

Awareness, Accessibility, and Utilization
of Health Care Services
by Migrant and Seasonal Farm Workers in Georgia

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Awareness, Accessibility, and Utilization of Health
Care Services by Migrant and Seasonal Farm
Workers in Georgia

By

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A report submitted to the
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Master of Public Health

Health Promotion and Education
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DEDICATION

*"Washing one's hands of the conflict
between the powerful and the powerless
means to side with the powerful,
not to remain neutral."*

- Paulo Freire

The present study is dedicated to the migrant and seasonal farm workers of the world and particularly those who took time out of their busy day to speak with me.

ACKNOWLEDGMENTS

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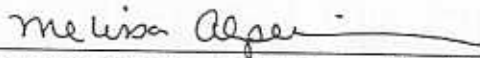
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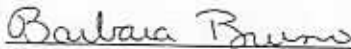
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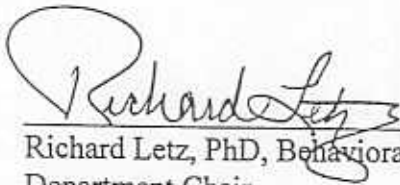
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Abstract

Awareness, Accessibility, and Utilization of Health Care Services by Migrant and Seasonal Farm Workers in Georgia.

Migrant and seasonal farm workers (MSFW) are at greater risk for health care problems due to their low socioeconomic status, occupational hazards, and migratory lifestyle. In addition, MSFWs face multiple barriers to accessing health care services. Most farm workers are uninsured and unfamiliar with the areas and local resources where they work. The Georgia Migrant Health Program (GMHP) was founded in 1990 to address the health care issues of the MSFW population in the state. A 1995 estimate places the maximum number of migrant and seasonal farm workers and their dependents during the peak harvesting months in Georgia at 100,359.

In the summer of 1995 an interview instrument was developed in Spanish and English to examine the level of awareness, accessibility, and utilization of health care services by MSFWs in the agricultural areas of south Georgia. One hundred interviews were conducted in two of the counties in which the GMHP operates. Housing sites were selected blindly by the interviewer from a list of migrant housing groups or camps in the counties. One member of every family dependent on migrant or seasonal farm work at the chosen sites was interviewed.

The interview collected data on demographics and travel patterns of the MSFWs. The MSFWs level of awareness of local primary care and outreach services, barriers to services, and utilization of services were also addressed.

Ninety-two percent of the sample were foreign-born Hispanics who preferred to be interviewed in Spanish. Older workers, women, and those traveling with family were more aware of services and women and those with family were more likely to have used services. More participants who had found the migrant health program through an outreach worker had used services than those who found the program through other means. The most common barrier cited was not knowing where to go for care. Knowledge of the program and registration for the program were correlated with use.

Recommendations include continuing and targeting outreach services either to women as gatekeepers of the community or to those segments of the population that are currently not being reached. Future studies to determine the significant barriers to care are needed, the data on barriers from the present study are very limited. Finally, more research is necessary to determine if knowledge and registration for the program can predict use of services.

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CHAPTER I

Introduction

Introduction

Migrant and seasonal farm workers have extreme difficulty accessing health care services due to their occupation and lifestyle (Rust, 1990; Goldsmith, 1989). The migrant and seasonal farm worker (MSFW) is subject to an unusual amount of barriers to accessing health care services. The majority of the MSFW population is poor, transient by nature, uninsured, and often unfamiliar with the area and local resources where they work. A large number of MSFWs in Georgia are unable to speak the English language and a small percentage are not documented citizens of the United States. It is often the case that the MSFW is at a greater risk for health care problems due to their socioeconomic status, occupational hazards, and substandard living conditions.

Migrant and seasonal farm workers and their families suffer from diverse health conditions. Skin ailments, eye problems, and injuries are some of the most common. The rate of tuberculosis in the MSFW population is six times that of the general population (Goldsmith, 1989). Infant mortality among migrant women is 125% higher than the national average, and the average life expectancy for farm workers is only 49 years (National Migrant Resource Program and Migrant Clinician Network, 1990).

Since the early part of this century, migrant and seasonal farm workers have been an important part of the U.S. economy. Agriculture in Georgia is a multi-billion dollar industry. In 1991, migrant and seasonal farm workers cultivated and harvested crops which accounted for more than \$300 million in sales by Georgia farms (Bureau of the

Census, 1994). The work that these manual laborers contribute to the agricultural industry is invaluable. There are an estimated three to five million migrant and seasonal farm workers and their dependents in the United States and some 100,000 in Georgia during the peak season each year (Winders, et al., 1995). MSFWs in Georgia pick peaches, watermelons, and tobacco, as well as vegetables of all kinds. They find work in the cotton gins, clearing fields, planting, packing, and loading agricultural products to be distributed throughout Georgia and the rest of the country. Migrant and seasonal farm workers have always had difficulty accessing the health care system in this country, however, as the population becomes increasingly foreign-born the issues of language, culture, and legal citizenship add greater complexity to the existing problems.

The agricultural industry of the United States depends on migrant and seasonal farm workers. Providing this workforce health care services is necessary to maintain the current agricultural economy and to serve the people on which our diet and sustenance is dependent. Because most farmers do not provide any type of insurance to MSFWs, the majority are uninsured and without resources to obtain health care services. Those workers who qualify for federal assistance programs like Medicaid only qualify in one state at a time, and must reapply in each state in which they work. Frequently, workers have to move to another state before they can receive the benefits of these programs.

Although there are many studies in the literature that look at the health care problems of migrant and seasonal farm workers in the United States in general, there is little known about farm workers' awareness of local services, accessibility to existing services, and their utilization of those services offered. Health care professionals

throughout the state of Georgia are concerned with improving services to this population. The communities in which the migrant and seasonal farm workers live and work are attempting to address the many issues presenting from the influx of this population. It is important to understand the situation regarding health care services for migrant and seasonal farm workers in Georgia in order to better learn how to use the limited resources of the state.

Purpose of the Study

The purpose of this study is to examine issues regarding awareness, accessibility, and utilization of health care services by migrant and seasonal farm workers in Georgia.

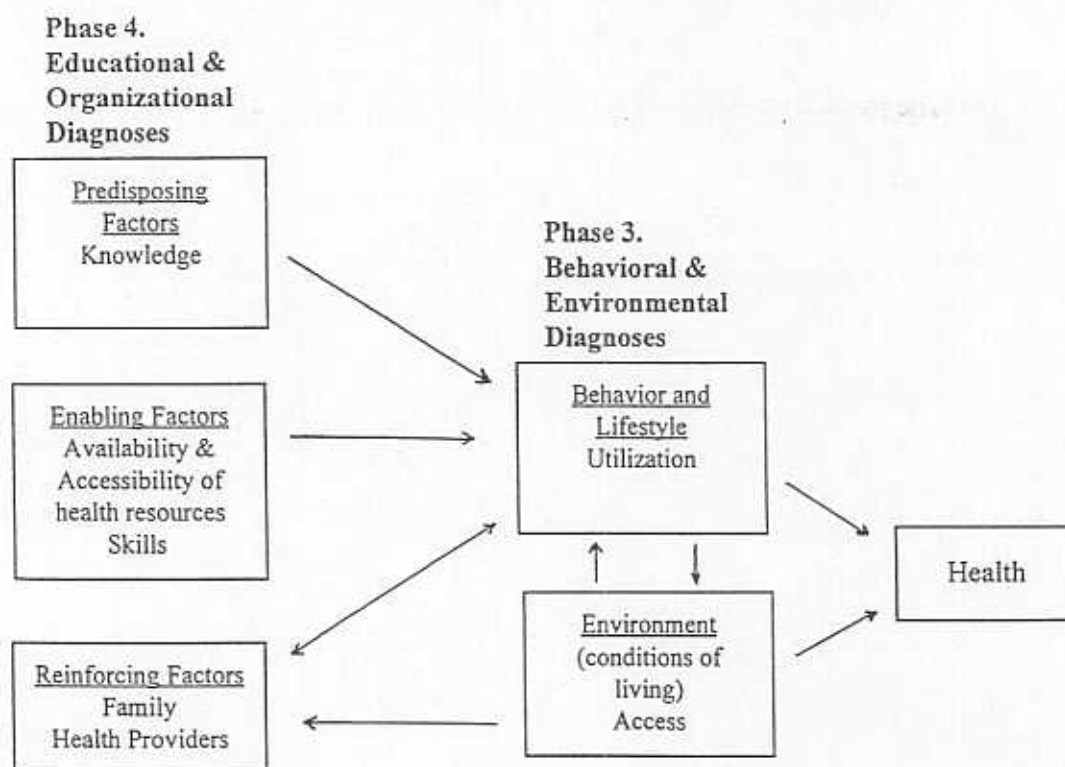
Theoretical Foundation

The present study explores issues of awareness, access, and utilization of health care services as they relate to personal, behavioral, and environmental factors affecting health care delivery to the individual migrant farm worker in rural Georgia. The theoretical basis for the study derives from two well - known models in health behavior and promotion. The early phases of Green and Kreuter's Precede-Proceed model and Bandura's Social Cognitive Theory provide the conceptual framework for the development of the study. The theoretical framework can serve as a reference point for shaping organizational change in migrant health services in Georgia.

Green and Kreuter's Precede-Proceed model would likely conceive of the present study as the early stages of health care planning. According to the theory, this research is

related to *Phase Three - Behavioral and Environmental Diagnosis* and *Phase Four - Educational and Organizational Diagnosis*, of the model. The constructs the present study considers from Phase Three are utilization (behavioral indicator) and access (environmental indicator). In Phase Four of the model, Green and Kreuter assert that any plan to influence behavior must consider three types of causal factors: predisposing, enabling, and reinforcing factors (Green and Kreuter, 1991). See Figure 1.

Figure 1. Phases & Constructs of the Precede-Proceed Model that Relate to the Present Study



For the present study, the significant predisposing factors are farm worker's knowledge and awareness of health care services. Enabling factors include the availability and accessibility of health care services, while family influences and experiences with the health care system and providers are considered reinforcing factors.

In Social Cognitive Theory (SCT), Bandura asserts that human behavior is explained through a three-way continually interactive relationship between personal factors, behavior, and environmental influences. Bandura has called this dynamic interaction, reciprocal determinism (Glanz, Lewis & Rimer, 1990). The constructs of the SCT that apply to the present research are defined in Table 1 and examples of how they relate to health care services for migrant and seasonal farm workers are presented.

Table 1.
Constructs of Social Cognitive Theory and Examples of Their Application to Health Care Services for Migrant and Seasonal Farm Workers

<u>Concept</u>	<u>Definition</u>	<u>Example</u>
Environment	Factors that are physically external to the person	Services available in county of work/ Where MSFW lives most of the year
Behavioral Capability	Knowledge and skill to perform a given behavior	Awareness/knowledge of the health care system and services for MSFWs
Reinforcements	Responses to a person's behavior that increase or decrease the likelihood of recurrence	MSFW's experiences with the health care system/providers

The constructs of the SCT outlined above provide the framework for examining awareness, access, and utilization in relation to personal, behavioral, and environmental variables for the present study.

The Precede- Proceed model and the Social Cognitive Theory provide support for the inclusion of the variables examined and the organization of the present research.

Research Questions

The present study will address the following research questions:

1. What level of awareness do migrant and seasonal farm workers in Georgia have of health care services?
2. What are the significant barriers to accessing health care services for migrant and seasonal farm workers in Georgia?
3. What are the health care utilization patterns of migrant and seasonal farm workers in Georgia?

Assumptions

The following assumptions are inherent in this study:

1. Respondents gave honest answers in the interview.
2. The questions in the Spanish version of the data collection instrument conveyed the same meaning as the questions in the English version of the instrument.

Definitions

Migrant Farm Worker: A worker whose principal employment is in agriculture on a seasonal basis and who establishes a temporary abode for the purpose of such employment. Migrant farm workers are usually hired laborers who are paid piecework, hourly, or daily wages and who have been so employed during the past twenty-four months. Dependent family members are included in the definition (National Association of Community Health Centers, 1992).

Seasonal Farm Worker: As above, except that the seasonal worker does not establish a temporary abode (National Association of Community Health Centers, 1992).

Health Care Services: Services that consist of activities related to health promotion, disease prevention, and diagnosis and treatment of disease.

Awareness: The amount of knowledge of, or familiarity with, health care services.

Accessibility: The level of ease in approaching, reaching, or using health care services and the level of ease in speaking with health care providers.

Utilization: The act of using health care services.

Barrier: Anything that obstructs access to health care services.

Precede - Proceed Model: A health promotion planning framework that includes a diagnostic phase called PRECEDE, and a developmental stage called PROCEED that initiates the implementation and evaluation process.

Social Cognitive Theory: A psychosocial model of behavior developed by Bandura that conceptualizes a triadic relationship between a person, the environment, and a behavior.

Reciprocal Determinism: A dynamic interaction of person, behavior, and the environment in which the behavior is performed.

CHAPTER II

Review of the Literature

The following review will examine existing literature on migrant health issues in general and will further discuss literature related to awareness, accessibility, and utilization of health care services by migrant and seasonal farm workers.

Introduction

"The fields of undiscovered knowledge in migrant health are vast and ready for harvest. More research is needed" (Rust, 1990, p. 1216). The research on migrant farm workers and their health is fragmented and frequently out of date. Several major literature reviews were undertaken in the 1980s. Rust (1990) reviewed MEDLINE files relating to migrant health between 1966 and 1989. The conclusions of these reviews are similar; there has not been enough quality research into the issues surrounding migrant health. Most of the research that has been conducted and documented focuses on barriers to care for migrant farm workers, nutritional status, dental health, pesticides, infectious disease, and health status as measured by diagnoses made in health clinics (Rust, 1990). Thus, many major components of migrant farm worker health have not been studied or documented. One issue in the literature is that research on migrants is usually conducted at the local or state level and can seldom be generalized to the larger national migrant population. Researchers have been unable to document the size and population characteristics of migrant farm workers in the US. This population is transient, not well defined, and not consistently captured in national population-based surveys, making it

virtually impossible to document the number of migrant and seasonal farm workers in this country (Slesinger, 1992). Other major unanswered questions in the migrant health literature include mortality and survival data, perinatal outcome data, data on chronic diseases, occupational risks, health-related behaviors, and accessibility to health care services (Rust, 1990). The present study will add to the migrant health literature by addressing access issues and researching migrant awareness of services and utilization patterns in the state of Georgia with an instrument that can be used by others at the local or state level.

Migrant and seasonal farm workers have been a major part of the U.S. agricultural economy since the early part of this century. Every state uses the labor of migrant and seasonal farm workers, and it is estimated that three to five million migrants, men, women, and children, live and work in the United States (Goldsmith, 1989). The country's first awakening to the migrant lifestyle came with John Steinbeck's 1939 novel, The Grapes of Wrath. During this time Franklin Delano Roosevelt's New Deal had attempted to address the problems of this workforce with the migrant health programs of the Farm Security Administration between 1935-1947. These programs were a federal effort to provide American agriculture with a more healthy and productive workforce through acute medical services, preventive medicine, and health education (Grey, 1993). The end of these migrant health programs came with the advent of World War II.

The current federal initiative to improve the health of the migrant workforce is the Migrant Health Program established when President Kennedy signed the Migrant Health Act in 1962. The Migrant Health Program is administered by the Department of Health

and Human Services and receives funds under Section 329 of the Public Health Service Act. The goal of the Migrant Health Program is to authorize the delivery of primary and supplemental health services to migrant and seasonal farm workers (Slesinger, 1992). This program has established migrant health programs in 33 states and Puerto Rico with 120 community health centers and clinics (Goldsmith, 1989).

Georgia is one of the states that receives federal support to run a migrant health program. The Georgia Migrant Health Program (GMHP) was established in 1990 to address the primary health care needs of the rapidly growing migrant and seasonal farm worker population in the state. The program is based in Atlanta in the Georgia State Office of Rural Health and Primary Care and has six satellite sites that serve farm workers in 18 counties. The GMHP is in need of a greater understanding of the population it serves and the issues surrounding delivery of services. The present research will add to this body of knowledge.

The migrant and seasonal farm workers' migratory lifestyle is plagued by poverty, substandard housing, occupational hazards, and poor health. The average annual household income is less than \$6,000 and housing conditions are often deplorable (Goldsmith, 1989). Migrants most often live in camps, trailers, apartment motels, or old houses. These facilities frequently lack electricity, plumbing, and heating or cooling capability. In eight major agricultural labor states, 35.2 percent of the farm worker housing lacked inside running water (NMRP, Date Unknown). Most often, several families will live in one structure, sometimes numbering fifteen or more people in one or two rooms. Housing is often near or in the fields, causing constant exposure to

agricultural chemicals. If housing is provided with a job, farm workers are suddenly homeless and unemployed when the job is completed (NACMH, 1995). According to the National Safety Council, farm work has become the most hazardous occupation in the U.S., outranking mining and construction work in terms of job-related injuries and death (NCPHCA, 1991). Low socioeconomic status, occupational hazards, and poor housing conditions contribute to the extremely poor health status of the migrant and seasonal farm worker population.

The average life expectancy for farm workers is 49 years compared with 76 years for the general U.S. population (National Migrant Resource Program and Migrant Clinician Network, 1990). Studies have found the infant mortality rate among migrant children to be more than twice the national average (NMRP, Date Unknown). Suffering from problems of the eyes and skin is common for migrants. Dermatitis is the most frequently reported occupational disease in agriculture (Slesinger, 1992). Dental problems are a major issue for the migrant population as well. Dental disease is the number one health problem for patients aged 10-14 (NMRP, Date Unknown). A Colorado study concluded that the dental needs of adult migrants were immediate and exceeded those of comparable populations (Littlefield, 1987). Nutritional status is also of great concern considering that the incidence of malnutrition among migrant farm workers is higher than any other sub-population in the US (NCPHCA, 1991). The use of pesticides is a constant contributor to the poor health status of migrant workers and their families causing not only short-term illness, but affecting unborn children and contributing to debilitating chronic disease (Rust, 1990). Infectious diseases are yet

another major concern for the migrant population. The living conditions and migratory lifestyle contribute to the spread of infectious disease. The death rates from influenza and pneumonia have been reported to be as much as 20 percent and 200 percent higher, respectively, than the national average (NMRP, Date Unknown). Farm workers are six times more likely to develop tuberculosis than the general population of employed adults. A recent study conducted by the CDC found that 44 percent of farm workers screened had positive tuberculosis skin test results (Goldsmith, 1989; NMRP, Date Unknown). A multidimensional approach must be adopted to address the many factors contributing to the poor health status of migrant farm workers. The national Migrant Health Program has begun to positively impact the health of this population. There is much more that needs to be learned to improve the health of farm workers and provide this country with a healthy and productive agricultural workforce.

Awareness of Health Care Services

The level of awareness of health care services implies the degree to which one is familiar with a service or program ranging from having simply heard of its existence to having used and understood the different components of that service. This concept of awareness is seldom mentioned in the migrant health literature or researched in the studies of migrant health. The Office of Migrant Health recently estimated that migrant health centers serve only about 13 percent of their target population (Slesinger, 1992). Researchers look at barriers to care to find out why such a small percentage of migrants is being served. The usual findings conclude that the major reasons migrants do not come

in for needed services are lack of money or transportation and loss of time from work. Very few researchers have asked migrants how aware they are of services, i.e., "Have you ever heard of services," "Do you know that services can be paid for on a sliding fee scale and cannot be refused based on inability to pay," and "Do you know that this clinic has nighttime hours every Tuesday?" Awareness as an enabling factor to help farm workers access health care services is under represented in migrant health research and literature. Only one study was found that addressed this issue. Slesinger and Ofstead (1990) in Wisconsin in 1989 looked at the migrant worker's level of knowledge and contact with migrant service organizations. They found that information about most programs had reached the majority of respondents and that most of the programs were being used by half or more of the migrants who had heard of them. Programmatically, if more research was conducted at the community level to gauge the degree of awareness of services, and awareness was found to be low, accessibility of services could be greatly increased by awareness campaigns of outreach and publicity.

Accessibility of Health Care Services

Access to health care services is a primary concern in the field of migrant health evidenced by the abundance of literature focusing on access issues. The barriers to accessing care for this population are complex and multidimensional. Migrant and seasonal farm workers live and work in rural areas that are chronically short of physicians and hospitals and where even the year-round population has difficulty accessing health care (Slesinger, 1992). Farm workers are rarely covered by health insurance, workers

compensation, or other standard employee benefits although they work in the most hazardous occupation in the country (NCPHCA, 1991). Although many farm workers fit eligibility profiles for programs such as Medicaid and the Food Stamp Program, very few are able to secure these benefits (NMRP, Date Unknown). Language and culture are major barriers to health care services for many migrant and seasonal farm workers. Approximately two-thirds of the workers in the United States are of Hispanic heritage (Slesinger, 1992). Many farm workers are unable to speak the English language and have cultural traditions of folk healing and medicine (Slesinger and Ofstead, 1990). Although at least eighty percent of farm workers are U.S. citizens or legal residents of the U.S., many report experiencing prejudice and hostility in the communities in which they live and work. The remaining undocumented workers are wary of the system and constantly in fear of arrest and deportation (Goldsmith, 1989; NMRP, Date Unknown). Poverty, lack of transportation, long work hours, and a migratory lifestyle also contribute to the difficulty of accessing needed services by migrant and seasonal farm workers (Slesinger and Ofstead, 1990; NMRP, Date Unknown; Goldsmith, 1989; NACMH, 1995).

Many migrant service organizations have implemented outreach programs to address farm workers' difficulty in accessing the health care system. The federal Migrant Health Program defines outreach as "making services known to the population and insuring that they can access all the services which are available" (NACMH, 1995). Despite this effort, in his review of the migrant health literature, Rust (1990) states that while services provided by migrant health centers may have improved the overall health of migrant families by improving their access to health care, there are very limited data

supporting this point. More research is needed to look at access issues and how outreach efforts can increase access to health care services for migrant workers.

The present study will highlight the major barriers to accessing health care for farm workers in Georgia communities. Migrant service organizations in the state can then identify strategies to reduce barriers and increase access to the health care system for the population they serve.

Utilization of Health Care Services

Utilization refers to how and why migrant farm workers choose to use or not use health care services, and what services are used and why. Utilization patterns alone cannot be used to determine the extent to which health needs are being met (Slesinger and Cautley, 1981). There is a small body of research that identifies how migrant and seasonal farm workers use the health care system. The factors that contribute to utilization behavior are multiple and complex. Chi (1985) discusses three major approaches to explain the relationship between various determinants and the utilization of health services among migrant farm workers in New York. The first approach is a social psychological perspective suggesting that utilization behavior is primarily a function of knowledge, perceptions of vulnerability to disease, severity of health problems, perceived benefits, and barriers to taking action. The second approach is a resource and opportunity approach that claims that utilization behavior is a result of the availability and accessibility of health services, and emphasizes structural, economical, and organizational variables. The third approach is a holistic perspective that synthesizes the major

components of the first two approaches. Here, utilization is a joint function of individual attributes and organizational factors (Chi, 1985). These varying approaches highlight the complexity of factors affecting the use or nonuse of health care services.

Most of the research conducted on migrant utilization behavior has been done in hospitals or clinics. The data are limited to presenting diagnoses and do not track ailments for which migrants do not seek care, seek the care of a traditional healer, or self treat. Studies usually use a nonrepresentative sample and seldom systematically research the importance of significant factors related to utilization behavior (Chi, 1985). A common conclusion of utilization studies is that most Hispanics, not only farm workers, practice what is called "crisis care," seeking care in critical situations when there is no other option (Munoz, 1988; Betchel et al, 1995). One study based on a sample of farm workers found that migrants receive much less preventive care than other groups in the U.S., especially for those under thirty years of age (Slesinger and Cautley, 1981). These data along with data from other studies indicate that a major issue in migrant health is increasing utilization of preventive care services by the migrant population (Slesinger and Cautley, 1981; Betchel et al, 1995).

A review of the literature on utilization patterns suggests that greater use can be made of existing services by the migrant population. Slesinger and Cautley in a study in 1981 suggest that publicizing information about existing services in migrant communities could be an effective strategy to increase utilization.

Summary

The existing literature on migrant health is difficult to locate, is not always rigorous in nature, and does not completely address the many complex issues that surround the health of this population. The data that do exist are most often local in scope and cannot be generalized to the migrant farm worker population as a whole. There is little data that researches the issues surrounding awareness of services by migrant and seasonal farm workers. The research on access issues discusses several classic common barriers to care for poor populations but does not exhaust the multiple factors that have an effect on access to health care services by this highly distinct and underserved population. Utilization behavior data for migrants also concentrate on very few issues and do not generate discussion and research of all of the possible complex factors associated with use or nonuse of health care services by migrant and seasonal farm workers. The present study will address issues of awareness, accessibility, and utilization of health care services by migrant and seasonal farm workers in Georgia.

CHAPTER III Methodology

Introduction

It is difficult to determine the best way to gather information on a population that is mobile, works long hours in rural areas, and is composed of many different ethnic and language groups. Many studies have looked at the medical records of migrant patients while others have done surveys of local groups of farm workers. Slesinger and Cautley note that officials from the National Center for Health Statistics and others who have used the Center's data suggest that in-depth local surveys are the way to address the needs of such unusual populations (Slesinger & Cautley, 1981). The present research used a detailed face to face interview to study the migrant and seasonal farm worker population in Georgia.

Target Population and Sample

The target population of the present study was the migrant and seasonal farm worker population. The federal guidelines of the Migrant Health Program define migrant farm workers as workers whose principal employment is in agriculture on a seasonal basis and who establish a temporary abode for the purpose of such employment. Migrant farm workers are usually hired laborers who are paid piecework, hourly, or daily wages and who have been so employed during the past twenty-four months. Dependent family members are included in the definition. The definition of seasonal farm workers is the

same except that the seasonal worker does not establish a temporary abode (National Association of Community Health Centers, 1992).

A non-probability convenience sample was used for this study because of the nature of the target population and the limited time and funding for the study. The sample of the present study was one hundred migrant and seasonal farm workers. There were an estimated 1,005 total workers in the study area at the time of data collection (Winders, et al., 1995). These numbers indicate an approximate ten percent response rate. However, calculating a response rate causes response to appear very low when one-hundred was the original target number for the sample due to the inability of a single interviewer to reach more people in the time allotted. Two counties in southern Georgia were selected as the study sites, both counties are part of the Georgia Migrant Health Program's service area. Toombs and Tift Counties were chosen based on the relatively large number of migrants working in the area at the time of the research and the availability of an outreach worker to assist the interviewer in locating farm workers. The local outreach worker generated a list of migrant living sites in the area and the interviewer selected approximately half of the sites for interviews. Only those workers who identified farm work as their principal source of income were included in the study. Three attempts were made to reach farm workers living at the selected sites. One hundred interviews were completed and no farm workers who were approached refused the interview.

Study Design and Procedures

The present research is a descriptive cross-sectional study. A face to face interview format was used.

An interview instrument was developed through review of other migrant and community health surveys and questions were formulated based on theoretical constructs of the Social Cognitive Theory and the Precede- Proceed model. The interview was translated into Spanish and reviewed by two native speakers, one from Colombia and one from Mexico, to ensure accuracy and understanding (see Appendix B). The questions selected for the interview were reviewed by an expert panel for inclusion in the study.

A single interviewer who spoke both Spanish and English was used to avoid error from inter-rater reliability, to reduce selection bias based on language, and to increase the response rate.

The interview instrument was pilot tested in a third project site of the Georgia Migrant Health Program (GMHP). Seven pilot interviews were conducted. Several minor changes to the interview instrument resulted from pilot testing.

Data collection took place in July and August of 1995. Toombs and Tift counties are located in southern, rural Georgia and are important agricultural areas. Toombs county is located near the city of Vidalia and therefore many of the migrants in the area work with the onion crop. At the time of the study there was also work in the fields picking tobacco, some vegetables were being harvested, and many men found work raking pine straw. Tift county, where the city of Tifton is located was also busy with tobacco picking and vegetables. The sites selected for interviewing were mostly trailer

parks or housing that farm workers rented generally the interviews took place inside a trailer or home. The interviewer spent one week in each county visiting the selected sites and interviewing farm workers. One member of each family living at the selected sites whose principal source of income was farm work was interviewed. Respondents chose the language of the interview (Spanish/English). Interviews lasted an average of five minutes.

Limitations

The sample size was limited by the time and funding for the study and by the single interviewer format. The original sampling method did not result in one-hundred interviews. Therefore, some interviews were conducted in locations other than originally selected sites and may bias the sample selection and representativeness.

Representativeness of the sample was biased by the collection of data in counties where the Georgia Migrant Health Program provides services and outreach. The sample may represent migrant and seasonal farm workers in Georgia for the demographic and travel information, however, the level of awareness and use of health care services among the sample is most likely elevated.

Data Collection Instrument

The fifty-one question interview instrument included demographic, travel, and health care related questions (see Appendix A). The instrument was designed to gather information related to the constructs of the Precede - Proceed model and Social Cognitive

Theory discussed in Chapter I. Therefore questions addressed environmental, personal, and behavioral factors that are suspected to affect health care service utilization by migrant and seasonal farm workers (see Table 2).

Table 2.
Theoretically - Based Interview Questions

Study Variables	SCT	Precede - Proceed	Interview Questions
Awareness (Dependent Variable)	<u>Person</u> Behavioral Capability	<u>Predisposing Factors</u> Knowledge Awareness	Do you know where to go if you need health care in this area? Do you know that there is a health program in the area that helps provide care for MSFWs?
Accessibility (Independent Variable)	<u>Person</u> Behavioral Capability	<u>Enabling Factors</u> Skills (health related)	Can you communicate in English?
Accessibility (Independent Variable)	<u>Environment</u> Environment	<u>Enabling Factors</u> Availability & Accessibility of health care resources	Have you ever met an outreach worker?
Utilization (Dependent Variable)	<u>Behavior</u> Reinforcements	Utilization <u>Reinforcing Factors</u> Health care providers	Did you go to see a health care provider? How was the overall service? Staff?

Questions on awareness such as "Do you know that there is a health program in the area that helps provide health care for migrant farm workers?" and "Do you know where to go if you need health care in this area?" related to personal factors. Questions related to behavior included "Do you carry medical records with you?", and "Did you go

to see a health care provider?". Finally, some of the questions that looked at environmental factors were "Are you here alone or with your family?", "Have you ever met an outreach worker?", and "Were interpretation services available in the clinic?".

The content validity of the instrument was supported by expert review. The reviewers included: Barbara Bruno, MA, Director of the GMHP, Russell Paulk and Frank Stilp, Project Coordinators of the GMHP, Filiberto Hernandez and Elia Vento, GMHP Outreach Workers, and Ken Resnicow, PhD, and Kathy Miner, PhD, professors and researchers of public health at Emory University. No additional measures were taken to ensure the validity and reliability of the instrument.

Measures

Categories for the dependent variables, awareness and use, were developed from various responses in the interview. Levels of awareness were created from two questions: "Do you know where to go if you need health care in this area?" and "Do you know that there is a health program in the area that helps provide care for migrant farm workers?". Those who responded "no" to both questions form the "unaware" group, those responding "yes" to the first question and "no" to the second, the "generally aware" group, and those who responded "yes" to both questions the "very aware" group.

Use categories were developed from the questions: "Have you had any need to see a health care provider since you've been in this area?" and consequently "Did you go to see a health care provider?". Those respondents who answered "no" to the first question form the "didn't need" group. Those who responded "yes" to the first question and "no"

to the second form the "need/didn't use" group, and those who responded "yes" to both questions are the "need/used" group.

Data Analysis

The completed interviews were entered into the Epi Info program and frequencies were calculated. The data set was then converted into SPSS for Windows for further analyses. Chi-square analyses were conducted to compare the dependent variables with independent categorical variables such as gender, preferred language, and county of interview. One-way ANOVA tests were done for comparison of the dependent variables with interval independent variables: age and time in the U.S. Results of the statistical analyses are reported in Chapter IV.

CHAPTER IV

Data Analysis and Findings

Results

Demographics

A total of 100 participants were interviewed (45 in Toombs County, 55 in Tift County). The estimated number of migrant farm workers in Toombs County for the month of July is 550 and in Tift County in August there are an estimated 455 workers. These numbers indicate an approximate eight percent response rate in Toombs and twelve percent in Tift. There were no refusals of the interview. Respondents included 37 women and 63 men. All respondents reported that their principal source of income was farm work. The mean age of participants was 28.5, the mode was 23, and the age range was 16-56 years of age. Ninety- one respondents reported that they were born in Mexico, one in Guatemala, and eight in the U.S. When asked what language he/she preferred to speak, ninety-two responded Spanish, eight English. Five of the respondents who preferred to speak Spanish answered "yes" to the question "Can you communicate in English?", 79 responded "no", and 15 "a little". The mean length of time in the U.S. (for foreign- born respondents only, $n = 92$) was 5.5 years. The majority of the respondents reported working with the tobacco crop (34%), vegetables (18%), or whatever work was available at the time (29%). Seventy- four respondents reported living in Georgia most of the year, eight in Texas, seven in Mexico, three in Florida, two in California, one in North Carolina, and five always traveling. Fifty-six participants reported working in the county in which they were interviewed prior to 1995. Many respondents reported that they came to Georgia directly from Mexico (38), some from Texas (13), and the others from a

variety of U.S. states. Fifty-seven participants reported that they were in Georgia with their families. Of those who were alone ($n = 43$), thirty had families in Mexico. Five respondents reported carrying a medical record with them as they migrated, however, 84% of those with family and children reported carrying child immunization records.

Awareness

What level of awareness do migrant and seasonal farm workers in Georgia have of health care services?

Analyses conducted with awareness found several significant associations (see Table 9). The levels of awareness, "unaware", "generally aware", and "very aware" consisted of 38, 9, and 53 respondents respectively (see Table 3). The number of respondents for each question varies due to skip patterns in the interview.

Table 3.

Percent of Sample by Level of Awareness

Levels of Awareness	Percent of Sample
Unaware	38
Generally Aware	9
Very Aware	53

Awareness was significantly related to gender ($\chi^2 = 18.7$, 2 df, $p = .00009$). Among women ($n = 37$), 81% were "very aware", 3% "generally aware", and 16% "unaware". Men reported being less aware (see Table 4) with 51% in the "unaware" group, 13% "generally aware", and 37% "very aware".

Table 4.
Level of Awareness by Gender

Gender	% Unaware	% Generally Aware	% Very Aware
Female	16.2	2.7	81.1
Male	50.8	12.7	36.5

A significant relationship was also found between awareness and the ability to communicate in English ($\chi^2 = 10.3$, 4 df, $p = .04$). Of those who reported that they could not communicate in English, 48% were "very aware" and 73% of those who reported communicating a little in English were "very aware" (see Table 5).

Table 5.
Level of Awareness by Ability to Communicate in English

Communicate in English	% Unaware	% Generally Aware	% Very Aware
Yes English	20.0	20.0	60.0
No English	45.6	6.3	48.1
A Little English	6.7	20.0	73.3

The variable for preferred language of the interview was not significantly associated with awareness. Awareness and being alone or with family were significantly related ($\chi^2 = 19.6$, 2 df, $p = .00006$). Of those in the "very aware" category, 77% reported living with family and 23% reported living alone (see Table 6). Sixty-one percent of those who reported being alone were "unaware" compared with twenty-one percent of those who reported being with family.

Table 6.
Level of Awareness by Traveling Alone or with Family

Alone/Family	% Unaware	% Generally Aware	% Very Aware
Alone	60.5	11.6	27.9
w/ Family	21.1	7.0	71.9

A fourth significant association was found between awareness and the county of interview ($\chi^2 = 10.2$, 2 df, $p = .006$). Of those who were interviewed in Toombs County, 53% were "unaware" compared with 26% of those interviewed in Tift County (see Table 7). Sixty-seven percent of those interviewed in Tift County were "very aware", thirty-six percent of those in Toombs County were "very aware".

Table 7.
Level of Awareness by County of Interview

County of Interview	% Unaware	% Generally Aware	% Very Aware
Toombs	53.3	11.1	35.6
Tift	25.5	7.3	67.3

Finally, awareness and where respondents reported living most of the year were significantly associated ($\chi^2 = 20.9$, 8 df, $p = .007$). Eighty-nine percent of those in the "very aware" group reported living in Georgia most of the year compared with two percent who reported living in Mexico most of the year. A significant relationship was found with age, $F(2, 97) = 3.98$, $p = .02$ (see Table 8). No significant association was found for awareness and time in the U.S.

Table 8.
Level of Awareness by Age

Age	Unaware	Generally Aware	Very Aware
Mean Age	26	27	31

Chi-square results for all of the variables discussed in the above text are presented in

Table 9.

Table 9.
Results of Univariate Analyses for Awareness

Variables	Statistic
Gender	$\chi^2 = 18.65, p = .00009^{**}$
English	$\chi^2 = 10.29, p = .04^*$
Preferred Language	$\chi^2 = .93, p = .63$
Alone/Family	$\chi^2 = 19.56, p = .00006^{**}$
County	$\chi^2 = 10.16, p = .006^{**}$
Live Most	$\chi^2 = 20.99, p = .007^{**}$
Age	$F = 3.98, p = .02^*$
Time in U.S.	$F = 1.29, p = .28$

Note. Significance = $*p < .05$, $**p < .01$.

Access

What are the significant barriers to accessing health care services for migrant and seasonal farm workers in Georgia?

Barriers to accessing health care were evaluated by asking those respondents who reported needing but not using health care services, why they had not received care. The respondents ($n=11$) were asked to give all reasons for not seeking care (see Table 10 for results).

Table 10.
Reported Barriers to Accessing Health Care

Barrier	% Responding Yes	% Responding No
No money	18	82
Transportation	18	82
Clinic hours	0	100
Loss of work wage	9	91
Didn't know where to go	45	55
No English	0	100
Other	27	73

Note. n = 11.

Forty-five percent cited "didn't know where to go" for care as a barrier. Lack of money and transportation were also cited as barriers. Of the three "other" responses, one was attributed to a recent problem, another to self-treatment, and the third to the distance of the clinic.

Utilization

What are the health care utilization patterns of migrant and seasonal farm workers in Georgia?

The categories of use, "didn't need", "need/didn't use", and "need/used" consisted of 57, 11, and 32 respondents respectively (see Table 11). Several significant associations were found for use (see Table 19).

Table 11.
Percent of Sample by Use Category

Category of Use	Percent of Sample
Didn't Need	57
Need/ Didn't Use	11
Need/ Used	32

A significant relationship was found between use and gender ($\chi^2 = 17.5$, 2 df, $p = .0002$). Only 32% of women reported that they didn't need care compared with 71% of men (see Table 12). Of those who reported that they needed but did not use services ($n = 11$), 64% were men and 36% women.

Table 12.
Category of Use by Gender

Gender	% Didn't Need	% Need/ Didn't Use	% Need/ Used
Male	71.4	11.1	17.5
Female	32.4	10.8	56.8

A significant association was found for use and preferred language ($\chi^2 = 7.2$, 2 df, $p = .03$). Of those who preferred to be interviewed in Spanish, 60% reported not needing care compared with 25% of those who preferred to be interviewed in English (see Table 13).

Table 13.
Category of Use by Preferred Language of Interview

Language	% Didn't Need	% Need/Didn't Use	% Need/Used
Spanish	59.8	8.7	31.5
English	25.0	37.5	37.5

Use and being alone or with family were significantly related ($\chi^2 = 14.7$, 2 df, $p = .0006$).

Of the respondents who reported need and use of services, 84% reported being with family, 16% reported being alone. For the participants who reported being in Georgia alone, 72% reported no need for care compared with 46% of those who reported being with family (see Table 14).

Table 14.

Category of Use by Traveling Alone or with Family

Alone/Family	% Didn't Need	% Need/ Didn't Use	% Need/ Used
Alone	72	16	12
Family	46	7	47

No significant association was found for use and ability to communicate in English or use and where respondents reported living most of the year. A significant relationship was found for use and knowledge of the migrant health program ($\chi^2 = 17.1$, 2 df, $p = .0002$). Of those who reported knowledge of the program ($n = 66$), 44% had needed and received care compared with 9% of those who did not know the program (see Table 15). Eighty-five percent of those reporting that they did not know about the program did not need health care services, forty-two percent of those who reported knowing of the program did not need services. Of those respondents who reported needing care and not using services, 82% reported knowledge of the program and 18% reported not knowing of the program.

Table 15.

Category of Use by Knowledge of the Program

Knowledge of Program	% Didn't Need	% Need/ Didn't Use	% Need/ Used
Yes	42.4	13.6	43.9
No	85.3	5.9	8.8

Significant associations were found for use and finding out about the program by word of mouth ($\chi^2 = 18.9$, 4 df, $p = .0008$) and through an outreach worker ($\chi^2 = 17.4$, 4 df, $p = .002$). Of those who reported finding the program through word of mouth, 38% needed and received care compared with 47% of those who reported finding out through an outreach worker (see Table 16).

Table 16.

Category of Use by Finding the Program through an Outreach Worker & Word of Mouth

How found program	% Didn't Need	% Need/ Didn't Use	% Need Used
Word/ Yes	44.1	17.6	38.2
Word/No	40.6	9.4	50.0
Worker/Yes	40.6	12.5	46.9
Worker/No	44.1	14.7	41.2

Use was not significantly related to reports of ever having met an outreach worker.

However, a significant association was found for use and registration with the program ($\chi^2 = 13.9$, 2 df, $p = .0009$). Of those registered for the migrant health program ($n = 45$), 61% reported needing and using services as compared with 14% of those not registered with the program (see Table 17). A larger percentage of those not registered with the program reported needing but not using services (27% not registered vs. 7% registered).

Table 17.

Category of Use by Registration with the Program

Registered	% Didn't Need	% Need/ Didn't Use	% Need/ Used
Yes	32.6	7.0	60.5
No	59.1	27.3	13.6

Like awareness, use was significantly related to the county of the interview ($\chi^2 = 10.6$, 2 df, $p = .005$). Only 2% of those interviewed in Tift County needed but did not use services compared with 22% of those interviewed in Toombs County (see Table 18). Thirty-six percent of those interviewed in Tift and twenty-seven percent of those in Toombs reported receiving needed care.

Table 18.

Category of Use by County of Interview

County of Interview	% Didn't Need	% Need/Didn't Use	% Need/Used
Toombs	51	22	27
Tift	62	2	36

Use was not significantly associated with age or time in the U.S.

Table 19.
Results of Univariate Analyses for Use

Variables	Statistic
Gender	$\chi^2 = 17.46, p = .0002^{**}$
Preferred Language	$\chi^2 = 7.19, p = .03^*$
English	$\chi^2 = 3.01, p = .55$
Alone/Family	$\chi^2 = 14.7, p = .0006^{**}$
Live Most	$\chi^2 = 11.58, p = .17$
Know Program	$\chi^2 = 17.10, p = .0002^{**}$
Word of Mouth	$\chi^2 = 18.88, p = .0008^{**}$
Ever met Worker	$\chi^2 = 17.38, p = .002^{**}$
Met Worker	$\chi^2 = 5.76, p = .06$
Registered	$\chi^2 = 13.94, p = .0009^{**}$
County	$\chi^2 = 10.59, p = .005^{**}$
Age	$F = .08, p = .92$
Time in U.S.	$F = .53, p = .59$

Note. Significance = $^*p < .05$, $^{**}p < .01$.

CHAPTER V

Conclusions, Implications, Recommendations

Summary

Migrant and seasonal farm workers (MSFW) experience extreme difficulty accessing health care services. An interview instrument was developed to explore issues related to accessibility and utilization of services by MSFWs in Georgia. One-hundred farm workers were interviewed face to face. Demographic data support findings from the literature that the farm worker population is generally young, increasingly foreign-born, and predominantly non-English speaking. Several demographic findings from this study suggest a shift from reports in the existing literature. The first is that most reports show that MSFWs spend very little time in each state in which they work. However, the data found that many of the workers interviewed (74%) reported living in Georgia most of the year. Secondly, a common finding is that most farm workers are single men and men away from families who live at a home-base. The present study found more than half of the respondents reported traveling and living with their families in Georgia. Lastly, some reports suggest that MSFWs will not carry health records with them, that they will get lost or destroyed. Findings from the present study suggest that MSFWs do carry vaccination records when they are given them.

Because of the lack of discussion in the literature on awareness, the findings in the present study are of particular interest. Several predictors of awareness were found. Older workers, women, and those with family were far more likely to be aware of services. Older workers may be more aware because they have a greater need for services

or because they have been in the migrant stream longer and know of local resources.

Women in many populations report a greater need for health care services than do men.

Like older workers, they may be more aware because of greater need. However, women are often seen as the caretaker of the family, particularly in the Hispanic culture.

Therefore, the women in the sample and those with family may be more aware of services because it is the woman's role to know how to care for the family. Predictors of awareness related to the environment included availability and accessibility of services; the number of respondents aware of services in Tift County was greater than that in Toombs County where there are fewer outreach services and no migrant health clinic. These data may be affected however, by sampling bias in Tift County. As expected, those who reported living in Georgia most of the year were more aware of available services. Several variables expected to affect awareness did not. No association was found with time in the U.S., and the inability to communicate in English did not negatively affect farm worker awareness.

Contrary to much of the existing literature, the most common barrier reported was not knowing where to go for health care services. Other responses support the frequently cited barriers of money, transportation, and loss of work hours. The data on barriers are limited by a single interview question directed at barrier information and the small number of respondents ($n = 11$).

The findings on use are similar to those for awareness. Women and those with families reported needing and using services more than men and workers alone. Again, this may be related to a greater need for services or to the woman's role as caretaker of

the family. Men traveling alone may be less likely to consider a health problem serious enough to seek care than would women in the family. Age and English-speaking ability did not predict use. Language of preference was associated with use, however, little variability in the data make it difficult to draw a conclusion. Findings confirm that knowledge of the program and registration for the program are correlated with use. It is not possible to explore if knowledge and registration can predict use because of the cross-sectional nature of the study. Other expected correlations included finding out about the program from an outreach worker and by word of mouth. More of those workers who reported discovering the program through program staff needed and used services. It is possible that use is higher for those who found out about the program through an outreach worker because the outreach worker was able to give the farm worker more information and to provide enabling services like transportation and interpretation. Like awareness, more use was reported in Tift County where more services were available and accessible. These county-specific data are subject to selection bias.

Implications

The findings of the present study support the use of the applied constructs of Social Cognitive Theory and the Precede - Proceed model in examining access and utilization issues for migrant and seasonal farm workers. The specific theoretical implications are that personal, behavioral, and environmental variables can individually affect awareness and use. One implication for research is the importance of considering awareness as a variable for examination. To increase awareness and use, results suggest

that implications for practice should include continuing and possibly targeting outreach services. Services appear to be reaching one segment of the farm worker population, therefore, practical implications include targeting those workers who are currently not being reached.

Limitations

Generalizability of the present study is limited by gathering data in two counties in the Georgia Migrant Health Program service area. Generalizing the findings to counties where no services specifically for migrant workers are available is not possible. However, results may be generalizable to areas that provide similar services.

Internal validity of the study may have been affected by interviewer bias and self report data which is subject to response bias and responses of social desirability. The power of some comparisons in the data are limited by sample size. Specifically, the data for barriers to care are limited by the number of respondents due to the skip pattern structure of the interview. Selection bias may be a significant limitation due to outreach worker influence on the selection of respondents and the inability to retain the original sampling method.

Despite these limitations, the present study provides a broader understanding of the migrant and seasonal farm worker population in Georgia. Results support changes in the environment of health care delivery through increasing the availability and accessibility of services. Findings also provide evidence on who is currently accessing services and highlight areas of need.

Recommendations

The findings of this study support several recommendations for migrant health programs. Programs should continue outreach services and consider targeting services either to women as gatekeepers of the community or to those segments of the community that are not currently being reached.

Further research is needed to explore the barriers to accessing care and determine if the significant barriers are systemic, cultural, or personal. Studies examining barriers might consider using a different methodology, possibly more qualitative, to collect richer data on what the most significant barriers are to accessing health care services. Further investigation of farm worker populations should consider a clear and unbiased sampling technique that is not related to any political influence in the community. Further studies should consider a research design that allows for examination of knowledge and registration with program services as predictors of use.

Future studies of migrant health access and utilization issues should consider some constructs of Social Cognitive Theory not employed in the present study. For example, self-efficacy and outcome expectancies in conjunction with the constructs considered in this study may be important for the examination of health care issues in relation to migrant and seasonal farm workers. More research is needed to explore circumstances where farm workers need and use primary health care services instead of choosing self-treatment, traditional healers, or waiting until a crisis occurs. Finally, it is recommended that the Georgia Migrant Health Program continue to explore the

population it serves in order to improve services.

REFERENCES

Bureau of the Census. *1992 Census of Agriculture, Vol. I, Geographic Area Series; Partio, Georgia*. Washington, D.C.: U.S. Department of Commerce, 1994.

Betchel G.A., Shepherd, M.A., Rogers, P.W. (1995). Family, Culture, and Health Practices Among Migrant Farmworkers. Journal of Community Health Nursing, 12 (1), 15-22.

Chi, P.S. (1985). Medical Utilization Patterns of Migrant Farm Workers in Wayne County, New York. Public Health Reports, 100 (5), 480-489.

Glanz, K., Lewis, F.M., Rimer, B.K. (1990). Health Behavior and Health Education: Theory, Research, and Practice. San Francisco, CA: Jossey-Bass Inc.

Goldsmith, M.F. (1989). As Farmworkers help keep America healthy, illness may be their harvest. JAMA, 261, 3207-3213.

Green, L.W., Kreuter, M.W. (1991). Health Promotion Planning: An Educational and Environmental Approach. (2nd ed.) Mountain View, CA: Mayfield Publishing.

Grey, M.R. (1993). Dustbowls, Disease, and the New Deal: The Farm Security Administration Migrant Health Programs, 1935-1947. Journal of the History of Medicine, 48, 3-38.

Littlefield, C., Stout, C.L. (1988). A Survey of Colorado's Migrant Farmworkers: Access to Health Care. MCN Clinical Supplement, 5 (1), 1-3.

Munoz, E. (1988). Care for the Hispanic Poor: A Growing Segment of American Society. JAMA, 260 (18), 2711-2712.

National Advisory Council on Migrant Health. (1995, September). Losing Ground: The Condition of Farmworkers in America. Recommendations of the National Advisory Council on Migrant Health. Bethesda, MD.

National Association of Community Health Centers. (1992, November). Community and Migrant Health Centers: Basic Information. Washington D.C.

National Migrant Resource Program. (Date Unknown). Facts About America's Migrant Farmworkers: Fact Sheet: Basic Health. Austin, TX.

National Migrant Resource Program and Migrant Clinician Network. (1990).

Migrant and seasonal farm worker health objectives for the year 2000. Department of Health and Human Services, Washington, D.C.

North Carolina Primary Health Care Association. (1991). Farmworker Facts. Cary, NC.

Rust, G.S. (1990). Health status of migrant farmworkers: A literature review and commentary. American Journal of Public Health, 80, 1213-1217.

Slesinger, D.P. (1992). Health Status and Needs of Migrant Farm Workers in the United States: A Literature Review. Journal of Rural Health, 8 (3), 227-234.

Slesinger, D.P., & Cautley, E. (1981). Medical Utilization Patterns of Hispanic Migrant Farmworkers in Wisconsin. Public Health Reports, 96 (3), 255-263.

Slesinger, D.P., & Ofstead, C. (1990). Migrant agricultural workers in Wisconsin. Madison, WI: University of Wisconsin-Extension, Department of Rural Sociology.

Winders, R., Akers, M.A., Coyne, J., Reinheimer, R., Robitscher, J. (1995). Migrant and Seasonal Farm Workers in Georgia: Estimates of the Migrant Health Program Target Population. Athens, Georgia: University of Georgia, Institute of Community and Area Development.

1. 43.75
Appendix A: English Version of Interview

ID# _____

Time began _____

Date _____

Time end _____

GEORGIA MIGRANT HEALTH SURVEY - ENGLISH

1. Sex

1.M

2.F

2. What language do you prefer to speak?

1.Spanish

2.English

3.Other _____

(if Spanish/Other, ask #3)

(if English, go to #4)

3. Can you communicate in English?

1.Yes

2.No

3.A little

88.Don't know

99.Refuse to answer

4. What is your principal source of income?

1.Farm work

2.Other _____

88.Don't know

99.Refuse to answer

(if farm work, ask #5)

(if other, go to #6)

5. What type of work do you typically do here?

CROP: _____

TASK: _____

6. How old are you? _____

7. Where were you born?
1. Mexico
2. USA
3. Other
88. Don't know
99. Refuse to answer
8. How long have you been in the US? _____
9. Where do you return to when the work season ends?
1. Mexico
2. Florida
3. Georgia
4. Always travelling
5. Other _____
88. Don't know
10. Where do you live most of the year?
1. Mexico
2. Florida
3. Georgia
4. Always travelling
5. Other _____
88. Don't know
11. How long have you been in this area? _____
(Tift/Toombs)
12. How much longer do you plan to stay here? _____
13. Have you been in this area before this year?
1. Yes
2. No
88. Don't know
99. Refuse to answer
(if yes, ask #14)
(if no, go to #15)
14. How many times have you come here? _____

15. Where were you last before you moved here? _____

16. Are you here alone or with your family?

1. Alone

2. Family

(if alone, ask #17)

(if family, go to #18)

17. Where is your family? _____

18. Do you carry medical records with you?

[Vaccination record for kids Y() N()]

1. Yes

2. No

88. Don't know

99. Refuse to answer

(if yes, ask #19)

(if no go to #20)

19. Where did you get them? _____

20. Do you know that there is a health program in the area that helps provide health care for migrant farm workers?

1. Yes

2. No

88. Don't know

99. Refuse to answer

(if yes, ask #21)

(if no, go to #29)

21. How did you find out about the program?

(Check all that apply)

1. Word of mouth

2. Outreach worker

3. Health Fair

4. Other social services referral (DFACS, WIC)

5. Other _____

88. Don't know

99. Refuse to answer

22. Have you ever met a worker from the migrant health program?

1.Yes

2.No

88.Don't know

99.Refuse to answer

(if yes, ask #23)

(if no, go to #26)

23. Do you remember his/her name or what he/she looks like?

1.Yes

2.No

88.Don't know

99.Refuse to answer

24. Where did you meet this worker?(Read choices)

1.At home

2.At the clinic

3.Health Fair

4.At my work

5.Other_____

88.Don't know

99.Refuse to answer

25. What did they do for you?

(Check all that apply)

1.Registered me/family for the migrant program

2.Transportation

3.Interpretation

4.Scheduled an appt.

5.Gave me information

6.Other_____

88.Don't know

99.Refuse to answer

26. Are you registered with the migrant health program?

1.Yes

2.No

88.Don't know

99.Refuse to answer

(if yes, ask #27)

(if no, go to #28)

27. Where were you registered?(Read choices)

1.At home

2.Health Fair

3.At the clinic when you needed care

4.At the clinic when you were with family/friends

5.At work

6.Other_____

88.Don't know

99.Refused to answer

28. Do you have a migrant health registration card?

(show them the card)

1.Yes

2.No

3.Had card, no longer has card

88.Don't know

99.Refuse to answer

29. Do you know where to go if you need health care in this area?

1.Yes

2.No

(if yes, ask #30)

(if no, go to #31)

30. Where would you go for health care?

(Check all that apply)

- 1.Private doctor's office
- 2.Hospital emergency room
- 3.Health Dept. Clinic
- 4.Migrant Health Center
- 5.Another type of clinic
- 6.Other_____
- 88.Don't know
- 99.Refuse to answer

31. Have you had any need to see a health care provider since you've been in this area?

- 1.Yes
- 2.No

(if yes, ask #32)

(if no, go to #41, unless single, then #51)

32. What was the need?

(Check all that apply)

- 1.An injury_____
- 2.Sickness or illness_____
- 3.A follow-up visit
- 4.A regular check-up
- 5.Preventive medicine care (WIC, immos, screening for STD)
- 6.For a prescription
- 7.Family planning
- 8.Pregnancy
- 9.Treatment for chronic illness
- 10.Other_____
- 88.Don't know
- 99.Refuse to answer

33. Did you go to see a health care provider?

- 1.Yes
- 2.No
- 88.Don't know
- 99.Refuse to answer

(if yes, go to #35)

(if no, ask #34)

34. Why didn't you go to a provider?
(Check all that apply, and go to #41, unless single then #51)
- 1.No money
 - 2.Transportation
 - 3.Clinic hours not convenient
 - 4.Loss of work wage
 - 5.Didn't know where to go
 - 6.Don't speak English
 - 7.No way to communicate with our outreach/clinic
 - 8.Other_____
 - 88.Don't know
 - 99.Refuse to answer

35. Where did you go?
- 1.Private doctor's office
 - 2.Hospital emergency room
 - 3.Health Dept. Clinic
 - 4.Migrant Health Center
 - 5.Another type of clinic
 - 6.Other_____
 - 88.Don't know
 - 99.Refuse to answer

36. How was the:

	good	satisfactory	unsatisfactory
1.Overall service	1	2	3
2.Staff	1	2	3
3.Waiting time	1	2	3
4.Clinic hours	1	2	3

37. Would you go back there?

- 1.Yes
- 2.No
- 88.Don't know
- 99.Refuse to answer

(if yes, go to #39)

(if no, ask #38)

38. Why wouldn't you go back there?_____

39. Were interpretation services available?
1.Yes
2.No
3.Not applicable
88.Don't know
99.Refuse to answer
40. Did the provider ask for any portable medical records?
1.Yes
2.No
88.Don't know
99.Refuse to answer
41. Has anyone in your family had any need to see a health care provider since you've been in this area?
1.Yes
2.No
(if yes, ask #42)
(if no, go to #51)
42. What was the need?
(Check all that apply)
1.An injury_____
2.Sickness or illness_____
3.A follow-up visit
4.A regular check-up
5.Preventive medicine care (WIC, immos, screening for STD)
6.For a prescription
7.Family planning
8.Pregnancy
9.Treatment for chronic illness
10.Other_____
88.Don't know
99.Refuse to answer
43. Did they go to see a health care provider?
1.Yes
2.No
88.Don't know
99.Refuse to answer
(if yes, go to #45)
(if no, ask #44)

44. Why didn't they go to a provider?
(Check all that apply, and go to #51)
- 1.No money
 - 2.Transportation
 - 3.Clinic hours not convenient
 - 4.Loss of work wage
 - 5.Didn't know where to go
 - 6.Don't speak English
 - 7.No way to communicate with our outreach/clinic
 - 8.Other_____
 - 88.Don't know
 - 99.Refuse to answer

45. Where did the person go?
- 1.Private doctor's office
 - 2.Hospital emergency room
 - 3.Health Dept. Clinic
 - 4.Migrant Health Center
 - 5.Another type of clinic
 - 6.Other_____
 - 88.Don't know
 - 99.Refuse to answer

46. How was the:

	good	satisfactory	unsatisfactory
1.Overall service	1	2	3
2.Staff	1	2	3
3.Waiting time	1	2	3
4.Clinic hours	1	2	3

47. Would they go back there?

- 1.Yes
- 2.No
- 88.Don't know
- 99.Refuse to answer

(if yes, go to #49)

(if no, ask #48)

48. Why wouldn't they go back there?_____

49. Were interpretation services available?

1.Yes

2.No

3.Not applicable

88.Don't know

99.Refuse to answer

50. Did the provider ask for any portable medical records?

1.Yes

2.No

88.Don't know

99.Refuse to answer

51. Do you have any suggestions to help make our services better?

Appendix B: Spanish Version of Interview

ID# _____

Time began _____

Date _____

Time end _____

GEORGIA MIGRANT HEALTH SURVEY - SPANISH

1. Sex

1.M

2.F

2. ¿Qué idioma prefiere usted?

1.Español

2.Inglés

3.Otro _____

(si Español/Otro, pregunte #3)

(si Inglés, vaya a #4)

3. ¿Puede usted comunicarse en Inglés?

1.Sí

2.No

3.Un poco

88.No sabe

99.Negó dar respuesta

4. ¿Qué es su principal fuente de ingreso?

1.Agricultura

2.Otro _____

88.No sabe

99.Negó dar respuesta

(si Agricultura, pregunte #5)

(si Otro, vaya a #6)

5. ¿Qué tipo de trabajo normalmente hace usted aquí?

PRODUCTO: _____

TRABAJO: _____

6. ¿Cuántos años tiene usted? _____

7. ¿En qué país nació usted?
- 1. México
 - 2. Los Estados Unidos
 - 3. Otro país _____
 - 88. No sabe
 - 99. Negó dar respuesta
8. ¿Por cuánto tiempo ha estado usted en los Estados Unidos? _____
9. ¿A donde regresa despues del tiempo de empleo?
- 1. Mexico
 - 2. Florida
 - 3. Georgia
 - 4. Siempre viajando
 - 5. Otro _____
 - 88. No sabe
10. ¿Donde vive el mayor parte del año?
- 1. Mexico
 - 2. Florida
 - 3. Georgia
 - 4. Siempre viajando
 - 5. Otro _____
 - 88. No sabe
11. ¿Cuánto tiempo lleva usted viviendo aqui en esta área(Tift/Toombs)? _____
12. ¿Cuánto tiempo más va usted a quedarse aqui? _____
13. ¿Ha estado usted aqui en esta área antes?
- 1. Sí
 - 2. No
 - 88. No sabe
 - 99. Negó dar respuesta
- (si Sí, pregunte #14)
- (si No, vaya a #15)
14. ¿Cuántas veces en total ha venido usted a esta área? _____

15. ¿Donde estaba usted antes de venir aqui/de donde vino? _____
16. ¿Está usted aqui sólo o con su familia?
1.Solo
2.Familia
(si Solo, pregunte #17)
(si Familia, vaya a #18)
17. ¿Donde está su familia? _____
18. ¿Lleva con usted registros de su historia médica?
PROBE: documentos o papeles con sus datos médicos
[Registros de vacunas para los niños S() N()]
1.Sí
2.No
88.No sabe
99.Negó dar respuesta
(si Sí, pregunte #19)
(si No, vaya a #20)
19. ¿De donde es esta historia médica? _____
20. ¿Sabe usted que hay aqui un programa de salud que ayuda a los campesinos migrantes?
1.Sí
2.No
88.No sabe
99.Negó dar respuesta
(si Sí, pregunte #21)
(si No, vaya a #29)
21. ¿Cómo se enteró usted al programa de salud migrante?
(Check all that apply)
1.Alguien me dijo
2.Trabajador del programa
3.Feria de salud
4.Otro servicio social (como DFACS, WIC)
5.Otro _____
88.No sabe
99.Negó dar respuesta

22. ¿Ha conocido usted a un/a trabajador/a del programa de salud migrante?

1.Sí

2.No

88.No sabe

99.Negó dar respuesta

(si Sí, pregunte #23)

(si No, vaya a #26)

23. ¿Recuerda usted el nombre de esta persona, o podría describirla?

1.Sí

2.No

88.No sabe

99.Negó dar respuesta

24. ¿Donde conoció a esta persona?(read choices)

1.En casa

2.En la clinica

3.Feria de salud

4.En mi trabajo

5.Otro _____

88.No sabe

99.Negó dar respuesta

25. ¿Cómo le ayudó esta persona?

(Check all that apply)

1.Me registró/familia para el programa de salud migrante

2.Transporte

3.Interpretó para mi

4.Me hizo una cita

5.Me dio informacion

6.Otro _____

88.No sabe

99.Negó dar respuesta

26. ¿Está usted registrado/a con el programa de salud migrante?

1.Sí

2.No

88.No sabe

99.Negó dar respuesta

(si Sí, pregunte #27)

(si No, vaya a #28)

27. ¿Donde fue registrado/a?(read choices)

1.En casa

2.Feria de salud

3.En la clinica cuando ud fue para algun cuidado de la salud

4.En la clinica cuando ud fue con um amigo/familia

5.En mi trabajo

6.Otro _____

88.No sabe

99.Negó dar respuesta

28. ¿Tiene usted una carta de registro como esta para el programa de salud migrante?(show the card)

1.Sí

2.No

3.Tuvó carta, pero no tiene mas

88.No sabe

99.Negó dar respuesta

29. ¿Sabe usted a donde ir si necesita algun cuidado de la salud en esta área?

1.Sí

2.No

(si Sí, pregunte #30)

(si No, vaya a #31)

30. ¿A donde iría usted?
(Check all that apply)
1. Medico particular
2. Sala de urgencias del hospital
3. Departamento de salud
4. Centro de Salud Migrante
5. Otro tipo de clínica
6. Otro _____
88. No sabe
99. Negó dar respuesta

31. ¿Desde que usted llegó aqui, ha tenido usted necesidad de ir al medico o enfermera?
1. Sí
2. No
(si Sí, pregunte #32)
(si No, vaya a #41, pero si solo a #51)

32. ¿Cual fue la necesidad?
(Check all that apply)
1. Un accidente _____
2. Enfermedad o malestar _____
3. Un control
4. Una visita regular(check-up)
5. Medicina preventiva(como vacunas, WIC)
6. Receta/remedio/medicina
7. Planificación familiar
8. Embarazo
9. Tratamiento por una condicion crónica
10. Otro _____
88. No sabe
99. Negó dar respuesta

33. ¿Fue usted a ver al medico o a la enfermera?
1. Sí
2. No
88. No sabe
99. Negó dar respuesta
(si Sí, vaya a #35)
(si No, pregunte #34)

34. ¿Por qué usted no fue a ver al medico/enfermera?
(Check all that apply, and go to #41, unless single then #51)
- 1.Falta de dinero
 - 2.Falta de transporte
 - 3.Horario de la clinica no es apropiado
 - 4.Perder horas de trabajo
 - 5.No sabía a donde ir
 - 6.No habla ingles
 - 7.Sin manera de comunicar con nuestro outreach/clínica
 - 8.Otro razón _____
 - 88.No sabe
 - 99.Negó dar respuesta

35. ¿A donde fue usted?
- 1.Medico particular
 - 2.Sala de urgencias del hospital
 - 3.Departamento de salud
 - 4.Centro de Salud Migrante
 - 5.Otro tipo de clínica
 - 6.Otro _____
 - 88.No sabe
 - 99.Negó dar respuesta

36. ¿Cómo fue?:

	bueno	de satisfacción	no de satisfacción
1.El servicio en general	1	2	3
2.La gente que trabaja allá	1	2	3
3.El tiempo que esperaba	1	2	3
4.El horario del lugar	1	2	3

37. ¿Regresaría usted a aquel lugar?

- 1.Sí
- 2.No
- 88.No sabe
- 99.Negó dar respuesta

(si Sí, vaya a #39)

(si No, pregunte #38)

38. ¿Por qué no regresaría? _____

39. ¿Habían personas que le ayudaron a traducir en aquel lugar?
- 1.Sí
 - 2.No
 - 3.No aplica
 - 88.No sabe
 - 99.Negó dar respuesta
40. ¿Alguien le preguntó por una historia médica en aquel lugar?
- 1.Sí
 - 2.No
 - 88.No sabe
 - 99.Negó dar respuesta
41. ¿Desde que usted llegó aquí, ha tenido algun miembro de su familia necesidad de ir al medico o enfermera?
- 1.Sí
 - 2.No
- (si Sí, pregunte #42)
(si No, vaya a #51)
42. ¿Cual fue la necesidad?
- (Check all that apply)
- 1.Un accidente_____
 - 2.Enfermedad o malestar_____
 - 3.Un control
 - 4.Una visita regular(check-up)
 - 5.Medicina preventiva(como vacunas,WIC)
 - 6.Receta/remedio/medicina
 - 7.Planificación familiar
 - 8.Embarazo
 - 9.Tratamiento por una condicion crónica
 - 10.Otro_____
 - 88.No sabe
 - 99.Negó dar respuesta
43. ¿Fue esta persona a ver al medico o a la enfermera?
- 1.Sí
 - 2.No
 - 88.No sabe
 - 99.Negó dar respuesta
- (si Sí, vaya a #45)
(si No, pregunte #44)

44. ¿Por qué esta persona no fue a ver al medico/enfermera?
(Check all that apply, and go to #51)
- 1.Falta de dinero
 - 2.Falta de transporte
 - 3.Horario de la clinica no es apropiado
 - 4.Perder horas de trabajo
 - 5.No sabía a donde ir
 - 6.No habla ingles
 - 7.Sin manera de comunicar con nuestro outreach/clínica ...
 - 8.Otro razón_____
 - 88.No sabe
 - 99.Negó dar respuesta

45. ¿A donde fue esta persona?
- 1.Medico particular
 - 2.Sala de urgencias del hospital
 - 3.Departamento de salud
 - 4.Centro de Salud Migrante
 - 5.Otro tipo de clínica
 - 6.Otro_____
 - 88.No sabe
 - 99.Negó dar respuesta

46. ¿Cómo fue?:

	bueno	de satisfacción	no de satisfacción
1.El servicio en general	1	2	3
2.La gente que trabaja allá	1	2	3
3.El tiempo que esperaba	1	2	3
4.El horario del lugar	1	2	3

47. ¿Regresaría esta persona a aquel lugar?

- 1.Sí
- 2.No
- 88.No sabe
- 99.Negó dar respuesta

(si Sí, vaya a #49)

(si No, pregunte #48)

48. ¿Por qué no regresaría?_____

49. Habían personas que le ayudaron a traducir en aquel lugar?

1.Sí

2.No

3.No aplica

88.No sabe

99.Negó dar respuesta

50. ¿Alguien le preguntó por una historia médica en aquel lugar?

1.Sí

2.No

88.No sabe

99.Negó dar respuesta

51. ¿Tiene ud algunas sugerencias para mejorar nuestros servicios?

