TB & CULTURAL COMPETENCY

Notes from the Field

Northeastern Regional Training and Medical Consultation Consortium Issue #8 Fall 2008

Working with Migrant Farm Workers

A VERY SICK FARM WORKER

Patricio had been traveling up to our state for a few years, arriving in the late spring as the harvests picked up and moving with the crops until there was no more work in late winter. He was a hard worker, with a young family back in Mexico who depended on his wages as a migrant laborer in the US He had been sick with fever, a productive cough, and extreme fatigue for some time when a non-profit migrant health organization (MHO) interpreter offered to take him to a local emergency room. He was treated for bronchitis, but two weeks later the interpreter brought him back, still weak and feverish, and now with hemoptysis. He was admitted and a few days later he was diagnosed with pulmonary TB.

ESTABLISHING RELATIONSHIPS

I was the public health nurse assigned to manage the case, working with the TB program and TB medical consultant for the region. Patricio was started on a regimen of INH, RIF, PZA, and EMB, pending the results of sensitivity testing. My first worry was having adequate access to an interpreter: there were none on staff at the hospital, and although I had used the language line before, I knew that a telephone service would not suffice for the on-going communication I was going to have with Patricio.

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Community health screening for farmwokers

Fortunately, the MHO interpreter was happy to collaborate on the case. Patricio's face lit up when he saw

> ***Watching as they talked, I realized for the first time what a shock it was for Patricio to learn his diagnosis and that he was terribly frightened of what might happen to him.***

'Miguel', as Mike, the interpreter, was known to the farm workers. Mike had a good rapport with the workers because he often drove one of the mobile medical vans and he was the person who brought Patricio to the hospital. Watching as they talked, I realized for the first time what a shock it was for Patricio to learn his diagnosis and that he was terribly frightened of what might happen to him. He asked many questions about the effects of the disease, how long he would be out of work, and whether his family might be at risk.

Mike and I took our time going through each step of diagnosis, susceptibility testing, the phases of treatment, and how we would deter-

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mine who might be a contact and be tested for infection. Mike also translated exactly what Patricio said, and this helped me get to know the patient better. For instance, I realized that he had very little experience with any health care system, whether in Mexico or the US, so I explained the need for monthly appointments at the TB program clinic once he was discharged. I also explained the need to test for HIV infection; although he was resistant at first, he did agree to it after hearing me out. Despite the fact that I spoke practically no Spanish, we established a good working relationship, in part because he saw that Mike trusted me and the TB program, to provide good care for him. Once he understood the process of treatment, Patricio was fully adherent to his appointments and medication.

IMPERFECT ISOLATION

That is not to say that we didn't experience some big challenges! The first came on a Friday afternoon, when I learned that Patricio was about to be discharged, although we did not have a report of sputum conversion yet. I had discussed the protocol for his discharge with the hospital infection control specialist, but she was not consulted before he was discharged. My primary concern was finding Patricio an adequately isolated place to stay: he shared a two-bedroom house with eight fellow migrant farm workers so returning home was not ideal. I contacted the manager of the only motel in the area and explained that the health department would take responsibility for the cost of Patricio's room until it was safe for him to go home. The manager considered our request but eventually declined to make a room available. The best remaining option was to arrange for home isolation.

Mike got Patricio's roommates and landlord together and we explained that Patricio had to avoid close contact until he was no longer infectious. They agreed to double up in one of the bedrooms, leaving the other for his exclusive use. We told them to leave the windows open and use fans to ventilate the house, and explained that Patricio would be wearing a surgical mask around them until the risk of infection was gone. We also pointed out that since they had been with Patricio for the past few months, they might be infected. I could see that this was a very frightening thought – it was clear that they had been extremely worried about Patricio as his health deteriorated – and I emphasized that they could be treated to avoid becoming ill. As we had done with Patricio, we explained that the state funded a program to control TB, so they could be treated at no cost. They were all focused on earning as much as possible here to build their futures back home, so avoiding illness was a powerful motivation for them. At the end of the conversation, they all said they were willing to be tested (see 'Contact Investigation', below). Because I was coming to the house for Patricio's Directly Observed Therapy (DOT), first daily and then a few times a week, they eventually became more comfortable around me, and that may have made it easier to accept treatment.

How could we ensure that his treatment would continue uninterrupted when he returned to Mexico? We were particularly worried given that we did not have drug-sensitivity results and this might have been a case of drug resistant or even multi-drug resistant TB.

Aside from Patricio's living arrangements, another challenge to maintaining adequate respiratory precautions came during the rides to the TB program clinic, located in a distant part of the state. I gave Mike instructions on using an N-95 personal respirator, and Patricio had a supply of surgical masks. Mike just joked about getting funny looks when they stopped to get gas, but I think that the six-hour ride wearing a personal respirator must have been the most tedious, if not difficult, part of the case for him.

As soon as I could, I talked to the infection control specialist about Patricio's discharge. I wanted to feel confident that any additional cases of TB disease and any contacts sent for evaluation would be handled appropriately. In a low-incidence state like ours, it is possible that the staff of a local hospital may not be completely familiar with TB infection and disease. The infection control specialist and I arranged to do some in-service training at the hospital to update everyone on procedures for evaluating and treating TB and LTBI patients.

A PATIENT ON THE MOVE

Once Patricio could return to work, I met him in the evenings for twice-weekly DOT. We were still waiting for susceptibility test results, so he continued on a four-drug regimen. Mike was available when Patricio had questions or concerns, such as the Sunday afternoon when the labor contractor Patricio worked with appeared and told him to get ready to go, that he was joining a crew in another part of the state. He immediately called Mike, begging him to call the contractor and explain that Patricio shouldn't leave the area.

We managed to resolve that situation thanks to Mike's quick response, but soon we faced a more serious challenge: Patricio's temporary work visa would expire in several weeks. He told us he thought that the contractor was applying for a visa extension on his behalf, but he didn't know much

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A HISTORY OF MISTRUST: IMMIGRANTS AND *'LA MIGRA'*

In the case described in this issue, Patricio was open to working with his health care team to complete TB treatment but was extremely hesitant to share information regarding his work permit or other aspects of his migration status in the US. This made it more difficult for the team to plan for continuing his treatment as the expiration date on his temporary work visa approached. Patricio's inclination toward silence about anything related to migration may have been hard for the team to comprehend, but it reflected a common sentiment among immigrants and migrants from Latin America, especially from Mexico.

To appreciate Latin Americans' general apprehension about US immigration authorities, it is helpful to understand Mexican perspectives on the United States Border Patrol, colloquially known as 'la migra' in Northern Mexico and among Mexican-Americans.

The Border Patrol

Formally established in the 1920's, the Border Patrol oversees the movement of people and goods across the U.S borders with Canada and Mexico, and constitutes the largest law enforcement body in the US. The Border Patrol reviews the legal status of all tourists, visitors, residents and citizens crossing the border, and apprehends and detains those with no or improper identification and authorization to enter the US. When the Department of Homeland Security was created following September 11, 2001, the Border Patrol became part of the new department and took on greater capacities to detect and prevent the entry of terrorists into the country through the northern and southern borders.[1] Equipped with sophisticated surveillance and tracking equipment for land, sea, and air operations, the Border Patrol may seem more of a military than a police force to people seeking to enter the US for jobs and economic opportunities.

The twentieth century saw a steady increase in the migration of Mexicans into the US labor force, primarily in agriculture throughout the West. At times immigrants from south of the border have been eagerly welcomed, as during World War II when their contribution was critical to the successful expansion of domestic food and industrial production. At other times the government imposed restrictions on legal immigration and the numbers of people trying to cross the border without proper documentation increased.

La Migra in Popular Culture

Since the 1920's Mexicans and Mexican-Americans in the cross-border region have used the popular music style known as *corrido* to recount tales of would-be immigrants caught by *la migra* and sent back to Mexico, to celebrate those who successfully outwitted agents to enter the US, and to criticize Border Patrol activities that Mexicans perceived as abusive, such as the deportation of more than a million people during 'Operation Wetback' in the 1950's. These *corridos* have made *la migra* familiar to all Mexicans and to Central Americans who come to the border region en route to the US. Agents of *la migra* appear in Mexican TV programs, both Mexican and US popular film and political cartoons, and other outlets of Mexican and Mexican-American popular culture.[2] Sometimes comically awkward, sometimes the embodiment of American efficiency, popular portrayals of the Border Patrol agent always retain at least a hint of menace. 'La migra is going to get you!' Mexican parents might threaten their children, admonishing them to behave.[3]

In addition to long-standing mistrust of the Border Patrol, several recent trends, corresponding with an intensification of debate over US immigration policy, may make immigrants and migrants in the US unwilling to draw attention to their migration status in any way. Recent regulatory changes allowing for deportations without judicial review in some areas along the US-Mexican border raised fears that legal immigrants, authorized tourists, refugees, and American citizens stopped in that area may be mistakenly deported to Mexico.[4] Deportations are usually processed through the Immigration and Customs Enforcement (ICE),[5] but many state and local officials have begun to use state and municipal statutes as bases for deporting undocumented foreigners without the involvement of ICE.[6] Hospitals in the United States also take steps to return immigrant patients to their countries of origin, often without the consent of patients or their families.[7] Even people with proper documentation may fear that if they are mistakenly identified as undocumented, they will be removed from the country before they can marshal the resources and expertise to rectify the mistake. A 2007 survey by the PEW Hispanic Center found that many US Hispanics perceive some negative impact from the current debate over immigration and resulting pressures to increase deportations. More than 50% of Hispanics and Hispanic-Americans surveyed reported worrying that they or a loved one may face deportation.[8]

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about it. How could we ensure that his treatment would continue uninterrupted when he returned to Mexico? We were particularly worried given that we did not have drug-sensitivity results and this might have been a case of drug resistant or even multi-drug resistant TB. Patricio did not think he could get medications in Mexico. He said that as far as he knew there were no public health care centers in the rural, isolated region that he lived in, certainly none in his village.

We suggested he be enrolled in the CureTB program, which maintains electronic patient records for enrollees and connects them to TB health care providers in other parts of the US and Mexico. We also offered to write a letter in support of a visa extension, explaining the negative impact of treatment interruption. As comfortable as he was with Mike and me, however, he seemed unwilling to have us intervene in the extension request. The TB control program was exploring options for extending his stay or transferring the case when the sensitivity testing results came back showing that he was pan-sensitive.

The TB consultant adjusted his regimen accordingly, and the TB Control Program enrolled Patricio in CureTB. I would have liked to refer him to a specific doctor in Mexico, but he was not specific about his destination. So with Mike's help, I coached Patricio in how to take the medications correctly, reviewed the side effects to look out for, made sure he had CureTB's phone number and written information sheets related to his treatment. He left shortly after, with a one-month supply of INH, RIF, and PZA. I wasn't expecting to see him again for some time, but in about a month I got a call from him – he had not left the country and I assumed he had received a visa extension. We restarted twice-weekly DOT, and the MHO that Mike worked with gave him a ride to his monthly appointments. Nearly three months later, he told me that he was going back to Mexico shortly. Again, we prepared him for one month of self-administered therapy to complete his prescribed regimen. When Patricio returned at the start of the next harvest season, he was seen in the TB program clinic and was deemed to have completed treatment.

The patients called on 'Miguel' to back them up, and Mike used diplomacy and patience to get the most dubious foreman to agree to release the patients.

THE CONTACTS

Patricio had been sick for some time before he was admitted to the hospital, and especially because he returned to his apartment while he was still infectious, I was determined to see that all his close contacts were properly evaluated. Mike and I spent a long time talking to Patricio's roommates and his landlord a few days after he came home. I explained the role of the health department in treating TB and LTBI, since like Patricio most of them had very little experience with a public health care system. Mike stepped out of the interpreter role, and talked about his own experience becoming infected and undergoing treatment for LTBI several years back. Since, as a member of the MHO, he was a trusted source of information among migrant workers, his own experience did have an impact on them. Having seen the extent of Patricio's illness, they seemed to take the risk of infection seriously. We tested 21 contacts, including his landlord, fellow residents, co-workers, and close social contacts. Fifteen of these had positive TST's, either at initial testing or at retesting several months later. Of those 15, 12 underwent treatment. The TB program and medical consultants weighed the pros and cons of prescribing the more common regimen of INH for 9 months versus a shorter regimen of 4 months of RIF. In the end, they decided on the shorter regimen, given our concern that some patients might return to Mexico before finishing the regimen,

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Brocolli cutter protects himself from sun and dust

ISOLATION OF INDIVIDUALS WITH INFECTIOUS DISEASE

Health care providers may be challenged to provide continuity of care for migrant workers and other temporary residents, whose authorization to stay in the US may expire before a course of treatment is completed. In cases involving some infectious diseases, health care workers can draw on federal and state regulations to ensure that patients remain in their care until any public health risks are eliminated.

- The Centers for Disease Control's Division of Global Migration and Quarantine (DGMQ) is authorized under the Public Health Act to prevent the entry of infectious disease into the US and between states within the country.
- DGMQ's efforts are directed at improving health in border areas and reducing the spread of infectious disease among international travelers, refugees, and immigrants.
- State, local, and tribal governments are authorized to limit the movement of infectious patients within their jurisdiction if necessary to protect the health and welfare of their population.
- In interstate and international cases, state, local, and tribal governments work in cooperation with federal officials.
- Infectious tuberculosis is one disease for which the CDC can act to isolate an ill individual and thus prevent exposure to others.
- Federal isolation of individuals is rare. However, an international travel with drug-resistant TB was placed in isolation in 2007.
- See the CDC/DGMQ fact sheet, 'Legal Authorities for Isolation and Quarantine' for more information on isolation of individuals with infectious disease.

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and that those remaining in the state would be moving among work sites and would be difficult to follow.

Several of the contacts on treatment did, in fact, return to Mexico before completing treatment. The TB control program ascertained that public health programs in Mexico do not offer treatment for LTBI, and we decided to entrust the contacts who were returning home with the remainder of their 4-month supply of RIF. They all carried written instructions for their regimens, and we reviewed the information with them individually as well. I gave each of them my card with the number to contact me when they returned.

For those who stayed in the area, perhaps the greatest challenge was making the long ride to the TB clinic for their monthly check-ups. It meant that they would have to miss a day of work. In addition to their own reluctance to miss a day's pay, some of their foremen questioned why it was necessary. The patients called on 'Miguel' to back them up, and Mike used diplomacy and patience to get the most dubious foreman to agree to release the patients. They usually went together and made the most of the outing, stopping off for an early dinner in a restaurant close to the TB clinic before making the long drive back home. They formed a bond on the trips and if one expressed doubts about completing treatment, the others would encourage him to stick it out. It helped that the TB program doctor spoke Spanish and took his time with the patients, inquiring about their overall health after completing their check-ups and addressing any concerns they had. On the drives, Mike sometimes reminded them that he had been through the experience too, and that he understood both how tiresome it could be and also what motivated them to undergo preventive therapy.

LESSONS LEARNED

Collaborate

We were able to see Patricio through his complete treatment due in large part to an effective collaboration between the health department staff and the Migrant Health Organization, especially Mike. The organization contributed not only Mike's time, but also the use of their vehicles for transportation, which is always a challenge in predominately rural state like ours. Mike not only provided interpreting services but also acted as a liaison between the patients and health department officials, facilitating trust and rapport that was essential to the outcomes we achieved. We also collaborated effectively with CureTB to ensure continuity of care for Patricio upon his return to Mexico.

The Power of Social Support

Mike built on his existing rapport with Patricio to create a supportive relationship that helped Patricio feel confident about his treatment and his providers. When Mike shared his own experience with the LTBI patients, it gave them a human face to connect to the concept of LTBI infection and it helped to create an atmosphere of

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MIGRANT FARM WORKERS AND TB

Forty-two percent of all hired farm workers in the US travel at least 75 miles from their homes to obtain agricultural jobs, and of these, 35% cross an international border for work. Increasingly, international migrants come from the southern states of Mexico rather than from the northern regions along the US border, where centuries of regular cross-border exchange have resulted in some familiarity with US culture and institutions. Migrant farm workers, like others in the agricultural workforce, receive low wages and have limited access to health insurance and health care.[9]

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Picking grapes in Coachella Valley

Compared to the general US population, migrant farm workers are at higher risk for developing tuberculosis. A recent study found a higher prevalence of latent tuberculosis infection (LTBI) among Mexicans and Mexican-Americans than the general US population, and the study also found that poverty is an independent risk factor for LTBI.[10] Thus, ethnicity, country of origin, and socio-economic status contribute to migrants' risk of developing TB. Migrants are also vulnerable to on-going transmission of TB, as well as other communicable diseases, in overcrowded, poorly ventilated worker residences and agricultural processing facilities.[11]

At the same time, unfamiliarity with US institutions, limited English skills, and concerns about revealing immigration status may deter migrants from seeking needed health care while in the US. Other barriers to care include geographic isolation, lack of transportation, and demanding work schedules that allow a minimum of time off for personal needs. Finally, migrants may forgo needed health care because of financial hardship. Even when migrant workers do begin treatment for TB or other diseases, continuity of care is challenging because many workers move over periods of several weeks, following the harvest season from region to region and state to state.[12]

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mutual support for LTBI treatment. Since they started treatment together and went to monthly appointments together, their mutual support grew over time.

Educate Health Care Providers as well as Patients

I was prepared for patients with little or no knowledge of TB and LTBI, and both Mike and I were careful to educate and re-educate, going through each step of our explanations and instructions and getting confirmation that the patients truly understood. I was initially surprised, however, to encounter hospital staff who were not completely familiar with the appropriate procedures for cases of infectious TB and LTBI. But in areas of very low incidence, TB providers may have to be prepared to do some in-service trainings and refreshers for their health care colleagues.

Get to Know Relevant Regulations and Resources

Most providers engaged in TB control are familiar with their state's procedures for ensuring treatment completion and involuntary restraint of persistently non-adherent patients. However, we were initially less aware of the federal government's regulations and procedures to approve or disapprove international travel for TB patients. In addition, over the course of Patricio's treatment I learned about a variety of resources to facilitate continuity of care for TB patients across borders, primarily in the border regions that link the southern US and northern Mexico (see 'Resources for Cross-border Care,' page 7).

Understand the Patients' Perspectives

I also became aware of the migrant

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AGRICULTURAL WORKERS IN THE US AT A GLANCE

In 2001-2002 The US Department of Labor conducted face-to-face interviews with 6,472 workers engaged in the production of agricultural crops for human and animal consumption. The resulting report provides a profile of the hired farm workforce in the US and highlights the important role of migrant workers, predominately from Mexico, in the production of food in the US.

US Hired farm workforce, 2001-2002*

Male	79%
30 years of age or younger	50%
Family income below US poverty guidelines	30%
Mexican-born	75%
US-born	23%
Foreign-born and arrived in the US less than one year ago	16%
No legal authorization to work in US	53%
US citizen	25%
Legal permanent US resident	21%
Temporary or other authorization to work in US	1%
Travel at least 75 miles to obtain farm work (migrant)	42%
Native Spanish speaker	81%
Native English speaker	18%
Unable to speak English at all	44%
Unable to read English at all	53%

*Source: "Findings from the National Agricultural Workers Survey (NAWS) 2001 – 2002: A Demographic and Employment Profile of US Farm Workers." US Department of Labor, Office of the Assistant Secretary for Policy, Office of Programmatic Policy. Washington, DC, 2005.

RESOURCES FOR CROSS-BORDER CARE

The CureTB Program (www.curetb.org) facilitates continuity of care for patients being treated for TB disease when they travel between Mexico and the US. CureTB provides patients with a 'Binational Health Card' specifying their treatment regimen and date of initiation.

The migrant Clinicians' Network (www.migrantclinician.org) developed TBNet to support completion of TB treatment by facilitating referrals and transfer of records to US, Mexican, and Central American providers. Migrating patients enrolled in TBNet can call a toll-free number for help locating a TB provider in a new area.

ADDITIONAL RESOURCES

Prevention and Control of Tuberculosis in Migrant Farm Workers: Recommendations of the Advisory Council for the Elimination of Tuberculosis. Morbidity and Mortality Weekly Reports, June 6, 1992 (RR10)

http://www.ncfh.org National Center for Farmworker Health (NCFH) provides information about farmworker health and services and products available for farmworkers throughout the US. The NCFH's Migrant Health Issues Monograph Series (2001), sponsored by the National Advisory Council on Immigrant Health, is available at this website.

Moua, M. et al, "Immigrant Health: Legal Tools/Legal Barriers," Journal of Law and Medical Ethics. Vol. 30: 3 (supplement) 2002, 189-196.

The CDC Division of Global Migration and Quarantine website, http://www.cdc.gov/ncidod/dq/index.htm, provides information about federal authority and mechanisms to prevent the introduction of infectious agents into the US and limit their spread in the country. Fact sheets on isolation and quarantine are available at this website.

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workers' extreme reluctance to undertake any activities that might draw attention to themselves as temporary workers in this country. Patricio and his fellow farm workers had all heard stories about unannounced visits by agents from U.S.Immigration and Customs Enforcement and felt that legal workers were vulnerable to being mistakenly detained in such raids. It seemed that for all of them, the fear of having their temporary work visas withdrawn for any reason, even because a foreman felt they were troublesome or prone to illness, influenced many of their decisions, including decisions about utilizing health care services. We had to take these fears into consideration in order to provide the best care for Patricio and for his contacts.

NOTES

1 For an overview of the organization and history of the Border Patrol, see the Customs and Border Patrol website: www.cbp.gov

2 Paul Allatson, Key Terms in Latino/a Cultural and Literary Studies. Malden, MA: Blackwell Publishing, 2007.

3 Rafaela Castro, Chicano Folklore: A Guide to the Folktales, Traditions, Rituals, and Religious Practices of Mexican Americans. Oxford: Oxford University Press, 2001; quoted in Allatson, Key Terms, page 44.

4 Rachael Swarns, 'US to Give Border Patrol Agents the Power to Deport Illegal Aliens,' New York Times, August 11, 2004.

5 Immigration and Customs Enforcement, Fact Sheet on Workplace enforcement http://www.ice.gov/pi/news/factsheets/worksite.htm and Office of Detention and Removal Operations Fact Sheet, http://www.ice.gov/pi/news/factsheets/dro110206.htm accessed 5/23/08

6 Damien Ewe, "States Take New Tack on Illegal Immigration," New York Times, June 9, 2008.

7 Deborah Sontag, "Immigrants Facing Deportation by US Hospitals," New York Times, August 3, 2008.

8 PEW Hispanic Center, '2007 National Survey of Latinos. As Illegal Immigration Issue Heats Up, Hispanics Feel a Chill.' Washington DC, December, 2007; pg 23.

9 "Findings from the National Agricultural Workers Survey (NAWS) 2001 – 2002: A Demographic and Employment Profile of US Farm Workers." US Department of Labor, Office of the Assistant Secretary for Policy, Office of Programmatic Policy. Washington, DC, 2005, 7-8.

10 Diane E. Bennett et al., 'Prevalence of Tuberculosis Infection in the US Population: The National health and Nutrition Examination Survey, 1999-2000," American Journal of Respiratory and Critical Care Medicine 2000; 177: 348-355.

11 Alice Larson, 'Environmental and Occupational Safety and Health,' in National Center for Farmworker Health, Migrant Health Issues Monograph Series, 2002.

12 See Jane E. Poss, "Factors Associated with Participation by Mexican Migrant Farmworkers in a Tuberculosis Screening Program," Nursing Research, January/February 2000 vol. 49 no. 1, 20-28.

NEW JERSEY MEDICAL SCHOOL
GLOBAL TUBERCULOSIS INSTITUTE
225 Warren Street, Newark, NJ 07101-1709
(973) 972-3270
www.umdnj.edu/globaltb