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UTILIZATION OF THE LAY/PEER HEALTH MODEL: CULTURALLY SPECIFIC STRATEGIES

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Trained lay/peer health advisors, who are recruited from the community, are effective in promoting healthy behaviors and in reducing barriers to health care for their fellow community members. Lay/ peer health advisors serve as cultural brokers between their peers and local health services agencies. In this role they communicate the health service needs and priorities of community members to health professionals, and they communicate critical health information back to their peers. The Centers for Disease Control and Prevention--National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) presents a discussion of population-specific (Hispanics, Blacks, Asians, and American Indians) peer health projects that have been funded by CDC--NCCDPHP. Panel presentations and audience participation will focus on culturally relevant issues and strategies that are critical to the success of peer health projects among diverse populations. Application has been made for CHES credits.

MORTALITY FROM TUBERCULOSIS BY OCCUPATION, 1985-1991

Ki Moon Bang, Ph.D., M.P.H. and Jay H. Kim, Ph.D.
NIOSH, Morgantown, WV

Tuberculosis (TB) incidence rate increased recently in the United States from 9.3 per 100,000 population in 1985 to 10.5 in 1992, and concern has arisen about elevated risk of TB in various occupational groups. To identify occupational groups at potentially increased risk, we conducted a proportional mortality study of pulmonary TB by occupation. This study used a dataset of over 4.7 million death certificates from 25 states which reported usual industry and occupation codes on death certificates from 1985 to 1991. The 3-digit census occupation codes were evaluated individually. The proportionate mortality ratio (PMR) was age adjusted internally. PMRs were computed by race, sex, and all groups. Occupations with significantly elevated pulmonary TB PMR for all groups included: vehicle washers (PMR=795, 95% confidence interval (CI)=291-1731); crushing/grinding machine operators (PMR=446, CI=122-1142); electric repairmen (PMR=340, CI=110-795), mixing/blending machine operators (PMR=316, CI=102-739); farm workers (PMR=282, CI=181-419); construction laborers (PMR=279, CI=218-352); brickmasons/stonemasons (PMR=271, CI=152-448); housekeepers/butlers (PMR=256, CI=103-528); mining machine operators (PMR=256, CI=173-366); and freight/material handlers (PMR=232, CI=107-441). Many other occupations had elevated risks but small numbers of observed deaths. These findings may be useful for occupationally targeted TB prevention programs and also generating new hypotheses regarding the epidemiology of TB.

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OCCUPATIONAL HEALTH: THE UNEQUAL REALITIES FACED BY PEOPLE OF COLOR

Derrick Hodge, Moderator

Workers of color often face the most hazardous conditions on the job. Consigned to the "back of the house" in hotels, to the blast furnaces in steel mills, to asbestos and lead abatement work, and to clean-up tasks in office buildings, restaurants and factories, disproportionate health outcomes have been revealed: excess cancer in Black women, shortened life expectancy in Black men, high rates of illness among maquiladora workers, high rates of lead poisoning in Hispanic employees, and miscarriages in Asian semiconductor workers. A similar excess "risk-burden" of toxic exposure placed on communities of color has resulted in a powerful movement for environmental equity. The strength of this movement has grown from community based civil rights movements, churches and grassroots activists in conjunction with the national environmental movement. The occupational health movment needs the same drive for justice and equity for better working conditions for people of color. This workshop will explore the extent of the problem, consider lessons from the environmental equity movement, and highlight grassroots campaigns against these unequal risks, with substantial opportunity for audience participation.

REVIEWING THE OPTIONS FOR PREVENTION OF TUBERCULOSIS IN HEALTH CARE WORKERS. Stansbury LG, Swinson AA. Occupational Medical Service, National Institutes of Health, Bethesda, MD 20892

The resurgence of tuberculosis in the US in the wake of the HIV epidemic and the collapse of public health funding requires a review of preventive strategies for health care workers. Historically, the debate on prevention has split along primary/secondary lines on the basis of 1) calculation of the infectiousness of TB and 2) understanding of the efficacy of available measures. Understanding this debate is critical to clear thinking about the future of prevention: key sources from the first three decades of TB treatment which frame this debate are reviewed. However, future research and practice must take a changing experience into account: review of the last fifteen years of the epidemiology, treatment and prevention of TB in the US and other industrial societies suggests an increased role for primary prevention strategies, most particularly in health care workers, and an urgent need for new treatment capabilities.

RACIAL AND ETHNIC HARASSMENT AT WORK

Anthony Bale, Ph.D., MPH

Although sexual harassment at work is beginning to be recognized as an occupational health problem, little attention has been paid to the health consequences of work-related harassment on the basis of race and ethnicity. With this work I attempt to introduce racial and ethnic harassment as a subject for occupational health research and practice. It draws upon the extensive critical inquiry into the connection between racial and ethnic harassment, work, indignities and emotional distress constituted by reported appellate decisions involving several types of torts, Title VII civil rights claims, workers' compensation cases, and other types of legal decisions. Using this material, it is possible to generate a picture of different types and circumstances of harassment, employers' legal responsibility and fault, the types of emotional and dignitary injuries to workers, prospects for compensation, sometimes involving large financial awards, and pathways to prevention.

OCCUPATIONAL EXPOSURE TO TUBERCULOSIS: THE NEW YORK CITY EXPERIENCE

With over 200,000 health care workers and one of the highest rates of MDR-TB in the nation, NYC is at the center of the epidemic. In the past, OSHA, and the New York State Public Employee Safety and Health Program (PESH) have issued enforcement guidelines for controlling TB in the workplace. This panel will examine the impact of these enforcement guidelines on both health care and non-health care worksites. The panel will include presentations on the following topics:

Overview of OSHA and PESH Guidelines: Content and Conflicts
Presenter: **Deborah Nagin, New York State Department of Health**

Impact of OSHA Regulation in Health Care: Review of OSHA Enforcement in NYC Hospitals
Presenter: TBA

Impact of OSHA Regulation in Non-Health Care Settings
Presenter: **Susan Klitzman, New York City Department of Health**

Labor/Occupational Health Perspective on Enforcement of TB Guidelines and Beyond
Presenter: **Laura Kenny, Service Employees International Union**

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PREVENTION OF OCCUPATIONAL TUBERCULOSIS: OSHA'S COMPLIANCE EXPERIENCE

Melissa McDiarmid, MD, MPH, Jonathan A. Patz, MD, MPH, Vanessa Holland, MD, MPH, Michael Montopoli, MD, MPH, Angela Presson, MD, MPH

In May of 1992, the Occupational Safety and Health Administration (OSHA) issued guidance to protect workers from tuberculosis in the region covering New York and New Jersey, the focus of a national epidemic. Following this action and responding to the increasing risk of TB exposure in the workplace nationwide, in October 1993, OSHA issued guidelines to protect health care workers from exposures in high-risk settings such as health care facilities, long-term care facilities, correctional institutions, drug treatment centers, and homeless shelters. The principal elements of a worker protection program are: 1) administrative controls, including the early identification and isolation of TB cases, worker training regarding hazards and control of TB, and medical surveillance via tuberculin skin testing; 2) engineering controls, such as negative pressure isolation rooms; and 3) use of personal protective equipment (utilizing HEPA respirators) as part of a worker respiratory protection program. To date OSHA has completed over 40 worksite inspections. Resulting citations primarily stemmed from insufficient employee medical surveillance programs or failure to record tuberculin skin test conversions, inadequate respiratory isolation for infectious patients, and inadequate respiratory protection programs. These findings combined with an update of the compliance experience regarding TB inspections, and the rationale for exposure control and abatement methods will be described.

CONTROL OF TB EXPOSURE IN DC METRO HEALTHCARE FACILITIES

Philip Hagan, MPH, CIH, CHMM, CET, RHSP
Patrick Lorimer, MPH

Objective: The purpose of this descriptive study was to identify and summarize the extent of actual engineering, administrative, and respiratory protective measures that have been incorporated into use by area healthcare facilities to comply with OSHA and CDC proposed guidelines in controlling nosocomial transmission of *Mycobacterium tuberculosis*.

Methods: Telephone interview, physical inspection, and data gathered from a questionnaire were used as sources of information.

Results: The use of engineering, administrative, and respiratory protective measures varied considerably between the healthcare institutions who participated in the study.

Conclusion: The financial burden for instituting these measures appeared to be the limiting factor in achieving compliance.

ABSTRACTS

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