pesticide poisoning. No other states or cities conduct

pesticide poisoning surveillance. Cases of acute TRF-related illness or injury consistent with the national case definition for acute pesticide-related illness or injury¹ and occurring during 2001–2006 (the latest years for which complete surveillance data were available) were provided to CDC by these surveillance programs. Cases of TRF-related illness or injury were classified by the state agencies as definite, probable, possible, or suspicious, according to pesticide exposure and health effects criteria. CDC classified the cases provided by NYCPCC. Data from the state agencies and NYCPCC were compared, and duplicate cases were eliminated. In addition to receiving reports from poison control centers, each surveillance program obtains case reports from several other sources, principally state agencies with jurisdiction over pesticide use (e.g., departments of agriculture) and workers compensation claims^{2,3}. Some California cases might have been missed because the CDPR contract with the California Poison Control System to receive poisoning reports lapsed after 2002 and was not reestablished until late 2006. Detailed information was collected on each case, including demographic data, signs and symptoms, illness or injury severity,[†] Environmental Protection Agency (EPA) toxicity category, identity of implicated pesticides, location of the exposure, and information on factors that might have contributed to the exposure. Three recent case reports are provided to illustrate common patterns observed in the surveillance data.

Case Reports

Case 1. In March 2008, a woman aged 38 years from Washington visited an emergency department with headache, shortness of breath, nausea, leg cramps, burning eyes, cough, and weakness after she was exposed to fumes from three TRFs (in 6-ounce cans) deployed nearly simultaneously by a downstairs apartment neighbor. One TRF each was set off in the crawlspace beneath the house, in the neighbor's apartment, and in the hallway. The building was an old house converted into apartments, with a single ventilation system connecting all apartments. The neighbor had orally notified some of the tenants but not the patient. The patient recovered completely within 3 days, and the illness was classified as low severity. The TRF dispensed a toxicity category III pesticide product that con-

tained permethrin and tetramethrin as active ingredients.

Case 2. In September 2007, a man aged 34 years who worked as a maintenance worker at an apartment complex in Michigan forgot to disarm the smoke detector before activating a TRF. Because the building elevator shuts down if a smoke detector is triggered, the maintenance worker (without respiratory protection) reentered the mist-filled apartment to disarm the detector. He had onset of cough and upper airway irritation approximately 1 hour after exposure, contacted a poison control center, and did not seek additional medical care. His symptoms resolved within 24 hours, and his TRF-related illness was classified as low severity. He was exposed to a toxicity category III pesticide product with pyrethrins, cyfluthrin, and piperonyl butoxide as active ingredients.

Case 3. In August 2007, a man aged 54 years in California simultaneously set off nine TRFs in his small 700 square foot (6,000 cubic foot) home. Each 1.5-ounce TRF can was designed to treat 5,000 cubic feet of unobstructed space and released a toxicity category III pesticide product containing cypermethrin. When the man returned 6 hours later, a strong odor prompted him to open the doors and windows and to vacate. Entering a second time 4 hours later, the man had onset of headache, dizziness, nausea, and vomiting. He visited an emergency department, where he was treated symptomatically for TRF-related illness with a nebulized anticholinergic bronchodilator, intravenous hydration, and intravenous medication for headache, nausea, and bradycardia. He completely recovered after 36 hours, and his illness was classified as moderate severity.

Surveillance Data

A total of 466 cases of acute, pesticide-related illness or injury associated with exposure to TRFs during 2001–2006 were identified. SENSOR-Pesticides reported 368 cases, CDPR reported 40 cases, and NYCPCC reported 58 cases. Median age of affected persons was 35 years (range: 0–90 years); 255 (57%) were female, and 55 (13%) were exposed while at work. Race information was available for 137 patients, of whom 101 (74%) were white, 17 (12%) were black, and 19 (14%) were of other races. Ethnicity information was available

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for 158 patients, of whom 31 (20%) were Hispanic. Three cases occurred among pregnant women, and approximately 44 cases occurred among persons with asthma.

A total of 372 (80%) cases were classified as low severity, 84 (18%) cases were moderate severity, and nine (2%) were high severity. One death was classified by the Washington State Department of Health as suspicious. (This death occurred in a female infant aged 10 months who was put to bed the evening of the day her apartment was treated with three TRFs. The infant was found dead the next morning.) Twenty-one persons were hospitalized for 1 or more days (range: 1–35 days), and 43 persons lost time from work or other usual activities because of their illness or injury.

A total of 394 (85%) TRF exposures occurred in private residences. Among the 388 cases for which information was available regarding who activated the TRF, 197 (51%) of the illnesses involved the person who activated the TRF.

Among the 463 cases for which information on the implicated TRF product was available, 449 (97%) occurred in persons who were exposed to products with pyrethrin, pyrethroid, or both as active ingredients. Health effects most commonly involved the respiratory system (in 358 [77%] cases). The most common factors contributing to exposure included an inability or failure to vacate before the TRF discharged, early reentry, excessive use of TRFs for the space being treated, unintentional discharge of a TRF, and failure to notify others nearby.

MMWR Editorial Note:

TRFs are registered by EPA for use by home owners and others. When activated, the TRF cans are designed to empty their contents completely. No special training or licensing is required to use a TRF. Although numerous media reports in recent years have described injuries and property destruction resulting from explosions caused by activation of TRFs in the presence of ignition sources (e.g., gas pilot lights and electrical appliances, such as air conditioners and refrigerators, that cycle off and on) (D. Richmond, California Department of Pesticide Regulation, personal communication, 2008), this is the first report in the scientific literature to describe the range of exposure circumstances and acute health problems associated with TRF usage.

TRFs generally release pyrethroids,

pyrethrins, or both. Pyrethrins are insecticides derived from chrysanthemum flowers (pyrethrum)⁴. Piperonyl butoxide and n-octyl bicycloheptene dicarboximide often are added to pyrethrin products to inhibit insects' microsomal enzymes that detoxify pyrethrins⁴. Although pyrethrins have little systemic toxicity in mammals, they appear to possess some irritant and sensitizing properties⁴ and have been reported to induce contact dermatitis, conjunctivitis, and asthma^{5,6}. In addition, anaphylactic reactions⁴ and health effects involving the neurologic, cardiovascular, and gastrointestinal systems have been reported⁶. Pyrethroids are a class of synthetic insecticides that are chemically similar to natural pyrethrins³ and have low potential for systemic toxicity in mammals. Signs and symptoms of pyrethroid toxicity include abnormal skin sensation (e.g., burning, itching, tingling, and numbness), dizziness, salivation, headache, fatigue, vomiting, diarrhea, seizure, irritability to sound and touch, and other central nervous system effects^{4,7}. Propellants and other solvents in the TRFs also might contribute to observed symptoms⁴.

The findings in this report are subject to at least five limitations. First, the number of reported cases is probably an underestimate of the actual magnitude of illnesses and injuries associated with TRFs. The surveillance systems that identified cases are passive and, therefore, might have missed some TRF-related illnesses and injuries. Second, in 2006, only 10 states had pesticide poisoning surveillance systems, and the data in this report might not be representative of the 40 states without such surveillance systems. Third, because most (85%) TRF-related case reports were obtained from poison control centers, some California cases might have been missed when the contract between CDPR and the California Poison Control System was not in effect. Fourth, TRF-related illnesses and injuries also might have been missed because exposure and health effects information was insufficient to satisfy the case definition in some instances (e.g., approximately 68 reports were excluded because information on TRF ingredients were not available, and approximately 100 NYCPC reports were excluded because health effects data were missing or sparse). Finally, although all cases were consistent with case definition criteria, the possibility of false positives cannot be excluded. Because clinical findings of pesticide poisoning often are nonspecific and no standard diagnostic test

exists, some illnesses related temporally to TRF exposures might be coincidental and not caused by TRFs.

TRFs can reduce pest populations and often are used by consumers as a low cost alternative to professional pest control services. However, because of their design to broadcast pesticides, they have a substantial potential for unintended exposures, especially when the pesticide label is ignored or misunderstood. Greater efforts are needed to promote safer alternatives to TRFs. Integrated pest management (IPM) control strategies need to be promoted and adopted. IPM can reduce indoor insect populations and minimize the need for insecticides⁸.

The public also should be warned about TRF dangers through broad media campaigns that explain the importance of reading and understanding the pesticide label, using the correct number of TRFs, and taking necessary precautions (e.g., turning off ignition sources and promptly leaving the premises). TRF labels should be improved to make information easier to find and understand. Current TRF labels indicate the number of cubic feet that one container will treat effectively for pests, which requires the user to employ arithmetic to calculate both the volume of space to be treated and the number of TRFs needed to treat a space of that size. Use of delayed-release TRFs also might prevent illnesses and injuries by allowing the user to vacate the premises before the insecticide is released. Notices should be posted on the exterior of spaces where TRFs are used, indicating when the TRF treatment will be made and when reentry into the space is permitted. Coinhabitants (and nearby neighbors, when multiunit housing is treated) also should be informed at least 24 hours before a TRF treatment is started. ■

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Occupational Health Disparities

The Occupational Health Disparities Institute is a part of the Occupational Safety and Health Section of the American Public Health Association (APHA). The Institute was initiated in 2007 to:

- Address disparities in occupational health, including issues of immigrant, migrant and minority workers, the intersection of social justice and occupational health, and international and border occupational health disparities
- Highlight scientific sessions at the APHA

annual meetings that address disparities in work-related health, focusing on disparities by race, ethnicity and immigrant status

- Promote discussion and collaboration among APHA members, across APHA sections, and with others working to address health disparities among workers
- Sponsor and encourage special scientific sessions, events, and publications devoted to addressing disparities in work-related illnesses and injuries

The Institute organized several successful sessions at APHA in 2007 and 2008. MCN actively participates in the Institute and organized two sessions at this year's APHA meeting – Dying to Work: The Migrant's Journey to Work in the US and Farmworkers Feed US All. The Institute is also compiling a special issue of the *American Journal of Industrial Medicine* based on sessions from 2007.

For more information on the Occupational Health Disparities Institute, visit <http://www.apha.org/membergroups/sections/aphasections/occupational/>

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- * Under the Sentinel Event Notification System for Occupational Risk (SENSOR)-Pesticides program, CDC provides cooperative agreement funding and technical support to state health departments to conduct surveillance of acute, occupational, pesticide-related illness and injury. Funding support also is provided by the Environmental Protection Agency. Health departments in 10 states (Arizona, California, Florida, Louisiana, Michigan, New Mexico, New York, Oregon, Texas, and Washington) participated through 2006. Additional information is available at <http://www.cdc.gov/niosh/topics/pesticides>.
- † Severity for SENSOR and CDPR cases was coded using standardized criteria (available at <http://www.cdc.gov/niosh/topics/pesticides>).

Low-severity illnesses or injuries consist of illnesses and injuries that generally resolve without treatment and where minimal time (<3 days) is lost from work. Such cases typically manifest as eye, skin, and/or upper respiratory irritation. Moderate severity illnesses and injuries consist of non-life-threatening health effects that are generally systemic and require medical treatment. No residual disability is detected, and time lost from work is <6 days. High-severity illnesses and injuries consist of life-threatening health effects that usually require hospitalization, involve substantial time lost from work (>5 days), and can result in permanent impairment or disability. Deaths are fatalities resulting from exposure to one or more pesticides. NYCPC uses similar criteria for coding severity.

- § EPA classifies pesticide products into one of four toxicity categories based on established criteria (40 CFR part 156). Pesticides with the greatest toxicity are in category I, and those with the least are in category IV.

Treatment of LTBI in Pregnancy

Editor's note: The following Q & A exchange took place on a midwifery list serve, with the response from MCN's Candace Kugel, CRNP, CNM, MS. It is shared here in hopes that it will be of interest to others.

Q: Is anyone treating with INH during pregnancy for a positive PPD with negative chest x-ray? There is an excellent article by Boggess, et al. (OB/Gyn 2000;96:757-762), which uses mathematical/statistical modeling to show that this is the best strategy in terms of TB prevention but no one seems to have adopted it. I am trying to come up with a rational, resource-conserving strategy that addresses our poor postpartum show rates, but am wary of the 2% risk of hepatotoxicity which seems like it might be higher in Latina women. Of course our positive population is mostly

uninsurable Mexican women and Southeast Asian women.

A: As you probably know, the decision of whether to treat LTBI during pregnancy is related to:

- 1) the risk status of the woman and
- 2) your confidence in being able to maintain contact with the woman postpartum.

There is a protocol that you can view at [http://www.harlemtbcenter.org/Assets/web_docs/LTBI%20pregnancy%20\(PINK\).pdf](http://www.harlemtbcenter.org/Assets/web_docs/LTBI%20pregnancy%20(PINK).pdf) that outlines the categories of candidates for whom treatment of LTBI in pregnancy is more highly indicated (HIV positive, recent contact of active TB case, immunosuppressed, etc.) and categories for those for whom you "may delay treatment until postpartum" (recent arrival from endemic country is what you are probably seeing most). So getting a good

exposure history is important, as is knowing how mobile the woman is likely to be.

If you decide that she is a candidate for delayed treatment, the increased risk of hepatotoxicity for Latinas apparently persists for 6 months postpartum, increasing the risk of losing contact with her even more. Two suggestions for women whom you feel are likely to move:

- 1) refer to your state health TB program or
- 2) enroll her in TBNet, a program of the Migrant Clinicians Network, that provides case management, referral, and records transfer for mobile patients under treatment for TB.

More info on that program is at www.migrantclinician.org/network/tbnet. We would be able to provide you with additional information or training if you'd like.



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43rd National Immunization Conference

March 30 – April 2, 2009
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www.cdc.gov/vaccines/events/nic

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National Oral Health Conference

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American Occupational Health Conference

April 26-29, 2009
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www.acoem.org

2009 National Farmworker Health Conference

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The American College of Nurse-Midwives

54th Annual Meeting & Exposition
May 21-27, 2009
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www.midwife.org

36th Annual International Global Health Conference

May 26-30, 2009
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www.globalhealth.org/conference_2009



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