

streamline

Carrying Medicine, Food, and Hope:

A Pharmacist's Perspective on Post-Disaster Community Engagement

By Marysel Pagán Santana, MS, DrPH, Puerto Rico Program Manager, Migrant Clinicians Network

It is critical that health centers continue to work on emergency and disaster responses, updating them as community needs change and as the duration and frequency of disasters in many parts of the country increase. Here in post-Hurricane Maria Puerto Rico, health centers are taking the lessons from the devastating 2017 storm to build stronger community-centered and community-driven emergency plans, particularly in the rural and agricultural regions where, too often, residents find themselves without resources or networks to rely on after a disaster. Migrant Clinicians Network has been supporting these efforts through “Mobilizing Communities in Puerto Rico to Meet the Needs of Vulnerable Populations Before, During, and After a Natural Disaster,” a multi-year project funded by the Bristol-Myers Squibb Foundation. One aspect of community plan fortification is in engaging all clinicians throughout the health center. Earlier this year, I connected with Carmelo Nistal Vargas, PharmD, a pharmacist at Corporación de Servicios Médicos (CSM), a rural community health center in Puerto Rico that participated in the first year of our community mobilization project. He shared his work as a clinician, his experience during Hurricane Maria, and his thoughts on the aftermath. *This interview has been edited for clarity and brevity. It was conducted in Spanish.*

How long have you been working as a community pharmacist?

I have been working as a community pharmacist in this community health center for over 15 years. This is a community phar-



Carmelo Nistal Vargas, PharmD, at left, makes visits in the community.

macy, although it works as a diagnostic and treatment center pharmacy too, so it has hospital-like services.

Why did you choose to study pharmacy? Why work with a community health center?

Initially, I wanted to work in the pharmaceutical industry and I studied Industrial Microbiology. When I completed the pharmacy degree at the Medical Sciences Campus of the University of Puerto Rico, I was still focused on working in the industry. I worked in the industry and spent some time in the pharmaceutical field but I concurrently began to explore the field of community pharmacy. I considered the options

and I discovered that [in the community pharmacy], I felt more comfortable and I could help people. I felt that I could get closer to people through the community pharmacy. I decided to leave the pharmaceutical industry and went on to serve in community pharmacies.

What did you do to prepare for Hurricane Maria in 2017? What did the pharmacy do to prepare before the hurricane?

I always take preparation seriously. In my house, we were always ready in terms of

food, water, flashlights, and radios. We had already been through other hurricanes and storms such as Hortensia and Hugo. Although Hugo did not directly affect the northern part of the island, I had fellow students at the university spend about three months without power. I had their experience in mind, so I had prepared well at home to face a storm of that magnitude.

In the pharmacy, we already had a contingency plan to protect the property and try to advance treatments and medication. We tried to contact patients to come pick up their medications. The plan allows us to dispatch medication seven days before the patient runs out. So, he or she has at least seven extra days of therapies or treatment. We had organized response teams to determine the logistics of the pharmacy operation like who will arrive first. We also focus on storage: that the medications are well stored and in good condition. That the power generator is functioning well to keep the medications that require refrigeration, such as insulin, at the correct temperature. Basically, [we're focused on] damage prevention efforts and making sure that we could run the pharmacy as soon as possible.

How were you affected by the emergency?

My home got flooded — I hadn't anticipated that. The street where I live had never been flooded, and it was flooded. There were about four feet of water in my house so we had to leave it. I was pretty much in the street in the middle of the hurricane. I lost all my belongings. I had to relocate before returning to work. On the Monday after the hurricane, I was already at work. There, we started working on a response plan. Of CSM's clinics, only the external clinics, in Hatillo and Utuado, were the ones that were operating at that time.

Were there challenges with the medication dispatch? Who decided how many days of medication could be advanced? How did insurance play in?

The [insurance companies] did not anticipate what could happen. There were no instructions on how to proceed. During Maria there were no statement or instruc-

tions to advance medications. There were concessions that were made after the hurricane and during the emergency, but not before. Now, after Hurricane Maria, when Hurricane Dorian approached [in September, 2019], we already had communications and instructions. Now the response is different, and there is a government plan [to address medications during emergencies].

What kind of direct services were you able to provide during Hurricane Maria?

Our executive director at that time organized a support team to provide services for the people in Utuado. We left with two other technicians, and the others stayed back at the pharmacy [in Hatillo]. The pharmacy continued to operate with limitations; we had an electric generator and that helped us a lot. We began to deliver medications without billing, thinking that we would bill once we had access to the system — the system was down. We gave these services as instructed by the CEO, something that many community pharmacies could not do because of the fear that they would not receive payment afterwards. We risked a bit as a center with federal funds. We had to do it, advance medications in Hatillo, and provide the requested medications even if we were not sure that providers would cover or authorize [them].

The team that was organized included medical staff, nurses, and even administrative staff, to visit patients who were isolated, those who had a physical condition, and could not arrive to our clinic. We participated actively. We organized a big medicine cabinet, [and] we made medication packages. The problem we had initially, and the dispute we had, was that once we arrived [and evaluated a patient] we could not return [to the pharmacy to fill a particular prescription], so we had to carry with us about everything we could think of. We had a large package with several bottles and boxes, and we tried to categorize the medications in the list. We tried to have basic medicines, especially for chronic diseases such as hypertension and diabetes. We also had antibiotics and analgesics. After the patient was evaluated, we tried to dispatch enough for the patient to resolve and keep his/her health stable. It worked this way: we identified a sector that may have people in need, we got there and approached a house to make a house visit, the doctor evaluated

the patient, and consulting the list we provided the doctor made the prescription with the patient right there for us to dispatch immediately. In the house, in the garage, wherever it was. We were always as careful as possible to maintain the processes with hygiene and aseptic protocols. It was well organized and executed.

How long were clinical brigades working this way?

Utuado was one of the most devastated towns by the hurricane. We were basically more than a month over there. The need was greater than our capacity to provide. Each day we went there, we found more need. More communities were identified that required assistance, or [another] senior center requested a visit in an isolated community. Utuado is large and the topography is very complicated. These mountains are sandy. It is very unstable. Every time we reached a place, what we saw was sand coming down from the mountain. A lot of mudslides and blocked roads. Isolated communities, which I believe, still have limited access to services.

When talking about and providing health services you have to evaluate the living conditions. We saw that. Sometimes the living conditions don't help the health condition. Their health doesn't improve due to lack of access to services or due to the limitations the patient has. If you see their quality of life and living conditions you realize that the problem is more complicated, it uncovers many things [that you do not see in the clinic].

Now that you are back in the pharmacy, has something changed? Is there a different dynamic?

What I can say is that we all liked the experience. I would like to do it again, a pharmacist that does house visits. The experience was very good... Perhaps if I was not able to give them their medications, their condition would worsen or it could have been worse, one does not know what could have happened. We continued to do these kinds of clinics, but of course when stability is achieved we are required to return to our usual positions and roles. Those are corporate decisions; we don't have the resources to do it all year. It would involve transportation and travel, and we have no way of sus-

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This publication is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling \$1,094,709.00 with 0 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

#MeToo in the Fields:

New Video and Curriculum to Eliminate Agricultural Worker Sexual Harassment

By Claire Hutkins Seda, Writer, Migrant Clinicians Network and Managing Editor, *Streamline*

When the #MeToo movement exploded into the national dialogue two years ago, Victoria Breckwich Vásquez, DrPH, MPH, Chair of the Washington Coalition to Eliminate Farmworker Sexual Harassment, feared that the movement was leaving out low-wage workers. “We felt something more was needed: specific conversations around farmworker health and safety in the workplace,” she said. “Despite nationwide efforts and lots of publicity and media, there is ongoing violence towards farmworker women and men that was going unrecognized and not talked about.”

Four years prior, Dr. Breckwich Vásquez had started labeling sexual harassment as an occupational health issue. Dr. Breckwich Vásquez was then working at the Pacific Northwest Agricultural Safety & Health Center (PNASH) at the University of Washington (UW), and as part of Yakima-based El Proyecto Bienestar, a collaboration between UW, Radio KDNA/NCEC, Yakima Valley Farmworkers Clinic and Heritage University. There, she conducted trainings with agricultural worker women on pesticides and other workplace hazards. A few agricultural worker women and a PNASH field staff person approached her to ask if she considered sexual harassment a health and safety issue, since that was on everyone’s minds, “and I stood there, without answers,” she admitted. “We proceeded to do our research, and no agricultural centers were addressing sexual harassment as an occupational health issue.

“Mostly, it’s seen as a legal issue — that an agricultural worker should file a complaint and get a lawyer,” she continued. “But it’s preventable, and so we focused on that: on prevention at the worksite... Going to work exposed [agricultural workers] to huge risks of being assaulted sexually.” As the #MeToo movement broke, she and her colleagues pushed for attention on the rampant sexual harassment that primarily agricultural worker women, and gender nonconforming workers and some agricultural men, had complained about for decades — and advocated for prevention strategies.

One of the early projects that El Proyecto Bienestar worked on was to write a script for a radionovela that agricultural worker women developed from their own experiences. Later, that script and another developed for a popular theater project with the



Cast and crew of training video filming. Yakima WA, September 2019

state’s Department of Agriculture were the basis for a video script. Together with a companion curriculum, this would be used to train supervisors, growers, and agricultural workers on sexual harassment. She recalled a conversation with a grower who sat on a grower advisory committee. He told her, “What I need, and my members need, is a tool for training. We can talk and talk about this being a thing they shouldn’t do, but we don’t have a way to reach them in their language, we have no tools available. We have some lawyers giving presentations, but it’s not interesting or engaging — what can we do to get a video?” A subcommittee formed and began work on a video, building a script based on true stories that committee members shared (as agricultural women have been a part of every process), and developing a curriculum around the script.

The video’s audience is wide: “The supervisors were frequently the perpetrators. Growers were ultimately responsible for worker health and safety and held legally responsible. Farmworkers were suffering from the inaction,” so the video is geared for all three, Dr. Breckwich Vásquez explained.

As the #MeToo movement continued to peel back the rampant harassment that women face, growers — who just a few years before were reluctant to support her work — were now supporting the video efforts as donors. PNASH, Equitable Food Initiative and a UW Royalty Research grant, with Dr. Jody Early as principal investigator,

were key as early funders. Individual and organizational donations by state agencies, growers and supportive organizations buoyed the two-year-long process. The Washington Coalition to Eliminate Farmworker Sexual Harassment grew out of that work. Bringing together people with backgrounds in agricultural work, academics, policy, and advocacy, the coalition began to meet regularly to discuss and coordinate the diverse efforts around the state to eliminate sexual harassment in the agricultural industry.

In the summer of 2019, after the script got feedback from agricultural workers, community members, and attorneys, the coalition contracted with Latino Northwest Communications to do the filming. “They recruited great actors, and worked with us on the script on the set,” she said. The film wrapped up and was released in late November.

“A fifteen-minute video isn’t going to change behavior,” Dr. Breckwich Vásquez admitted. “We built a training that used the video as a tool, to have these kinds of discussions in the workplace.” The video is now available for free, and the companion curriculum is available for the cost of shipping and handling.

The main character, Juana, is named after Dr. Breckwich Vásquez’s mother, who moved from Peru to escape a difficult family life, to

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Witness to Witness:

Helping Health Care Supervisors Address Trauma, Moral Injury, and Burnout

By Claire Hutkins Seda, Writer, Migrant Clinicians Network and Managing Editor, *Streamline*

Clinicians are overwhelmed. But what exactly is fueling the emotional exhaustion? Clinician burnout, says Kaethe Weingarten, PhD, is just part of the problem, particularly in health centers motivated by a mission. Conditions in the workplace, like compacted patient schedules, lengthy performance measures, and frustration with electronic medical records are often cited as major factors in clinician burnout and they build up over time. The issue is so widespread that it has been declared an “epidemic” in newspapers across the country. Yet, Dr. Weingarten argues, what affects many clinicians is multifaceted. Mission-driven workplaces like health centers, seeking to serve those with few resources, may set the stage for burnout, as employees feel motivated or obligated to work longer hours or accept larger caseloads, to further the mission and not let patients down.

Layered on top of burnout is the trauma of caring for people who have experienced violence and violation. Secondary traumatic stress is an acute reaction to exposure to the

story or client that experienced the primary trauma — and it’s a common response among health care providers.

Just as troubling, but less recognized, is vicarious traumatization: “like burnout on a timeline,” Dr. Weingarten said in a recent MCN webinar for supervisors. “It doesn’t happen all of a sudden. It’s a slow, gradual process whereby exposure to trauma and the traumatic lives of the people that we work with really alter our worldview.” With vicarious traumatization, the world no longer feels safe; optimism fades.

These empathic responses to our workplaces pose the risk of real and lasting health concerns. “Moral injury” is a term often reserved for veterans, but Dr. Weingarten finds it useful in talking about the work of health care providers. “It has to do with what happens to us when we feel that we are working inside of systems where the systems themselves are failing to meet the needs of the people we deal with,” she said, wherein clinicians feel they are failing to consistently meet the needs of people they

are serving due to inadequacies of the systems of which they are a part. “It transgresses their moral code,” she added.

In response to widespread moral injury, Dr. Weingarten developed Witness to Witness, a program to provide short-term support to clinicians and other helpers in high-stress jobs working with clients who are themselves experiencing high levels of stress and trauma. She and the American Family Therapy Academy (AFTA) partnered with Migrant Clinicians Network to offer the program, particularly for clinicians working on the border. Through Witness to Witness, volunteer therapists from AFTA speak via phone or video chat for several sessions to talk through what they have witnessed and how it affects their work. This year, the focus broadened, with a specific initiative for clinicians and other service providers who worked through the Camp Fire, the terrifyingly rapid conflagration that burned down Paradise, California, killing 86 people, injur-

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ing many more, and leaving tens of thousands of residents homeless.

In partnership with Migrant Clinicians Network, Dr. Weingarten presented several webinars in the fall of 2019 specifically for clinicians to better understand and manage workplace trauma, including “Witnessing: Understanding the Effects of Overexposure to Stories of Trauma and What to Do About It,” and a follow-up webinar, “Witnessing: How Supervisors and Administrators Can Strengthen Peer Support in the Workplace.” A pre-webinar survey captured the feelings and emotions of 307 participants in the first webinar. While most indicated that they believed that the staff in a health care setting are the most stressed, the data showed otherwise. The supervisors were found in the survey to have the highest stress levels of the hierarchy of administrators, supervisors, and clinicians.

Dr. Weingarten surmises that supervisors are “sandwiched” with responsibilities from the expectations of their administrators and the needs of their frontline staff, both of which they may struggle to fulfill. The pre-webinar survey found that supervisors could recognize when staff were stressed, but didn’t have procedures in place to monitor or address it. Supervisors also indicated other obstacles to their emotional responses: insufficient training to offer trauma-sensitive debriefing; a fear of showing vulnerability to their staff; confusion around showing emotions when objectivity is a cornerstone of good medicine; concern about using time on emotional healing instead of reaching productivity goals or directly serving patients; and other logistical and time constraints. But, Dr. Weingarten noted, much of these obstacles and concerns can be overcome.

“The research literature is completely clear that social support is the most effective antidote to stress,” Dr. Weingarten said in response. In a follow-up survey conducted ahead of the second webinar geared towards supervisors and administrators, almost none of the respondents said they had a group or team process in place to offer social support, or that there were regular ways for a team to use social activities as a way of building support. “When there isn’t social support, people withdraw and isolate — it’s an amplifier of stress and distress,” Dr. Weingarten said. “That’s really the current we’re trying to work against.”

The second webinar focused on strategies for supervisors and administrators to develop social support within the constraints of the health center world. She gave approaches to improve the work climate through leadership and culture development, to assure staff members know that processing trauma is an important part of their work during work hours. She provided numerous ways to improve work culture: “Know your staff,” she

recommended as one measure. “What motivates them? What’s their work style?” She also drew up example social structures that could be developed and encouraged, including brief team meetings, a buddy system, regular team social events, mindfulness app support, and self-care check-ins. She provided numerous resources (see resources and sidebar) for participants after the webinar as well.

“How we manage our witnessing of violence and violation, of microaggressions and moral injury, have ramifications with a whole host of people with whom we’re involved: personal, institutions we work with, and society as a whole,” Dr. Weingarten said during the webinar. “We’re not just individuals doing the work we do. We’re in positions of authority, so we carry an extra responsibility.”

RESOURCES

MCN’s webinars on Witness to Witness and trauma in the workplace are archived on our website.

Visit <https://www.migrantclinician.org/archived-webinars.html> to watch.

For more info on Witness to Witness or to sign up for sessions with an AFTA volunteer, visit <http://afta.org/w2w/>.

Read MCN’s article, “Witnessing: How Clinicians Can Move From Traumatic Stress to Empowerment While Serving Their Immigrant Patients,” from the fall 2018 issue of Streamline: <https://bit.ly/2Xfr6pY>.

For further reading, Dr. Weingarten recommends this STAT opinion piece by Simon G. Talbot and Wendy Dean: “Physicians Aren’t ‘Burning Out.’ They’re Suffering From Moral Injury,” at <https://bit.ly/2NL7qHv>. She also points to “Practicing G.R.A.C.E.: How to Bring Compassion Into Your Interactions With Others,” by Roshi Joan Halifax, at <https://bit.ly/2Ko2Z3l>.

Here are some of the resources presented particularly for supervisors. For the full list, please watch the archived webinar.

Managers Who Lead: A Handbook for Improving Health Services, by Management Sciences for Health: <https://bit.ly/376G9XL>

Vicarious Resilience, by Pilar Hernandez-Wolfe, PhD: <https://bit.ly/376GdGZ>

Ideas for team meetings to help with workplace stress



1) Plan to meet daily or weekly for 10-15 minutes at a set time. Be consistent.



2) Preferably convene no fewer than 3 people at a time and no more than 12.



3) Rotate who facilitates the meeting.



4) Go around “popcorn style” (when each person is ready to speak, s/he/they speak) and say one word or phrase to sum up how you are feeling right now about the work situation.



5) Play a two to five minute mindfulness exercise. These are readily available as free apps (Insight Timer, Headspace and Calm all have good tools for this). Listen to this exercise together. Take deep breaths.



6) Share an anecdote in relation to work that made you feel useful, hopeful, appreciated, acknowledged or grateful. If no one has anything to share for item #6, move to item #7.



7) Share something you did for self-care that was helpful.



8) Conclude with offering a word or phrase for how you feel right now after this team meeting.

Designed by Kaethe Weingarten, Ph.D., Director, Witness to Witness Program, afta.org/w2w
Direct questions, comments and feedback to Kaethe at kaethew@gmail.com

Access this resource at: <https://bit.ly/2NNJP99>.

taining it at the moment. Almost everything we gave on the street we donated — we did not recover it in reimbursements and we did not bill it. If we make this dynamic throughout the year, it would require some external [financial] resources. I still think it's necessary.

Health services have to move towards the community. It is difficult because of topography and road access. Perhaps it seems like we impact fewer people that way, but these patients are in need — people who live alone or have no way of moving. There were patients we reached, who had no one. We were the ones who visited them. Nobody else. Elderly people, many abandoned people, many people with disabilities. They were always there, we just happened to see it because a hurricane had passed and it made us look.

With the migration of young people [from Puerto Rico to the mainland US], there are more people left alone. The abandonment of the elderly by their grown children is real. The impact on the health and [availability of] treatment of these elderly people is significant because they [can't read the instructions well] or do not know what they are taking. They make mistakes with their medications. They need the support and supervision to be able to comply with their treatment.

Any particular story you remember from this experience?

I remember a person who lives in Utuado, an elderly person who takes care of her son, a mature adult with disabilities. It is a difficult situation for this caregiver. This woman worries that she will die and leave her son without a caregiver. They lived in an isolated place, had no help or neighbors. So we were their support. I also remember a community in Utuado. They embodied the best qualities of what Puerto Ricans are today. They are very friendly, humble, and hospitable. You feel comfortable and at ease. We still keep in touch with them. It is as if we have known them for a lifetime.

There were so many cases — all were iso-



Photo courtesy of CSM

They were always there, we just happened to see it because a hurricane had passed and made us look.

lated people. Sometimes we were for a long time on a road that seemed so desolate — and in the end we found a house with an elderly patient. That was repeated often. [We saw] people catching rainwater or without power, and living conditions that do not allow someone to take care of their health.

How did you manage your personal situation while helping others?

As for my situation, I got over it with work. My situation was uncomfortable, but at the same time I saw the situations of others, I realized that I was fine [compared to them]. My coworkers supported me. My workplace was the place where I forgot about it and it made me think that what I had lost, I could recover.

It was a team effort. We called it “missions”. We all arrived under no matter the conditions — it rained and flooded for sever-

al days after the hurricane. It has been the best experience. It demonstrated the commitment of each employee and strengthened team dynamics. The [health center] did more than was expected. It was a work of commitment [to the community], not just compliance with funders and the government. Always with the same disposition, we don't get tired.

There is a need for us to make these in-house visits. This may be a model for other clinics. I feel very proud of what we did. [The hurricane] exposed us to this dynamic [of community work and home visits]. We will never forget it. We carried more than medicines and food; perhaps we brought hope to those who had never been visited.

Learn more about MCN's work in Puerto Rico: <https://bit.ly/2Kwekyc>.

Visit the Bristol-Myers Squibb Foundation: <https://bit.ly/2rRBqJb>.

■ **New Video and Curriculum to Eliminate Agricultural Worker Sexual Harassment** continued from page 3

work as a nurse in Los Angeles. Dr. Breckwich Vásquez recognizes her mother's own fierce motivation and unending energy in the agricultural women she works with who generously shared their own difficult stories in hopes of making change. “[Juana, the main character, shows] amazing vulnerability during certain parts of the video, but she knows her work, her value, and she speaks justice and she keeps going, she doesn't turn back,” Dr. Breckwich Vásquez said. “So many farmworker women have

that same sense of justice — they just want others to not experience what they went through.”

Resources:

Access the video and order the curriculum at: <https://deohs.washington.edu/pnash/toolkit>

Read more about PNASH's work on prevention of sexual harassment in agriculture: <https://deohs.washington.edu/pnash/sexual-harassment>

Connect with the Washington Coalition to Eliminate Farmworker Sexual Harassment on Facebook: <https://www.facebook.com/WCEFSH/>

The Power and Control Wheel for immigrant women, in English and Spanish, is a great resource for use in the exam room, from Futures Without Violence: <https://www.futureswithoutviolence.org/power-and-control-tactics-used-against-immigrant-women/>

Casa de Esperanza is a nonprofit national resource center focused on sexual violence with culturally appropriate and engaging resources in English and Spanish. Health centers can present Spanish-language signage to encourage those suffering from abuse to get help; Casa de Esperanza offers a 24/7 bilingual hotline for those needing assistance: 651-772-1611. <https://casadeesperanza.org/es/>

Increasing Access to Vaccinations at the Mexican Consulate

By Claire Hutkins Seda, Writer, Migrant Clinicians Network and Managing Editor, *Streamline*

Roxana Pineda, Migrant Clinicians Network's Ventanilla de Salud Coordinator and Health Network Associate, is bursting with resources and data and fact sheets. "They say, 'I need more information.' And I say, 'I can give you more information!'" she laughed. The information she's giving is about vaccinations — but she does more than just provide information. At the Mexican Consulate in Austin, Pineda provides health outreach and organizes weekly health fairs to increase health access for Austin-area Latinos through MCN's partnership with Ventanilla de Salud, a program of the Institute for Mexicans Abroad to help Mexicans and their families residing in the US to access health services. Under a project launched in the spring of 2019, she and her MCN team began to work directly with Consulate visitors who may not have easy access to immunizations to first get them information and resources about vaccines, and then link them up with a City of Austin Public Health team at a Consulate health fair where the vaccine is available for free. And it is working.

"In the last few months, the work of Roxana has been incredible. Immunization is important," emphasized Nelly Salgado de Snyder, MA, DSW, a visiting scholar and researcher from the Instituto Nacional de Salud Pública de Mexico. Salgado de Snyder stepped into the vaccination project that Pineda and MCN's Deliana Garcia, Director of International Projects and Emerging Issues, had developed for three undergraduate interns. The project aimed to engage male visitors to the Mexican Consulate to better understand why Latino men have lower vaccination rates than women, and to follow up immediately with any resources or information to enable them to get vaccinated if they choose. Salgado de Snyder, leaning on decades of research, evaluated the initial questionnaire and methodology.

"I helped [the interns] understand what methodology is. I gave them a class on research methods: how to go about collecting information, the importance of constructing a survey properly, what the procedures are," she recalled. "They were very receptive." Salgado de Snyder followed up that training with more on how to develop unambiguous and concise research questions. Then, the interns applied their new knowledge to the vaccination project, and developed a questionnaire to pilot. After a short pilot period and some minor resulting adjustments, the interns, supported by Pineda and Salgado de Snyder, began to engage with male visitors to the Consulate.



The research team:
Nelly Salgado de Snyder,
Roxana Pineda, Brenda Pérez,
Alondra Morales,
Dania Diaz. Not pictured:
Jessica Calderón

"People at the consulate are there to get a passport or a birth certificate; they're just waiting... but the men were reluctant," she recalled. Many would avoid looking at the young researcher-interns, hoping they wouldn't approach. "But we would introduce ourselves, tell them we're conducting this very brief survey, and request verbal consent," pushing ahead despite verbal cues, Salgado de Snyder said. Anecdotally, the interns found that women were far more willing to be approached, even asking the researchers why they weren't being included. Many reluctant men were spurred on by their wives or female partners to participate. "What was interesting was that when men saw that other men were responding to the questionnaire, they'd be more willing to participate," Salgado de Snyder also noticed. "Men we had approached and said no, when we returned 10 or 15 minutes later, after they saw other men responding and that there was nothing to worry about, they'd say, 'okay, I'll respond.'"

The results of their work were evident within a few weeks. Every Friday, Pineda organizes a community health fair in conjunction with numerous Austin health agencies that provide direct services, including the provision of vaccinations for free to anyone who needs them. After the research participants answered the questions, Pineda and the interns followed up with more information and resources, including an invitation to a Friday health fair, for the men and their families. Following the start of the research project, Pineda saw an increase in the provision of vaccinations at the Friday health fairs. She credits the outreach provided while research was conducted as one factor, in addition to increased presence on social media and a growth in partnerships.

"Many [of the men we interviewed] thought that vaccines were medication, so they have this misunderstanding that if you don't get sick, you don't need them. That's misinformation," Salgado de Snyder said. "We explained to them, no, it's to prevent illness. Very often, men are the only bread-

winners in the family, and they work in very high risk jobs, so if they get sick, the consequences for the family will be terrible."

"We try to provide examples of why they are important, for example, tetanus. For men, it's really important," Pineda added. She, like Salgado de Snyder, emphasizes it's not just for the [tetanus] — it's a money-saver. Even for those not employed in jobs that have high injury rates, men still engage in risky behavior in the home during basic home maintenance, Pineda said. "If you get a cut or injury, and go to the hospital, they can charge you, just for the vaccine, more than \$100. If they get the vaccine for free, then they can tell the nurse, 'I've already had this vaccine.' With everyday examples like this, I make the economic case," to get the vaccine.

Salgado de Snyder is now evaluating the data they collected and, along with Pineda and the undergraduate interns, plans to publish their findings. "It's a win-win," Salgado de Snyder said. "We really need to strengthen this area of research. The interns got to learn a little more about conducting research, and we can benefit from the information we collected."

Resources

Pineda and her team bring information to visitors to the Mexican Consulate about the benefits of vaccinations. She recommends Centers for Disease Control and Prevention pages for factsheets and information, including:

CDC's Vaccination Resources For Partners includes waiting room videos, posters, fact sheets, and more: <https://www.cdc.gov/vaccines/hcp/adults/for-partners/>

CDC's Adult Vaccination Resources For Educating Your Adult Patients has more specific resources for specialized groups, like Spanish speakers and adults with chronic conditions. It also has disease-specific resources: <https://www.cdc.gov/vaccines/hcp/adults/for-patients/index.html>

CDC's Adult Vaccination Resources: Educating Adult Patients: Vaccination Resources has colorful flyers, posters, and print ads: <https://www.cdc.gov/vaccines/hcp/adults/for-patients/adults-all.html>



Migrant Clinicians Network
P.O. Box 164285 • Austin, TX 78716

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calendar

January 14, 2020

MCN Webinar: Health Network: A Care Coordination Program for Mobile Patients

www.migrantclinician.org/webinars.html

January 15, 2020

MCN Webinar: Addressing the Cultural Dimensions of Pain Management

www.migrantclinician.org/webinars.html

February 5, 2020

MCN Webinar: Cost of Care

www.migrantclinician.org/webinars.html

February 11-13, 2020

Rural Health Policy Institute

Washington, DC
www.ruralhealthweb.org

February 12, 2020

MCN Webinar: Diabetes: Continuous Quality Improvement

www.migrantclinician.org/webinars.html

February 19-21, 2020

Western Forum for Migrant and Community Health

Sacramento, CA
www.nwrpca.org

March 16-19, 2020

Policy and Issues (P&I) Forum

Washington, DC
www.nachc.org/conferences/policy-and-issues/

March 19-20, 2020

ASCHA North American Agricultural Safety Summit

Las Vegas, NV
ashca.org/2020-safety-summit/

March 24, 2020

MCN Webinar: Health Network: A Care Coordination Program for Mobile Patients

www.migrantclinician.org/webinars.html