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streamline

Beyond Social Determinants: Considering Structural Processes in Health Outcomes

By Claire Hutkins Seda, Director of Communications, Migrant Clinicians Network

A patient's medical history is rarely comprehensive enough to indicate the forces at play that cause vulnerabilities that lead to health problems. Instead, the clinician may only react to the circumstances presented in the exam room. To improve care for patients, remove barriers to care, and improve the patient-provider relationship, many efforts have been made to expand the lenses through which one views such an encounter; these efforts have led to the incorporation of frameworks of cultural humility and social determinants, for example. In a recent four-part webinar series on structural competency, Seth Holmes, PhD, MD, a physician and medical anthropologist at University of California, Berkeley, who authored the book on migrant health *Fresh Fruit, Broken Bodies*; Deliana Garcia, MA, Chief Programs Officer of International and Emerging Issues with Migrant Clinicians Network; and Cheryl Seymour, MD, Professor in the Maine Dartmouth Family Medicine Residency and with the Maine Migrant Health Program, encouraged participants to look beyond the charts, and even beyond the social determinants and health equity factors that initially led to the health challenges, to consider the structural forces at play that created those barriers.

"When I work with clinicians… I like to ask them to think of a particular patient — someone with diabetes or a chronic condition — and think through: why is that person sick? A lot of times the ideas that people come up with … are [related to] biology, behavior, or culture," explained Dr. Seymour in the opening session of the series. "There's another way to think about why people are sick. That is the idea of the social structures that influence a lot of other aspects of their daily lives."

As an example, Dr. Seymour presented the case notes of a recent patient in Maine who attended a check-up at a community

health center. The patient, a 66-year-old Haitian migrant farmworker, presented to the clinic with partially completed medical bottles labeled in English, a hemoglobin A1C of 12.6, and very high blood pressure. Because the measures for her previously diagnosed conditions were uncontrolled, she was marked on her chart as "non-adherent."

In talking with the patient directly, Dr. Seymour found that she had immigrated to the US with temporary protection status (TPS) from Haiti after a natural disaster displaced her. Through friends, she found employment with a "crew boss" who contracts with East Coast farmers. This led her to move for work every two to three months across the entire Eastern seaboard. Because of her reliance on her employment, she was experiencing limited food choices, isolation, mobility, poverty, and little to no access to a kitchen. In examining her prescription, which was worn out (perhaps indicating that she had been traveling with it for some time) and which only had instructions in English, Dr. Seymour found that after her diagnosis with diabetes, she was provided with drug samples. Many of these factors contributed to the patient's current health state, and her inability to address her diabetes and hypertension through diet, exercise, and medical compliance – and the recognition of these many factors is an important first step, but, Dr. Seymour argues, should not be the last step. "We stop at, 'well, this is a Black person, or this is a farmworker, and they're more likely to live in a densely populated area, they're more likely to have less access' – all of these [factors], we put in from the realm of a risk or characteristic of that individual. That's great [that] people understand that – but there's another 'why' that we're not asking. Why are these people more likely to be in this situation?" This is where the structural framework comes in.

Taking a structural lens, Dr. Seymour further broke down this patient's story using an arrow diagram to point out the structural forces like policies and health systems (in red) that contributed to the factors that led to the patient's health conditions.

"These words in red are a way that we are presenting in a visual way to you the social structures that cause, or are related to, these elements that are part of this patient's story," said Dr. Seymour. "The premise, the idea that we're trying to introduce… is that

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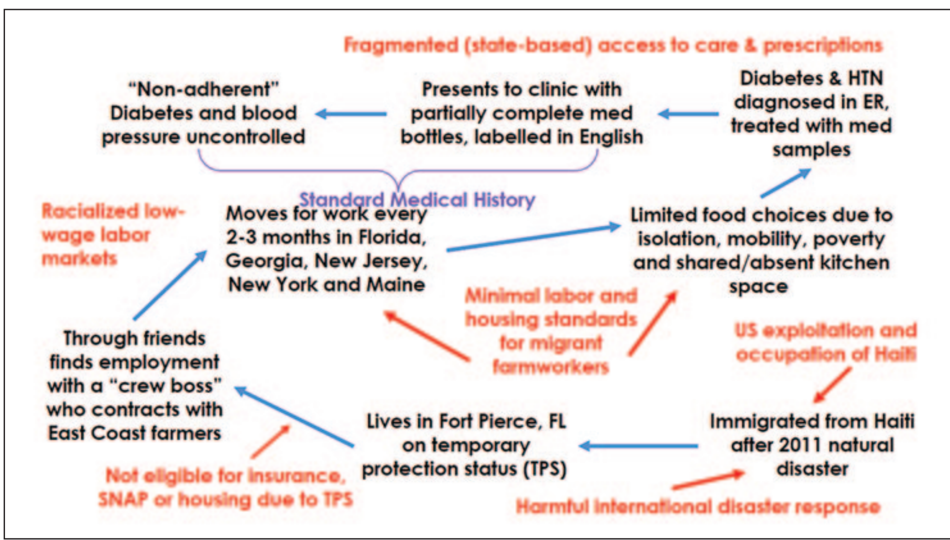
the US foreign policy relationship… those policies and decisions made at a very different level… than my patient in Maine, those decisions are directly impacting and relevant to her A1c of 12.6, as is the lack of labor and housing standards, the way that access to care is fragmented in our country, etc."

These structural forces create the barriers that affect the health of patients. The screenings that are in place today at health centers name the social determinants of health – poverty, social isolation, lack of transportation, food deserts – that drive the health conditions of our patients. However, these screenings do not give clinicians a complete picture of what created the social determinants in the first place. To build a more comprehensive understanding of why a patient is ill, one must look outside of the individual's experience, and into the larger social structures – policies and regulations, immigration practices, and health care systems – to identify root causes.

Of course, many of these root causes are not structures that clinicians in a health care setting can easily influence for better patient health outcomes. But building structural humility – the act of clinicians paying attention to the role of structures in patients' lives, and working with patients with these structural forces in mind – is a key first step. "Being aware of these factors and encouraging clinicians to connect patients with important social work, community health, and other community resources can be important in preventing the clinician from blaming the patient's behavior, biology, or culture inappropriately," added Dr. Holmes. "In other words, the structural lens helps clinicians avoid inappropriate etiological understandings and inappropriate recommendations."

"Structural humility reminds us not to make assumptions about the role of structures in patients' lives, but instead encourages us to collaborate with patients and communities in developing responses," explained Dr. Holmes. By considering the structures at play, clinicians can alter their entire view of their patients and their patients' needs. For example, health advocates often talk about agricultural workers as a "vulnerable population," due to the many barriers to good health and quality health care that they encounter. But the individuals who make up an agricultural workforce are not inherently vulnerable – they are made vulnerable by the structures that they interact



with in the course of their work. Therefore, an agricultural worker patient who is struggling with his health and is "noncompliant" is not just struggling because he's an agricultural worker and it's inevitable. He is experiencing and responding to structural forces that developed over time.

"This is meant to counter the usual way we think about it in health, and show us that [vulnerability] comes from structures that can be changed and can be resisted," noted Dr. Holmes.

Implicit Frameworks

"If we are not thinking structurally, then we are thinking through another implicit framework," added Dr. Seymour. Implicit frameworks are ways of thinking or lenses through which one looks at a patient's situation that may be automatic, deeply ingrained in our processes and practices, or adapted through education and experience. Implicit frameworks that are common in medical practice include cultural, behavioral, and biological or genetic frameworks.

Cultural frameworks were built as a response to the understanding that many clinicians in the past, particularly white, male physicians, were making assumptions about their patients based on their own experiences, and making clinical decisions in an ethnocentric way. "Cultural competence reminds us that people have different experiences and backgrounds," said Dr. Holmes, which is important and useful to ensure that different people's experiences and lifestyles are recognized. "But sometimes, it ends up listing traits for ethnicities – which gives us a way to not have to explain" the issues that a patient is facing by instead chalking it up to their ethnicity. "It can be a shortcut so people don't think of what else is going on," he said.

Dr. Seymour again gave an example related to her Haitian agricultural worker patients. Taking a patient history from a person from Haiti "flows differently than other types of interactions I've had," she said. This can lead a provider to conclude that getting a complete and chronological patient history from a Haitian patient will be very difficult or impossible, because Haitians "must not think of time the way that we do," she said. "What is true is that, yes, of course, there are all kinds of things that are different from one culture to the next," but when culture is singled out as the reason for the struggle, "we're putting that on the patient, which then absolves me as an individual and also absolves the system from creating the place [and] an opportunity to actually communicate effectively. Rather than me figuring out another way to get the information I think I need to help them, I'm just like, 'it's going to be hard to get a timeline.'"

Behavioral frameworks are another way of thinking about a patient's history that places the onus on the individual's behavior to explain illness. "The patient is choosing to eat certain foods, or to not take their medication," Dr. Holmes related. Another example is the agency with which people choose to migrate to the US to do farmwork. "People are choosing to come to this country – but there are forces that are informing

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[these choices].” While they may have made the choice to migrate, their options to stay in their home country may be limited or eliminated due to poverty, political instability, climate disasters, and other factors. These factors in turn may be resultant from geopolitical decisions and international policies from here in the US.

Biology and genetics are other frameworks that one must be wary not to lean on too heavily without considering the structural factors behind them. “Every time we talk about a health disparity, if we don’t include in that conversation some kind of structural acknowledgement, then [from] a statement that big – ‘Black patients have more severe hypertension, have higher mortality from cardiovascular disease, period,’ without that additional structural clarifier — one might internalize the idea that Black people just have higher blood pressure, that there’s something about having black skin that makes you more likely to die, that it’s something about the biology or genetics of that person that is leading to that health disparity,” offered Dr. Seymour. “Whereas, if we pull back from that, we can name all these different social structures that have led to poor health status, for example, for Black Americans.”

But “we can’t just be focused on vulnerabilities and what is hampering the person. We need to consider the vital structures that must be in play so that the person can take full advantage of their opportunities,” adds Deliana Garcia, Chief Program Officer of International and Emerging Issues for MCN. “Everyone needs and deserves humane housing, health and safety, and meaningful work, and other structures that are vital for a thriving community.”

Clinicians’ Role in Structural Competency

Dr. Seymour acknowledges that building an arrow diagram of a case to identify the many causes of a patient’s health concerns and the structures that are imposing on those causes is not something that a clinician can do for each patient. “I would not have the information to do that – which is, kind of, one of the points. In the absence of having the context and the ability to do some structural analysis, we end up using other ways of thinking and other lenses,” she noted. But building structural awareness is an important role that clinicians fill, “as important as actions at large levels to alter those structures. Both need to happen,” she added.

In order to think in structures, clinicians can gather information, find partners, work within the community, to determine what the community believes is important. The role of clinicians “is not to necessarily to have the answers; in fact, it’s usually not to have the answers,” Dr. Seymour explained. “What we do have is a great amount of power, and our ability to narrate that the cause of this problem is not going to be sufficiently addressed by [solutions like] a blueberry rake, or by a new access point – that there’s more that needs to be done, our ability to say that, in the forums that we have, is important.”

All three presenters are active in the Structural Competency Working Group (www.structcomp.org), which has developed a set of screening questions to help clinicians uncover and understand structural vulnerabilities. “The attribution, the causality of the harm, is still not, ‘this patient is food insecure.’ Yes, we should get them food – but it continues to point to the fact that food insecurity has a structural cause, which can be ameliorated. Maybe not now, but we can’t lose track of that while we’re meeting the immediate social needs,” said Dr. Holmes. (See sidebar for example questions from the screening.)

A Structural View of Clinical Care

This structural approach can be taken to review a clinician’s own experiences in health care provision and the barriers they face within their health center.

“We saw during COVID that clinicians came up against a number of structural barriers that they could not affect – limited PPE, insufficient staff, historic number of deaths, and no reliable treatment or prevention,” said Garcia. “It was chalked up to burnout, but we know that these were insurmountable structural barriers that clinicians confronted daily, and their spirits took a beating. We know that this results in moral injury because the outcome violated their values and professional commitment.”

Resources

Watch the archived webinar series, “Structural Competency: Working Toward Health Equity for Farmworker Patients and Communities,” on MCN’s archived webinars page: https://www.migrantclinician.org/webinar/structural-competency-working-toward-health-equity-farmworker-patients-and-communities

Access numerous resources about structural competency on the Structural Competency website: https://structuralcompetency.org/structural-competency/

Learn more about the Structural Competency Working Group and access their curriculum and archived webinars on structural competency for clinicians: https://structcomp.org/

Read the research that shows its impact in the peer-reviewed article, “Structural Competency: Curriculum for Medical Students, Residents, and Interprofessional Teams on the Structural Factors That Produce Health Disparities”: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7182045

Structural Vulnerability Assessment Tool

In a journal article entitled “Structural Vulnerability: Operationalizing the Concept to Address Health Disparities in Clinical Care” in *Academic Medicine*, Dr. Holmes with Philippe Bourgois PhD, Kim Sue MD, PhD, and James Quesada PhD published an assessment tool to “highlight the pathways through which specific local hierarchies and broader sets of power relationships exacerbate individual patients’ health problems is presented to help clinicians identify patients likely to benefit from additional multidisciplinary health and social services.” Here, we excerpt one list of screening and personal questions on discrimination.

Discrimination

[Ask the patient] **Have you experienced discrimination?**

- Have you experienced discrimination based on your skin color, your accent, or where you are from?
- Have you experienced discrimination based on your gender or sexual orientation?
- Have you experienced discrimination for any other reason?

[Ask yourself silently] **May some service providers (including me) find it difficult to work with this patient?**

- Could the interactional style of this patient alienate some service providers, eliciting potential stigma, stereotypical biases, or negative moral judgments?
- Could aspects of this patient's appearance, ethnicity, accent, etiquette, addiction status, personality, or behaviors cause some service providers to think this patient does not deserve/want or care about receiving top quality care?
- Is this patient likely to elicit distrust because of his/her behavior or appearance?
- May some service providers assume this patient deserves his/her plight in life because of his/her lifestyle or aspects of appearance?

Access the entire article which includes other screening questions on financial security, residence, risk environments, food access, social network, legal status, and education: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5233668/

The Structural Forces Underpinning Pesticide Exposure

By Claire Hutkins Seda, Director of Communications, Migrant Clinicians Network

[Editor's Note: This article uses the concepts discussed in the previous article as a framework for approaching pesticide exposure.]

Agricultural workers bear a disproportionate burden of pesticide exposure in the United States. While that pronouncement may seem obvious (as agricultural workers apply the chemicals, work in fields that have been sprayed by the chemicals and are exposed in other ways including by pesticide drift), numerous structural factors place agricultural workers at an increased risk of exposure, unnecessarily exposing them to chemicals when they should be protected and safe. In a new research article published by the Brookings Institution, a US-based think tank focused on social sciences, authors Nathan Donley and Robert Bullard, PhD outline how diet, housing, occupation, and institutional failings result in higher pesticide exposures for agricultural workers. Here, we briefly review each of these elements outlined by the article, and then expand the lens by taking a structural look at why each element may be contributing to pesticide exposure.

Diet

The consumption of organically grown food reduces one's pesticide exposure, as the food itself is grown without synthetic pesticides. Organic food, however, is more expensive and less widely available than conventionally grown food. Agricultural workers live in rural communities, many of which are designated as "food deserts" with few outlets in which to purchase food, and even fewer that may stock specialty items like organic produce. With very limited income, or income that is designated for other needs including to send to their home communities, agricultural workers are unlikely to be able to afford organic food. Looking further into these access issues, rural areas continue to drop in population, simultaneously as the consolidation of grocery stores has reduced the number of outlets where the remaining rural residents can buy food. While Walmart, one of the few remaining grocery stores in many rural areas, has rapidly increased the amount of organic food available in its stores in the last 10 years, and aims to provide it at a lower price point, agricultural workers on average make just $20,000 per year,[1] making even the least expensive staples sometimes out of reach. (See this issue's article on food insecurity.)

The poverty wages that agricultural workers receive are rooted in an agricultural system that began with slavery and exploitation, note the authors of the article. "This history explains why 98% of US farmland is owned by whites and the vast majority of agricultural laborers are people of color," they noted. While the race and ethnicity of most agricultural workers have transitioned from African American to primarily people from Mexico and Central America, the exploitative conditions and poverty wages remain largely unchanged, due to structural forces that demand low-cost fresh produce and devalue farmwork, and policies to support those demands. The Fair Labor Standards Act of 1938, for example, specifically excludes farmworkers from core labor rights including minimum

wage and overtime, which still stands as federal policy to this day.

Housing

Workers often live close to farms in employer-provided housing where their risk of pesticide exposure is higher, due to proximity to pesticide application, inability to avoid exposure even indoors in substandard housing, and poor access to safe drinking water. Those who live off-farm still likely reside in agricultural communities with limited access to safe, quality housing. Redlining, the discriminatory practice of actions like denial of mortgages or other loans to people of color to prevent their access to certain areas; the use of eminent domain for economic development; and racially motivated zoning ordinances are outlined in the article as historical factors that reshaped neighborhoods, removing access for people of color to live in clean, safe neighborhoods and relegating them to less healthy and/or less safe areas. Further, people of color are unable to "utilize monetary gains to change occupations or move away" from polluted areas. The authors were careful to note that the racial disparities are not solely a result of poverty. "Race and ethnicity remains [sic] a potent predictor for many pollution threats regardless of income level," the authors concluded, adding the example: "African Americans who make $50,000-$60,000 a year tend to live in neighborhoods that are more polluted than neighborhoods inhabited by whites with annual incomes of less than $10,000."

The manufacturing of pesticides also has structural considerations. Because of the housing practices outlined above, most pesticides are manufactured in low-income communities of color, and facilities in lower-income areas typically invest less in pollution reduction than in higher income areas. Structural considerations that resulted in this situation include the role of income and race in representation and personal connections, that lead to power imbalances and unfair policies.

Occupation and Institutional Failings

Pesticide exposure among agricultural workers could be reduced, but US occupational safety and health policy specifically excludes agricultural workers. "Agricultural exceptionalism" is evident in the regulatory norms for agricultural workers; agricultural workers are excluded from most of the protections afforded other workers through the Occupational Safety and Health Administration. Another example is the double standard created by the Food Quality Protection Act of 1996, in which the general population has more protection against pesticides through food and water than the workers who encounter the chemicals directly on the farm. Additionally, the article outlines numerous practices and loopholes that perpetuate inadequate pesticide regulation at the federal level.

Solutions

Solutions are readily available. Agricultural workers, as a vulnerable workforce in a high-hazard industry, require strong, consistent regulatory protections, equal to or greater than that of workers in other industries. The authors outline a structural approach to reducing pesticide exposure, outlining eight specific solutions: eliminating or reducing the pesticide safety double standard; implementing practices to better monitor and address real-world harms to impacted communities; strengthen worker protections; reduce harms from unintended pesticide use; adequately protect children; codify prior informed consent for the export of unregistered pesticides; protect communities near agrochemical production and storage facilities; and assess and rectify regulatory capture by industry with the EPA Pesticide Office.

While the article does not emphasize the role of clinicians in pesticide exposure, the clinical role in pesticide prevention and reporting is significant, in the absence of sufficient occupational safety and health protection, especially given the many vulnerabilities that agricultural workers face that may prevent them from understanding the risks of pesticides or having sufficient agency to report abuses. Clinicians need to be trained to recognize the signs and symptoms and to manage pesticide overexposure. Additionally, clinicians must screen their patients on their occupations. Accurate identification can lead to improved diagnostic decisions by the clinician. Clinicians are encouraged to incorporate three concise and effective screening questions in the primary care setting:

1. Occupation: Describe what you do for work/Describa lo que hace en su trabajo.
2. Activities and Causes: Are there any physical activities that you do – at work or away from work – that you feel are harmful to you?/ ¿Hay alguna actividad física – en su trabajo o en otra lugar – que crea usted es dañina para usted?
3. Substances and Physical Hazards: Are you exposed to chemicals, fumes, dusts, noise, and/or high heat at your work or away from work? Do you think these are harming you?/¿Está usted expuesto a químicos, gases, polvo, ruido, y/o altas temperaturas en su trabajo o en otro lugar? ¿Piensa usted que estas cosas lo pueden dañar?

Access a printout of these three questions in English and Spanish with graphics here: https://www.migrantclinician.org/toolsource/resource/eoh-screening-questions-primary-care.html

Tools and resources on Migrant Clinicians Network's website include:

- Comic books: Full-color comic books in English and Spanish: https://www.migrantclinician.org/pesticide-comic-books.html
  - *Juan abre los ojos*: *Como protegerse de los pesticidas* is a general comic book on pesticides for agricultural workers.
  - *Aunque cerca… Sano* educates parents on the risk of pesticide exposure for children.
  - *Poco veneno… No mata* covers the risks of pesticides and ways to minimize the risks in the home setting.
  - *Lo que bien empieza… Bien acaba* addresses pesticide exposure in women of reproductive age.
  - *Nadie sabe que repira… ¡Hasta que le falta el aire!* is our newest comic book on respiratory health. (See accompanying article for more on this resource.)
- Pesticide Exposure Reporting and Workers' Compensation Map: Developed with Farmworker Justice, this map provides clinicians with state-specific pesticide reporting requirements as well as workers' compensation criteria. https://www.migrantclinician.org/pesticide-reporting-and-workers-compensation-agriculture-interactive-map.html
- Pesticide webpage: All of these resources are outlined on our Pesticides page, including additional resources on clinical guidelines on acute pesticide exposure, cholinesterase testing protocols, and more. https://www.migrantclinician.org/explore-environmental-justice-and-worker-health/pesticides.html
- *Recognition and Management of Pesticide Poisonings 6th Edition:* EPA's essential clinical reference for recognizing and managing pesticide overexposures. https://www.epa.gov/pesticide-worker-safety/recognition-and-management-pesticide-poisonings

The open source article is available in its entirety on the Brookings Institute website: https://www.brookings.edu/articles/us-pesticide-regulation-is-failing-the-hardest-hit-communities-its-time-to-fix-it/

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Photo Credit: Earl Dotter

Food Insecurity:

Tools and Resources to Bring Food as Medicine to Agricultural Communities

By Claire Hutkins Seda,
Director of Communications,
Migrant Clinicians Network

Yolo County, California sits just northeast of the San Francisco Bay Area, with rolling coastal foothills sloping down into the fertile Sacramento Valley. The output of this agricultural region is diverse, from tomatoes and seed crops, to rice, wheat, and other grains, to fruit and nut orchards. With a poverty rate of 19.5%, Yolo County is the most impoverished county in the state. Consequently, food insecurity is a concern.[1]

To better understand the food needs of the county, Yolo Food Bank and partners launched its first Yolo County Food Access Survey. The results, released in April 2024, found that 29.2% of Yolo County households are food insecure. Of those working in Yolo County's agricultural industry, however, the number rises sharply: 52.9% of agricultural worker households are food insecure. Of households that were food insecure, 27% did not know they qualified for food assistance, and 17% said the food provided by food banks rarely or never meet their traditional, cultural, religious, or nationality needs. Almost 21% did not know where to access food assistance.

Yolo Food Bank's newest project in partnership with Sutter Health seeks to address these concerns specifically for agricultural worker families. Its new Cultivo program features pop-up food distributions that mirror the popular and effective mobile health clinics that have become a mainstay in meeting the health needs of migrant agricultural worker communities across the country. The

pop-ups will bring fresh, culturally appropriate foods to the fields, farms, packing plants, canneries, and residences to reduce access barriers.

The new initiative builds on clinicians' longstanding history of using food as medicine. Jack Geiger, MD, the founder of the modern community health center movement, saw children dying in the Mississippi Delta region of malnutrition and diarrhea, so his team began writing prescriptions for food, paying for the food out of the pharmacy budget. When those payments were questioned by the state government as inappropriate, Dr. Geiger responded, "The last time I looked at my textbooks, the most specific therapy for malnutrition was food." Since the formation of the health center system, such efforts like produce prescriptions have become an important complement to health and nutrition assistance programs like the Supplemental Nutrition Assistance Program to emphasize the powerful health consequences of healthy food, acknowledge the social determinants to health, and help community members manage chronic disease while lowering health care costs.[2] Food-as-medicine interventions vary widely, and include cash-like supplements, produce prescription, healthy food prescription, in-kind interventions, medically tailored groceries, nontailored meals, medically tailored meals, and community garden projects. Regardless of the intervention type, some key elements can make them most successful when serving an agricultural worker population:

1. Center the community as you build the program and communication plan – and incorporate sufficient understanding, knowledge, and training. Engage the community to understand what types of foods their community lacks, where they prefer to receive the food and education, and what other barriers may exist. Consider in particular the values different parts of the community may hold that may inhibit their ability to receive or use food. For example, do some families who have food insecurity refuse food because they value their self-sufficiency? There is stigma around accepting free food. Do other families accept food, but discard it because they don't know how to prepare it, or they do not want to disappoint a community leader by rejecting the offering? Are there other food provision alternatives – like providing meals at community events – that may be more successful in providing healthy, nutritious, culturally appropriate food that may overcome stigma?
   a. Build the key elements of effective community mobilization: situation analysis; community resource mapping; strategic planning; communication; process of health communication; community implementation; and documentation, monitoring, and assessment. The seven steps are outlined in a recent *Streamline* article: https://www.migrantclinician.org/streamline/resources-featured-streamline-spring-2024
   b. Build a thorough communication plan. You can use MCN's communication manual, "Designing Community-Based Communications Campaigns," which is available in English and Spanish. https://www.migrantclinician.org/resource/designing-community-based-communication-campaigns-manual.html
2. Utilize a community health worker model with a community participatory approach. Engaging community health workers has been demonstrated to increase effectiveness of interventions of all kinds, including food security interventions. In a 2023 study, researchers provided study participants with either home deliveries of locally grown produce and shelf-stable food, or the same home deliveries of produce and food with additional support from CHWs. Eighty-one percent of those with CHW support saw a statistically significant reduction in A1C over the course of the intervention; no significant change in A1C was found in the group receiving food without CHW support.[3]
3. Leverage and strengthen partnerships.
   a. Long-term connection: Community partners build trust and open doors. Many health centers built partnerships during the COVID pandemic with community-based organizations like local churches, schools, flea markets, even barber shops. These partnerships benefit from regular renewal and ongoing collaboration. This improves effectiveness of the food intervention but also sets the health center on a path for long-term partnership.
   b. Accessibility: Food producers and distributors can make it easier for their workers to access food by permitting on-site pop-ups for the intervention, as is occurring in Yolo County. Health centers can emphasize that food programs benefit their businesses by reducing illness and health care costs.
4. Take into account disaster response. Food programs should be built for ongoing, long-term engagement and support of the community. One way to strengthen the program is to consider potential disruptions or changes in community needs as a result of a disaster like a flood, extended heat wave, significant storm, wildfire/smoke event, etc. Transportation, distribution location, air quality, food spoilage, and staffing are some of the aspects of the program that may need to shift in the wake of an emergency. Watch MCN's archived webinar, Emergency Management, available in English and Spanish, for more information: https://www.migrantclinician.org/webinar/emergency-management-2023-11-09.html
5. Weave in education that is accessible in terms of literacy and cultural context. Agricultural workers can engage in and be more receptive of the project if they understand why their clinicians are prioritizing food as medicine and how it will benefit their health. This includes trainings on rights and eligibility for people of all immigration and health statuses.
   a. Consider incorporating MCN's comic book, My Health is My Treasure: A Guide for Living Well with Diabetes, available for download in English and Spanish: https://www.migrantclinician.org/resource/my-health-my-treasure-guide-living-well-diabetes-comic.html
6. Connect with other food programs outside the area to network with regional food hubs, which seek to connect regional farmers with local consumers. Learn more about regional food hubs in the resource, "Regional Food Hub Resource Guide," created by the USDA Agricultural Marketing Service: https://www.ams.usda.gov/sites/default/files/media/Regional%20Food%20Hub%20Resource%20Guide.pdf
7. Train health center staff. For produce prescription programs, the Centers for Disease Control and Prevention highlight additional key components, including staff training in the following areas. Read their entire guide, "Components of Fruit and Vegetable Programs": https://www.cdc.gov/nutrition/php/incentives-prescriptions/essential-components.html
   - Screening patients.
   - Determining program eligibility.
   - Enrolling patients.
   - Referring patients to fruit and vegetable programs.
   - Protecting patient data.
   - Tracking participation and outcomes.
   - Conducting patient follow-up.

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Serving Pediatric Migrant Patients with Specialty Care Needs

By Robert Kinnaird, Communications Project Coordinator, Migrant Clinicians Network

Access to pediatric psychology and behavioral health services are critical for some migrants, like agricultural worker families, to achieve well-being, yet many struggle to gain access to specialty care while migrating. Children with learning disabilities require special kinds of care and need evaluations to get the proper education that matches their needs. Migrant Clinicians Network's SCAN (Specialty Care Access Network) program helps children in need of specialized care and resources when migrant families arrive in the United States. In 2023, SCAN assisted 78 infant patients and 238 child patients from all over the world.

Children with special needs face difficulties regardless of immigration status, says Laszlo Madaras, MD, MPH, Chief Medical Officer for Migrant Clinicians Network. "Even children with insurance… can struggle to get care because there are so few practitioners for pediatric psychology in many parts of the country," said Dr. Madaras. "Many of these children are also traumatized, going through dangerous crossings like the Darién Gap. This trauma can inhibit normal psychological development, and with children who already have developmental delays, can have a devastating impact on their growing years."

Laszlo Madaras, MD, MPH, Chief Medical Officer for Migrant Clinicians Network, assists a young migrant patient at an immigration shelter in McAllen, Texas.

Three patients, two with autism and one with cerebral palsy, were among those registered in the SCAN program in 2023. Former Health Network Associate Camila Velasquez spent hours communicating and coordinating with the parents of the SCAN patients, along with interpreters, health centers, and other community organizations in the receiving community, to coordinate not just the child's complex medical care, but also connection to basic services like school enrollment support. Additionally, and most critically, Velasquez leaned on MCN's network of SCAN champions: volunteer pediatricians and pediatric specialists. Across the country, SCAN champions work with our team to refer patients to specialists that meet their needs, using their existing network and expertise to find the right match for our patients.

While most of MCN's staff is bilingual in English and Spanish, allowing for ease of communication with Spanish-speaking migrants coming from Latin America, MCN frequently requires outside interpretation services for migrants coming from other locations. To help a Russian five-year-old with autism, we had to rely on interpretation services and the hard work of a community health center. The patient needed an evaluation in order to enroll in school as a student with special needs. This can be a difficult process for a recent immigrant parent, but it ensures the best possible education for their child's needs.

"I reached out to the patient's family a total of nine times," Velasquez said. "I reached out to the federally qualified health center (FQHC) a total of five times. The hard part was the language barrier. The patient's mom would use Google to translate when we would message each other, and we used an [interpretation] line during calls."

"What stood out to me was how quick and efficient the FQHC I sent them to was when it came to getting them care. When a patient is in that area, I know exactly where to send them now," Velasquez said.

Our SCAN program typically relies on SCAN champions. This case was an unusual one, as the fast and responsive FQHC found the proper care for our patient before there was a need to engage a SCAN champion in the region to find support for the patient.

Another patient, a five-year-old from Ecuador with autism and a speech delay who moved to a major metropolitan area with her family, needed a SCAN champion. "The hardest part of this case was getting them the care the patient needed. For diagnoses such as autism and developmental delays, it unfortunately takes time to get them into therapy or get them evaluated," Velasquez explained.

Our SCAN champion in the area accelerated this, connecting the patient to a university hospital that was equipped to meet the needs of the patient. "Using a SCAN champion expedited the appointment process, including evaluations and checkups," Velasquez said. "The patient was also approved for family care insurance offered in the state and was connected to a speech therapist."

Another patient, one with cerebral palsy, arrived in the Southwest from Mexico. At six years old, the patient required regular appointments and a wheelchair. Due to the specific nature of the patient's needs, Velasquez called on two SCAN champions to assist. "The patient was able to be cared for by a colleague of the champions," Velasquez said. A patient navigator from the health center also assisted, connecting the family to financial services before regular appoint-

continued on page 9

Sexual Violence in the Fields

New Resource for Clinicians

By Claire Hutkins Seda, Director of Communications, Migrant Clinicians Network

Sexual violence continues to be a significant and widespread issue in the agricultural workplace, yet many survivors do not get the medical and legal assistance they need. Of the estimated 2.4 million agricultural workers in the United States, approximately one-third identify as female. While sexual violence can happen to anyone, most of the occurrences of sexual violence are perpetrated against women. Many agricultural workers may be reluctant to disclose sexual violence or seek help from clinicians or others for numerous reasons. Fear is a primary motivator. Across many cultures, stigma may be attached to the survivors of sexual assault and acts of sexual violence may be normalized. Further, communication barriers due to language, cultural norms, or a lack of comfort and trust in the exam room may prevent an agricultural worker from attempting to convey such an emotional or painful occurrence. Agricultural workers who experience sexual violence are often already experiencing a workplace power imbalance, and many workers are reluctant to report the perpetrator for fear of workplace retaliation; others do not believe there is any recourse for which they are eligible or that would be worth exposing the incident. Of course, the many barriers to accessing health care of any kind – poverty, lack of transportation, poor integration into the community, lack of familiarity with the health care system – reduce survivors' opportunities to discuss the incident and find support. For these and other reasons, only a fraction of estimated incidents of sexual violence in agriculture are disclosed.

A new clinicians' guide provides in-depth support, best practices when receiving a report of sexual violence, and a basic primer on legal options, so that clinicians at community health centers are equipped to support agricultural worker survivors. "Sexual Violence in Agricultural Worker Communities: A Guide for Clinicians," is an 11-page full-color guide developed by Farmworker Justice and Migrant Clinicians Network and available in English and Spanish. Questions answered include "How will you know if your patient has experienced sexual violence?" and "How can you support survivors of sexual violence?" The guide also features survivor stories and short quotes from community health workers and agricultural worker advocates. A section called, "What legal options are available for survivors?" provides clinicians with next steps, from recommended documentation and reporting, to a chart of legal avenues available to agricultural workers.

Access the new clinician's guide:

In English:
https://www.migrantclinician.org/resource/sexual-violence-agricultural-worker-communities-guide-clinicians.html

In Spanish:
https://www.migrantclinician.org/es/resource/violencia-sexual-en-las-comunidades-de-trabajadores-agricolas-una-guia-para-proveedores-de

Other Resources

Hombres Unidos is MCN's peer-led five-session curriculum where men from the community teach fellow men about family violence. The popular curriculum is aimed at primary prevention of sexual and intimate partner violence in the Latinx migrant community: https:/www.migrantclinician.org/disabled/hombres-unidos-contra-la-violencia-familiar.html.

Farmworker Justice's list of multilingual resources on sexual violence in agricultural worker communities: https://www.farmworkerjustice.org/resource-categories/sexual-harrassment-violence.

Sexual Violence Against Farmworkers: A Guidebook for Social Service Providers from Southern Poverty Law Center: https:/www.splcenter.org/sites/default/files/d6_legacy_files/downloads/publication/OVW_SocialServiceProviders.pdf.

Understanding Male Socialization, Stigma, and Reactions to Sexual Violence, from the National Sexual Violence Resource Center: https:/www.nsvrc.org/working-male-survivors-sexual-violence/Understanding

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Serving Pediatric Migrant Patients with Specialty Care Needs continued from page 8

ments started, answering questions, and helping the family feel confident their child would receive the care they needed and that they would have financial support throughout the process. "The next day was fully focused on the patient's care," she added, explaining how the patient navigator was able to ease their concerns and allow them to focus entirely on the needs of their child. "The patient's parents were so happy with the level of care they received and thanked me for connecting them."

Velasquez served these three patients while simultaneously managing a full caseload of other patients with complex needs moving all around the country, including one child with a ventricular septal defect, and one child with a heart murmur. The SCAN program and its champions help young patients and their families every day, easing the stress of caring for a sick or disabled child and helping recent immigrants navigate our complex health care system with the input of case managers, pediatricians, and specialists. This work saves lives – but it also ensures a quality of life for families that need support, like the families of the children with disabilities in need of evaluations, wheelchairs, and education resources.

Learn more about SCAN and its parent program, Health Network, on the Health Network page: https://www.migrantclinician.org/our-work/health-network.html

New Resource:

Naloxone Use Among Immigrant Agricultural Worker Communities

By Robert Kinnaird, Communications Project Coordinator, Migrant Clinicians Network

Opioid overdose as a result of the increasing prevalence of fentanyl is a serious threat.[1] Naloxone, widely known by the brand name Narcan, can be administered during an overdose to prevent death. While many resources exist to get naloxone in the hands of those who may need it, not everyone knows how to use this medication. For immigrant and migrant populations like agricultural workers, access and instructions are not the only barriers. Legal concerns can impede lifesaving action, and instructions can be overly complex for migrants with limited formal education. Although evidence is limited on the abuse of opioids among agricultural workers, construction workers, an industry with a large percentage of migrant and immigrant workers and high occupational injury, are at a high risk of experiencing an opioid overdose.[2]

To serve health centers in their outreach efforts to agricultural workers, Migrant Clinicians Network has created general and simple instructions on the process of administering naloxone with photographs demonstrating use. This resource also includes basic information on Good Samaritan laws, which vary state by state, as well as guidance on storing and preserving naloxone to maintain its efficacy. The resource also contains information on how expired naloxone can still be the difference between a fatal overdose and a nonfatal one.

If a clinician is concerned that a patient may be using opioids or may be near people that use opioids frequently, they may walk the patient through this handout, as well as helping them familiarize themselves with local and state Good Samaritan laws that may apply to them and services that can provide them with naloxone when needed.

Access the new resource on MCN's website:

In English:
https://www.migrantclinician.org/resource/instructions-using-naloxone.html

In Spanish:
https://www.migrantclinician.org/es/resource/instrucciones-para-usar-naloxona.html

References

1 National Institute on Drug Abuse. Drug Overdose Death Rates. Website. 14 May 2024. https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates

2 Dong XS, Brooks RD, Cain CT. Overdose fatalities at worksites and opioid use in the construction industry. Published 2019. Accessed June 5, 2024. https://stacks.cdc.gov/view/cdc/85344

INSTRUCCIONES PARA USAR NALOXONA

(más comúnmente conocida como NARCAN™)

Este medicamento se usa para tratar sobredosis por heroína, fentanilo y medicamentos opioides recetados.

Confirme la sobredosis de opioides y llame al 911

Los signos de una sobredosis de opioides incluyen:

- La persona NO se despierta, aunque le grite, le sacuda por los hombros o le frote con fuerza en la mitad del pecho.
- La respiración es lenta, irregular o se detiene.
- La pupila es muy pequeña, como del tamaño de la punta de un alfiler.

Llame al 911 o pídale a alguien que llame. Ponga a la persona sobre su espalda.

Uso de Naloxona en inhalador

La naloxona se administra con un aerosol nasal que se coloca directamente en la fosa de la nariz. Cada inhalador contiene una dosis.

Sujete el aerosol nasal con el pulgar en el émbolo.

Coloque la punta del inhalador en la fosa nasal. Presione firmemente el émbolo para administrar la dosis de Naloxona.

¡LLAME al 911 si aún no lo ha hecho! Además de Wyoming y Kansas, todos los estados tienen "Leyes del Buen Samaritano".

La naloxona debe hacer efecto en dos o tres minutos. Si la persona no se despierta en tres minutos, utilice otro inhalador para administrar otra dosis. ES SEGURO SEGUIR ADMINISTRANDO NALOXONA.

¡QUÉDESE CON LA PERSONA!

Hable con ella y manténgala despierta. Si se duerme, puede aplicarle otra dosis.

El inhalador de Naloxona debe mantenerse a una temperatura entre 2 y 25 grados centígrados (36° F y 77° F) y fuera de la luz directa del sol. Recomendamos mantenerlo refrigerado. No lo congele ni lo deje en el coche. **Usar un inhalador de Naloxona expirado es mejor que no usar nada.**

Si usted o una persona que conoce corre el riesgo de sufrir una sobredosis, le recomendamos que se informe sobre las Leyes del Buen Samaritano de su estado aquí: **pdaps.org/datasets/good-samaritan-overdose-laws-1501695153**

LA MAYORÍA DE LOS ESTADOS FACILITAN LA OBTENCIÓN DE NARCAN GRATUITAMENTE.

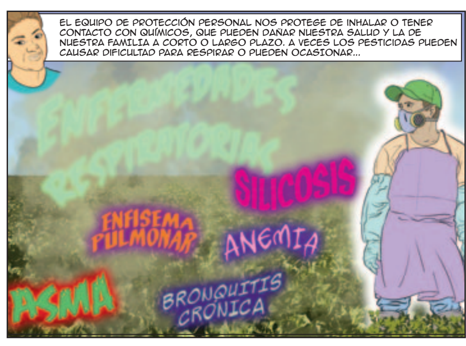
Para más información consulte: nextdistro.org/naloxone

New Comic Book on Respiratory Health

Migrant and seasonal agricultural workers experience significant exposure to air pollution that increases their risk of adverse health outcomes including respiratory illnesses. A review of epidemiology research articles between 2000 and 2020 found a "consistent pattern of increased respiratory illness in relation to agricultural dust exposure."[1] Exposure to air pollution increases agricultural workers' risk of severe respiratory disease; for example, since the start of the pandemic, numerous studies have found a connection between exposure to fine particulate matter (PM2.5) and increased risk of SARS-CoV-2.[2]

Additionally, as the climate crisis progresses, agricultural workers are experiencing more air pollution exposures, including increased ground-level ozone on hotter days, increased dust and pollen, and more frequent exposures to wildfire smoke. Hotter, more humid conditions further strain the respiratory system. As exposures increase, however, most workplaces have not increased their efforts to provide training or protective equipment and regulations to protect workers continue to lag. During one smoke event in Washington State, for example, 72% of agricultural workers reported being exposed to an unhealthy amount of air pollution, 72% reported no changes were made to their work activities to reduce exposure, and 100% reported little to no information was provided on how they could protect themselves from smoke.[3]

In response to these significant risks colliding with few workplace protections, Migrant Clinicians Network created a new comic book to assist clinical teams in providing basic education on respiratory health risks and protection for numerous work settings like in agriculture, construction, demolition, and more. Available in Spanish as "Nadie sabe que respira…¡Hasta que le falta el aire!"



and in English as "Clear the Air! Protect Your Health from Bad Air," the full-color comic book provides image-based learning on the respiratory system, particulate matter, the Air Quality Index, and the use of personal protective equipment in an accessible manner that takes into account literacy and cultural context, so that workers can protect themselves. The comic reviews the many sources of air pollution, from farm equipment, to industrial manufacturing, to wildfire smoke, to post-disaster respiratory hazards like mold and contaminated indoor air.

"Comics have proven to be an effective educational tool for health providers in the task of sharing and communicating complicated concepts in simple and easy terms and circumstances that are related to the experiences of those who read them," explained Alma Galván, MHC, Director of Community Engagement and Worker Training, who spearheaded the comic along with Myrellis Muñiz-Márquez, MPH, Program Manager, who coordinated the project; Amy Liebman, MPA, Chief Program Officer of Workers, Environment, and Health; illustrator Salvador Sáenz; and a team of MCN writers and editors, with funding from the Thoracic Foundation. The MCN team worked closely with Gerardo Reyes Chavez, of the Coalition of Immokalee Workers and a Florida farmworker, to create a narrative that corresponded to the realities of agricultural workers across the US. He also hosted three radio shows to speak to workers about respiratory health. Reyes and MCN worked together to organize a consultive group last year with a group of agricultural workers to review the resource so it could be tailored to their experiences.

The comic book, which complements MCN's numerous pesticide comic books, is available in a form that users can download and print to distribute in their own communities.

Download the new comic book:

In Spanish: *Nadie sabe que respira… ¡Hasta que le falta el aire!*: https://www.migrantclinician.org/es/resource/nadie-sabe-que-respira-hasta-que-le-falta-el-aire.html

In English: *Clear the Air! Protect Your H ealth from Bad Air:* https://www.migrant clinician.org/ resource/clear-air-protect-your-health-bad-air.html

Access the pesticide-related comic books: https://www.migrantclinician.org/pesticide-comic-books.html

Access all of MCN's comic books: https://www.migrantclinician.org/resources/717/comic-book/index.html

References

1 Clarke K, Manrique A, Sabo-Attwood T, Coker ES. A Narrative Review of Occupational Air Pollution and Respiratory Health in Farmworkers. Int J Environ Res Public Health. 2021;18(8):4097. Published 2021 Apr 13. doi:10.3390/ijerph18084097

2 https://www.sciencedirect.com/science/article/pii/S2666765722001053

3 Mattawa Farmworkers' Under the Smoke. University of Washington. 2018. Accessed 4 June 2024. https://deohs.washington.edu/pnash/sites/deohs.washington.edu.pnash/files/WildfireSmoke-2018-sf.pdf

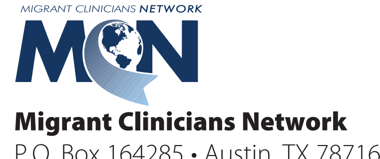
View All Resources and References on the MCN Website

Please visit our Summer 2024 issue webpage on MCN's website where you can access all of the resources and references mentioned in the issue.

You can find this page at

https://www.migrantclinician.org/services/publications/streamline/resources.html

or point your phone's camera at the QR code for instant access.



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

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Migrant Clinicians Network
P.O. Box 164285
Austin, Texas, 78716
Phone: (512) 327-2017
Fax (512) 327-0719
www.migrantclinician.org
E-mail: cseda@migrantclinician.org

Giorgio Franyuti, MD
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Kim Nolte, MPH
Chief Executive Officer

Claire Hutkins Seda
Director of Communications,
Managing Editor

calendar

North American Refugee Health Conference
August 5-7, 2024
Minneapolis, MN
https://nrcrim.org/NARHC

Community Health Institute (CHI) and Expo Conference
August 24-26, 2024
Atlanta, GA
https://www.nachc.org/conferences/chi/

Rural Health Clinic Conference
September 24-25, 2024
Kansas City, MO
https://www.ruralhealth.us/events/schedule

CHAMPS/NWRPCA Primary Care Conference
October 26-29, 2024
Denver, CO
https://web.nwrpca.org/events/2024-CHAMPS-NWRPCA-FALL-PRIMARY-CARE-CONFERENCE--1736192/details

American Public Health Association Annual Meeting & Expo
October 27-30, 2024
Minneapolis, MN
https://www.apha.org/events-and-meetings/