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Factors Affecting Health Care Access and Utilization Among U.S. Migrant Farmworkers

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Abstract

There are over 3 million seasonal and migrant farmworkers in the U.S. agricultural industry with a significant percentage of farmworkers documented or native to the United States. Migrant farmworkers live below the federal poverty levels at high rates and experience low health care access and utilization. Guided by the fundamental cause theory, the purpose of this phenomenological study was to examine the lived experiences of migrant farmworkers and identify the factors impacting their health care access and utilization. Face-to-face interviews were conducted with 12 migrant farmworkers who had worked in Southwest Texas agricultural stream. Data were analyzed and coded to identify themes. Findings indicated that although lack of health insurance was a decisive factor in whether migrant farmworkers accessed or utilized health care services, distance to services, inflexible working hours, and cultural factors related to seeking care also influenced participants' lack of access to and utilization of health care services. Results may be used to aid local, state, and federal agencies in assisting migrant farmworkers in bridging the gap in health care and obtaining needed services.

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Table of Contents

List of Tables

Chapter 1: Introduction to the Study

In 2003, Hansen and Donohoe described the migrant farmworker, highlighting the occupation and socioeconomic conditions in the United States in the Edward R. Murrow documentary (1960), *Harvest of Shame*. The film brought the plight of migrant farmworkers into the public's awareness. Since that time, little has changed in this economically and medically vulnerable population (Borjan, Constantino, & Robson, 2008). Migrant farmworkers are one of the most impoverished and underserved populations in the United States (American Public Health Association, 2014; Hansen & Donohoe, 2003).

Inconsistencies in health care in this community were not limited to socioeconomic status. Ethnicity, geographic location, and insurance status are factors that can adversely affect the health of a community. The authors of the Kresge report (2012) identified health disparities in the migrant farmworker population because of "over representation of racial and ethnic minority workers in a hazardous industry, lack of occupational safety and health interventions" (p. 17). Although both governmental and health care agencies had researched the health issues related to migrant farmworkers over the past two decades, only two migrant health programs in the 1980s resulted from their study (Bail et al., 2012). The Migrant and Seasonal Agricultural Workers Protection Act was passed in 1983 and the Immigration Reform and Control Act in 1986 (National Center for Farmworker Health [NCFH], n.d.). The latter was a penalty-based measure against the hiring of illegal workers but provided an avenue for legal immigrant status for those working 90 man-days (NCFH, n.d.). It was not until 1996 that the Health Centers

Consolidation Act consolidated all regional health care for migrant farmworkers under one structured community health organization, the Office of Minority Health (NCFH, n.d.).

The NCFH (2015) found that in Arizona and Georgia, a decrease or elimination of the presence of agricultural workers had a devastating effect on the state's output as reflected in a study by the University of Georgia. The NCFH found that agricultural output was negatively affected by House Bill 87 and decreased the annual output by over $181 million. Although Clark, Surry, and Contino (2009) posited that an estimated 15% of the U.S. gross domestic product was spent in health care each year, more than 47 million Americans had no health care insurance coverage and used emergency rooms for all their health needs. Within this population of uninsured, only 1 in 5 farm workers could obtain health insurance through either their employer or through the state or federal governments (Clark et al., 2009). The low rates of health insurance made it difficult for the uninsured populations to obtain health care, as more than two thirds of this population is living in poverty (Clark et al., 2009).

Although health care services had become more accessible, there remained a disproportionate number of migrant farmworkers who were not utilizing health care services (Rosenbaum & Shin, 2005). There was also a lack of empirical studies addressing health care utilization by migrant farmworkers. The significance of the current study was related to the need to identify the cause for the low rate of utilization of services by farmworkers. The examination of these factors may assist in determining how agencies could affect health care utilization among migrant farmworkers.

In this chapter, I present the background and statement of the problem, the purpose of the study, the research questions, the theoretical framework, and the assumptions. This chapter also provides discussion of the significance of the study, the rationale for the methodology, the nature of the study, and definitions of relevant terms used in the study. The chapter concludes with the study's assumptions, limitations, and delimitations, as well as a summary of the key details of the study.

Background

Migrant farmworkers are essential to the agricultural industry in the United States and are among the most vulnerable population (Derose, Escarce, & Lurie, 2007). Derose et al. (2007) noted that factors contributing to migrant farmworkers' vulnerability are socioeconomic and immigrant status, language, geographical locations, and culture. Both political and social marginalization shape the vulnerability associated with migrant farmworkers in a community that is socioeconomically deficient (Adler & Newman, 2002). Approximately 61% of farmworkers are living below the federal poverty levels (Kersey-Matusiak, 2018). Wages for migrant workers are less than $7,500 per year for nonmarried individuals and less than $10,000 per year for 50% of married workers (Hansen & Donohoe, 2003).

Migrant farmworkers, as a vulnerable population, have severely limited options when it comes to health care. Restrictions on federal and state policies further alienate migrants who work in the agricultural industry. Rosenbaum and Shin (2005) found in a study on Medicaid and the uninsured that only 22% of farmworkers and family members were covered by private health insurance or Medicaid. Farmworkers whose average

annual family income fell below the national poverty level were unable to obtain needed medical care (Farmworkers Justice, 2013.). Additionally, Medicaid excludes documented immigrants for the first 5 years of residence in the United States. Those individuals who are eligible to receive Medicaid are faced with strict out-of-state residency requirements (Rosenbaum & Shin, 2005). In the United States, there are approximately 400 federally authorized clinic sites, but they reach only 12-15% of the migrant population (Hansen & Donohoe, 2003). Although agricultural employers with 11 or more employees are subject to the U.S. Department of Labor's Occupational Safety and Health Administration (OSHA) regulations regarding public health provisions for workers, these provisions included drinking water, handwashing, and toilet facilities. Hansen and Donohoe (2003) found noncompliance and violations in nearly 69% of field inspections. According to national reports, the agricultural industry experiences one of the largest incidences of illness and injuries for any occupation (Hawkes et al., 2007). Each year more than 22.7% of farmworkers are fatally wounded due to occupational accidents or related illness (Weigel & Armijos, 2012). The increased risk and injury are due to several factors that include the physical aspect of their work, unpredictable environments, living conditions, and lifestyle factors (Brower, Earle-Richardson, May, & Jenkins, 2009). Cooper et al. (2006) reported that occupational hazards related to cutting tools (57%), tractors (59.8%), repetitive hand movements (44.7%), and bending or stooping (45%) were the main sources of injuries. Other risks associated with the increased exposure to chemicals result in a population with chronic pain, respiratory illnesses, skin infections, cancer, and infectious diseases (Rosenbaum & Shin, 2007).

In an analysis of all injury types, researchers discovered that few farmworkers sought or received medical care (Simsek, Koruk, & Doni, 2012; Thierry & Snipes, 2015). There are varied reasons reported in the literature as to why farmworkers do not utilize health care, tend to self-medicate, or prolong the time until they seek professional health care. Among these reasons are their limited financial resources, work mobility, inflexible working hours, and lack of knowledge on the care of injuries (Finch, Frank, & Vega, 2004; Kutlu & Koruk, 2014). However, the limited use of health care services by migrant farmworkers is not congruent with a lower need for health care (Simsek et al., 2012). Health care professionals, through their experiences with migrant farmworkers, have identified deterrents for migrant farmworkers seeking medical care. Arcury and Quandt (2007) categorized the factors as linguistic, cultural, mobility, and paid time off (Derose et al., 2007); Hoerster, Beddawi, Peddecord, and Ayala, 2010).

Inability to access and utilize health care due a lack of financial resources is a global, national, and state problem. The National Agricultural Workers Survey estimated that between 2011 and 2012, 37% of farmworkers reported employer-based insurance, 23% reported government subsidized insurance, 19% reported insurance paid by spouses, and 8% had insurance under their spouse's employer. The National Center for Health Statistics (2017) noted that in 2016 approximately 10% of individuals under the age of 65 did not have medical insurance compared to 85% of migrant farmworkers under the age of 65.

In research related to health care in private settings, Anthony (2011) found that access is unattainable for many migrant farmworkers due to their constant movement

throughout the growing season. The lack of portability means that, for many migrant farmworkers, Medicaid coverage ends when they move away from a state. The lack of portability also creates difficulty for farmworkers in completing applications for assistance or receiving coverage for the short duration they are living and working in a state (Farmworker Justice, 2013). Services offered at primary and specialty practice offices and nonemergency care hospitals are contingent upon the ability of the farmworker to pay, making it unaffordable for many immigrants (Hetrick, 2015).

Frank, Liebman, Ryder, Weir, and Arcury (2013) corroborated these findings in their research on migrant farmworkers. Frank et al. noted that the lack of ability to pay for services and lost wages while obtaining care are the basis for less frequent utilization of health care by migrant and seasonal farmworkers than by other low-income populations. Hoerster, Mayer, Gabbard, Kronick, Roesch, Malcarne, and Zuniga (2011) discovered that, in California, half as many migrant farmworkers received medical care compared to the national averages among other workers. Additionally, Rosenbaum and Shin (2005) posited that less than 20% of documented immigrants were found to have any form of employee-sponsored health insurance. The issue is that despite benefits that may be available to migrant farmworkers (i.e., health insurance, medical clinics), there continue to be other factors that affect access and utilization of health care by farmworkers.

Problem Statement

There are over three million seasonal/migrant farmworkers in the U.S. agricultural industry (NCFH, 2012). Although an integral part of the agricultural community, migrant

farmworkers experience several obstacles related to their occupation. Migrant farmworkers who live below the federal poverty levels have limited access to and underutilize health care while also experiencing marginalization in the health care system (Holmes, 2006).

Feldman et al. (2009) examined health care utilization of farmworkers in eastern North Carolina. Feldman et al. selected seasonal farmworkers from nine counties to gather information related to the utilization of health care by farmworkers for minor and major health concerns. Feldman et al. found no specific issues related to the low rate of health care utilization among farmworkers but noted that medical visits among these individuals were rare. Hamilton and Lovering (n.d.) found that adult uninsured migrant workers who seek medical attention often delayed until a problem became critical. The result was overcrowding of emergency departments with longer wait times and increases in uncompensated care for those without medical insurance. The Health Management Associates (2016) estimated that $7,985,254 was spent on uncompensated hospital costs, $3,126.239 on uncompensated dental and clinic charges, and $3,825.572 on other uncompensated charges (i.e., pharmacy, physician, ambulance). The gap I identified in the literature related to the data on the experiences of migrant farmworkers in Southwest Texas regarding health care access and utilization. This study focused on the problem of low access and utilization of health care by migrant farmworkers and the issue of health insurance.

Purpose of the Study

The purpose of this qualitative phenomenological study was to understand how access and utilization was experienced and understood by the people most impacted by the limitations to both (i.e., migrant farmworkers). This study focused on migrant farmworkers in Southwest Texas and the health care issues unique to their community. The lived experience of migrant farmworkers' health perceptions was also assessed. Finally, I explored the association between health care access, utilization, health insurance status, and culture.

Research Questions

The research questions that guided this study included the following central question and subquestions (SQs):

Central question: What is the meaning of access and utilization of health care for migrant farmworkers in Southwest Texas?

SQ1: What is the experience of migrant farmworkers in El Paso County accessing and utilizing health care?

SQ2: What is the experience of migrant farmworkers related to obtaining health insurance and utilization of health care services?

SQ3: How does the culture of migrant farmworkers in El Paso County affect health care utilization?

SQ4: How does distance affect utilization of health services?

Theoretical Framework

The theoretical framework used in this study was the fundamental cause theory (FCT). Link and Phelan (1995) developed the FCT to explain the relationship between social factors (i.e., socioeconomic status [SES]) and health disparities. This theory indicated that longevity in a population declined for those who lived below the poverty level, were powerless, and lacked prestige (Flaskerud & DeLilly, 2012). As applied to the study on migrant farmworkers, this theory held that SES, health insurance, and other barriers influenced the experiences of migrant farmworkers and their ability or opportunity to access health care (see Flaskerud & DeLilly, 2012).

Stigma or a perceived lack of honor or dignity was a consequence of how an individual and others perceived migrant farmworkers. According to Li, Stanton, Fang, and Lin (2006), stigma was a characteristic used to separate individuals from what was considered the normalized social order. Link and Phelan (2001) proposed a conceptual framework for stigma. Stigma was identified as labeling differences between individuals, stereotyping (labeling individuals by negative characteristics), separation (placing certain individuals into categories), status loss (devaluation of individuals leading to inequitable outcomes), and discrimination or systemic "disapproval, rejection, and exclusion toward specific individuals" (Phelan, Lucas, Ridgeway, & Taylor, 2014, p. 16). Stigma had come to represent negative social, economic, and political connotations that allowed for stereotyping, separation, and exclusion of a specific race, sex, religion, etc. Stigmatization was likened to discrimination and attributed to the treatment of migrant farmworkers in health care. Social relationships or social capital was defined by Adler

and Kwon (2002) and Dekker and Uslaner (2001) as forming bonds while bridging gaps between diverse individuals. How people interact communally allowed individual members to achieve their goals (Chen et al., 2011). Chen et al. (2011) further posited that integration into a community by migrants was dependent on their ability to reconstruct their social capital. Migrant farmworkers' decreased capacity to integrate into a community could mark the group with undesirable attributes (stigma) and separate them from the mainstream population (Phelan, Lucas, Ridgeway, & Taylor, 2014). The consequence of internalizing the stigma could lead to emotional or health issues that cause the individual to accept negative beliefs about themselves and could result in the avoidance of medical treatment (Phelan, Lucas, Ridgeway, & Taylor, 2014).. This stigmatizing action or enacted stigma could result in inequality and discriminatory actions against migrant residents who are considered inferior to the nonmigrant residents in the community. Chen et al. (2011) found in their study of Asian migrant farmworkers that migrants encountered adverse health outcomes due to stigmatization and a lack of social capital, which prevented migrants from obtaining health care or psychosocial support. Decreased assistance with health care for a psychological referral or callous response by health care personnel related to health inquiries were complaints commonly listed by migrant farmworkers (Chen et al., 2011).

The FCT and the phenomenological focus of this study was on the lived experience of the migrant farmworker and whether the experience was related to SES or an identified phenomenon such as underutilization of health care. In Link and Phelan's (2001) theory, SES of migrant farmworkers was a primary cause of health care inequities

that persisted over time and could be attributed to underutilization of health care. The data obtained from interview questions were examined for factors that contributed to health care and how migrant farmworkers' responses could affect and influence policy and practice.

Nature of the Study

A qualitative approach was used in this study. Qualitative studies involve nonnumerical data collected in the form of statements from subjects during interviews, observed behaviors, pictures, or written records to obtain an in-depth understanding of a phenomenon in its natural environment (Christensen, Johnson, & Turner, 2010). A qualitative approach was used to analyze associations between cultural beliefs, health insurance status, and other bases for the lack of access and utilization of available health care services. A qualitative approach provided valuable information to answer the research questions of this study. Phenomenology was used because the purpose of the study was not to develop a theory but to examine a phenomenon. Langdridge (as cited in Davidsen, 2013) noted that the emphasis of phenomenological research changes depending on whether it is a pure description or informed interpretation. Lincoln and Guba (as cited in Davidsen, 2013) noted that cultural, social, and interpersonal contingencies as well as theory shape phenomenological research.

The hermeneutical approach of phenomenology focuses on a multiperspective point of view of the participants and is oriented toward the lived experience and interpreted texts of life such as language, the symbolism of a culture, and how both affect the individual (Creswell, 2007; Smith, 2013). Hermeneutic theory of phenomenology

were used to develop the central research question: What does it mean to migrant farmworkers to have access to and the ability to utilize health care?

The essence of the experience of a phenomenon (health care access and utilization) for migrant farmworkers was accomplished through in-depth, semistructured interviews. In-depth interviews provided an opportunity to ask follow-up questions that were relevant to the study. The rationale for using a hermeneutical phenomenological approach was the knowledge that a participant's outcome was not a one-dimensional event but a composite of all of his or her experiences. The qualitative phenomenological approach was appropriate for this study because it relied on several participants to describe the collective meaning or perception of lived experiences and provided descriptive data related to participants' ability to access health care (see Creswell, 2007; Maxwell, 2013).

The target population in this study was migrant farmworkers in Southwest Texas. I used nonprobability convenience sampling to obtain the study sample. Participants was recruited from the Centro De Los Trabajadores Agrícolas Fronterizos and Texas Governor's Office of Migrant Affairs. Prior to recruitment, I placed a poster in the agencies describing the research and providing my contact information. The study included unstructured interviewing techniques and open-ended questions related to health care access and utilization.

The interviews covered the experiences of migrant farmworkers and their utilization of emergency department, public ambulatory care centers, clinics (to include yearly screenings), and all acute inpatient admissions. The data obtained from the

interviews were sorted, filtered, and transcribed into Microsoft Word for Windows before entering the data into NVIVO Version 12 for Windows.

Definitions

Culture: The customary beliefs, social forms, and material traits of a racial, religious, or social group (Merriam-Webster, n.d.).

Health care access: The timely use of personal health services to achieve the best health outcomes (Ishfaq & Raja, 2015).

Health care utilization: The use or amount of usage per unit population of health care services (Akinbami et al., 2012).

Health insurance: Comprehensive care through Medicaid, employer-sponsored plans, or Health care.gov plans. Health care utilization refers to how frequently a farmworker acquired health care service whenever deemed necessary. The Agency for Health care Research and Quality (NHQR, 2014) defined health care access as "the timely use of personal health services to achieve the best health outcomes" (p. 1).

Migrant farmworker: An individual employed in the agricultural industry as a seasonal or other temporary employee and not required to be absent from his or her permanent place of residence.

Socioeconomic status: The standing of a person or group in a community or society based on education, occupation, and income, often used as a benchmark for investigating health inequalities (Loh, Moy, Zaharan, & Mohamed, 2015).

Underinsured: Insufficient coverage or inability to afford the out-of-pocket responsibilities not covered by the insurer (Patient Advocate Foundation, 2012).

Assumptions

I assumed that the use of sampling in the migrant farmworkers in Southwest Texas rather than the entire population of farmworkers in Texas would produce an accurate representation of the health care access and utilization of migrant farmworkers. This assumption followed the fact that I could not get relevant information from the entire population and only had data access regarding health care access and utilization of migrant farmworkers in Southwest Texas. The second assumption is that the participants will answer truthfully. The relevance of this assumption is that in the present political climate, many migrant farmworkers are hesitant to speak about their employment.

Scope and Delimitations

The study was restricted to Southwest Texas, thereby limiting the demographic sample. Although there were migrant farmworkers in other parts of Texas, I had greater access to the population of migrant farmworkers in this area. There were no direct observations of farmworkers' interactions with the health care system. The focus was on the participants and their experiences with health care access and utilization. I did not measure access and utilization rates, which were time consuming and difficult to obtain. I aimed for in-depth insights from the relevant population.

Limitations

This study was anchored in the phenomenological approach of hermeneutical inquiry. I sought to understand the lived experience of migrant farmworkers. The lived experiences of participants directed the quality of data, analysis, outcomes, and conclusions. Addressing limitations or biases was essential in this study. Preconceived

personal or professional beliefs could contribute to researcher bias that arises from data obtained from the participant or researcher (Sarniak, 2015). Although I have worked as a school nurse with migrant families, I did not live in proximity to migrant farmworkers where the research was conducted. Therefore, researcher bias, (the use of data obtained from the participant to confirm preconceived personal beliefs) was not an issue during this study. Patton (2014) found that with qualitative inquiry, the focus is not on the relatively small sample, but on the purposeful selection of information-rich participants. Limitations associated with insufficient sample size could create bias when determining relationships from the obtained data. The sample size in a phenomenological study is determined using the rule of thumb of less than or equal to 10 (Patton, 2014). The interview process was continued until data saturation was reached. To ensure uniform representation, I selected farmworkers with similar demographics representative of the population (see Moore, Mercado, Hill, & Katz, 2016).

In hermeneutic phenomenology, Gadamer (as cited in Van Manen, 2011) found that language had a significant role, like questioning and human understanding. Language fluency or not understanding the native language of the participants could have impacted the ability to understand responses and adequately explain the findings. Language issues were addressed by ensuring that all participants spoke and understood English.

Creswell (2013) posited that data triangulation involves the collection of data from different sources and entails corroborating evidence to validate a perspective from different types of sources such as time, space, and person. Begley (1996) proposed that triangulation varies based on the time the data were collected, people involved in the data

collection process, and the setting. In the current study, interviews provided an excellent source of information, and the accuracy of the accounts by participants were imperative as a foundation for reliable data. Finally, although I made every attempt to ensure participant involvement, an agency could have denied physical access to the participants at a designated site. Multiple sites for the selection of participants helped me avoid this obstacle.

Significance

It was essential to understand how access and utilization of health care were experienced and comprehended by the people most impacted by the limitations to both. This knowledge may contribute to the improvement of health care delivery and provide a better understanding of migrant farmworkers and their health care needs. Identifying the unique challenges faced by migrant farmworkers in Southwest Texas may also provide essential data for future policy and practice on health care access and utilization among the migrant community. Finally, this study may provide information that could aid local, state, and federal agencies in assisting migrant farmworkers in obtaining needed services.

Summary

The purpose of this qualitative phenomenological study was to examine health care access and utilization among migrant farmworkers in Southwest Texas. I also explored the health insurance status, cultural beliefs, language, and utilization of available health care services among the target population. The data were collected using in-depth interviews and analyzed through the development of themes and coding of data

using NVIVO-12. The literature review in Chapter 2 presents the findings of prior research regarding health care access and utilization among farmworkers.

Chapter 2: Literature Review

In a politically, socially, and economically charged environment, the needs of the migrant farmworkers (MSFWs) have the potential to become lost among issues surrounding immigration in the United States. There is little known about the unique health needs of migrant farmworkers and what influences their decisions to access and utilize health care. As of 2014, an estimated 9.3 million undocumented individuals were living and working in the United States (Bailey & Dougherty, 2014). Six percent of farmworkers are documented or native to the United States, and over 70% of the documented farmworkers are permanent residents (NCFH, 2012).

Many farmworkers live below poverty levels, have limited access to health care, and experience marginalization in the health care system (Holmes, 2006). Acrury and Quandt (2007) obtained data collected from the California Agricultural Workers Health Survey, a statewide cross-sectional household survey conducted in 1999. The study included 654 workers using comprehensive physical examinations and personal risk behavior examinations by third-party medical professions. A cross-sectional, multistage stratified sampling frame included seven communities in California's agricultural region. Individuals were 18 years and older and currently worked as hired labor in the agricultural industry. The survey findings indicated several areas of interest such as family composition, health insurance status, and utilization of health care. Other areas assessed included physical examinations and a risk behavior interview that focused on drug use, health habits, and worker's compensation insurance.

Access to health care is a major issue for farmworkers because of the risks associated with this occupation (Arcury et al., 2012). Farmwork is considered one of the most physically and psychologically risky occupations due to the exposure to chemicals, hazardous work conditions, long work hours, and low pay (Acury & Quandt, 2007; Arcury et al., 2012). Documented and undocumented farmworkers may experience a range of cultural, structural, legal, financial, or geographic barriers along with discrimination, unemployment, and separation from the family unit; together, these barriers and stressors create health risks that are associated with agricultural occupations (Feldman et al., 2009). Deringer (2010) estimated that over 70% of migrant farmworkers lack health insurance and less than 15% have employer-sponsored coverage.

Researchers have found that migrant farmworkers' exposure to chemicals created an increased risk of occupational illness, including respiratory illness, chronic pain, cancer, infectious diseases, and skin infections (Arcury et al., 2014; Rosenbaum & Shin, 2005). Migrant farmworkers also experienced a high risk of injury associated with physical working conditions and use of equipment (Arcury et al., 2012; Weigel & Armijos, 2012). Despite these increased risks, researchers found that few farmworkers sought medical care for injuries (Simsek et al., 2012; Thierry & Snipes, 2015). Researchers who investigated the reasons that farmworkers infrequently sought medical care found that reported barriers to care included financial limitations, inflexible working hours, the mobility of the work, and lack of knowledge regarding proper care of injuries (Finch et al., 2004; Kutlu & Koruk, 2014). Migrant farmworkers' limited use of health care services did not, however, reflect a lack of need for medical care (Simsek et al.,

2012). Further research is needed to understand the factors associated with migrant farmworkers' access to and utilization of health care services. To address this gap in knowledge, I conducted a qualitative phenomenological study to examine health care access and utilization among migrant farmworkers in Southwest Texas.

To obtain research for this literature review, I conducted an extensive search of several databases. Priority was given to recent publications in peer-reviewed journals. Databases searched included PsycINFO, Medline, EBSCO, CINAHL, ProQuest, PubMed, ScienceDirect, Healthsource: Nursing/Academic Edition, Psychology and Behavioral Sciences Collection, and Academic Search Premier. I also used the Google Scholar search engine. Search terms included *migrant farmworkers, undocumented farmworkers, seasonal workers, farmworkers, migrant workers, health insurance, Affordable Care Act, access to medical care, access to health care, Latino folk medicine,* and several combinations of these terms. Articles published from 2012 through 2018 were prioritized. Of the 59 references obtained for this review, 39 articles (66%) were published between 2012 and 2016, and 20 articles (34%) were published prior to 2012.

The following section provides a discussion of the theoretical framework and its relevance to this study's problem and purpose. The following sections include discussion and critical analysis of relevant research. Included in the discussion are (a) barriers to accessing health care services for migrant farmworkers, (b) occupational safety and health of migrant farmworkers, (c) health outcomes associated with migrant farmworker status, (d) utilization of health care by migrant farmworkers, (e) migrant farmworkers' perspectives on health care, and (f) programs and interventions to address health care

access for migrant farmworkers. This chapter concludes with a discussion of the gap in the research literature that the present study intended to address, and a summary of key points discussed in the chapter.

Theoretical Framework

I used the fundamental cause theory (FCT) as the guiding theoretical framework. Link and Phelan (1995) developed the FCT to explain the relationship between SES and disparities in disease and morbidity. According to FCT, social conditions represent a fundamental cause of disparate health outcomes among people of diverse SES backgrounds (Link & Phelan, 1995). Researchers have documented a robust relationship between socioeconomic resources and morbidity and mortality, and this relationship has endured over years of research (Flaskerud & DeLilly, 2012). Although the most common causes of severe illness and mortality have changed over time as medical science has advanced, low SES continues to be a strong predictor of poorer health outcomes (Flaskerud & DeLilly, 2012). According to Link and Phelan (1995), social factors cause health disparities because they affect an individual's access to health and other resources, impact multiple risk factors for disease, and remain consistently associated with disease incidence despite variation in other predisposing risk factors.

Researchers used the FCT in a study of mortality regarding socioeconomic factors (Phelan, Link, Diez-Roux, Kawachi, & Levin, 2004). The researchers drew data from the National Longitudinal Mortality Study (NLMS) from 1994 through 2003 (Phelan et al., 2004). The NLMS contains data on all deaths in the United States including causes of death and contains information on each deceased person's SES (Phelan et al., 2004). The

researchers used educational attainment and family income to create a composite variable for SES (Phelan et al., 2004). Further, the researchers developed classifications of the deceased based on disease preventability and cause of death to include less preventable disease intervention (Phelan et al., 2004). In their analysis, Phelan et al. (2004) found support for the FCT because persons of higher SES were less likely to have died of preventable causes compared with persons of lower SES. These findings indicated that SES was directly related to health management and mortality (Phelan et al., 2004).

Although applications of the FCT within studies of migrant farmworkers' health care access were not located, a literature search yielded a study that addressed mental health disparities across racial or ethnic groups using the FCT as a framework. Dinwiddie, Gaskin, Chan, Norrington, and McCleary (2013) used the 2006 American Medical Association Area Research File along with the 2000 United States Census data to examine access to mental health services for a sample of over 15,000 individuals who were White, African American, or Latino. Dinwiddie et al.'s findings indicated that Latinos who lived in segregated neighborhoods were less likely to have local access to psychiatrists, which resulted in Latinos in these areas using nonpsychiatric medical professionals for their mental health care. Because residential segregation is associated with socioeconomic factors, the researchers suggested that low access to psychiatrists within Latino neighborhoods was consistent with the FCT; this was because Latinos' access to quality mental health care was directly impacted by their low SES (Dinwiddie et al., 2013). Migrant farmworkers often live in poverty, have lower rates of access to health insurance, and often lack access to social and tangible supports (Altschuler, 2013).

Because of this population's disadvantaged status, the FCT was a useful framework through which to investigate and analyze migrant farmworkers' health care access.

Literature Review

Migrant Farmworkers and Barriers to Health Care Access

Several researchers investigated the barriers to accessing health care by migrant farmworkers. This section provides a discussion of these barriers, which included language and communication barriers, cultural barriers, and use of alternative medicine as a barrier to access medical care. Issues related to mobility are also discussed, including the impact of frequent work location changes and the lack of reliable access to transportation for health care. This section also addresses the impact of financial and legal barriers on migrant farmworkers' access to health care services, as well as issues related to inaccessible medical providers.

Language and Communication Barriers

Barriers associated with health care utilization are related to barriers identified by health care professionals. Arcury and Quandt (2007) listed these barriers as linguistic, cultural, mobility, and paid time off for migrant farmworkers. Migrant farmworkers who work in the agricultural trade speak various languages depending on their location in the United States. Indigenous languages can include French Creole, South Asian, and Spanish. Although Spanish is the most prevalent language spoken among farmworkers, the Latino community includes Native American (Mixteco, Tarasco, or Quísche) and regional dialects, which create barriers within a particular subculture (U.S. Department of Labor, 2012).

English proficiency affects not only the quality of care but also the safety of the migrant farmworker. The ability to communicate medical facts to a provider and understand instructions is essential in obtaining quality medical care, although many provisions have been made to assist nonnative speakers (i.e., interpreters and written instructions in native language; Derose et al., 2007). Altschuler (2013), who drew upon a review of the literature and professional clinical experience to explore issues related to migration and health care, reported that language barriers between migrant individuals and health care workers could affect a physician's ability to diagnose or determine the severity of health conditions. Altschuler presented themes from the literature on migration and health care that were grounded in descriptions of clinical examples from the researcher's professional experiences. Communication difficulties that arise from language barriers can also decrease the migrant individual's ability to understand recommendations for care and treatment as explained by doctors, which can adversely impact health (Altschuler, 2013). Language barriers have been associated with poorer quality of medical care and follow-up care for migrant individuals (Altschuler, 2013). In research of Dutch migrants, de Graaf and Francke (2009) found that health care providers identified communication problems led to a lack of health care access and utilization due to insufficient knowledge or understanding of the illness.

The perspectives of Altschuler (2013) and Derose et al. (2007) on the impact of language and communication barriers upon health care for non-native speakers. The research findings on migrant farmworkers' exemplified conditions such as poor access to care as a risk factor. Bail et al. (2012) provided an example of how language barriers can

seriously impact the quality of care migrant individuals receive. Bail et al. (2012) engaged in participant observation at the Farmworker Family Health Program and conducted a series of in-depth interviews with a key informant over the course of three months. The informant, Jackie, had been a member of the Latino community and an advocate for local migrant farmworkers for several years, which provided her with a depth of knowledge and insight about the social and health issues experienced by migrant farmworkers (Bail et al., 2012). The informant shared a story about a migrant farmworker who delivered her baby while in the United States was informed after her child's birth that the baby lacked a brain stem. Language barriers prevented the mother from understanding the diagnosis and the medical choices to address the condition (Bail et al., 2012). Because of this misunderstanding, the woman provided unassisted care to her newborn for four weeks before seeking further medical care for observed abnormalities (Bail et al., 2012).

Confirming the findings of researchers discussed above, Bailey and Dougherty (2014) also found that language barriers adversely affected the quality of medical care obtained by migrant farmworkers. Bailey and Dougherty (2014) conducted a needs assessment of migrant farmworkers employed at the Philadelphia Park Racetrack; although these workers did not engage in farm work, they experienced similar language-related barriers to obtaining health care. These researchers found that misinterpretation caused health practitioners to mistakenly assume that migrant workers understood and agreed with their diagnoses and treatment plans (Bailey & Dougherty, 2014). However, the agreeable responses of migrant workers reflected Hispanic cultural norms related to

etiquette, and not with the plan of treatment (Bailey & Dougherty, 2014). Such misunderstandings resulted in health providers believing that they had provided efficient treatment for medical conditions when the migrant individuals did not fully understand diagnosis or treatment information (Bailey & Dougherty, 2014).

The consistent finding of researchers discussed in this section was that communication difficulties created challenges for obtaining quality health care for migrant workers. Researchers suggested that use of interpreters would help to clarify communication between migrant farmworkers and medical care providers (Altschuler, 2013). Federally funded health facilities are required to provide interpreters under the Civil Rights Act of 1964 Title VI (Derose et al., 2007). These provisions may not benefit farmworkers who are unaware of the law or are dependent on physicians who willingly accept care for the uninsured, Medicaid recipients, or health care under the Affordable Care Act (Derose et al., 2007). Additionally, researchers have found that other assistive communication approaches have been helpful to migrant persons when obtaining medical care. The approaches included the use of visual aids and drawings, repeating pertinent information to verify understanding, and paying attention to gestures and other nonverbal indicators when discussing medical care (Altschuler, 2013).

Low Health Literacy as a Barrier to Medical Care

Another barrier to accessing health care related to communication was the low reading ability of many migrant farmworkers. Bailey and Dougherty (2014) reported that many migrant farmworkers have low educational levels and corresponding low reading abilities. Low literacy among migrant farmworkers adversely impacted their abilities to

understand useful health information from written sources (Bailey & Dougherty, 2014). The researchers reported an association between low educational attainment and low health literacy, which had many negative health effects including medication errors, poor medication compliance, failure to obtain preventive medical care, and more frequent hospitalization (Bailey & Dougherty, 2014). Similarly, Finlayson, Gansk, Shain, and Weintraub, (2014) found a link between low health literacy and decreased rates of dental care for children of Latino farmworkers in California. The researchers found that the inability to identify signs and symptoms of dental concerns in their children was associated with parents seeking less frequent dental care (Finlayson et al., 2014).

To summarize, researchers found that migrant farmworkers experienced language and communication barriers that adversely impacted their access to medical care. Unclear communication resulting from language differences, negatively affected physicians' abilities to understand the nature and severity of migrant individuals' conditions (Altschuler, 2013). Imprecise communication also decreased individual migrants ability to understand their diagnosis and treatment plans as explained by physicians (Bail et al., 2012). Communication difficulties also extended to written health materials which impacted health literacy, as migrant farmworkers often had low educational status and reading comprehension skills (Bailey & Dougherty, 2014). Overall, language and communication barriers had a direct association with poorer quality of medical care and treatment plan implementation for migrant farmworkers (Altschuler, 2013). The next section I will discuss cultural barriers and alternative medicine.

Cultural Barriers and Alternative Medicine

Culturally, many of the attributes that accompany barriers are prevalent within all farm-working groups and include, but not limited to health beliefs, embarrassment, shame, fatalism, cost, transportation, and fear (Arcury & Quandt, 2007). The "hot-cold" or humoral theory is a health belief identified as a barrier to health care utilization and is responsible for farmworkers either delaying or ignoring medical care (Arcury & Quandt, 2007). In humoral theory, disease is viewed as entities separate from the body, which creates an imbalance in our bodies. Humors are composed of black bile (melan chole), blood, phlegm, and yellow bile (Harvard University, n.d.). Illnesses such as susto and caida de mollera are considered diseases related to an imbalance between the humors.

Other researchers also found that cultural differences created barriers to health care access for migrant farmworkers. Weigel and Armijos (2012) conducted a 10-month study on migrant farmworkers, their food security, nutrition, and health. The participants were migrant farmworkers along the border of Mexico (El Paso and Dona Ana County) with no reference to documentation status. Weigel and Armijos (2012) found that migrant farmworkers often preferred self-medication, spiritual leaders, and herbalists to treat or prevent illness. Researchers also noted that migrant farmworkers acknowledged they returned to Mexico for acute illness or treatment (Weigel & Armijos, 2012). The participants also noted that cost of medical care and ability to access professional care in Mexico was less time consuming and less expensive than in the U.S. (Weigel & Armijos, 2012). Weigel & Armijos (2012) found that 77.2% of participants paid for medical care on an out-of-pocket basis due to lack of insurance and that 12.8% of participants had

insurance through the Mexican Social Security Institute, a governmental organization that assists public health, pensions and social security. Another 2.8% had insurance through a Mexican health program, a public medical insurance, and 7.1% had Medicare or Medicaid from the United States (Weigel & Armijos, 2012).

Although Weigel and Armijos (2012) found that self-medication was a common practice among migrant farmworkers, their study did not examine the reasons for this practice. Horton and Stewart (2011), however, did investigate the reasons for the widespread practice of self-medication among migrant workers using a sample of 23 Mexican migrant farmworkers in Mendota, California. The researchers collected data for using participant observation and conducted multiple in-depth individual interviews with participants regarding self-medication (Horton & Stewart, 2011). The researchers found that all 23 participants reported taking medications that had not been prescribed by a physician and provided a variety of reasons for this behavior (Horton & Stewart, 2011). The most common reason for taking unprescribed medication was to avoid missing a day of work; participants reported that taking time off for medical appointments cost them needed pay and could also cost them their jobs (Horton & Stewart, 2011). Cultural factors associated with self-medication included a belief by migrant farmworkers that Mexican drugs were stronger than medications in the United States and distrust of the local health care system (Horton & Stewart, 2011). Lack of funds to cover the cost of a medical appointment and lack of health insurance, however, were financial reasons associated with self-medication (Horton & Stewart, 2011). Other researchers also found that Hispanic migrant farmworkers commonly used medications such as antibiotics without

prescriptions (McCullagh, Sanon, & Foley, 2015). Of the six participants who discussed self-medication during interviews with researchers, none provided cultural reasons for self-medication; all participants explained their use of medications without prescriptions was a means of conserving their limited financial resources (McCullagh et al., 2015).

Cultural differences between migrant workers and health care providers also resulted in challenges to obtaining quality care and support. Bail et al. (2012) described a series of communication inaccuracies that led to misinterpretations between a migrant woman who was a new mother and a health care worker who was providing in-home education and support related to infant care. The young mother had received an ample supply of baby food that the health care worker found unused since her last visit; because of this observation, she became concerned that the baby was not receiving adequate nutrition (Bail et al., 2012). The health care worker became frustrated with the young mother who had been feeding her baby a traditional broth in accordance with her background and culture (Bail et al., 2012). The young mother, it was discovered, had not used the baby cereal because she had never used this type of food and did not know how to prepare it; however, the health care worker's cultural assumptions prevented her from identifying this barrier (Bail et al., 2012). In another example of miscommunication based on cultural differences, the health care worker urged the young mother to obtain a crib for the baby, and the young mother agreed (Bail et al., 2012). The young mother created a cuna which was a type of sling that she had seen her mother make (Bail et al., 2012). When the health care worker observed the sling hanging in a closet, she became

very distraught and yelled at the mother; however, the young mother was merely acting upon her cultural traditions (Bail et al., 2012).

Agricultural Industry Work Culture

The work culture within agriculture represented another possible barrier to seeking medical care for migrant farmworkers (Arcury et al., 2012). Arcury et al. (2012) examined the health and safety culture of the agricultural industry using a sample of 300 migrant farmworkers in North Carolina. The researchers surveyed participants about their experience of pain, their perceptions of the safety and health culture of their employers, and whether they had worked while ill or injured (Arcury et al., 2012). Although a majority of farmworkers who completed surveys acknowledged a high-risk of injury and illness resulting from their work, a significant portion reported working while injured rather than the time to attend medically to the injury (Arcury et al., 2012). Many migrant farmworkers reported seeking medical care only for severe injuries or illnesses (Arcury, Grzywacz, Sidebottom, & Wiggins, 2013). The researchers suggested that this behavior was related to cultural aspects of agricultural work, in which injuries and accidents were seemingly an expected part of the job (Arcury et al., 2012). This work culture, coupled with a culture of masculinity that downplayed the seriousness of danger or injury, was associated with higher risk of harm and lower likelihood of seeking care for illness or injury (Arcury et al., 2012).

In summary, cultural factors contributed to lower access to health care services for migrant farmworkers. Cultural beliefs such as the “hot-cold” humoral theory of disease were related to voluntary delay or avoidance of medical care for migrant

farmworkers (Arcury & Quandt, 2007). Researchers also found a link between cultural practices of self-medication without a prescription or use of folk therapies and lower rates of medical care access for migrant workers (Horton & Stewart, 2011; Weigel & Armijos, 2012). Cultural norms of the agriculture industry were also identified as possible barriers to seeking medical care for injuries and illnesses for migrant farmworkers (Arcury et al., 2012). The expected nature of injury and illness in agricultural work may have resulted in migrant farmworkers downplaying the seriousness of conditions and failing to seek professional care (Arcury et al., 2012). The following section will discuss the impact of mobility and transportation barriers upon access to health care for migrant farmworkers.

Barriers Related to Mobility and Transportation

Low-income, underinsured, and uninsured individuals commonly reported transportation barriers when seeking medical care (Syed, Gerber, & Sharp, 2013). Consistent with these findings, researchers found that the seasonal mobility of migrant farmworkers had been a significant reason for the difficulty in obtaining health data on utilization of health care (Schmalzried & Fallon, 2012; Slesinger & Cautley, 2010). Seasonal migration between states also limited acquiring health care and utilization due to lack of knowledge in locating health services (Arcury & Quandt, 2007). Frequent changes in mobility additionally resulted in issues with retaining health care providers. Arcury and Quandt (2007) noted that approximately 40% of farmworkers found it challenging to locate follow-up care, thus preferring to delay care until their return visits to the same community.

Closely associated with mobility was insufficient transportation to health care facilities to obtain care. Schmalzried and Fallon (2012) conducted interviews with 42 migrant farmworkers in Ohio to examine factors associated with health care access. The researchers found that lack of transportation to medical clinics were one of the most frequently reported barriers to accessing health care among participants (Schmalzried & Fallon, 2012). The lack of driver's license or automobile insurance account for an estimated 42% of farmworkers in the U.S. who either drive or had access to cars for transportation to health care facilities (Arcury & Quandt, 2007). Lack of transportation or access to transportation resulted in a dependency on employers or friends to supply transportation for various necessities of daily living such as groceries, laundry, and health care (Arcury & Quandt, 2007). Temporary migrant farmworkers who were present in the U.S. legally via the H-2A visa were entitled to employer-provided transportation to essential health services (Feldman et al., 2009). In a survey of 186 Mexican migrants, researchers found that participants who reported transportation barriers were seven times more likely to have forgone needed medical care within the previous year compared with participants who could reliably access transportation (Martinez-Donate et al., 2014).

In summary, mobility and transportation issues created obstacles to accessing health care for migrant farmworkers. Because migrant farmworkers frequently changed working locations, they may have difficulty finding medical offices and developing a stable relationship with a medical provider (Arcury & Quandt, 2007; Slesinger & Cautley, 2010). Lack of reliable transportation was associated with delays in care, as well as more frequently forgoing needed medical care for migrant farmworkers (Arcury &

Quandt, 2007; Martinez-Donate et al., 2014). The next section will provide a discussion the financial barriers to obtaining health care experienced by migrant farmworkers.

Financial Barriers to Seeking Medical Care

The costs associated with seeking medical care created another significant barrier to obtaining care for migrant farmworkers. According to the Bureau of Labor Statistics (2015), in 2014, the median annual salary for agricultural workers was $19,330 or $9.30 per hour. This limited wage not only provided financial support for family members in the U.S., but often provided for family who remained in their native countries Connor, Layne, & Thomisee (2010). Traditionally farmworkers are not paid for time off related to illness or for health care visits (Arcury & Quandt, 2007; Schmalzried & Fallon, 2012). In a working conference of occupational health experts who specialized in the agricultural industry, Arcury et al. (2013) found that since most migrant farmworkers did not receive sick pay or other paid time off. Any time away from work to seek medical care resulted in lost wages; this prospect of losing wages was experienced as a barrier to seeking medical care for illness and injury by many migrant farmworkers (Arcury et al., 2013). In an associated finding, interviews with 23 Mexican migrant farmworkers, Horton and Stewart (2011) found that participants had declined to take medical time off from work out of fear that they would lose their jobs. In interviews with 42 migrant farmworkers in Ohio, Schmalzried and Fallon (2012) found that migrant farmworkers felt a sense of urgency to work according to the needs of the crops; participants noted that failure to respond to the often-sensitive demands of crops would result in termination of their

employment. The next section I will discuss the lack of access to medical providers as a barrier experienced by migrant farmworkers.

Lack of Access to Medical Providers

The gaps between the migrant farmworker and the health care provider who diagnose and treat various conditions include cultural and linguistically appropriate services. The increase in migrant populations have created a strain on governments to provide health care services (Ghent, 2008). This strain was expected to increase with the U.S. acceptance of refugees (Ghent, 2008). There were few health centers servicing farmworkers throughout the U.S. as of 2012, and 154 federally funded health centers that provided health services to approximately 807,000 migrants (Bail et al., 2012). There were also 247 health centers with no subsidy served an additional 39,000 migrants (Rosenbaum & Shin, 2005).

Finlayson et al. (2014) conducted a study that illustrated the importance of local access to medical providers. Their sample included 213 randomly selected Hispanic farmworker families in Mendota, California who participated in interviews about their children's dental care and associated factors (Finlayson et al., 2014). The researchers investigated agricultural workers' children's dental care and found that having a local dental clinic was associated with more frequent care (Finlayson et al., 2014). The researchers suggested that because the farmworkers who had health insurance often had Medicaid, having a higher number of dentists who accepted this form of insurance increased access to dental care for farmworkers and their children (Finlayson et al., 2014). Lack of local access to migrant health centers or clinics that accepted Medicaid

created additional barriers to accessing health care for migrant farmworkers (Finlayson et al., 2014; Rosenbaum & Shin, 2005).

Legal Barriers to Accessing and Utilizing Medical Care

Migrant farmworkers who were not in the U.S. on a legal basis and sought medical care may have created legal concerns. In a case study of the migrant farmworkers' conditions in southern Georgia, Bail et al. (2012) found that concerns about illegal status prevented some migrant farmworkers from seeking medical care. One migrant worker who experienced severe multiple health conditions did seek care and was hospitalized but provided a false name to evade deportation (Bail et al., 2012). According to the principal informant for this case study, migrant workers commonly gave false identification and names if they sought medical care in order to avoid detection of their illegal residency status (Bail et al., 2012). In many cases, migrant workers would delay seeking medical care for as long as possible due to legal issues (Bail et al., 2012; Feldman et al., 2009). The key informant shared another account of a migrant worker whose behavior and effect had substantially changed over time. It was when the worker was urged to seek medical care that he learned of a brain tumor that was causing these health changes (Bail et al., 2012).

Fear of deportation was not consistently related to avoidance or delay of medical care in the reviewed research. López-Cevallos, Lee, and Donlan (2014) recruited 179 Mexican migrant farmworkers from eight labor camps in northwest Oregon to participate in surveys regarding their use of medical services, their church attendance, and their fear of deportation. All 179 participants who responded to the surveys accessed medical care

through a Federally-Qualified Health Center (FQHC), and the researchers suggested that their relationships with providers through the FQHC provided them with the security to seek medical care despite their illegal residency status (López-Cevallos et al., 2014). The researchers found that although 87% of undocumented farmworkers reported fear of deportation in surveys; their fear of deportation was not associated with reluctance to seek medical care (López-Cevallos et al., 2014). Another consideration was that the majority of participants attended church, which the researchers found was associated with higher use of medical services (López-Cevallos et al., 2014). The researchers suggested that church membership functioned as an enabler of health care access for undocumented farmworkers who participated in the study (López-Cevallos et al., 2014).

Overall, conclusions from this segment of the research reviewed were unclear. Although some migrant farmworkers experienced barriers to medical care due to fear of deportation (Bail et al., 2012), others were not similarly affected (López-Cevallos et al., 2014). It is possible that differences in methodology influenced the differences in findings between these studies. López-Cevallos et al. (2014) surveys of 179 undocumented farmworkers allowed them to voice their feelings about deportation and its effect on their health behaviors. On the other hand, the case study by Bail et al. (2012) drew upon the experiences and perspectives of a key informant, who reported on behalf of migrant farmworkers. It is possible that the key informant in Bail et al.'s (2012) case study overstated the effects of deportation fears upon seeking medical care.

Occupational Health and Safety in the Agricultural Industry

As the previous section illustrated, migrant farmworkers experienced a range of barriers that commonly prevented or delayed these individuals' access to medical care. The potential risks to health and safety of migrant farmworkers associated with lack of health care access was magnified when considered within the occupational health and safety context of the agricultural industry (Liebman et al., 2013). Although agricultural work was one of the most dangerous types of work, limited legal health and safety protections were provided for this industry (Liebman et al., 2013). Despite multiple efforts to reform laws, agricultural exceptionalism, a condition that precluded agricultural workers from many health and safety protections, had continued in the U.S. for decades (Liebman et al., 2013). The Occupational Safety and Health Administration (OSHA) that ensured workplace health and safety has frequently been absent from agricultural industries; policies requiring handwashing facilities, bathrooms, and drinking water in crop fields were rare examples of OSHA regulations that safeguarded farmworkers (Liebman et al., 2013).

The Worker Protection Standard (WPS) was a law that required personal protective equipment and employee training related to hazardous chemicals; however, the researchers noted that this law previously lacked enforcement in agriculture (Liebman et al., 2013). Further, unlike in other industries, OSHA had no requirement regarding medical monitoring of farmworkers who had experienced exposure to hazardous chemicals on the job (Liebman et al., 2013). The researchers reported that violations of health and labor regulations in agriculture were rarely investigated by federal agencies

(Liebman et al., 2013). An apparently systemic undervaluing of the health and safety of migrant farmworkers was also associated with safety climates among individual employers in the agricultural industry (Arcury et al., 2012). In researcher conducted by Kearney, Rodriguez, Quandt, Arcury, & Arcury, (2015), 87 individual Latino youth farmworkers in North Carolina were interviewed and evaluated the safety climates of their employers. The researchers asked participants a collection of questions about their work activities, safety practices on the job, and their perceptions of their employers' concern for worker safety (Kearney et al., 2015).

Responses indicated that most participants perceived their employers as having low regard for worker safety, and an inadequate safety climate at work was associated with lower rates of engagement in safe work practices by participants (Kearney et al., 2015). These findings were consistent with those of Arcury et al. (2012), who surveyed adult migrant farmworkers in North Carolina. Participants of this study also reported perceptions that their employers had low levels of concern for worker health and safety (Arcury et al., 2012). Although a majority of participants reported that their employers had informed them of dangers on the job, a majority also reported that their employers rarely praised safe practices and that new workers did not receive safety instructions (Arcury et al., 2012). Over 80% of participants reported that they never attended safety meetings and that personal protective equipment was not consistently available when needed on the job (Arcury et al., 2012). Contextualized within the broader occupational safety and health system deficiencies in agriculture described by Liebman et al. (2013), these findings suggested an overall low systemic regard for the health and safety of

migrant farmworkers (Kearney et al., 2015). The lack of protective laws and inadequate enforcement of legal safety and health protections created health vulnerabilities for this population; lack of reliable access to health care services compounded the risk of poor health outcomes (Arcury et al., 2012). The next section I will discuss in more detail the health outcomes associated with migrant farmworker status.

Health Outcomes Associated with Migrant Farmworker Status

Researchers found that barriers to health care access and utilization coupled with risk factors associated with working in agriculture resulted in several poor health outcomes for migrant farmworkers. For example, Arcury et al. (2012) surveyed 300 migrant farmworkers in North Carolina to examine their current experience of pain and depressive symptoms. Approximately 40% reported symptoms that were consistent with elevated musculoskeletal pain associated with their work activities of planting, cultivating, harvesting, and loading materials (Arcury et al., 2012). These findings were consistent with previous research that found 39% to 55% of migrant farmworkers experienced musculoskeletal pain (Frank, Liebman, Ryder, Weir, & Arcury, 2013; Kelly, Glick, Kulbok, Clayton, & Rovnyak, 2012). The researchers noted that 27.9% of participants reported depressive symptoms, but no association was found between these symptoms and the experience of unsafe conditions on the job (Arcury et al., 2012). Further, many participants reported continuing to work while injured rather than seeking medical care; this choice may have been partially related to perceptions of the employer's priorities (Arcury et al., 2012). Specifically, 26.3% of participants reported that their employer was most concerned with having the work completed quickly and

inexpensively, which may have created a barrier to taking time off work to obtain care (Arcury et al., 2012). The researchers also found that the experience of musculoskeletal pain was correlated with age, which suggested that this health condition developed over time and possibly worsened due to lack of proper medical care (Arcury et al., 2012).

In a review of the literature related to migrant farmworkers and health needs, Frank et al. (2013) also found that health risks interacted with low access to medical care to increase susceptibility to severe health conditions for this population. For example, farmworkers experienced a higher risk of developing chronic health conditions such as high blood pressure, obesity, and high cholesterol (Frank et al., 2013). Due to lower levels of access to medical care, migrant farmworkers were more likely to neglect these chronic health conditions and increased the likelihood of developing more acute health problems such as heart disease and vascular conditions (Frank et al., 2013). Similarly, ignored dental problems due to low access to dental care were more likely to develop into serious oral health issues over time (Frank et al., 2013). Frank et al. (2013) reported that migrant farmworkers were more likely than members of the general population to have cavities, missing teeth, and multiple decaying teeth. A similar pattern of risk for health issues combined with lack of access to care exacerbated susceptibility to mental health problems often experienced emotionally by migrant farmworkers in their journey to the U.S. (Frank et al., 2013). Altschuler (2013) noted that the emotional health of migrant workers was exacerbated by low access to the family and other social support systems they left behind to seek work.

Migrant Farmworkers and Mental Health

Other researchers examined specific mental health concern and stress related to the migrant farmworker lifestyle. Kossek & Burke (2014) suggested that migrants experienced additional stressors that are specific to their living and working conditions. They proposed that acculturative stress presented in migrants due to the difficulties associated with integrating into a new culture (Kossek & Burke, 2014). The researchers studied three variants of acculturative stress: demand stresses, opportunity stresses, and constraint stresses (Kossek & Burke, 2014). Demand stresses were related to a conflict with the dominant culture; opportunity stresses related to migrants' chances for higher levels of achievement in their new countries compared with their old countries (Kossek & Burke, 2014). Constraint stresses were related to obstacles to integration into the mainstream culture of their new countries (Kossek & Burke, 2014). In focus groups with migrant farmworkers in North Carolina, researchers asked participants to talk about their experiences of depression, stress, and coping (Winkelman, Chaney, & Bethel, 2013). The researchers used open-ended questions with follow-up probes to encourage participants to elaborate upon their perspectives and experiences (Winkelman et al., 2013). The researchers found that participants often reported a form of acculturative stress in association with separation from family members who stayed behind in their native countries (Winkelman et al., 2013). Mental stress and depression were most commonly described as resulting from separating from, and missing families when in search of work (Winkelman et al., 2013). Migrant workers further identified language, discrimination,

and exploitation resulting in additional reports of feeling stress over their documentation status and fears of deportation (Winkelman et al., 2013).

In a related study on stress in migrant workers, Carvajal et al. (2014) obtained a sample of 299 Mexican or Mexican-American farmworkers in the border region of Yuma County, Arizona through random selection of census blocks. Interviewers sought participants by going door-to-door in selected areas and requesting the participation of any household members who were 20 years of age or older and who had worked in agriculture within the previous year (Carvajal et al., 2014). Interviewers conducted surveys to collect information from participants about socio-demographic information, their experience of stress, and their current mental and physical health conditions (Carvajal et al., 2014). The researchers found that elevated stress was significantly associated with poorer reports of mental and physical health functioning (Carvajal et al., 2014). The researchers also found that 38% of the farmworkers who participated reported poor health, compared with 17.3% of Arizona residents and 24.4% of Latino Arizona residents (Carvajal et al., 2014).

Although the researchers did not assess for the effects of this variable, they suggested that lack of access to health care was related to the increased experience of stress and health problems for migrant farmworkers (Carvajal et al., 2014). Frank et al. (2013) further suggested that stress associated with long work hours, irregular periods of unemployment, and physically demanding work conditions are additional concerns related to mental health problems for migrant farmworkers. Winkelman et al. (2013) found that stress and depression in migrant farmworkers were reported in association

with lack of financial resources and separation from family. Low access to mental health care services would be expected to exacerbate stress and mental health issues (Frank et al., 2013).

Migrant Farmworkers and Prenatal Care

Prenatal care is another area of medical attention that is often lacking among migrant farmworkers. Frank et al. (2013) reported that less than half of pregnant migrant women who are farmworkers received prenatal care. Lack of access to prenatal care resulted in pregnant women experiencing poor nutrition, lacking prenatal vitamins, and failing to obtain even basic medical care during pregnancies (Frank et al., 2013). Poor nutrition, lack of medical care, and exposure to physical strain and agricultural chemicals during pregnancy all combined to create risks to fetal health for migrant farmworkers (Frank et al., 2013). Other researchers also found that lack of prenatal care for migrant farmworkers created risks to fetal health that were unknown to young mothers due to lack of health literacy and previous experience (Bail et al., 2012).

To summarize, migrant farmworkers were employed within an industrial context that did not provide substantial protection of their health and safety (Liebman et al., 2013). Migrant farmworkers engaged in dangerous work, which created a higher risk of illness, injury, and mental health issues (Arcury et al., 2012). In combination with these risk factors, lack of access to health care was associated with higher frequencies of chronic health conditions that may become severely exacerbated over time due to medical neglect (Frank et al., 2013). Physical health, dental health, prenatal health, and mental health was all placed at greater risk due to migrant farmworkers' lifestyles, separation

from social support networks, and lack of access to health care (Altschuler, 2013; Carvajal et al., 2014; Frank et al., 2013). The next section I will discuss research related to utilization of health care services by migrant farmworkers.

Health care Access and Utilization Among Migrant Farmworkers

Researchers have investigated the disparities in health care access, utilization, and health insurance status among migrant farmworkers. This section discussed research pertaining to health insurance coverage for the general population as well as the migrant farmworker population. It also discussed the implications of the Affordable Care Act for migrant farmworkers of documented and undocumented status. Finally, this section discussed the relationship between health insurance status and health care utilization for migrant farmworkers.

Workers' Compensation

Workers' compensation is a form of insurance coverage that applies to employees injured on the job (Frank et al., 2013; Liebman et al., 2013). Although workers' compensation, a requirement in other high-risk industries (i.e., fisheries and forestry), the laws regarding workers' compensation in agriculture vary across the U.S. (Frank et al., 2013; Liebman et al., 2013). Several states did not require workers' compensation for farmworkers, and other states required this coverage based upon the number of employees and days worked by each employee (Frank et al., 2013). Farmworkers with an H-2A visa, which allowed them to work on a temporary basis in the U.S., were automatically eligible for workers' compensation. However, Frank et al. (2013) noted that farmworkers with H-2A visas represented a small proportion of all migrant

farmworkers. The infrequent availability of workers' compensation for migrant farmworkers commonly prevented access and utilization of medical care when those workers became injured upon the job (Frank et al., 2013; Liebman et al., 2013). The next section I will discuss other forms of health insurance and their utilization within the migrant population.

Health Insurance, Health Care Access, and Utilization

The United States Census Department (2015) reported that approximately 10% of U.S. citizens lacked any form of health insurance in 2014. Anthony (2011) noted that access to health care in private settings was out of reach for many migrant farmworkers. Services offered at primary, and specialty practice offices and nonemergency care at hospitals were contingent upon the ability of the farmworker to pay, making the cost unaffordable for many immigrants. Frank et al. (2013) corroborated these findings in their research on migrant farmworkers. It was those barriers that caused migrant and seasonal farmworkers to utilize health care less frequently than other low-income populations.

Hoerster et al. (2011) found that in California, half the migrant farmworkers received medical care when compared to the national averages among other workers. Researchers Rosenbaum and Shin (2005) posited that of documented immigrants, less than 20% were found to have any form of employee-sponsored health insurance. Clark, Surry, and Contino (2008) observed that although 15% of the gross domestic product (GDP) was devoted to health care annually, those without health insurance were unable to take advantage of many of the health services. The problem was a global, national, and

state problem. Article 25 of the United Nations Declaration on Human Rights indicated that health care was a basic human right regardless of nationality or legal status (World Health Organization [WHO], 2008). Article 25 further implied that denying such rights was ethically and morally wrong (WHO, 2008). Migrant farmworkers, as a vulnerable population, had severely limited options when it came to health care.

Rosenbaum and Shin (2005) studied migrant and seasonal farmworkers (MSFW), their health challenges, access to health care, and health insurance coverage. Rosenbaum and Shin (2005) asserted that over 85% of MSFW's were underinsured or uninsured when compared to 37% of other low-income adults. Health care access among this population was also found to be low, with only 20% of MSFW's reportedly used health care services from 1998-2000 (Rosenbaum & Shin, 2005). The research was supported in a previous study conducted in 1999 by the California Agricultural Worker Health Survey (CAWHS) (Villarejo et al., 2010). The cross-sectional health survey included a question related to family composition, personal demographics, health insurance status, utilization of health care services, and other topics related to health and work history (Villarejo et al., 2010). Rosenbaum and Shin (2005) also found that 73% of males lacked any form of health insurance coverage and 25% had never visited a health clinic. Females in the study with incomes of $10,000-$12, 500 were worst with 69% females lacking health insurance coverage, and 13% have never visited a health clinic (Rosenbaum & Shin, 2005). When compared to workers with the same economic status, migrant farmworkers and their families were overwhelmingly uninsured. The costs associated with health insurance coverage removed the option of obtaining coverage and limited access for the MSFW

seeking health care services due to high associated costs (Cristancho, Garces, Peters, & Mueller, 2008).

Affordable Care Act

The Affordable Care Act (ACA) of 2010 required that all employers with 50 or more employees provide health insurance (Kresge Foundation, 2012). The result was that many companies were providing company funded medical clinics within the farming communities (Kresge Foundation, 2012). Furthermore, Frank et al. (2013) noted that the enactment of the ACA would provide health coverage for many lower socioeconomic workers in the United States, but it was unclear how the implementation of the ACA would affect the health insurance status and health care access of migrant farmworkers. Researchers in this article stated that the ACA might influence the under and uninsured immigrant workers who were unable to afford health care. However, the researchers expressed concern that the shortage of primary care providers and staff to treat migrant workers could result from policy changes under the ACA (Frank et al., 2013).

Following the implementation of the ACA, some researchers had assessed the health insurance status of migrant farmworkers compared with the general population. Moore, Mercado, Hill, and Katz (2016) obtained a sample of 293 farmworkers in Sonoma County, California from September 2013 to January 2014. The vast majority of the participants (95%) were male, Hispanic, or Latino, and although the researchers did not discuss the residency status of participants, they noted that 88% reported Sonoma County as their permanent residence (Moore et al., 2016). Participants completed surveys to describe their health conditions and their health insurance status; the researchers found

that 29.6% of participants had health insurance in the United States, compared with 85.7% of Sonoma County residents who had health insurance (Moore et al., 2016). Further, 43.9% of farmworkers reported having fair or poor health, compared with 13.1% of Sonoma County residents who reported similarly (Moore et al., 2016).

The researchers noted that the implementation of the ACA would not be expected to affect undocumented workers' insurance status, as they are not eligible for health insurance coverage under this law (Moore et al., 2016). The researchers expressed concern, however that farmworkers continued to report much lower rates of health insurance coverage compared with the general population, even after the passage of the ACA (Moore et al., 2016). The 29.6% of farmworkers with health insurance in Moore et al. (2016) study was comparable with the 27% of male migrant farmworkers who had some form of health insurance in Rosenbaum and Shin's (2005) study conducted over ten years previously. Similarly, Deringer (2010) conducted a study prior to the implementation of the ACA and found that about 30% of migrant farmworkers had some form of health insurance. Although these studies documented disparities in health insurance status among migrant farmworkers both before and after the ACA, they did not address whether participants were eligible for insurance. Additionally, these studies did not address any reasons for lack of utilization with available health insurance. The next section discussed a study in which researchers examined the relationship between health insurance status and medical care access among migrant farmworkers.

Relationship Between Health Insurance, Medical Care Access, and Utilization

In the present study, the researcher was interested in examining the relationship between health insurance status of migrant farmworkers and their access to medical care. Martinez-Donate et al. (2014) surveyed 186 Mexican migrants they recruited for participation at the border city of Tijuana, Mexico. The researchers obtained their sample through random sampling of venue-time pairs, in which the location and time of day of recruitment varied randomly (Martinez-Donate et al., 2014). The researchers approached prospective participants at the Tijuana Airport, a large bus station, and the deportation office in this city to invite them to participate in the study (Martinez-Donate et al., 2014). To be included in the study, individuals needed to be born in Mexico or another Latin American country excluded Tijuana residents. Other limitations included individuals who traveled for work, to look for work, or because of a change in residency (Martinez-Donate et al., 2014). Participants were both Northbound and Southbound and included individuals who had been deported from the United States (Martinez-Donate et al., 2014).

Participants completed surveys to provide information on their health care access, including health insurance status, utilization of health care services, and availability of a regular source of medical care (Martinez-Donate et al., 2012). The definition of access to health care was the timely use of personal health services to achieve the best health outcomes. Common health care access indicators included health care utilization, availability of a usual source of care, and forgone or delayed health care. The researchers found that 71% of participants did not have health insurance in the United States; further, approximately 11% of participants had gone without needed health care in the previous

year (Martinez-Donate et al., 2014). The researchers found that having health insurance was a significant predictor of access, but no data was found on the increased utilization of medical care within the previous year for these participants (Martinez-Donate et al., 2014). Migrants with health insurance were four times more likely to report having a regular source of medical care compared with migrants without health insurance (Martinez-Donate et al., 2014). The researchers noted that having a usual source of care, or a medical home, was associated with higher frequencies of obtaining preventive care and optimal disease management (Martinez-Donate et al., 2014). In the next section, migrant farmworkers' perspectives on health care was discussed.

Migrant Farmworkers' Perspectives on Health Care

There was a link between agricultural workers' vulnerability in their occupation and low access to health insurance, fear of health authorities, lack of job security and documentation. Acrury & Quandt (2007) obtained data collected from the California Agricultural Workers Health Survey (CAWHS), a statewide cross-sectional household survey conducted in 1999. The survey interviewed 654 workers using comprehensive physical examinations and personal risk behavior examinations by third-party medical professions. A cross-sectional, multi-stage stratified sampling selected seven communities within California's agricultural region. The ages of individuals ranged from 18 years and older who currently worked as hired labor with the agricultural industry. The survey identified several areas of interest such as family composition, health insurance status, and utilization of health care. Other areas that were assessed included physical examinations and a risk behavior interview that focused on drug use, health

habits and Worker's Compensation insurance. Researchers noted that access to health care was an important issue for farmworkers because of the risks associated with this occupation (Arcury et al., 2012). Farm work was considered one of the most physically and psychologically risky occupations due to the exposure to chemicals, hazardous work conditions, long work hours, and low pay (Acrury & Quandt, 2007; Arcury et al., 2012). What researchers discovered was that health beliefs among farmworkers in many ways affected their utilization of health care (Arcury & Quandt, 2007). Acrury and Quandt (2007) found that the majority of Hispanic farmworkers used either folk or self-medication as a means of utilization of health care. In research by Zoucha and Purnell (2003), heritage contributed greatly to the standard of living associated with migrant farmworkers. Workers from lower SES were considered "present-oriented," and had a more difficult time fitting in within local communities. The worker's income stability was thought to be significant, and with no means for planning for a future, many workers considered the future as indefinite, planning accordingly (Arcury & Quandt, 2007). Many workers became eligible for the Women, Infants, and Children Program (WIC) through Medicaid if in a location an extended period (Arcury & Quandt, 2007).

Summary and Conclusions

In summary, the scholarship related to migrant farmworkers and the utilization and access to health care provided an opportunity for further research in decreasing identified barriers. Previous studies has highlighted the barriers to access to health care for migrant farmworkers. These barriers included lack of transportation to medical appointments, inability to cover the costs of medical appointments and legal concerns

related to deportation (Arcury et al., 2013; Schmalzried & Fallon, 2012). Migrant farmworkers also experienced difficulty communicating with health care providers because of language differences, which resulted in reduced quality care (Altschuler, 2013; Bailey & Dougherty, 2014). Cultural differences were related to misunderstandings between patients and doctors and use of alternative methods of care for some migrant individuals (Bail et al., 2012; Weigel & Armijos, 2012). Lack of access to medical providers was another barrier to accessing health care (Hess, 2012). Notably, researchers found that lower utilization of medical care services was associated with health insurance status, suggesting that higher rates of insurance coverage might increase the frequency of medical care for migrant farmworkers (Martinez-Donate et al., 2014). These barriers were not new but illustrated the current need to address these issues relative to the change in the political environment and the potential influx of new immigrants within the next two years. The purpose of this qualitative study was to examine health care access and utilization among migrant farmworkers in Southwest Texas, United States. The next chapter will provide a detailed explanation of the methodology that would be utilized to address this study's research questions.

Chapter 3: Research Method

Research related to health care access or its effect on utilization in the migrant farmworker population of Southwest Texas was limited, which created a gap in knowledge regarding the challenges affecting this community. I conducted the present study to explore the beliefs, attitudes, and needs of migrant farmworkers in Southwest Texas, and to examine the relationship between health care access, disparities, and their effects on utilization of health care services. The disparities included the association between health insurance status, culture, geography, and health care access and utilization. In this chapter, I present details regarding the research methodology and data collection procedures.

The four objectives of this chapter are to (a) describe the research strategy and design of this study, (b) discuss the target population and tools used to obtain data, (c) explain the participant selection procedures and permissions obtained for access, and (d) explain the procedures used to obtain and analyze the data. Additionally, I discuss the ethical considerations, trustworthiness, potential researcher bias, and limitations. I also identify and discuss transferability of data across other contexts and settings. Finally, I include a summary of the principal points regarding the research methodology.

Research Design and Rationale

Qualitative research methods are used in various disciplines from program evaluation, health care queries, human development, and policy research (Cottrell & McKenzie, 2011). A qualitative design includes gathering textual data, analyzing data to identify themes, and describing the experiences of the participants (Leedy & Ormond,

2010). In qualitative methods, causality is not assessed, and interview questions are open-ended (Corbin & Strauss, 2014). Qualitative researchers explore the meaning individuals or groups ascribe to a social or human problem in their lives (Creswell, 2007). This research method involves analysis of inductive and deductive data from participant interviews to identify patterns or themes (Creswell, 2013; Creswell & Poth, 2015). What distinguishes qualitative research from other methods is the flexibility of the research design that begins with a formulated research question (Marshall & Rossman, 2011). In the current study, qualitative research methods were used to understand how health care utilization by migrant farmworkers health was affected by insurance, geographical location, and culture. Specifically, I examined how culture, insurance status, and geography impacted health care utilization among migrant farmworkers.

The qualitative phenomenological approach was appropriate for this study because it included several participants who described the common meaning or perception of lived experiences and related to their ability to access health care (see Creswell, 2007; Maxwell, 2013). Phenomenology is unique in this approach begins not with a theory, but with a phenomenon under investigation (Simon & Goes, 2011). According to Langdridge (as cited in Davidsen, 2013), the focus of phenomenological research changes depending on whether it is a pure description or informed interpretation. Lincoln and Guba (as cited in Davidsen, 2013) noted that cultural, social, and interpersonal contingencies as well as theory shape phenomenological research. Smith (2013) divided phenomenological studies into various types of experiences: perception, thought, memory, imagination, emotion, desire, volition to bodily awareness, embodied

action, and social activity including language. According to Husserl (as cited in Smith, 2003), the previous experiences were the intentionality or the directedness of the individual experience. The rationale for using phenomenology in the current study was to acknowledge that a participant's outcome was not a one-dimensional event but a composite of all of his or her experiences. The hermeneutical approach of phenomenology shares a multiperspective point of view of the participant and is oriented toward the lived experience and interpreted texts of life (Creswell, 2007; Smith, 2013). In-depth, semi-structured interviews included the concept of multiperspective point of view and allowed me to define the areas of interest while providing an opportunity to ask other questions that might be relevant to the study.

Research Question

The purpose of this phenomenological study was to explore and understand the lived experience of health care utilization among participants who worked in the agricultural trade as migrant farm workers. The aim was to explore the barriers to obtaining health care and to make recommendations for future implementation of resources to aid the migrant population. The central research question was the following: What does it mean to migrant farmworkers to have access to and utilize health care?

Participants

The target population in this study was migrant farmworkers in Southwest Texas which made up less than 14% of the total population of farmworkers in Texas (Bowen, 2012). In 2015, there were approximately 200,000 migrant farmworkers in Texas, 9,702 of whom were located in Southwest Texas (Bowen, 2012). The study sample was from

the population of migrant farmworkers registered with the Texas Farmworkers Union, Texas Governor's Office of Migrant Affairs, and Border Farmworkers Center.

Sampling and Sampling Procedures

Researchers use nonprobability convenience sampling to select a subset of the available population of participants based on their accessibility (Baker et al., 2013; Cottrell & McKenzie, 2011). I used nonprobability sampling to identify an appropriate subset of the target population. The minimum sample size of 10-12 participants ensured sufficient data for the study. Several factors affected the sample size. The sample had to be broad enough to ensure that all relevant perceptions were revealed and to achieve data saturation (see Mason, 2010). Phenomenological studies addressing health care services typically involve a sample size between 8 and 52 participants (Martins, 2008). However, all migrant farmworkers in the target population were considered potential participants in the study.

Recruitment

The goal of this study was to study the utilization of health care services among migrant farmworkers 20 years of age or older. The agencies used for recruitment included: Centro De Los Trabajadores Agrícolas Fronterizos Border Farmworker Center and Texas Governor's Office of Migrant Affairs. The agencies were governmental and private not-for-profit organizations dedicated to the health status of farmworkers and their families through information, training, and technical assistance. Purposeful selection of participants for this study was based on their current occupation and the criteria set for inclusion in the study. I placed a poster in the agencies describing the research and

requesting individuals to participate in a study on access and utilization of health care (see Appendix A). The flyers addressed the research study and provided my contact information. Individuals who were interested in participating in the study were instructed to contact me using the information provided in the flyer. After eligible participants contacted me, I scheduled a time for the interview. Before the interview, I asked the participants to sign a consent form and complete a demographic form for relevant background data. I then conducted the study using semistructured interviewing techniques. I asked open-ended questions about access and utilization of health care.

Role of the Researcher

Qualitative research is different from quantitative research in that the qualitative researcher is personally involved in every phase of the research process (Fink, n.d.). Prior to the study, I had the opportunity to observe the participants and their health issues. Over the last 15 years, I worked with migrant farmworker families as a community and school nurse and had firsthand knowledge of issues related to their health care. This experience may have influenced the data collection process due to my familiarity with the working conditions, limitations, and fears of the migrant farm worker community. Although this familiarity may have created potential bias, there were no difficulties with maintaining a professional relationship with the participants.

Instrumentation: Semistructured Interviews and Phenomenology

The primary data collection tools for this study were me and the semistructured interview protocol (see Appendix C). Natural scientific methods for obtaining a description from another individual using an interview is a subject-subject relationship

(Zagórska, 2005). The basis for this relationship is the premise that researcher looks at the consciousness of the individual without objectification (Englander, 2012). The main research question is developed based on criteria for discovering the meaning of the lived world (Brinkmann & Kvale, 2015; Englander, 2012). The central question in the current study was the following: What is the meaning of access and utilization of health care for migrant farmworkers in Southwest Texas?

The semistructured model, chosen for its flexibility, allows the researcher to understand the world from a participant's point of view, to obtain access to the participants' lived everyday world, and to clarify the meaning given to the experience (Patton, 2014). SES and cultural practices, based on the FCT, were considered when developing the interview protocol. Each open-ended question provided an opportunity for me to obtain data on migrant farmworkers' experiences accessing and utilizing health care. The protocol suggested by Creswell (2013) and Patton (2014) was developed with semistructured interview questions as a guide (see Appendix C). The interview questions were reviewed prior to the initial contact by the Executive Director of the Centro De Los Trabajadores Agrícolas Fronterizos, who worked one-to-one with migrant farmworkers along the Texas-New Mexico border.

Pilot Study

To further refine the interview guide, a pilot study was conducted before recruitment of participants for the full study. Krathwohl and Smith (2005) posit that pilot studies aided the researcher in clarify the wording of the questions and determine whether the questions were yielding the desired information (p. 21). I selected two participants for

the pilot study, reviewed the wording of the interview instructions, and the procedure with the participants. Data collection for the pilot study duplicated that of the main study. The results of the pilot study aided me in examining any changes to the instrument or data collection procedures prior to conducting the full study.

Data Collection

I obtained signed informed consent documents from each individual who agreed to participate prior to the interview and assured the respondents of their anonymity in the event of their participation. The primary source of data was obtained from open-ended interviews (see Appendix C). The strength of this approach was that it simplified the interview process and data could be readily analyzed and compared (Calenzuela & Shrivastava, n.d., p. 4).

The obtained data from the interviews included the experiences of migrant farmworkers, their utilization of emergency department (ED), public ambulatory care centers or clinics, and acute inpatient admissions. Farmworkers' experience with readmissions and their health insurance status, geographical data, and culture influences that affected health care decisions was also explored. The interviews began with open-ended questions such as: "What do you do when you are ill?" All interviews were tape-recorded with a length of the interview that varied from 30 – 40 minutes. As compensation, an endowment of a $5.00 gift card and a small meal was offered to individuals participating in the study.

Validity and Reliability of Instrument

An assessment of the instruments credibility was dependent not only on its validity but also its reliability. The validity of the instrument was determined by the researcher's answer to the question of whether the instrument adequately measured the phenomenon related to the subjects (Sullivan, 2011). I used the director of the agency as an expert in the field or a content expert and asked him to review the instrument as a method of assessing validity of the data collection tool.

Data Analysis Plan

In qualitative research, data analysis consisted of preparing and organizing the textual data taken from the transcripts and recordings; it was giving structure and meaning to a collected mass of data (Creswell, 2007; Hilal & Alabri, 2013). I reduced the data into themes through coding, condensing of the coding, and further reducing the data into figures that would be additionally analyzed to create nodes. I identified three general analysis procedures used by authors of the qualitative research. The most commonly used were critical ethnographic, systemic approach, and traditional approach (Creswell, 2007). Madison's ethnographic approach was appropriate for this study because it introduced creating a point of view that signaled interpretive framework, which were central to the analysis of theoretically oriented qualitative studies (Creswell, 2007).

The interviews were conducted in English and the participants allowed time to review the completed transcripts for clarification. The data obtained from the interviews was sorted, filtered, and transcribed into Microsoft Word for Windows before transferring the data into an Excel file. The data was then imported into Nvivo 12 for

Windows database as a classification sheet with attributes such as age, gender, and health insurance status. A confidential identification marker was assigned for each interviewee. I explored and coded all my sources, gathering data about the topic to create nodes for each question, beginning with the general topics of utilization and access of health services. I expanded to more specific topics of health insurance status, culture, and geographical location. These nodes were then reduced further to nodes called “health insurance” under which two nodes “no insurance” and “insurance” allowed me to refine the code to themes. I coded for other emerging themes, and created memos to record the findings using queries. Once the nodes were created, they were catalogued into a hierarchy, and drew connections between themes to compare attitudes based on demographic attributes (Hilal & Alabri, 2013). This process was instituted with each code until a visualized model or graph would tell the story of each participant. I utilized NVIVO 12 to perform a cluster analysis diagram that revealed posts grouped by word similarity.

Ethical Considerations

Primary source of data for this study was human participants who were considered a vulnerable population. Participants initially had an aversion to discussing their experience because of the nature of the questions and fear of future repercussions were considered and addressed. Thus, ethical considerations were important factors of the study, and to safeguard the confidentiality and anonymity of participants, I utilized anonymization of the data to ensure there was no identifiable information. I additionally maintained beneficial data with no recording of client names/identifiers in the research

documents. I sought approval of the Walden IRB, and no data was collected or participants contacted until consent was granted. All data collected in the study was stored and will be safely kept for five years after the completion of this study on a password-protected computer accessible only by me. After five years of completion of the study, all data will be deleted and destroyed with appropriate shredding programs such as Windows File Shredder.

Trustworthiness and Potential Research Bias

Guba, (as cited in Shenton, 2014) proposed that four criteria should be considered by qualitative researchers to demonstrate trustworthiness in a study. The constructs posited by Guba were (a) credibility, (b) transferability, (c) dependability, (d) and confirmability (as cited in Shenton, 2014). Credibility in qualitative research asked the question of how congruent the findings are with reality? I adopted well-established research methods such as conducting interviews with attention to sessions on data gathering and data analysis (Gill, Stewart, Treasure, & Chadwick, 2008). Additionally, having a familiarity with the culture that was participating in the study (migrant farmworkers) and using convenience sampling reduced the potential for researcher bias. Finally, I checked the accuracy of the account by members, used data triangulation through three sources of data (i.e., time, space, and person), and a collection of in-depth interviews (Hussein, 2009). The participants also had the opportunity to refuse to participate in the study (Shenton, 2004).

The transferability or external validity in this study considered whether other researchers could apply the utilized research method and data analysis to other situations

and populations. I confirmed that there was sufficient data about the fieldwork to enable others to make a transfer, and dependability would ensure that if others employed the same techniques in this study, would obtain similar results (Shenton, 2004). Finally, although confirmability or concern with objectivity and potential research bias could create issues with the validity of the study, the use of triangulation addressed some of these issues and reduced the effect of investigator bias. I have found no personal or professional bias at this time.

Limitations

The quality of the research is one of the objectives of qualitative research, and every research method had its limitations. Possible limitations of this proposed qualitative study was divided into two categories, methodological and researcher limitations (University of Southern California Research Guide, n.d.). Methodological limitations included (a) data collection measures used during the study could create obstacles for the researcher if the process of gathering the data inhibited the ability of the researcher to conduct a thorough analysis of the results (University of Southern California Research Guide, n.d.). This limitation was corrected by my acknowledgment of the deficiency and need for future research, and (b) the ability to independently verify self-reported data collected called upon the acknowledgment of trust in the honesty of the participant. Currently, there are no solutions for self-reported verification limitations.

The limitations were also related to contact with the participant such as (a) access denial to the venue or physical access to the participants by the agency or the individual. A solution was use of multiple site availability for selection of participants addressed this

issue; (b) cultural bias or the inaccurate view of the individual was an additional researcher limitation. This challenge could reflect on the researcher if it was used to support a specific theory or finding. I viewed the problem critically and sought the assistance of the chair to review the problem and data. (c) Language fluency or not understanding the native language of the participants could have had an impact on the ability to adequately explain the study or understand the responses. The solution to this problem in selecting participants who were English speaking.

Summary

The study considered was a qualitative, phenomenological research design to examine experiences with health care access and utilization among migrant farmworkers in Southwest Texas, United States. The target population in this study was the migrant farmworkers residing in Southwest Texas. I used nonprobability convenience sampling that utilized the selection of a subset of the available population of participants based on their accessibility. The data was collected using in-depth interviews and analyzed through the development of themes and coding of data using NVIVO 12 analysis. The results obtained from the data collection procedures was presented in detail in Chapter 4 and the methodology chapter.

Chapter 4: Results

The purpose of this qualitative phenomenological study was to understand the phenomenon of access and utilization of health care through the lived experience of migrant farmworkers in the Southwest Texas region. This chapter presents results of analyzed data related to the utilization of health care by migrant farmworkers with minor and major health concerns, cultural barriers, and health insurance as well as geographical locational effects. This study's focus was to identify themes, key components, and practices relating to higher-SES and the resources to engage in prevention or treatment by migrant farmworkers in Southwest Texas. In this chapter, I describe the relationship between health care access, utilization, health insurance status, and culture. The qualitative study addressed the lived experience of migrant farmworkers' access to and utilization of health care along the Southwest Texas border. Individual interviews with migrant farmworkers provided data for analysis. A purposive sample of 12 migrant farmworkers provided data that were analyzed to identify themes.

Phenomenological studies rely on choosing research participants whose commonality is their lived experience and contextual understanding of the phenomenon, which in the current study was migrant farmworkers' access to and utilization of health care. The research design includes elements shaped by cultural, social, and interpersonal contingencies as well as theory (Lincoln & Guba, as cited in Davidsen, 2013). The telephone interviews included open-ended questions and were recorded using a voice activated recorder.

NVivo 12 qualitative software was used to assist in identifying, coding, and establishing emergent themes based on common experiences (see Richards, 1999). This study was guided by following central question and subquestions (SQs):

Central question: What is the meaning of access and utilization of health care for migrant farmworkers in Southwest Texas?

SQ1: What is the experience of migrant farmworkers in El Paso County accessing and utilizing health care?

SQ2: What is the experience of migrant farmworkers related to obtaining health insurance and the utilization of health care services?

SQ3: How does the culture of migrant farmworkers in El Paso County affect health care utilization?

SQ4: How does distance affect the utilization of health care services?

Results

I conducted in-depth one-on-one interviews to explore migrant farmworkers' experiences to discover their values and behaviors in accessing and utilizing health care services. The central research question addressed the relevance of access and utilization of health care for migrant farmworkers in Southwest Texas. The first subquestion addressed the lived experiences of migrant farmworkers when attempting to access and utilize health care. The revealed themes were related to medical necessity, culture, denial, referral, and lack of availability of clinics. The second subquestion addressed migrant farmworkers' experience regarding obtaining health insurance and health care utilization. The data analysis revealed themes related to a lack of knowledge, outreach services, and

financial barriers. The third subquestion related to migrant farmworkers' cultural beliefs and their effect on health care utilization. The themes that emerged were health beliefs, religion, preventive behavior, and financial perceptions. The fourth subquestion addressed the effect of distance on the utilization of health care services. Thematic analysis revealed themes related to location, availability, work hours, and transportation.

Pilot Study

Prior to the recruitment of participants for the full study, I conducted a pilot study by selecting two participants. The purpose of the pilot study was to examine the clarity of the wording of the questions and determine potential time frames required for answering the questions and establish whether the questions would yield the desired information. I received initial approval by Walden University IRB (06-13-19-0148972) and contacted the Centro De Los Trabajadores Agrícolas Fronterizos site and met with the director to discuss placement of the approved flyer for advertising this study in the recreational rooms, cafeteria, and front windows. After 2 days, I was notified by the agency that several candidates responded to my posters. I visited the agency and met one-on-one with and screened 18 potential candidates. Two participants who represented local migrant farmworkers were selected for the pilot study. The next day I returned to the agency, spoke with the other 16 potential candidates, and selected 10 participants for further interviews and recruitment for the study based on age (20 years and older), gender (for diversity), and employment status as farmworkers. Four potential candidates did not return for the interview, and I discovered they had left El Paso to work in another state.

The data obtained from the participants in the pilot study were included in the full study in order to increase the efficiency of the main study

During the pilot study, when I attempted to interview each candidate, I discovered each had difficulty concentrating during the interview process. I discovered hunger and fatigue as the explanation for the inability of the participants to concentrate on the interview questions. Each participant I attempted to interview interrupted the questioning and left the office to buy a burrito. This created an interruption in the progression of the interview when the participant failed to return after 30 minutes. I determined that providing a small meal prior to the interviews might prevent this delay, so I submitted a request for change in procedures form to the Walden University IRB requesting permission to offer a small meal to the participants prior to the interview. The request was approved, and all subsequent interviews included the provision of a small meal prior to starting the interview. The informed consent and other related documents required no further changes. Over a 4-week period, I interviewed the purposely selected 10 additional candidates face-to-face for this qualitative phenomenological study.

Setting

The interviews were conducted at the Centro De Los Trabajadores Agrícolas Fronterizos in central El Paso, a community center dedicated to farmworkers and low-income residents along the Mexico-Texas border. The Centro De Los Trabajadores Agrícolas Fronterizos provides lodging facilities and medical services in a modest clinic staffed by medical students from the local university. The clinic also provides English classes, arts, and recreation for children and adults. This setting was a place where

farmworkers met and resided during the work week and created a reluctance by the participants to freely share their information because of their "fear of outsiders".

A week prior to the interview, I was able to schedule a meeting with the participants at the research site, which allowed them to review the consent form and ask any lingering questions. I noticed there was tension when discussing the research and the procedures. The migrant farmworkers who had health insurance had concerns about whether the new president would make changes to the Affordable Care Act, (ACA) and others worried whether they would be able to afford health insurance in the future. In 2017, the new administration was perceived by the migrant community as being antagonistic to Hispanic migrant farmworkers. Additionally, the new administration signed H.R. 1628, the American Health Care Act, a replacement for the Affordable Care Act. The American Health Care Act would “no longer pay a key ACA health care subsidy and increase health insurance premiums” (American Health Care Act, 2017, p. 1). When these concerns were brought to my attention, I explained that policies related to health were going through several modifications before the final resolution would be presented. I also provided information on agencies with expertise on the subject upon request by participants.

Demographics

Twelve participants were interviewed for this study. These participants were purposively recruited from the Centro De Los Trabajadores Agrícolas Fronterizos, a community center. Most of the participants were male (11) and one female. Ten participants indicated their ethnicity as Mexican-American or Hispanic; two identified

their race as Native American. Demographic data were obtained from each participant including (a) age, (b) gender, (c) ethnicity, (d) education, (e) marital status, and (f) employment status. Table 1 presents the demographic data for the 12 participants interviewed. Additional information was obtained from broadening the line of questions during the interview process to include (a) insurance, (b) the number of clinics available locally, and (c) clinic distance.

Table 1

Participant Demographics

ID	Age	Gender	Race	Insurance	Education (grade level)	Marital status	Employment status
MF1	48	M	H	Yes	7th	M	S
MF2	57	M	H	No	8th	M	S
MF3	49	M	H	No	9th	M	S
MF4	28	M	H	No	8th	S	S
MF5	41	M	H	No	6th	M	S
MF6	59	M	H	No	7th	M	S
MF7	69	M	H	No	8th	M	S
MF8	60	M	H	No	9th	M	S
MF9	63	M	NA	No	10th	M	TW
MF10	17	M	NA	No	6th	M	S
MF11	65	F	H	Yes	5th	D	S
MF12	74	M	H	Yes	5th	M	S

Note. NA = Native American, H, =, Hispanic, and TW = temporary worker.

Data Collection

The respondents interviews were conducted at from the Centro De Los Trabajadores Agrícolas Fronterizos. The total number of migrant farmworkers screened were eighteen with twelve participants selected to participate in the study. The interviews consisted of seven broad, open-ended questions (see Appendix C) as a guide to provide a consistent model for the interviews. Data collection also included an additional eight demographic survey questions which provided background information related to the participant's health access and utilization. The selected participants were 28 years and older, 11 males, one female, one temporary worker, and 11 seasonal workers. Two respondents reported having health insurance.

The instrument I used for data collection was semi-structured interviews which focused on each participant lived experiences with health care access and utilization. The participants responses were also recorded using a digital recorder. A copy of the interview protocol and informed consent form (see Appendix C and D) were given to all participants and the contents explained prior to the interviews. All participants who agreed to participate in the study signed an informed consent form using their initials. Each participant was greeted and offered a small meal prior to the interview as noted in the change in procedures. Following their meal, each was escorted to a spare office previously assigned by the director. I reviewed the documents and confidentiality of the procedures with the interviewees. I also explained that the interview would be recorded and how the information would be used from my research. Throughout the interview, I

focused on participants response, visual cues of the participant and the tape recording allowed the participant to elaborate on the questions.

The interviews occurred over a four-week period and averaged 30-40 minutes for each participant across two days with a five-minute break to prevent fatigue. Each interview was conducted in a way that provided data saturation that was rich, vital, and substantive of the participants experience with the phenomenon of health care access and utilization (Fusch and Ness, 2015, p. 1409; Moustakas, 1994, p.116).

The phenomenological interviews involved obtaining descriptions of aspects of experiences of individuals in the "lifeworld. The supposition was that in a community, lives are shared through culture and linguistics, and their experiences identified and named consistently" (Bevin, 2014, p. 4; Kvale and Brinkmann, 2009, p.31). The transcribed interviews provided information on the low access and utilization of health care by migrant farmworkers.

Data Analysis

The data analysis was based on Bryman & Burgess (1994) steps for inductive analysis and Creswell (2013) qualitative content analysis process. Each participant's unique experience was examined, and data analyzed focusing on their lived experience as migrant farmworkers along the Texas-Mexico border (Southwest Texas).

In Step 1, The transcripts were read thoroughly, and the text data was recorded and reduced into a concise format. In Step 2, each participants interview was transcribed into Nvivo Pro precisely as recorded on digital recording and clarified vague statements from notes. Personal feelings related to the questions was withheld. In Step 3, I

established associations between research purposes and ensured that the results were directly related to the raw data related to the phenomenon studied and used verbatim quotes to ensure accuracy (Bryman & Burgess, 1994); Creswell, (2013). In Step 4, the interview transcripts were coded, and data organized concisely. The transcripts were then reread to determine whether new codes emerged from the data. None were determined. In Step 5, codes or labels were assigned and identified in the notes and transcripts. Data were organized into themes and subthemes to the link thematic relationship according to the inductive reasoning process (Creswell, 2013).

To suspend judgment and bracket personal opinion or what I already knew, I used Husserl's epoché's method when collecting and examining the data (Bednall, 2006). Cottrell and McKenzie (2011), noted that epoché or bracketing is often used to understand particular health care issues. As a result by demonstrating the validity of the data collected, analyzing of data, and reducing the information into significant statements, I was able to combine the information into themes that emphasized the lived experiences of the participants (Creswell, 2013; Chan, Fung, & Chien, 2013). Prior to developing my research questions, I began a reflexive journal where I listed personal conceptions conflicts relating to migrant farmworkers that may have tainted the research process. This journal allowed me to identify and address preconceptions throughout the research process (Tufford & Newman, 2018).

Coding Procedure

Prior to the interview, a file was created for each participant interviewed (i.e., MF1, MF2, MF3). Once data collection was completed, the data from the interview was

transcribed by the researcher and analysis begun. A packet containing research notes, the consent form, and demographic? A confidential identification marker was assigned to each participant. Questionnaires were saved in a manila envelope with the participants identifying marker. The envelope will be kept according to the Walden University protocol. No identifiable information was included in the transcripts or recordings, thus protecting participant confidentiality. Once transcribed, the data were clustered into nodes and themes according to experiences related to health care access and utilization. Excluded from the data was repetitive information and data unrelated to the description of the phenomenon. The data were analyzed and transcribed using Memoing (marginal notes), which formed the basis for creating the initial codes. A digital framework was developed after transcripts were completed, and the data was organized and transferred into an Excel document separated into columns using codes derived from questions as headings as described in Table 2. Throughout the process of data analysis, each statement was evaluated at an equal value (horizontalization).

The number of times a word appeared in the responses was represented as a visual illustration or word cloud and aided in an in-depth classification of themes. Each participant interview was read, and the data coded twice using Nvivo to ensure accuracy.

Table 2

Nodes with Themes and Subthemes Taken from Transcription

Node	Theme	Subtheme
Don't get sick	Denial of necessity	Culture
Illness or injury reason to see MD	Medical necessity	Culture
OTC medication use	Preventive behavior	Financial; self-medication
No money to see doctor	Perceived availability	Financial
No Services available near	Availability of services	Location
Physician must speak Spanish	Preferred traits	Language
Must be experienced	Preferred traits	Quality of service
Go to ED for serious illness	Medical necessity	Financial
Clinic too far away	Availability of service	Location
I don't have insurance	Perceived barrier	Financial; lack of access
Insurance would be helpful	Health beliefs	Financial; lack of utilization
Preference for healers	Availability of services	Religious Culture
Transportation to clinic is problematic	Work-related issue	Lack of access
No pay if goes to clinic	Work-related issue	Financial
The clinic is closed when I get off	Transportation	Availability; lack of access
Long work hours		Lack of utilization; financial

Table 3

Themes and Corresponding Subthemes by Research Question

Research questions	Theme	Subthemes
SQ1: What is the experience of migrant farmworkers in El Paso County accessing and utilizing health care?	Medical Necessity	Availability; denial; referral; culture
SQ2: What is the experience of migrant farmworkers related to obtaining health insurance and utilization of health care services?	Lack of Knowledge	Financial; outreach
SQ3: How does the culture of migrant farmworkers in El Paso County affect health care utilization?	Health belief	Religion; preventive behavior; financial
SQ4: How does distance affect the utilization of health services?	Location	Availability; work hours; transportation

Theme 1: Medical Necessity (Accessing Health Care)

The analysis of medical necessity explored the health conditions that led respondents to seek health care services and traits they were seeking in a health care provider. The data revealed that none of the respondents visited a hospital for minor illness or injuries but had cause to visit the hospital due to complications as a result of health issues. One of the main reasons participants disclosed for visiting the emergency department (ED) or health clinics was severe illness or health conditions that necessitated further medical intervention. The majority or 7 out of 12 participants noted that they rarely saw a doctor for minor illnesses such as colds, the flu, or what they considered

minor injuries. The participants who did see a physician only did so because of what they considered serious illness or injury.

Participant MF1 stated “I only visit the emergency if I am seriously injured or too sick,” and participant MF11 affirmed, “I went to the emergency department when I hurt my foot and was referred.”

MF5 stated “I don’t really see doctors for anything. I don’t need to. If I have a cold or feel sick, I drink tequila and feel better, or I use Mexican medicine or Alka-Seltzer. That’s all I need.”

Some of the named conditions migrant farmworkers listed for visiting the clinic or ED include;

- Heart condition (HTN, CHF)
- Illness (Pneumonia)
- Serious injury (broken ankle)
- Skin Disease (warts; unknown rash)

Several respondents denied ever seeing a physician but instead listed seeking medical care for dental and vision problems. One respondent, MF9 noted the following: “I don’t need to see the doctor, so I don’t go. Haven’t been for years. But I did go to see a dentist because I had a bad tooth. Does that count?”

MF7 stated “I don’t get sick…it’s been years since I saw a doctor. Once I had problems with an eye infection and had to see an eye doctor. But that was a long time ago.”

The subthemes were related to the availability of services, denial, referral to health care, and the culture of the migrant farmworkers that affected their decisions to access health care. For many migrant farmworkers, the ability to obtain access to and receive health care services is dependent on transportation. All respondents identified the limited number of health care clinics located within their reach as a cause of concern. The distance to providers and lack of transportation and clinic hours also contributed to their infrequent use of health care services. Because many of the migrant farmworkers are employed in rural communities, a majority stated that they "put off" seeing a doctor until they have to or wait for the community agency to provide care through an outreach clinic from the local medical school. The majority of respondents when questioned about geographical location and its effect on their seeking and utilizing health care, stated that they attempted to avoid absence from work because of lack of pay should they take time off. As an example, MF1 stated that "If I am injured or too sick, I ask my boss for a ride to the doctor. If he can't, then I use my telephone and call someone to come and pick me up and take me." MF3 stated, "I can't get to a doctor if I have no car. Also, if I go to the doctor, I don't get paid. So why would I take a lot of time and go to the doctor? Everyone has to get paid right? If I have to, I wait. I wait." MF2 "If I need to I ask my friend or family members…It just takes too long to get to the doctor."

When it came to how they learned of available health services, the majority of the respondents relied on family, friends, the internet, and medical referrals provided by the Centro De Los Trabajadores Agrícolas Fronterizos community clinics. The agency also provided periodic medical care using medical students from the local school and was

instrumental in assisting one respondent in obtaining health insurance and obtain information on local health care services.

MF4 stated, “When I become sick, I found that my family members and others I work with will tell me about a doctor to take of me and because they may know good doctors.” MF5 stated, “To find a doctor I look up the doctor on the phone that will see me, I also use the internet, or I use a phonebook. It doesn’t matter which one as long as I find a doctor.” MF9 stated, “If I need to find a doctor, my friends will help me or family members.” MF6 stated, “I once got a referral from the farmworkers agency, they have a clinic there and am able to see their doctors who come and treat us.”

The majority of respondents shared health care beliefs of many of the migrant culture of denying the need for doctors or medical care and would prefer to “ride it out.” The majority 11 of 12 also denied any type of preventive health care. Although there was a delay in seeking medical care for chronic illness and minor injuries, the respondents noted that most of their illnesses or injuries were resolved through self-medication. MF10 noted, “I don’t’ really need to see a doctor anyway. I take pills from stores, so do not need medical doctors most of the time.” MF8 stated, “I take herbs given to me to help with my sickness, and this is good for my hypertension.” MF7 stated, “I do not get sick. When I do see a doctor, it is if I get injured or I’m too sick to care for myself. Then I take pills from the store or rest until I feel better.”

Language was considered an obstacle for a majority of Migrant farmworkers when seeking health care services. Rosenbaum and Shin (2005) noted that 9 out of 10 migrant farmworkers read or speak little or no English and face significant language

barriers when accessing and utilizing medical services. All of the respondents stated that the ability to comprehend and communicate with medical personnel was essential for proper diagnosis and treatment of illness or injuries. In research by Meuter et al. (2015), found that migrant patients who were considered linguistically challenged, (where English is not their first language), must use a second language during health care encounter or rely on an interpreter. This problem they posited create limitations or barriers that could lead to psychological stress which could result in medical communication errors.

Understanding language in the context of a medical encounter is critical for communicating and understanding their health problems (Meuter et al. (2015). The analysis of data affirmed the results from previous research that determined that the ability to speak the same language as previously identified was considered significant by Latino migrant farmworkers in deciding to seek access to and utilization of health care. All twelve respondents identified language as an indicator for whether they would choose a particular clinic to utilize. MF3 stated, “If I can get checkup or physical. I want a doctor who speaks Spanish because I speak Spanish. It does not matter if the person is old, or female or male.” MF6 stated, “Language is important for me. I want a doctor who speaks Spanish and experience of doctor also matters. The gender or age of the person (doctor) is not important to me. Men or women can be good doctors.”

One respondent discussed an appointment where the medical student did not speak Spanish and was not certain whether they understood their medical problem. Another described a visit to a local hospital where the doctor did not speak her language

and had to wait for a translator. MF8 stated, “I want a doctor who speaks Spanish. It is my language, and If they speak my language, then I can tell them what is wrong with me. If not, then they cannot understand me.”

Theme 2: Lack of Knowledge (Health Insurance)

Health insurance is a problem for the majority of migrant farmworkers with only 3 of the 12 reported having insurance. Three of the respondents with health insurance denied that it influenced their decision to seek medical care. While those without health insurance stated that insurance would help them access health care and noted a lack of knowledge relating to obtaining insurance and finances as barriers may preclude their attaining coverage. Although outreach services are provided to the migrant farmworkers by various agencies throughout El Paso, the majority still were uncertain or cautious as to how and where to apply for health insurance. The respondents who did have insurance noted that they discovered the information through the Centro De Los Trabajadores Agrícolas Fronterizos. One respondent, MF5 stated, “Living at the agency, people used to come by, and we would see a doctor. We had people here a week, ago and they sign you up for dental, insurance.”

The financial aspects related to health care are linked to migrant farmworkers accessing, and utilization of health care services was tied to the unpaid time-off required to seek medical care for illness or injury. Although professional care is available in neighborhood clinics, many of the respondents considered the small fee still too expensive with their limited salaries. Participant MF1 recalled that “I work far away from the clinic… I no take time, or I don’t get paid.” MF2 stated, “I don’t get paid if I go to

doctor and stay too long. The clinic will have to be closer." MF3 noted, "Yes health insurance would help, but that doesn't matter because I don't have insurance, so I don't have a choice.

Theme 3: Cultural Beliefs (Health)

Health beliefs affects how Hispanics view their health care, and views are often shared within a culture. The belief that culture played a considerable part in migrant farmworkers decision in delaying medical care or avoiding medical treatment was not observed in this study. A significant proportion of respondents denied that their culture affected whether they accessed or used health care services. Of the 12 respondents, 10 indicated that despite the respect they have for their culture, they seldom visit local healers, and believed doctors are more experienced and efficient than local healers based on their past experience. MF1 found that "Both are different, ` and it depends on the situation whether I see doctors or healers. Healers are more spiritual. I see doctor if I need more experience." MF3 noted, "It depends on how I see and what I need. I see doctors or curandero whoever. It's all about what they know about my illness." MF5 stated, "I see doctors for when I get very sick, but the healers in my culture do not help. They just help take your money. If I am not really sick, I take pills from the pharmacy." MF6 stated, "My culture is important to me, but it does not matter when I see doctors. But the healers they like to take my money and do nothing for it. I try not to see them. I would rather wait and see someone in the clinic."

However, a small number of the respondents noted that they often patronize local healers because they felt that healers provided effective herbal remedies to some ailments

at a lower cost. In addition, some respondents selected either of the two (physician/healer) based on the severity of their condition. Respondents noted that local healers are often after their money and two believed healers helped them get well. MF7 stated "Does not. I see doctors, but I like curanderos, they give better medicines, cures for the same illness." MF4 stated that "It does not affect me. I know that Doctors have more knowledge. We have Healers who want you to believe they are real, but I don't' think they are real".

Several of the migrant farmworkers admitted to using traditional treatments as well as western treatments in health care. One of the common practices is utilizing a healer or *curanderos* to treat simple and serious illness/injuries. Although the worker may visit a healer, the majority stated that they preferred doctors when choosing health care. One respondent, MF7 explained, "I see doctors, but I like curanderos, they give better medicines, cures for the same illness." MF8 stated, "I see doctors, but the healers do help my high blood pressure. They give herbs to help with your sickness, and this is good for my hypertension."

Other preventive behaviors such as the use of over-the-counter were identified by migrant farmworkers because of the lower cost. One respondent verbalized the use of "alcohol" as a remedy for mild illnesses. Another respondent stated they used prescription medication from Mexican pharmacies. MF 10 stated, "I take pills from store so do not need medical most of the time. So that's what I do if I need medical care." MF3 stated, "I do not see doctor for colds or something recently, I can get pills at the pharmacy (OTC)."

Theme 4: Location (Distance to a Clinic)

Data related to geographical location revealed various responses related to this theme. Local clinics are an average of 10 miles from the farms which employ migrant farmworkers. Clinical access and distance are noted in *Table 4*. Although the distance means there are no health care clinics within walking distance for respondents, the majority noted that distance from their workplace to the hospital or clinic did not in any way deter them from seeking medical care. The majority or 10 respondents received support from their bosses, friends, family members and colleagues in obtaining transportation to the health facilities. MF2 noted, “I will ask my friends, family or someone else.” MF8 stated, “I work far from the clinic. If I get sick then the Boss will give me a ride if he can’t, then others with the car are able to take me.”

However, two respondents pointed out they would often ignore access to medical care because there were no transportation available. The following responses captured the essence of this theme: MF3 stated, “If I have no way to get to a doctor if I have no transportation.” MF10 noted, “Does not matter the location. If I need help I will get a ride from the boss, if he won’t take me, I don’t go to the doctor and buy medicines from the local pharmacy or go over to Mexico.”

Table 4

Clinic Access

Participant	Number of Clinics	Distance to Clinic
MF1	1	30 minutes away
MF2	2	30 minutes away
MF3	1	1 hour away
MF4	2	1 hour away
MF5	2	20 minutes away
MF6	1	1 hour away
MF7	1	30 minutes away
MF8	1	1 hour away
MF9	1	15 minutes away
MF10	1	1 hour away
MF11	1	1 hour away
MF12	2	1 hour away

Respondents who did not cite distance as an issue were quick to note that long work hours would not allow them adequate time to visit a health care clinic. All of the respondents acknowledged working hours from 6:00 a.m. to 5:00 p.m. on weekdays when local clinics are open. Working 11 hours or more allows less time for farmworkers to find medical care or schedule appointments and the financial penalty for missed hours tend to discourage workers from seeking health care. This sentiment is reiterated in statements

by: **MF7** stated, “I would have a problem with them or If the clinic is too far away from where I live or work. I mean I work far away from the clinic. If I get really sick, I will ask my boss to take me. If no take me, I no take time, or I don’t get paid.” MF3 had the same opinion, “I have no way to get to the doctor, and if I have no transportation. If I just go to doctor, I don’t get paid.”

Evidence of Trustworthiness

The four criteria considered to demonstrate trustworthiness in this study were (a) credibility, (b) transferability, (c) dependability, (d) and confirmability (Guba as cited in Shenton, 2004). Credibility for this study was established by addressing the question of how congruent the findings were with reality. I used audiotaped one-on-one interviews conducted over multiple sessions with attention to gathering substantial descriptions of migrant farmworkers experiences with access to and utilization of health care. The member-checking procedure, according to Creswell (2013), increased the validity of the study. The data were obtained and analyzed to the point where no new findings, insights, themes, or concepts were detected, and saturation was reached. I also obtained data on the culture in the context of health care as it related to migrant farmworkers.

Additionally, although I had a familiarity with the culture of the participants in the study (migrant farmworkers), I reduced the potential for researcher bias by using convenience sampling. Finally, I checked the accuracy of the responses by participants using triangulation of sources obtained during the pilot study, in-depth interviews using private setting, and comparison of diverse points of view on health care (insured vs. uninsured) by migrant farmworkers.

The transferability or external validity in this study was related to whether other researchers could apply the research method and data analysis to other situations and populations. I ensured that there was sufficient data about the fieldwork and responses of participants through the use of digital audio recording which was transcribed precisely and coded to protect anonymity. The process would ensure that if others employed the same techniques in this study would obtain similar results (Shenton, 2004).

Finally, issues with confirmability, or concern with objectivity and potential researcher bias could create problems with validity of the study. In order to establish confirmability, I made regular entries or field notes within the Nvivo 12 program on the logistics of the study. Within the journal, I wrote information on the research methodology, my values and interests which might affect the research and questions regarding the analysis procedures. I also used triangulation of sources at different points of times throughout the study to compare migrant farmworkers different viewpoints and reduce the effect of researcher bias. Currently, I have found no personal or professional bias at this time. The data to support the results are presented in the next section.

Summary

The results from the semi-structured interviews presented in Chapter 4 used a purposive sample of 12 migrant farmworkers in Southwest Texas. The interviews explored how access and utilization of health care were experienced and understood by the individuals most impacted by the limitations to both. The data was collected, analyzed, and specific themes extracted based on the frequency of detailed responses.

The analysis of the collected data provided a greater comprehension of the migrant farmworker's lived experience in accessing and utilizing health care in Southwest Texas.

Based on the responses, a majority of participants in the study shared similar lived experiences related to the phenomenon of health care access and utilization. Many identified culture, language, and geographical location as impacting their ability to access and utilize health care. Chapter 5 will include an in-depth examination of the association between the FCT theory and the themes. I will also discuss my interpretation of these findings, implications for social change and recommendations for actions and necessity for future research.

Chapter 5: Discussion, Conclusions, and Recommendations

There are an estimated 2.5 to 3 million agricultural workers in the United States, and approximately 85,600 of those migrant and seasonal farmworkers are in Texas (NCFH, 2008). Migrant farmworker communities have cultural norms and values unique to their population. According to the NCFH (2014), migrant farmworkers are one of the most economically disadvantaged populations in the United States and may experience a range of cultural, structural, legal, financial, or geographic barriers along with discrimination, unemployment, and separation from the family unit. Rosenbaum and Shin (2005) found that migrant farmworkers lacked health insurance or employer-sponsored coverage. Rosenbaum and Shin also found that a lack of English-speaking skills contributes to barriers that hinder health care access and utilization. A better understanding of migrant farmworkers' heath perceptions and health care access and utilization experiences may be used to improve health care delivery and provide a clearer recognition of migrant farmworkers and their health care needs.

The purpose of this qualitative phenomenological study was to understand the lived experience of migrant farmworkers and the barriers that inhibit their accessing and utilizing health care. I used qualitative data collection to focus on health care issues unique to the migrant farmworker community. Face-to-face, in-depth interviews with 11 male and one female migrant farmworker in Southwest Texas were conducted. The data were collected and analyzed to answer the central question: What is the meaning of access and utilization of health care for migrant farmworkers in Southwest Texas?

In a phenomenological study, a participant's experience is not considered a one-dimensional event but rather a composite of all of his or her experiences (Rodriguez & Smith, 2018). This approach was used to provide a rich narrative to describe the personal experience of migrant farmworkers accessing and utilizing health care along the Southwest Texas border. Data collection involved in-depth interviews with 12 migrant farmworkers in El Paso, Texas. To ensure accuracy of data, I digitally recorded the interviews and transcribed them verbatim. NVivo 12 and Excel was used for analysis and data management on a password-protected computer. Inductive coding was used to analyze the raw data, which aided in identifying themes. This chapter presents an interpretation of the study findings in relation to the conceptual framework used to guide the study. I also present the limitations of the study, recommendations for further research, and implications for social change.

Interpretation of the Findings

All respondents in this study were migrant Hispanic farmworkers residing in a community agency. All respondents spoke Spanish as their primary language but spoke English as a second language. One respondent was female and 11 were male. Respondents discussed their lived experiences with access to and utilization of health care in Southwest Texas. The data analysis revealed that low-income migrant farmworkers shared similar experiences. The fundamental cause theory (FCT) posits that poor (lower income) and undereducated individuals have worse health outcomes than those who have more income and education (Phelan et al., 2004). SES also affects disease outcomes among migrant farmworkers who lack access to and utilization of

resources or health care services that can be used to avoid risks or minimize the consequences of a disease once it occurs (Flaskerud & DeLilly, 2012). As applied to this study on migrant farmworkers, FCT theory held that SES, social support systems, health insurance, and other barriers influenced the experiences of migrant farmworkers and their ability or opportunity to access and utilize health care (see Flaskerud & DeLilly, 2012).

According to Link and Phelan (1995), social factors cause health disparities because they affect an individual's access to health, and other resources directly impact multiple risk factors for disease and remain consistently associated with disease incidence despite variation in other predisposing risk factors. Link and Phelan also reasoned that health care providers are unable to appreciate why health inequalities exist if there is no clarification of why inequalities persist under certain conditions that should either eliminate or reduce them. The literature reviewed for this study indicated that migrant farmworkers often live in poverty, have lower rates of access to health insurance, and lack access to social and tangible supports (Altschuler, 2013).

The farmworkers in the current study were questioned using a demographic questionnaire to obtain data on age, marital status, language, educational level, and insurance status (see Table 1). Schensul (1999) reasoned that in order to collect valid and reliable data, researchers must frame questions in a manner that is culturally appropriate. Most of the farmworkers (11) in the current study were identified as having less than high school education, and education levels ranged from fifth to 10th grade. The findings were similar to those by the NCFH (2012) who estimated the average highest education level of migrant farmworkers was middle school (Grades 1-9). Health insurance was also an

issue with health care access and utilization with two of the 12 respondents identified as insured. These data were similar to those reported by the NCFH (2012) who found that 14% of agricultural workers reported being covered by employer-provided health insurance plans. Most of the respondents in the current study reported a lack of adequate income as well as a lack of information as reasons for not obtaining health insurance.

The first research subquestion was the following: What is the experience of migrant farmworkers in El Paso County accessing and utilizing health care? Through data analysis, a key theme that emerged was medical necessity. Medical necessity referred to health conditions that led respondents to seek health care services. Of the 12 respondents interviewed, 10 identified as having sought some form of medical care within the past 2 years, and two noted that they did not need any medical care. Most participants noted that they rarely saw a doctor for minor illnesses such as colds, the flu, or what they considered minor injuries.

The participants who did see a physician only did so because of what they considered serious illness or injury. Most participants acknowledge delaying treatment for common or chronic illness due to the infrequency of medical services, but none reported adverse health effects. This finding was consistent with research by Rosenbaum and Shin (2005), who noted that only 20% of migrant farmworkers used available health care services. Bail et al. (2012) posited that late diagnosis of serious illness or disease was a result of a lack of access and utilization of health care. Unlike the findings by Bail et al., none of the respondents in the current study noted any adverse events as a result of

delaying medical care. Bail et al. also posited that delayed diagnosis of treatable conditions could lead to an increased burden on the health care system.

When participants in the current study sought medical care, they named the agency where they resided as their first choice of medical care. The agency is a federally funded center that provides free intermittent medical care from students from the local university. Care is provided Monday through Friday and includes extended hours to accommodate the migrant workers. Respondents who used the clinics did so for various health conditions and reported experiences with health care as generally acceptable. Most participants denied having had serious negative experiences.

The second research subquestion was the following: What is the experience of migrant farmworkers related to obtaining health insurance and utilization of health care services? This question addressed clinical experiences of insured and uninsured respondents. Analysis of the data revealed themes related to lack of knowledge of and financial barriers to obtaining health insurance as well as how outreach within the community affects migrant farmworkers obtaining health insurance. Lack of knowledge by migrant farmworkers on how and where to obtain health insurance was related to whether insurance affected participants' choice in accessing and utilizing health care clinics and physician services. Most respondents (9 out of 12) denied having health insurance, and those who lacked insurance noted that they were not aware of how to obtain health insurance. A few participants stated that although outreach agencies visited the community agency where they resided and provided literature on obtaining health insurance, they continued to have difficulty with understanding the process and how it

would affect them financially. Several participants admitted that health insurance coverage would have increased their access to and utilization of medical care.

The three respondents who identified as insured (two with Medicare and one with ACA insurance) acknowledged that possessing insurance was an advantage that allowed them access to and utilization of medical care, but they admitted that they did not utilize their insurance for minor illnesses. The other nine respondents who reported having no insurance conceded that lack of coverage limited their ability to access or utilize health care services in the United States, which resulted in them relying on local free clinics or going to Mexico for health care needs. Findings from previous studies were consistent with this finding. In a study by Rosenbaum and Shin (2005), migrant farmworkers were identified as more likely to be poor and lack health insurance. These factors diminished access to and utilization of health services. Phelan, Link, and Tehranifar (2010) noted that according to FCT if migrant farmworkers had access to greater resources (health insurance), they would be better able to maintain their health and obtain medical care. However, findings from the current study indicated that having health insurance does not ensure that the migrant farmworker will access or utilize health services.

The financial factors related to migrant farmworkers accessing and utilizing health care services include unpaid time off required to seek medical care for illness or injury. Although professional care is available through neighborhood clinics, many of the respondents considered the fee too high with their limited salaries. This finding was consistent with the U.S. Farmworker Fact Sheet (n.d.), which indicated that only 28% of farmworkers report employer compensation for time off in cases of illness or injury. The

U.S. Farmworker Fact Sheet also indicated that nontraditional hours of conventional medical and social services for farmworkers are not always available, and efforts to work with employers who would enable migrant farmworkers easier access to medical providers, social services, and preventive health education are often nonexistent.

The third research subquestion was the following: How does the culture of migrant farmworkers affect health care utilization? This question addressed how culture affects health care access and utilization. Analysis of the data revealed themes related to health belief, religion, preventive behavior, and the financial aspects of health care access and utilization. The results of this study indicated that culture plays a minimal role in health care access and utilization among this population. Amerson (2008) posited that widespread use of alternative health care practices among Hispanics include herbal remedies, over-the-counter medications, curanderos (faith healers), self-prescribed antibiotics, and (limpias) spiritual cleansing. Amerson also noted that various cultural health practices could affect how migrant farmworkers interacts with traditional health care systems. Contrary to the Amersons study, I found no direct effect related to the interaction between traditional health care and alternative practices.

Several of the respondents in the current study verbalized respect for local healers and primarily used their services because they provided a low-cost alternative to conventional health services and were more accessible. Most of the respondents in the current study reported a preference for established traditional physicians and conventional health care services when they are available. Respondents also stated the preference for traditional care whey they are able to access the services. Two respondents

in the current study had unfavorable views related to local healers, and believed healers were more interested in the money than the individual's health. The participants perceived doctors as more qualified and experienced than healers. Among migrant farmworkers, the data from the current study found parallels to previous research where the majority of the respondents admitted to self-medication for minor injuries or illnesses. In the current study, I identified no association between culture and self-medication. Previous research by Horton & Stewart (2011) also suggested that some migrant farmworkers felt that Mexican drugs were stronger than those found in the U.S. which was consistent with my findings.

Health disparities, according to FCT theory and is evident in the current study of migrant farmworkers, I found that preventive behavior and financial difficulties are related to the availability of preventive health resources for low migrant farmworkers and access to health care services (Link and Phelan, 1995). In the current study, most of the respondents denied receiving preventive health care and preferred to self-medicate for minor illness or injuries. One of the 12 respondents identified as receiving any type of preventive care as part of his treatment and rationalized that the physical was part of the free clinic and "it didn't cost him anything…he did not have to pay."

The fourth research subquestion was the following: How does distance affect the utilization of health services? Geographic location is listed by Healthy People 2020 as one of the major disparities that create barriers to health equity and is often linked to discrimination or exclusion (Healthy People, 2020). Analysis of the data from the current study found that 9 of the 12 migrant farmworkers identified geographical location or

distance as an issue to access and utilization of health care services. Three respondents found that distance created issues with finding adequate transportation to medical clinics. Respondents in the current study listed supervisors, companions, relatives, and associates as alternative means of transportation to clinics or hospital locations. Respondents who cited geographical location as a problem also verbalized the use of self-medication as an alternative to health care utilization.

Consistent with these findings, Syed, Gerber and Sharp (2013) and Buzza et al., (2011) found that transportation barriers or geographical location a significant impediment in accessing and utilization of health care. Findings from a previous study by Martinez-Donate et al. (2014), found that 186 Mexican migrants reported transportation issues were seven times more likely to have forgone needed medical care within the previous year compared with participants who could reliably access transportation. In the current study I found that 6 out of 12 stated using the local agency, the Centro de los Trabajadores Agrícolas Fronterizos, if no transportation was available to other medical services. The agency is staffed by medical students from the local college and provides medical clinics for migrant farmworkers three days a week. These findings support the FCT theory that available resources (transportation) influence access to health care services (Chang and Lauderdale, 2009).

Limitations of the Study

Participants gender, sample size, and researchers bias, fear, access to participants, cultural bias and language were the principal limitations in this study. The gender of the participants in the current study consisted of 11male and one female. Female migrant

workers account for 22% of farmworkers compared to 78% male (NCFH, 2012). In the current study, the respondents were drawn from the small number of migrant farmworkers who frequented the Agriculture agency along the border of southwest Texas. Therefore, the study may not adequately depict the experiences of the majority of Mexican-American females.

The sample size for the current study was 12 volunteer participants who met the criteria of the study. The findings of the current study was based on the responses from the limited participants. A smaller sample size may potentially prevent the findings of a study from being extrapolated (Faber and Fonseca, 2014). A smaller sample size can also lead to voluntary response bias where respondents who participated in the study already had access to and knowledge of the research and participated because they felt strongly about the topic. In the current study I used purposive sampling to select participants from related professions which fit the research question.

One additional potential limitation in the current study was related to researcher bias. The researchers affinity with their subjects, data, theories, and concepts can lead to issues with trust and rigor of the research procedure (Norris, 2007). I addressed this limitation through transcribing detailed notes, using triangulation of the collected data, memo writing, and audio recording as methods to increase trustworthiness. I established an audit trail using memos and encouraged participants review of their transcribed interviews to ensure accuracy.

This current study was dependent on access to participants who were migrant farmworkers and a potential limitation. To ensure the availability and access to

participants, multiple sites were considered, and the Centro De Los Trabajadores Agrícolas Fronterizos in central El Paso was selected for the research. Fear of immigration officials was a unique limitation in this study. Participants were hesitant to share their stories but reconsidered after reassurance and transparency of information provided. Although all participants were either resident aliens or citizens their privacy concerns were addressed by my assurance and the center's director that the study was not a part of a government scheme. I accepted the participants information as truthful and focused on administering and obtaining data from each participant.

Cultural bias or misconceptions of an ethnic group as a limitation that was addressed by seeking assistance and guidance of my methodology chair. Although I had worked with migrant farmworkers families as a school nurse, and in that position had unconditional regard for the migrant farmworker. I developed an objectivity in overseeing the medical care of migrant farmworkers children and brought this impartiality to this current study. I am aware that complete relativism is not possible.

A potential limitation is language or the ability to understand responses and adequately explain the study. I addressed this problem by selecting participants who were bilingual.

Recommendations

This study was designed to be an exploratory look into the lived health care experiences and challenges of migrant farmworkers along the border of Southwest Texas when accessing and utilizing health care services. The themes that emerged from this study focused on perceived barriers that migrant farmworkers face within the medical

community. The study findings can be an opening into other perspectives in research on the impact of gender, culture, and location on migrant farmworkers. A major challenge for migrant farmworkers in Southwest Texas is the lack of local medical clinics that provide primary care within the geographical range of the work site. The second challenge is a lack of information on how and where to obtain medical insurance. Although there are outreach agencies to assist with providing material on health insurance, further research is required for assisting farmworkers with obtaining insurance.

The experiences of migrant farmworkers were limited to those who reside at a community sponsored agency. The findings of this study will contribute to the knowledge of migrant farmworkers culture and their expectations when accessing and utilizing health care. Future investigative studies could be on the lived experiences of other rural migrant communities to determine not only their differences but similarities in accessing and utilization of health care. The data would provide information on how to deliver consistent preventive and chronic health services to all migrant farmworkers. Future investigative studies could also explore the effect of mobile medical units on migrant health care. Finally, future qualitative research could be conducted within this population to explore how public health organizations and migrant communities can develop and implement programs related to providing services to migrant farmworkers.

Implications

This study will create positive social change by providing essential data that provide knowledge of migrant farm workers and their health care needs and practices in Southwest Texas can aid in improving the health and wellness of farmworkers. The data

from this research also supports the need for health care services that are more accessible and affordable.

The results of this study uphold the existing data related to migrant farmworkers regarding access to and utilization of health care and can be used to heighten awareness of the challenges and barriers farmworkers continue to face in Southwest Texas. Furthermore, the findings can heighten the awareness and understanding of the additional health care needs of the migrant farmworker community in providing accessible local outreach clinics. Current health care policies and regulations in Texas, while providing Medicaid and Medicare for the young and elderly, do not provide or guarantee access to health care services within all locations for many migrant farmworkers. Thus, the results of this study can be used to support the need for clinics that are within reach of farmworkers.

It is important to understand whether health insurance or other factors were barriers and the impact those limitations had on access and utilization. The FCT as applied to the study on migrant farmworkers holds that health insurance influence the experiences of migrant farmworkers and their ability or opportunity to access health care (Flaskerud & DeLilly, 2012). The knowledge obtained from this study will contribute to the improvement of health care delivery to migrant farmworkers by providing additional insights into the unique challenges related to their health care needs. Finally, this study provides information that can aid local, state, and federal agencies in assisting migrant farmworkers in obtaining needed health services.

Conclusion

This phenomenological study was implemented to understand the lived experience of migrant farmworkers accessing and utilizing health care services in Southwest Texas. The interview questions were loosely based on Patient Satisfaction Questionnaire (PSQ) and delved into the cultural beliefs, language, and health insurance status as well as location concerns that migrant farmworkers encounter when seeking health care. The findings of this study demonstrated how various barriers such as SES, limited access to health care, and language marginalizes farmworkers and affect health care access and utilization (Feldman et al., 2009).

This current study confirmed that while lack health insurance was a deciding factor on whether migrant farmworkers accessed or utilized health care services, distance to services, inflexible working hours, and cultural aspects related to seeking care were all essential factors in decisions on health care. Amenities related to health care can be improved by recognizing that the aforementioned barriers have to be addressed through coordination, communication, and collaboration of medical and nonmedical services to provide quality health care services to migrant farmworkers.

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Appendix A: Interview Questions

This interview is being conducted as part of an evaluation process to help plan for future health care needs of migrant farmworkers. The purpose of this qualitative phenomenological study is to understand how access and utilization are experienced and understood by the people (migrant farmworkers) most impacted by the limitations to both. In addition, I will also explore the association between health care access, utilization, health insurance status, culture, and locality. The following are the research questions that will guide this study:

Central Question: What does it mean to migrant farmworkers to have access to and the ability to utilize health care?

SQ1: Some individuals have difficulty deciding when choosing to utilize health care.

a. What experiences aided your decision in seeking medical care?

a. What specific health care features were you seeking when you sought medical care?

SQ2: **I am interested in knowing what your experience is in accessing health care access?

a. How did you find out about clinics or physicians?

b. **What previous experience have had with clinics and physicians?

c. **What about the clinic or physician appealed to you?

d. What does not appeal to you when choosing a clinic or physician?

SQ3: In what ways do you feel health insurance influenced your decision in seeking health care?

SQ4: In what ways do you feel your culture affects your utilization of health care?

SQ5: **As you think of your present employment, how do you feel your geographical location affected your access and utilization of health services?

**PQS-18 related questions

Appendix B: Interview Protocol

Exploring all aspects that affect health care access and utilization in the "migrant farmworker population

Time of interview:

Date:

Place:

Interviewer:

Interviewee: Demographics

Coded: Male: ____ Female: _____ Age: _____ Insurance: _____

Description of Project:

This interview is being conducted as part of an evaluation process to help plan for future health care needs of migrant farmworkers. The purpose of this qualitative phenomenological study is to understand how access and utilization are experienced and understood by the people (migrant farmworkers) most impacted by the limitations to both. In addition, I will also explore the association between health care access, utilization, health insurance status, culture, and locality.

Questions:

1. What is your experience in accessing health care access?
2. What is your experience with utilization of health care?
3. Do you have health insurance?

4. Does it affect you seeking health care?
5. How do you feel your culture affect your utilization of health care?
6. How does your geographical location affect utilization of health services?
7. How does your geographical location affect access to health services?

**Thank you for participating in this interview. The interview responses will be kept confidential.