In addition to teaching fascinating and thought-provoking classes, your favorite Community Health faculty members also pursue their academic interests through research projects. One common type of public health research is community-based participatory research (CBPR). By definition, CBPR refers to “a collaborative approach to research that equitably involves, for example, community members, organizational representatives, and researchers in all aspects of the research process.” In other words, CBPR projects enable university and institutional scholars and community members to partner and explore topics of mutual interest. A unique aspect of CBPR is that an advanced degree or extensive knowledge of research methods is not required to get involved. There is space for everyone to learn, participate, and contribute in this inclusive process. This past summer, I had the privilege to work with CHP Assistant Professor Cora Roelofs on her CBPR project in Lowell, MA.

Lowell Cambodian Asbestos Worker Survey
Dr. Roelofs’ research interests include the prevention of workplace exposures to hazardous substances, with a focus on immigrant worker populations. In the past few years, she learned that significant numbers of Cambodians were employed in the asbestos abatement trade in Massachusetts. While she was able to find numerous research studies arguing that exposure to asbestos, a mineral fiber commonly found in pipe insulation, increases the risk for lung disease in the present occupational health literature, she could not find any studies exploring the health outcomes of Cambodian asbestos abatement workers in the U.S. As a result, Dr.

Like many of my peers, I applied to Tufts with the goal of tackling the premed track and spent my first year here checking requirements off of that list. I knew for certain that I liked science and that I hoped to eventually have a career in serving others. To my freshman self, that meant medical school and becoming a physician. As I became more involved with the Community Health Program, however, other equally exciting and potentially rewarding options began to present themselves to me. I realized that science and helping people can be combined to achieve wonderful and exciting things in every arena, far from a doctor’s office.

While my pool of options had grown, my biology and community health majors didn’t seem to be pushing me in any one clear direction. I enjoyed an array of classes, from Cell Biology to Community Mental Health. I took required labs and enjoyed working in them, but never felt drawn to pursue additional lab research outside of classes. I knew public health was of interest to me and hoped to apply my community health degree after graduation, but felt confused about how exactly I wanted to try to do so – until discovering the field of health communications. This area seeks to fill the void between researchers and the media and to convey health information and programs in a way that is accessible and exciting to the target audience.

When I took some time for self-reflection and discussion with friends and family, I began to assess my hobbies and interests outside of school. Writing, design, social media, and people were all factors that lead me to the field of health communication. I
FROM THE DIRECTOR

In my short time here at Tufts, I have heard many students express the desire to make Community Health their primary major. Since 2002, when Community Health changed from a certificate program to a secondary major, more than 1300 students have graduated from the program. Students who have taken CH as a secondary major have managed to fulfill the requirements of two majors, general education requirements, and have even studied abroad and/or completed pre-med requirements. While these accomplishments are impressive, many have expressed a primary interest in CH and wished to be able to focus in this field without having to meet the requirements of another major.

Discussions about making CH a primary major have been ongoing for some years. Today, we have been granted primary major status. Tufts now joins many of its peer schools in offering CH as a primary field of study. The details and timeline for implementation of this change have yet to be determined. Nonetheless, we wanted to share this news with all of you, as many of you have played an important role in moving us toward this goal.

Stay tuned for more specifics about the new primary major in Community Health!

Asbestos cont’d from page 1

Roelofs recognized an opportunity to do what no one else had done before: to investigate the work-related determinants of health among Cambodian asbestos workers in Lowell, MA, which hosts the second largest population of Cambodians in the U.S. She collaborated with the Cambodian Mutual Assistance Association (CMAA), a community-based organization, to develop the Lowell Cambodian Asbestos Worker Survey (LCAWS). CMAA was the ideal community partner, given its longstanding history of and commitment to serving Cambodian American residents in Lowell. With approval from the Institutional Review Boards at Tufts and the University of Massachusetts Lowell, the immediate goals of the LCAWS were to learn about the exposure and protection experiences of the asbestos workers and assess signs of possible respiratory health problems. Beyond this occupational health survey, long-term plans included organizing a Community Wellbeing Fair and sharing the results with the Cambodian community through local media.

CBPR in Action

Between conducting literature searches on the documented health concerns of Cambodian refugees and taking copious notes during key-informant interviews, I also provided feedback on the LCAWS, which is a 48-item survey that assesses the work history, exposure experience, and health access of the asbestos workers. The survey was initially written in English, but was later translated into Khmer by bilingual CMAA staff members who also served as survey assistants. Translating the survey segued to several important and occasionally time-consuming aspects of CBPR work, such as finding eligible participants and collecting survey response data. The plan was for the survey assistants to recruit participants from neighborhood businesses, Buddhist temples, and community programs throughout July and August.

Next Steps

The end of the summer meant the start of the planning process for the Community Wellbeing Fair in the Spring of 2015. Attendees will have the opportunity to receive helpful tips on healthy living, meet staff of the Lowell Community Health Center and other local organizations, and enroll in MassHealth, a statewide Medicaid
Meet the Newest Members of the Community Health Faculty!!
Stephanie Sharabianlou ’15

The Community Health Program is proud to welcome two new faculty members, Professor Carolyn Leung Rubin and Professor Shalini Tendulkar. They are both passionate about their students and have a lot of great advice, so stop by and get to know them—this should be enough to get you started:

Professor Rubin

Why she loves the CHP: “It attracts students who want to make a difference, and helps them find where that difference can be.”

What community health means to her: Strengthening our communities. “It really values lived experiences and people’s stories. It means fighting for things that are invisible or not in the popular press. It’s about finding power in community… It’s all our responsibility to fight for social justice. The only reason we have what we have is because others fought for our rights before.”

What she thinks you should read: Alice Waters and Chez Panisse by Thomas McNamee. “She started [an entire] movement without knowing what it would become. It shows how you just put one foot in front of the other. Sometimes you don’t know where it’s taking you but life has a path for all of us and we have to not be afraid to make decisions, take risks, or be unsure of ourselves.”

Which reality TV show she would win: Top Chef. She spent her undergrad at UCLA throwing gourmet cooking parties with homemade southeast Asian and Chinese food.

She believes in: Self-care. “We need to take better care of ourselves. We are at a point in the world where we carry too much stress, which influences our health, our family lives, and our communities. Students need to think about taking care of themselves and finding balance.”

Secret talent: She makes a lot of her son’s clothes in bright, colorful fabric. She wants to revolutionize how we dress little boys so they don’t grow up with gendered messages.

Professor Tendulkar

What she was doing before Tufts: A whole lot of research. “I have been doing a lot of Community Based Participatory Research and evaluation work. I am interested in health disparities, in the health of immigrant and minority groups and developing and testing community based interventions to address health concerns in collaboration with community partners.

What surprised her about teaching undergraduate courses: The students. “I’m surprised by how many students, even early on in their Tufts career have a purpose or a vision for their professional pursuits. I’ve also been really impressed with the caliber of students in CH. They are really committed to social justice.

Secret to success in Community Based Participatory Research (CBPR): People skills. “It’s really important to hone your skills as far as building relationships with people. You really have to put yourself out there and be comfortable in uncomfortable positions.

Why you need to register for her class: I care deeply about working with students and developing their skills related to the courses I am teaching but important life skills as well. As a bonus, I love to bake and enjoy bringing sweet treats to class when I can.

What she cares about: Our future. “I enjoy providing career advice to students and helping them navigate through their professional pursuits. I remember being a young person and not always having access to advisors and mentors, so I feel compelled to provide advice on careers and networking and be available to students.

Asbestos cont’d from page 2

health insurance program. Ideally, participants of the LCAWS who indicated experiencing respiratory symptoms on the survey will be invited to attend and receive a pulmonary physical exam and spirometry procedure to assess lung function. These respiratory health screenings will be provided by members of the Pulmonary, Critical Care, and Sleep Medicine team of the Tufts Medical Center. In the meantime, Dr. Roelofs and several CMAA staff members will focus their attention on this year’s 142nd American Public Health Association Annual Meeting in New Orleans, LA, where they will reflect on their university-community partnership and results from the LCAWS in an oral presentation to students, health care professionals, and educators from all over the world.

From start to finish, CPBR projects require plenty of time, effort, and commitment. However, it definitely feels worth it when you are working toward a positive change and brighter future for the community. Working on the LCAWS enabled me to examine “community health” firsthand. For personal growth and real-world experience, I encourage all interested students to get involved with CBPR work. If there is a topic that strongly interests you, feel free to contact a faculty member who does work in that area of study. You may be able to get involved in current or future research projects. Furthermore, if you are interested in occupational health and/or immigrant and refugee health, look out for Immigrant and Refugee Health (CH188-10) and other similar classes.

Endnotes:
Abstract

Hispanic construction workers face injury and fatality inequities in the United States every day. Over 30% of the Hispanic workforce is employed in the construction industry. Hispanics are more likely than their non-Hispanic white counterparts to die or get injured while at work. Construction is a dangerous industry, and Hispanics are disproportionately placed in roofing and labor activities, the most dangerous of construction trades.

To examine the current surveillance of this inequity, national statistics from the Bureau of Labor Statistics, Census of Fatal Occupational Injuries, and the Center for Construction Research and Training were reviewed. Existing studies were examined to determine current causal hypotheses for the inequities. Current causal hypotheses include language barriers, cultural differences, lack of or inadequate safety training, supervisor emphasis on and attention to safety, and standard enforcement or work organization. Language barriers, cultural differences, and worker safety training hypotheses were found to be weak study targets for interventions because they emphasize the worker but involve factors that are beyond the worker’s control. Both supervisor emphasis on and attention to safety, and standard enforcement or work organization hypotheses are strong study targets for interventions because they put emphasis on the institution and involve factors that are under the administrative control of influential people with decision making authority.

Evidence from the literature and the critical thinking gained from CEE 158 resulted in the development of a conceptual framework for an ideal intervention. This intervention would address all five targets and create a hierarchy of responsibility involving supervisors and workers. An ideal intervention combines a supervisor-training program and a peer lead participatory safety training program.

Background

Construction is one of the largest industries in the United States. It currently employs 7.13 million in the civilian labor force (1). It is also one of the most dangerous industries in the U.S. In 2002 construction represented 20.3% of all occupational deaths, and in 2012 the CFOI (Census of Fatal Occupational Injuries) recorded a total of 775 fatalities (1,2). Rates of nonfatal injuries and illnesses resulting in days away from work have also been consistently high. The construction industry consistently ranks as one of the highest risk industries in the United States. (4,5,6).

Falls from heights is the leading cause of construction fatalities and traumatic injuries, followed by struck-by incidents, and contact with electric current (4). In 2012, CFOI data reported 280 deaths from falls out of the total 775 fatalities for the construction industry, or 36% (2). In 2006 work related falls were the second leading cause of nonfatal injuries in construction, even workers who fall from heights as low as ten feet or less can require lost work days that amount to over a month (7).

Figure 1. Although non-fatal injuries and illnesses in construction have declined over-all, the number of nonfatal injuries and illness among Hispanic construction workers nearly doubled between 1992 and 2006. Source: CPWR data brief, Vol. 2 No. 2, 2010

The U.S. construction industry currently employs the second highest percentage of Hispanic workers after agriculture. The number of Hispanic workers in construction tripled to 3 million between 1996 and 2006. As of 2012 Hispanics comprise one fourth (or 24.4%) of the employees in the industry (11,17) and this percentage is estimated to grow 2.9% annually by 2020 (9).

Hispanic workers hold a considerably small proportion of professional/management (3%) and service/administration (5.8%) jobs in the construction industry and are mostly employed in construction and extraction jobs (87%) (10).

Figure 2. Between 2003 and 2008, construction laborer ranked the highest in the number of work related deaths among all construction trades. The roofing trade incurred the third largest number of fatalities Source: CPWR data brief, Vol. 2 No. 2, 2010

continued on next page
This summer, I worked as an intern for the Heart Healthy Initiative for Hispanic Adults (HIP), a program dedicated to improving the cardiovascular health of older Latin American immigrants. The program, funded by UMass Lowell, offers older Latinos and Latinas in Boston weekly education sessions and Zumba classes. Since almost every participant in the study is an immigrant, the intervention strategy focuses on keeping up healthy diet and exercise in the United States. These weekly classes are held at the Boston Center for Youth and Families (BCYF) locations in Roxbury and East Boston. With knowledge of the structure of the study, and direct work with participants, I saw the firsthand effects of the program.

Participants must be between the ages of 45 and 75, identify as Latino/a, and be Spanish speakers. The strict criteria allow the educational seminars to be tailored to the diet and culture of many Latino immigrants. Also, many participants tend to find common ground between language, culture, and ethnic background. This ensures a strong sense of community within study groups, giving them more motivation and inspiration to improve their cardiovascular health and overall well-being.

To recruit participants for the study, all 5 researchers and myself went to the streets of Roxbury and Mission Hill to pass out fliers with information about the HIP. Recruiting happened roughly once a week from 9-noon. Going from door, to door, to door, with information about the HIP. Recruiting happened roughly once a week, we sometimes went through an entire block of empty houses. In contrast, many pedestrians were not very interested, didn’t have the time to participate, or weren’t qualified for our study.

As we started to feel the harsh rays from the sun beating down on our necks, we were occasionally blessed with one or two recruits at the end of the day. These people were thrilled to see how hard we were working and told us about their own successes and failures in becoming healthier adults. It was touching to see how excited people were to improve the quality of their life. The prospect of finding more participants gave me hope for the future success of the program.

Since its start in 2004, the HIP has collected data from over 1,000 participants. Each person is studied for 12 months at a time, and, either during the first or second 6 months is enrolled in the intervention classes. When HIP researchers can recruit a group of 30 participants, they take them and split them into two separate groups. One group, consisting of 15 participants, starts their intervention 1 month after recruitment, while the other group does not have any intervention for 6 months. All participants must have interviews, phlebotomy tests, and measurements taken at the beginning, middle and end of the 12-month study period. At the beginning of the summer, I conducted a few 6-month participant interviews in English and Spanish. Everyone I interviewed loved to tell me about their detailed exercise routines and diets, and how they were working hard on eating less fast food and more vegetables. It seemed that the program motivated them to be healthier people, since they dedicated time to improving their health outside of the intervention.

The Heart Healthy Initiative has a community health educator, who teaches the weekly seminars in Spanish so that there are no language barriers and miscommunications. The educator tries to make the information presented relatable to all participants, and provides real world examples related to the immigrant experience. Class topics include exercise, cholesterol, sodium intake, and reading nutrition labels, which present a wide range of information on not only heart health but on improving quality of life in the United States. Zumba classes, conducted in Spanish and English, start at a beginners level, so that everyone is able to take part in the exercises. The HIP also provides participants with a yearlong membership to the BCYF site within their area. Not only are participants able to include the in their daily schedule, but also they’re able to keep it up for an entire year, to continually better themselves.

As an intern, I attended the first 6 weeks of intervention classes at the East Boston site of the BCYF. I worked alongside the Project Manager (and my boss), CH alum Shioban Torres, and the community educator, Augusto Angulo. Together, we set up the lecture slides, collated worksheets into information packets, and called participants to remind them about the following week’s class. Shioban and I also attended the Zumba classes, translating instructions into Spanish. Working directly with the participants was the most rewarding part of the summer, because I would see them grow and gain confidence in their health knowledge every single week. Week by week, they were becoming more familiar with nutrition labels, learning how to include physical activity into their weekly schedules, and actively participating in class. I was impressed with their almost immediate dedication to the program and their livelihoods, and it was fulfilling to work with them directly.

Hypotheses

**Language Barriers:**
Communication challenges resulting from lack of a common language between employers and employees, are frequently cited among the reasons for the higher rates of injuries and fatalities or as a key factor to address in order to mitigate the current inequity (11).

**Cultural Differences:**
Cultural issues stem from the theory that every worker coming from a different country has a different set of beliefs regarding work ethics, and company loyalty that relationships at work (12).

**Lack of or inadequate safety training:**
In a study of foreign-born Hispanic construction workers in New Orleans 57% of the 42 interviewed had never received any safety training. In an additional study targeting young Latino’ immigrant construction workers, it was found that they frequently performed tasks that pose significant injury risks (13). Despite the high-risk tasks, 24% of the respondents had no safety training at all while another 24% had less than an hour of safety training (14).

**Supervisor Emphasis on and Attention to Safety:**

“Construction Workers” cont’d from page 4
In the Spring of 2014 GlobeMed at Tufts experienced a re-partnership. GlobeMed, as a national organization, pairs university students with grassroots health organizations in a sustainable, long-term partnership that focuses on empowerment of both groups. After three years of strong partnership between GlobeMed at Tufts and Nepal-based nonprofit Possible Health, we were re-partnered with the non-profit nongovernmental organization PHASE (Practical Help Achieving Self Empowerment) Nepal. Just as this partnership with PHASE actualized, we found ourselves at the end of the academic year, and a team of five chapter members, including myself, prepared to head to Nepal to intern with PHASE. This internship is a critical component of the GlobeMed model. Called the “GrassRoots Onsite Work” (GROW) internship, the trip serves as an opportunity for GlobeMed members to travel and experience the partner organization firsthand, to strengthen relationships, to evaluate projects, and to bring back valuable knowledge to the GlobeMed chapter at Tufts.

As the first team to intern for our new partner organization, we entered our trip with the responsibility of fostering and strengthening our new GlobeMed at Tufts-PHASE Nepal partnership. With this responsibility came many questions. In a world of “voluntourism,” service trips, and projects implemented with good intentions but often lacking in evaluation of community needs and plans for sustainability, what does it mean to truly be a “partner” in the fight for global health equity? What is the best way for student groups like GlobeMed at Tufts to affect change in a global health context? How did this trip fit in with GlobeMed at Tufts’ work in a larger sense as a chapter as a whole? Throughout the course of our internship, some of the answers to these difficult questions unfolded, and the meaning of partnership became clearer.

PHASE Nepal is a nongovernmental, nonprofit organization dedicated to breaking the cycle of poverty in Nepali communities by providing support in the areas of livelihoods, education, and health care. The five members of our team spent our six weeks observing PHASE’s work in each of these areas. We observed auxiliary nurse midwives providing critical care to entire communities, we met with farmers who had benefitted from PHASE’s farm training, and spent extensive time in schools observing PHASE education programs, which aim to promote critical thinking and improve teaching skills in Nepali public schools. Our team was asked to work specifically with two PHASE-supported public schools to implement government-supported “child club” programs. Child clubs are extracurricular groups formed with the aim of promoting discussion of child rights, student empowerment, and health topics along with supporting general sports and games for Nepali students. Our team spent a large portion of our time mobilizing students and teachers to take charge of these clubs, and planning for their continuation after we left.

Through these experiences, our GlobeMed at Tufts team now has extensive knowledge of our partner organization. Though when we arrived in Nepal, we knew very little of PHASE and they knew very little of us. Over the course of the six weeks in Nepal, our knowledge of their mission and model expanded immensely, and both PHASE Nepal and our team grew in mutual understanding. Having the responsibility of solidifying and strengthening the new relationship between our two groups showed me the undeniable power and importance of partnership. Rather than approaching the partnership as a group of students looking to impose our own ideas and projects, we observed and responded to the needs of the communities PHASE supports. I learned that partnership means flexibility and responsiveness to community needs rather than imposing assumptions. In getting to know the PHASE staff, we were forced to confront what we did and did not know about development work and global health issues in general. We asked questions about PHASE, and they asked questions about GlobeMed at Tufts. I learned that partnership means open communication and honesty. Most important to me, I learned that partnership means sustainability. It means that my team and I traveled to Nepal to learn about PHASE so that the GlobeMed at Tufts chapter at home can continue to effectively advocate and support PHASE for years to come. Next summer another group of GlobeMed members will intern with PHASE and continue to strengthen our partnership. Partnership means that our time abroad was only the starting point, not the end-game in fostering a strong and mutually beneficial relationship in pursuit of global health equity and lasting change.
Like most people, I hadn’t heard of child life before actually beginning work in the Tufts Medical Center child life department this summer. Sure, the title “child life specialist” had come up on some data entry I’d done for the hospital, but it sounded more like a new age therapist than a bona fide profession. Even when I was applying for the position of summer intern, I couldn’t begin to guess what my job would entail. My interview was somewhat enlightening, as it took place in Ace’s Place, the Tufts Floating Hospital for Children’s playroom. The playroom was and is full to the brim with fun stuff – we even have parents express their desire to spend more time playing and crafting with us. From table hockey and pool to board games and jigsaw puzzles, cars and dolls to arts and crafts, and even movies and CDs, the playroom contains every possible distraction and comfort technique you can imagine. That was my first clue: in some way, shape, or form, our job is to make kids happier.

Child life specialists are the yang to physicians and nurses’ yin. Where health care professionals are worried about healing the sick and fixing damaged bodies, child life specialists are entirely focused on the emotional well-being of pediatric patients and their parents. The field is based on the very basic premise that spending time in the hospital is hard. It’s a stressful situation in a stressful environment, surrounded by other people’s similarly stressful situations. Very few people, even chronically ill repeat visitors, enjoy trips to the hospital, but kids are kids, and they have the same needs and wants, regardless of the health and functionality of their bodies. Child life specialists are hyperaware of the way different children react to and cope with the fear and pain associated with being hospitalized, and their goal is to ease the process as much as possible. Not surprisingly, there are as many methods of care and comfort as there are scared and unhappy children. Talking, playing, distracting, and interacting, with or without friends or family, all are techniques which child life specialists employ to ease children through difficult times. The most remarkable thing is how logical and simple most child life tools truly are.

One morning, while I was doing my rounds on the inpatient floor, I heard a young boy screaming, wailing, and all-around causing a ruckus. To my surprise, few to no health care providers leapt to his aid, working, I believe, on the assumption that whoever was with him could handle the strain. When I learned the clearly painful and terrifying event would occur every six hours, I waited for his harried ophthalmologist to step out, and immediately recommended that she call for a child life specialist before the next procedure began. Six hours later, we received a call asking for help. With no prior knowledge of the child and no time to build a strong rapport, Andrea Pappaconstantinou, director of child life, grabbed some toys and headed down to help. When she returned, it was with profuse thanks and compliments from the doctors she’d helped, so I was naturally curious what magical techniques she’d employed to calm a clearly frantic patient. What she told me was shocking in its simplicity. She had every doctor, nurse, and technician introduce themselves to the boy by their first name. Everyone who was to touch him had to first say what they’d be doing, why, and, with complete honesty, whether or not it would hurt. His mother was allowed to hold his hand through the whole thing, and if he asked, he could be given a break, on the understanding that the procedure would need to be finished, one way or another. No part of these instructions required any sort of magical knowledge of the inner workings of children, only the understanding that children require a little more explanation than adults, and the willingness to make the child, if not physically comfortable, then emotionally so.

Such an emphasis on caring and communication is what sets child life apart from other health care-related professions. Despite a desire to help and heal, the education and technical know-how physicians and technicians must have can often overshadow the needs of the patient as an individual. Working in child life gave me an immense appreciation for how much can be done to improve the hospital experience for children. Before this summer, I felt that the distress and discomfort of being hospitalized could only be marginally alleviated, but child life truly has the ability to make hospital visits, if not fun, then certainly low-stress. Though I have a keen eye towards practicing pediatric medicine in the future, I firmly believe that the lessons I will take away from my internship are universally applicable. Children are intelligent, aware, and responsive to their surroundings, and with a little effort and education, proper and intentional communication makes life easier for both them and any adults with whom they interact.

Health Communications cont’d from page 1

paired these interests with my academic interests and started thinking about the bigger picture of what I’d like to spend my time doing beyond graduation and the pieces started to fall into place. I did some research to see whether Tufts offered classes specifically in health communication and found the Dual Degree program on the CHP webpage. The Health Communications Masters program, as described on the program webpage, is “designed for students [to] learn to develop, deliver, and evaluate health promotion and disease prevention programs and campaigns; to disseminate health information to diverse audiences; and to develop, formulate and implement health policy initiatives.” It’s a great fit for me because it lies at the intersection of science and public health and writing, media and communication.

I had the opportunity to work as a health communications intern for a community health project in Everett this summer, and that work solidified my decision to apply to the program. There I had the opportunity to redesign their webpage, run social media accounts and create content based on public health research in areas like social justice and urban agriculture. I’m excited to study and work in a field that allows for creativity while also building upon my longstanding interests in health, science, writing, design and new media. I’m thrilled to be able to pursue an awesome opportunity offered by Tufts!

Check out the webpage to learn more about the B/MS H-COMM dual degree program: http://publichealth.tufts.edu/Academics/HCOM-Program/BachelorsMS-Dual-Degree-Program
“Construction Workers” cont’d from page 5

A study on work safety climate for Latino residential construction workers concluded that employers and supervisors should be trained so that they actively support work safety for their employees (15). Of the 119 Latino residential framers, roofers, and general construction workers 69.7% of them reported that worker safety practices are very important to management (16). However, when asked if supervisors do as much as they can to make their job safe, only 40.3% (40% for roofers) reported that this was the case.

Standard Enforcement or Work Organization:
An example of this would be falls—the highest cause of death among Hispanic construction workers, especially roofers. Under OSHA regulations (29 CFR 1926.501(b)(8)), “workers engaged in... construction six feet or more above lower levels must be protected by conventional fall protections” such as guardrail systems, safety net systems, or personal fall arrest systems (PFAS) (16).

Intervention framework
The hypotheses listed above all have valid components that encompass factors that impact the health and safety of Hispanic construction workers. Like all issues with health inequities, the cause of higher prevalence of work-related injuries and fatalities in Hispanic construction workers is multifactorial. There is no one single manner in which this inequity can be addressed, and no one single solution that will start the process. An intervention designed to address just one or two of these components would not be successful. A successful intervention would have to consider all five of these areas. The intervention would also have to be designed in a way that puts more structural responsibility on supervisors and institutions, while also emphasizing participatory responsibility for employees in an environment that fosters respect and understanding between the two.

Works Cited:
(11) Dong, X. S. (et. al) (June 01, 2010). American Journal of Industrial Medicine, 53, 6, 561-569.