An analysis of one hundred-one Fulton County D. P. W. Cases in which some member of the family group with diagnosis of active tuberculosis was under care of Fulton County Health Department as of October 1, 1947

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Atlanta University
AN ANALYSIS OF ONE HUNDRED-ONE FULTON COUNTY D. P. W. CASES IN WHICH SOME MEMBER OF THE FAMILY GROUP WITH DIAGNOSIS OF ACTIVE TUBERCULOSIS WAS UNDER CARE OF FULTON COUNTY HEALTH DEPARTMENT AS OF OCTOBER 1, 1947

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BY
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CHAPTER I

INTRODUCTION

Tuberculosis, Phthisis, Consumption, or Hectic Fever are a few of the names given to the disease which Robert Koch in 1882 discovered was caused by a germ called the tubercle bacillus. This germ may attack any organ in the body, but the lungs are most frequently affected. This study will deal with patients suffering with tuberculosis of the lungs.

Though many agencies and private individuals have worked long and ardously to combat the spread of the disease, there are still about 60,000 deaths caused by tuberculosis each year.\(^1\)

Because of the stigma which has been attached to tuberculosis through the years, prevention has been generally obscured until very recent times. Doctor Biggs, in his report to the New York City Board of Health in 1895, pioneered in laying the groundwork for preventive programs when he secured the reporting of known cases of tuberculosis in that city.\(^2\)

Such organizations as the National Tuberculosis Association of which the Atlanta Association is a local, and which sponsored this study, were the outgrowths of the efforts of Doctor Herman Biggs, Doctor Flick, and Henry Phipps, who were among the first to be interested in the prevention and control of this disease.

Purpose of the Study

This study is designed to show the relationship of poverty and its

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\(^1\)Tuberculosis (Metropolitan Life Insurance Company Publication), Metropolitan Life Insurance Company Press, 1946, p. 2.

attendant factor of poor diet, inadequate housing, low income, and un-
hygienic conditions to the incidence of tuberculosis among the white and
Negro clients who have received, or are receiving public assistance as
of October 1, 1947. It is being made with the cooperation of the Fulton
County Department of Public Welfare.

In sponsoring this study, the Patient Service Division of the Atlanta
Tuberculosis Association aims to point out the need for public assistance
for indigent families, where there is a tuberculous member, in an effort
to curb the increasing number of tuberculosis cases in this area.

Public assistance is not to be presented as a curative measure, but
as an important factor in preventing serious breakdowns in the family struc-
ture. It is to be looked upon as a means to insuring a degree of stability
for the family, both economically and emotionally, since an individual's
emotional ills are often directly related to his economic problems.

Scope and Limitations

This study is limited to the patients of the Fulton County Health De-
partment, who were receiving relief as of October 1, 1947, or whose families
had been known to that agency. It is not confined to any racial group, but
is the combined total of Negro and white patients in Fulton County. Patients
living within the city limits of Atlanta are excluded, as there is another
similar study being made of the Atlanta area. The patients studied compris-
ed the entire case load of the known tuberculous clients in the agency as of
October 1, 1947.

Method of Procedure

Case material was used from the files of the Fulton County Welfare De-
partment. In order to identify the tuberculous patient, the card files on active tuberculosis patients at Fulton Clinic were consulted.

By the use of a schedule, the data was collected and used in charts and tables illustrated in the study.

Location of the tuberculosis cases will be known on a map of Fulton County, in order to indicate in which areas there is greatest concentration of active cases known to the Health Division.
CHAPTER II

PROGRAMS FOR THE CONTROL OF TUBERCULOSIS

For many centuries "The Great White Plague", or "The Captain of the Men of Death", as tuberculosis was called to express the great toll of lives taken by it, presented a stubborn problem which baffled the scientists and medical men, as to the origin of the disease. With little or no knowledge of the origin, it was practically impossible to check the spread of this dreaded malady.

Tuberculosis is an infectious, communicable disease caused by the tubercle bacillus (discovered by Robert Koch in 1882). The bacillus induces the formation of tubercules which grow in size through continued action of the organisms. In pulmonary tuberculosis, usually these tubercles tend to soften, breakdown, and are expelled, leaving behind an ulcer or a cavity. General symptoms are indigestion, constant loss of weight, rise in body temperature, poor appetite, and a tired feeling, "all over". More definite indications are lingering coughs, spitting of blood, pains in the chest, and "night sweats". Since these symptoms appear sometimes months after infection, there may be considerable damage to the lungs when they are recognized.

With modern diagnostic methods, X-ray, tuberculin tests fluoroscopy, the sputum examination, and bronchoscopy, there is a possibility of clearing up every suspected case of tuberculosis, through early recognition of the condition. Present day examinations when skillfully done cause but little discomfort to a patient; and he benefits by having a prompt and correct diagnosis so that treatment may be undertaken early enough to be effective.
In the development of tuberculosis, infection is the greatest factor to be reckoned with. The disease is usually the result of intimate, massive exposure, the rate of infection varying directly with the degree of exposure. Infection may result from any number of methods of contact, some of the most common being as follows:

1. Through germ-laden droplets or sputum discharged from the lungs of a person who has active tuberculosis.

2. Through kissing.

3. Through dust containing tuberculosis germs.

4. Through objects of common use, such as water glasses, dishes, eating utensils, or bed linen.

5. Through milk.¹

To check the spread of infection and thus prevent and control tuberculosis, the education of the public is being carried on by the National Tuberculosis Association, and its approximately 2,900 affiliated state and local associations. Anti-tuberculosis organizations in the United States were formed to unite into a body the groups and individuals interested in the subject; and to develop programs to embrace the public health department, municipal, county and state, (the control of tuberculosis being an official function).

In a good program for the control of tuberculosis, planning and growth are the outstanding components.² The program should be administered by the state health department. The intensive work in the field should be done by the local health officer. The state department should cooperate

¹Tuberculosis (Metropolitan Life Insurance Company Publication), Metropolitan Life Insurance Company Press, 1946, p. 2.
with him by providing laboratory and clinic services. The local physicians will work with the health officer so that case finding and reporting, and periodic, systematic examinations of contacts may be made, if control is to be a reality.

The purpose of the anti-tuberculosis agencies whether public or private may be summarized as follows:

1. To prevent and control mass infection from tuberculosis.

2. To discover, as far as possible, all cases of tuberculosis in each community.

3. To provide adequate treatment for all ages, with a view of restoring as many persons as possible to normal community life.

4. To create through popular education, a health consciousness in the community so that the support of the public for programs of anti-tuberculosis work may be forthcoming.

5. To study the manifestations of tuberculosis in the individual and the community in order to furnish the necessary knowledge on which sound programs may be built.

6. To organize community activity, local, state and national, furtherance of these aims and purposes.¹

The financing of agencies carrying on programs for the control of tuberculosis varied according to the type of agency. The state tuberculosis control units of which the county division was a part, got its funds from taxes, federal, state and local. This money was granted through appropriations made specifically for the development of such programs. Funds were made available for research, education services, the operation of clinics and sanatoria, and other services necessary for an adequate program in each locality.

The National Tuberculosis Association, a voluntary agency, and its local affiliates, secured the bulk of their funds from the annual sale of Christmas seals which became community projects for the local associations. The first years' problems of organization and finance proved that membership fees and donations could not meet the needs of the associations.

Since 1910 the Christmas Seal Sale had been the method used for the support of local, state and national associations. Other private agencies, hospitals, preventoria, sanatoria and clinics, had been supported by means other than the seal sale. In some area community chests helped to support such institutions; in others, public funds were granted.\textsuperscript{1} The increasing number of public institutions had tended to reduce the number of charitable and semi-private institutions. More and more the control of tuberculosis was becoming a public health program; and more and more the official agency was assuming the responsibility for controlling the disease.

\textsuperscript{1}Ibid., p. 453.
The Atlanta Tuberculosis Association was founded in 1907 by the Associated Charities, Atlanta, Georgia. In 1909, it was organized as the Atlanta Anti-Tuberculosis and Visiting Nurses Association. In 1933, the name was changed to that which it bears today.

The association operated under a constitution and by-laws which stated its purpose, eligibility to membership, the responsibilities of the board of directors, and the existence of a Negro branch. The administrative functions were the responsibility of the executive secretary, who was employed by the executive committee of the board, and who was paid out of the agency's funds.¹

The purpose of the association was similar to that of the National Association, and was subject to the supervision of the Georgia Tuberculosis Association. Finances for the support of the program were derived from the annual Christmas Seal Sale, the Community Chest, city and county taxes, and from gifts and donations.

For many years, the Atlanta Tuberculosis Association assumed complete responsibility for the tuberculous patients in this area. With the growing recognition of the tuberculosis problem as one which could not be successfully handled by a single agency, the Fulton County Health Department in 1940 added a tuberculosis program.

¹Atlanta Tuberculosis Association, "Constitution and By-Laws" (Atlanta: Atlanta Tuberculosis Association, 1943), pp. 82-8.
Whenever an adult is ill, his chief concerns are restoration of his working capacity, and his ability to meet his financial obligations. If he has any funds, he does not wish to exhaust them, if he is poor he may have some feelings about accepting care from relief or charitable organizations. These things are especially true when tuberculosis attacks one.

Out of the individual's desire for financial independence, the possibility of having to accept a position of dependence, hospitalization, deprivation, and special assistance, has come a special service for tuberculous patients. The Patient Services Unit of the Association. This division employed the services of trained social workers who helped the patient and his family in making the necessary adjustments; and who served as coordinators in helping the families to utilize advantageously, the services of the agencies cooperating to make the tuberculosis control program effective.

Though an official, voluntary agency, the Atlanta Tuberculosis Association functioned for many years as the only agency with an anti-tuberculosis program in this area. The value of the services rendered by it cannot be overestimated.

Fulton County Health Department

In the state of Georgia, there had been an attempt in 1875 to create a State Board of Health. The failure of the legislature to appropriate funds for its operation in 1877, left the state with no department for twenty-three years. In 1903, the second State Board of Health was organized under an act of the Legislature; it has continued in operation up to now.
In 1914, with the passage of the Ellis Health Law, there was created a board of health in every county in the state. This law provided for the employment of a full-time county officer upon two successive recommendations of the grand jury.\(^1\) Thus was created the necessary legislation for the establishing of the Fulton County Health Department.

As this study dealt with tuberculosis solely, attention was focused upon that phase of the Department's program. No attempt was made to describe the numerous health services provided throughout Fulton County for other diseases and conditions.

The tuberculosis control program was organized in 1940. During this year there was rapid development on a sound medical and nursing basis. Health centers were established throughout the county, also, responsibility for home nursing and case finding services were taken in Old Campbell and Old Milton Counties, which had been incorporated into Fulton County.

In 1941, home nursing services and case findings were extended into the Sandy Springs area. By January 1, 1942, the Health Department had responsibility for the tuberculosis program throughout the entire county.\(^2\)

The local voluntary agency which had done tuberculosis work no record of reported cases, and very little knowledge regarding their patients, which could be helpful in determining how many cases of tuberculosis there were in the county. The nurses were able to gather and compile sufficient data to start a registry in 1941, after careful study and considerable time spent in the collection of materials.\(^3\)

\(^1\)State of Georgia Department of Public Health, Annual Report 1944 (Atlanta, Georgia, 1945), p. 10.

\(^2\)"Tuberculosis In a Generalized Health Program" (Atlanta, Georgia, Fulton County Health Department, 1946), p. 15 (Mimeoographed)

\(^3\)Ibid.
Another phase of the program, case finding, involved the greatest effort, amount of time, and expense.¹ For the most effective results, a portable machine was purchased, which could be used to make 14 x 17 flat plates or 35 mm photofluorographic films. The machine was being used at each of the seventeen health centers, once monthly at the small centers, and twice monthly at large centers. It was also used for special groups such as schools and industrial plants. Contacts of known cases were filmed, also requests were filled from agencies in the community, any individual, and any patient recovering from a recent illness.²

All reported studies show that the largest number of clinically active tuberculosis cases were to be found among household contacts of cases.

Fulton County, therefore, established a policy of examining all contacts in white households at six-months intervals, and contacts in Negro households at three-months intervals.³

It should be mentioned that the policy of the Fulton County Health Department in tuberculosis control was the same for both Negroes and whites; the Health Centers were operated so as to give clinic days for both races.⁴ X-ray service was available at the 117 Mitchell Street Central Clinic on each Monday and Friday. The large centers had two X-ray clinics each month, managing about 120 appointments at each clinic, while the smaller centers had monthly schedules, and gave approximately thirty appointments.

¹Ibid.
²Ibid.
³Ibid.
⁴Interview with Mrs. Taylor (Fulton County Health Department, Atlanta, Georgia, April 5, 1948).
Tuberculin tests were made on children of one, three, and five years of age. Those with positive reactions received special study.

A final but important service to be mentioned here was home visits. On request of the physicians, receipt of a written request from a hospital or clinic, home visits were made. Diagnosed cases, suspects and contacts, patients who needed sputum examinations were visited. The staff attended to patients receiving pneumothorax refills, those making final application or arrangements for sanatorium care, and patients who have returned from the sanatorium.

This information gave evidence that the Fulton County Tuberculosis Central Division offered a general health program which called for intensive work in the discovery, reporting, and follow-up of tuberculous patients. Since its organization in 1940, there has been great improvement in the general health in this area, and a noticeable decrease in the death rate from tuberculosis.

Fulton County Department
Of Public Welfare

Though there was evidence of a public welfare program in Fulton County in the early 1930's, the Department of Public Welfare as it existed was organized in 1937. It was a unit of the Georgia Department of Public Welfare which was created in July 1937, through the passage of six legislative acts signed by E. D. Rivers, the governor.

It was essential that a state agency be created with sufficient authority to deal for the entire state with Federal agencies having funds available, since the latter were prohibited from dealing directly with the counties. It was essential, too, under Federal rules and regulations
that the services offered to any part of the state should be available equally in every county. The Department for each county was to consist of a board of five members, a director, and such other personnel as was necessary to the functioning of the Department.  

The Board members served without compensation; meetings were held regularly on the third Thursday of each month. The Board named the administrator of the Department, who had to be certified according to the regulations of the State Merit System.

The Fulton County Department was housed at 160 Pryor Street, S. W. in Atlanta. The organization was planned so as to handle direct contacts with the clients, and to provide services necessary for the operation of the Department. The programs for which it was responsible were: (1) General Assistance, (2) The Children's Division; (3) Old Age Assistance; (4) Aid to Dependent Children; and (5) Aid to the Blind.

**Intake.**—First contact was made with the applicant for assistance, there were separate sections for white and colored. Here the applicant was interviewed, temporary emergency assistance could be granted, assignments were made to the districts for handling necessary investigations.

**District.**—Workers in this unit completed initial and special investigations, made decisions on rejections of applications or continuation of grant, made recurrent reviews, transferred cases, closed cases, and made final certification to the State Department on accepted Special Assistance cases.

**Children's Division.**—This department was responsible for the ac-
ceptance of all children committed to it by the Juvenile Court of Fulton County. Other responsibilities were, the placement of children in approved foster homes or institutions, investigating and reporting to the Superior Courts on all petitions filed for adoption of children, and the certification of children eligible for Crippled Children Services.

Registration.— This section handled the clearance of all forms on new cases through its own master index and the Social Service Index, as well as with other agencies and other departments. It kept a register of each case, and a filing system on all closed cases.

Accounting Department.— All financial matters of the Department were handled by this unit.

Clerical and Typist Divisions.— These took care of all correspondence for the supervisors and case workers, the filing of records, and the preparation of special reports on cases.¹

The Department operated under the State Merit System regulations. Since 1941, all positions have been filled from the register of the Merit Council. Salary scales were set by the council. In recent years, the County Department has found it necessary to supplement the amounts in order to obtain better trained personnel.

An educational feature of the Department was the Student Division, in which students from the Atlanta University School of Social Work receive field work training in the handling of case loads, intake procedures, and some clerical experience. The supervisor of this unit was employed by Atlanta University. Because of this advantage of having a faculty mem-

ber of the school in the Department, case material for this study was
supplied, even though it necessitated additional work on the part of the
clerical staff.

The full cooperation of a public welfare agency with the health de-
partment and other agencies in a tuberculosis control program cannot be
over emphasized. In recent years the Fulton County Department of Public
Welfare has been requested to assume more responsibility for tuberculous
patients, as care for them was not included in the program of other social
agencies, i.e., Family Welfare, which cannot plan for long-term illnesses
in the family. Evidence of the role which the Department of Public Wel-
fare has taken was shown by the fact that all individuals used for this
study had at some time been known to this agency.
CHAPTER IV

AN ANALYSIS OF THE PATIENTS STUDIED

The patients used for this study comprised a group of active tuberculous who were known to the county welfare agency. This group may not be used for drawing any conclusions as to race, sex, age, educational status, economic status, due to the limitations imposed by the study. Rather, it only gives an index to the circumstances surrounding these persons, in the specific area, who shared two common factors, namely: poverty and illness.

Of the one hundred and one patients whose families were public assistance recipients, the clerks were unable to locate or to identify fourteen of them. Though the Health and Welfare Departments recognized the existence of these patients, the study could only include information from those which were available.

Race

Race has often been cited as one of the principal factors in the incidence of tuberculosis. Whether the high rate in the Negro group was the result of race was questionable. It was true, however, that among Negroes there was greater tendency to overcrowding, low-income, and limited education, which were great aids to the rapid spread of the disease. How much was due to racial susceptibility and how much to social and economic factors was hard to determine.¹

Of the eighty-seven individuals, sixty-two or about seventy-five

¹Chadwick and Pope, op. cit., p. 27.
percent were white, while twenty-three or less than twenty-five percent were Negroes. The great difference shown by these figures was due to the small number of Negroes living in Fulton County, outside of Metropolitan Atlanta.

Sex and Age

The rate of infection in tuberculosis rose from birth to adult life. For the first three years of life, the incidences were relatively small; between three and twelve years of age, it was at the lowest of any age group.

Although the rate of infection in boys and girls is equal throughout the age period five to nineteen, the incidence of disease, and apparently the susceptibility to disease, is consistently higher among girls. This is especially marked in the fifteen to nineteen age group, and in our experience girls developed tuberculosis some three years earlier than boys.¹

In adolescence, the disease becomes a menacing problem, and in women it reached its crest in the group between twenty and twenty-four years. So much had been said about tuberculosis as a disease of girls and young women that its ranges upon men had not been sufficiently recognized.

As a result of the more rapid decline of tuberculosis in this country there are today 156 deaths among males to every 100 deaths in females, and only at the ages ten to thirty is the mortality higher in females. Tuberculosis is increasingly becoming a disease of older, occupied men.²

Of the number of patients in this study forty-nine were males and thirty-eight were females. Fifty-eight of the individuals held the position of head of the household, of these, forty-six were males and

twelve females. The remaining twenty-nine consisted of twenty women, who were housewives, eight patients, who were children of the relief recipients, and one person, who was a relative of the Public Welfare client.

The following table shows the distribution of patients according to race, age and sex.

Table 1

<table>
<thead>
<tr>
<th>Race, Age and Sex Distribution of Patients</th>
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<tbody>
<tr>
<td>Total</td>
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<tr>
<td>-------</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>8</td>
</tr>
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</tr>
<tr>
<td>8</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>4</td>
</tr>
</tbody>
</table>

It was shown that the greatest number of men had active tuberculosis between the 30-34 and 55-59 age ranges. These figures offered proof of the necessity for seeking aid in welfare agencies, because between these ages the male was attempting to support a family, usually having to assume full responsibility.
Place of Birth

It is significant to note the comparatively small number of these patients who were born in Fulton County. The social histories revealed that out of the eighty-seven, only eighteen were born in Fulton County, while forty-four were born in other sections of Georgia. There were eleven whose birthplaces were given as outside of state, Mississippi, South Carolina, Alabama, and Tennessee being named most frequently. For thirteen of the patients, no name of the place of birth was indicated. There was one person whose former home was given as the British West Indies.

Marital Status

That marital status had any relationship to the incidence of tuberculosis was questionable. Young women in the early child bearing period were exposed to greater risks than the single women, but the question of susceptibility remained unsettled.

In this group there were sixty who were married, thirteen single, five separated, two divorced and seven widowed. Only two, a boy nine years of age and a girl of fourteen had not reached the legal age to enter into marriage.

Of the sixty who were married, there were two families in which both the husband and wife were tuberculous, one was white and the other Negro.

The marital status of the patients is shown in Table 2 below:
Table 2

MARITAL STATUS OF THE PATIENTS

<table>
<thead>
<tr>
<th></th>
<th>Married</th>
<th>Single</th>
<th>Separated</th>
<th>Widowed</th>
<th>Divorced</th>
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<tr>
<td>Total</td>
<td>61</td>
<td>13</td>
<td>5</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Male</td>
<td>39</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Female</td>
<td>22</td>
<td>3</td>
<td>5</td>
<td>7</td>
<td>2</td>
</tr>
</tbody>
</table>

Occupational Status and Monthly Income

In view of the fact that the records used for this study were those of public assistance cases, there was practically no income in the families studied other than the Department of Public Welfare grants. The same held true in the case of occupations. When the individual was approved for assistance, he was required to present a medical statement showing that he was unemployed or had limited capacities. With the exception of sixteen cases, all of the clients studied were unemployed.

Of the sixteen, one was a laborer earning approximately $40.00 per month, two were students in school, one was a domestic worker who earned about $55.00 per month, another was a sawmill worker whose income was not given. The remainder did not engage in any kind of work outside of their homes.

According to the work histories, many had been gainfully employed at one time or other. Occupations listed were: textile workers, carpenters, mechanics, farmers, machinists, domestic servants, food handlers, night watchman, peddlers, seamstresses, and electrician. Two male clients had
served in the armed forces for brief periods of time.

In only three cases, that of a Negro laborer, a maid, and a white sawmill worker were there records of patients returning to work.

It is fitting to indicate here that these records were kept for the purposes of the Welfare rather than Health Department, therefore, much information dealing with health was omitted from the recording. In addition, some of the individuals were known to the Department of Public Welfare only during the Work Progress Administration Program, and had not had active cases in the Department since the onset of the present illness.

Previous Assistance Record

If poverty was to be considered as a factor directly related to the incidence of tuberculosis, this section would have given some proof to substantiate the belief. It was significant to note that fifty-five or about seventy-two percent of these cases showed that the families had been known to relief agencies for many years, some dating back to Federal Emergency Relief Administration. Only twenty-eight had no previous experience with agencies, while in four cases there was no information given.

Among the private agencies which were frequently listed as assisting these patients were: American Red Cross, Family Welfare Society, Child Welfare, and various church and fraternal organizations.

As of the date of the study there were twenty-nine families receiving grants, nine individuals receiving sanatorium care, one case had been transferred, one cancelled, or rejected, forty-five closed, and one applicant withdrew his application.

In Table 4, the period for which the family had received help was
shown, also the status of the case (if not active).

Size of Family

The largest family group found in the records studied consisted of ten members. The next highest was eight, several families had seven members. There were ten individuals who did not belong to a family group.

The size of the family could well be used as an indicator in public welfare for both need and the amount of the grant. (Shown in Table 3). In the discussion of sex and age, it was pointed out that fifty-eight of the patients were heads of their families. With the head of the house incapacitated, where there are from two or three to ten members, need becomes evident. Also, where the family was large, there was danger of other members becoming infected, if nothing was done to assist the family in meeting economic and social needs.
### Table 3

**TYPE AND SIZE OF PUBLIC ASSISTANCE GRANTED**
**ACCORDING TO SIZE OF FAMILY**

<table>
<thead>
<tr>
<th>Number in Family</th>
<th>Type of Grant Received</th>
<th>Amount of Grant</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Aid to Dependent Children</td>
<td>$85.50</td>
</tr>
<tr>
<td>6</td>
<td>&quot;</td>
<td>69.00</td>
</tr>
<tr>
<td>5</td>
<td>&quot;</td>
<td>54.00</td>
</tr>
<tr>
<td>10</td>
<td>&quot;</td>
<td>64.00</td>
</tr>
<tr>
<td>3</td>
<td>&quot;</td>
<td>39.00</td>
</tr>
<tr>
<td>3</td>
<td>&quot;</td>
<td>39.00</td>
</tr>
<tr>
<td>4</td>
<td>&quot;</td>
<td>24.00</td>
</tr>
<tr>
<td>6</td>
<td>&quot;</td>
<td>19.50</td>
</tr>
<tr>
<td>4</td>
<td>Old Age Assistance</td>
<td>45.00</td>
</tr>
<tr>
<td>6</td>
<td>&quot;</td>
<td>45.00</td>
</tr>
<tr>
<td>3</td>
<td>&quot;</td>
<td>37.50</td>
</tr>
<tr>
<td>6</td>
<td>&quot;</td>
<td>32.50</td>
</tr>
<tr>
<td>3</td>
<td>&quot;</td>
<td>36.50</td>
</tr>
<tr>
<td>1</td>
<td>&quot;</td>
<td>28.00</td>
</tr>
<tr>
<td>4</td>
<td>&quot;</td>
<td>27.00</td>
</tr>
<tr>
<td>2</td>
<td>&quot;</td>
<td>16.50</td>
</tr>
<tr>
<td>4</td>
<td>Direct Relief</td>
<td>43.92</td>
</tr>
<tr>
<td>4</td>
<td>&quot;</td>
<td>15.80</td>
</tr>
<tr>
<td>3</td>
<td>&quot;</td>
<td>15.64</td>
</tr>
<tr>
<td>1</td>
<td>&quot;</td>
<td>14.64</td>
</tr>
</tbody>
</table>

In a study made by Twinam, the Clinician in the Berkshire Project, it was brought out that one-third of the new cases arising in a rural community could be traced to a source of infection in the family.2

**Clinical and Sanatorium Experience**

Clinical.— In the treatment of tuberculosis, two factors are important for checking the spread of infection, and the subsequent restoration of the

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1 State of Massachusetts, Berkshire County.
2 Chadwick and Pope, op. cit., p. 96.
individual to normal activity. These factors are early discovery of the
disease and proper treatment. To carry on the necessary operations for
discovery and effective treatment, the well staffed, conveniently located
clinic was a necessity. The clinic and consultation services should be
the main areas for the attack on tuberculosis.

There is no standard treatment for tuberculosis; judgment of need for
treatment is an individual problem. In a pamphlet issued by the National
Tuberculosis Association in 1940, tuberculosis cases were divided into
three classes based upon need. These were as follows:

1. Those with lesions, healed beyond doubt, and therefore not
in need of treatment.

2. Those with lesions which are actually or potentially unstable
and therefore in need of treatment.

3. Those with lesions of questionable status, and therefore in
need of further observations.1

The diagnostic status of the patients used for this study, as was
shown by the title, was active tuberculosis hence all patients should have
received some kind of treatment.

As is indicated on a map of Fulton County (Figure 1), there were
seventeen clinics at which treatment for tuberculous patients were given.
These clinics were conveniently located, and as has been stated, served
both Negroes and whites.

Patients who were diagnosed before the establishment of the tuber-
culosi control unit in the County Health Department, were treated at the
Atlanta Tuberculosis Association Clinic. There were thirty individuals

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1National Tuberculosis Association, Diagnostic Standards and Classifi-
cation of Tuberculosis (New York: National Tuberculosis Association, 1940),
p. 22.
of the eighty-seven used in this study whose first clinical experience was at the Atlanta Tuberculosis Association Clinic.

As of the date of this study, the distribution of patients at the Fulton Clinics were as follows: Central Clinic, 117 Mitchell Street, S.W., three patients; East Point, seven; Center Hill, three; College Park, four; Fairburn, three; Palmetto, three; Rockdale, three; Bankhead, one; Howell, Mill, one; Ben Hill, one; Hapeville, two; Roswell, two; and for ten of the patients, the exact location of the clinics attended was not specified.

Not all the patients studied received care at a clinic, there were six who preferred to use their own private physicians, four who refused clinic services, and twenty-two for whom there was nothing in the recordings to indicate whether they were known to any clinic. Four of the patients had died before the study was made.

Sanatorium.-- An important question which arises when planning a tuberculosis control program is what are the facilities for isolation of the patient.

Since 1946, with the closing of Battle Hill Sanitorium, which was located in Atlanta, Fulton County had been without a sanitorium in which tuberculous patients could be isolated. Therefore, all patients who were diagnosed and whose prognosis warranted hospitalization were sent to the State Hospital, Battey, at Rome, Georgia. Patients whose conditions were termed too far advanced, were not admitted, and had to remain at home.

Due to the shortage of beds, the patients who were accepted for hospitalization, were placed on the waiting list, and had to frequently wait.

for long periods of time, before beds were available.

The need for sanatoria was expressed in the Annual Report of the State Public Health Department for 1944.

It is hoped, that an expansion of hospital and sanatorium facilities can be brought about so that the terrible need of hospitalization for tuberculous patients requiring it may be met.¹

As this study comprised the Department of Public Welfare's entire case load of active tuberculous patients, who lived outside Atlanta, in Fulton County, there was no definite period of time used to designate the beginning of contacts with the welfare or health department. Therefore, in giving information on the number of patients who had received hospital care, this study included experiences at Battle Hill, Alto, Grady Hospital, and Battey.

Table 4

**DISTRIBUTION OF PATIENTS ACCORDING TO PERIOD OF ILLNESS AND LENGTH OF TIME FAMILY HAD RECEIVED ASSISTANCE**

<table>
<thead>
<tr>
<th>Period in Years</th>
<th>Number of Illnesses</th>
<th>Number Received Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3</td>
<td>33</td>
<td>46</td>
</tr>
<tr>
<td>4-6</td>
<td>22</td>
<td>7</td>
</tr>
<tr>
<td>7-9</td>
<td>13</td>
<td>4</td>
</tr>
<tr>
<td>10-12</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>13-15</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>16-18</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>19 and above</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Not given</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Cases closed or rejected</td>
<td>0</td>
<td>27</td>
</tr>
</tbody>
</table>

There were thirty white patients and six Negroes who were admitted to the sanatorium for treatment; eight whites refused care, as did four Negroes. Hospitalization was not recommended for seven whites and one Negro, the condition of these patients was too far advanced to warrant it. According to the records, there were eight whites and five Negroes who never got to the sanitorium for some reason or other; and sixteen whites and six Negroes for whom absolutely no information was given concerning hospital care in the case records.
CHAPTER V

SOCIO-ECONOMIC FACTORS IN TUBERCULOSIS

Chadwick and Pope, in their book, "The Modern Attack on Tuberculosis" stated that before planning a campaign to eradicate tuberculosis, that special hazards should be considered. Among the items listed as special hazards were social and economic conditions.

Low economic level and density of population are recognized environmental factors in the incidence of tuberculosis. So closely related are these conditions growing out of the environment to those termed social, it is difficult to discuss them separately.

It has already been shown that the majority of these patients, before coming to the Department of Public Welfare, were practically poverty stricken. Educational standards for this group were extremely low. It was fitting to assume, therefore, that out of the combined forces of poverty and lack of education, there had evolved a chain of factors, which could be called contributing factors to the incidence of tuberculosis among these persons comprising the study.

The Importance of Housing

Overcrowding and congestion were aids to the spread of tuberculosis infection.

In most rural areas, the problem of housing has proven a stubborn one. By and large, the houses are small, frame structures, and often without windows. There is usually no running water, nor are there facilities for the disposal of waste.
When a family moves into one of these houses, there has been no pervious renovating nor cleaning of the premises. If the former tenant had tuberculosis, the next renter moves in with the grrms.

A significant fact concerning the rural family is that when there are marriages, usually the son or daughter remains in the home with the patients. This study revealed that there were four such families where sons and daughters had brought their mates into the home. In the course of time these had offspring, who were exposed to cases of active tuberculosis. In one instance a child was stricken with tuberculous meningitis and died.

There was not sufficient information to show the housing conditions of all of the patients studied, therefore, a general picture will be given.

There were cases of families of seven and eight persons living in one room, in which all of the household activities were carried on. In other families, both children and adults were found sleeping in the same room, with the patient. There were several instances of an entire family having to occupy one room because the other rooms of the house were unfit for habitation.

The recording showed that only a small number of the patients complained to the Public Welfare Worker about the housing conditions. In most cases the patient seemed to be satisfied. There was a very small number of cases where roomers (persons not belonging to the family group) were taken into the homes.

In Figure 2, map of Fulton County, there have been shown the area in which the patients studied had residence. From the addresses found in the Department of Public Welfare's records, it was discovered that there
were thirty-one patients living just outside of the city limits of Atlanta, thirteen lived in East Point, nine in College Park, five in Fairburn, four in Roswell, and four in Palmetto. Other communities which were less densely populated, such as Woodstock, Dunwoody, Egan, Union City, Red Oak, had one or two cases each.

Strengthening the fact that there is higher incidence of tuberculosis around urban areas, it was discovered that 40% of the total number of patients studied, lived nearest Atlanta. The East Point area had 15% of the total, while in nearby College Park there were 10% of the number studied. It appeared evident that the closer the contact the individual had with congested urban living conditions, the more likely he was to become tuberculous; while the farther away from the city, the better his chances were to resist infection.

Types and Importance of Public Assistance Received by Patients

As has already been pointed out, the private welfare agencies in the county are unable to do long-term financial planning for clients. Therefore, in the case of the tuberculous client, his only recourse was the County Department of Public Welfare.

It must be borne in mind that this agency is tax supported and functions within the realm prescribed by certain acts of the legislature. To receive assistance, there were certain requirements for eligibility which had to be met. If the patient could not satisfy these requirements, no assistance could be granted him.

The types of relief given by the Department of Public Welfare were listed in Chapter 3, in the section describing the functions of that De-
partment. From the list, there were eleven of the patients studied who were receiving the Aid to Dependent Children grant, thirteen receiving Old Age Assistance, and five Direct Relief.

The amount of the grant was computed upon the basis of the authorized budgetary needs of the family group, allowing eighty-five percent of the total needs, less the income, if there is any.¹

The largest Aid to Dependent Children grant discovered through this study was for $85.50 for a family group of ten persons, while the smallest was for $19.50 for a family of six. The largest amount given in the Old Age Assistance class was for $45.00 for two in the family, where a special diet was indicated. The smallest grant in this class was for $16.50 for a family of two persons. Direct Relief grants ranged from $43.92 for a family of four to $14.64 for a single person.

Under the Direct Relief Program, the Department could purchase clothing and supplies for clients being admitted to the sanitorium at Rome,² Georgia. Of the thirty-six patients admitted to Battey, at least ten requested the department to furnish them with the standard articles of clothing suggested by the hospital staff. These articles were:

1. Five pairs of pajamas (if patient could afford)
2. One sweater
3. Four wash cloths
4. Two pairs of socks
5. One bath robe
6. Bedroom slippers
7. Toothbrush, paste and soap.³

²Ibid., p. 27.
³Battey Station Sanatorium Policies and Recommendations" (Rome, Georgia, State Department of Health, 1948), (Mimeographed.)
Many persons with tuberculosis, especially those from the lower income groups, must seek assistance because there was usually no income nor resources in the family. Those who had managed small savings found that these were expended long before the disease became arrested sufficiently for returning to work. As for the too far advanced patients, there was every indication that assistance was a necessity, since this group would be the least likely to return to work.

Less than one-fourth of the number of patients owned their own homes, therefore, rent, food, fuel, clothing, and incidentals had to be taken into consideration. The patient who had no means of acquiring these, if he was able, would try to find employment. In so doing, he would spread infection to others as well as hinder the possibility of his becoming cured. If he were not able to work, the wildest bid of speculation would not adequately describe the situation which might result.

When the public assistance agency accepted a tuberculosis client, that agency was aiding in the control of the disease as well as meeting the economic needs of the family.

The Role and Value of Social Service for Tuberculous Patients

The activities of the social worker should be directed toward a concern with the social and emotional problems of the individual. The problems most frequently encountered in the tuberculosis patient and those which demand the most skillful handling are emotional.

Attention to these is a necessary part, if not the essence of social treatment, a fact which is yet to be appreciated.¹

¹Henry B. Richardson, Patients Have Families (New York, 1945), p. 218.
The actual treatment may itself contribute additional fears, and the isolation of the patient from his family and normal environment may aggravate his already greatly disturbed state. The patient has many other fears such as loss of status in the home and in the community. His economic needs are often one of the major causative factors in the emotional distress which he suffers.

It is the function of the social worker to discover, evaluate, and assist in the solution of whatever emotional, economic, and other social factors which may hinder the patient from adjusting to his medical problem. She can help specifically by dealing with the ill person's attitude towards his diagnosis and the recommended treatment plan. She can help the members of his family accept the medical recommendation by giving them the assistance they may need in the solution of their own problems. She can maintain a supportive relationship which will help to sustain both the patient and his family throughout the period of medical care.

How successfully these problems are handled by the social worker will depend upon the resources within the patient's own family and the community, plus her own skill and the individual's ability to accept her help.

She will know what resources are available in the state and local community, and will work with the doctor and the nurse in obtaining the care which is recommended for the patient. Often it is necessary that she interpret these services to the sick person and to his family. Likewise, it is often necessary to interpret the patient's situation to the cooperative agencies which may participate in the plan of care for him.

The problem of tuberculosis has far reaching emotional components that must be understood and handled if the patient is to be treated effectively. In a tuberculous patient, we have to
deal with a degree of fear, helplessness and feeling of rejection, not seen in many other illnesses.¹

There are three phases in tuberculosis which gave rise to grave psychological problems, the diagnosis, hospitalization, and discharge. The diagnosis probably came as a shock which the patient was not emotionally prepared to accept. To him hospitalization meant a separation from family and friends, and a cessation of earning capacity. At discharge from the hospital a revised pattern of living and working should be worked out.² In eliminating emotional strain and stress, the social worker could render an important service.

Fears and anxiety dominated the individual in the diagnostic period; regression and aggression during hospitalization and fear, hostility and rejection after being discharged. During the entire course of his illness, he had a strong need for love and protection.³ The well trained social worker understands these things, and is able to work with the patient and his family in avoiding aggravating situations which may block recovery or reactivate his condition.

Finally, the medical social worker is a part of the medical setting, she must be able to work with the doctor and nurse. She must be able to interpret the doctor's diagnosis and instructions to the patient, and assist him in carrying them out. She must act as the liaison person between the patient, his family, and the community, using discretion in her actions. She will aid the patient in acquiring all available resources

²Ibid.
³Ibid.
necessary for treatment. In case of economic need, she may refer the patient and his family to agencies offering financial assistance.

Tuberculous patients in the Fulton County area were helped with their social problems through the Patient Service Division of the Atlanta Tuberculosis Association. The Public Welfare Worker, despite her heavy case load, was often able to render some personal services, and give comfort and supportive treatment. Because of the heavy case load, the Public Welfare Worker could not give these patients any intensive case work treatment, regardless of the need for guidance and assistance. Therefore, there was a need for medical social worker in this area who could aid the patient in making the proper adjustments.
CHAPTER VI

SUMMARY AND CONCLUSIONS

Tuberculosis has been a menacing health problem from ancient times down to the present day. Great progress has been made in the control of the disease since 1882, when Robert Koch discovered that it was caused by the tubercle bacillus. Streptomycin, the new experimental treatment of this decade may some day revolutionize the medical care of the tuberculous patient, and be as important as Koch's discovery, though there is not enough known about it yet, for the treatment to be generally accepted.

In many communities there is still a need for more generalized programs for tuberculosis control, which will include case finding, case reporting, clinical, sanatorium care, and social service. Although the death rate from tuberculosis in this country has decreased considerably during the last decade, the disease still claims about 60,000 persons each year. Considering all of our educational programs, this figure is too high. There is somewhere a tendency to minimize the disease, upon the part of officials, physicians or patients. There should be a realization of the fact that tuberculosis is a serious problem.

From this study of a group of Fulton County's relief clients it is not concluded that tuberculosis is a poor man's disease. It may seize anyone who is exposed to the bacilli, and who is not physically up to par or who is susceptible.

Recognition is given to the fact that poverty is a predisposing factor in the incidence of tuberculosis. Poverty fosters overcrowding, inadequate
diet, poor housing and unhygienic living conditions, which have been shown as factors which aid in the spread of the infection.

This study recognizes the fact that the case records which were used, were kept for the purpose of the Department of Public Welfare. The material for the most part was insufficient and too brief for an intensive study. However, from these records, the following conclusions were reached:

The Atlanta Tuberculosis Association, an unofficial voluntary agency, had done and is yet performing an unestimable service, in this area, in the treatment and control of tuberculosis. From 1909 to 1940 this agency was the only one in Fulton County doing tuberculosis work.

The Fulton County Health Department had made great progress with its tuberculosis control programs, since its beginning in 1940. There have been set up a central clinic and sixteen health centers, located throughout the county. At the central clinic X-rays are made, physical examinations given, and pneumothorax refills are administered. At the health centers, tuberculin tests, consultation, photofluorography, and pertiteneum refilled are available. Referrals are made from the clinic to the sanatorium or hospital, in cases where thoracic surgery is indicated.

There is no proof of susceptibility based on sex, age, race, marital status nor occupation.

Poverty is a contributing factor to the spread of tuberculosis infection. It is the antecedent of overcrowding, malnutrition and poor housing conditions.

Tuberculosis is a public health program of great importance requiring a well organized county health department with facilities and activities
to carry on an effective program for control of the disease.

There is continued need for cooperation between social agencies, both public and private in planning for an individual with a disease or the chronicity of tuberculosis. A single agency cannot handle the many applications which arise.

There should be provided in Fulton County a sanatorium to house the county's tuberculous patients. Also, provision should be made for the care of the cases diagnosed as too far advanced to be accepted for hospitalization at Battery Sanatorium.

In recognition of the fact that the person with tuberculosis in confronted with the greatest crisis of his life, a need is evident for more social service for these individuals. From the diagnostic period, to hospitalization, until he is discharged and afterwards, there should be counselling and guidance in relation to the needs of the individual patient.

Despite the numerous educational programs, provided for the general public, there are large numbers of persons in Fulton County, who do not show an intelligent attitude toward tuberculosis.

The majority of the patients studied had experienced economic dependency for a number of years. Many had had contact with welfare agencies, public and private for periods ranging as high as twelve years.

Finally, health and welfare authorities, and other agencies performing social services, must acknowledge the fact that the tuberculous individual's problems are the entire community's burden. In controlling the spread of the disease, and easing the emotional problems connected with it, the total community's resources must be mobilized and made accessible to all patients.
Figure 1. Location of Clinics
Figure 2. Location of Patients
Schedule For Collection of Data

Case Name ________________________________________ Case Number _____

Race ______________________ Sex __________ Date of Birth ______

Place of Birth ______________________ Address ______________________

Marital Status: Married ___ Single ___ Divorced ___ Separated ______

Widowed ______

If patient is a child, state position in the family group ______

If patient is an adult, state position in the family group ______

Educational Status (Circle highest grade completed): 0123456789 10 11 - College - 12 3 4

Graduate Study - 1 2 3 Degree

Occupation as of date of study ______________________

Former Occupation ______________________

Present monthly income:

| $1.00 - 10.00 | $11.00 - 20.00 | $21.00 - 30.00 |
| $31.00 - 40.00 | $41.00 - 50.00 | $51.00 - 60.00 |
| $61.00 - 70.00 | $71.00 - 80.00 | $81.00 - 90.00 |
| 91.00 -100.00 |

Reason for Application:

How long has family received aid from D.P.W.? ______________________


Number in family ______ Number of Dependents ______ Others in family ______

Number of deaths ______ State cause ______________________

When did patient first discover that he had tuberculosis?

What did he do about it?
Schedule For Collection of Data

Where diagnosed? ___________________________ How? ___________________________
X-Ray? ___________________________ Sputum? ___________________________

Treatment:
Clinical experience: ___________________________
Sanitarium experience: ___________________________ Where?
______________________________
Length of Time? ___________________________

Type of relief received, October 1, 1947? ___________________________
Amount of relief received? ___________________________

Plan for patient:
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