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TB*Net*: Celebrating 10 Years of Binational TB Care

The need for a comprehensive tracking and referral network that helps provide continuity of care services for mobile populations with active tuberculosis or TB infection has long been identified by front-line providers and other public health officials as essential for the effective treatment of TB. Ten years ago, MCN initiated a binational tuberculosis tracking and referral project, called TB*Net* designed to meet this need. TB*Net* was originally meant to help migrant workers in the US maintain continuity of care as they migrated between public health jurisdictions in the agricultural areas of the United States. It quickly expanded to include the homeless, immigration detainees, prison parolees, or anyone who might be mobile during their treatment.

In the early 1990s, MCN was a founding member of the Binational Health Data Transfer Task Force. Other members of the task force included representatives from the Instituto Nacional de Salud Pública, Escuela de Salud Pública de México (National Institute of Public Health of Mexico, School of Public Health), Secretaría de Salud del Estado de Guanajuato (Department of Health of the State of Guanajuato), Pennsylvania Department of Health, Centers for Disease Control and Prevention, HRSA Office of Minority Health, the National Institutes of Health, and Muhlenberg College. The task force developed and piloted the GUA-PA Project, a demonstration system of data transfer. The GUA-PA system was designed to test the technical, financial, legal, and political aspects of data sharing between two countries. Demographic and clinical data of Mexican migrant patients was col-

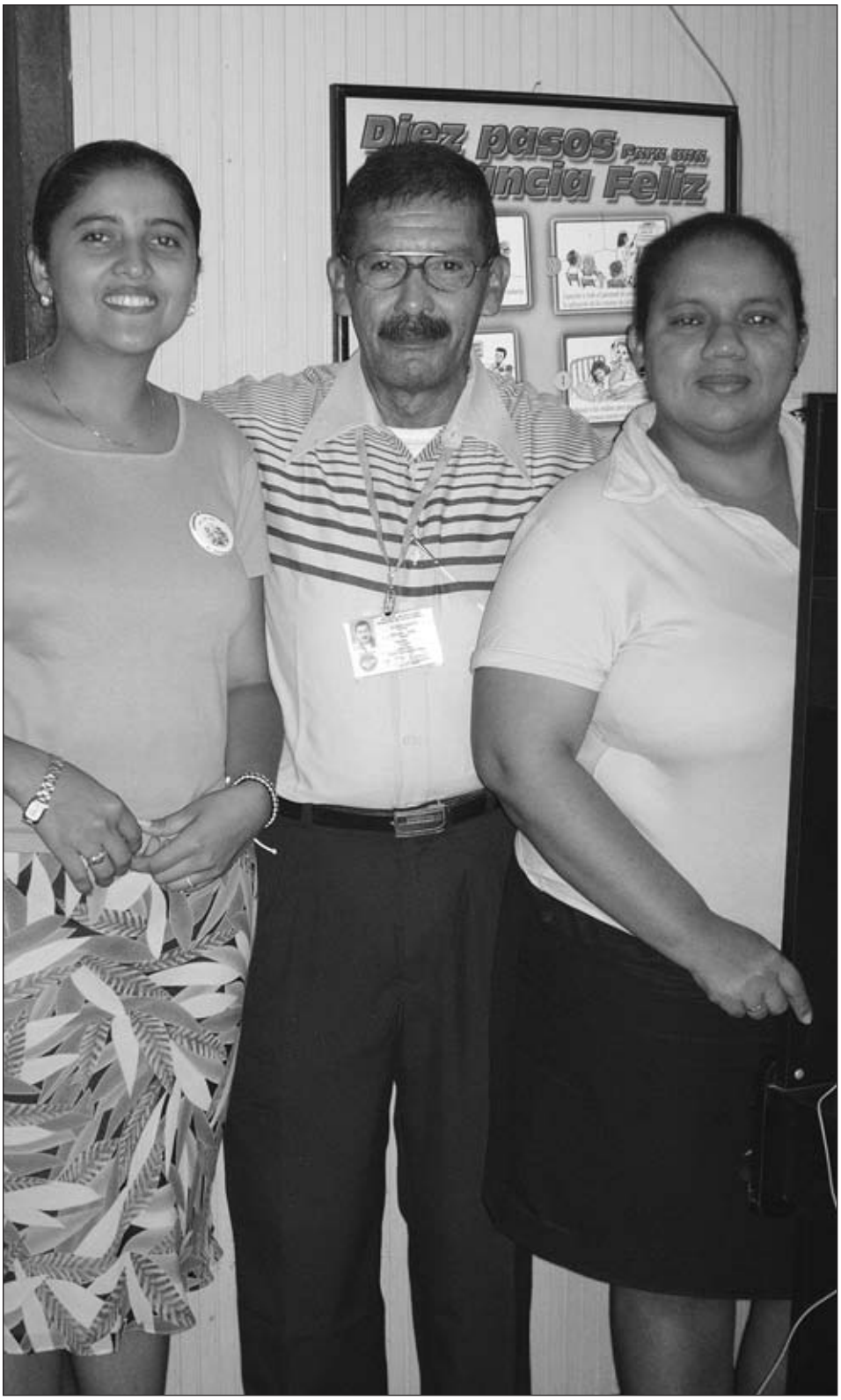
continued on page 2

TBNet staff Nathan Svedvik, Jeanne Laswell, and Raul Arce

TB*Net*: Celebrating 10 Years of Binational TB Care continued from page 1

lected and made available to front-line health care providers in Mexico and in the United States.

On July 27, 1994, the first successful exchange of sentinel disease information took place between Pennsylvania and Guanajuato, Mexico. This transfer of information enabled the Department of Health of the State of Guanajuato to locate and bring to medical care the sexual contact of a migrant who was diagnosed and treated for syphilis in Pennsylvania. This information sharing represented the first successful electronic interface of public health systems between the interiors of two countries for the purpose of intervening in the spread of communicable diseases by way of contact tracing. In an evaluation of this system, principal barriers to utilization of the data transfer system appeared to be financial and political.



TB program staff, Dixiana Reyes, Wilfredo and Juanita from Hospital Atlantida in La Ceiba, Honduras.

In 1996, in partnership with the Texas Department of Health, the El Paso City-County Health and Environmental District, the American Lung Association of Texas, and the Pan American Health Organization, TB*Net* was implemented as a comprehensive tracking and referral network for farmworkers and other mobile populations dealing with TB. TB*Net* provides a central location where the medical records of TB patients are stored and can be accessed by the treating provider. It also provides a toll free number that patients can call to get assistance in finding a source for treatment or other needed supports. Since 1996, TB*Net* has managed over 2500 patients. TB*Net* has assisted patients who have stayed within the United States as well as those who have moved abroad - from the Texas/Mexico border all the way around the world to China. TBNet has shown that providing complete TB treatment to migrant patients can be successful and that it is possible to provide continuity of care to mobile populations.

A Case Study of Effective International Collaboration

To ensure patients continue and finish their treatment for TB in their home countries, TBNet depends on reliable relationships with local clinics and hospitals scattered throughout the towns and cities of

continued on page 3

TB*Net*: Celebrating 10 Years of Binational TB Care continued from page 2

Central America. One such hospital with which TBNet has developed a successful relationship is Hospital Atlantida in La Ceiba, Honduras. TBNet staff has worked with Dixiana Reyes and other staff at this hospital to successfully complete treatment for dozens of patients. The following case illustrates successful collaboration as well as some of the difficulties associated with the binational management of TB patients.

TBNet Patient #2246

This patient was first enrolled in TBNet on August 26, 2005, through Port Isabel ICE. The cultures had already come back positive for M. tuberculosis and the patient was to be deported to Honduras. Treatment had been initiated at Port Isabel Immigration Customs Enforcement (ICE) facility on July 12, 2005.

TBNet staff first called the patient's wife in La Ceiba, Honduras to verify the address that the patient had put on the enrollment forms (8/31). Once the address was verified, TBNet contacted the Honduras National TB Program in Tegucigalpa to coordinate the continuation of care. After conversing via phone TBNet staff emailed the patient's medical records to the Honduran TB program. Because of the patient's address, he was assigned to the Hospital Atlantida in La Ceiba, Honduras. To follow-up, TBNet staff sent a fax with the clinic details to LCDR William Rekward, the Port Isabel ICE staff person who had sent the original enrollment. Over the next month, TBNet staff periodically contacted Port Isabel ICE staff to inquire as to if the patient had been deported. On October 28, 2005 TBNet staff was told that the patient had been deported on October 17th.

On November 1st, TBNet staff called the patient's phone number in La Ceiba and spoke to a family member (the patient was not available) and asked them to encourage the patient to go to the Hospital Atlantida to continue treatment. On the same day, TBNet staff sent an email to the Honduras National TB Program, asking for an update when the patient was seen at Hospital Atlantida. On November 22nd, TBNet staff received an email from Dixiana Reyes, who coordinates treatment for the TB patients at Hospital Atlantida. She requested more medical information on the patient, as it appeared very little information had reached them from the national program. TBNet staff emailed Dixiana the medical records, including consent form and the International TB Notification Form, asking her to please send notification as to whether the patient was in treatment at Hospital Atlantida. The next day, Dixiana emailed back saying the patient was in his second phase of treatment, taking medications 3 times per week. Now satisfied that the patient was receiving the necessary treatment, TBNet staff did not do any follow-up until after the New Year. On January 6th, after sending Dixiana an email requesting an update on the patient's treatment, TBNet staff received a response stating that although the patient has received treatment at Hospital Atlantida in November, the patient did not show up for treatment in December. They had sent hospital staff to the patient's house and his family members had said they would make sure the patient went back to the hospital, but he never showed up. TBNet staff immediately called the patient's phone number and was told by a neighbor that the patient was at work and it was unknown when he would return. TBNet staff emailed Dixiana, to let her know that it appeared the patient was still in the area. She was encouraged to try to locate the patient again so that he could reinitiate treatment. On January 10th, TBNet staff was able to speak with the patient's mother. His mother agreed that it was very important for him to complete treatment but said that her son simply would not listen to her. She said he is stubborn and at times drinks heavily. Regardless, she said she would keep trying to convince him. TBNet staff provided her with encouragement and told her that staff from Hospital Atlantida may be coming by again to talk with her son.

After several unsuccessful attempts to talk with Dixiana over the phone, she was sent an email on January 25th asking for an update. She responded on January 30th explaining their internet had been down but would investigate and email us back very soon. When nothing had been heard from Dixiana by February 14th, TBNet staff emailed Dixiana again, asking for information. On February 23rd TBNet staff called Dixiana directly. She said that their internet had had problems but that she had access now and would send the information via email. That same day, we received an email from Dixiana stating that the patient had reinitiated the second phase of treatment on January 10th, taking medication three times per week. Now confident the patient was receiving adequate treatment, TBNet staff waited four weeks before requesting an update. On March 23rd, TBNet staff emailed Dixiana, asking her for an update. She emailed back the same day saying that the patient was continuing treatment. On April 27th, TBNet staff called Dixiana again to ask for an update. She said she would investigate and email us the information. That same day, Dixiana emailed to say the patient had completed treatment, but did not give a date. We emailed her back, asking for the date treatment had been completed. We did not receive a response, so we called Hospital Atlantida on May 12th, but Dixiana was not available to find the information. On May 15th, TBNet staff emailed Dixiana again requesting an end date for treatment. On May 16th, Dixiana emailed back stating she had thought the patient had already finished treatment, but that she was just informed that in fact he would finish on May 19th. With this information, TBNet staff closed the case. ■

AgJOBS Enjoys Victory in Senate

Adrienne DerVartanian, Staff Attorney, Farmworker Justice

On May 25, 2006, farmworkers achieved a major victory in the Senate with the inclusion of the Agricultural Job Opportunities Benefits and Security Act, S. 359 (AgJOBS), in the Comprehensive Immigration Reform Act of 2006, S. 2611, which passed by a vote of 62-36. Opponents of AgJOBS unsuccessfully sought to prevent AgJOBS from being included in the bill and to eliminate the major worker benefits and protections from the AgJOBS sections.

AgJOBS is a compromise between farmworker advocates (led by the United Farm Workers of America) and major agricultural employers. The primary sponsors of AgJOBS are Senators Larry Craig (R.-Idaho), Edward Kennedy (D.-Mass.), and Dianne Feinstein (D.-Cal) in the Senate and Reps. Chris Cannon (R.-Utah) and Howard Berman (D.-Cal.) in the House of Representatives. AgJOBS contains two main parts: (1) an "earned adjustment" program allowing many undocumented farmworkers to obtain a temporary immigration status and then, through continued agricultural work, permanent status; and (2) revisions to the H-2A temporary foreign agricultural worker program.

On May 15, 2006, after a failed attempt to pass an immigration bill in early April, the Senate took up immigration reform again and began debating the Comprehensive Immigration Reform Act of 2006, S. 2611, sponsored by Senators Specter, Hagel, Martinez, Kennedy, McCain, and others, which includes AgJOBS. Senator Chambliss (R-Ga.), who has a history of introducing anti-worker immigration bills making one-sided changes to the H-2A agricultural guestworker program, again attempted to defeat the AgJOBS compromise. Senator Chambliss submitted a dozen amendments that would have undermined the AgJOBS compromise by eliminating the AgJOBS earned legalization program and removing several key labor protections from the H-2A

guestworker program. These amendments were very similar to the proposal Chambliss offered in April 2005, which lost by a vote of 77-21. The Senate debated and voted on two of his amendments.

The first of Sen. Chambliss's amendments would have slashed wage rates in the H-2A agricultural guestworker program by making the federal minimum wage inapplicable to H-2A agricultural guestworkers and abolishing the historical adverse effect wage rate (AEWR), which is a special wage protection created in response to wage depression during the Bracero guestworker program. The American Farm Bureau Federation lobbied heavily for this amendment; however, many other major agribusiness employer groups continued to support the AgJOBS compromise. On May 22, the Senate voted 50-43 against the Chambliss wage amendment by voting to table it, meaning that it was removed from further consideration.

Sen. Chambliss then went forward on another amendment which would have undermined the blue card program by imposing heavy fines, unrealistic English language requirements, and overly burdensome work requirements on farmworkers applying for the legalization program. Again, AgJOBS supporters were successful in defeating this amendment. On May 24, 2006, by a resounding vote of 62-35, the Senate voted to table the amendment.

The following day, May 25, 2006, the Senate passed the Comprehensive Immigration Reform Act of 2006, S. 2611, which included AgJOBS. Now the Senate bill must be meshed with the House immigration bill, HR 4437 during a House-Senate Conference Committee. HR 4437 has served as the impetus for many rallies recently, bringing hundreds of thousands of immigrants and immigrant advocates to the streets to protest HR 4437's harsh provisions, such as criminalization of millions of undocumented persons, including children. HR 4437 fails to address the immigration crisis in agriculture and does not provide a realistic solution for the undocumented, who are the majority of the agricultural workforce.

Whether and how the House and Senate bills can be merged and whether AgJOBS would survive such a merger are questions to be played out over the next months. Please visit the Legislative News section of the Farmworker Justice website (www.farmworkerjustice.org) for updates about immigration reform. ■

Note: The Farmworker Justice Fund recently changed its name to Farmworker Justice.

Preparing for the Possibility of Pandemic Influenza

MCN is working closely with the Emergency Communication Team at the Centers for Disease Control and Prevention (CDC) to distribute helpful information about pandemic flu to frontline clinicians. We will also be working together to develop culturally appropriate patient education materials which we will make available as soon as they are developed. The following information is the first in a series of articles we will be running about disaster preparedness. Future issues of Streamline will feature articles that deal specifically with how to prepare and work with a mobile population in the case of disaster.

Planning for pandemic influenza is critical for ensuring a sustainable healthcare response. The Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) have developed the following checklist to help medical offices and ambulatory clinics assess and improve their preparedness for responding to pandemic influenza. This checklist is modeled after a pandemic preparedness checklist for hospitals and should be used in conjunction with guidance on healthcare preparedness planning in Supplement 3 of the HHS Pandemic Influenza Plan. Many of the issues included in the checklist are also relevant to other outpatient settings that provide episodic and chronic healthcare services (e.g., dental, podiatric, and chiropractic offices, ambulatory surgery centers, hemodialysis centers). Given the variety of healthcare settings, individual medical offices and clinics may need to adapt this checklist to meet their unique needs. Further information can be found at www.pandemicflu.gov.

This checklist identifies key areas for pandemic influenza planning. Medical offices and clinics can use this tool to identify the strengths and weaknesses of current planning efforts. Links to websites with information are provided throughout the document. However, actively seeking information that is available locally or at the state level will be necessary to complete the development of the plan. Also, for some elements of the plan (e.g., education and training programs), information may not be immediately available and it will be necessary to monitor selected websites for new and updated information.

1. Structure for planning and decision making.

TASKS ☐ Not Started ☐ In Progress ☐ Completed

Pandemic influenza has been incorporated into emergency management planning for the organization.

A planning committee[1] has been created to specifically address pandemic influenza preparedness for the medical office or clinic.

A person has been assigned responsibility for coordinating preparedness planning for the practice or organization (hereafter referred to as the pandemic influenza response coordinator). (Insert name, title and contact information)

_____

Members of the planning committee include the following: (Insert below or attach list with name, title and contact information for each)

Administration: _____

Medical staff: _____

Nursing: _____

Reception personnel: _____

Environmental services (if applicable): _____

Clinic laboratory personnel (if applicable): _____

Other member(s): _____

_____

A point of contact (e.g., person assigned infection control responsibility for the organization or an outside consultant2) for questions/consultation on infection control measures to prevent transmission of pandemic influenza has been identified. (Insert name, title, and contact information) _____

_____

2. Development of a written pandemic influenza plan.

TASKS ☐ Not Started ☐ In Progress ☐ Completed

Copies of relevant sections of the Department of Health and Human Services Pandemic Influenza Plan have been obtained from *www.hhs.gov/pandemicflu/plan*; copies of available state pandemic plans also should be obtained. _____

_____

A written plan has been completed or is in progress that includes the elements listed in #3 below. _____

_____

The plan describes the organizational structure (i.e., lines of authority) that will be used to operationalize the plan._____

_____

Plan incorporates and compliments the community response plan. _____

_____

3. Elements of an influenza pandemic plan.

TASKS ☐ Not Started ☐ In Progress ☐ Completed

A plan is in place for surveillance and detection of pandemic influenza in the population served.

- Responsibility has been assigned for monitoring public health advisories (federal and state) and informing members of the pandemic influenza planning committee and/or the pandemic influenza response coordinator when pandemic influenza is in the United States and when it is nearing the geographic area (e.g., state and/or city). (For more information, see www.cdc.gov/flu/weekly/fluactivity.htm) (Insert name, title and contact information)

  _____

- A system has been created to monitor and review influenza activity in patients cared for by clinical staff (i.e., weekly or daily number of patients calling or presenting to the office or clinic with influenza-like illness) and among medical office or clinic staff. (For more information see *www.cdc.gov/flu/professionals/diagnosis/*) (Monitoring for seasonal influenza activity is performed to ensure that the monitoring system for pandemic influenza will be effective and will ensure that organizations can detect stressors that may affect organizational capacity, such as staffing and supply needs, and hospital and emergency department capacity [and supply needs] during a pandemic)
- A system is in place to report unusual cases of influenza-like illness and influenza to the local or state health department. (For more information see *www.hhs.gov/pandemicflu/plan/sup1.html#outpat* and *www.hhs.gov/pandemicflu/plan/sup5.html#nov*)

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A communication plan has been developed.

- Key public health points of contact for pandemic influenza have been identified and arrangements have been made for telephone, facsimile, or e-mail messaging.

  Local health department contact: (Insert name, title and contact information)

  _____

  State health department contact: (Insert name, title and contact information)

  _____

- The office or clinic's point person for external communication has been assigned. (Having one person who speaks with the health department, and if necessary, media, local politicians, etc., will help ensure consistent communication is provided by the organization) (Insert name, title and contact information)

  _____

- A list has been created of healthcare entities and their points of contact (e.g., local hospitals/health facilities, home health care agencies, social service agencies, emergency medical services, commercial and clinical laboratories, relevant community organizations [including those involved with disaster preparedness]) with whom the medical office or clinic anticipates that it will be necessary to maintain communication and coordination of care during a pandemic. (Attach or insert location of contact list)

  _____

- The pandemic response coordinator has contacted local or regional pandemic influenza planning groups to obtain information on communication and coordination plans, including notification when updated plans are created. (For more information on state and local planning, see *www.hhs.gov/pandemicflu/plan/part2.html#overview*)
- A list or database has been created with contact information on patients who have regularly-scheduled visits and may need to be contacted during a pandemic for purposes of rescheduling office visits or assigning them to another point of care. (Insert location of list/database)

  _____

A plan is in place to provide an education and training program to ensure that all personnel understand the implications of, and control measures for, pandemic influenza

- A person has been designated to coordinate education and training (e.g., identify and facilitate access to education and training programs, maintain a record of attendance at education and training programs). (Insert name, title and contact information)

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- Current and potential opportunities for long-distance (e.g., web-based) and local (e.g., health department or hospital sponsored programs, programs offered by professional organizations or federal agencies) education of medical and nursing personnel have been identified. (*http://www.cdc.gov/flu/professionals/training/*)
- Language and reading-level appropriate materials on pandemic influenza (e.g., available through state and federal public health agencies and professional organizations) appropriate for professional, allied and support personnel have been identified and a plan is in place for obtaining these materials. (For more information see *www.cdc.gov/flu/professionals/patiented.htm*)
- Education and training includes information on infection control measures to prevent the spread of pandemic influenza. *www.hhs.gov/pandemicflu/plan/sup4.html* _____

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Informational materials for patients on pandemic influenza that are language and reading-level appropriate for the population being served have been identified, and a plan is in place to obtain these materials. (For more information see www.cdc.gov/flu/professionals/patiented.htm)

- The roles of medical and nursing personnel in providing health care guidance for patients with pandemic influenza have been established.

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A plan for triage and management of patients during a pandemic has been developed.

- A system is in place for phone (and e-mail, where appropriate) triage of patients to determine who requires a medical evaluation, to limit office visits to those that are medically necessary.
- Plans have been developed to manage patient care at the height of the pandemic including the following possibilities:
  - Temporarily canceling non-essential medical visits (e.g., annual physicals).
  - Designating separate blocks of time for non-influenza and influenza-related patient care.
  - Local plans and criteria for the disposition of patients following a medical evaluation (e.g., hospitalization, home health care services, self- or family-based care at home) have been discussed with local hospital and health care agencies and local health department. (Flexibility will be necessary based on hospital bed capacity)

An infection control plan is in place and includes the following:
(For information on infection control recommendations for pandemic influenza see *www.hhs.gov/pandemicflu/plan/sup4.html*)

- A specific waiting room location has been designated for patients with symptoms of pandemic influenza that is segregated from other patients awaiting care. (This may not be feasible in very small waiting rooms, in which case the emphasis may be on use of masks as noted below)
- A plan for implementing respiratory hygiene/cough etiquette is in place. (For more information see *www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm*)
  - Signage (language appropriate) directing patients and those accompanying them to notify reception personnel if they have symptoms of pandemic influenza has been developed or a source of signage (e.g., CDC website above) has been identified.
  - Signage (language appropriate) on Respiratory Hygiene/Cough Etiquette instructing symptomatic persons to use tissues to cover their cough to contain respiratory secretions and perform hand hygiene has been developed or a source of signage (e.g., CDC website above) has been identified.
  - The plan includes distributing masks to symptomatic patients who are able to wear them (adult and pediatric sizes should be available), providing facial tissues, receptacles for their disposal and hand hygiene materials in waiting areas and examination rooms.
  - Implementation of Respiratory Hygiene/Cough Etiquette has been exercised during seasons when influenza and other respiratory viruses (e.g., respiratory syncytial virus, parainfluenza virus) are circulating in communities.
  - If patients with pandemic influenza will be evaluated in the same location as patients without an influenza-like illness, separate examination rooms have been designated for evaluation of patients with symptoms of pandemic influenza.
  - A policy is in place that requires healthcare personnel to use Standard (*www.cdc.gov/ncidod/dhqp/gl_isolation_standard.html*) and Droplet Precautions (i.e., mask for close contact) (*www.cdc.gov/ncidod/dhqp/gl_isolation_droplet.html*) with symptomatic patients.
  - The policy includes protection of reception and triage personnel at initial points of patient encounter.

A vaccine and antiviral use plan has been developed.

- vWebsites where current federal and/or state health department recommendations for the use and availability of pandemic influenza vaccines and antiviral medications have been identified. (For more information see *www.hhs.gov/pandemicflu/plan/sup6.html*)
- An estimate of the number of personnel and patients who would be targeted as first and second priority for receipt of pandemic influenza vaccine or antiviral prophylaxis, based on HHS guidance for use, has been developed. (*www.hhs.gov/pandemicflu/plan/appendixd.html*) (This estimate can be used for considering which patients may need to be notified first about vaccine or antiviral availability, anticipating staffing requirements for distribution of vaccines and antivirals, and for procurement purposes)

An occupational health plan has been developed and includes the following:

- A liberal/non-punitive sick leave policy for managing personnel who have symptoms of or documented illness with pandemic influenza. The policy considers:
  - The handling of staff that become ill at work.
  - When personnel may return to work after recovering from pandemic influenza.
  - When personnel who are symptomatic, but well enough to work, will be permitted to continue working.
  - Personnel who need to care for their ill family members.
  - A system for evaluating symptomatic personnel before they report for duty and tested during a non-pandemic influenza period.
  - Mental health and faith-based resources that are available to provide counseling to personnel during a pandemic.
  - The management of personnel who are at increased risk for influenza complications (e.g., pregnant women, immunocompromised healthcare workers) by placing them on administrative leave or altering their work location.
  - The ability to monitor seasonal influenza vaccination of healthcare personnel.
  - The offer of annual influenza vaccine to medical office or clinic personnel.

Issues related to surge capacity (i.e., dealing with an influx of patients and staff and supply shortages) during a pandemic have been addressed. (For more information see *www.hhs.gov/pandemicflu/plan/sup3.html#surge*)

- Plans for managing a staffing shortage within the organization due to illness in personnel or their family members have been addressed.
- Staff have been encouraged to develop their own family care plans for the care of dependent minors and seniors in the event community containment measures (e.g., "snow days," school closures) are implemented. (*www.pandemicflu.gov/planguide/checklist.html; www.pandemicflu.gov/planguide/familyhealthinfo.html)*
- The minimum number and categories of personnel necessary to keep the office/clinic open on a given day have been determined.
- Plans for either closing the office/clinic or recruiting temporary personnel during a staffing crisis have been addressed.
- Anticipated consumable resource needs (e.g., masks, gloves, hand hygiene products, medical supplies) have been estimated.
- A primary plan and contingency plan to address supply shortages have been developed and each details procedures for acquisition of supplies through normal channels, as well as requesting resources when normal channel resources have been exhausted.
- Plans include stockpiling at least a week's supply of consumable resources, including all necessary medical supplies, when there is evidence that pandemic influenza has reached the United States.

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[1] The committee could be very small (e.g., two or three staff members) or very large, depending on the size and needs of the organization.

[2] Formal memorandum of understanding or contract may be needed if an outside consultant is used.

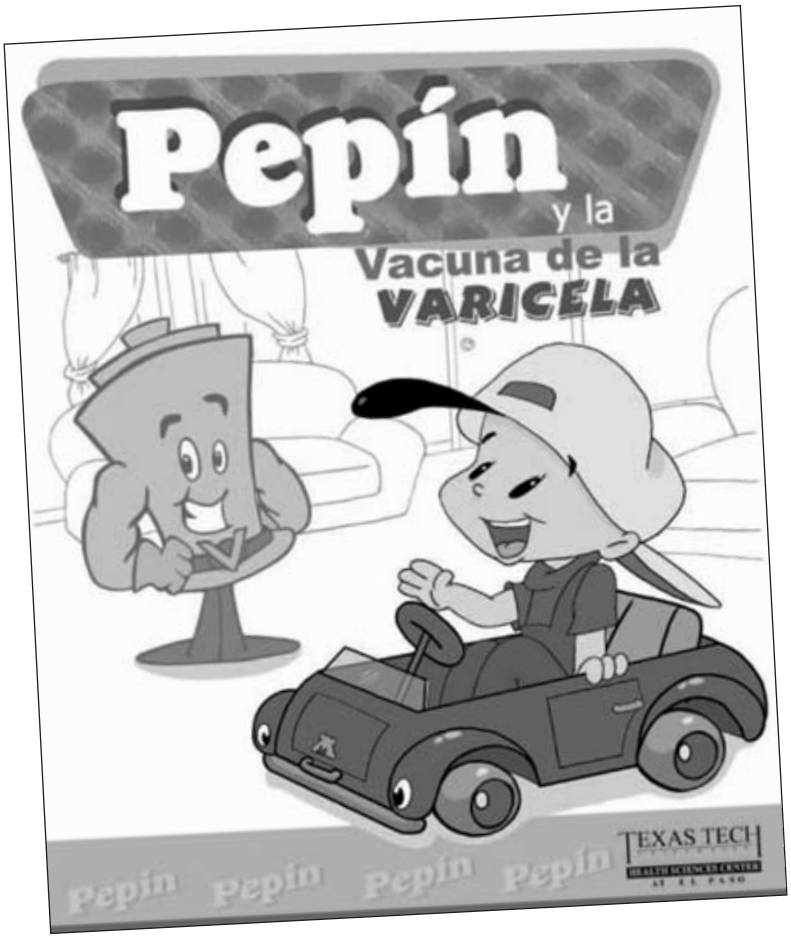
Using Animated Cartoons to Improve Communication about Vaccines

Marie Leiner, Ph.D., Department of Pediatrics. Texas Tech University Health Sciences Center – El Paso.

Delivering vaccine communication to a diverse population can be very challenging. Communicating the age-appropriate immunization schedule, the science and the safety of vaccines involves highly complex information which must be effectively communicated to a diverse audience.

Strategies to improve the effectiveness of patient education include the use of printed materials[1], videos[2], computer-based programs[3], graphic symbols[4] and a combination of easy-to-read written materials with added oral instructions[5-8]. Animated cartoons have unique attributes which can provide significant advantages over many other formats. In the first place, animation involves motions that capture the viewer's attention and trigger visual interest for the information presented, which makes learning more appealing and enjoyable to viewers. In the second place, animation can combine other elements including sound, color, and a combination of visual and written material. This promotes learning for both visual and auditory learners.

Animated cartoon presentations of immunization information have been demonstrated to overcome many communication barriers[9] if they successfully incorporate three important design elements. The first critical element is the use of narration instead of dialogue. Narrative forms can tell a complex story quickly and with relatively few words. In addition, the narrative structure presents concepts in a more fluid, progressive manner which makes for a more natural learning process. The second key element is the presentation of a situation that is easy for the viewer to relate to, to understand and to emulate. By presenting the information through animated cartoons, it is possible to provide more flexible characters and situations. A character can be created in such a way as to appear the same all the time and does not look like a specific ethnic group or possess a specific gender. Finally, the length of the presentation has an important implication in the learning process. Viewers, by nature, will not be attentive for long periods and are more predisposed to watch educational material if the presentation is short.



Generally, a large amount of information can be presented in 8-10 minutes if the presentation is well-designed.

A thorough understanding of health information depends on the mechanisms used to convey the relevant content. Communicating information about vaccines requires a presentation that considers disparities caused by low literacy, educational levels and beliefs directly related to risks and benefits of immunizations. To gain the interest, compliance and understanding of vaccines in all segments of our population every available tool must be used to reduce miscommunication between health providers and patients and their families. Animated cartoons offer an innovative strategy to communicate complex information and can help health providers to overcome barriers of communication with their patients.

For more information about the Pepin animated series on a variety of immunization topics please visit MCN's website at www.migrantclinician.org/excellence/immunizations. ■

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EPA to Phase out Pesticide that Poisons Farmworkers

Seattle, WA — The Environmental Protection Agency has announced that it will phase out the use of a pesticide that poisons farmworkers. EPA took the action after as part of a settlement of a lawsuit brought by farmworkers challenging EPA's decision to allow continued use of this pesticide.

"This pesticide has put thousands of workers at risk of serious illness every year," said Erik Nicholson of the United Farmworkers of America. "The phase out is welcome, although it should have come years ago."

The pesticide, azinphos-methyl ("AZM"), is a highly toxic organophosphate neurotoxin. Organophosphate pesticides, derived from nerve agents used during World War II, attack the human nervous system. Exposure can cause dizziness, vomiting, seizures, paralysis, loss of mental function, and death. Farmworker families and communities are exposed to organophosphates through "take-home" exposures on clothing, cars, and skin.

Under federal law, EPA decides which pesticides may be used throughout the United States. In 2001, EPA had found that AZM poses unacceptable risks to workers, but it allowed the pesticide to continue to be used for four more years because less toxic alternatives were more costly. Farmworker advocates had challenged that decision in federal court in Seattle because EPA failed to account for the costs of poisoning workers, exposing children, and polluting rivers and streams to the detriment of endangered species. The farmworker groups bringing the lawsuit were United Farm Workers of America ("UFW"), Sea Mar Community Health Centers, Pineros y Campesinos Unidos del Noroeste ("PCUN"), Beyond Pesticides, and Frente Indígena Oaxaqueño Binacional. As a result of the lawsuit, EPA committed to reconsider whether to ban AZM, and on June 9, 2006, it announced its decision to phase-out AZM use completely within four years.

In its proposed decision, EPA would phase out all uses of AZM by 2010 with some uses phased out by 2007. The decision would also eliminate aerial spraying, require 100 foot buffers around water bodies, reduce application rates, require buffers around buildings and occupied dwellings, and require medical monitoring of workers entering fields sprayed by AZM.

"It is outrageous that EPA allowed continued use of this pesticide knowing that it would expose farmworkers to unacceptable risks of pesticide poisonings," said Patti Goldman, an attorney for Earthjustice. "Since growers have already had four years to shift to other pest controls, there is no reason to subject workers and their communities to more poisonings for another four years."

AZM is used primarily to kill insects on orchard crops such as apples, cherries, pears, preaches and nectarines. The highest uses occur in Washington, Oregon, California, Michigan, Georgia, New York, New Jersey and Pennsylvania.

"EPA had turned its back on the men, women, and children who are threatened by an extremely hazardous pesticide that should be replaced with new safer alternatives," said Shelley Davis, attorney for the Farmworker Justice. "It is time to make that shift now." ■

For further information, please visit these websites:

Earthjustice:
http://www.earthjustice.org/campaign/display.html?ID=9

Farmworker Justice:
http://www.fwjustice.org/

Feedback from the Field

Tiendas are in the News!

Tiendas, those little Mexican or Hispanic stores that now appear in even small rural towns, provide more than a taste of home to their customers. In addition to importing foods, wiring money, and providing a central location for folks to visit, tiendas also may be offering unregulated medical care. It's not only tiendas, but also other marketplaces with similar missions, selling goods to immigrant groups, that serve as medical centers for their clients. A number of news articles have recently addressed this issue. Misunderstandings go two ways: both US medical personnel and immigrant patients need assistance in distinguishing safe lawful practices from harmful ones. Here we'll highlight two recent stories:

- The North Carolina Medical Board published a story in 2005 called "Tiendas and Contraband Pharmaceuticals." While it quite accurately pointed out that there is a two tier system for obtaining prescription medications in this country, it failed to recognize the access issues and cultural factors that play a vital role in patient medication management. Not only do some patients self-diagnose and self-treat, but for some immigrants, this represents the only option of which they are aware. For others, this is considered to be a good option because it is trustworthy. The North Carolina Board suggested reporting patients who use this illegal method of obtaining prescriptions via tiendas. However, MCN's concern is that clinicians must educate and integrate before all else—in many cases patients are not choosing to "break the law," but are doing their best to treat health concerns in a foreign situation. Migrant/Community Health Centers can play a vital role in linking tiendas, pharmacies, patients, and providers so that all are aware of US prescription drug practices and so that those in need can have safe, effective, affordable medi-

continued on page 7

Celebrating the MCN 2006 Unsung Hero!

On May 22nd, 2006 at the National Farmworker Health Conference, MCN honored Dr. Horace Harris, our 2006 Unsung Hero. MCN Unsung Heroes are distinguished by their demonstrated dedication to migrant health. Qualifications also include innovation in service delivery or prevention strategies. Other attributes include their leadership skills or contributions to the health of those who need it, but often do not get it. The following was written by Margie House of Tri-County Community Health Center in North Carolina explaining why Dr. Harris is an Unsung Hero.

Dr. Harris started at Tri-County Community Health Center (TCCHC) as a National Health Service Corp (NHSC) Officer on July 5, 1990 and 16 years later he is still here. When Dr. Harris began working at TCCHC it was in a double-wide trailer shared with administration and he was the only dentist. Our patient population consisted of migrant and seasonal farmworkers and the Medicaid population. Dr. Harris decided that the dental program was so busy we needed another dentist and successfully recruited a NHSC Officer. Dr, Harris retired from the NHSC on March 2, 1998 and stayed here at Tri-County as the Dental Director and part of the management team. Under Dr. Harris's leadership every time a satellite clinic was opened dental services were included. Dr. Harris works closely with physicians because he understands how important oral health is to the overall health of our patients. Dr. Harris started an outreach program to go to the Migrant Head Start programs in our area and the surrounding counties, he works with other organizations helping those who can't come to the center or a dentist office receive the dental care they need by volunteering on the Baptist Men's Medical/Dental Bus that travels all over the State. He has organized the Bus to be at our new satellite centers so patients can be seen before the new centers were even built. Working closely with UNC-Chapel Hill Dental School, Dr. Harris has arranged for students and residents to do rotations at TCCHC. Currently he is working with UNC Dental School to build a new dental building with 18 operatories that will become a satellite teaching center. Dr. Harris has dedicated himself to the TCCHC patient population and has worked hard to make dental care a strong part of the overall health care of patients. Today TCCHC has dental services in our main site as well as three satellite centers and we employ a total of six dentists.

MCN's 2006 Unsung Hero
Horace Harris, DDS

In January of this year Dr. Harris was hit by a car while he was walking outside one of the satellite dental sites. He sustained nearly fatal injuries in this accident and has faced many months of recovery. During the healing process he has not stopped caring and working on the dental programs that matter so much to him. He stays in touch with administration and his staff via e-mail and phone calls. His number one priority is to get back to work.

I see Dr. Harris as an unsung hero because his heart and soul is in making sure the patient populations we serve receive the care they need and he has tirelessly worked toward making this happen.

TB*Net*: Celebrating 10 Years of Binational TB Care continued from page 6

cines. To read the North Carolina Medical Board story, please follow this link: *http://www.ncmedboard.org/Clients/NCBOM/Public/PublicMedia/no205.pdf*

- The Associated Press recently published a story entitled "Unsafe Imports Find Way to Store Shelves" (David B. Caruso, NY, 3/20/06). It reports that unregulated foreign medicinal imports are flooding shops frequented by immigrants and those seeking alternative remedies. Of 13.7 million products, only about 75,000 are sampled for safety concerns. It cites the sale of a compound sold for flu-like illness that contained mercury levels 2,190 times higher than deemed safe. Similar articles have reported lead toxicity in children's vitamins and candies, and heavy metals in creams, pills, and soaps from around the world. There is tremendous variation in the ingredients found in unregulated medications, whether labeled or not. A complete medication history includes a check on these over the counter products used as adjuncts to good health. To read the article, please go to: *http://muse.jhu.edu/journals/journal_of_health_care_for_the_poor_and_underserved/toc/hpu17.1.html*

To better understand the patient community, we recommend that providers visit tiendas in their areas and get a sense for what is being sold. As much as is possible, providers can take this opportunity to talk to the store owners and try to influence or advise on what should be stocked. As much as is possible, Migrant/Community Health Centers and health care providers can attempt to work collaboratively with the tiendas to better protect patient health and safety. ■

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calendar

2006 Annual Convention and Community Health Institute
August 25-29, 2006
Chicago, Illinois
National Association of Community Health Centers
301-347-0400
http://www.nachc.com

19th Annual East Coast Migrant Stream Forum
October 19–21, 2006
Sheraton Myrtle Beach Convention Center Hotel
Myrtle Beach, South Carolina
202-347-7377
http://www.ncchca.org/East%20Coast%202006.htm

14th Annual HIV/AIDS Update and Border Health Summit
October 25 – 27, 2006
South Padre Island, Texas
Valley AIDS Council, Texas/Oklahoma AETC
1-800-333-SIDA
http://www.valleyaids.org

The 16th Annual Midwest Stream Farmworker Health Forum
November 9-11, 2006
Hotel Albuquerque at Old Town
Albuquerque, New Mexico
1-800-531-5120

http://www.ncfh.org/00_clt_mwfsf.php

2006 International HIV/AIDS Meeting
November 17- 21, 2006
Baltimore, Maryland
Institute of Human Virology
410-706-8614
http://www.ihv.org

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