2022

Health Belief Effects on Preventive Health among Hispanic Migrant and Seasonal Farmworkers

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Walden University
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Abstract

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Dissertation Submitted in Partial Fulfillment

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Doctor of Philosophy

Nursing Interdisciplinary Health

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Abstract

Migrant and seasonal farmworkers (MSFWs) are the unhealthiest workers in the United States and experience barriers to preventive healthcare. While faced with numerous health risks, many Hispanic MSFWs may not seek preventive health services or have access to them when they need them. The purpose of this study, guided by the rural nursing theory, was to understand the beliefs/health seeking behaviors of MSFWs and how they described usage of preventive health services. Fourteen Hispanic farmworkers volunteered to do telephone or in person interviews. The codes and categories were reviewed to identify patterns and make connections between the data using Saldana's cycle coding. Four main themes were revealed: definition of health, health beliefs, health behaviors, and usage of preventive health. Definition of health is a collection of phrases that farmworkers used to define what health meant to them individually. Health beliefs are phrase(s) that define how they saw the importance of health in their everyday life. Health behaviors are the activities they used to keep themselves healthy. Usage of preventive health services are explanatory phrases that described their health care choices and experiences. Nurses and other health care professionals can use the findings of this study to tailor healthcare strategies to reflect farmworker healthcare beliefs. Additional studies are needed in U.S. rural locations to gather more information about MSFW's healthcare needs and beliefs on which to form evidence-based interventions. Positive social change may occur when farmworkers have routine preventive care improving patient-provider relationships, decreasing healthcare costs, and enhancing patient outcomes.

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Dedication

I would like to dedicate this research project to the migrant and seasonal farmworkers that provide fresh produce for the families of the southeastern United States.

Acknowledgments

I would like to acknowledge my scholarly mentors Dr. Leslie Hussey and Dr. Janice Long who provided support and encouragement through my academic journey. I also want to acknowledge my friend and mentor Bobby Holbrook whose constructive criticism and support guided me in the early years of my academia career.

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Chapter 1: Introduction

Farmworkers are one of the United States' most essential members of the agricultural labor force. Farmworkers move around the United States, planting, cultivating, harvesting, and preparing fruits and vegetables year-round (Student Action with Farmers [SAF], 2018). Despite their economic and cultural contributions to any one community, farmworkers are the lowest paid ($11,000 annually), least protected, and unhealthiest workers in the United States (SAF, 2018). The H2A Temporary Agricultural Workers program allows U.S. employers to bring foreign persons as "guest" workers to perform seasonal agricultural labor under a temporary visa (U.S. Citizenship and Immigration Services [USCIS], 2018).

The United States has an estimated 2.5-3 million agricultural workers. The agricultural worker population is comprised of those who migrate (16%) and those who are seasonal (84%; National Center for Farmworker Health [NCFH], 2018). The majority (73%) of agricultural workers are foreign-born, with 68% originating from Mexico (NCFH, 2018). Hispanics also travel from Puerto Rico, Cuba, and Central and South America to the United States to work in agriculture (MHP Salud, 2014). Agricultural workers were 72% male and 28% female. The NCFH (2018) survey demographics reported their participant's ability to speak English as 27% spoke English "not at all", 32% spoke a "little" English, and 31% stated they spoke English "well" (NCFH, 2018).

The Fair Labor Standards Act of 1938 set the minimum age for farm work at 12, increasing health risk in children and sustaining the median school grade completed at a sixth-grade level (SAF, 2018). Exposure to pesticides, occupational injuries, heat stress,

dermatitis, parasite infections, and tuberculosis are chronic health concerns in agricultural farmworkers. Poor housing conditions increase the risk of lead poisoning, respiratory illness, ear infections, and diarrhea (SAF, 2018). Agricultural work is rated one of the most dangerous occupations. While faced with numerous health risks, agricultural workers may not have access to or seek preventive services to address every day health concerns.

Access to healthcare has two components which are characteristics of the community and opportunities to enter the healthcare system, both vary per population (Shreffler-Grant, 2013). Rural healthcare services present barriers for migrant and seasonal farmworkers (MSFWs) to receive preventive care. The barriers identified within healthcare practices are a lack of an interpreter and culturally competent staff, wait time, attitude of staff, lack of childcare services, and hours of services (Schmalzried & Fallon, 2012). Healthcare practitioners that understand the culture are more likely to respect the patient's choices, value, culture, and perception of illness, creating better relationships and quality of care (Schmalzried & Fallon, 2012).

The National Agricultural Workers Survey (NAWS, 2011-2012) found 61% of respondents had used healthcare services in the last two years, 41% had seen a private provider, 31% had used a federally qualified health center, and 12% had used an emergency room (Farmworker Justice & NCFH, 2015). Forty-six percent of respondents reported paying for healthcare services out of pocket. NAWS respondents reported barriers to obtaining healthcare such as cost of healthcare, language barriers, not being treated well due to immigration status, lack of transportation, services too far away, and

needed services were not offered (Farmworker Justice & NCFH, 2015). The barriers identified gaps in access to preventive health services.

MSFW's reverence for healthcare providers, fear of law enforcement, and lack of offerings to patient preference inhibit their expression of healthcare beliefs, behaviors, and use of healthcare needs. A knowledge deficit exists with healthcare providers on the perception of MSFWs healthcare beliefs and behaviors. In this qualitative study of MSFWs, I interviewed MSFWs about their beliefs regarding healthcare in the United States. I will provide local healthcare providers with MSFW preferences and beliefs regarding their healthcare in the United States. In Chapter 1, I provided the background, problem statement, purpose statement, research questions, theoretical framework, nature of the study, definitions, assumptions, scope and delimitations, limitations, and significance of the problem.

Background

The Health Resources and Services Administration reported MSFWs healthcare visits at the migrant health clinics consisted of 24.71% hypertension, 14.84% diabetes, and 8.32% asthma (Hu et al., 2016). Rosado et al. (2013) stated the Hispanic culture perceived thinness as poor health, therefore failing to recognize obesity. Because obesity has consequences of increased cardiovascular disease, endocrine, and mental health problems cultural misconceptions must be identified and addressed. MSFWs felt preventive healthcare was vital to their family's well-being, therefore further studies are needed to determine factors that inhibited, suppressed, or encouraged the MSFWs ability to speak freely to healthcare providers. However, reverence for health providers

prohibited MSFWs from expressing their wishes and preferences during office visits overshadowing their desire to change the healthcare plan (Newton, 2016). A greater knowledge of the health beliefs of MSFWs will inform a healthcare provider's ability to plan, implement, create, and deliver healthcare to the population.

MSFWs have cultural stressors beyond health conditions. According to Rhodes et al. (2015), unlicensed immigrants have expressed fear of law enforcement related to racial profiling. The inability to get a state-issued driver's license and threat of police enforcement prevents Hispanics from accessing and using health services; relying on others for transportation is unavoidable. Unlicensed immigrants avoided driving even in cases of emergencies which delayed preventive care and urgent medical treatment.

Patient preferences strongly affected the access and adherence to healthcare needs. Herman et al. (2016) explored the importance of patient preferences when seeking mental health services. They found that the physician's language, cultural competence, and location influenced patient's participation in healthcare. Thus, primary care providers also needed to consider the patient preferences when creating patient-centered care options.

Problem Statement

MSFWs experience barriers to preventive healthcare in the southeastern United States. Delayed preventive care leads to more acute medical needs. In this study, I addressed the MSFW's health beliefs/health seeking behaviors, and how MSFWs described usage of preventive health services. An exploration of structural factors that impeded healthcare is needed to improve conditions in the community.

Winters et al. (2006) identified the need for comparison studies to compare locations to address the diversity, health perceptions, and practice needs of the area studied. Rural healthcare services present barriers for MSFWs to receive preventive care. Schmalzried and Fallon (2012) found barriers to preventive care within rural healthcare practices include lack of an interpreter and culturally competent staff, wait time, attitude of staff, lack of childcare services, and hours of services. According to Zwi et al. (2017), not only are barriers present that prevent care, the therapeutic relationship between ethnocentric physician providers and the multicultural patient is found to be inhibited. Strict compliance to evidence-based care without cross cultural communication has a negative effect on health plan compliance.

In 2011, a coalition in southwest Florida focused on the top six health problems common to the local ethnic groups (Monaghan, 2011). The diagnoses included HIV/AIDS (40% of county's HIV/AIDS population), hypertension, diabetes, pesticides, injuries caused by citrus harvesting equipment, and eye safety. Furthermore, they found that if medical attention was not available on the work site, workers reported self-medicating and delaying appointments with health providers. Rosales et al. (2012) found a delay in diagnosis and treatment of a medical condition is found to place an increased burden on the healthcare system.

MSFWs experience barriers when seeking preventive services in rural areas and have a need for expression of perception (Connor et al., 2014; Fleischer et al., 2013; & Rosado et al., 2013). The perceptions and cultural beliefs of MSFWs play an important role in the adoption of prevention interventions and health standards (Connor et al., 2014;

Fleischer et al., 2013). Perceived barriers to care/lack of access should be identified and validated to improve health outcomes. MSFWs identified barriers such as isolation, transportation, cost, frequent mobility, cultural differences, language, fear related to legal status, loss of wages during time off, lack of insurance, knowledge deficit on when and where to use healthcare services, limited-service hours, discriminatory treatment, and difficulties leaving work (Hege et al., 2015; Hoerster et al., 2011; Luque & Castaneda, 2012; Rhodes et al., 2015; U.S. Department of Labor, 2016). Alleviating barriers should be part of the plan when creating preventive health service opportunities.

The primary and preventive health services in a large agricultural area in the southeast United States are limited to the local health department. Hispanic respondents to a Pew Hispanic Center and Robert Wood Johnson Foundation study reported the lack of a primary care provider (PCP) was due to infrequency of illness. However, healthcare providers stated that fear of being deported forced respondents to avoid seeking medical attention until faced with an emergency (Lubin, 2014). The absence of a PCP limited healthcare seeking behaviors, preventive screening, and timely diagnosis of health issues. A trip to a medical facility means a day of lost wages and additional transportation costs (Rosales et al., 2012). Therefore, many immigrants avoid medical treatment unless faced with an emergency or an acute illness. Hu et al. (2016) explored characteristics of MSFWs and access to primary and preventive care at migrant health clinics. Most migrant health clinic patients are below the federal poverty line, uninsured, and do not speak English. Of the MSFWs who used the migrant health clinic's preventive services, 50% had a physical exam in the last two years, 96% of the women had a pap smear and

50% had mammograms, and less than 30% of patients had a colonoscopy. Despite the preventive services provided at the clinic, 24% of MSFW patients were unable to access medical care, 26% had a delay in care, and 10% were unable to get needed prescriptions. Efforts are still needed to enhance outreach efforts, transportation assistance, and linguistic and cultural competence. According to Newton (2016), MSFW parents report being uncomfortable questioning a health provider; therefore, the farmworker's beliefs and perceptions are not being considered in the plan of care. Cassady et al. (2012) stated that "individuals worry about the risk that most directly affect their well-being and will address these needs first…a health threat, no matter how serious…may not be top priority due to other more imminent concerns; food, deportation, shelter, and employment" (p. 1106). When healthcare providers acknowledge the health beliefs of a patient the acknowledgement-built trust.

Healthcare policies restrict MSFW's access to care based on immigration status. According to Lubin (2014) policies restricting care often add a stigma to immigrants as undeserving. The perception of immigrants pertaining to poor medical care is attributed to their immigration status, financial status, race/ethnicity, and language. Mixed-status families, citizens, and undocumented immigrants shied away from public services fearing unwanted scrutiny by immigration officials. Ingram et al. (2015) concluded that community health workers could bridge the cultural gap between its residents and the healthcare system, creating a voice for its residents to define their healthcare needs. Understanding the MSFWs health beliefs and behaviors would broaden the knowledge base of factors influencing healthcare compliance such as interpreters, cultural

competence, and location, which could improve preventive health and the well-being of the community. Preventive programs that fit the health beliefs of MSFWs would increase the success of community interventions.

The current problem is supported in recent research. MSFWs experience barriers when seeking preventive services in rural areas such as isolation, transportation, cost, frequent mobility, cultural differences, language, fear related to legal status, loss of wages during time off, lack of insurance, knowledge deficit on when and where to use healthcare services, limited-service hours, discriminatory treatment, and difficulties leaving work. The perceptions and cultural beliefs of MSFWs play an important role in the adoption of prevention interventions and the absence of a PCP limited healthcare seeking behaviors, preventive screening, and timely diagnosis of health issues

Purpose Statement

The purpose of the study is to understand the MSFW's health beliefs/health seeking behaviors, and how MSFWs describe usage of preventive health services. Health beliefs are usually secondary to work and assessed in relation to work and its activities (Long & Weinert, 1989). The two rural nursing theory (RNT) concepts I explored were the health beliefs and health seeking behaviors of MSFWs in the southeastern United States.

A phenomenological, qualitative study is a research design that researchers use to explore how human beings make sense of experiences and convert them into consciousness (Patton, 2015). In-depth interviews with farmworkers who have lived-

experiences with barriers to care explain their perceptions and behaviors (Patton, 2015). The farmworker's culture and experiences dictated the response to health-related issues.

Research Questions

RQ1: What are the prevention health beliefs of Hispanic migrant and seasonal farmworkers in the southeastern United States?

RQ2: What is the prevention health-seeking behaviors of Hispanic migrant and seasonal farmworkers in the southeastern United States?

RQ3: How do Hispanic migrant and seasonal farmworkers describe their usage of preventive health services in the southeastern United States?

Theoretical Foundation

The RNT was adapted from a paradigm first described by Yura and Torres (1975) and later revised by Fawcett (1984). Yura and Torres reported the need for a conceptual framework to acknowledge the nursing vision in baccalaureate nursing programs. The curriculum review identified four major concepts: man, society, health, and nursing. Man is a unique bio-psycho-social-spiritual being with basic needs. Society is man's environment, family, community, nation, and universe. Health identified wellness and illness along a continuum. Nursing encompassed the nursing process. The explanation of concepts provided focus to the specific learning objectives in the nursing curriculum. Outlining the philosophy, objectives, and behavior expectations lessened the gap between theory and practice.

The structural holarchy of contemporary nursing knowledge is a metaparadigm, "global concepts that identify the phenomena of central interest to a discipline" (Fawcett,

2005, p. 4). Fawcett (1978) initially revealed four central themes of nursing: person, environment, health, and nursing. In 2005, Fawcett's proposal updated the definitions of the concepts for the nursing metaparadigm: human beings, environment, health, and nursing. Human beings are individuals who can be recognized in a culture, family, community, and who participate in nursing. The environment is a human beings' significant other, physical surroundings, and how nursing is used in the community. Health is defined as the human process of living and dying (Fawcett, 2005). Nursing is the action taken by nurses on behalf of human beings, the process of interaction between nurses and participants, and the nursing process itself; assessment, planning, intervention, and evaluation (Fawcett, 2005). Further explanation of the paradigm is found in Chapter 2.

The RNT is a middle range model that describes how nurses care for persons in rural areas (Winters, 2013). The theory emerged after researchers acknowledged that rural persons have unique perceptions, and the nurses were generalists. The RNT concepts identify the health seeking behaviors of rural persons and their families: work and health beliefs, isolation and distance, self-reliance, lack of anonymity, outsiders, and newcomers. Isolation and distance relate to the average number of miles from emergency and primary care services. Self-reliance and independence are to do for oneself. A lack of anonymity and outsider/insider, rural nurses generally know their patients beyond the nurse-patient relationship. The RNT is a framework used to address the identified barriers to care for MSFWs. Rural dwellers required a unique approach that addressed the special needs of the population. Duplicating an urban nursing model for use in a rural area would

be inadequate to fulfill the needs of MSFWs. Chapter 2 provides a detailed description of the RNT.

Nature of Study

I used a phenomenological qualitative research design using in-depth interviews to explore the MSFW's health beliefs regarding preventive healthcare. Hermeneutic phenomenology aims to create a deep rich account of the phenomenon rather than an accurate definition, "investigating the experience as it is lived" (Kafle, 2011, p. 191). Auto-hermeneutic is the exploration of one's own experience with information (Gorichanaz, 2017). Qualitative studies are suited for the health sciences as they provide factual responses to questions about people's feelings toward a specific space, its features, and the people using them (Colorafi & Evans, 2016). I conducted telephone and face-to-face interviews with English speaking MSFWs over 18 years of age, which included individuals who work on a farm and relocate their residences during the growing season to follow the crops and farmworkers who remain in the same residence but travel a wide geographic area to work with different employers and crops during the growing season. An audio recorder was used when consented to capture verbatim interviews. I used open coding with Atlas.ti to analyze the qualitative data.

Definitions

The terms for this study are defined below.

Health: Health is defined as "the ability to work, be productive, and do usual tasks" (Winters, 2013, p. 6).

Health beliefs: Health beliefs are personal convictions that influence health behaviors (Farlex, 2018).

Health seeking behaviors: Health seeking behavior, a NANDA International nursing diagnosis, is a state in which "a person in stable health is actively seeking ways to alter his/her personal habits or environment to move toward a higher level of health" (Farlex, 2018, para. 19). Stable health is defined as "achieving of age-appropriate illness prevention measures, with reporting of good or excellent health, and signs or symptoms of disease, when present, being controlled" (Farlex, 2018, para. 19).

Migrant farmworkers: Migrant farmworkers are those individuals who work on a farm and relocate their residences during the growing season to follow the crops (U.S. Department of Housing and Urban Development [HUD], n.d.).

Preventive health beliefs: Preventive health beliefs are personal convictions that influence health behaviors (Farlex, 2018).

Preventive health services: Preventive health services are health services that consist of measures to prevent disease (Farlex, 2018).

Seasonal farmworkers: Seasonal farmworkers are farmworkers who remain in the same residence but travel a wide geographic area to work with different employers and crops during the growing season. Florida is one of the states with the longest growing season (HUD, n.d.).

Work beliefs: Work beliefs are what fulfills one's usual function. Health beliefs are usually secondary to work and assessed in relation to work and its activities (Long & Weinert, 1989).

Assumptions

An assumption for this study was that MSFWs desire quality healthcare services to maintain their personal health. Another assumption was that MSFWs would participate in preventive health services if their cultural needs were met. Lastly, I assumed the study participants would provide true answers to my research questions. Assumptions are necessary as I would not ask them to support my research questions.

Scope and Delimitations

The literature review revealed that the MSFW weighed health beliefs, perceptions of healthcare providers, cultural competence of staff, and promotional strategies to determine their use of healthcare services. According to Long and Weinert (1989), the way people defined health had a direct impact on whether they sought healthcare services, understanding the local definition of health assisted in planning successful health interventions.

The scope of my study was to include a small sample size of five to15 MSFWs who spoke English, were over 18 years of age, and who worked in one geographic location in the southeastern United States. I did not include MSFWs who did not speak English and/or were under 18 years of age. I explored two concepts of the RNT, health beliefs and health behaviors of MSFWs. The remaining concepts of the RNT, work beliefs, isolation and distance, self-reliance, and outsiders/insiders, were indirectly related to the research questions and were discussed only when presented by the interviewees.

Alternative theories that could have been used in place of the RNT were the health belief model, social cognitive theory, and the health promotion model. However,

those theories did not include the unique needs of the rural dwellers and their community and had been eliminated as a theoretical choice. If the study's focus had been the prevention of occupational injuries, ethnography would have been a better theoretical selection. A description of occupational health practices in the field would be better studied through a culture of group behaviors. Instead, I preferred to discover a shared worldview, phenomena, of health seeking behaviors within a specific community. According to Patton (2015), a phenomenological approach focuses on how one interprets the phenomena one experienced, developing a worldview. An analysis of interview data identified basic elements of the health care experience to be common to members of a specific community. Phenomenological study results can be related/transferable to other studies of the same experience.

Limitations

Due to the Covid pandemic two interviews were conducted via a phone interview rather than direct observation in their natural environment. Participants contributed information that was filtered through their worldview, not all interviewees were able to articulate their perspective. The interviewer/researcher may interject bias into the analysis of the results (Creswell, 2014). As a Caucasian female, my social location may have been an obstacle, as I am not fluent in the native language(s) of the Hispanic MSFW. However, during local health fairs the MSFWs allowed me to participate in their preventive healthcare and accepted needed referrals. Having grown up in a farming family, I did have a few common issues for conversation. I kept in mind that their priorities may differ from my own.

The researcher as an instrument may have introduced strategic, ethical, and personal bias into the qualitative study (Creswell, 2014). Researchers should disclose their bias, values, personal background, history, culture, and social economic status all of which shape their interpretations (Creswell, 2014). Deficient orientation is a type of bias, viewing people from a cultural group as lacking certain knowledge creating a power dynamic (inequality) in the research relationship. A shift to resource orientation provided me with the MSFWs' lens: the strength, skills, and knowledge in which to view self and others (see Ravitch & Carl, 2016). While applying academic principles to the pursuit of the MSFW's perception, I also needed to include the collective knowledge through life experiences into my conclusions.

Generalization of qualitative studies are limited as the findings are specific to the individuals, site, or places under study (Creswell, 2014). Qualitative researchers can achieve generalization by repeating the study in another location with a new population. However, strict attention to protocol and documentation are needed to repeat a study. According to Grove et al. (2013), communicating research findings, positive and negative, shape the development of knowledge and should be disseminated through presentations and journals to healthcare professionals. Ravitch and Carl (2016) described transferability as a way in which qualitative studies can be applicable to a broader context while maintaining the richness of the original study. Descriptive and inferential field notes create a systematic and structured reflection of the data for future research endeavors.

Significance

A delay in diagnosis and treatment of a medical condition increases the burden on the healthcare system. Primary care increases access to care, enhances patient outcomes, and reduces disparities (Hu et al., 2016). Clinical preventive services save money, provided high quality care and were effective in reducing death, disability, and disease (U.S. Department of Health and Human Services [USHHS], 2016). NAWS 2013-2014 reported 23% of agricultural workers sought care in a private medical office or clinic in the last 2 years, most paying out-of-pocket (U.S. Department of Labor, 2014). However, healthcare programs that conflicted with rural economics (growing season) were not used by agricultural workers.

In my study I identified the perceptions of MSFWs and explained the likelihood of adopting preventive health behaviors. Validating, acknowledging, and applying the perceptions of the MSFWs when creating, planning, implementing, and delivering rural care increased the MSFW population reached during prevention campaigns (Cassady et al., 2012). The practical application of the data can be used to identify the need to install Spanish speaking, culturally competent staff into primary care offices and in health prevention initiatives. Healthcare workers can use the knowledge to tailor preventive interventions to reflect MSFWs beliefs.

Positive social change can occur when MSFWs seek routine preventive care, improving patient-provider relationships, decreasing healthcare costs, and enhancing patient outcomes. Long and Weinert (1989) stressed that nurses need to impart a nonjudgmental intervention for patients who present for delayed treatment and place a

strong emphasis on preventive healthcare education. The assumption was MSFWs would attend preventative healthcare services when their needs are better met. Understanding the MSFWs health beliefs and health seeking behaviors broadened the knowledge base of healthcare providers to factors influencing healthcare compliance such as interpreters, open communication, and incorporating MSFWs perceptions into the plan of care which can improve preventive health and the well-being of the community.

Summary

The United States has an estimated 2.5-3 million agricultural workers, the majority (73%) of which are foreign-born, with 68% from Mexico (NCFH, 2018). MSFWs have reported/experienced barriers when seeking preventive services in rural areas: isolation, transportation, cost, frequent mobility, cultural, language, fear related to legal status, loss of wages during time off, and limited access to healthcare (Hege et al., 2015; Hoerster et al., 2011; Luque & Castaneda, 2012; Rhodes et al., 2015; U.S. Department of Labor, 2016). Reverence for health providers prohibit MSFWs from expressing their perceptions and preferences, overshadowing the MSFW's desire to be involved in their healthcare plan.

The absence of a PCP limits positive health seeking behaviors, preventive screening, and timely diagnosis of health issues (Rosales et al., 2012). The physician's language, cultural competence, and location influences compliance with healthcare. Patient preferences strongly affect the access and adherence to healthcare needs, but many immigrants avoid medical treatment unless faced with an emergency or an acute illness due to fear.

The purpose of my study was to understand the MSFW's health beliefs and how it affected preventive healthcare. Health beliefs are secondary to work and assessed in relation to work and its obligations. Preventive programs that fit the health beliefs of the MSFWs increase preventive health compliance. With this phenomenological, qualitative study I explored how human beings make sense of preventive health seeking behaviors. I interviewed English-speaking MSFWs over 18 years of age in the southeastern United States. The RNT as a theoretical framework and its individual concepts is described in Chapter 2.

Chapter 2: Literature Review

Health belief effects on preventive health among MSFWs are not well defined. MSFW parents report being uncomfortable questioning a health provider about their children, therefore the farmworker's parental beliefs and perceptions are not being considered in the plan of care (Newton, 2016). Acknowledging the health beliefs of a patient validates their perceptions and builds trust with the healthcare providers.

Access to healthcare services promotes and maintains health, prevents, and manages chronic disease, and a comprehensive approach attempts to achieve health equality in America (USHHS, 2018). Farmworkers face numerous barriers to care such as lack of insurance, knowledge deficit on when or where to use healthcare services, cost, transportation, limited-service hours, language, fear of immigration enforcement, social isolation, discriminatory treatment, difficulties leaving work, and a lack of culturally competent care (Hege et al., 2015; Hoerster et al., 2011; Luque & Castaneda, 2012; Rhodes et al., 2015, USHHS, 2018). Barriers to health services leads to unmet health needs, delays in care, inability to receive preventive services, and hospitalizations (USHHS, 2018). A delay in diagnosis and treatment of a medical condition increases the burden on the healthcare system. Primary care increases access to care, enhanced patient outcomes, and reduced disparities (Hu et al., 2016). Clinical preventive services save money, provide high quality care and are effective in reducing death, disability, and disease (USHHS, 2016). Mitigating barriers to preventive care will increase access for MSFWs.

The literature review on health belief effects on preventive health among MSFWs identified the need to make comparison studies between rural locations to address the diversity, health perceptions, and practice needs of the area being observed. Bales et al. (2013) suggested practitioners inform patients of risk factors related to living in rural areas such as available healthcare services and community support. Once informed, the practitioner should respect the healthcare decisions of the patient. Lack of mutual patient-physician communication could inhibit or deter farmworkers from seeking acute or preventive care.

Rural healthcare services present barriers for MSFWs to receive preventive care. The barriers identified within healthcare practices are lack of an interpreter and culturally competent staff, wait time, attitude of staff, lack of child care services, and hours of service (Schmalzried & Fallon, 2012). Ethnocentric physicians inhibit a therapeutic relationship with multicultural patients. Strick compliance to evidence-based care without cross cultural communication has negative effects on health plan compliance (Zwi et al., 2017). Educating healthcare professionals to the cultural needs of the MSFW could assist in improving the patient-provider relationship when providing preventive health care.

MSFWs experience barriers to preventive healthcare in the southeastern United States. Delayed preventive care leads to more acute medical needs. In this study I addressed the MSFW's health beliefs/health seeking behaviors, and how MSFWs described usage of preventive health services. An exploration of structural factors that impeded healthcare was needed to improve conditions in the community.

The purpose of the study is to understand the MSFWs health beliefs and how it effects preventive healthcare. The U.S. Department of HHS (2016) states preventive programs that fit the health beliefs of the population increase compliance. A broader knowledge base of farmworker beliefs and service needs will increase the success of community interventions, therefore decreasing chronic illness, increasing quality of life, and decreasing cost of long-term healthcare.

Long and Weinert (1989) stated that rural dwellers define health as "the ability to work, to be productive, and to do usual tasks" with little emphasis on life-prolonging health behaviors (p. 7). The connection between RNT concepts and general nursing knowledge is understanding the client's health behaviors and planning healthcare services accordingly. Long and Weinert found rural residents place little importance on comfort and life-prolonging preventive measures. The knowledge of how rural residents define health has a direct impact on their healthcare behaviors and use of services. Since health is the ability to work, healthcare programs need to be available outside work hours and farming seasons. Effective health promotion strategies should mitigate the stressors/barriers of the local population being served (Carvajal et al., 2014). Strategies to enhance culturally competent care included improving access to resources, education, and mentoring. Zwi et al. (2017) identified the health beliefs system as having three models: biomedical, spiritual, and traditional. Patients with complex medical problems and multiple beliefs can participate in concepts that cross models; these patients tend to show dominance in traditional health beliefs and cultural practices. Incorporating patient preferences with primary care involvement was found to be crucial components in

matching farmworkers to appropriate services (Herman et al., 2016). Healthcare providers could gain a better understanding of their patients and improve the physician-patient relationship by learning the local cultural/folk practices (Kirk et al., 2014; Schmalzried & Fallon, 2012; Shearer, 2016). Understanding the MSFWs definition of health, health beliefs and behaviors could mitigate the barriers to seeking preventive health.

The RNT identifies health seeking behaviors of rural persons and their families (Long & Weinert, 1989). Fawcett's (2005) metaparadigm for nursing theory is discussed, definitions of which remain the same through the latest printed text. The methods and theoretical applications used to determine rural healthcare needs are varied, several are reviewed for their strengths and weaknesses. The dominant themes discovered in this literature review were use of health beliefs, participation of primary care providers, health promotion strategies, and cultural competence of healthcare staff.

In Chapter 2, I provide a description of the theoretical foundation for the RNT, its origins, the rationale for choosing the RNT, and its application to similar research studies. I explored the method of phenomenology and its use in qualitative research related to MSFWs perceptions and health beliefs of preventive services and health promotion strategies. A MSFW's perception of preventive health is affected by the lack of a primary care provider, health promotion strategies, and cultural competence.

Literature Search Strategy

I completed a database search in EBSCO; ProQuest, CINAHL, Ovid and Thoreau. The search words I included were *migrant, seasonal, rural, farm workers, Hispanic,*

prevention, preventive health, health behaviors, health beliefs, and combinations of each. I also used the search words *transient, migrant, psychology, agriculture,* and *attitude to health* in PubMed. The initial research began with a problem statement that included seven concepts. The process of narrowing the research topic decreased the number of search words. A limitation was identified early in the review because public health and agricultural publications were not located in all databases. Publications review dates ranged from 1975 (theory) through 2018. Data were categorized into four groups: theory, health promotion, prevention, and perceptions.

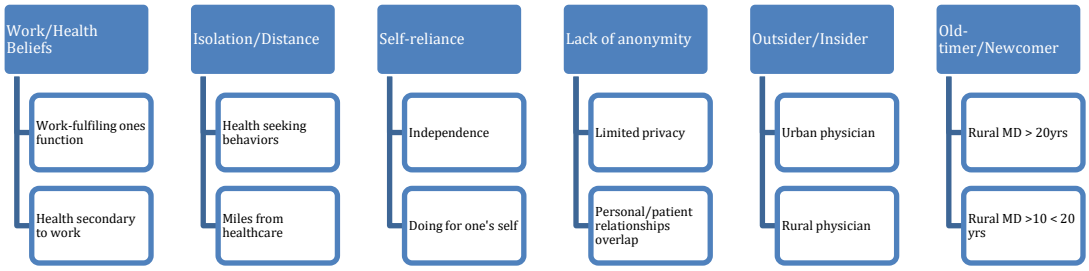
Theoretical Foundation

Theory

The RNT is a middle range model that describes how nurses care for persons in rural areas (Winters, 2013). The theory emerged after researchers acknowledged that rural persons have unique perceptions, and the rural nurses were generalist. The concepts of RNT are work and health beliefs, isolation and distance, self-reliance, lack of anonymity, outsiders, and newcomers. A visual representation of the concepts is presented in Figure 1. Rural persons prefer to seek care informally from healthcare workers they are familiar with although their anonymity is limited in small or rural towns.

Figure 1

RNT Concepts



Origin

The RNT was adapted from a paradigm first described by Yura and Torres (1975) and later revised by Fawcett (1984; Winters, 2013). Yura and Torres reported the need for a conceptual framework to acknowledge the nursing vision in baccalaureate nursing programs. The curriculum review identified four major concepts: man, society, health, and nursing. Man is a unique bio-psycho-social-spiritual being with basic needs. Society is man's environment, family, community, nation, and universe. Health identified wellness and illness along a continuum. Nursing encompassed the nursing process. The explanation of concepts provided focus to the specific learning objectives in the nursing curriculum. Outlining the philosophy, objectives, and behavior expectations lessened the gap between theory and practice.

The first component of the structural holarchy of contemporary nursing knowledge is metaparadigm, "global concepts that identify the phenomena of central interest to a discipline" (Fawcett, 2005, p. 4). Fawcett (1978, 1984) initially revealed four

central themes of nursing: person, environment, health, and nursing. Fawcett's (2005) proposal defined the concepts for the nursing metaparadigm: human beings, environment, health, and nursing. Human beings are individuals who can be recognized in a culture, family, community, and who participate in nursing. The environment is a human beings' significant other, physical surroundings, and how nursing is used in the community. Health is defined as the human process of living and dying. Nursing is the action taken by nurses on behalf of human beings, the process of interaction between nurses and participants, and the nursing process itself; assessment, planning, intervention, and evaluation.

The RNT concepts identify the health seeking behaviors of rural persons and their families: work and health beliefs, isolation and distance, self-reliance, lack of anonymity, outsiders, and newcomers (Winters, 2013). According to Long and Weinert (1989), work beliefs are what fulfills one's usual function. Health beliefs are usually secondary to work and assessed in relation to work and its activities. Isolation and distance relate to the average number of miles from emergency and primary care services. Self-reliance and independence are to do for oneself. A lack of anonymity and outsider/insider concepts refers to the fact that rural nurses generally know their patients beyond the nurse-patient relationship.

The knowledge of how rural residents define health has a direct impact on their healthcare behaviors and use of services. According to Winters (2013), rural residents place little importance on comfort and life-prolonging preventive measures. Since health is the ability to work, healthcare programs need to be available outside work hours and

farming seasons. The self-reliance of rural residents stifles their enthusiasm to engage in programs outside of their community; delaying consultations until they are acutely ill. The rural nurse's ability to promote health related to work is more effective than promoting an intervention for a longer life. Long and Weinert's (1989) research indicated that rural persons organized their views according to social environment, guiding interaction and relationships for healthcare. In-depth interviews will capture the MSFWs definition of health and views of their environment.

Williams et al. (2012) and Lee and McDonagh (2013) each conducted a literature review of the rural nursing concepts and identified a lack of support for the definition of rural health. Lee and McDonagh identified varied strategies in self-reliance resulting in different health seeking behaviors such as a visit to the emergency room versus self-medicating. Lee and McDonagh suggested revising the definition of health for rural dwellers is "being able to do what they want to do; it is a way of life and a state of mind; there is a goal of maintaining balance in all aspects of their lives" (p. 22). Self-reliant rural dwellers made healthcare decisions depending on their self-assessment of the illness severity and the resources needed to seek care. The recommendation from Williams et al. (2012) was for future researchers to identify the rural concepts relevant to the phenomenon of study and apply the most appropriate definition. However, this recommendation did not provide nursing researchers with a solid theoretical foundation.

Application of Theory

Theoretical Propositions

Williams et al. (2012) conducted a literature review to identify the state of science in rural nursing and the use of the theoretical principles that guide it. The authors revealed that although rural nursing research had increased over the last 20 years, the level of evidence was low and lacked a solid theoretical foundation. The research studies reviewed often reflected the use of Lee and Winter's rural concepts, however the definitions are imprecise. Of the 295 articles, six used the RNT as a foundation. Only one study attempted to validate the RNT concepts by exploring the health perceptions and needs of rural adults. The study identified the need to make comparison studies in various rural locations to address the diversity, health perceptions, and practice needs of the area; to develop evidence-based interventions in the area and for rural persons who seek care in urban settings. Participants were interviewed about illness using the symptom, action, timeline (SATL) acronym for illness management (Lee & Winters, 2004). Knowledge of a rural person's management of chronic illness assisted healthcare persons in determining whether to treat locally or transfer to an urban care facility. McCoy (2009) viewed RNT from the nursing perspective; rural nurses are generalists who need knowledge in rural health. Staff development and orientation in rural facilities were limited due to poor staffing, limited research knowledge, lack of interest from administration, lack of resources, and organizational support. A strategy to bring evidence-based practice (EBP) to rural nursing was to partner the rural facility with an urban hospital, teaching the rural

nurse to read, interpret, and implement best practice (McCoy, 2009). EBP education improves the knowledge and practice of the generalist rural nurse.

Thomlinson et al. (2004) identified multiple definitions for the term rural exist and the definition used should be appropriate for the question of study. Winters (2013) defined rural as "sparsely populated" whereas Merriam-Webster (2018) defined rural as "of or relating to the country, county people or life, or agriculture" (para. 1). The U.S. Census bureau defined "rural as what is not urban" while Ratcliffe et al. (2016) stated an urbanized area is a territory of greater than 50,000 people and an urban cluster consists of "at least 2,500 and fewer than 50,000 people" (p.1 & 3). Agricultural areas of the southeastern United States were considered outside the urbanized area as defined by the U.S. Census (Rural Health Information Hub, 2018). The U.S. Census definition was used for this study.

Long and Weinert (1989) stated that rural dwellers defined health as "the ability to work, to be productive, and to do usual tasks" with little emphasis on life-prolonging health behaviors (p. 7). The connection between RNT concepts and general nursing knowledge is understanding the client's health behaviors and planning healthcare services accordingly. Long and Weinert further defined rural persons as being self-reliant and resisted seeking healthcare services from strangers or obtaining services outside of the community. The identified characteristics resulted in rural persons delaying care until they are acutely ill. An intervention for preventive health knowledge is needed.

Lee and McDonagh (2013) conducted a literature review to identify the support and/or arguments against the viability of the RNT theoretical statements. Few citations in

the literature review focused on health perceptions and the needs of rural persons. The knowledge of health perceptions, behaviors, and needs of the community's individuals is paramount to the creation of health promotion strategies (Bales et al., 2013; Thomlinson et al., 2004). Health concepts cannot be generalized between rural communities. The health beliefs and resources of residents influence their health behaviors. Lack of transportation and available medical services influenced decision making when faced with acute and chronic illness, rural residents procrastinated making a specialist appointment due to the winter season (Thomlinson et al., 2004; Wathen & Harris, 2006). Although some rural characteristics are common among rural communities, each community has unique health beliefs and practices (Thomlinson et al., 2004). Lee and McDonagh suggested a new series of definitions for the RNT concepts which included health-seeking behaviors, choice, environmental context, and social capital.

Theory Literature Analysis

Burdette (2012) used the RNT in conjunction with Orem's self-care theory to explore whether a positive relationship existed between self-care agency (SCA), self-care practices (SCP), and obesity among 224 rural women with an average age of 52.15 years. Orem's definition of self-care agency is "the complex acquired capability to meet one's continuing requirements of self" (Burdette, 2012, p. 5). Orem's definition of self-care is the "practice of activities that individuals initiate and perform on their own behalf in maintaining life, health, and well-being" (Burdette, 2012, p. 5). The positive relationship hypothesis was not supported as participants reported no impact of care due to distance from healthcare providers. The relationship between SCA, SCP, obesity, and the rural

environment (distance, isolation, self-reliance, old-timer/new comer) require further study to include diverse populations and ethnic groups.

Bales et al. (2013) used the RNT to explore the health needs and perceptions of rural persons living in Montana City, Montana. A descriptive analysis was used to conduct semi-structured interviews of five women and one man aged 37 to 76 years. Open coding revealed six major themes of self-reliance, hardiness, conscientious consumer, informed risk, community support, and inadequate insurance. Studies by Chafey et al. (1998) and Wirtz et al. (1998) showed that self-reliance and hardiness were themes that had previously been revealed. Bales et al. (2013) identified to be self-reliant one must be able to take care of ones' self. Hardiness is the ability to be adaptable, have a positive attitude, and the endurance to complete a task. The new themes created were conscientious consumer (choice), informed risk (rural resources), community support (pulls together), and inadequate insurance (cost). Bales et al. recommended practitioners inform patients of risk factors related to living in rural areas, community support, and available healthcare services and then respect the healthcare decisions of the patient. Further research is needed to assist practitioners in providing the highest quality healthcare to rural individuals.

Rolland (2016) explored the rural influence on emergency room (ER) nurses as patients transitioned from curative to end-of-life care using RNT. The purpose of Rolland's study was to identify gaps in rural nursing care and how to support dying patients and their families; results showed that distance, resources, and connectedness between residents and the community had the greatest impact on ER nurses. One

ambulance could potentially cover a 20-mile radius. Tele-stroke and tele-med services provided guidance for patient stabilization. The familiarity between medical personnel and community residents kept residents from reaching out to larger hospital facilities for services and prompted residents to assist with resuscitative efforts when needed. The greatest asset of rural nurses is self-reliance which is the ability to keep patients alive with limited resources until help arrived. Strategies to assist ER nurses with the transition between curative care and end-of-life care included improving access to resources, education, and mentoring.

Theory Rationale- Relation to Study

The NAWS (2014) reported MSFWs encountered general barriers when accessing healthcare such as expense, language, transportation/distance, lack of knowledge of available services, lack of health services, hours of availability, and fear of job loss. The RNT provides a framework to address the barriers to care for MSFWs such as work and health beliefs, isolation and distance, self-reliance, and outsiders/insiders. Rural dwellers require a unique approach that addresses the special needs of the population. “How people define health and illness has a direct impact on how they seek and use healthcare services” (Winters, 2013, p. 8). Duplicating an urban nursing model for use in a rural area is inadequate to fulfill the needs of the MSFW population.

Literature Review Related to Key Variables and/or Concepts

The literature review revealed that the MSFWs used health beliefs, perceptions of healthcare providers, cultural competence of staff, and promotional strategies to determine their use of healthcare services. Health maintenance is not a top priority during

risk assessments with emancipated migrant youth (EMY) as the most likely cause to seek medical care was an emergency (Peoples et al., 2010). A misconceived perception inhibits or deters a farmworker from seeking acute or preventive care.

Studies Related to Methodology

Phenomenology, a philosophical approach, seeks the meaning, structure, and essence of the lived experience of a phenomenon for a specific group of people (Patton, 2015). My study sought to describe how farmworkers describe, perceive, judge, remember, and make sense of the phenomenon of preventive health. Qualitative methods attempt to explain how human beings attach meaning to their lived experiences, interviews reveal their meanings (see Patton, 2015). The methodologies in the literature review were not well defined, however semi-structured interviews, focus groups, and case studies were used in qualitative approaches to gain the perception of MSFWs regarding their use of healthcare services.

Approach to Research

Lee and Winters (2004) used a naturalistic approach with field research to gather data on rural perceptions which used an open-ended approach which allowed themes to emerge during interviews. The naturalistic approach allows events to unfold without predetermined constraints. The limitations of the study were a small sample size, a convenience sample, and the study was not transferable due to lack of diversity (see Ravitch & Carl, 2016). However, the naturalistic approach allows the researcher an avenue to make sense of the lived experience.

Barker et al. (2017) used an ethnographic qualitative approach with interviews and focus groups, to explore Latino farmworkers use of domestic (table) salt. Barker and colleagues used a humoral framework to understand how the Latino population explained their worldview of illness and healing. The qualitative study identified two themes, importance of balance in health and health beliefs on the use of salt. A weakness of the qualitative approach was that it limited transferability due to the small sample size (Ravitch & Carl, 2016). It does however create descriptive context for future researchers.

Burdette (2012) performed a mixed methods study using a non-experimental predictive correlational design with two instruments Denyes self-care agency instrument, and Denyes self-care practices instrument, and open-ended interviews to examine the relationship between self-care and obese rural women. The basis of the study was grounded in a nursing theoretical framework. Qualitative findings provide detailed information about a smaller group, increasing the depth of information but decreasing the generalizability (Patton, 2015). The quantitative approach measured a substantial number of participants with a limited number of questions, providing a broad precise generalizable set of findings.

Rolland (2016) conducted a deductive content analysis with grounded theory to conduct semi-structured interviews to identify factors that influence how a rural nurse transitions from curative to end-of-life care. A comparative analysis of the interview data was conducted between two urban and two rural hospitals, a systematic analysis of observations for consistencies and meaning. According to Patton (2015), the deduction

method attempts to support existing general concepts, explanations, and/or theories. The deductive findings may confirm a concept, but does not generate new knowledge.

Long and Weinert (1989) conducted a mixed methods ethnographic survey using a convenience sample to collect survey data from farmers and ranchers in Montana regarding their rural culture in relation to healthcare. The survey provided a standardization for data collection and the “retroductive” process collected data over several years. According to Patton (2015), an ethnographic study assumes that a group of people interacting over time develop a culture, a pattern of behaviors and beliefs that become a standard within the group. The study conducted in Montana would be indicative to the area and population studied.

Herbst and Gonzalez-Guarda (2016) conducted a descriptive qualitative study to explore the perspectives of well-being in migrant farmworkers (MFW's) residing in south Florida. Focus groups and individual interviews were conducted using the developmental system theory and Prilleltensky's conceptualization of well-being. Individual barriers to well-being were identified as alcohol use, stress, cultural and linguistic difficulties, low education levels, and poverty. Community barriers were the communal perception of illness and health beliefs. Contextual factors included fear of deportation and discrimination. The participants identified several solutions to improve MFW’s well-being such as increasing the number of providers in prevention and mental health, a central location for education and services, parenting skills classes, and the need for social services. A limitation of the study was multiple countries of origin influenced the MFW's perception of well-being. The conclusion was the need for culturally

diverse/sensitive providers who understand the socio-contextual factors of migrants to improve the care and advocacy for the well-being of MFWs.

Lopez-Cevallos and Lee (2013) conducted a cross sectional study interviewing 179 MFWs in northwestern Oregon. Their study explored the correlation between fear of deportation (barrier) and church attendance (opportunity), did MFWs associate either factor with the use of medical and dental care. Healthcare utilization was found to be low in that demographic despite their need for care: medical care utilization was only 37% and dental care 20%. The results showed that although fear of deportation was the most identified barrier, it was not linked to medical and dental use in northwestern Oregon. The cultural competence and trusted providers of the local outreach program was integral in connecting MFWs to medical and dental programs. The results were not generalizable as the sample was small and from one mobile screening location.

Rawolle et al. (2016) conducted a descriptive qualitative study using semi-structured interviews to explore the perceptions of farmers' health in southern Australia. Participant recruitment began with a list from previous studies and snowballed, introductions to relevant information with rich contacts (see Patton, 2015). Pseudonyms were used to protect participant's privacy if direct quotes were presented in the literature. The participants "perceived health as being able to function and complete farmwork" (Rawolle et al., 2016, p. 312). The farmers felt their work helped maintain fitness, but included its own set of health hazards. Stress, occupational hazards, community activities and support all influenced health seeking behaviors.

Hall et al. (2016) used a cross-sectional correlation study to explore the compliance of hypertension treatment with Latino MSFWs. The data collected on blood pressure control was a single instance to a set of questions. Standardized questions were asked and analyzed one by one. The weakness of this method was that the questions were predetermined, so the interviewer could not pursue topics that appeared at the time of the interview (see Patton, 2015). However, standard questions promote credibility.

Horton and Stewart (2012) conducted an ethnographic qualitative study using in-depth interviews. Twenty-three Hispanic farmworkers in California were interviewed regarding their use of self-medication. Horton and Stewart's study found that occupational vulnerability (lack of job security) rated higher as a barrier than lack of insurance or lack of legal documentation. The self-medication use of antibiotics was the focus of the study. Hispanic immigrants felt their country's unregulated injectable antibiotics were stronger than American medications. However, they failed to recognize the difference between viral and bacterial infections to properly select the medication used. The proposed intervention was a public dissemination of information about antibiotic resistance, risk of self-prescription, and risk of self-medication. One such intervention could decrease unregulated use of antibiotics without medical advice if the circumstances of the MFWs lifestyle was considered.

Luque et al. (2012) conducted a sequential explanatory mixed-method design to identify the benefits and barriers of the human papillomavirus vaccination for Latin farmworkers. Triad interviews were conducted with small focus groups within the community. The focus group participants could potentially have known each other,

leading to more in-depth discussions. Sequential sampling during fieldwork led to new information and research directions as the inquiry unfolds, the technique lent to data collection flexibility (see Ravitch & Carl, 2016). Multiple data sources provide rigor and validity in the research study.

deRose (2017) conducted a qualitative hermeneutic phenomenological study to explore Latino immigrant parent's life experience in seeking required vaccinations for their foreign-born children. Unstructured interviews were used to reveal the parent's perspective of the healthcare system in the U.S. The main theme was trust issues; trusting themselves as parents to vaccinate their children, trusting or mistrusting the U.S. healthcare system providers, and mistrusting the U.S. healthcare system (deRose, 2017). Parents had to trust themselves to have the ability to navigate through barriers such as language, transportation, and healthcare literacy. Mistrust came from disrespect from providers and a lack of acknowledgement of previous immunization, ignoring foreign shot records and revaccinating. A mistrust of the healthcare system came from the distinguishable treatment between U.S. and foreign-born siblings. deRose (2017) concluded that consistent vaccination practices regardless of immigration status would improve trust between immigrant patients and healthcare providers. A trusting relationship with healthcare providers came from a caring attitude, one who shows kindness and concern for the Latino clients.

Tavares and Tocantins (2015) used social phenomenology in a qualitative study to explore the actions of nurses in the eradication of preventable diseases through vaccination and education. Although the nurse had the knowledge to assist in controlling

the disease with vaccination, the user's lifestyle and access to services needed consideration for successful integration of vaccine programs. Education on lifestyle choices, health literacy, and available services allowed the user to make informed choices and become an active participant in their preventive healthcare.

Migrant and Seasonal Farmworker Health Beliefs

Perceptions of preventive services

According to Rawolle (2016), Australian farmers perceived health as the ability to work and disabled or unhealthy when unable to perform their duties. Peoples et al. (2010) and Shearer (2016) noted an increased knowledge of safety information for MSFWs was related to a lower perceived risk and greater control however, it did not necessarily change preventive behaviors. Cassady et al. (2012) and Shearer noted the absence of personal experience may decrease the perceived risk of an illness or injury. Cassady et al. (2012) explained the priorities of farmworkers over medical concerns:

> individuals worry most about the risk that most directly affect their well-being and will address these needs first often overlooking other issues, for immigrant families…a health threat, no matter how serious…may not be top priority due to other more imminent concerns; food, deportation, shelter, and employment. (p. 1106)

According to Connor et al. (2014), adolescent farmworkers were able to understand the cause and effect of health behaviors, however their perceptions are understudied. Peoples et al. (2010) found that generally, an EMY's health maintenance was a low priority. An acute illness was a more likely reason to seek medical attention.

EMYs reported a lack of knowledge regarding the location of medical services, how to pay for services, and where to find health information. Peoples et al. further noted the lack of knowledge regarding occupational and/or environmental risk factors prevented EMYs from employing preventive measures resulting in occupational injuries such as heat stroke. The perception of discrimination and isolation were found to impact the risk of occupational injuries going untreated (Bail et al., 2012; Connor et al., 2014; Snipes et al., 2017). The health beliefs and perceptions of preventive care discussion brought researchers full circle to the cost of care and its effects on health.

Health beliefs

The health beliefs system has three models which are biomedical, spiritual, and traditional. Zwi et al. (2017) stated Western medicine is biomedical which is reactionary, illness focused, and considers body and mind separate. Migrant workers may have a limited understanding of western medicine. South American cultures commonly follow the spiritual model which focuses on strong beliefs in tradition and values. Illness is beyond the farmworker's control, caused by supernatural forces such as deities, ghosts, or ancestors, witches and sorcerers. Illness prevention is linked to good relationships with families and respect to ancestors. The traditional model of health beliefs encompasses traditional Chinese and Ayurvedic medicine which is practiced in Asian and Indian sub-continent countries. Zwi et al. further stated the body, natural environment, relationships, and the supernatural are all connected, and these connections are regulated by managing opposites and similarities, balancing hot and cold, ying and yang, and the flow of chi/energy. Illness prevention is the maintenance of connections and the balance and

harmony in one's life. During complex medical problems patients that held multiple beliefs, or adhered to concepts that crossed models, tended to show dominance in traditional health beliefs and cultural practices.

According to Barker et al. (2017), the use of food, plants, and botanical products to prevent illness and restore health has been used by cultures from Asia, Latin America, and Europe since Greco-Roman times. Latinos in California's central valley believed salt to have healing properties that maintain thermoregulation, heat exhaustion and dehydration, and hot-cold equilibrium. Salt was also used to treat stomach aches, fever blisters, pain, swelling, mosquito bites, and foot soaks. High blood pressure was treated with dark soda or coffee with a pinch of salt. The goal of preventive medicine in the Latino population was to reduce the risk of extreme/quick exposure to additional hot/cold elements that would cause an imbalance.

According to Zwi et al. (2017), America, Australia, and other western countries are individualistic societies meaning that health decisions are made by the individual. Collectivist societies; Chinese, Japanese, African American, Indian, and Aboriginals consider the needs of the family over the individual. Akita (2017) stated Latin America is in the middle of the societal spectrum and while maintaining native influence, contains an overwhelming western culture in tradition, language, and consumer products. Incorporating the individuals' cultural preferences builds trust with the healthcare provider.

Effects on Preventive Health

Primary Care Providers

According to Hu et al. (2016), routine access to a primary care provider has been shown to improve patient outcomes and reduce health disparities. McCoy et al. (2016) conducted a randomized community study to examine the distribution and characteristics of access to healthcare via a PCP. MSFWs in and around Immokalee, Florida participated in a human immunodeficiency viruses (HIV) risk reduction intervention, a significant difference was found between those who stated they had a PCP and those that did not. The majority of Hispanic (62.6%) participants did not have a PCP. MSFWs who were undocumented were not eligible for Medicaid and documented workers have a five-year waiting period to enroll creating barriers to care. The access to healthcare was measured by whether or not the participant had a PCP. The McCoy et al. study showed a strong correlation between having insurance and a PCP. Farmworkers who lived in Immokalee for more than five years tended to be more financially stable and had a PCP. Ultimately, community and migrant health centers should tailor their services to improve the connection to a PCP and access to healthcare.

Patient preferences and primary care involvement were found to be crucial components in matching farmworkers to appropriate services (Herman et al., 2016). Healthcare providers who were perceived as disrespectful inhibited the delivery of healthcare services to MSFWs. MSFWs expressed barriers within healthcare practices as lack of an interpreter, waiting time, attitude of staff, lack of child care services, and hours of service (Schmalzried & Fallon, 2012). Immigrants of Mexican descent specifically

reported barriers of cultural beliefs and experiences, long work hours, inflexible health services, fear of immigration enforcement and inadequate English skills to use preventive and routine services (Carvajal et al., 2014). Understanding humoral theory, the "balance between key material or metaphoric elements necessary for health," assisted PCPs in understanding the health practices of the population and devised education that related to the beliefs of the client (Barker et al., 2017, p. 2). The belief in many Latin American cultures was that an imbalance in the humoral elements (hot/cold/ and wet/dry) results in illness or disease (Barker et al., 2017). Ethnocentric physicians who were unable to recognize their bias and identify cultural differences, inhibit a therapeutic relationship with multicultural patients. Zwi et al. (2017) noted strict compliance to evidence-based care without cross cultural communication can have negative effects on health plan compliance. Kirk et al. (2014) noted patients who reported lack of culturally competent communication with their healthcare provider had an AIC 1% higher than those patients with positive patient-provider communication. Improving healthcare workers' cultural competence and recognizing patient preferences will assist providers in matching farmworkers to appropriate healthcare services.

Health Promotion Strategies

Effective health promotion strategies should mitigate the stressors/barriers of the local population being served (Carvajal et al., 2014). Participation in screening programs have been low due to the geographic or physical location, farmworkers transportation issues, and conflicts with work schedules (Luque et al., 2012). Mobile clinics at nontraditional locations could increase access to prevention services. Vaccine telephone

outreach programs were received in a positive light, but migrant workers frequently changed address and phone numbers (Brown et al., 2016). Latinos found traditional media, radio, and printed fliers from church, physicians, and schools' credible sources of healthcare information (Arcury et al., 2017; Cassady et al., 2012). However, Tovar-Aguilar et al. (2014) found word of mouth was the most effective tool to provide health and safety information to farmworkers. Zwi et al. (2017) concluded that staff trained in cultural competency, used multidisciplinary teams, kept clinics open longer, decreased the cost of services, provided transportation, offered home visits, and advocated for MSFWs in the community would increase access to healthcare. Ingram et al. (2015) concluded that community health workers could bridge the cultural gap between its residents and the healthcare system, creating a voice for its residents to define their healthcare needs. Effectively implementing strategies to mitigate barriers in the community served.

Cultural Competence

Healthcare providers could gain a better understanding of their patients and improve the physician-patient relationship by learning the local cultural/folk practices such as hot and cold therapy and food preparation (Kirk et al., 2014; Schmalzried & Fallon, 2012; Shearer, 2016). A healthcare provider's understanding of cultural beliefs, cultural preferences, and use of cultural competence could have a positive effect on health disparities (Kirk et al., 2014). Health disparities increase when farmworkers move from one geographic area to another and a period of acculturation occurs when attempting to take on the habits, language, and patterns of the local majority (Hall et al.,

2016; Zwi et al., 2017). Migrant families had a variety of social needs with each migration such as education, housing, and employment which often take precedence over health needs during acclimation. A lack of consistent healthcare access increased chronic illness (Hall et al., 2016; Zwi et al., 2017). A better understanding of these barriers will assist healthcare workers in promoting preventive care with migration.

A phenomenological, qualitative study explores how human beings make sense of experiences and convert them into consciousness. In-depth interviews with farmworkers who had lived-experiences with barriers to care explained their perceptions and behaviors (see Patton, 2015). The farmworker's culture and experiences dictated the response to health-related issues.

Summary and Conclusions

The major themes and deficiencies discovered in this literature review on MSFWs health beliefs and how it effects preventive healthcare were use of health beliefs, participation of primary care providers, health promotion strategies, and cultural competence of healthcare staff. Patients that held multiple beliefs tend to show dominance in traditional health beliefs and cultural practices. PCPs were found to be a crucial component in matching farmworkers to appropriate healthcare services. Health promotion strategies should mitigate the stressors/barriers of the population being served. A healthcare provider's understanding of cultural beliefs, cultural preferences, and use of cultural competence should improve the physician-patient relationship, decreasing healthcare disparities.

Rural residents placed little importance on comfort and life-prolonging preventive measures. The connection between RNT concepts and general nursing knowledge is understanding the client's health behaviors and planning healthcare services accordingly. Researchers have learned that MSFWs encounter general barriers when accessing healthcare. Since farmworkers equate health with the ability to work, healthcare programs need to be available outside work hours and farming seasons.

The literature reviewed on rural dwellers and farmworkers included studies consisting of all white participants with no feelings of isolation or lacking transportation. The sample size of many studies was small, lacked diversity, and were conducted in only one or two locations making it difficult to transfer the results to other locations. All but a few studies completed in the southeastern United States related to occupational injuries and neglected preventive health issues. A gap exists between farmworkers and the healthcare system.

Community health workers could bridge the cultural gap between rural residents and the healthcare system, defining specific healthcare needs. Understanding the MSFWs health beliefs and how it affected preventive healthcare would broaden the knowledge base of needed services. Preventive programs that fit the health beliefs of farmworkers would increase the success of community interventions, therefore decreasing chronic illness, increasing quality of life, and decreasing cost of long-term healthcare (USHHS, 2016).

An exploration of structural factors that impeded healthcare was needed to improve conditions in the community. A healthcare provider's understanding of cultural

beliefs, cultural preferences, and use of cultural competence are part of the provider-patient relationship needed to close the gap in healthcare disparities. The acknowledgement of a patient's health beliefs from the healthcare provider validated the patient's perceptions and built trust within the community. I provide details on the research method and data analysis in Chapter 3.

Chapter 3: Research Method

The purpose of the study was to understand MSFW's health beliefs, health seeking behaviors, and how they describe usage of preventive health services. A broader knowledge base of farmworker beliefs and service needs will decrease chronic illness, increase quality of life, and decrease cost of long-term healthcare (USHHS, 2016). The concepts I sought to identify were the health beliefs and health seeking behaviors of Hispanic MSFWs living in rural areas. The research design of this phenomenological study, role of the researcher, participant selection, procedures, and analysis of the data collected are discussed in Chapter 3.

Research Design

The following research questions guided my study:

RQ1: What are the prevention health beliefs of Hispanic migrant and seasonal farmworkers in the southeastern United States?

RQ2: What is the prevention health-seeking behaviors of Hispanic migrant and seasonal farmworkers in the southeastern United States?

RQ3: How do Hispanic MSFWs describe their usage of preventive health services in the southeastern United States?

I used a phenomenological qualitative research design and the RNT as a framework to address the barriers to care for MSFWs such as work and health beliefs, isolation and distance, self-reliance, and outsiders/insiders. Colorafi and Evans (2016) stated qualitative studies are suited for the health sciences as they provide factual

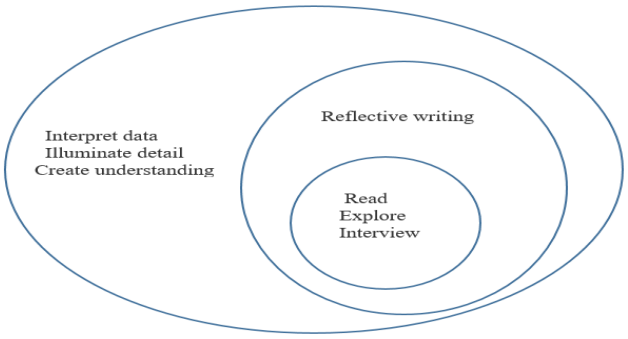
responses to questions about people's feelings toward a specific space, its features, and the people using them.

Phenomenological research, rooted in philosophy and psychology, focuses on the lived experience of individuals who have experienced the same phenomenon. (Creswell, 2014; Patton, 2015). The hermeneutic phenomenological research paradigm is based on ideas, "a loose collection of logically related assumptions, concepts, and propositions that orient thinking and research," negotiated by scholars over time (Kafle, 2011, p. 193). A phenomenological, qualitative inquiry analyzes an experience to find common elements within specific societies; how words, concepts, and theories shape the experiences of an individual life. Phenomenology is not a fact-finding inquiry looking for generalizable answers. Instead, transferability is based on the ability of the study's findings to be transferred to a similar situation with different individuals and settings (Pratt, 2012). The aim of phenomenology is to provide an explanation of the participant's perception and individual beliefs (Charalambous et al., 2008). Hermeneutics provides nursing with a philosophical stance imbedded in subjectivity; supports an individual's perception and beliefs providing an explanation of their meaning (Charalambous et al., 2008). Figure 2 provides a visual representation of the hermeneutics research cycle. Phenomenology is the study of a human being's experience and hermeneutics is the meaning of the experience (Pratt, 2012). In-depth interviews revealed how MSFWs explain their perceptions and health seeking behaviors in relation to preventive health (see Patton, 2015). The farmworkers' experiences dictate the response to health-related issues. To study a culture, a researcher must respect, appreciate, and seek to preserve the values and

ways of the culture (Groves et al., 2013). The researcher must identify and manage bias throughout the study.

Figure 2

Hermeneutic Research Cycle



The researcher's understanding of a phenomenon is only a partial view of the experience. According to Kafle (2011), the challenge to understanding it is to take what is described without inserting a preconceived bias due to their own experiences. However, the researcher does need a basic knowledge of the phenomenon they wish to study to connect with the individuals who are telling of their experiences. Kafle reviewed several author's approaches to hermeneutic phenomenological methodology, a nonlinear and a systematic approach. The nonlinear approach suggests six activities to explore a phenomenon: "commitment to an abiding concern, oriented stance toward the question, investigating the experience as it is lived, describing the phenomenon through writing and rewriting, and consideration of parts and whole" (Kafle, 2011, p. 191). The systematic approach suggests the following steps: locate participants, select data collection techniques, data storage methods, data analysis strategies, and validation and

truthfulness techniques. My research design, role as the researcher, participant selection, procedures, and analysis of the data collected are discussed in this chapter.

Role of the Researcher

The researcher is the primary instrument of qualitative research (Ravitch & Carl, 2016). The researcher as an instrument may introduce strategic, ethical, and personal bias into the study. The application of academic principles was used in the pursuit of the MSFW's perception which includes the exploration of collected knowledge of their life experiences. Bias can occur if a researcher views people from a cultural group as lacking certain knowledge or creating a power dynamic (inequality) in the research relationship. However, a shift to resource orientation allows the researcher to recognize the strength, skills, and knowledge of individuals as the lens in which to view self and others (Ravitch & Carl, 2016). I managed researcher bias by using field notes to document my feelings for examination after the interview, authentic collaboration and mutual influence. Authentic collaboration identifies and acknowledges the differences and stances on local issues with those that are interviewed (Ravitch & Carl, 2016). Mutual influence drives both parties to interact, learn, shift, and change relationally.

As the interviewer, I was an observer-participant recording responses and observing verbal responses. As a Caucasian female my social location may have been an obstacle. I am not fluent in the native language(s) of the Hispanic MSFW. The reflexivity process of self-awareness provided reminders that MSFW priorities may differ from my own. As a community volunteer, nurse, and community member I have some experience with the healthcare needs of MSFWs. However, acknowledging stereotypes upfront

regarding race, age, class, gender, ethnicity, or sexual preference with the interviewee opens communications. Inviting the participants to be educators of their experiences dispelled misconceptions for the researcher (Rubin & Rubin, 2012). Interviews were conducted via telephone and/or in a place of the participant's choosing. Due to the COVID-19 pandemic, face to face interviews were delayed.

I had no direct reports or instructor relationships with the interview volunteers. Volunteers were recruited from the community. No gatekeeper or community stake holders (businesses, community groups, organizations, or associations) were involved in the participant selection process.

Methodology

The RNT provided a framework to address the barriers to care for MSFWs such as work and health beliefs, isolation and distance, self-reliance, and outsiders/insiders (see Winters, 2013). Rural dwellers require a unique approach that addresses the special needs of the population. "How people define health and illness has a direct impact on how they seek and use healthcare services" (Winters, 2013, p. 8). Duplicating an urban nursing model for use in a rural area would be inadequate to fulfill the needs of the MSFW.

Participant Selection

Participant selection included MSFWs over 18 who are English speaking individuals who work on a farm and relocate their residences during the growing season to follow the crops and farmworkers who remain in the same residence but travel a wide geographic area to work with different employers and crops during the growing season.

Purposeful sampling is the method of selecting participants that are unique as their experiences, roles, perceptions, relationships, and/or occupations can answer your research questions (Ravitch & Carl, 2016). I used the purposeful sampling method to recruit the first two participants for my study.

According to Walden University (n.d.), a phenomenological approach using in-depth interviews requires five to 10 participants to reach saturation. Creswell (2014) suggested three to 10 participants to examine the lived experience of MSFWs however, there is no exact number to standardize qualitative research. In-depth interviews provide information from a small group which can be valuable if it is information-rich (greater depth, less breadth; Patton, 2015). Fewer participants, due to limited time and resources, allows for a narrower focus that is open to what emerges. Flyers were placed in the local tattoo parlor, a private gym, laundry mats, libraries, and in rural newspapers. Flyers were also distributed to three Florida farm owners and supervisors. Due to COVID-19 the first two participants were telephone interviews. The first two participants were a product of purposeful selection. I screened respondents to the flyer with selection criteria questions such as Are you a migrant or seasonal farmworker? Are you over 18 years of age? and do you speak fluent English? I requested MSFWs recommend new participants for this study (snowballing). From the initial referrals, my goal was to recruit seven to 10 additional enculturated participants from those interviewed (see Ravich & Carl, 2016). I had 14 participants in my study.

Instrumentation

In-depth interviews were used to explore the MSFW's health beliefs regarding preventive healthcare. Participants provide historical information while the researcher maintains control over the line of questioning. The participants were interviewed via phone at an appointed time or in face-to-face interviews in an agreed upon location. Informed consent was obtained. Creswell (2014) suggested an interview protocol for asking questions and recording the data. An interview guide (Appendix D) and field notes (Appendix E) were used to guide the event and document actions and emotions that cannot be picked up with the audio-recorder. The interview guide is a predetermined introduction, a set of interview questions, and a conclusion to guide the researcher and provide a uniform plan for each interview. All forms are published materials modified to fit the need to the interview.

Procedures for Recruitment, Participation, and Data Collection

Initial contact with a potential participant can occur through a letter or acquaintance, a personal introduction will provide credibility as they vouch for the researcher (see Rubin & Rubin, 2012). Latino immigrant parents in hard-to-reach rural areas of California suggested community health messages be delivered by radio and fliers from church and their children's schools as small media is viewed as believable sources of health information (Cassady et al., 2012). Interviewees feel important when approached as the most experienced worker (Rubin & Rubin, 2012). Ultimately, handing out flyers at the farmer's market was more successful than the newspaper ads.

Data Collection

I collected data by conducting semi-structured open-ended interviews, using an audio-recorder (with consent) to be transcribed later. I created an interview guide (Appendix D) with my questions. I kept field notes (Appendix E) to describe the location, what happened during the interview, how long it lasted, and what was learned from the participant (see Rubin & Rubin, 2012). I planned to do one interview per day, with a goal of 30 days for completion. Snowballing did not produce a sufficient participant pool. So, I posted flyer ads in the surrounding communities' newspapers and handed out flyers at the farmer's market.

Emergent design is a real time approach to research design, data collection, and data analysis that developed in response to what was learned, an ongoing recognition of local talent, resources, knowledge, and concerns. Emergent design seeks to develop the research data into an educational approach that resonated with the local experience, culture, interest, and experience (Ravich & Carl, 2016). The relationships built during the research process needed to occur without imposing outside, academic, and Western ideals upon the participants.

Participants were offered the opportunity to read interview dictation after I reviewed transcripts. A debriefing at the end of the interview advised participants of the opportunity to member check data and the participant's contact information would be collected. Member checking allows participants to read the final report to verify accuracy of the data collected (Creswell, 2014). Participants declined the member checking opportunity.

Data Analysis Plan

Data organization and management was an ongoing process. I stored the data on a password protected personal computer and backed up in the Goggle cloud. I transcribed audio files and conducted precoding, coding, and analysis so I could identify similarities that connected statements or events. Connecting strategies assisted me in identifying similarities in the data (see Ravitch & Carl, 2016). A binder using handwritten notes was used along with computer software.

I used open coding using Computer-Assisted Qualitative Data Analysis Software (QDAS) to compile data. QDASs can retrieve data from Word or Excel, sort and combine data, search for key words or phrases, and retrieve passages connected to codes. The more sophisticated QDAS programs will suggest connections between data (Rubin & Rubin, 2012). However, the QDAS programs do not conduct data analysis, which is a task that I completed. The QDAS, Atlas.ti (2018), includes key features such as the display of semantic links, multiple language capability, works with multiple documents simultaneously, imports reference materials, and projects can be shared through multiple devices (laptop/desktop). Dictation, field notes, and audio files were uploaded into Atlas.ti after each interview.

Issues of Trustworthiness

The internal validity of my research was established by methodological triangulation, saturation, and reflexivity. Methodological triangulation includes interviews, an observation sheet, field notes, and an interview guide to collect data. Ongoing data analysis reaches saturation when nothing new is being learned from the

information-rich interviewees (Ravich & Carl, 2016). My beliefs, social experiences, schooling, emotion, and culture may not be subjective. I used bracketing during the interview process to concentrate on the experience being studied.

External validity includes a rich description of the data so that other researchers can compare your results with other contexts (transferability). A solid research design as described in Chapter 3 lend to dependability, using in-depth interviews to answer the phenomenology research questions. Confirmability is the ability to confirm your data through reflexivity and triangulation (Ravich & Carl, 2016). There will be no intra or inter coder reliability as I am the only coder.

Ethical Procedures

In 2015, I completed the National Institute of Health's ([NIH], 2018) certified training course "Protecting Human Research Participants", certificate number 173760. The NIH course met the Walden requirement for research training. I received institutional review board (IRB) approval from Walden University on October 30th 2019. The approval number for my study is 10-30-19-0081611. A renewal for one year was obtained in October 2020. There were no community partners or stake holders, so I was not required to have an additional institutional review board application or letters of cooperation for community interviews. Undocumented MSFWs are considered a vulnerable population and I had concerns that participation in research might incriminate them as illegal immigrants (Walden University, 2018). I did not question their citizenship status. According to Florida's Statute (2018), chapter 395.1041, section 2f, access to emergency services and care "in no event shall the provision of emergency services and

care…be based upon citizenship…insurance, economic status, or ability to pay for medical services" (para. 12). No obligation to report an undocumented worker was found in the Florida Statues. Because 68% of MSFWs are of Mexican origin ethnicity was a sensitive topic. Discussing my social location at the beginning of the interview may have dispelled misconceptions about my research purpose.

Informed consent was reviewed to include the voluntary nature of the study and the risk and benefits of participating in the study. There were no adverse effects for refusing to answer any questions or withdrawing from the study early. I changed participant names to participant #1-14 to protect confidentiality and store the actual names, voice, and transcript data on a password protected computer and in the Goggle Cloud. A research specific digital recorder was locked in a fireproof box when not in use. Coded data access was limited to my dissertation committee members at Walden University. I may publish the findings of my study in a nursing journal at a future date.

Summary

The purpose of the study is to understand the MSFW's health beliefs, health seeking behaviors, and how they describe usage of preventive health services. A phenomenological qualitative research design using the RNT as a framework addressed the barriers to care for MSFWs in the southeastern United States. Hermeneutics provides nursing with a subjective design that supports an individual's perception and beliefs while providing an explanation of their meaning.

As the researcher, I was an observer-participant recording verbal responses and observing emotional and physical responses. As a Caucasian female my social location

may have been an obstacle. I am not fluent in the native language(s) of the Hispanic MSFW. However, as a community volunteer, nurse, and community member I have some experience with the healthcare needs of MSFWs. I used the reflexivity process of self-awareness to remind myself that MSFW priorities may differ from my own.

Participant selection included five-15 MSFWs over 18 who were English speaking, individuals who work on a farm and relocate their residences during the growing season to follow the crops and farmworkers who remain in the same residence but travel a wide geographic area to work with different employers and crops during the growing season. I recruited participants using flyers placed in the local tattoo parlor, a private gym, laundry mats, libraries, rural newspapers, and handing out flyers at the farmer's market. I collected data by conducting semi-structured open-ended interviews and offered the participants an opportunity to read interview dictation after I reviewed the transcripts. I stored the data on a password protected personal computer and backed it up in the Goggle cloud. I used open coding with Computer-Assisted Qualitative Data Analysis Software (QDAS) to compile and make connections within the data.

The internal validity of my research was established by methodological triangulation, saturation, and reflexivity. External validity included a rich description of the data so that other researchers can compare their results with other contexts (transferability). As undocumented MSFWs are considered a vulnerable population the IRB reviewed my proposal for any potential harm that may occur during the research process.

Chapter 4: Results

The purpose of my study is to understand the MSFW's health beliefs/health seeking behaviors, and how MSFWs described usage of preventive health services. Health beliefs were usually secondary to work and assessed in relation to work and its activities (Long & Weinert, 1989). The research questions I explored were as follows:

RQ1: What are the prevention health beliefs of Hispanic migrant and seasonal farmworkers in the southeastern United States?

RQ2: What is the prevention health seeking behaviors of Hispanic migrant and seasonal farmworkers in the southeastern United States?

RQ3: How do Hispanic migrant and seasonal farmworkers describe their usage of preventive health services in the southeastern United States?

The setting, demographics, data collection techniques, data analysis process, evidence of trustworthiness, and results are discussed in Chapter 4.

Settings

The setting did not have any personal or organizational connections that influenced the study. No contracts or budgets contributed to or influenced the study. The COVID-19 pandemic did not seem to interfere with the workings of the market; booths were open, no owner/worker wore a mask or eyewear, approximately half of the shoppers were wearing masks. Each booth was approximately 400 sq feet and had a small personal area in the back providing privacy for the interview.

Demographics

I interviewed 14 seasonal farmworkers who identified as Mexican and Hispanic: 13 Mexican and one Hispanic. Three of the interviewees where female and 11 were male. The ages of the interviewees ranged from 21 to 61years. Six of the 14 farmworkers had health insurance and seven reported having a primary care provider. Six farmworkers were born in the United States, two have lived in the United States for over 10 years, and six for more than 20 years.

Table 1

Demographics

Age Range	Female (3)	Male (11)	No PCP (7)	Yes PCP (7)
20-29		3	2	1
30-39	1	3	1	3
40-49	1	1	1	1
50-59	1	3	2	2
60-69		1	1	

Data Collection

Snowballing did not produce a sufficient participant pool, so I published an ad in two rural newspapers read by the farming community. I received no responses from the newspaper listings from May 2020-August 2020. Due to the COVID-19 pandemic, I was unable to complete face-to-face interviews for several months per Walden University's guidelines. When face-to-face interviews resumed, I wore a face mask, eyeglasses, and used hand sanitizer. None of the farmworkers at the market wore a mask. No hand sanitizer was present in the individual booths.

Data were collected by telephone and face-to-face interviews. The two telephone interviews were conducted in the summer of 2020. The telephone interviews were digitally recorded. Twelve face-to-face interviews were conducted in the Spring of 2021 on two separate days at an outdoor farmers market. I conducted six interviews each day. Each interview took approximately 20-30 minutes. I recorded the face-to-face interviews by hand with paper and pen.

I attempted to engage the community at four health fairs prior to the farmers market without success. My first four attempts at the farmers market to engage with the farmworkers also resulted in failure. Using my preplanned introduction, the response to participate was either “no” or “no hablo English”. The farmworkers would not speak with me when a recorder was present, even a clipboard gave them pause. The first market day I wore the Walden University polo and slacks. A Spanish speaking colleague accompanied me to the farmers market, she stood back, watched, and listened to my preplanned presentation and offered feedback. My colleague suggested I put away the clipboard and the recorder and rephrase my introduction. The second market day I wore a nursing T-shirt and used a small notebook and pen. Reluctant participants were given an introduction to my study in Spanish. Once the introduction was complete, farmworkers were willing and sometimes eager to participate, their ability to speak English improved with knowledge of my intentions. Each booth was approximately 400 sq feet and had a small personal area in the back. Farmworkers preferred to answer questions today rather than schedule an appointment with me at another location on another day.

The newspaper ad and the farmers market were recruitment strategies added to the approved data collection plan when snowballing did not occur. The IRB reviewed my initial contact with the farmworkers and the interview process at the market. The IRB concluded that no harm came to the participants during data collection and approval to continue data analysis was granted.

Data Analysis

Data analysis began with precoding during the first interview; using field notes to annotate an observation or personal feeling. Although I intended to use open coding to sort and combine data and search for key words or phrases, I decided I needed a more descriptive method. I chose Saldana's (2016) cycle coding; first and second cycle coding with pattern coding in the second phase. All 14 interviews were used in the analysis as there were no divergent cases. I codified the data and arranged it systematically into categories. Saldana's coding allowed data to be grouped, organized, and reorganized into a meaningful explanation during the two identified phases.

The two telephone interviews were recorded, and I transcribed the data manually the same afternoon. Ravitch and Carl (2016) considered these transcriptions real-time data. The field notes for those calls consisted of activities that interrupted the interview on the other end of the line. Face to face interviews were conducted on two different days at the farmer's market: six interviews each day. Although I intended to do one interview per day, it would have taken 12 weeks to complete this task using the marketplace. Handwritten notes and initial jottings were taken as the farmworkers did not wish to have a recorder present. None of the interviewees volunteered to participate in the opportunity

to read interview transcripts once dictation was complete; the market farmworkers did not wish to share personal contact data. It took several days after each market day to transcribe all six interviews. My field notes were helpful in keeping each interviewee fresh in my mind. No farmworker expressed a divergent view from the group.

Phase 1

Each transcript was used as a unit for data analysis. I began with a generic descriptive coding in the first cycle creating a detailed inventory of the data topics like a word or short phrase, the "basic topic" of qualitative data (see Saldana, 2016). I looked for patterns, repetitive data that appeared more than twice, words and phrases that repeated as each interview was conducted and transcribed. Since I transcribed the data myself, I was able to reflect on each unit as it was added to the collective. Transcripts, field notes, and demographics were added to a binder for easy viewing prior to uploading into Atlas.ti. The initial analysis of the data was reviewed on paper. I got overwhelmed looking at the whole project. I decreased personal bias by jotting my feelings of the experience onto the field notes and reviewing them later. After each transcription I reread the data and used sticky notes tallying different data topics for later analysis. The iterative process yielded 51 initial basic topics.

Phase 2

The descriptive coding in Phase 1 progressed through inductive reasoning to categories in Phase 2. I used Saldana's (2016) In Vivo coding in the second cycle, using words and phrases to gain the perspective and actions of the interviewees. Atlas.ti, a computer-assisted QDAS, was used to compile and make connections within the data.

The 51 basic codes were reviewed, manually entered, and grouped into color coded categories in Atlas.ti. A code manager Excel sheet was exported, which provided the codes and categories at a glance. Manual transcripts were uploaded as Microsoft Word documents and handwritten notes were scanned as PDF documents into the Atlas.ti program where cycled coding was used to sort data and create datasets. I found it easier to inductively analyze the data on paper. Saturation was achieved during the second market day interviews. In Phase 2 themes emerged that reflected the research questions. No farmworker expressed a divergent view from the group.

Organization of Codes and Categories

Code development began with a descriptive coding list in the first cycle to In Vivo coding in the second cycle. Progression from data topics to participant phrases organized by research question. In Phase 2 the categories were further sorted into themes which in turn reflected the research questions: definitions of health, health beliefs, health behaviors, and usage of preventive health services. The additional categories created during the second cycle, outside the three research questions, assisted in my refining the worldview of the participant: parent's health and treatment of illness, whether they were treated well at last visit, the reason for last visit, relationship with their PCP, and did they feel the area had the preventative care they needed.

Relationships of Codes and Categories

Once the code manager was exported, I created a visual representation of the codes and categories separated under each research question. The final categories are displayed with their code lists (see Figures 3, 4, and 5).

Figure 3

Relationships of Codes, Categories, and Themes: Health Beliefs

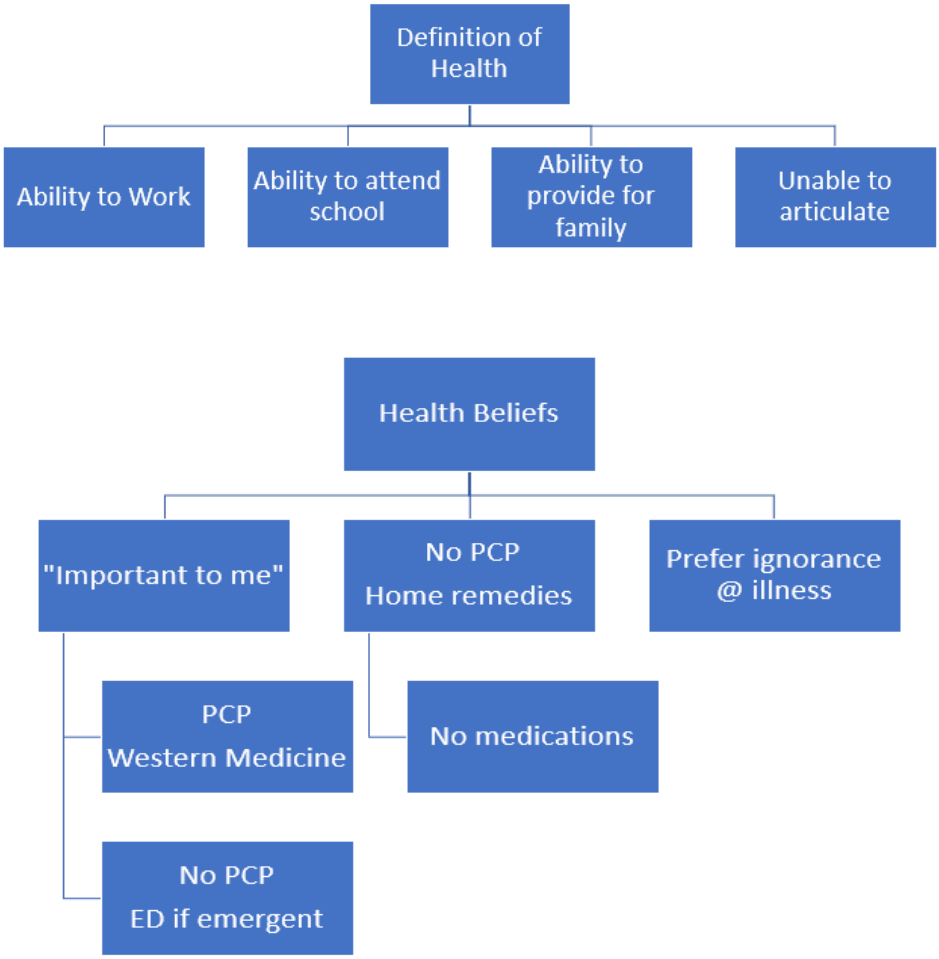


Figure 4

Relationships of Codes, Categories, and Themes: Health Behaviors

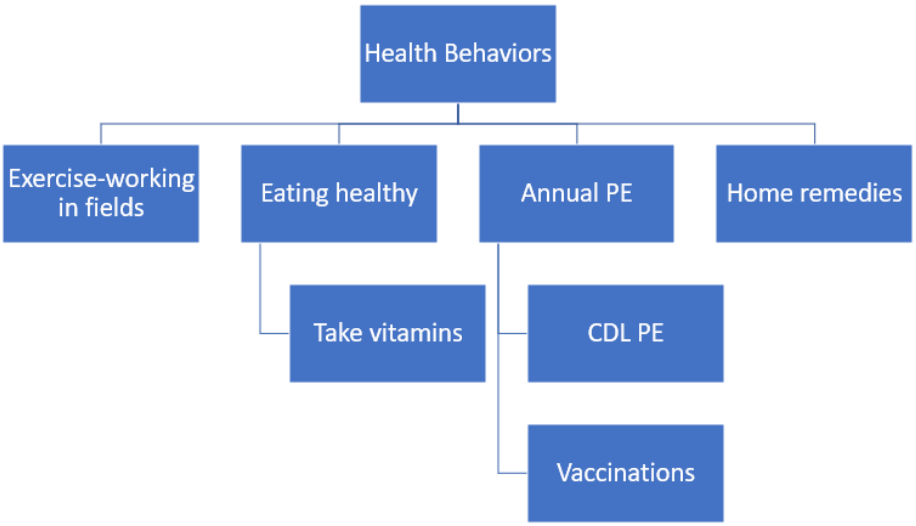
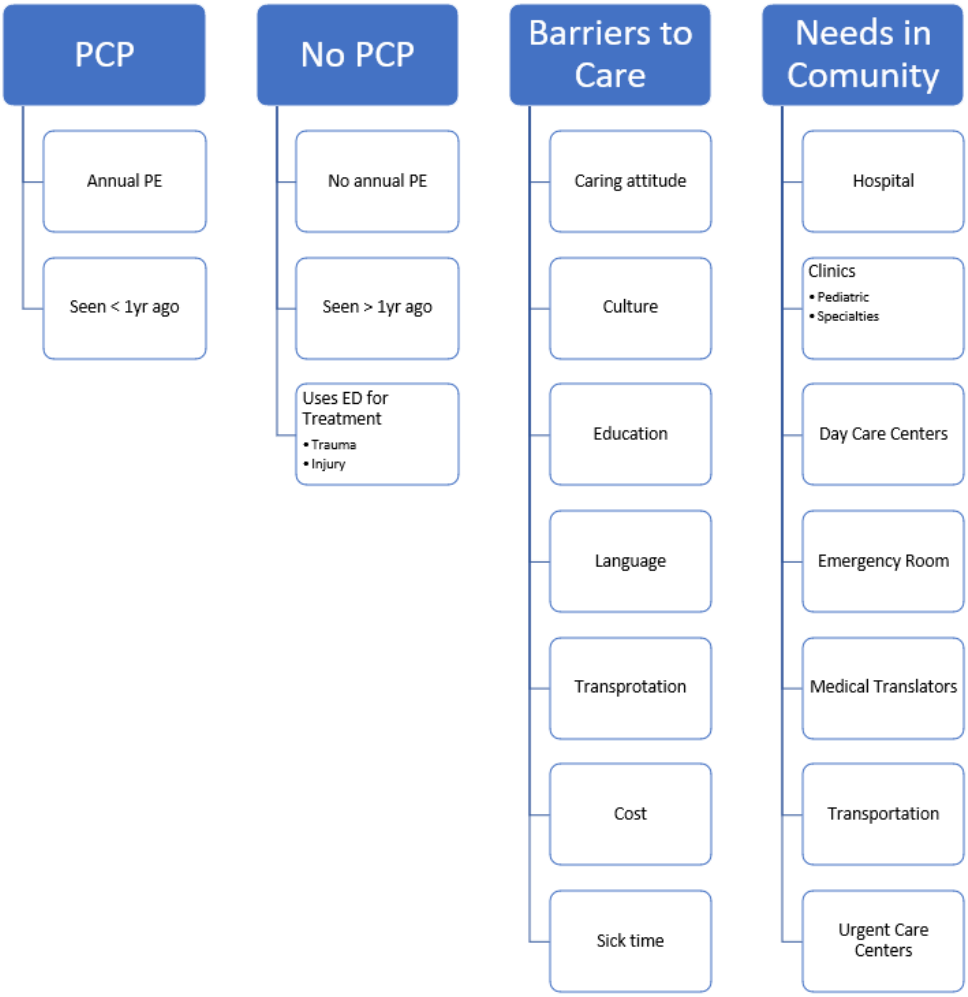


Figure 5

Relationships of Codes, Categories, and Themes: Usage of Preventive Health Services



Thematic Analysis Process

I reviewed and reorganized the codes and categories each phase, identifying patterns and making manual connections between the data with each additional transcript. The code manager kept an updated list of codes and categories. The inductive process

resulted in four major themes that emerged from the final categories: definition of health, health beliefs, health behaviors, and usage of preventive health services.

Evidence of Trustworthiness

Credibility was established by methodological triangulation, saturation, and reflexivity. I conducted face-to-face interviews and phone interviews using an interview guide, an observation sheet and field notes to collect data. The two recorded interviews were transcribed and are considered real-time data (see Ravitch & Carl, 2016). My field note scribbles were turned into fuller field notes over several days following the market day session; transcribing the spoken interview into a written record. A number was assigned to each interview, data were numbered and documents were uploaded, compiled, and coded in Atlas.ti. Atlas.ti is an instrument that allowed me to make meaningful inferences as a researcher (see Ravitch & Carl, 2016). The field notes and reflections on each interview provided reflexivity; evaluation of my presence and tools upon the interviewee.

Transferability was achieved with in-depth interviews. The greater the grasp of English of the participant, the more details emerged regarding their health behaviors and beliefs. Participants with a lesser English vocabulary gave shorter answers to the questions asked. However, the basic data points were captured and can be used for comparison. Future researchers should consider environmental context when attempting to replicate a similar study in their region (Ravitch & Carl, 2016). The ability to speak Spanish would have allowed me to better communicate with the interviewee.

Dependability was achieved by using the same approach to the in-depth interviews. One geographical location (city) was used to gather data about the area. The participants were all Mexican/Latino giving a similar community-based testimony to the data (see Ravitch & Carl, 2016). All participants were seasonal workers, the migrants had already begun leaving the area when the interviews began. Adjustments to the data collection props and plan early in the interviews produced a consistent interview style.

Confirmability is the ability to confirm data through reflexivity and triangulation. My experience as a nurse and an educator lends me multiple perspectives on health beliefs and behaviors; culture, ethnicity, and race. I believe myself able to step back and seek the nature of the research question. Data triangulation was achieved through interviews done on separate days at different times with varied age groups; field notes were used to describe the interview atmosphere and environment (see Ravitch & Carl, 2016). The field notes assisted me to find meaning and explain the social context through the experiences of the participants.

Results

Fourteen participants were interviewed. The participants were asked nine questions aligned with my three research questions. The research questions were created to support a phenomenological qualitative research design using the RNT as a framework to address the barriers to care for MSFWs. I used a demographic sheet, field notes, and an interview guide during each semi-structured interview. The questions were created to understand the participants' definition of health, health beliefs, health behaviors, and

perception of preventative health in the southeastern United States. The interview guide included the following questions:

1. Tell me how you stay healthy (if migrant during migration).
   a. Do you get annual check-ups?

2. What does health mean to you?
   a. Explain

3. What type of illness or injury takes you to visit your doctor? How often do you go to the doctor?
   a. Why did you go the last time?

4. What helps you get to your doctor appointments? What keeps you from going?
   a. Can you give me some examples?

5. What did your mom and dad do when you were sick as a child?
   a. How did your parents treat illness?

6. Is there a resource that would assist you in using health services?

7. Tell me about your last experience with preventive services in Florida.
   a. Did you attend a health fair or doctor's office?

8. What are your thoughts about the preventive services in SW Florida?
   a. Can you get what you need locally?

9. Tell me about your relationship with your primary care provider.
   a. How are you treated at the doctor's office?

The categories began as basic topics; words and phrases; the responses to the original nine questions. Four main themes emerged from the inductive data analysis; definition of health, health beliefs, health behaviors, and usage of preventive health services. No one participant presented data that diverged from the group. However, age groups had conflicting comments as their family dynamics and world views differed. The

data from the participant's responses guided In Vivo coding in Phase2. In this section I provide participant quotes to illustrate thematic development by research question.

Research Question 1

What are the prevention health beliefs of Hispanic migrant and seasonal farmworkers in the southeastern United States? The prevention health beliefs of Hispanic migrant and seasonal farmworkers in the southeastern United States viewed health as important. However, they viewed going to work as more important than taking time off for preventive appointments. When asked what does health mean to you, 11 participants stated almost identically, the ability to go to work. Many interviewees felt that going to work, the physical rigor of farm work as exercise kept them healthy.

Participant Response Examples

Definition of Health/Health Beliefs.

- "I can live longer and take care of my family" (Participant one).
- "I am able to get out of bed and be more active with my kids; to be able to stay up and not be so sleepy, tired, and lazy" (Participant two).
- "Health is important, [but I] only go to the emergency room if I cannot fix it [injury] at home" (Participant three).
- "I stay healthy so I can work," but could not elaborate on his health beliefs or routine (Participant four).
- "Staying healthy means a lot to me," but he was unable to articulate what health meant (Participant five).
- "The ability to go to work" (Participant seven).

- "Being able to provide for her kids and the people in the community" (Participant eight).
- "Mexicans do not want to know what we have, [my parents] did not go to the doctor" (Participant 11).
- "Health is important, I need to work and take care of my family" (Participant 12).

Research Question 2

What is the prevention health seeking behaviors of Hispanic migrant and seasonal farmworkers in the southeastern United States? The prevention health seeking behaviors of Hispanic migrant and seasonal farmworkers in the southeastern United States were exercise (work), eating healthy, and annual physicals. The two male interviewees without insurance, age 30 and 35, only sought a physical to meet the commercial driver's license (CDL) renewal criteria. The seven with primary care providers who received annual physicals ranged in age from 21-52 years; three females and four males. The remaining five used the emergency room for any health requirements. Home remedies were taught to 9 participants as children and are still used by only three participants today. The seven participants who have a PCP were seen in the office within the last year. The seven who do not have a PCP were seen greater than a year ago and only for an injury or CDL license renewal.

Health Behaviors

- "I stay healthy by doing manual labor; working in the cabbage fields 5 a.m. to 6 p.m. daily" (Participant nine).

- "I take vitamins to stay healthy so I can attend school and go to work" (Participant six)
- "I only go to the emergency room for an injury if I cannot fix it at home" (Participant three).
- A married male with four children stated that "two years ago I started a diet, I eat very healthy. I exercise, do a lot of running." He has taught the children hand washing; "we all wash our hands and stay clean." He reports getting his physical every two years for his CDL license and annual flu shots (Participant two).
- "I do not visit doctors' offices; I only go to the emergency room" [for work related injuries] (Participant four).
- "I see my PCP every six months and attended the flu clinic" (Participant five).
- A 61-year-old male, hasn't been to the doctor in over 20 years. He stated "I eat healthy. I do not take any medications or herbals." However, he "would go to the hospital if it was an emergency" (Participant seven).
- "I eat healthy" (Participant 13).

Second generation Hispanic adult children learned improved health behaviors as they had families themselves; seeking medical attention for their children and improving self-health prevention behaviors. When participant one was a child, her parents were migrant farmworkers who traveled from Georgia to Michigan and back again. "They didn't know [about preventive health] all they did was work and travel." Her mother was

diagnosed with Diabetes at age 25 and is now deceased. Her father received a head injury from a farming accident and has had three strokes; she is now his primary care giver. When asked about her health practices she stated “yes, I do that [annual physical] and get my shots, my flu shot.”

Research Question 3

How do Hispanic migrant and seasonal farmworkers describe their usage of preventive health services in the southeastern United States? Six (42.8%) of the 14 interviewed stated they received an annual physical. Two (14.2%) had a physical every two years. Six (42.8%) did not seek out annual physicals. Hispanic seasonal farmworkers describe their usage of preventive health services in the southeastern United States as “we have what we need, we have what we need, but I don’t use it, we do not have what we need locally so we have to travel to get services, or I don’t know what is available locally.” Many farmworkers were unable to articulate what preventive services they received. If asked if they got a flu shot, they would answer yes or no. Not one answered with a list of services that they sought such as mammogram, prostate exam, immunizations etc. The male farmworkers ages 21-30 who did not mention family had a small worldview; did not know the needs of the community, so unable to articulate if services were available. The participants over 30 or who had families had a larger worldview and identified services that were needed in their area.

PCP

- A 39-year-old mother of two, stated she cannot get her children the care they need; one has asthma and the other autoimmune

disorders. “A [routine] 0900 appointment at the clinic-you will be there until 1pm. [The clinic] triages emergent visits, it can be 30 minutes before you are seen for an asthma attack. Instead, I go straight to the emergency room [50 miles away] where we will be seen” (Participant eight).

- “I follow up regularly with my PCP about my hypertension” (Participant 12).
- “I follow up with my PCP for cholesterol medications” (Participant 13).

No PCP

- I am healthy, I don’t need any preventive services; [local city] has all of the services I need” (Participant six).
- “My mom took me to the doctor when I was little. I do not know [local] clinic hours, I have not used them” (Participant 10).
- A 27-year-old father stated “I have a daughter, but don’t have visitation. I don’t know what services she needs” (Participant 11).
- “I don’t think I am healthy. I occasionally go to the doctor, but I don’t’ have a PCP” (Participant 14).

The National Center for Farmworker Health Inc. (NCFH) (2021) stated agricultural workers would face barriers to seeking COVID-19 vaccinations; transportation, time off work, limited internet access for appointments and language barriers. Two interviewees were well informed on COVID-19 immunization events in the

community. “Farmworkers were turned away from CVS pharmacy because they had not made an appointment online” (Participant eight). Participant nine stated “the 99 Market was giving Covid vaccines free to the community”. COVID-19 information was passed word of mouth among the farmworkers. Additionally, participant nine expressed the need for more health services during season. As well as posting the available services in a place the migrant farmworker could find it.

Summary

My data analysis yielded four main themes to answer the three research questions. *Definition of health* is a collection of phrases that farmworkers used to define what health meant to them individually. *Health beliefs* are phrase(s) that defined how they saw the importance of health in their everyday life. *Health behaviors* are the activities they used to keep themselves healthy. And *usage of preventive health services* are explanatory phrases that described their health care choices and experiences. I provide a discussion, conclusions, and recommendations in Chapter 5.

Chapter 5: Discussion, Conclusions, and Recommendations

The United States has an estimated 2.5-3 million agricultural workers NCFH (2018). The agricultural worker population is comprised of those who migrate (16%) and those who were seasonal (84%; NCFH, 2018). The majority (73%) of agricultural workers were foreign-born, with 68% originating from Mexico (NCFH, 2018).

The 2011-2012 NAWS found 61% of respondents had used healthcare services in the last two years, 41% had seen a private provider, 31% had used a federally-qualified health center, and 12% had used an emergency room (Farmworker Justice & NCFH, 2015). Forty-six percent of respondents reported paying for healthcare services out of pocket. NAWS respondents reported barriers to obtaining healthcare such as cost of healthcare, language barriers, not being treated well due to immigration status, lack of transportation, services too far away, and needed services were not offered (Farmworker Justice & NCFH, 2015). The barriers identified gaps in access to preventive health services.

The purpose of my study is to understand the MSFW's health beliefs/health seeking behaviors and how MSFWs described usage of preventive health services. The two RNT concepts I explored were the health beliefs and health seeking behaviors of MSFWs in the southeastern United States. For the nature of the study, I used a phenomenological qualitative research design using in-depth interviews to explore the MSFW's health beliefs regarding preventive healthcare.

Fourteen Hispanic seasonal farmworkers were interviewed. Key findings showed the farmworkers identified health as the ability to go to work and care for their families.

The prevention health seeking behaviors were exercise (work), eating healthy, and annual physicals. Hispanic seasonal farmworkers describe their usage of preventive health services in the southeastern United States as “we have what we need”, “we have what we need, but I don’t use it”, “we do not have what we need locally so we have to travel to get services”, or “I don’t know what is available locally”. Many farmworkers were unable to articulate what preventive services they received.

Additional findings showed that men under 30 had a narrow worldview; they did not have knowledge of available services, community needs, nor did they use preventative services themselves. The men and women above age 30 with families understood resources needed to remain healthy and whether the services were available locally; barriers and needs were identified.

Interpretation of the Findings

The major themes and deficiencies discovered in the literature review on MSFWs health beliefs and how they affect preventive healthcare were use of health beliefs, participation of primary care providers, health promotion strategies, and cultural competence of healthcare staff.

Health Beliefs

The prevention health beliefs of Hispanic migrant and seasonal farmworkers in the southeastern United States viewed health as important. However, they viewed going to work as more important than taking time off for preventive appointments. Many participants stated health was the ability to go to work; the physical rigor of farm work as exercise kept them healthy.

Primary Care Physicians

According to Winters (2013), access to primary care physicians promotes and maintains health and prevents disease in those that have access and improves outcomes and decreases disparities. A self-assessment is made before farmworkers select a health resource. Participants agreed that barriers to health care included transportation, cost, insurance benefits, poor treatment-no respect for time, difficulty leaving work, cultural competence, and no evening or weekend clinic hours. Participants concurred that barriers delayed care and left health needs unmet. Schmalzried and Fallon, (2012) concluded that PCPs were a crucial component in matching farmworkers to appropriate healthcare services. Healthcare practitioners that understand the culture were more likely to respect the patient's choices, value, culture, and perception of illness, creating better relationships and quality of care. Herman et al. (2016) found that the physician's language, cultural competence, and location were an important influence on the patient's participation in healthcare. Thus, the PCP needs to consider the patient preferences when creating patient-centered care options.

Health Promotion Strategies

Since farmworkers equate health with the ability to work, healthcare programs need to be available outside work hours and farming seasons. According to Carvajal et al. (2014), effective health promotion strategies should mitigate the stressors/barriers of the local population being served. However, health strategies in the local area were not mitigating barriers. Clinic and/or PCP services were not available after working hours. Many farmworkers did not have phones/computers and appointments for a COVID-19

immunization could not be made without internet access. “Farmworkers were turned away from CVS pharmacy because they had not made an appointment online” (Participant eight). A strategy to mitigate the electronic barrier is needed in the local area.

Cultural Competence

Kirk et al. (2014) found a healthcare provider’s understanding of cultural beliefs, cultural preferences, and use of cultural competence could have a positive effect on health disparities. Schmalzried and Fallon (2012) found barriers to preventive care within rural healthcare practices included lack of an interpreter and culturally competent staff; the therapeutic relationship between ethnocentric physician providers and the multicultural patient was found to be inhibited. According to Zwi et al. (2017), strict compliance to evidence-based care without cross cultural communication had a negative effect on health plan compliance. According to Carvajal et al. (2014), strategies to enhance culturally competent care included improving access to resources, education, and mentoring. The inclusion of cultural preferences and beliefs improves healthcare seeking behaviors.

Confirmed Findings

Farmworkers reported health as the ability to work, be active, and complete daily tasks. Rawolle et al. (2016) stated that farmers felt their work helped maintain fitness but included its own hazards. When unable to complete daily tasks, an assessment was made to use a home remedy, the clinic, or find a ride to the emergency room. “If I had a tummy ache, they [my parents] used home remedies. Four years ago, I went to the emergency room for a broken ankle” (Participant nine). If the farmworker did not have a car, a local

woman was available for hire to drive the sick to the emergency room. Participant five stated transportation was an issue in the community; “taxis are expensive, buses only run certain hours, even if a friend can drive, you may not have enough money for gas.” The local emergency medical service was reported to treat farmworkers as "just another injured Mexican” (Participant eight). A strategy to mitigate transportation barriers is needed.

Long and Weinert’s (1989) research indicated rural persons organized their healthcare views according to social environment, guiding interaction, and relationships. The farmworkers of the southeast United States incorporate their family’s use of home remedies, knowledge of the community and available services, and resources to guide their use of healthcare services. My findings align with the literature. Those participants interviewed with a large worldview offered their perception of barriers and needs for the local community, a stand-alone emergency room, a hospital, specialists for all ages, pediatric clinic, and transportation.

Barriers

The participants were asked “What keeps you from going to a doctor’s appointment?” The following topics were repetitive: a caring attitude, culture, education, language, transportation, cost, and sick time. Participant 14 stated “doctors in the area need to treat people better, no respect for their time, when the kids have an appointment, you wait all day to be seen. Participant eight stated we “need more Pediatricians at the clinics who are bilingual”. Participant one stated “information on available services need to be posted so migrant workers can find them” when they are in town. The cost of care

at the local hospital, 50 miles away, was identified as expensive for those without insurance. Participant 13 stated her insurance did not always cover the local specialist. Participant 12 stated "migrant workers have no insurance and the local hospital is expensive." Participant two, a lead farmworker stated there is no sick time in farm work, "if they do not come [to work], they do not get paid, but…if they have to go, they have to go" [to the doctor]. Therefore, the participants identified multiple barriers to see a doctor.

Disconfirmed Findings

Hu et al. (2016) stated that access to primary care physicians decreases disparities. However, Hu et al.'s results suggested further efforts are needed to enhance access to medical care; transportation and linguistic and cultural competence. The U.S. Department of HHS (2016) stated that clinical preventative services provide high quality care. According to Participant eight, the local clinics [SE United States] are overbooked and walk-ins are triaged for an acute appointment. "A [routine] 0900 appointment at the clinic-you will be there until 1pm. [The clinic] triages emergent visits, it can be 30 minutes before you are seen for an asthma attack". The local clinics have limited hours, long wait times, and no specialties to care for patients with advanced issues, they are referred 45 minutes away. No interviewee stated mistrust as a reason for not seeking care.

Needs-Extended Knowledge

According to Bales et al. (2013), the farmworker is capable of initiating self-care; however, they may not be able to maintain or continue the requirements, due to available services and barriers. Self-reliance means the farmworker has choices. A conscientious consumer will decide to seek care depending on the type of injury, illness, and time of

year. According to Participant eight, "[The clinic] triages emergent visits, it can be 30 minutes before you are seen for an asthma attack. Instead, I go straight to the emergency room [50 miles away] where we will be seen". Knowledge of preventive healthcare services will assist the conscientious consumer to make informed choices during their self-assessment of healthcare needs.

Limitations of the Study

The trustworthiness of qualitative research refers to the way(s) that I as the researcher declared my findings; being faithful to the participant's experience(s) (see Ravitch & Carl, 2016). Due to the COVID pandemic, seasonal crop rotations, and my lack of the Spanish language it took over a year to connect with my participants. Two interviewees provided information via a phone interview rather than direct observation in their natural environment; eliminating visual ques that would have added richer detail to the experience. Participants contributed information that was filtered through their worldview, not all interviewees were able to articulate their perspective of preventive health. As a Caucasian female my social location may have been an obstacle, as I am not fluent in the native language(s) of the Hispanic MSFW. The interviewer/researcher may interject bias into the analysis of the results (Creswell, 2014). I kept in mind that their priorities may have differed from my own.

Recommendations

Future researchers should consider environmental context when attempting to replicate a similar study in their region (Ravitch & Carl, 2016). Comparison studies are still needed in various rural locations to address the diversity, health perceptions, and

practice needs of the area; to develop evidence-based interventions (see Lee & Winters, 2004). In addition, education on available health practices and services needs a wider distribution to the targeted population.

Implications

Positive Social Change

Positive social change can occur when MSFWs seek routine preventive care; improving patient-provider relationships, decreasing healthcare costs, and enhancing patient outcomes. Long and Weinert (1989) stressed that nurses need to impart a nonjudgmental intervention for patients who present for delayed treatment and place a strong emphasis on preventive healthcare education. My assumption was MSFWs would attend preventative healthcare services when their needs are better met. Understanding the MSFWs health beliefs and health seeking behaviors broadens the knowledge base of healthcare providers to factors influencing healthcare compliance such as interpreters, open communication, and incorporating MSFWs perceptions into the plan of care which can improve preventive health and the well-being of the community.

The practical application of the data will be used to identify the need to ensure there are Spanish speaking, culturally competent staff into primary care offices and in health prevention initiatives. Healthcare workers can use the knowledge to tailor preventive interventions to reflect MSFWs beliefs. The RNT provides a framework to address the barriers to care for MSFWs such as work and health beliefs, isolation and distance, self-reliance, and outsiders/insiders. Rural dwellers require a unique approach that addresses the special needs of the population. “How people define health and illness

has a direct impact on how they seek and use healthcare services" (Winters, 2013, p. 8). Duplicating an urban nursing model for use in a rural area is inadequate to fulfill the needs of the MSFW population.

Conclusion

Long and Weinert's (1989) research indicated rural persons organized their healthcare views according to social environment, guiding interaction, and relationships. The farmworkers of the southeast United States incorporate their family's use of home remedies, knowledge of the community and available services, and resources to guide their use of healthcare services. The results of this study aligned with the literature; the data explained the Hispanic seasonal worker's definition of health, health beliefs, health seeking behaviors and use of preventive health services.

Hispanic seasonal farmworkers identified health as the ability to go to work and care for their families. The prevention health seeking behaviors were exercise (work), eating healthy, and annual physicals. The farmworkers describe their usage of preventive health services in the southeastern United States as "we have what we need", "we have what we need but I don't use it", "we do not have what we need locally so we have to travel to get services", or "I don't know what is available locally." Many farmworkers were unable to articulate what preventive services they received. Although this was one study with only 14 participants, I found that second generation foreign and U.S. born farmworkers who grew up with home remedies could learn to use preventive health as they established themselves in the area in which they work.

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Appendix A: Interview Questions

1. What are the prevention health beliefs of Hispanic migrant and seasonal farmworkers in the southeastern United States?
    a. Tell me how you stay healthy?
    b. What does health mean to you?
    c. What type of illness or injury takes you to visit your doctor?
    d. What helps you go for your doctor appointments? What keeps you from going?
    e. What did your mom and dad do when you were ill as a child?
    f. Is there a resource that would assist you in using healthcare services?
2. What are the prevention health seeking behaviors of Hispanic migrant and seasonal farmworkers in the southeastern United States?
    a. Tell me about your last visit with a doctor or health fair.
    b. What do you think about preventive health services in SW Florida?
    c. Tell me how you are treated by your PCP or doctor's office when you go for a visit.
3. How do Hispanic MSFWs describe their usage of preventive health services in the southeastern United States?
    a. How often do you go to the doctor's office?
    b. What health services do you use?
    c. What services do you feel are missing in this area of Florida?

Appendix B: Recruitment Flyer

Volunteers Needed: You are invited to participate in a research study focused on understanding the Migrant and Seasonal Farmworker's health beliefs, health seeking behaviors, and the use of preventive health services.

You are eligible if you:

Are a migrant and/or seasonal farmworker,

Are over the age of 18,

Speak English

The study involves an interview that will last approximately one hour.

The results of the study will be used to create a voice for local residents and define their healthcare needs.

If you are interested in participating or have any questions about the study, please call

Angie Trawick, RN

Appendix C: Recruitment Letter

Dear Farmworker,

I am a Walden University PhD student working on my dissertation in nursing. My topic is Health Belief Effects on Preventive Health among Migrant and Seasonal Farmworkers. You are a key member of the agricultural community and I would like to talk with you about how you see and use the preventive healthcare services in remote areas of southwest Florida where you live and work. Beginning in April 2019, I will talk with a number of farmworkers who will help me understand their views of preventive healthcare services. Would you be willing to give me one hour of your time in the next 2 weeks? As a nurse and a patient, I understand the challenges of getting to and receiving healthcare. However, I do not fully understand the challenge you face in a remote area of the county. I would appreciate speaking with you any time of day at your convenience. Your opinions would be a great addition to my research. If you have any questions about my research, please call me at.

Sincerely,

Angela Trawick, MSN, RN

Appendix D: Interview Guide

Interview Guide Example
Date:
Time:
Interviewee Code #:
Location of Interview:

Parts of the Interview	Interview Questions
Introduction	
	Hi, my name is Angie Trawick. I am a PhD student at Walden University and my goal is for you to educate me in the barriers you face in receiving preventive healthcare. Thank you very much for participating in my study. This should last about 1 hour. Your answers will only be shared with my Dissertation Committee Members. However, I will not identify you in my documents, and no one will be able to identify you with your answers. You can choose to stop this interview at any time. Also, I need to let you know that this interview will be recorded for transcription purposes.
	Do you have any questions?
	Are you ready to begin?
Question 1:	1. Tell me how you stay healthy. a. Do you get annual check-ups?
Question 2:	2. What does health mean to you? a. Explain
Question 3:	3. What type of illness or injury takes you to visit your doctor? How often? a. Why did you go the last time?

Question 4:	4. What helps you go to your doctor appointments? What keeps you from going? a. Can you give me some examples?
Question 5:	5.What did your mom and dad do when you were sick as a child? a. How did your parents treat illness?
Question 6:	6. Is there a resource that would assist you in using health services?
Question 7:	7. Tell me about your last experience with preventive services in Florida. a. Did you attend a health fair or doctor's office?
Question 8:	8. What are your thoughts about the preventive services in SW Florida? a. Can you get what you need locally?
Question 9:	9.Tell me about your relationship with your primary care provider. a. How are you treated at the doctor's office?

Closing:

1.Thank you for your answers. Do you have anything else you'd like to share?
2. Do you have any questions for me?
3. Would you like to be a participate in member checking the data collected?
4. Would you like a copy of the transcript?
    a. Please provide contact information.
5. Thank you for your time. Goodbye.

Appendix E: Field Notes Guide

Intro: Field notes are taken during an observational event to record and remember behaviors, activities, and events. They are also used to record and distinguish the researcher's experience and interpretation of those events.

Field notes general consist of 4 parts:

1. Some record-keeping notes (e.g., date, time, etc.)
2. Descriptive information: where you attempt to accurately record the "facts" of the situation
3. The meaning/reflection of what you observed
4. Reflexive notes - How did this affect you? What personal moment did this bring up? How did it alter or inform you?

Date: Time of Interview: Your Physical Setting: Name of Participant:
Describe physical setting(s) in which the interview takes place
Participant (identify and briefly describe. What is their role in the interview?) How did the individual respond? Briefly describe.
Other unusual or interesting setting characteristics?

Meaning and Reflection.	
What meaning did you observe in the interview? (there may be more than 1)	Reflection (impressions, thoughts, critiques, unanswered questions)
Reflexivity: How has this made you aware of, or changed something, about yourself?	