Improving Outreach to At-Risk Latino Populations for Pandemic Influenza and Public Health Emergency Preparedness

Prepared by the Health Initiative of the Americas, School of Public Health, University of California, Berkeley

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Table of Contents

Introduction	1
Why are Latinos considered an "at-risk" population?	2
Challenges for Public Health	3
Reaching the People: Collaborating for Outreach and Education	4
Immunizations: Empowering People and Providers during a Pandemic	7
Next Steps: Emergency Preparedness Starts Now	9
Conclusion: Changing the Way Public Health Does Business	10

Introduction

Effective communication requires the appropriate messages, messengers, and methods.

In the event of a public health emergency, such as a pandemic influenza, it is important that health authorities are able to quickly reach the entire potentially affected population with appropriate information. Effective emergency risk communication requires the selection of appropriate messages, messengers, and methods of delivery to disseminate information to audiences before, during, and after the event.

Reaching the population can be very challenging, especially when dealing with "at-risk populations". According to the Pandemic and All-Hazards Preparedness Act, at-risk populations are described as individuals or groups whose needs are not fully addressed by traditional service providers, or who cannot comfortably or safely use the standard resources offered during preparedness, response, and recovery efforts.[1] These groups include individuals from diverse cultures, those who have limited English proficiency or are non-English speaking, or are transportation disadvantaged, among others. These characteristics very well define a large proportion of the Latino population in the United States.

This document is an updated version of the "Best Practice Guidelines: Outreach to Latino Hard-to-Reach Populations: Emergency Preparedness", published by the Health Initiative of the Americas (HIA) in 2010. It provides best practices to support public health authorities and providers in connecting with community-based organizations in their efforts to reach the at-risk Latino population in the event of a pandemic or a public health emergency. Meredith Miller Vostrejs, Independent Consultant contributed to this previous version.

During the 2009-2010 H1N1 Influenza Pandemic, HIA played a key role in California in the efforts of informing, educating, and mobilizing the Latino community, as well as conducting research to better understand the perceptions and beliefs of this population about the H1N1 influenza and the vaccine. Some of those efforts and findings are reflected on here.

Why are Latinos considered an at-risk population?

Key Points: Why the Concern?

- Latinos comprise 15% of the U.S. and 37% of the California population.
- Latinos are disenfranchised from the U.S. health care system; 1/3 lack health insurance.
- Barriers to care: cost, transport, language, literacy, clinic hours, immigration status.

At-risk populations challenge the way public health is delivered, especially during public health emergencies. Although Latinos comprise 15% of the U.S. population, they represented 30% of all reported H1N1 cases during the early spring wave of the pandemic[2] and Latinos were hospitalized at higher rates in all age groups. Latino children younger than 18 years of age accounted for 27% of reported 2009 H1N1 influenza-associated deaths in the U.S. while constituting just 21% of the population.[3]

While preventive behaviors and vaccinations are proven effective ways to reduce influenza transmission, morbidity, and mortality, the adult Latino population has been less likely than non-Latino whites to receive influenza vaccination (25% vs. 39% as of December 2009).[4] Yet research indicates that there is a high acceptance rate of flu and other vaccines among hard to reach (HTR) Latinos.[5,6,7,8] This acceptance occurs alongside fears, questions and concerns that exist within the general population, yet due to language or culture these concerns may not be fully and effectively addressed by health authorities.

In spite of their large population and substantial contribution to the nation's economy, a significant number of Latinos remain disenfranchised from the U.S. health care system. Approximately one-third of Latinos lack health insurance: the highest uninsured rate of any racial or ethnic group in the U.S. In California, 99% of the farmworker population is Latino and over 70% of them lack health insurance.[9]

More than 25% of Latino adults in the U.S. lack a usual health care provider; this is twice the rate of non-Latino Blacks and three times the rate of non-Latino Whites. A similar proportion, 25%, report obtaining no health care information from medical personnel in the last year; yet more than eight in ten report receiving information from media sources such as TV and radio.[10]

Those least likely to have a usual provider include men, young, less educated, and/or uninsured individuals. Foreign born and less assimilated Latinos (those who mainly speak Spanish, lack U.S. citizenship or are recent immigrants to the U.S.) are less likely than other Latinos to have a usual place to go for medical treatment or advice.[11] Language is an enormous barrier when accessing health services and 77% of Latinos in California report speaking a language other than English at home.[12]

"There is no epidemiological or clinical evidence that suggests that Latinos are more susceptible to either 2009 H1N1 or seasonal influenza or to poorer health outcomes by virtue of their race/ethnicity alone".

- CDC, 2010

Challenges for Public Health

Key Points:

- Some immigrants are more vulnerable to public health emergencies than other groups due to preexisting health and social disparities, migration history, or living conditions
- Need to develop trusting relations with at-risk populations *prior* to and during an emergency essential for access to care.

Accurately identifying at-risk populations is challenging. The term 'at-risk" has been used in relation to a wide array of individual or group characteristics and settings, such as economics, ethnicity, culture, geography, attitudes, or behaviors.

With regard to public health, "at-risk" individuals are those who, due to social or structural determinants, do not benefit equally from public health approaches designed to improve the health of the whole population. These individuals or groups of people generally experience limited access to care. This notion of "at-risk" implies there are barriers that make it challenging for people to seek or receive appropriate, quality healthcare or that the services are not available.

For years the public health system has attempted to increase health education, outreach, and interventions with at-risk groups. Yet these individuals and communities continue to pose a challenge to existing public health outreach efforts even during non-emergency circumstances—during public health emergencies this challenge is exacerbated. For example, influenza is easily contagious, thus inadequate preparedness or an untimely response with vulnerable or at-risk populations increases the risk of infection in the general population. In this context, vulnerability is not a personal deficiency but an interaction of many individual and community level risks over which an individual or family may have limited control.[13] Accordingly, some immigrants may be more vulnerable to public health emergencies than other groups due to preexisting health and social disparities, migration history, or living conditions.[14]

As the public health and medical communities engage in emergency preparedness and response with at-risk populations, it is important to understand not only the lives and social realities of this population, but also the public health paradigm in which health education, outreach, and immunizations is being carried out. The identification of at-risk individuals helps to better serve the population, yet the term "at-risk" can inadvertently be stigmatizing. For example, the underserved may be seen as service resistant, thereby implying that the problem lies with at-risk individuals themselves as opposed to the public healthcare system's approach.

Focus group participants rejected fear as an ineffective way to deliver information, and instead recommended messages that are informative in tone and emphasized family.

Reaching the People: Collaborating for Outreach & Education

Key Elements For Success

Based on HIA experiences and lessons learned from other emergency preparedness and response efforts, there are three key elements for successful outreach and education with Latino and other at-risk populations prior to, during, and after a pandemic:

1. Build relationships with community-based organizations (CBOs), local leaders and other stakeholders to develop trust and community linkages in advance;
2. Tailor communications to deliver culturally, linguistically, and educationally appropriate information; and
3. Ensure relevance to the lived realities of the target population so messages and behavior change recommendations relate to the perceptions and socio-economic realities of the population.

Community-based organizations are critical to effective disaster planning and response with vulnerable populations.

Effective outreach and education with at-risk populations is essential for emergency preparedness and response at the local, state, and national levels. What makes it effective? And how can it best be delivered during a public health emergency?

1. Build Relationships: CBOs are Key Partners!

Working effectively with at-risk populations during a public health or other emergency requires significant preparation and relationship building with communities well in advance of the crisis—working with at-risk Latinos is no exception. Community-based organizations (CBOs) are a critical ingredient in effective disaster planning and response, particularly as a link to marginalized and vulnerable populations. Community groups are more likely than other disaster relief providers to employ culturally and linguistically competent staff and are more likely to have earned the confidence of the populations they serve.[16]

Identifying trusted community leaders, including faith-based organizations, is integral to reaching Latino subpopulations.[17] Additionally, promotores (community health outreach workers) have been identified as trusted sources of disaster information.[18]

The first national guidance on at-risk populations and pandemic influenza, developed by ASTHO (Association of State and Territorial Health Officials), recommends joining an existing network or creating a network with representatives from at-risk individuals, CBOs, faith-based organizations, and other key partners.[19] The local Binational Health Week (BHW) task forces are comprised of trusted community leaders and may be a natural local entry point for health department emergency preparedness and response efforts. Collaboration not only builds trusting relationships with diverse

Key Points: Reaching the People

- Preparation and relationship building must occur well in advance of emergency.
- Promotores are cost-effective, culturally appropriate workforce for at-risk Latino preparedness and response.
- Communication must be tailored to culture, language, literacy, and socio-economics.

Meager living conditions may inhibit compliance with official guidance on disease containment.

stakeholders, but also leverages human and financial resources to increase impact. Community organizations should be involved in emergency preparedness planning from the beginning and engaged at every step.

2. Tailor Communications: Speak to Me!

Communication is a critical component of emergency outreach and education. It is most effective when developed in partnership with community organizations to ensure appropriateness, understanding, and adoption of recommended behaviors. In an emergency, messages must not only inform and educate but also mobilize people to follow public health directives. For people to act, they must understand the message, believe the messenger and have the capacity to respond.

While no message is suitable for all populations, effective communication with at-risk populations has three common components:

- Audience appropriate messages
- Trusted messengers
- Effective outreach methods[20]

Planners often think that translating generic messages into multiple languages is a sufficient way to adapt them to different ethnic groups. However, messages based exclusively on technical content are unlikely to be fully effective in promoting desired social behaviors and social action. Messages should be adapted to reflect local perceptions of disease transmission, and feasible and locally relevant calls to action.[21]

How messages are delivered is also a significant barrier – or opportunity – to reach at-risk populations. For example, more than 80% of Latinos surveyed report receiving health information from media sources such as TV and radio in the past year, and 79% say they are acting on this information.[22] Spanish media, such as Radio Bilingüe and Radio Campesina, are reaching migrant farmworkers and other at-risk Latinos.

While internet and new social media are being touted as innovative ways to reach Latinos, one study concluded that information on English and Spanish web sites was poor and inconsistent, and high reading levels were required for comprehension.[23] Participants in HIA's focus groups cited access to Internet as a challenge for some at-risk individuals, and many preferred radio over television because it was perceived as less sensational, more believable, and more available.

Further, engaging trusted CBOs and local leaders, as well as using non-traditional media venues (folk theater, social and religious gatherings, etc.), may be more effective in reaching at-risk groups than disseminating centrally-generated messages through mass media.[24]

Messages should be adapted to reflect local perceptions of disease transmission

"We should take care of our health first, especially if we have a family to provide for, but a lot of people don't want to ask for a day off, for fear of losing their jobs."

- H1N1 Campaign male focus group participant

Word-of-mouth is often the most effective communication method among at-risk populations.

Appropriate training of promotores and community leaders is important before and during an emergency to assure that the information disseminated is accurate and follows the intended mobilization of the at-risk population. At the same time, promotores can provide public health authorities with valuable and timely information about how the target population is receiving messages and also inform about specific behaviors and beliefs that could interfere with desired outcomes.

Advance planning for successful communication with Latino and other HTR stakeholders during emergency preparedness and response may include:

- Identifying HTR barriers to communication
- Identifying trusted messengers (individuals and media)
- Review research to better understand HTR culture, perceptions of health, and motivations for health seeking behaviors
- Translation of key content into Spanish and other indigenous languages
- Culturally appropriate graphics for low literacy/non-English speaking audiences

3. Relevance - Reality Check!

Communications are most useful when they are open and transparent in addressing the concerns and priorities of targeted populations. Messages must be culturally grounded, personally relevant, and strong in promoting self-efficacy about protective behaviors.[25] Thus, recognizing the cultural and socio-economic realities of at-risk populations is paramount to identify information and behavior change strategies that are relevant, applicable, and adoptable.

For instance, CDC recommends three steps to prevent pandemic and seasonal flu: get vaccinated (when available); take everyday preventive actions, including frequent hand washing and covering coughs and sneezes; and staying home when sick.[26] Yet meager living conditions may inhibit compliance with official guidance on disease containment.[27] At-risk Latinos tend to live in poverty and have limited work benefits, precarious child care arrangements, cramped substandard housing, and other living conditions that interfere with their ability to follow infection mitigation and control measures.[28]

For example, no H1N1 Influenza focus group participant suggested a sick person stay home from work or school, or be isolated at home to avoid infecting others, when discussing H1N1 Influenza prevention. Even when discussing access to preventive care, such as immunizations, many of them, especially male participants, expressed the work schedule as one of the main barriers.

Recent analyses of a state's emergency preparedness communication materials targeting low-income African American and Hispanic populations found them inadequate, and concluded that many materials were inappropriate for certain vulnerable populations (e.g. recent immigrants) because of readability issues, cultural references, language, or required health literacy level.[29] Further research is needed to accurately integrate at-risk Latino populations' unique culture, values, education, health-seeking behaviors, and perceptions into emergency preparedness and response strategies.

Immunizations: Empowering People and Providers during a Pandemic

"I know that we should get the vaccines, before getting sick. They're to prevent diseases. But I, like everyone, was afraid to get this particular vaccination, so I haven't gotten it yet."

- H1N1 Campaign focus group participant

As with the H1N1 influenza in 2009, pandemics can challenge the public health infrastructure and health providers to maximize outreach, education, and immunization efforts. Empowering people and providers to increase access to care, particularly immunizations, is critical for emergency preparedness and response efforts with at-risk populations.

Analysis from the H1N1 Influenza campaign and other research identified several important factors to consider for improving immunization rates with at-risk Latinos during public health emergencies:

- Latinos have a high acceptance rate of vaccinations
- Disparities exist due to systemic barriers and missed opportunities
- Accurate information delivered in a culturally and linguistically appropriate manner is needed to address fears and misconceptions
- Informed and trusted health providers, including promotores, are essential to encourage immunizations
- Health disparities are not adequately addressed in current influenza immunization plans.[30]

Bridging the Gap: At-Risk Latinos and Influenza Vaccinations

Influenza vaccination rates among disadvantaged minority and at-risk populations are lower than in other groups. They are also at increased risk of influenza-related morbidity and mortality due to socio-economics, lifestyle, and chronic diseases such as asthma and diabetes. According to the CDC,[31] although seasonal influenza vaccination coverage for all racial and ethnic groups was low during 2008-2009, Latinos were less likely than non-Latino whites to receive influenza vaccination. Identifying the challenges and opportunities to improve influenza immunization rates among the at-risk Latino population is critical, and can yield a large impact if understood and acted upon successfully.

Barriers to immunization for at-risk Latino populations include:

- Frequent mobility
- Fear of being deported due to immigration status
- Lack of sick leave from work
- Unfamiliarity with the U.S. healthcare system
- Language barriers, especially for indigenous Latinos that do not speak English or Spanish
- Lack of health insurance and cost
- Transportation
- Misconceptions about vaccine risks and benefits
- Missed opportunities due to immunizations not being available or not being recommended by health providers.

While research suggests high acceptance rates and intent to get vaccinated for flu among Latinos, this acceptance exists alongside rumors, fears, questions and concerns about the safety and importance of flu vaccines. Misconceptions are evidenced among the general population, yet what is unique to at-risk Latinos is that cultural and language barriers impede these concerns from being effectively addressed.

When I asked my doctor if I should get the vaccine for the H1N1 he said, "I'm not planning on getting the vaccine for me or my family, but if you want it, it is up to you."

- H1N1 Campaign focus group participant

Latinos believe vaccines are good and important, especially among people from Mexico where immunization campaigns are strong.

Latinos typically have a great deal of respect for authority figures and the role of physicians is important in promoting health.[32] Health providers–doctors, nurses, promotoras–have been identified as critical, trusted messengers to ensure Latinos get vaccinated.[33] During the 2009 and 2010 influenza seasons, some health providers contributed to lower than desired immunization rates by not encouraging immunizations or providing comprehensive information about flu vaccine safety and recommendations.

Experience from the H1N1 Influenza campaign and other immunization campaigns suggest the following to empower people and providers to improve immunization rates during a pandemic:

- Provide free or low-cost immunizations;
- Facilitate immigrants' access regardless of legal status by partnering with CBOs and trusted local leaders, and reducing documentation requirements;
- Go where people naturally gather, such as churches, supermarkets, shopping malls, swap-meets, work sites, and social/cultural gatherings;
- Provide Spanish and other language translation to address people's concerns. Partnering bilingual trained promotores with nurses/ doctors during vaccination clinics has proven to be very effective;
- Educate providers to encourage vaccinations and provide comprehensive information.

Don't Assume Access – Facilitate It!

Current guidance on allocating the pandemic influenza vaccine does not include specific at-risk populations, such as racial/ethnic or migrant populations, in priority target populations for H1N1 vaccines.[34] However, "the weight of available evidence indicates that social disparities in vaccine coverage are likely to occur in the absence of careful planning to prevent them."[35]

Next Steps: Emergency Preparedness Starts Now

Ten actions that departments of public health and other stakeholders can do right now to improve emergency preparedness and response efforts with the at-risk Latino population are identified below.

1. **Identify at-risk Latinos in your locale:** who they are, where they live, how many, what is their socio-economic status, which language they prefer to speak, what are their cultural practices, where do they access health care and information, and which are their trusted sources.

2. **Integrate at-risk Latinos** into existing preparedness and response plans; they could serve as bridges between the public health authorities and the target populations.

3. **Prepare educational materials** and test them to ensure they are appropriate in terms of language, culture, literacy, socio-economics; and address fears or misconceptions.

4. **Determine appropriate media** for routine and emergency information with at-risk Latinos in Spanish and indigenous languages. This includes mass media such as television, radio, newspapers, internet, as well as social and community networks.

5. **Partner with an existing community collaborative** to build and sustain relationships with CBOs and local leaders.

6. **Select key community partners** and agree on shared roles and responsibilities in the event of a pandemic.

7. **Work with promotores** to strengthen the health workforce; train and engage them in preparedness and response efforts with at-risk Latinos.

8. **Educate health providers** to encourage immunizations and provide accurate information about the safety and necessity of influenza vaccines in case of a pandemic.

9. **Establish non-traditional vaccination sites** to maximize reach and access.

10. **Plan ahead** to determine your agency assets and needs to better work with at-risk populations for pandemics and public health emergency preparedness and response.

Conclusion: Changing the Way Public Health Does Business

Latinos' increasing presence in and significant contribution to communities and economies in the United States require that they are integral partners and beneficiaries in emergency preparedness and response efforts from the local to national level. However, Latinos and other at-risk populations remain disenfranchised from the public healthcare system and confront systemic barriers to care during routine times, which are often exacerbated during public health emergencies.

It is important to recognize that at-risk populations are not necessarily service resistant—the main problem lies in the fact that they are not addressed by traditional public health outreach mechanisms.

In order to successfully include the entire population into emergency action plans, diverse methods of reaching the population, such as those described in this document for at-risk Latinos, must be implemented since the population itself is so diverse.

Ultimately, the success of emergency preparedness and response with at-risk populations depends on a collective commitment to preparation, innovation, and collaboration to reach those in need.

Suggested Resources

- At-Risk Populations and Pandemic Influenza: Social Mobilization and Behavior Change Communication for Pandemic Influenza Response: Planning Guidance. USAID. 2009. www.globalhealthcommunication.org/tools/88
- Communicating in the First Hours, First Hours Resources: Key Websites and Online Resources. CDC. www.bt.cdc.gov/firsthours/resources/websites.asp
- Enhancing Public Health Emergency Preparedness for Special Needs Populations: A Toolkit for State and Local Planning and Response. Rand Corporation. www.rand.org/pubs/technical_reports/2009/RAND_TR681.pdf
- Influenza: Seasonal and Pandemic /Influenza Estacional y Pandémica, Manual for Community Health Workers. Health Initiative of the Americas, School of Public Health, UC Berkeley. 2010. http://hia.berkeley.edu
- National Resource Center on Advancing Emergency Preparedness for Culturally Diverse Communities. www.diversitypreparedness.org/
- Planning Guidance for State, Territorial, Tribal, and Local Health Departments. ASTHO. June 2008. http://astho.org
- Public Health Workbook to Define, Locate and Reach Special, Vulnerable, and At-Risk Populations in an Emergency. CDC. http://www.bt.cdc.gov/workbook/
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