

streamline

The Migrant Health News Source

Promotor(a) de Salud Programs:

Strengthening the Community from Within

Anica Madeo, MSW, MPH, Migrant Health Promotion

“Camp Health Aides are an invaluable link between staff and the populations we serve.

Camp Health Aides create trust, break down cultural barriers and facilitate access to care.”

-Program Coordinator, Northwest Michigan Health Services, Inc.

Promotores and Promotoras de Salud are community members who are trained to increase their communities’ access to and use of health resources. Ideally, they belong to the same culture and speak the same language as the people they are serving. Also referred to as Community Health Workers or Advisors, Lay Health Workers or Camp Health Aides, Promotores(as) provide services such as peer health education, first aid, screening tests, translation and social support. When a problem is outside their range of knowledge or skills, they make referrals to local health centers and social service providers. They also help community members overcome barriers to accessing care. Given proper training and resources, Promotores(as) can successfully link their communities with available health care resources.

Promotor(a) programs are similar in many ways to outreach programs. Both are designed to improve the health of farmworkers by connecting Migrant and Community Health Centers and other organizations with the farmworker community. Promotor(a) programs are defined by who

is doing the work, whereas outreach is defined by what is being done. Outreach may be completed by Promotores(as) or by other staff such as health educators, nurses, physicians, social workers or case managers. As trusted community members, Promotores(as) have a unique understanding of farmworker strengths and needs. Ideally, an outreach program includes both Promotores(as) and other staff who work together with health centers and other organizations.

As members of the communities they serve, Promotores(as) are in a good position to extend the reach of Migrant and Community Health Centers and to improve the ability of health centers to serve hard-to-reach populations. According to the National Community Health Advisor Study, Promotores(as) provide an important link to services, which can result in:

- Reduced emergency room visits, length of hospital stay and certain complications
- Increased trust between clients and the health care delivery system, promoting improved timely use of services and better

adherence to treatment instructions

- Increased focus on meeting individual needs associated with health care delivery, such as obtaining non-medical services that reduce barriers to care (ie. transportation, translation, emotional support, etc.)
- Increased availability of cost-effective, culturally competent home- and clinic-based services¹

Another benefit of Promotor(a) programs is an increase in health center referrals. According to the *Journal for Minority Medical Students*², clinics that incorporated Migrant Health Promotion’s Camp Health Aide Program saw increased usage. They reported seeing fewer people with colds and more people with early infections. Because of the increase in early interventions, emergency room visits declined.

While there are many benefits to including a Promotor(a) program in health center services, there are often a variety of barriers to overcome before a program can be initiated. One of the main concerns expressed by clini-

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MCN would like send a Great Big Thank You

to everyone who participated in our Mother’s Day campaign.

Thanks to your generous donations, you helped make our campaign a success! We offer a very warm and heartfelt Thank You to our artists for generously donating their talent, time and fabulous artwork to this effort. A special thank you goes to R T Freeman for his painting of the mother nursing her infant, a work he created especially for MCN’s campaign.

We are also grateful to Sarah Henly Shepard for allowing us to use her photograph of mother and child.

Your generosity helps MCN ensure access to essential prenatal and health care services for migrant women! Thank you.





icians is how to ensure that *Promotores(as)* are giving out accurate information. This concern can be addressed by creating a close relationship between clinicians and *Promotores(as)*. Clinicians can serve a variety of roles in *Promotor(a)* programs. They often serve as either Program Coordinators or Directors and are involved in developing program objectives and evaluation plans. They can also support the programs by including *Promotores(as)* in case management and promoting recognition of the *Promotores(as)* by posting photos and contact information in the health center. Perhaps most importantly, clinicians can be involved in *Promotor(a)* training by performing periodic clinical reviews of training curricula and health education materials and providing feedback to the Coordinator. They can also participate as guest speakers during trainings. In this way, clinicians help train *Promotores(as)* on specific topics while simultaneously deepening their own knowledge of the needs and strengths of farmworking communities.

Finding funding can be another potential challenge in starting a *Promotor(a)* program. How much money can the health center invest in a new program? At a minimum, funds should be available for a Program Coordinator position and for reimbursing *Promotor(a)* travel expenses. Whenever possible, *Promotores(as)* should be compensated with wages, stipends or other incentives (depending on the funding source). This makes involvement possible and compensates for lost work hours and time spent away from their families. While it is possi-

ble to have a volunteer program, there are some distinct benefits to hiring *Promotores(as)* as employees with a stipend or wage. First, it may decrease turnover during the program season and increase the number of *Promotores(as)* that stay with the program from year to year. Second, obtaining liability insurance to cover volunteers is often a challenge. If *Promotores(as)* are hired by the health center, and are paid stipends or wages, then Federal Tort Claims Act (FTCA) coverage applies.³ Finally, compensating *Promotores(as)* may increase their connection to the health center and commitment to their work. Health centers can also create opportunities for *Promotores(as)* to advance to other positions within the center. For instance, experienced *Promotores(as)* make excellent outreach workers.

Promotor(a) programs are run in many ways, with a range of funding sources and program topics. Some health centers fund programs using base or outreach funding from HRSA's Bureau of Primary Health Care, while others get funding from a variety of sources, including foundations and local and state departments of health. Some programs focus on health topics such as diabetes, asthma, or dental care, while others focus on a particular group such as teens or women. Many programs include classes and demonstrations focused on nutrition or exercise. Others include creative components like theater troupes or documentary filmmaking. The range of possibilities allows each health center to tailor their program to the strengths

and needs of the communities they serve.

Whatever the focus of the program, *Promotores(as)* can provide a unique link to the community. They can integrate information about health and the health care system into the community's culture, language and value system, thus reducing many of the barriers to health services. With the appropriate resources and ongoing training and support, *Promotores(as)* improve the health of their communities by linking their neighbors to health care and social services, by educating their peers about disease and injury prevention, by working to make available services more accessible and by mobilizing their communities to create positive change.

For more information or for support in starting or strengthening a *Promotor(a)* program, please contact:

Migrant Health Promotion
Capacity-Building Assistance Team
(734) 944-0244
capacity@migranthealth.org
www.migranthealth.org

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Work-Related Injury Deaths Among Hispanics – United States, 1992-2006

Editor's Note: We bring our readers this timely article given the large representation of Hispanic workers, including migrant and seasonal farmworkers, employed in high risk occupations and seen by clinicians at federally funded Migrant and Community Health Centers. This full version of the Center for Disease Control's Morbidity and Mortality Weekly Report (MMRW) June 6, 2008 / Vol. 57 / No. 22; 597-600 is available at <http://www.cdc.gov/mmwr/weekvol.html>.

Hispanics are among the fastest-growing segments of the U.S. workforce¹. In 2006, an estimated 19.6 million workers in the United States were Hispanic, 56% of whom were foreign born*². To characterize work-related injury deaths among Hispanic workers in the United States, CDC, the Bureau of Labor Statistics (BLS), and certain state agencies analyzed data from 1992–2006. This report summarizes the results of that analysis, which indicated that, during 1992–2006, a total of 11,303 Hispanic workers died from work-related injuries.† The death rate for Hispanic workers decreased during this period; however, the rate was consistently higher than the rate for all U.S. workers, and the proportion of deaths among foreign-born Hispanic workers increased over time. During 2003–2006, 34% of Hispanic worker deaths occurred in the construction industry. Additional efforts are needed to reduce the risk for death among Hispanic workers because of projected increases in their employment, involvement in work with high risk for injury, susceptibility to miscommunication caused by language differences, and other potential risks associated with culture and economic status.

The BLS Census of Fatal Occupational Injuries (CFOI) collects data on fatal occupational injuries from multiple federal, state, and local sources, including death certificates, workers' compensation reports, medical examiner reports, and police reports. Approximately 95% of cases are verified by at least two independent sources³. To be included in CFOI, the decedent must have been employed at the time of the event, engaged in a legal work activity, or present at a site as a job requirement. CFOI excludes deaths that occurred during a worker's normal commute to and from work and deaths related to occupational illnesses. A decedent is classified as Hispanic if documentation is available indicating that the decedent was of Mexican, Puerto Rican, Cuban, or Central or

South American descent, or of other Spanish culture or origin, regardless of race. Deaths of undocumented workers are included. In this report, certain data are presented only for the period 2003–2006 because, in 2003, industry coding changed to the 2002 North American Industry Classification System. Death rates were calculated for workers aged >16 years, using estimates of employed civilian workers from the BLS Current Population Survey (CPS)². CPS is a monthly survey of approximately 60,000 households that uses a combination of in-person and telephone interviews with a single person reporting for all household members. Undocumented persons are included in CPS.

Work-related injury deaths among Hispanic workers during 1992–2006 totaled 11,303, approximately 13% of all U.S. work-related injury deaths during that period. Median age of Hispanic decedents was 35

years, compared with a median age of 42 years for all workers. Approximately 95% of Hispanic decedents were male. The annual work-related injury death rate for Hispanic workers exceeded the rate for all U.S. workers every year during 1992–2006, with the exception of 1995. In 2006, the work-related injury death rate for Hispanic workers was 5.0 per 100,000 Hispanic workers, compared with rates of 4.0 for all workers, 4.0 for non-Hispanic white workers, and 3.7 for non-Hispanic black workers. During 2003–2006, the work-related injury death rate for foreign-born Hispanic workers was 5.9, compared with a rate of 3.5 for U.S.-born Hispanic workers.

During 1992–1996, homicide was the most common fatal event among Hispanic workers. However, during 1997–2006, highway incidents§ were the most common



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■ Work-Related Injury Deaths Among Hispanics continued from page 3

fatal event, with the exception of 2000 and 2006, when falls to a lower level were most common. Work-related homicides among Hispanics decreased 37% from 1992 to 2006, while the number of falls to a lower level increased approximately 370% during the same period.

During 2003—2006, 67% of Hispanic decedents were foreign born, an increase from 52% in 1992. Approximately 70% of these decedents were born in Mexico. During 2003—2006, the most common industries employing Hispanics who died from work-related injuries were construction (34%), administrative and waste services (11%), agriculture/forestry/fishing/hunting (10%), and transportation/warehousing (10%). Of those states with 30 or more work-related injury deaths among Hispanics during 2003—2006, the highest numbers of fatalities were in California (773 deaths), Texas (687), and Florida (417); however, the highest fatality rates were in South Carolina (22.8 per 100,000 Hispanic workers), Oklahoma (10.3), Georgia (9.6), and Tennessee (8.9).

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Editorial Note:

Although work-related injury death rates declined generally and among Hispanics in the United States from 1992 to 2006, disparities between Hispanics and all workers persisted, with Hispanics consistently experiencing higher rates. In 2006, rates for Hispanics and all workers were above the Healthy People 2010 target for work-related injury deaths of 3.2 deaths per 100,000 workers (objective 20-1)⁴. Foreign-born Hispanic workers were at especially high risk, and a large proportion of deaths occurred in the construction industry. Much of the increased risk for Hispanic workers likely can be attributed to holding high-risk jobs⁵. However, an analysis of Hispanic work-related injury deaths in the construction industry found that Hispanic workers also had elevated rates when compared with non-Hispanic workers in the same occupations (e.g., laborers or roofers)⁶.

In-depth investigations of approximately 200 deaths of Hispanic workers by CDC's National Institute for Occupational Safety and Health and state public health and labor agencies during 1992—2006 suggested characteristics that contributed to higher numbers of work-related injury deaths among Hispanic workers, including inadequate knowledge and control of recognized safety hazards and inadequate training and supervision of workers, often exacerbated by different languages and literacy levels of workers (CDC, unpublished data, 2008).¶ Preventing work-related injury deaths among Hispanics will require 1) employers to take additional responsibility for providing a safe work environment, 2) safety and health agencies to provide employers of Hispanic workers with safety information and ensure compliance with existing regulations, and 3) researchers and health communication professionals to develop additional materials that are culturally appropriate and effective for workers who speak different languages and have varying levels of literacy. In addition, labor unions, community groups, and workers themselves can contribute to research and prevention measures.

The findings in this report are subject to at least five limitations. First, the number of deaths of Hispanic workers might be undercounted in the CFOI database⁶, resulting in an underestimate of the death rate among Hispanics. Second, Hispanic ethnicity might have been misclassified in CFOI, which relies on secondary data sources, and also in CPS, which uses a single reporter for all household members. Third, the number of Hispanic workers might be undercounted in the CPS, which relies on stable residences for sequential interviews and largely collects data via telephone. An undercount of the total population of Hispanic workers would result in overestimate of Hispanic work-related injury death rates⁶. Fourth, Hispanic workers are a heterogeneous population, and analyses that aggregate deaths for all Hispanics might mask differences among subpopulations. Finally, the data do not address potential contributors to Hispanic worker risk associated with cultural and social norms or economic status. For example, Hispanic workers, especially those who are foreign born, might be more willing to perform tasks with higher risk and more hesitant to decline such tasks for fear of losing their jobs.

CDC, the Occupational Safety and Health Administration (OSHA), and other agencies have provided additional Spanish-language occupational health and safety materials and training opportunities for employers, supervi-

sors, and workers^{7,8}. OSHA has worked with employers to publicize best practices for Hispanic worker education and training programs⁸. In addition, federally supported research projects are exploring grassroots approaches to improving occupational health and safety among Hispanic and other immigrant workers.** Others agencies can build upon these projects to develop culturally competent programs that engage Hispanic workers in identifying and addressing their occupational health and safety concerns. ■

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* Does not reflect any immigration status.

† Data from 2001 exclude fatalities resulting from the September 11 terrorist attacks.

§ Defined as incidents on public roadways that involved vehicles or equipment.

¶ Individual case reports of Hispanic worker deaths are available at <http://www2a.cdc.gov/NIOSH-FACE/state.asp?Category=0009&Category2=ALL&Submit=Submit>.

** Additional information available at http://www.dph.sf.ca.us/phes/work_unidos.htm.

Take Heed in Contact with OP Pesticides

by Helen Murphy, MHS, FNP, RN -- Pacific Northwest Agricultural Safety and Health Center, University of Washington

Editor's note: This column is printed with permission from Western Farmer-Stockman, where it was originally published in September 2007.

HERE has been talk about restricting organophosphate, or OP, pesticides in agriculture. (Many have already been taken off the market for household use.) Why all this fuss? It relates to the growing body of evidence that they have some long-term effects on the nervous system in children. But how clear is this evidence on the neurological long-term effects?

The long-term consequences of acute OP poisoning are better understood for adults than children. First noted in the 1950s, doctors were reporting memory and attention deficits, as well as increased depression, anxiety and irritability following adult OP poisoning. Could children be similarly affected?

A recently published study tested 9- to 10-year-old school children who had been poisoned by OP pesticides at age 2. They found small, but statistically significant, movement impairments. This prompted researchers to question whether repeated low levels of exposure would have any long-term effects in children. Animal studies have shown that organophosphates disrupt the nervous system's normal growth and development. As a result, there was concern that human exposures during pregnancy and infancy may be a risk.

Special concerns for children

Compared to adults, children's pesticide exposure and absorption is greater, and they are also more sensitive to the health effects for several reasons:

- Little ones learn about the world by touching and putting things in their mouths. If pesticides are on their toys or hands, they are easily exposed.
- They spend more time near the ground and outside. If pesticides are in the soil or floors, crawling can expose the skin and kick up respirable dust.
- Pound for pound, children have greater skin surface, drink, eat and breathe more than adults. If pesticides are on surfaces or in food, water or air, they will get a bigger dose than adults.
- A child's brain and nervous system grow rapidly between the second half of pregnancy and 18 months.
- Babies are less able to break down OPs into harmless substances.

Studies with mothers, children

Three studies — two urban and one rural — are following mother-child pairs from pregnancy through early childhood. Exposure was measured in air inhaled by the mother, in the umbilical cord blood, and in the blood and urine from both mother and child. Two studies looked at infant reflexes in the first months of life (a marker of nervous system function) and found a link between mothers with higher exposures to OP pesticides during pregnancy and abnormal reflexes in their infants.

Two studies found mothers with higher exposures to OPs during pregnancy have children who do not perform as well on mental development tests at ages 2 to 3 compared to the children of mothers with lower expo-

sure. One found poor motor development in toddlers of mothers with higher exposure.

These studies suggest potential problems for children exposed to low levels of OPs. However, these studies do not reflect the final answer. While the effects on children exposed during pregnancy are similar across studies, they are not consistent when considering exposure in young children. Also not yet known is if these effects will persist into school age, or whether poor test results will lead to any disabilities later in life.

Nevertheless, researchers recommend erring on the side of caution while follow-up of these children continues and other studies contribute to the evidence. That means pregnant women or preschool-age children should minimize their OP exposure. ■

Pesticide Patient Education Materials

Lo Que Bien Empieza...Bien Acaba is a full color, educational comic book in Spanish that helps women of reproductive age and pregnant women understand the risks associated with pesticide exposure and ways to minimize exposure. The comic book targets women in rural and urban areas and women in various occupational exposures: occupational, para-occupational exposures (take home) and in-home.

Aunque Cerca Sano educates parents about children's risks to pesticide exposure and ways to minimize these risks.

Arcury TA, et al. *Pesticides & Pregnancy Handout and Poster* (English and Spanish). Winston-Salem, NC: Wake Forest University School of Medicine, 2007. Available at: http://www1.wfubmc.edu/fam_med/Research/Educational/Pesticide.htm.

Download copies from our website or order copies to distribute by contacting aliebman@migrantclinician.org

Visit MCN's website. www.migrantclinician.org/excellence/environmental to access more pesticide patient education materials!



Lawsuit Settlement in Case for Baby Born without Arms and Legs

Shelley Davis, JD, Farmworker Justice

Carlitos Candelario Herrera is not a typical toddler: he cannot walk, run or throw a ball. Carlitos was born in December 2004 without arms or legs. His mother, Francisca Herrera was working for Ag-Mart farms in Florida and North Carolina while she was pregnant with Carlitos. During Herrera's pregnancy, Ag-Mart used at least five pesticides known to cause birth defects and three pesticides that have shown mutagenic effects in animal studies.

Carlitos' parents filed suit against Ag-Mart in 2006 to obtain the compensation needed to properly care for him. In March 2008, the case was settled and while the exact terms of the settlement are confidential, Carlitos' lawyers have stated that the settlement is worth "millions" and will provide enough money to care for Carlos throughout his life.

Both Carlitos' young mother and father are indigenous workers who come from Guerrero, Mexico. Neither the maternal or paternal families had histories of birth defects. A 2006 report by the North Carolina Department of Health and Human Services found that "there is a plausible association between ... [Carlitos'] mother's possible occupational pesticide exposures in North Carolina and the limb defects seen in her child."¹

In a court document summarizing the evidence collected, Carlitos' attorneys revealed that Carlitos' mother had reported feeling pesticide-related health effects to her supervisor on numerous occasions, but was instructed to simply sit by the edge of the field until she felt better. Other Ag-Mart employees have also reported adverse health effects that they believe were caused by

pesticide exposure, similarly they report having received no assistance from the company. Finally, a toxicologist, who examined all the evidence of record, stated that, in his opinion, it was probable that the pesticide exposure to Carlitos' mother contributed to or caused Carlitos' birth defects. ■

References

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Clinical Pesticide Resources

Below is just a sample of what you will find on our web page: www.migrantclinician.org/excellence/environmental There's much more!

A Migrant Farmworker Occupational Health Reference Manual for Clinicians

Produced by NYCAMH and MCN, offers information for the diagnosis and treatment of occupational injuries. This online resource provides information on farmworker crop profiles, diagnosis and treatment, patient education, cultural competency, and much more.

Recognition and Management of Pesticide Poisonings

This edition covers about 1,500 pesticide products in an easy-to-use format. Toxicology, signs and symptoms of poisoning, and treatment are covered in 19 chapters on major types of pesticides. It is edited by Dr. Routt Reigart and Dr. James Roberts, and is published by EPA's Office of Pesticide Programs. Both English and Spanish versions are available.

Occupational Exposure History Tools

Simple questions for screening occupational exposures and taking occupational exposure histories.

National Pesticide Practice Skills Guidelines for Medical & Nursing Practice

This NEETF publication outlines the knowledge and skills that health professionals need to have about pesticides. This document is part of a national initiative aimed at ensuring that pesticides issues become integral elements of education and practice of primary care providers.

Pesticide Clinical Guidelines

MCN Clinical guidelines to address pesticide exposure. Developed by Dr. Dennis H. Penzell based on his experience as medical director of a Migrant and Community Health Center that responded to one of the country's largest pesticide poisoning incidents.

National Pesticide Medical Monitoring Program

Provides informational assistance for clinicians in the assessment of human exposure to pesticides.

EXTOXNET

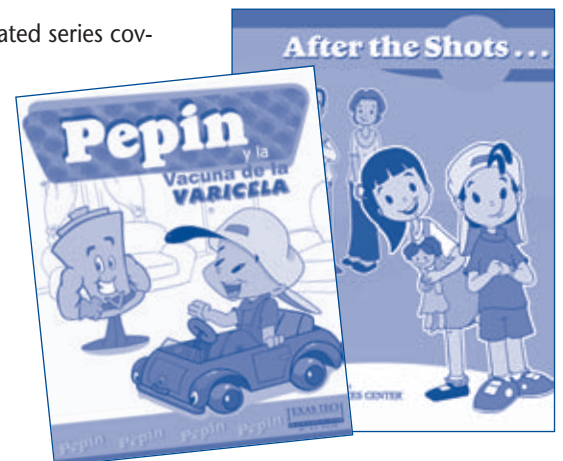
Objective, science-based information about pesticides - written for the non-expert.

Immunization Comic Books Now Available!

MCN announces the availability of the immunization Pepin comic books. This animated series covers seven immunization topics: Td, Chickenpox, MMR, DTaP, Hep A, Hep B, and After the Shot. These low literate, popular education materials are available in English and Spanish to help clinicians educate parents about the importance of getting their children vaccinated.

Also available to order are copies of the "Recommended Vaccines for Recent Immigrants from Mexico" brochure are still available to order. This guide provides recommendations for clinicians offering vaccines to non high-risk recently arrived Mexican immigrants, by age, to bring them up to date with the US recommendations.

For more information about MCN's immunization educational materials and to order your copies, please visit our website at <http://migrantclinician.org/excellence/immunizations>, or contact Kate Bero, Immunization Initiative Manager, at (512) 579-4518 or kbero@migrantclinician.org. ■



NEWSFLASHES

HRSA Announcement: Radiation Exposure Screening and Education Program (RESEP) Launching National Outreach Campaign

The Health Resources and Services Administration's (HRSA) Radiation Exposure Screening and Education Program (RESEP) is launching a "National Outreach Campaign" to spread the word about resources for people who were exposed to radiation through nuclear arms testing or the uranium mining industry between 1942 and 1971.

We are asking you to help us spread the word – many people have moved away from the site of their initial exposure and do not know that they are entitled to medical screening and financial compensation.

The RESEP program supports screening programs, medical referrals, and the preparation of medical documentation related to radiogenic illnesses. RESEP also refers individuals diagnosed with radiogenic cancers and chronic diseases to the Radiation Exposure Compensation Act (RECA) Program, administered by the Department of Justice, which provides payments in the amounts of \$50,000 to \$100,000.

It is important to identify individuals potentially adversely affected so that they are screened and evaluated by a health care professional. We would appreciate your support:

- Help us distribute our comprehensive brochure: We have developed a brochure that explains who is eligible, what RESEP offers, and how to receive benefits. You can obtain printed copies of the brochure free of charge from the HRSA Information Center by calling 1-888-ASK-HRSA, or you can download the booklet from the HRSA Web site at: <http://ruralhealth.hrsa.gov/radiationexposure/>.
- Include information in your newsletter or in an email to your constituents: We can provide you with a drop-in newsletter article to include in your next newsletter or in an email to your constituents.
- Include a link to our Web site: Information about RESEP is available on our Web site at <http://ruralhealth.hrsa.gov/radiationexposure/>. You can include a link to our Web site on your Web site or in communications to your constituents.

We sincerely appreciate this partnership, and thank you for your efforts to reach out to individuals suffering health consequences as a result of radiation exposure. For questions, please contact Ms. Vanessa Hooker, Public Health Analyst, HRSA's Office of Rural Health Policy, at (301) 594-5105.

Expertise in Pesticide Exposure Now Available

The National Pesticide Information Center (NPIC) at Oregon State University now responds to pesticide questions in over 170 different languages.

NPIC can connect with technically trained interpreters in real-time to assist clinicians and Promotoras with pesticide related questions in Spanish, Mixteco, Haitian-Creole, Mandarin and many more.

Brochures, flyers, and magnets about NPIC are available in low literate Spanish and English versions, free of charge, by contacting 800-858-PEST. NPIC is also launching a new Spanish website that focuses on pesticides and useful resources. This website can be accessed at www.npic.orst.edu/es

NPIC answers over 24,000 questions each year from across the nation regarding pesticide toxicology, safe use practices, and regulatory issues. Trained pesticide specialists provide confidential service to the general public, farmworkers, medical community, and regulatory officials by delivering objective, science-based information about pesticides.

Healthcare providers seeking medical information or assistance relating to human pesticide exposure can contact Dr. Daniel Sudakin, M.D., M.P.H., co-principal investigator and medical toxicologist for NPIC and principal investigator for the National Pesticide Medical Monitoring Program.

For more information call 1-800-858-7378, seven days a week, or email npic@ace.orst.edu. Visit the website at www.npic.orst.edu or www.npic.orst.edu/es. NPIC is a cooperative agreement between Oregon State University and the U.S. Environmental Protection Agency.

The BANDANA PROJECT

Farmworker women use bandanas to protect themselves from the sun and dust. They also use bandanas to hide their faces from perpetrators, in hopes that they will become less visible – a silent protest and symbol of solidarity.

The BANDANA PROJECT, launched by Esperanza: The Immigrant Women's Legal Initiative of the Southern Poverty Law Center in June 2007, is a national event aimed at

raising awareness about sexual violence and harassment against farmworker women, sparking advocacy and activism in response and creating solidarity and support for farmworker women. Cities across the country are participating, creating bandanas to show support for farmworker women. These bandanas will become a part of the National BANDANA PROJECT and will be displayed at the Southern Poverty Law Center. For more information go to the Southern Poverty Law Center website (<http://www.splcenter.org>)

Venomous Snake Resources Available in Spanish

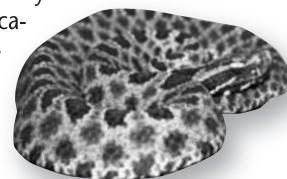
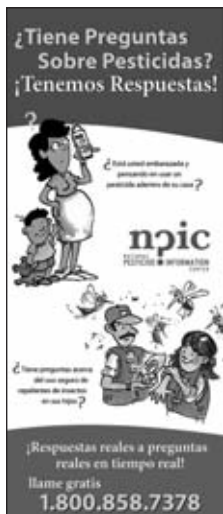
Dr. Steve Johnson and Monica McGarrity of the University of Florida / IFAS Plant City Campus have recently produced an educational poster entitled "Venomous Snakes of the Southeast",

which is available in both English and Spanish. This poster uses a combination of watercolor illustrations, line drawings, maps, and text to describe the six venomous snake species and their look-alikes, where you might find them, and how to recognize a venomous snake. The poster also gives tips for responding to snakebite emergencies — what you should and should NOT do in case of venomous snakebite. Funding for this project was graciously provided by the university of Florida/IFAS and the USDA / Renewable Resources Extension Act. Original watercolors, line drawings, and poster design by Dale A. Johnson. Go to http://ufwildlife.ifas.ufl.edu/serpientes_venenosas.shtml to preview the poster.

To request FREE copies of the poster for display at your location, please email Monica McGarrity at monicaem@ufl.edu the following information:

Your Name
Organization/Clinic Name
Full Mailing Address
Contact Information —
Email address and telephone number
Number of posters requested

There are also a variety of fact sheets by Dr. Steve A. Johnson, Dr. Martin B. Main, and Monica E. McGarrity on the topic of snake identification and safety, currently available only in English, that you may find useful. As these materials are translated into Spanish, they will be posted on this webpage. If you would like to be notified when new materials are available (or would like to assist with translation), email Monica McGarrity at monicaem@ufl.edu.





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Providence, Rhode Island
www.ncchca.org

National Summit of Clinicians for Healthcare Justice

October 23-25, 2008
Washington, D.C.
www.allclinicians.org

American Public Health Association Annual Meeting

San Diego, California
October 25-29, 2008
www.apha.org

Midwest Stream Farmworker Health Forum

November 19 – 22, 2008
New Orleans, Louisiana
www.ncfh.org

Western Migrant Stream Forum

January 23-25, 2009
San Diego, California
www.nwrpca.org



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