AN EXPLORATORY STUDY ON BARRIERS TO MEDICAL SERVICES UTILIZATION BY MIGRANT WORKERS

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AN EXPLORATORY STUDY ON BARRIERS TO MEDICAL SERVICES UTILIZATION BY MIGRANT WORKERS

A Thesis

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Division of Social Work
Abstract
of
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The purpose of this exploratory research was to identify the barriers that exist for migrant workers in accessing medical services. This study focused on the following barriers: occupational health risks, rural areas, cultural beliefs, economic status, and language. A sample of thirty-nine migrant farmworkers who participated at the E Center Migrant Program in Yuba County, California, was recruited. All 39 participants were from Mexico and completed a 30-item questionnaire. Descriptive statistics and chi-square tests were employed to analyze the data. The findings of this study support findings of other research studies, indicating that this under-served population continues to face the same barriers. More specifically, results from this study revealed that high percentages (46%) of the participants suffer illnesses from pesticides. In fact, thirty-eight percent of the participants had skin problems due to working in the fields. Based on the findings sixty-seven percent of the participants had no knowledge of healthcare programs and fifty-nine percent did not have medical coverage. Finally, the results of the study indicate that the potential barriers for Mexican migrant farm worker continued to be prevalent.

Chrystal C. Ramirez Barranti, PhD., MSW

Date
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Migrant farmworkers are significant contributors to the economic growth in the United States (National Center for Farmworkers Heath Inc., 2002 (NCFH). Everyday farmworkers wake up to an early day to harvest and cultivate fruits and vegetables we consume. These workers and their families make huge sacrifices earning little pay. Agriculture work has consistently ranked as one of the most dangerous occupations in the United States, next to construction work (Martin, Abella, & Kuptsch, 2006). Migrant workers are exposed to occupational hazards, overcrowded housing, unclean water, and unsanitary conditions; however they have little or no access to health care (NCFH, 2002). Migration determined by crops, legal status, and the rural location make health care access even harder to obtain.

Many farmworkers who follow the crops are Hispanic knowing little or no English (Migrant Health Promotion, 2005). Many of the workers come from Mexico and other Latin American countries that include Guatemala, El Salvador, Honduras, and other Central American countries. The Census Bureau (2000) estimated there were 8.7 million illegal foreigners in the US in 2000, more than twice as many as the 3.8 million in 1990 (Loh & Richardson, 2004). Legal status of many migrant workers makes it hard to determine how many individuals and their families work in agriculture. Estimates in the farmworker population vary, but it is known that each year a large group of workers and their families, between 3 to 5 million people, leave their homes to follow the crops
What is certain about this population is that there are several barriers that make health care utilization difficult for migrant workers. These barriers include but are not limited to: accessibility, cost, language, undocumented legal status, eligibility to programs, and low income to pay out of pocket. Roughly, 75% of migrant workers are uninsured and only 15% to 20% utilize federally funded health services (NCFH, 2002).

Migrant farmworkers work under hard labor conditions and expose themselves to illnesses that perhaps if detected in the early stages and with proper routine medical care could decrease mortality rates and ensure a longer life span. The health status of migrant farmworkers is at the same standard of most third world nations (NCFH, 2002). In a nation as rich as the United States, it is important that the health services be available for this disadvantaged group. For this reason, these researchers have chosen the following question in trying to understand the lack of available medical services to migrant workers. The research question that guides this study is “What barriers exists that affect utilization of medical services among migrant workers?”

Exploring the issues that affect utilizations of medical services in this particular group is not only vital for these individuals’ lives but it is also a topic of concern for social workers to address. According to an article published in the Urologic Nursing Journal (Goertz, Calderon, & Goodwin, 2007) many migrant workers fail to utilize medical services because of social economic factors, language barriers for non-English speaking minorities, and cultural differences (Goertz, Calderon & Goodwin, 2007). Social economic factors hamper health care education and access. The 2000 U.S Census
Bureau reported that 6.6 million families live below the poverty level in the United States, and of these, 22.7% are Hispanics. Migrant workers who are Non-English speaking avoid seeking health care, do not access preventative services, and are less compliant with medication treatment due to basic misunderstanding (Goertz, Calderon & Goodwin, 2007). Cultural differences also affect migrant workers from utilizing medical services. Cultural differences can include schedules, values, and priorities (Goertz, Calderon & Goodwin, 2007).

Identifying what specific factors contribute to the lack of utilization of medical services for migrant workers gives social workers an idea of how to assist with those barriers and understand the need of health services for migrant workers. Social workers can advocate for adequate health care for migrant workers through public awareness, advocacy, policy change, and appropriate resources. These are just a few of the elements that need to be on the agenda of social workers in advocating for these underserved and understudied individuals.

Statement of Collaboration

This study is a co-authored research project. The completed thesis project represents a collaborative work effort carried out by Erika Houston and Lucia Orta. Both writers became very passionate about looking further into what barriers exist for migrant workers in the United States. Driven by the commitment to explore at a deeper level what challenges migrant workers undergo when utilizing medical services, both writers contributed equally to the conceptualization, literature search, methodology, data collection and data analysis, and writing of this thesis project.
Background of the Problem

Migrant workers are exposed to occupational hazards that affect their well-being. More than half the illegal migrants come from North and Central America, including 3.9 million or 44 percent from Mexico. About 40 percent are 18 years to 29 years old, 54 percent are male, and 62 percent are Hispanic (U.S. Census Bureau, 2000). There are many health conditions that affect the worker as well as their families. Approximately, 313,000 farmworkers suffer from pesticide related illnesses (Acury, 2007). These related illnesses include gastrointestinal, respiratory, ear, nose, and throat infections. Pesticide related illnesses are increased by poor hygiene and unsanitary conditions (Acury, 2007). Many children experience similar symptoms as a result of indirect contact to pesticides when coming in contact with a parent or sibling who is exposed to pesticides. Farmworkers are often exposed to harsh climate conditions without access to water; this leads to heat stroke and dehydration (Acury, 2007).

Chronic health problems may include chronic dermatitis, fatigue, headaches, sleep disturbances, anxiety, memory problems and different kinds of cancers, birth defects, sterility, blood disorders, and abnormalities in liver and kidney functions are other health problems that migrant workers experience (Migrant Health Issues, 2005). In addition, migrant workers suffer from other health issues in greater numbers when compared to the rest of the population. Examples of these higher incidences are cardiovascular disease, diabetes, and asthma (Larson, 2005).
Health problems also occur among migrant workers because of unsanitary conditions. A lack of proper sanitary facilities in the field and crowded living conditions are responsible for spreading many infectious diseases such as tuberculosis and other communicable diseases. According to the California Department of Public Health (CDPH) 2008 report, the majority of TB cases were from Asian/Pacific Islanders at 43% and Hispanics at 39%. The CDPH 2008 report shows an increase of TB cases and TB rates. This makes California the second state with the highest TB rate in the nation. Tuberculosis (TB) is also prevalent in Hispanic children. TB rates among children under the age of five are six to seven times greater among Hispanics (CDPH, 2008).

Although a number of occupational health risks have been identified through studies of agricultural workers, migrant workers face a multitude of barriers in accessing medical services in the United States. It is estimated that there are over 3 million migrant and seasonal workers with only 20% having health insurance (National Agricultural Workers Survey [NAWS], 2005). Most farmworkers do not have access to regular, affordable health care. Farmworkers rarely have coverage through their employers or public programs, and they do not earn enough money to pay for health insurance. Seventy-two to 78% of farmworkers are uninsured (NAWS, 2005).

Over half of the farmworkers surveyed in the National Agricultural Workers Survey (2005) said accessing medical care was “difficult,” and 77% of these same respondents cited cost as the major difficulty. To make matters worse, farmworkers typically cannot afford to take time off from work or risk losing their jobs to seek medical care. Child care, transportation problems, language, cultural differences, and limited
clinic hours also create barriers for migrant workers in utilizing medical care. It is necessary to continue exploring these barriers and find new solutions to this subject to improve the conditions and health of all farmworkers.

Statement of the Research Problem

Agriculture is not only hard labor but occupational exposure can have enormous health risks to the farmworker. Farmworkers’ living conditions, chemical and machinery exposure, salary, climate, and lack of protection by labor laws place farm works in jeopardy with their health (NAWS, 2005). Demographics complicate health accessibility for many of these workers. Research has shown that the challenges that farmworkers face in accessing appropriate health care are many. Farming does require farmworkers to locate themselves in rural areas, but demographics should not be an obstacle to promoting efficient medical services to farmworkers.

Medical professions’ and government’s lack of understanding of the barriers that are present for farmworkers contributes to the under-utilization of medical services among migrant workers. Farmworkers are major contributors to the economy of the United States yet have little or no labor protections (NAWS, 2005). It is important to understand what barriers prevent farmworkers from utilizing medical services. Policy change that will enable affordable and effective medical services to these people needs to become a priority. Farmworkers can no longer afford to put their lives at risk without appropriate health care programs and laws that protect them. This study attempts to
increase the knowledge and understanding of the barriers experienced by migrant farmworkers in accessing needed health care.

*Purpose of the Study*

Working conditions for migrant works and barriers to utilization to medical services can contribute to significant health risk. Barriers that prevent migrant workers to access medical services can also be associated with the usage of health care in the United States. The purpose of this study is to quantitatively explore the barriers (factors) that exist for migrant workers that contribute to the lack of utilization of medical services for themselves and their families, and whether or not medical services are easily available to migrant workers.

The secondary purpose for this study is to identify accurate and current barriers that exist for migrant workers and their families. The expectation is to give healthcare personnel and social workers greater insight of how to assist with overcoming those barriers and understand the need of health services for migrant workers. It is also anticipated that results from this study will support the promotion of policy changes in health care policy that will provide migrant workers access to healthcare.

*Research Question*

This exploratory study investigates the following research question: What are the barriers to medical services utilization by migrant workers and their families?
Theoretical Framework: The Ecological Perspective

To understand the barriers that exist for migrant workers in the utilization of medical services, the most proper theoretical framework to apply to this research is the ecological perspective. The ecological perspective explores the individual and the dynamic transactions with their environment. The ecological perspective makes clear the need to view people and environments as a unitary system within a particular cultural and historic context. Both person and environment can be fully understood only in terms of their relationship, in which each continually influences the other within a particular context (Bronfenbrenner, 1979).

The ecological perspective uses ecological concepts from biology as a metaphor with which to describe the reciprocity between persons and their environments. The focus is on the goodness of fit between an individual or group and the places in which they live out their lives (Coady & Lehmann, 2008). Goodness of fit in the ecological perspective explains that in any situation where people have to mobilize their resources to meet life’s demands, they perform a balancing act. When there is a goodness of fit, the demands are manageable, the resources are sufficient, and people are able to rise to the challenge in their environment (Coady & Lehmann, 2008). If the demands are more than people feel they can bear, they tend to become stressed, disorganized, and the quality of life decreases. Ecological thinking emphasizes how people, demands, and resources easily and constantly interact, influencing each other (Coady & Lehmann, 2008). This
theoretical framework in the research will emphasis as (Bronfenbrenner, 1979) explained that:

Applying an ecological approach is best understood as looking at persons, families, cultures, communities, and policies and to identify and intervene upon strengths and weaknesses in the transactional processes between these systems (p.1).

Migrant workers are influenced by the environmental realities that affect the utilization of medical services in their particular living areas. Looking at migrant workers’ families, cultures and communities from an ecological perspective in this study will offer better understanding of the barriers that exist for them in attempting to utilize medical services. In this study the ecological perspective provides a framework to understand the medical needs of migrant workers in relation to accessing health care, and the environmental forces that contribute to this particular dilemma. The ecological perspective is a model that contributes to understanding and analyzing the barriers that exist to accessing health services by this under-served population. Identifying the goodness of fit in relation to medical needs and accessibility and availability of health care is an illuminating process supporting possibilities for intervention and the improvement of quality of life.

Definition of Terms

The following terms are used throughout this project and are relevant when working with this particular group.
• Migrant farmworker- Department of Labor definition used in the NSAW is an individual who is employed in agricultural employment of a seasonal or other temporary nature, and …is required to be absent overnight from his permanent place of residence (NASW, 2005).

• Seasonal farmworker- A term which means an individual who is employed in agricultural employment of a seasonal or other temporary nature and is not required to be absent overnight from his permanent residence: (1) When employed on a farm or ranch performing field work related to planting, cultivating, or harvesting operations; or (2) When employed in canning, packaging, ginning, seed conditioning or related research, or processing operations, and transported, or caused to be transported, t or from the place of employment by means of a day-haul operation. (Hansen, 2003)

• Curandero-a holistic healer (Fernandez, Galanti, Spector, 1999).

• Curanderismo- the Spanish verb curar means to heal. Therefore, curanderismo is translated as a system of healing. The goal of curanderismo is to create a balance between the patient and his or her environment, thereby sustaining health (Wurges, 2001).

• Farmer’s Lung- an occupational lung disease caused by allergy to fungal spores that grow in inadequately dried stored hay, straw, or grain, which then becomes moldy. An acute reversible form can develop a few hours after exposure; a
chronic form, with the gradual development of irreversible breathlessness, occurs with or without preceding acute attacks (NCFH, 2002).

Assumptions

The assumptions to be considered in this study regarding the many barriers that migrant farmworkers experience in attempting to utilize health care service include: 1) There is less access to medical care due to living in rural areas; 2) Most migrant workers do not access medical care for themselves and their families due to cultural beliefs in remedies or alternative medicines; 3) An increased number of migrant workers do not access healthcare due to lack of income and economic challenges; 4) Migrant workers experience language barriers in utilizing medical resources; and 5) Migrant workers have difficulty meeting criteria for healthcare programs due to legal status.

Justification

A major goal of studying the barriers that exist for migrant workers in attempting to utilize health services is to better understand the challenges they encounter in accessing these services. The significance of the study is to educate others in the social work field about the difficulties that migrant workers and their families have in accessing medical care. In so doing, awareness of the conditions in which they work and the health risk factors they are exposed to everyday will be increased. For example, they suffer disproportionately from chronic illness and are unable to receive proper treatment (Dowling, Rodriguez & Toller, 2002).
Also, migrant workers have fears about getting laid off from work or even deported if they advocate for medical service in their communities (Dowling, Rodriguez & Toller, 2002). These are harsh realities faced by a vulnerable population, and the profession of Social Work needs to respond. For example, one of the foundational values of the Social Work professional calls for Social workers to advocate for under-served populations such as migrant farmworkers. According to the National Association of Social Workers Code of Ethics, *Social Work’s primary goal is to help people in need and to address social problems. Migrant farmworkers, a vulnerable population, are in great need of the profession’s focus* (NASW, 2002).

Furthermore, this study will provide information that can bolster social worker cultural competence and awareness of how migrant workers struggle to receive medical services. This study may encourage the realization of how vital it is for social workers to advocate for programs which will alleviate the barriers for migrant workers to access healthcare. These findings may be used to help promote the development of adequate policy making, better services in the medical agencies, and employer support for health plans for migrant workers. Gaining a better understanding of the barriers for migrant workers face in utilizing medical services can inspire a dialogue between social work advocacy and medical delivery systems.

*Limitations*

Participants for this study were recruited from Yuba County, California at the E Center, Head Start Program. A non-probability sampling method was used, and 30
participants were identified. Therefore, information gained from this study cannot be
generalized to the larger population of migrant workers in the United States. This
exploratory study concentrates on the barriers to accessing medical services by migrant
workers and their families.

Summary

Migrant workers continue to face barriers that exclude them from utilizing
adequate healthcare services. Chapter One discussed the background of the problem, the
theoretical framework, assumptions, justification, and limitations for this exploratory
research. Chapter Two focuses on the literature review and themes found in the literature
that discusses the durability of barriers that continue to exist for migrant workers in
accessing medical services. The study methodology is presented in Chapter Three which
addresses how the study was conducted, and the data was collected. In Chapter Four the
researchers address the findings in the research study. Finally, Chapter Five of the study
will discuss the exploration of the findings and the contribution of the researchers to the
social work profession in developing new policy and programs for this population.
Chapter 2

LITERATURE REVIEW

Introduction

Migrant farmworkers are an essential support to the nation’s agricultural industry. Nearly three million workers earn their living through migrant or seasonal farm labor (NCFH, 2002). Migrant farmworkers and their families confront health challenges stemming from the nature of their work, their extreme poverty and mobility, and living and working arrangements that impede access to health coverage and care (Rothenberg, 1998). Despite the harsh conditions migrant workers face every day, health care insurance and medical services are limited.

According to the National Agriculture Workers Survey conducted in 2000, 85% of migrant and seasonal farmworkers were uninsured. Uninsured migrant workers and their families use very little health care compared to other low-income people (NAWS, 2005). The lack of health insurance by their employers or affordability of private insurance makes it difficult to obtain adequate medical services. Currently, few programs exist to aid migrant workers in the fight for health care coverage. Although, the first act to provide some supplemental health service was established in 1962, still today, many migrant workers continue to experience problems accessing health care.

This literature review consists of historical background of medical services and health care insurance established within American society as a foundational background upon which to consider the critical issue of migrant farmworkers and access to health care. A review of the literature on challenges that migrant workers face in accessing
health care and needed medical services has resulted in several themes that are important to the discussion. The following themes are discussed below: characteristics of migrant farmworkers, issues of documentation and access/use of health care, occupational health risks, rural areas, economic status, cultural beliefs, and language. Finally, gaps that exist in the literature will be identified.

History of Mexican Migration and Agriculture Labor in the U.S

During 1850 and 1880, the United States was expanding cattle ranches in the Southwest, and California was increasing fruit production. This heightened the need for U.S employers to import foreign manual labor (Sin Fronteras Organizing Project [SFOP], 2006) Before Mexican workers supported American agriculture, it was the Chinese who filled the labor gap. Nearly 200,000 Chinese were legally contracted to cultivate California fields, until the Chinese Exclusion Act (SFOP, 2006). Then it was the Japanese who replaced the Chinese as field hands but they were thrown out in 1903 and replaced by Filipino workers.

Construction of the railroad between Mexico and the U.S. during 1880 and 1890 lured large numbers of Mexican workers to south-eastern North America. Sin Fronteras Organizing Project, states that 60 percent of the crews which worked the western railroads were Mexicans (SFOP, 2006). In the course of 1850 and 1880, 55,000 Mexican workers immigrated to the U.S. and found themselves in areas which had just recently belonged to Mexico; 63% in Texas, 13.7% in California. 7.6% in New Mexico and 3.1%
found themselves in other North American states working in agriculture, mining, and the railroad industry (SFOP, 2006).

The Mexican Revolution of 1910 signified an increase of immigrants to the U.S. It is estimated that between 1910 and 1917, 53,000 workers per year migrated to the U.S (SDOP, 2006). World War I also contributed to the migration of Mexican workers. They not only worked in agriculture at the time but also in the steel industry and service area. Then in 1942 when the U. S. entered its Second World War, military production consumed the county’s entire manual labor force and outside labor was needed. In order to alleviate the shortage of manual labor in agriculture the United States and Mexico signed a treaty for the recruitment and employment of Mexican citizens titled *The Bracero Treaty* (SDOP, 2006).

This special class of immigrants would not only provide a major contribution to the agriculture industry but also would start a new wave of low wage manual labor force for the U.S. Over 80,000 braceros workers were admitted to enter to the U.S only for specific brief harvest periods beginning in 1917 (Jansson, 2005). With a fairly open broader between Mexico and the U.S, many more immigrants entered the United States under the Braceros Program for more than 20 years. Large groups of braceros applicants came via train to the northern border (SDOP, 2006). Ciudad Juarez, across the border from El Paso, Texas, became a hotbed of recruitment and a main gathering point for the agricultural labor force (SDOP, 2006). The Bracero Treaty officially ended on May 30, 1963, but agriculture workers continued to come to the U.S. until 1964 (SDOP, 2006). It is evident that this movement allowed the U.S economy to stabilize during an uncertain
period. Today despite working conditions and low wages farmworkers face, immigrants continue to be the “muscle” of a multibillion dollar industry for the United States.

**Characteristics of Migrant Farmworkers**

Farmworkers travel throughout the U.S. serving as the backbone for an agricultural industry that grosses millions of dollars a year. According to the 2000-2001 findings of the National Agricultural Workers Survey (NAWS), the average age for farmworkers is 33; 79% are men, 80% speak Spanish; 18% are able to speak English, and 2% reported speaking other languages (Creole, Mixteco, Kanjobal); and the median level of education is the 7th grade (NCFH, 2002). Most importantly, the survey demonstrated that forty-four percent self-reported that they could not speak English "at all"; 53 percent could not read English "at all." Migrant farmworkers produce millions of dollars for the U.S but their economic contributions has not been reflected in the wages they are paid.

Farmworkers represent some of the most economically disadvantaged people in the United States. The National Center for Farmworker Health demonstrates that nearly three-quarters of farmworkers earn less than $10,000 per year in the U.S (NCFH, 2002). This puts three out of five farmworker families living below the poverty level and most farmworkers fall at least 100 percent below the federal poverty level (Barranti, 2005).

The low income earned by farmworkers make it difficult for families to find adequate housing or any housing at all. More often than not, when housing is found, it is substandard, unsafe, and lacking in proper sanitation (Barranti, 2005). Unsafe and inadequate housing represents health risks to these families. Despite efforts to improve
wages, housing, and health issues, farmworkers living conditions have not shown significant improvement in the past thirty years.

*Issues of Documentation and Access/Use of Health Care*

The population of farmworkers is racially and culturally diverse, and their legal status options vary. The data from the most recent NAWS, 2000 study indicates that 52% of farmworkers are not citizens or legal residents of the United States, while another report from the same time period argues that the majority of migrant and seasonal farmworkers are U.S. citizens or legal residents (NCFH, 2002). The Braceros Program which started in 1942 and ended in 1964 was one of the primary ways that farmworkers from Mexico first entered the agriculture workforce. More than 4.5 million Mexicans were legally contracted for work in the U.S (America on the Move, 2007).

Today, some farmworkers enter the workforce by work programs while others enter because of lack of education or limited English skills. Their legal status takes various forms temporary workers permits, visas, legal permanent residence, undocumented, and citizenship. A survey done by the National Agricultural Workers Survey showed that in 2001-2002, 53 percent of the hired crop labor force lacked work authorization, down from 55 percent in 1999-2000. Another 25 percent of the crop workers in 2001-2002 were U.S. citizens, 21 percent were legal permanent residents, and one percent were employment-eligible on some other basis. The remaining 1 percent comprised individuals with temporary work permits, such as foreign students, refugees
and asylees, and persons who had pending applications for adjustment of status under family preference (NAWS, 2004).

Farmworkers who represent the undocumented portion face challenges to accessing health care. Undocumented Hispanics are more likely to be uninsured and less likely to have a usual source of healthcare (Predit, 2009). The eligibility requirement for government programs poses a significant problem to undocumented individuals who need health care. California’s Medi-Cal program, for example, is only available to adults and children with limited income resources. (Department of Health Care Services [DHCS], 2007).

In order to qualify for this benefit program, individuals must be a resident of the State of California, a US national citizen, permanent resident, or legal alien, in need of health care/insurance assistance, whose financial situation would be characterized as low income or very low income (DHCS, 2007). Medi-Cal also provides coverage for either pregnant, blind, those who have a disability or a family member in the household with a disability, have responsible for children under 19 years of age, or who are 65 years of age or older. These qualifications leave undocumented workers with the only option of emergency Medi-Cal.

_Occupational Health Risks_

Agriculture is considered to be one of the most dangerous occupations in the United States (NCHF, 2002). Agriculture is also known to be a major industrial component in the United States, which relies largely on migrant workers (NCFH, 2002).
Migrant workers not only expose themselves to hard labor conditions but also huge occupational health risks which can include death. The average life span of a farmworker in the U.S. is forty-nine (Barranti, 2005). These risks include the use of heavy machinery and strenuous work for long hours in a day.

According to the National Center for Farmworkers Health (NCFH, 2002) other occupational hazards can include pesticide exposure, skin disorders, infectious diseases, lung problems, hearing and vision disorders, and strained muscles and bones, and even death (NCFH, 2002). Along with mining, hunting, and construction, farming had the highest worker fatality in 2007. In 2007, for every 100,000 agriculture worker in the U.S. there were 25.7 occupational deaths (Peridt, 2007). This compares to an average rate of 3.7 deaths for every 100,000 worker in all other industries during this same year (Peridt, 2007).

Chemicals used to deter or destroy insects in crops, known as pesticides are a big contributor to occupational health risks to workers. Pesticides are used daily in farm work which can be very harmful to the human organ system. Pesticides can be one of the variables that contribute to other disorders or diseases for migrant workers. A 2006 study (Peridt, 2007) on farmworkers in California found that acute effects of pesticide exposure include headache, nausea, eye irritation, muscle weakness, anxiety and shortness of breath. Studies indicate that pesticide exposure is associated with chronic health problems such as (NCFH, 2002):

- Respiratory problems
• Memory disorders
• Dermatologic conditions
• Cancer
• Depression
• Neurologic deficits
• Miscarriages and infertility
• Birth defects

In severe cases, pesticide exposure can lead to convulsions, coma and even death (NCFH, 2002).

Farmworkers can normally work 10-12 hours a day. They can start as early as 4:30am and can work until 6 in the evening. These kinds of work hours expose workers to the hot sun emitting harsh rays, often with little access to shade and drinking water. Climate conditions like these can cause heat stress and dehydration. Research from (Peridt, 2007) 1992 to 2006, documented 423 workers in agriculture and non-agriculture industries who died from heat exposure. Crop workers have an average annual heat-related death rate of 39 per 100,000, compared with .02 from all U.S. civilian workers (NCFH, 2002). Research from 2005 by the National Agriculture Workers Survey, (NAWS), showed that 20 percent of the farmworkers reported having no access to drinking water. This type of neglect from employers increases the chances for heat stress for migrant workers. Working under the sun for long periods of hours can also put farmworkers at higher risk for developing skin cancer.
Skin cancer is not the only concern for migrant workers. Other skin problems can occur more easily such as dermatitis, a skin inflammation or swelling, most commonly caused by an allergic reaction. Tobacco crop workers can experience green tobacco sickness at least once while working the season (Quandt, Arcury, Preisser, Norton, & Austin, 2000). Information from the Bureau of Labor Statistics (BLS, 2000) shows almost half of all reported occupational illnesses within agriculture are associated with skin diseases or disorders. An article in The Journal of Health Care for the Poor and Underserved (Hansen, 2004) reports that occupational dermatitis often occurs on the hands, migrant workers may suffer a reduction in their work capability and/or income.

Infectious diseases are another major issue of concern for agriculture workers. Infectious diseases among farmworkers are caused by poor sanitation and overcrowded conditions. Inadequate drinking water and washing in housing areas and at work contribute to infectious disease risks such as tuberculosis and parasites. In the 2005 National Agricultural Workers Survey (NAWS), 5% of the farmworkers reported having no access to water for washing, while 7% had no access to toilets in the fields, both of which the U.S. Department of Agriculture calls significant percentages (NCFH, 2002). The same report noted that urinary tract infections (UTI) are also a risk and concern for migrant workers. Lack of toilets in the workplace and harsh working conditions contribute to UTIs for migrant workers.

Respiratory problems can also be associated with the agriculture work that migrant workers perform. Exposure to organic and mineral dusts, animal and plant dusts, toxic gases, molds, and other irritants to the respiratory system are daily risks that
attribute to asthma, chronic bronchitis, and Farmer’s Lung for migrant workers NCFH, 2002). Farmworkers have a significantly higher death rate for a number of respiratory conditions, including hypersensitivity pneumonitis (proportionate mortality more than 10 times higher than expected), asthma, bronchitis, histoplasmosis, tuberculosis, pneumonia, and influenza (NCFH, 2002).

The respiratory system is not the only thing that is compromised by migrant workers. Occupational health risks also include vision and hearing problem for workers. The work environment that these workers are exposed raises the risk of multiple eye irritants encounters. These foreign objects can cause infections, allergic reactions, eye irritations, and corneal and other eye trauma (NCFH, 2002). Chronic irritation and sun can cause cataracts, a clouding of the eye lens, and pterygium, a growth that obstructs the cornea (NCFH, 2002).

Heavy machinery that is used in agriculture work as well as constant bending, twisting, heavy carrying, and long hours produce strains to the muscle and bones of migrant works. Musculoskeletal injuries are very common types of injuries to farmworkers. Farmworkers most often reported pain is in the shoulders, arms, and hands. The most common injuries that cause farmworkers to miss work are: sprains and strains, accounting for 30 percent of missed work, and back pain at 25 percent (NCFH, 2002).

The National Center for Farmworker Health also reported that from 1999 to 2004, almost 20 percent of farmworkers reported musculoskeletal injuries (NCFH, 2002). Occupational health hazards are heavy risks for migrant workers. Health risks such as these not only prove that farmwork is dangerous, and requires hard labor, but also
produces various health risks that impede migrant works ability to work. Most importantly early treatment, proper care, and accessibility of medical facilities for these occupational risks produce a greater risk to their health.

First Public Medical Service

The first public medical service in the United States can be traced back to the passage of an Act in 1798 that provided care and relief of sick and injured merchant seaman (The Office of Public Health Service (PHS, 2004). This was the first federally funded program that was available, a series of marine hospitals were established in port cities across the country. In 1870 reorganization converted the loose network of local hospitals into a centrally controlled system headed by the Surgeon General modeling after the military (PHS, 2004). As public concerns about the spread of epidemic diseases intensified in the late 19th century, the Marine Hospital Service (renamed the Public Health Service in 1912) was given increasing responsibilities for quarantine inspection of ships arriving from foreign ports.

Federal legislation in 1891 also mandated the medical inspection of all arriving immigrants, assigning this task to the Marine Hospital Service (PHS, 2004). The law specified the exclusion of "all idiots, insane persons, paupers or persons likely to become public charges, persons suffering from a loathsome or dangerous contagious disease" and criminals (PHS, 2004). The physicians who performed the medical inspections saw themselves, in the words of one of them, as "watchdogs at the gate" (PHS, 2004). Immigrants entering this country would go through varies tests to inspect their medical
state as well as their mental state before being allowed to enter the U.S. By 1924 more than twelve million people had entered the United States through Ellis Island. Each of these immigrants passed under the careful eye of physicians of the U.S Public Health service (PHS, 2004). These medical inspections performed by these physicians would determine the fate of an immigrant.

Today immigrants no longer enter the United States through Ellis Island nor do they wait to be medically examined by physicians. This method is a thing of the past, but public concerns of spreads of epidemic diseases are still a concern and a new strategy has been established. The H1N1 pandemic has increased urgency to monitor and control communal diseases. For this reason, under the authority of the Immigration and Nationality Act (INA) and the Public Health Service Act, the Secretary of Health and Human Services publicized regulations outlining the requirements for the medical examination of aliens seeking admission into the United States (Center for Disease Control [CDC], 2008).

A medical examination is mandatory for all refugees coming to the U.S. and all applicants outside the U.S. applying for an immigrant visa. Aliens in the United States who apply for adjustment of their immigration status to that of permanent resident are also required to be medically examined (CDC, 2009). Aliens applying for nonimmigrant visas (temporary admission) may be required to undergo a medical examination at the discretion of the consular officer overseas or immigration officer at the U.S. port of entry, if there is reason to suspect that an inadmissible health-related condition exists (CDC, 2009).
Other efforts to control communicable disease are made by outreach programs established by U.S Department of Health and Human Services Administration (HRSA). Health Center Programs are community-based and patient-directed organizations that serve special populations with limited access to health care such as migrant workers (HRSA, 2009). The Migrant Health Center program provides support to health centers to deliver comprehensive, high quality, culturally-competent preventive and primary health services to migrant and seasonal farmworkers and their families with a particular focus on the occupational health and safety needs of this population (HRSA, 2009).

In 2008, HRSA-funded 156 migrant health centers, which served more than 834,000 migrant or seasonal farmworkers and their families. It is estimated that HRSA-funded health center programs serve more than one quarter of all migrant and seasonal farmworkers in the United States (HRSA, 2009). It is estimated that there are three million migrant and seasonal farmworkers in the U.S (HRSA, 2009). A recent study by Dr. Gomez (HRSA, 2009) for the National Advisory Council on Migrant Health (NACMH), demonstrate that 2.2 million Migrant & Seasonal Farmworkers (MSFW) are without health services in the U.S.

The study also showed that younger, healthy workers do not seek health care and other migrant and seasonal farmworkers (MSFW) might not seek health center services because they know they need specialty care, which the centers do not provide (HRSA, 2009). Health centers for migrant workers can deliver free or low cost primary health services but the percentage of workers it reaches is relatively small and service delivery is limited. Health centers many times do not provide specialty treatments and pharmacy
services do to the cost being too high for the patient. The lack of health services centers provide leave migrant workers at a standstill on their health care needs.

**Use of Emergency Rooms**

Unlike countries in Europe, Health care benefits are not uniformly experienced by all who live in the United States. More than 47 million Americans, which include migrant farmworkers, have no health coverage (Clark, Surry, & Contino, 2009). For this reason, many find themselves visiting the emergency room for all of their health needs. More than 55% of visits to emergency rooms are for minor medical problems or routine care—not for potentially life-threatening events (Clark, Surry, & Contino, 2009). Only 1 out of 5 farmworkers are able to obtain health insurance through their employer or either through state of federal governments (Clark, Surry & Contino, 2009).

The lack of health insurance and poverty level make it increasingly difficult for uninsured and undocumented individuals to obtain health care. The difficulty of having no insurance and only being able to qualify for Emergency Medicaid for undocumented, temporary, and recent legal immigrants, represents frequent visits to the ER. According to the Kaiser Commission on Medicaid and the Uninsured (KCMU) some 13% of adult non-citizens and 20% citizens report an emergency room visit in 2008 (Kaiser Family Foundation, 2009). Since so many people experience difficulties with obtaining health coverage, and emergency room visits are increasing, healthcare reform in the U.S has become a hot political topic.
Health insurance in the United States also became a topic of concern. Health insurance started around the mid-1800s. One of the first insurance plans dates back as early as the Civil War. These first insurance plans only offered coverage against accidental injuries related to travel by rail or steamboats (Northern California Neurosurgery Medical Group [NCNMG], 2007). As primitive as these first insurance plans were, they did pave the way to a more comprehensive health care that would also cover illnesses and other types of injuries. The first group policy offering comprehensive benefits was by Massachusetts Health Insurance of Boston in 1847 (NCNMG, 2007).

During the 1890s, Insurance companies started offering the first individual disability and illness policies and by 1929, the first modern group health insurance plan was formed. By 1932, nonprofit organizations like Blue Cross and Blue Shield offered group health plans (NCNMG, 2007). These two organizations were successful because they were able to negotiate contracts at a discount with doctors and hospitals in return of prompt payments and an increase in volume of patients.

In the 1940s and 1950s, employee benefit plans increased due to strong unions’ bargaining for better benefits packages which included tax free and employed sponsored health insurance. At the same time, government programs that would cover health care cost began to develop and disability benefits started to be included in social security coverage. In September of 1962, migrant workers health was a concern of Congress. Congress passed the Migrant Health Act signed by President John F. Kennedy on
September 25, 1962 (NCFH, 2002). This was the first law that established the authorization for delivery of primary and supplemental health services to migrant farmworkers.

Three years later, President Lyndon Johnson signed Medicare and Medicaid as amendments to Social Security legislation (Jansson, 1992). Medicare was created as a health insurance program for people ages 65 years or older. Medicaid is a needs-based social welfare program that is state and federally funded. It provides health insurance coverage to low income individuals, children, pregnant women, and people with disabilities. Although immigrants could be definitely considered part of this group of individuals, California’s Proposition 187 in 1994 challenged immigrants’ eligibility for state-funded programs (Jansson, 1992). Although eventually overturned, Proposition 187 would have become a major obstacle for immigrants who largely contribute to farm working in the United States since the 1900s.

A surge in anti-immigrant sentiment was reflected in the passage of California’s Proposition 187. More specifically, Proposition 187 not only represented an increase in the border patrol but also had the more devastating effects of denying “illegal” Latinos education, health care as well as other benefits. Statistics show that about one of every four members of the population in the U.S relies on two government-sponsored health programs (Moniz/Gorin, 2002). Luckily, the proposition was overturned for by a number of legal challenges that found the Proposition to be unconstitutional in July 29, 1999.

When the 80s and 90s came, the cost of health care rose quickly, which pushed employer-sponsored group insurance plans from “fee for service” to “managed care
plans” that were cheaper (NCMNG, 2007). By the mid 1990s, many Americans were enrolled in managed care plans. According the National Library of Medicine (NLM) study, *The effect of managed care on the incomes of primary care and specialty physicians*, published in 2008, managed care was intended to reduce unnecessary health care costs through a variety of techniques which include economic incentives for physicians and patients who select less costly forms of care; increase beneficiary cost sharing; control of inpatient admissions and length of stay; and programs for reviewing the medical necessity of specific services (NLM, 2008).

In 1993, President Bill Clinton presented Congress a health care reform plan intended to guarantee health insurance for all Americans and legal residents. Congress failed to pass this health care reform called the “Health Security Act of 1993” proclaiming it would be too costly and excessively regulated. The Health Insurance Association of America in 1999 stated that the number of people without insurance was growing and projected it to reach 60 million by 2007 (Moniz & Gorin, 2002). Today the issue of American’s health care system is a hot topic for President Obama. Universal health care is one of the primary agendas that many Americans are hoping the President is able to target. Under this new health care reform a large portion of Americans would be covered hopefully extending coverage to migrant workers.

After long debates over the new health care reform bill, The House of Representatives passed the new bill on November 7th, 2009. The final vote came down to 220-215. The Affordable Health Care for American Act would guarantee health coverage to 96 percent of the population and prohibit private insurance companies from denying
coverage to pre-existing conditions or raise the prices due to gender (CNN, 2009). The passage of the bill in the House represents a great victory but it is too early to determine its fate. The bill will still need to be passed by the Senate and what this bill really encompasses is still unclear to many Americans. Many Americans fear what this bill will represent for them including migrant workers.

The history of health care services demonstrates that there is a difference in public opinion regarding who has the right to be covered and who should pay for health insurance. Government programs began to emerge when it was noted that there were limited resources and a need for health services for limited income individuals. The problem with this is that individuals who do not fit into the qualifying categories or cannot afford private insurance because of their income earned are left with no health services, sometimes only resorting to utilizing Emergency Rooms in hospitals. These challenges along with other themes to follow in this research reveal the health care limitations for many migrant workers in the United States.

**Rural Areas**

Migrant workers living in rural areas have less accessibility to transportation, medical facilities, resource centers, as well as fewer employment opportunities. Migrant workers can run into many challenges while trying to meet their basic medical needs. Living in rural areas can isolate individuals and make it difficult to access general medical resource. Migrant workers, by the very nature of their work in agriculture have to reside in rural areas due to their work in the fields; they have limited health care or no health care services (Dowling, Rodriguez & Toller, 2002). Many migrant families do not
own a vehicle and must rely on other means of transportation, such as a friend or co-worker. Some agencies provide free transportation, but these services are also very limited (Cason & Snyder, 2004). Migrant workers have less access to medical services in the rural areas because there are very few providers available to them.

In many rural areas, there is a lack of providers who accept government insurance programs; providers cite low reimbursement rates, and increased paperwork and administrative duties as reasons (Dowling, Rodriguez & Toller, 2002). Accessing health care is made especially difficult by transportation problems. Although, some scholars (Dowling, Rodriguez, & Toller, 2002) have noted that a rural health infrastructure has been addressed and many efforts had been made to serve this rural areas. They continue to state that more comprehensive medical facilities as well as transportation to these facilities is needed (Dowling, Rodriguez, & Toller, 2002). While, there is an effort in some rural areas to provide transportation to health facilities, it is still a barrier for many farmworkers and their families.

Furthermore, farmworkers living in rural areas need public transportation, due to many of them not having driver’s licenses. Agricultural workers continue to face dangerous conditions on their way to work every day due to the limited transit options that are currently available to them. Because the average annual income for agricultural workers is $11,525, many face serious financial constraints that limit their ability to afford a car, insurance, maintenance, and fuel (Cason & Snyder, 2004). In addition, well over half of all farmworkers in California lack proper immigration documents and are ineligible for a driver’s license. Nonetheless, 39% of all agricultural workers still drive
their own vehicle, with or without a license (Cason & Snyder, 2004). It is often out of sheer necessity and lack of options that some farmworkers take the risk to drive without licenses in order to provide for their families.

*Cultural Beliefs*

Many farmworkers and their families embrace traditional healing methods, and practice them in their home as if they were in their country of origin (Fernandez, Galanti, Spector, 1999). Preventive healthcare has always been a challenging issue in Latino health culture. A series of factors and beliefs play an overwhelming role in maintaining the use of preventive medicine and healthcare at low levels. In an article titled “The Hispanic Community” from the Cultural Diversity organization (Fernandez, Galanti, Spector, 1999) explains:

The prevention of illness is an accepted practice that is accomplished with prayer, the wearing of religious medals, or amulets, and keeping relics in the home. Visiting shrines, offering medals and candles, offering prayers and the lighting of candles is a frequently observed practice. Many homes have shrines with statues and pictures of Saints. The candles are lit here and prayers are recited by the families (p.1).

The literature about the long lasting traditions of Hispanic families shows that the beliefs in Curanderismo are defined as a medical system (Fernandez, Galanti, Spector, 1999). Curanderismo is a coherent view with historical roots that combine Aztec, Spanish, spiritualistic, homeopathic, and scientific elements. The curandero is a holistic
healer; the people who seek help from him do so for social, physical, and psychological purposes. Since the curandero has a religious orientation, much of the treatment includes elements of both Catholic and Pentecostal rituals and artifacts: offerings of money, penance, confessions, lighting candles, wooden or metal offerings in the shape of the afflicted anatomic part, and laying on of hands (Fernandez, Galanti, Spector, 1999).

These cultural beliefs can be a barrier for many migrant workers, due to their formal religious beliefs, which are blended with traditional folk beliefs in the culture’s healing practices, through traditional healers (Bokinskie & Evason, 2009). Curanderos/a generally dedicate their lives to serving the physical and mental health needs of their local population (Zaveleta, 2000). Therefore, it is reasonable to understand that many Latinos who have these cultural practices will be more inclined in following their cultural traditions. Many farmworkers have adapted their healing methods in this western society do to many of them embracing the natural healing system instead of the practice of western medicine (Zaveleta, 2000).

Economic Status

The most challenging barrier of all for migrant workers is their economic status. The University of Florida Food and Resource Economics Department in the 1990s showed that minimum wage was $5.15 per hour and agricultural workers were entitled to this hourly rate for every hour they are on the farm. While minimum wage laws establish a floor for hourly earnings, piece rate hourly earnings are typically much higher since the worker's earnings are tied directly to individual productivity (Roka & Emerson, 1999).
Although, the minimum wage today cannot be compared to that in the 1900s, farmworkers continue to struggle to pay for adequate health services. In 2006, migrant crop farmworkers received $7.52 per hour, compared with $8.53 per hour for settled crop farmworkers (Kandell, 2008). Beyond monetary compensation, migrant farmworkers are less likely than settled farmworkers to have health insurance (Kandell, 2008). Since many migrant farmworkers travel with their families, including their children, the disadvantages of low earnings, lower health insurance rates, and changes in location extend to their families. Though, some earn enough money to pay for health insurance, in many cases they do not, and these uninsured individuals have difficulty paying for health services (Kandell, 2008).

Many workers come to the U.S. to save money and/or send money back to their families. Therefore, spending money on an expensive visit to the doctor is often not an option (Cason & Snyder, 2004). Poverty rates, of course, are higher within this population due to the difficulty in making a deserving wage for their work in the fields. Most of the family’s annual income is earned during harvest season, and it is common for all family members, including children, to work during that time. Frequently, workers are victims of payment disputes between growers and contractors: if contractors are not paid, neither are the workers.

Language

The issue of language as a barrier to migrant workers accessing medical services has been discussed in articles and studies like Cason & Snyder (2004) and Guzman &
Cook (2001). According to the article, *The Health and Nutrition of Hispanic Migrant and Seasonal Farmworkers* (Cason & Snyder, 2004) a significant barrier to obtaining health services for many migrant farmworkers is that they do not speak English. If care is sought it may be difficult for individuals to understand the treatment, such as the need to take medications or the importance of follow-up care (Cason & Snyder, 2004). They lack English-language skills and are subject to relying on other people to translate for them. Frequently patients and providers must rely on a fellow worker who understands some English, which means communication is often hazy. Although more and more materials are available in Spanish, health care and social service workers still report the language barrier to be huge (Cason & Snyder, 2004). In that same article, language barriers contribute to health care disparities for Latinos in the United States of America.

According, to the Robert Wood Johnson Foundation (Guzman & Cook, 2001), past surveys have shown that language barriers have caused many Spanish-speaking Latinos to skip care. In fact, 19% of the Latino adults surveyed reported that, due to language barriers, they had not sought care when they needed it (pg. 56). The health care providers said that language difficulties make it harder for a patient to understand and follow through on the information that a doctor provides about a medical condition or disease, and also increases the risk that a doctor will not learn about some medication or home remedy that a patient is using. Language barriers also make it more difficult for the doctor to compile a complete, accurate medical history (Guzman & Cook, 2001).
Overview of Barriers

The literature contribution to this study facilitates a general idea of what migrant workers needs are when accessing healthcare services. Migrant workers continue to tackle the barriers of rural areas, low economic status, cultural beliefs, language and legal status in utilizing healthcare services. It is consistent throughout the literature that transportation problems, long wait times in community clinics decreased preventative screening, language problems, cultural differences, and lack of a regular source of care also impact access and care (Dowling, Rodriguez, & Toller, 2002).

Migrant workers find themselves in an environment where their basic health needs are not met. In addition to the lack of insurance and availability of health care providers, past negative experiences with the healthcare system may also impede the health care access for migrant agricultural workers and their families (Dowling, Rodriguez, & Toller, 2002). Migrant workers are forced to use emergency rooms to get treatment for their illnesses (Dowling, Rodriguez, & Toller, 2002). Cultural differences with respect to ideas about health and illness are a factor as well, as the role of medicine in treatment of symptoms mean that even multilingual providers may not fully understand what their patients are experiencing and what they desire (Dowling, Rodriguez, & Toller, 2002).

The fragmented care necessitated by the patchwork of payment systems and health services means that patients may see a new provider every time they seek medical care (Dowling, Rodriguez, & Toller, 2002). Unfortunately, this is a reality to many
farmworkers and their families. Also, the income for migrant workers is essentially the major barrier for these families. Workers are reluctant to complain about wages or conditions for fear of losing their jobs or causing employers to report them to Immigration and Naturalization Services (Dowling, Jennifer & Rodriguez, 2002).

Gaps in the Literature

In reviewing the literature on the topics of migrant farmworkers living in rural areas, their cultural beliefs, economy, languages, and legal status barriers, data is lacking on educating families one on one regarding health care resources. There is little data overall on efforts to alleviate farmworkers’ barriers to health care. Data like the data found on the Robert Wood Johnson Foundation study (Guzman & Cook, 2001) show that Latinos/Hispanics in general have had the same barriers in utilizing health care for decades. Studies like the one carried out by Roka & Emerson (1999) and Rothenberg (1998) were conducted in the late 1990s as shown in the literature review. Therefore, new research is necessary to continue exploring the barriers that migrant farmworkers have in accessing adequate health care.

While conducting the research for this study, it was found that there is a lack of qualitative research connected to seasonal migrant farmworkers and the barrier they have in utilizing healthcare. Many studies as shown by Dowling, Rodriguez & Toller (2002) recognize that there are multiple barriers that may be related to migrant farmworkers. These studies tend to use quantitative research methods, thus not fully exploring other possible barriers for this population. This study explores in detail the barriers that exist
for migrant workers in utilizing medical services. It is critical to inform social work and medical professionals about the extent of the problem for migrant farmworkers to access quality healthcare in an attempt to provide some insight into this area of research.

**Summary**

In conclusion, the literature review addressed past and present challenges for migrant workers that complicate access to medical services or enrollment in health insurance. The literature review indicates some of the obstacles that play a big part for migrant workers and their families in seeking medical care. It is important to consider the history behind medical services, and how laws are established depending on the perception of society’s ideology. The challenge is to understand the migrant workers’ experience and comprehend why many workers do not seek medical services. Continuing research allows social workers to observe gaps in the literature and critique the research in the study. It is vital to find solutions to the barriers that are presented to migrant workers in accessing medical service. In the following chapter, the methodology used for this study is discussed.
Agricultural labor is a strenuous occupation that is much needed in the U. S but the demands are huge for the worker. Workers start their days very early and long hours are expected with little pay. Their work may not include fringe packages such as 401ks, or health benefits. Many of the workers do not have health care plans given by their employers and have many challenges when able to utilize health services. Both researchers throughout the years working in different agencies have come across many challenges that farmworkers face with health care.

Many farmworkers work in rural areas were health care facilities are limited or too far to travel. Farmworkers also find health care to be too costly to obtain on their own. One of the researchers who worked at Head Start, located in Yuba County found that there was little or limited health care services available to farmworkers in the area. Many of the services available to farmworkers covered only basic health care needs which did not include medicinal costs or additional medical treatments.

There is little recognition to the challenges or limitations that farmworkers face when confronting health care services. The purpose of this study is to help social workers, advocates, and agencies understand what particular barriers continue to hinder farmworkers from accessing health care. Secondly, findings from this study may help improve the services in the area by increasing knowledge capacity for culturally sensitive social work practice and increasing awareness of the need to provide services in their

Chapter 3
METHODOLOGY

Introduction
native tongue. Finally, this study will help health care facilities understand what health concerns are present for migrant farmworkers and their families, which can help create appropriate and affordable programs fit to their needs. The research design and methodology used in this study is described below.

Description of the Research Design

The research design used for this study was exploratory. This was the most appropriate research design for this study because it helped the researchers gather preliminary information that will help define problems, provide insight concerning the relationship among variables, and allowed the researchers opportunity for recommendations regarding thesis topic. In particular, a 39 item questionnaire was developed to help provide the opportunity to identify various barriers from which study participants could select as the being the most significant to them. This particular study design could provide a measurable result for the study. The researchers worked with quantitative methods to help identify which barriers existed in utilization of medical services for migrant workers. A sample was recruited from two Yuba County Head Start Migrant Centers during monthly parent policy council (PPC) meetings.

Sampling Procedures

An availability sampling method was employed for this study to recruit human subjects. Thirty-nine participants were recruited for the study. The criterion for inclusion in this study was the participants needed to be 18 years of age or older. Both male and female participants were included. Participants needed to be migrant workers and clients
of Head Start Migrant Program in Yuba County. No inducements or incentives were provided and survey was solely on a voluntary basis. The participants in this study consisted of 7 males and 32 females over the age of 18 years old. Participants were Latinos who nationalities included Central America, Mexico, Mexican-American or of other origin not specified on the survey. Individuals were recruited from Yuba County, where they were receiving services from E Center Head Start Migrant Programs. This agency serves Latino migrant works and provides child care free of cost to low income families, during the agriculture season.

The researchers sent an e-mail followed by a telephone call to E Center’s Director in Yuba County, requesting authorization to recruit the people they serve in the Head Start program. After authorization was obtained by E Center Director to approach their clients as potential research participants, the researchers then obtained permission from two center directors located in the Yuba County area to recruit participants during the parent policy council meeting.

**Instrumentation**

A survey questionnaire was developed to gather data concerning health care access and barriers. The questionnaire was developed in both English and Spanish. Each participant was given a survey questionnaire that included 30 questions (see Appendix D for English and Spanish). The researchers using available literature developed the study questionnaire. The questions were closed ended questions with multiple choice answers. The questionnaires were designed to obtain information about the individuals’ family
health history, forms of healing, medical facilities in their area, and means of transportation used. The first eight questions were to obtain background information. The remaining 30 questions were designed to gather medical facility utilization, health history, knowledge of resources, transportation and child care method, and healing methods used.

*Data Collection Procedures*

Data were collected using quantitative measures. The process of collecting data for this research was to find a minimum of 39 voluntary farm working participants residing in Yuba County who met the parameters identified for participation in this research study. After obtaining authorization with an agency that serviced migrant workers (Head Start Migrant Program in Yuba County), the researchers identified a time with center directors to try to recruit willing participants. This data was collected over the period of two months, during two parents meeting during the months of June and August, 2009. During the two meeting the researchers verbally described the nature of the study, the purpose of the study, the contribution that the participants can make by doing the study questionnaire, and assured them of the confidentially. The presentation was made in Spanish.

Participants who were interested in being part of the study were given a written consent form (Appendix C in Spanish or English). Participants were offered consent forms both in English and in Spanish and completed the version that best met their language of preference. The researchers answered any questions that participants had
before having obtained the signatures on the consent documents. The researchers were sensitive to the participants’ literacy skills and were conscious that this population may not have adequate reading ability. Prior to the start of this survey questionnaire, all participants signed the consent form, acknowledging that all information pertaining to this study had been fully explored and clarified to them face-to-face. The consent form also included information on resources in the community that participants could access should they experience any distress related to their participation in the study.

Once consent forms had been given, read, signed, and given back to the researchers, the researchers handed out the questionnaires. Similar to the consent form, questionnaires were provided in both English and Spanish. (see Appendix D). The first part of the questionnaire focused on gathering background information such as age, gender, ethnicity, income, and employment status. The second part of the questionnaire asked participants questions regarding transportation issues, distance of medical facility, healing methods used, form of child care, medical history, and resources known to them. The participants took 15-20 minutes to finish the questionnaires. No inducements were offered and participation was purely voluntary. At any time participants had could have exercised the right to terminate the survey questionnaire process.

The survey questionnaire was be collected and stored separately from consent forms. The researchers and their thesis advisor were the only persons to have access to all consent forms, survey questionnaires, and other documents for this study. A secured and locked compartment located in one of the researchers’ homes was used to store and secure all study documents. The signed consent forms and the questionnaires were kept in
separate locations. All consent forms; survey questionnaires, and data were to be destroyed at the time the study is completed and no later than July, 2010.

**Data Analysis**

Data was coded and inputted in SPSS and statistical applications were run. In addition to descriptive statistics, to analysis the data the researchers cross tabbed the question of *source of transportation* with *how far was the nearest medical facility*. Cross tab was also done with question regarding *household income* with *type of healing method* used. The last cross tab used was on questions related to *language used at home* with *interpreter availability*. There were no open-ended questions in our data analysis.

**Protection of Human Rights**

The Protocol for the Protection of Human Subjects was submitted to and approved by the Committee for the Protection of Human Subjects in the Division of Social Work, CSUS. The study was approved at the level of “minimal risk” on May 13, 2009 (ID 08-09-133). No physical procedures were involved in the study, but “minimal risk” of discomfort as a result of participating in the interview was considered possible. Participants who choose to be part of the study might be dealing with current distressing issues related to health care and other issues related to questions asked on the survey.

A local resource referral was provided for participants should they become upset and need of support. The referral source was: Harmony Health Center in Marysville. The agency’s contact information was provided on the consent form. The researchers eased participants’ discomfort and concerns by reminding them that no information that
specifically identifies their individual identities would be disclosed at any given time, situation, or for any reason. In addition, they were assured that the survey questionnaire would be kept separate from consent forms. All participants were informed that they could decline to participate in the study at any time if they wished.

Summary

The researchers have found that there continues to be many common barriers for migrant farmworkers in the utilization of medical services. The literature review indicates that the common barriers continues to be the household income, transportation, language, methods of healing and medical program availability and distance to medical facilities. This chapter presented the details of the study methodology. The researcher’s data confirm many of the barriers to be significant for migrant farmworkers. As social workers there is a great concern about understanding the barriers that continue to affect this population. Results of the study are discussed in the next chapter, Chapter 4.
Chapter 4

ANALYSIS OF DATA

Introduction

This chapter will explore the study data results of the following research question, *what are the barriers to medical services utilization by migrant workers?* First, the demographic characteristics of the study participants and the overall findings of the survey questions are discussed. The results of exploring what barriers for migrant farm workers exist in accessing medical services are illustrated with the significant or non significant association of the chi-square tables. A summary description of the data association of the chi-squares of the study will be discussed after each table. All of the percentage results were rounded to the nearest whole. A sample size of thirty-nine migrant workers who currently worked in agriculture was surveyed. The survey questionnaire included thirty items which concentrated on the demographics, possible barriers to accessing medical services, availability of types of medical services, and potential medical issues.

The participants were from two Yuba County Head Start Migrant Center Programs, who were invited to participate in the study during monthly parent policy council (PPC) meetings, during the month of June and the month of August, 2009. Participants in the PPC meetings completed the surveys in 10-15 minutes.
Demographics

The first part of the survey asked questions that identified the demographics of the participants. Results of these questions are presented in Table 1 below. Out of the total of 39 participants included in the study, there were 32 females, and 7 males. Females accounted for 82 percent of the total sample, and males accounted for 18 percent.

The ethnicity of the participants was predominately Mexican who represented 95 percent of the total sample and 5 percent were Mexican-American. Ninety-seven percent of the participants’ primary language was Spanish and 3 percent were bilingual. The ages of the participants ranged from 26 years of age through 52 years. More specifically, 74 percent (n=39) of the participants were in the 26 – 37 year range; 13 percent were ages 18-25; 5 percent represented ages 37- 40 and 5 percent of the sample was made up of those ages 41-52. Only 2 percent were older than 52 years of age.

A majority of the sample were married (eighty-seven percent; n=39) with only 10 percent reporting that they were single. Three percent of the participants reported that they were divorced. Overall, the annual income per individual of the sample was between $10,000 and $20,000. For example, 93 percent (n=37) of the total sample reported that they earned between $10,001- $20,000 and only 2 percent indicated that they earned between, $20,000-$30,000. Five percent of the participants did not respond to this question. Household size varied from 2 people to over 10 people. Forty-four percent (n=39) had 3 to 4 family members in the household, 41 percent reported they lived with 5to 6 people in the household and 15 percent reported to live with more than 6 members
in the household. Ten percent of the sample did not respond to this question. The employment status of the participants was high. Ninety-seven percent (n=39) of the total sample was made up of seasonal migrant farm workers and three percent were year round migrant farm workers.

Table 1

Demographics

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Higher Percentages</th>
<th>Lower Percentages</th>
<th>Lowest Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender Identification</td>
<td>n=39</td>
<td>82% Females</td>
<td>18% Males</td>
<td></td>
</tr>
<tr>
<td>Ethnicity of participant</td>
<td>n=39</td>
<td>95% Mexican</td>
<td>5% Mexican-American</td>
<td></td>
</tr>
<tr>
<td>Primary Language</td>
<td>n=39</td>
<td>97% Spanish</td>
<td>3% Bilingual</td>
<td></td>
</tr>
<tr>
<td>Ages of participants</td>
<td>n=39</td>
<td>74% between 26-37 years</td>
<td>13% between 18-21 years</td>
<td>5% between 51-52 years</td>
</tr>
<tr>
<td>Status of the participant</td>
<td>n=39</td>
<td>87% married</td>
<td>10% single</td>
<td>3% divorce</td>
</tr>
<tr>
<td>Annual Income</td>
<td>n=37</td>
<td>93% between $10,000-$20,000</td>
<td>2% between $20,000-$30,000</td>
<td></td>
</tr>
<tr>
<td>Household</td>
<td>n=39</td>
<td>44% 3-4 members</td>
<td>41% 5-6 members</td>
<td>15% 6 or more members</td>
</tr>
<tr>
<td>Employment</td>
<td>n=39</td>
<td>97% seasonal farmworkers</td>
<td>3% migrant farmworkers</td>
<td></td>
</tr>
</tbody>
</table>
Findings of the Barriers

The survey included questions of possible barriers such as transportation, distance of medical facilities, systems of cure, childcare resources, and time for physical exam. Also, questions concerning years of residence in their area (Yuba County), where the participant seeks medical attention, how many days they are allowed of sick leave from work and finally how they paid for their medical services. Results of these questions are presented in Table 2.

Table 2
Barriers

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Higher percentages</th>
<th>Lower percentages</th>
<th>Lowest percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation</td>
<td>n=39</td>
<td>78% Car</td>
<td>8% Public</td>
<td>5% Light rail</td>
</tr>
<tr>
<td>Distance of medical facilities</td>
<td>n=38</td>
<td>51% 6-14 miles</td>
<td>39% 0-5 miles</td>
<td>5% 15-30 miles</td>
</tr>
<tr>
<td>Systems of cure</td>
<td>n=39</td>
<td>64% Rx</td>
<td>20% Home Remedies</td>
<td>8% Herbal</td>
</tr>
<tr>
<td>Childcare resources</td>
<td>n=35</td>
<td>41% Afterschool Programs</td>
<td>26% Daycare Facilities</td>
<td>20% No childcare assistance</td>
</tr>
<tr>
<td>Years of residence</td>
<td>n=35</td>
<td>51% 2-5 ys.</td>
<td>23% Over 10 ys.</td>
<td>15% 6-10 yrs.</td>
</tr>
<tr>
<td>Kinds of medical services</td>
<td>n=37</td>
<td>84% Clinic</td>
<td>5% ER visits</td>
<td>2% Spiritual healer</td>
</tr>
<tr>
<td>Years of health checks</td>
<td>n=38</td>
<td>51% Once a year</td>
<td>26% Per five years</td>
<td>21% Never</td>
</tr>
<tr>
<td>Payment system</td>
<td>n=38</td>
<td>64% Cash</td>
<td>28% Medi-Cal</td>
<td>5% Other</td>
</tr>
</tbody>
</table>
Means of transportation included cars, public transportation, friends, family and light rail.

In general, 78 percent ($n=39$) of the participants reported that they used a car for transportation; while the outcome for both public transportation and friends resulted at 8 percent of the sample. Two percent of the participants reported that they used family members for transportation, and 5 percent used the light rail for transportation.

Furthermore, the distance of medical facilities from the participant’s home ranged from 0 miles through 46 plus miles of distance. Out of the Thirty-nine participants, only 39 percent ($n=38$) reported to be 0 to 5 miles from a medical facility. The highest percentage of 51 percent reported to be 6 to 14 miles of distance from a medical facility, whereas 5 percent reported that the facility was 15 to 30 miles distance. One participant (3 percent) reported travelling 46 plus miles to the nearest facility.

Options of system of cure in the survey included prescribed medication, herbal, homemade remedies, and none. Out of the total sample, 64 percent ($n=39$) reported using prescribed medication. Seven percent of the sample used herbal remedies as a method of healing and the second highest percentage, or 20 percent, reported to use home remedies. Seven percent of the participants did not report a system of cure.

Additionally, childcare resources for the total sample included the following results: three percent reported that their children stayed with a friend or family member, and a majority of 41 percent ($n=35$) had their children in afterschool programs. Twenty-six percent utilized a daycare facility as a resource, whereas 20 percent of the sample reported having no childcare assistance at all. Ten percent of the sample did not respond to this question.
The participant response of the years of residence in their current area being Yuba County ranged from two years through over ten years. For the most part out of the 39 participants 51 percent (n=35) had resided in Yuba County between two and five years, and 15 percent between six and ten years. Twenty-three percent reported to live in their area of residence for over ten years. Out of the total sample, four participants did not answer the question.

In addition, eighty-five percent (n=37) of the sample reported that they visited their local clinic for medical treatment. Only one person (3 percent) from the sample reported that they go to the hospital and two (5 percent) go to the emergency room for medical care. One of the participants reported to go to a spiritual healer and four participants did not answer the question.

Moreover, out of the 30 participants who responded to the question of how many years it takes them to get their medical physicals, 51 percent (n=38) reported that they go every year. Twenty-six percent only get their physicals done every five years. For this question 21 percent of the thirty-nine participants have never gotten a physical done. One participant did not answer the question.

Also, the thirty-nine participants were asked about their payment system for their medical care. Out of the total sample size a high percentage of 64 percent (n=38) paid in cash. Only 28 percent of the participant had Medi-Cal which pays their medical services. Two participants of the sample meaning 5 percent used other payment forms which were specified, and one participant did not answer the question.
Findings of Medical Services

The survey incorporated questions of possible medical services for this population in their area of residence. This part of the survey asked about availability of interpreters, medical facility days of service, waiting time for appointments, adequate healthcare service, and knowledge of programs in the community, availability of mobile clinics, medical insurance and time of sick leave from work. Results of the findings are presented in Table 3 below.

Table 3

Medical Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency</th>
<th>Higher Percentage</th>
<th>Lower percentage</th>
<th>Lowest Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of interpreters</td>
<td>n=38</td>
<td>82% Yes</td>
<td>15% No</td>
<td></td>
</tr>
<tr>
<td>Medical facility days of service (7day a week)</td>
<td>n=36</td>
<td>64% No</td>
<td>28% Yes</td>
<td></td>
</tr>
<tr>
<td>Waiting time for appointments</td>
<td>n=34</td>
<td>44% 2-3 days</td>
<td>28% Same day</td>
<td>7% longer than a week</td>
</tr>
<tr>
<td>Adequate healthcare</td>
<td>n=37</td>
<td>53% No</td>
<td>41% Yes</td>
<td></td>
</tr>
<tr>
<td>Knowledge of programs</td>
<td>n=38</td>
<td>67% No</td>
<td>31% Yes</td>
<td></td>
</tr>
<tr>
<td>Community mobile clinics</td>
<td>n=37</td>
<td>54% No</td>
<td>41% Yes</td>
<td></td>
</tr>
<tr>
<td>Medical insurance</td>
<td>n=39</td>
<td>59% No</td>
<td>41% Yes</td>
<td></td>
</tr>
<tr>
<td>Work sick leave</td>
<td>n=26</td>
<td>33% 1-2 days</td>
<td>31% 0 days</td>
<td>5% 3-5 days</td>
</tr>
</tbody>
</table>
The majority of the participants reported that they had interpreters available to them. Eighty-two percent (n=38) reported yes, they have interpreters at the medical facilities in their area and 15 percent answered no to this question. Only one person did not respond to the question.

The survey asked participants if the medical facilities where the participants attend for medical services were open seven days a week. The participants were asked to respond either yes or no to the question. Twenty-eight percent (n=36) reported that their medical facilities were open seven days a week and 64 percent indicated that the medical facilities where they attended were not open seven days a week. Three participants did not answer this question.

Additionally, the participants were asked how many days they had to wait for their appointment which the range of possible response was from same day to longer than a week. Forty-four percent (n=34) reported to wait for two to three days. Twenty-eight percent of the participants reported that they were seen on the same day. Eight percent reported wait time was four to six days, and 7 percent waited longer than a week. Five participants did not respond to the question.

The participants were asked if they received adequate healthcare. The answers were either yes or no. Of the 39 participants, 54 percent (n=37) reported they had adequate healthcare. Forty-one percent of the participants reported that they do not have adequate healthcare service at their medical facilities. Fifty-nine percent (n=39) reported that they did not have medical insurance coverage and 41 percent reported that they did to have a medical insurance.
Likewise, participants were asked if they had knowledge of medical programs in their area. The outcome of sixty-seven percent (n=38) reported no to this question. Thirty-one percent of the total sample indicated yes indicating that they had knowledge of medical programs. One participant did not answer the question.

Also, the survey asked if the participant had a mobile clinic in their community and they could respond yes or no. Fifty-four percent (n=37) indicated they did not have a mobile clinic in their community. Leaving only forty-one percent reporting they did have a mobile clinic in their community. Out of the total sample, two participants did not respond to the question.

To further explore medical accessibility for the participants in the study participants were asked about medical insurance. Fifty-nine percent (n=39) reported that they did not have medical insurance coverage and 41 percent reported to have a medical insurance.

Finally, the participants were asked how many days they were given for sick leave from work which ranged from 0 days through 6 plus days. Out of the 39 participants, thirty-three percent (n=26) reported that they are only allowed to be sick one to two days and 30 percent of the participants stated they were given 0 days. Five percent reported three to five days and one percent report more than six days. Thirteen of the participants, which are 28 percent of the sample size, disregarded the question.

Findings of Medical Issues

The last part of the survey asked questions pertaining to possible medical issues for the migrant workers based on the literature review findings. This part of the survey
contained the questions that follow: how important is your medical care, do you have chronic illness, do you have eye problems caused by working in the fields, do you have skin problems due to the workplace, and do you have an illness from pesticides? Results of the finding are presented in Table 4.

Table 4

Medical Issues

<table>
<thead>
<tr>
<th>Medical care importance</th>
<th>Frequency</th>
<th>Higher Percentage</th>
<th>Lower percentage</th>
<th>Lowest percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>n=39</td>
<td>100% Very important</td>
<td>13% Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic illness</td>
<td>n=39</td>
<td>87% No</td>
<td>13% Yes</td>
<td></td>
</tr>
<tr>
<td>Eye problem cause by working</td>
<td>n=39</td>
<td>74% No</td>
<td>26% Yes</td>
<td></td>
</tr>
<tr>
<td>Skin problems from the workplace</td>
<td>n=39</td>
<td>61% No</td>
<td>38% Yes</td>
<td></td>
</tr>
<tr>
<td>Illness from pesticides</td>
<td>n=39</td>
<td>54% No</td>
<td>46% Yes</td>
<td></td>
</tr>
</tbody>
</table>
In addition, when the participants were asked how important was their medical care a striking majority of the thirty-nine participants responded very important, accounting for 100 percent (n=39) of the sample. Eighty-seven percent (n=39) of the participants report that they have no chronic illness, leaving five participants (13 percent) reporting yes to a chronic illness.

Also, the participants were asked if they had eye problems caused by working in the fields and 74 percent (n=39) reported no and 26 percent answered yes to this question. Additionally, thirty-nine percent (n=39) reported yes to having skin problems from the workplace and 61 percent reported, no, they have no skin problems from the workplace.

Lastly, the participants were asked if they had an illness from pesticides use at work. Forty-six percent (n=39) reported yes to having an illness from pesticides. Out of the thirty-nine participants, 54 percent reported not having an illness from pesticides.

**Chi-Square Findings**

To continue exploring the barriers that exist for the migrant farmworkers, three chi-squares were run to explore if there were any associations between the possible barriers, the accessibility of medical services and medical issues for this sample. The results of the chi-square are illustrated in Tables 5, 6 and 7 below.

The chi-square test was performed to look at the association between the participant’s knowledge of medical programs and the frequency of which they typically have their personal health physical. When separating the data to perform the chi-square the question regarding the time to get a health physical was collapsed into a 2x2 table n=38. The findings of the chi-square indicate that there is an association between the
barrier in having knowledge of health programs and frequency of physical ($X^2 = 4.18$, df =1, $p<.041$).

Table 5

*Frequency of health physicals*

<table>
<thead>
<tr>
<th>Knowledge of programs</th>
<th>Frequency of health physicals</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Once a year</td>
<td>5 years</td>
<td>Never</td>
<td>Total</td>
</tr>
<tr>
<td>Yes</td>
<td>10</td>
<td>1</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>% of Total</td>
<td>26%</td>
<td>3%</td>
<td>2%</td>
<td>32%</td>
</tr>
<tr>
<td>No</td>
<td>10</td>
<td>9</td>
<td>7</td>
<td>26</td>
</tr>
<tr>
<td>% of Total</td>
<td>26%</td>
<td>23%</td>
<td>18%</td>
<td>68%</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>10</td>
<td>8</td>
<td>38</td>
</tr>
<tr>
<td>% of Total</td>
<td>52%</td>
<td>26%</td>
<td>20%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Looking at Table 5 it should be noted that 68 percent (n=38) of the participants reported that they had no knowledge of medical programs and a low percentage of 32 percent had knowledge of the programs. This is a significant finding because half of the participants, 26 percent, that get a medical physical every year, are people that do not have knowledge of medical programs. Twenty-three of the participants get a physical every five years without the knowledge of medical programs.
The following chi-square represents the outcome between the workplace and medical issues from pesticides for this population. The findings will be illustrated in Table 6 below. The chi-square was performed without a need to collapse any of the data. The chi-square results indicate and demonstrate an association between skin problems at the workplace and illness from pesticides. Therefore, the findings of this particular chi-square test was significant with a compute of a 2x2 table, N=39 resulting on (x^2=7.245; df=1; p<.007).

Table 6

_Skin issues_

<table>
<thead>
<tr>
<th>Illness from pesticides</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yes</strong></td>
<td><strong>Count</strong></td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>% of Total</td>
<td>28%</td>
<td>18%</td>
<td>46%</td>
</tr>
<tr>
<td><strong>No</strong></td>
<td><strong>Count</strong></td>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td>% of Total</td>
<td>10%</td>
<td>44%</td>
<td>54%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>Count</strong></td>
<td>15</td>
<td>24</td>
</tr>
<tr>
<td>% of Total</td>
<td>38%</td>
<td>62%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The chi-square was significant with 46 percent (n=39) of the total sample having illness from pesticides. Also, the results on Table 6 show that out of the total sample size,
38 percent reported having skin problems due to their work in the fields. Therefore, the findings indicated that there is an association between these two factors, and this is also found in the literature review for this study.

Finally, when separating the data a chi-square test was executed to continue exploring the association between medical knowledge and healthcare participation. The findings are in Table 7 below. The chi-square illustrates that there is a statistically significant association between healthcare participation and knowledge of medical services. The findings of the chi-square test result in significance (x² = 9.50; df = 1; p<.002).

Table 7

<table>
<thead>
<tr>
<th>Knowledge of Programs</th>
<th>Adequate Healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Yes</td>
<td>Count</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
</tr>
<tr>
<td>No</td>
<td>Count</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
</tr>
<tr>
<td></td>
<td>% of Total</td>
</tr>
</tbody>
</table>
The results indicate that 51 percent of the sample (n=37) had no knowledge of health programs and no healthcare insurance, making the association significant for a migrant farmworker to access medical services. The findings in this test demonstrate a significant number, 57 percent of the total sample (n=37), that have no adequate healthcare. Overall, the table illustrates that 70 percent of the participant report to have no adequate healthcare services and no knowledge of medical programs although they participate in the Head Center Program. This means that the participants that are seasonal farmworkers continue to be underserved.

Summary

The outcomes of this study are solely from the thirty-nine participants from the Head Start Program in Yuba County. The findings of this study indicated that the majority of the respondents were females who composed 82 percent of the sample size. The ethnicity of the participants was predominately Mexican, with 95 percent of the total sample. Ninety-seven percent of the participant primary language was Spanish.

Additionally, the data analyses indicated with a high percentage of forty-six percent of the participant who are migrant farmworkers to suffer illnesses from pesticides in the work place. Also, the data shows that thirty-eight percent of the participants have skin problems due to working in the fields.

Based on the findings from the sample, sixty-seven percent had no knowledge of healthcare programs and fifty-nine percent did not have medical coverage. The results of
the study indicate that the potential barriers for Mexican migrant farm worker continue to be prevalent. Furthermore, a discussion of these result are specified in Chapter 5 along with the recommendations and limitations of the study.
Chapter 5

RECOMMENDATIONS AND CONCLUSIONS

Introduction

This chapter will provide limitations and implications of this study. The results presented in Chapter 4 will be compared to the barriers of migrant workers found in the literature of this underserved population. Additionally, this chapter will present the limitations to the study and provide future applications for social work practice and policy advocacy. Furthermore, the chapter will provide suggestions for potential research and provide recommendations to social work field on how to better serve this underserved population. Finally the chapter will provide the summary and conclusion from this study.

Discussions of Results

Presented in the literature was a review of the challenges and barriers that exist among migrant workers in the United States when trying to access healthcare. Migrant farmworkers experience obstacles similar to other disadvantaged low income groups when utilizing healthcare. This study explored the barriers exist that affect utilization of medical services among migrant workers in Yuba County area. Barriers that affect utilization of medical services were found similar to some of the barriers identified in the literature.

As a result of the data analysis, it was found that some of the challenges in accessing medical services in the study were hours of operation, wait time for appointments, knowledge of programs and type of medical service used. Many
participants only had access to a clinic which provided limited medical care and many times did not offer extensive treatments to their care. Most importantly, participation in healthcare programs was low and a high percentage of individuals had no medical insurance coverage. These findings are devastating since the majority of workers earn less than $20,000 a year and are required to pay out of pocket when seeking medical services. According to the most recent findings of the NAWS (2005), nearly three-quarters of U.S farmworkers earn less than $10,000 a year and three out of five farmworker families have incomes below the poverty level.

Other significant issues found in the study were skin problems and illnesses from exposure to pesticides in the workplace. A 2006 study (Peridt, 2007), done on farmworkers in California found that exposure to pesticides can cause nausea, headaches, eye irritation, and skin problems. Other studies indicate that pesticide exposure can cause health problems such as respiratory, cancer, dermatologic conditions and neurologic deficits (NCFH, 2002). These finding are among the most significant road blocks that make health care access difficult for this group and are consistent with the results from various studies reviewed.

There was lack of statistical significance among barriers such as transportation, language, distance of medical facility and childcare resources in the findings of this study; although information from literature indicates that these barriers are significant for migrant workers in the United States. The Health and Nutrition of Hispanic Migrant and Seasonal Farm Workers (Cason & Snyder, 2004) report indicates that a significant barrier to obtaining health services for many migrant farm workers is that they do not
speak English and rely on other people to translate. Also, transportation appears to be a significant obstacle in the literature. Transportation services are limited in rural areas that make accessing medical facilities difficult for migrant workers (Carson & Snyder, 2004).

Limitations

Significant limitations to this study include the small sample size of 39 participants, not having equal gender representation, and a sample that was primarily focused in one particular region of Yuba County, California. Additionally, the sample size limited the researchers’ focus to one nationality, which was the Mexican population. Ages of 18 and below were excluded in the study, which provided limited findings for the study. More information on other Latinos with different nationalities should be included in future studies. In other future studies, minors should also be considered. More significantly, the participants’ personal experience was not captured since the study was quantitative and did not gather subjective experiences.

These limitations suggest future studies be performed as this is a significant topic that affects migrant workers accessing health services and a concern to the professionals in the field of medical services. Future studies should include survey questions that focus on the participants’ experience of denial when accessing medical services. This would provide important information to each participant’s unique challenges that may provide future assessment to improving medical service practice.
Implications

Since minimal knowledge related to what are the barriers to medical services utilization by migrant workers and their families is known, information from this study can have long term implications for social workers and professionals in the field of health services. Findings from this study reveal that certain barriers present as challenges for migrant workers in being able to access medical services. The inability of accessing medical services represents significant health consequences for migrant workers which should not be minimized.

Determining the factors which contribute to impeding migrant workers from utilizing health care can be difficult to assess with such a population. Migrant workers tend to follow the crops according to the seasons and live in rural areas, which make study availability almost impossible at times for these individuals. Social workers know that changes in the biological, psychological, and social dynamics of these individuals needs to always be considered, but most importantly it is necessary to account for the impact of the multiple moves farmworkers undergo in a short period of time. The multiple moves in rural surroundings can literally signify life or death when trying to access health services for this group of individuals and their families. In order to provide adequate, affordable, and reliable health services to migrant workers, all level of practice needs to assess and consider the barriers presented for these workers and their families. When these barriers are seriously considered, active change can occur that will potentially limit road blocks for these individuals when accessing health services.
At the micro level, medical staff and medical social workers can work hand in hand to provide the necessary medical and social service needs of migrant workers. Medical staffs who commit themselves to working with migrant workers should be informed of what illnesses are more prevalent for this population. Findings from the survey indicate that 46% of the participants experienced illness from pesticides. This finding demonstrates that training and public awareness needs to be created to address specific health concerns among migrant workers.

In addition, medical staff should have some basic knowledge of what chemicals such as pesticides, migrant workers are being exposed to and the potential health risks when being in contact to such chemicals. Findings from the study demonstrate an association between illness from pesticides and skin problems. Results show that out of the total sample size of 39 participants, 38 percent have skin problems due to their work in the fields. This type of statistical knowledge will not only support an increase in awareness, but can alert early detection when seeing patients in a hospital or clinic setting. This knowledge can also allow better preparation to assist migrant workers in the detection of their illnesses caused by certain chemicals used.

Furthermore, medical professionals will need to consider the ongoing challenges migrant workers face with language. Setting up appointments, arranging for transportation, or communicating symptoms over the phone or in person are all challenging and intimidating tasks. These challenges can deter migrant workers from seeking medical treatment early on. Medical professionals will need to be better prepared to serve these individuals in their preferred language. Bilingual staff or translation
services need to be in place in hospitals or clinics that are frequently visited by migrant workers.

Social workers working at the micro level of practice can assist migrant workers in overcoming barriers through various roles such as advocacy, outreach, activists, educating and brokers—not clear what this is?. As mandated by the NASW’s (2000) Code of Ethics, social work must strive for social justice and honor the imperative to work on behalf of those who are poor, vulnerable, and oppressed. Social workers can advocate and demand social justice for this disadvantaged group by lobbying and becoming activists. Lobbying for migrant workers can influence decisions being made by legislators on laws that deeply impact migrant workers and their family’s participation in health care programs.

Advocating for basic human needs such as equal and proper health care to all migrant workers regardless of legal status can reduce many barriers faced by this population. Social workers can be activists and volunteer in non-profit organization groups that strive to promote the rights of migrant workers. As activists, social workers become allies to migrant workers as well as provide their professional skills working hand in hand to devise strategies to make necessary changes to the concerns of migrant workers. Findings from the survey demonstrate that 59% of the participants are not provided medical insurance by their employers. Activism is a movement that can stimulate action that can make an impact to migrant workers human rights, providing them the dignity and respect long deserved.
Social workers can specifically help to overcome barriers experienced by migrant workers through outreach. Results from the study shows that 53% of migrant workers do not participate in any health care programs. Outreach can provide the opportunity to reach out to more migrant workers and provide access to health care services, in hopes to increase utilization of medical services. Outreach may best be done with the assistance of Spanish speaking activists and people known to migrants. Additionally, an educator role of a social worker can provide valuable information that will empower these individuals when dealing with their medical needs. The educator can provide health education classes, knowledge of migrant workers rights, proper handling of chemicals and information on pesticides, all important components that will allow awareness.

Finally, in the role of broker can help link migrant workers with community resources and services. Results from the survey shows that 68% of migrant workers who participated have no knowledge of programs available to them. Knowledge of resources is crucial in providing basic needs and preventing incurable illnesses for migrant workers. The role of an agent can help migrant workers obtain emergency food, housing, legal aid, transportation assistance, or other resources that can assist to overcome barriers when accessing health care. Most importantly, an agent can help put various parts of the community in touch with one another to enhance their mutual interests of assisting migrant workers to access health care and limiting the barriers presented.

At the Mezzo level of practice, hospitals, clinics or agencies that provide services to migrant workers should implement policies as well as develop programs that target resolution to the barriers currently being experienced by farmworkers. Findings from the
study shows that medical services are not conveniently available when searched. Sixty-four percent of the participants in the study reported that medical services were not available 7 days a week if needed. Furthermore, 44% of participants found themselves waiting 2-3 days for appointments, while 7% waited longer than a week. Clinics and hospitals should consider the hours of operations in place and accommodate hours that work for this population. New programs and clinics need to consider the location of the building of service, taking into consideration accessibility to migrant workers.

Finally, at the Macro level of practice, information from this study shall be provided to community health providers, private and non-profit agencies, and medical health professions in the field to bring awareness of the issues affecting migrant workers and the utilization of medical services. It is hopes that this will initiate in making future studies top priority. Moreover, bringing awareness to communities and society about the challenges migrant workers face when accessing medical services will potentially motivate individuals to demand changes in policy on a national level that will provide these hard working individuals with the medical care they deserve as human beings.

Recommendations

The purpose of this study was to explore the barriers to medical services utilization by migrant workers. The following section is a list of recommendations developed for social workers and professionals working in the medical field and with migrant farm workers:

- Expanding more Mobile Clinics in small rural communities, which will bring
health care to the farm areas, particularly if the clinics have multi-lingual staff or translators available. Mobile Clinics could potentially serve a wider population of agriculture workers and rural residents.

- Primary care outreach can be obtained by utilizing religious events or programs like Head Start, that serve migrant workers as sites for basic screening that provide services such as vaccinations, TB, blood pressure, early signs of pulmonary problems, or skin problems. Potentially providing referrals for future treatments in other participating programs.

- Additional interpreters, care advocates, prescriptions and health education information primarily for Spanish-speaking populations and in other indigenous languages.

- Cultural Competency, which requires providers to understand beliefs, values, traditions and practices of the migrant culture, and language training for health care and social service workers, is needed.

- English classes for the migrant workers and their families to help bridge the gap of communication. This is a role that advanced level college students could play.

- Like many rural communities, there is simply a shortage of care available at convenient hours or available at all for migrants. Clinics and hospitals should provide service hours that accommodate migrant workers’ off hours and days off, even if it represents closing later in the day or opening on weekends.

- Hospitals and clinics should provide information and referrals through a 24/7 toll free, bilingual hotline.
• Transportation is a barrier that can deter migrant workers from seeking services. Designing and implementing a one stop center that provides health education, health screening and dental care will limit migrant workers from making various challenging trips.

• Provide educational materials in Spanish (e.g. outreach, flyers, intake forms, referral information, office signs, websites, etc.).

• Conduct “Know your employee rights” workshops and provide knowledge of programs available in the community to migrant workers.

• Provide health education classes that are facilitated by medical staff and social services. These classes can be a more effective way of educating migrant workers since the literature in this study and data obtained from the researchers’ data conclude that migrant workers education level is minimal and reading maybe a challenge.

• Transportation services should be available and offered in clinics and by the employers to assist workers to Medical appointments, vaccinations and treatments.

• Conduct consumer satisfaction surveys of patients and analyze available clinical and service data to make changes in program design and delivery that will improve the quality of care and encourage active engagement of migrant farm workers in improving their health status and obtaining necessary treatment.
Conclusions

Migrant farmworkers face numerous obstacles in accessing health care services and abstain from or delay medical care that could potentially decrease skin problems and other illnesses caused by pesticides exposure. According to the literature and data analysis of the surveys gathered for this study, migrant workers have more health problems than the general public. The unsafe conditions, unsanitary working conditions and low wages, should mandate that these individuals be given priority to health coverage either by their employers or offered by governmental health programs that are of no charge or little cost.

It is evident that the few programs that are available to these workers lack knowledge as to the significant barriers that impede migrant workers in utilizing medical services. Barriers such as knowledge of programs in the area, transportation, hour of operations, wait time for appointments and continuity of care leave migrant workers vulnerable to many health conditions with little options. In order to facilitate the utilization of medical services to migrant workers, these obstacles need to be considered to provide culturally competence services that meet migrant workers specific needs.

Limitations to this study may make it difficult to determine the true significance of these findings. The sample size in the study was small and minors were not included in the study, and therefore it may be necessary to repeat this study with a larger sample size to determine if the same results will emerge and show more similar significance to the literature. It may be beneficial if a qualitative study could be conducted in the future to
obtain participants’ personal and unique experience of the barriers to utilizing medical services which can offer further finding that explore this topic.

Since migrant workers move around in rural communities to follow the crops, minimal knowledge to the specific barriers to medical service utilization by migrant workers is known. Further studies would be crucial to making this topic a research priority. Information from this study can be used as a contribution to the profession of social work and social workers who work with migrant workers. At the same time, this study hopes to encourage participation in such an important topic that has been overlooked for so long.

It is mission of these researchers and their ethical responsibility to continue studying the need of migrant workers to provide these medical services. Therefore, through this study the researchers find that there continues to be a need to advocate and develop policies which will provide adequate services for this population in the United States.
APPENDIX A

Letter to E Center Head Start
LETTER TO E CENTER HEAD START

Erika Houston & Lucia Orta
430 E. 16th Street
Marysville, CA 95901
April 29, 2009

Andrea Dailey
Family & Community Service Manager
E Center Head Start
1128 Yuba Street
Marysville, CA 95901

Dear Andrea:

I am writing you to see if we could obtain permission to recruit the center’s clients to participate as human subjects for our theses project before the summer ends. I am working with Lucia Orta, another MSW student at Sacramento State University. I know that E center is an agency dedicated to helping migrant workers through education, health, social services, and resources available in their communities. For this reason, my partner and I thought E center could be of great assistance to us in obtaining participates for our theses. You see Lucia and I are also passionate about this population and it is why we decided to do our theses on this population. Our exploratory study is on the barriers to medical services utilization by migrant workers. We hope you and E center can grant us permission. Thank you so much and we hope to hear from you soon.

Sincerely,

Erika Houston
Lucia Orta
APPENDIX B

Authorization Letter from E Center Head Start
April 30, 2009

Human Subjects Review Committee
Department of Social Work
California State University at Sacramento

Dr. Committee Members:

This letter is verification that E Center grants Erika Houston and Lucia Orta to administer a voluntary survey at our Migrant Seasonal Head Start center in Yuba County. It will be clearly stated to the parents that the survey is exclusively for the purpose of research and that completing the survey is voluntary. It is also E Center’s expectations that both Erika and Lucia will coordinate in advance with the Center Education Supervisor and/or Yuba County Regional Manager in regard to the date and time anticipated to be present at the center.

Sincerely,

Andrea Dailey
Family & Community Services Manager
E Center Head Start Programs
APPENDIX C

Consent to Participate in the Research
Consent to Participate in Research

I understand that I am being asked to participate in a research which will be conducted by Erika Houston and Lucia Orta, Masters of Social Work students at California State University, Sacramento. The purpose of the study is to investigate what barriers exist to utilization of medical services for migrant workers.

I understand that this is a one-time questionnaire that consists of 30 questions about me and my family's health, forms of healing, medical facilities in my area, and means of transportation.

I also understand that the questionnaire may require 15 minutes of my time. Some of the items in the questionnaire may seem personal, but I do not have to answer any question if I don't want to. Through this research, I may gain additional insight into factors that affect utilization of medical service. Or, I understand that I may not personally benefit from participating in this research. However, it is hoped that the results of the study will be beneficial for future social workers to advocate for adequate health care for migrant workers through public awareness, advocacy, policy change, and provide appropriate resources.

I understand that the researchers will hand the survey to me. Or read it to me if I have difficulty. I understand that I will fill out the questionnaire anonymously and place the completed questionnaire into a large manila envelope and seal it shut. I will then hand the sealed envelope to the researcher.

I understand that this study presents minimal risks to me but that I may encounter feelings of guilt or embarrassment from thinking about my own attitudes or behaviors related medical practice. I understand that should I experience psychological discomfort, I should contact Harmony Health Resource Center in Marysville, located at 1908 N Beale Road, # E, Marysville CA 95901, (530) 742-5005 for counseling service, available in Spanish and English.

I understand that my responses on the questionnaire are anonymous and that the surveys will be destroyed as soon as the data has been processed, or no later than one year after they were collected. Until that time, I understand that they will be stored in a secure location. The signed consent form and the questionnaires will be stored in separate locations. I understand that there will be no way of identifying me as a human subject.

I understand that I will not receive any compensation for participation in this study. I understand that if I have any questions about this research, I may contact Erika Houston at (707) 344-2745 or by email at eh36@saclink.csus.edu or Lucia Orta at (530) 755-8005 or by email at lo34@saclink.csus.edu. I may also contact their advisor,
Dr. Chrys C. Barranti al (916) 278-4161 or at barranti@saclink.csus.edu. I have been offered a copy of this form to keep. I understand that my participation in this research is entirely voluntary. I may decline to be a participant in this study without any consequences or loss of benefits by E center.

I acknowledge that I have read and fully understand this informed consent form. My signature below indicates that I have read this page and agree to participate in the research.

___________________________________ Signature of Participant
_______________________________ Date
Consentimiento para participar en esta investigación

Entiendo que me están pidiendo participar en una investigación cuál será conducida por Erika Houston y Lucia Orta, ambas de las estudiantes de Trabajo Social de la Universidad del Estado de California, Sacramento. Cual propósito del estudio es investigar qué barreras existen en la utilización de los servicios médicos para los trabajadores emigrantes.

Entiendo que éste es un cuestionario de una que responderé solo una vez y que consiste en 30 preguntas sobre la salud de mi y mi familia, las formas de instalaciones curativas, médicas en mi área, y los medios del transporte.

También entiendo que el cuestionario puede requerir 15 minutos de mi tiempo. Algunos de los artículos en el cuestionario pueden parecerse personales, pero no tengo que contestar a ninguna pregunta si no lo deseo. Con esta investigación, puedo ganar la un beneficio adicional en los factores que afectan la utilización del servicio médico. También entiendo que no puedo beneficiarme personalmente participando en esta investigación. Sin embargo, se espera que los resultados del estudio serán beneficiosos para que los profesionales Trabajadores Sociales en el futuros puedan abogar por el cuidado médico adecuado para estos trabajadores emigrantes con haciendo conciencia pública, defendiendo sus derechos, abogando cambio políticos/sociales, y proporcionando los recursos adecuados.

Entiendo que los investigadores me darán el cuestionario o será leído mi si tengo dificultad. Entiendo que completaré el cuestionario anónimo y colocare el cuestionario terminado en un sobre grande de color manila que será sellado. Entonces daré el sobre sellado al Investigador.

Entiendo que este estudio me presenta riesgos mínimos emocionales pero que puedo encontrar sensaciones de culpabilidad o de la vergüenza de mi propia conducta en relación con la práctica médica. Entiendo que si tengo disgusto psicológico de la experiencia, yo debo entrar en contacto con Harmony Health Resource Center in Marysville, located at 1908 N Beale Road, # E, Marysville CA 95901, (530) 742-5005 para recibir servicios de consejería adecuados, disponible en español e inglés. Entiendo que mis respuestas en el cuestionario son anónimas y que los cuestionarios serán destruidos tan pronto como se hayan procesado los datos, o a más tardar dentro de un año después de que fueron recogidos. Hasta ese tiempo, entiendo que serán almacenados en una localización segura. La forma firmada del consentimiento y los cuestionarios serán almacenados en localizaciones separadas. Entiendo que no habrá manera de identificarme como participante humano. Entiendo que no recibiré ninguna remuneración en la participación en este estudio. Entiendo que si tengo cualesquier preguntas sobre esta investigación, puedo entrar en
contacto con a Erika Houston al (707) 344-2745 o por correo electrónico a eh36@saclink.csus.edu o Lucia Orta al (530) 755-8005 o por correo electrónico a lo34@saclink.csus.edu. Puedo también entrar en contacto con a su consejero universitaria, el Dr. Chrys C. Barranti al (916) 278-4161 o barranti@saclink.csus.edu. Me han ofrecido una copia de esta forma a la subsistencia.

Entiendo que mi participación en esta investigación es enteramente voluntaria. Puedo declinar ser un participante en este estudio sin ninguna consecuencia o pérdida de ventajas por E Center. Reconozco que he leído y entiendo completamente esta forma informada del consentimiento. Mi firma abajo indica que he leído esta página y acuerdo participar en la investigación.

Firma Del Participante ___________________ Fecha __________________________
APPENDIX D

Survey Questionnaire
Survey Questionnaire

1. What is your nationality?
   Central American_____  Mexican_____  Mexican-American_____  Other___________

2. Gender  F______  M______

3. How old are you?
   15-25______  26-37_________  37-41______  41-52 older_______

4. What is your marital status?
   Married_____  Divorce_____  Widow_____  Single______

5. What is your household income?
   $5,000 to $10,000 ____  $10,001-$20,000 ____  $20,001-$30,000_____
   $30,001 or more_____

6. How many in people are in your household? ________

7. What is your employment status? Migrant worker____  Seasonal Migrant _____

8. What is the primary language used at home?
   English_______  Spanish _______  Bilingual _______  Other________

9. What is your source of transportation?
   Car______  Public Transportation_____  Friend_______  Family_____
   Light Rail_______  Car pool_________  Walk_______  None_______

10. How far away do you live from a hospital or medical facility?
    0-5 miles______  6-14miles_____  15-30 miles______  31-45miles ______
    46 or more miles_____

11. What method of healing do you use when you get sick?
Prescription Medication ____ Herbal ____ Home remedies’ ____
Curanderas/Spiritual Healers ______ None______

12. What is your method of childcare?
Family or friend_____ Childcare Center_______ after School programs_____
Don’t have one_____

13. How many years have you live in the area you are in now?
0-1years_____ 2-5years_______ 6-10 years_______ over -10 years_____

14. When you seek medical attention where do you go?
Clinic____ Hospital ____ Emergency Room ____ Spiritual Healers ____
Other please describe______________

15. How often do you get a physical?
Once a year______ every five years_____ every ten years _____Never_____

16. Do they provide interpreters for you at the Clinic or Hospital?
Yes______ No_____

17. Is the medical facility open seven days a week?
Yes______ No_____

18. How often have you gotten sick because of work in the past year?
1-2 times____ 3-5 time_______ 6-9 times_______ 10 or more________

19. How long do you have to wait to be seen or have an appt. with your physician?
Same day____ 2-3 days _____ 4-6 days ______ a week or longer_____

20. How do you pay for your medical services? Employer insurance______
Cash _____  50/50 employer/cash _____  Medical ______
Medicare______  other_________

21. How many days are you allowed being sick in your job?
0 days______  1-2 days_______  3-5 days_______  6 or more_______

22. Do you consider you have an adequate health care? Yes ______  No_______

23. Do you know of any programs available to you and your family for medical
   assistance? Yes____  No____

24. Do you have a mobile clinic in your area? Yes _____  No____

25. Are you exposed to pesticides in your work? Yes___  No_______

26. Have you experienced Skin irritation? Yes___  No_______

27. Have you experienced Eye problems? Yes ____  No______

28. Does your family have medical insurance? Yes_____  No____

29. Do you have a chronic illness due to work? Yes______  No____

30. How important is your health?
   Very important_____  somewhat important_____  not that important____
   Neutral______  Not important at all____
Survey Questionnaire (Spanish)

1. ¿Cuál es su nacionalidad?

Central Americano/a _____ Mexicano/a ____________ Mexicano – Americano/a _____ Otra ____________

2. ¿Cuál es su orientación sexual?

Femenina _____ Masculino _____

3. ¿Cuántos años tienes?

18-25 ____________ 26-37 ____________ 37-41 ________ 41-52 mayor _____

4. ¿Cuál es su estatus marital?

Casado/a _____ Divorciado/a _____ Viudo/a _____ Soltero/a _____

5. ¿Cuál es su ingreso económico anual? ______

$5,000-$10,000 _______ $10,001-$20,000 _______ $20,001-$30,000 _______

$30,001 o mas ______

6. ¿Cuántas personas viven en su casa? ______

7. ¿Cuál es su situación de empleo?

Jornalero migrante _____ Jornalero temporal _____

8. ¿Cuál es el idioma utilizado principalmente en su casa?

Ingles _______ Bilingüe ____________ Español _________ Otro _______

9. ¿Cuál es su transporte principal?
Carro _______ Trasporte Público _______________ Amigo _________
Familia__________
Caminar _______ Trasporte colectivo___________ Tren rápido___________
Ningún_______
10. ¿A qué distancia vive usted de un hospital o centro médico?
0-5 millas_______ 15-30 millas_________ 30-45millas _________ 45millas o
mas________
11. ¿Qué método de sanación utiliza cuando está enfermo/a con más frecuencia?
Medicamento prescrito___ Hierbas___ Remedies Caseros___ Curanderas____
Ningún tratamiento____
12. ¿Cuál es su método de cuidado de sus hijos?
Amigos___ Familia___ Centro escolar___ Programas federales____
13. ¿Cuántos años hace que vive en su zona residencial?
0-1 años____ 1-5 años____ 6-10 años ____ más de 10 años____
14. ¿Cuando usted busca atención médica cual lugar visita usted más frecuentemente?
Clínica___________ Hospital___________________ Sala de
Emergencia____________
Curandera___________________ Otros, por favor especifique___________
15. ¿Con qué frecuencia va usted hacerse su examen físico?
Una vez por año__________ Cada cinco años____________
Cada diez años______ Nunca____________
16. ¿Le ofrecen a un intérprete?
17. ¿La instalación médica está abierta los siete días de la semana?
Si_______ No________

18. ¿Cuántas veces has llegado enfermo a causa del trabajo en el último año?
1-2 veces____ 3-5 veces________ 6-9 veces _______ 9 o más________

19. ¿Cuánto tiempo tiene que esperar a ser visto o tener una cita con su médico?
Mismo día______  2-3 días______  4-6 días_______  una semana o mas______

20. ¿Cómo paga por sus servicios médicos?

Empleador _______  De su bolsillo _______  50/50 empleador o su bolsillo _______ Medicare_______  otro________

21. ¿Cuántos días se le permitió estar enfermo en su trabajo?

0 días_______  1-2 días______  3-5 días_______  6 o más________

22. ¿Considera usted que tiene un adecuado cuidado de la salud?
Si ______ No____

23. ¿Sabe usted de todos los programas disponibles para usted y su familia de asistencia médica?

Si_______ No____

24. ¿Tiene usted una clínica móvil en su área?

Si ______ No____

25. ¿ Está expuesto/a a los plaguicidas en su trabajo
26. ¿Ha experimentado irritación de la piel?
   Si _____  No _____

27. ¿Ha experimentado problemas oculares?
   Si _____  No _____

28. ¿Tiene su familia una seguridad médica?
   Si _____  No _____

29. ¿Tiene usted alguna enfermedad crónica a causa de su trabajo?
   Si _____  No _____

30. ¿Qué tan importante es su salud?
   Muy importante _____  mas o menos importante _____  no muy importante _____
   meda igual _____  no es importante _____
REFERENCES


http://www.migrantclinician.org/migrant_info/health_problems.php


Commission for Medicaid and the Uninsured on-line database on the Kaiser Family Web: http://www.kff.org/about/kcmu.cfm


