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ORIGINAL PAPER

Fear of Deportation *is not* Associated with Medical or Dental Care Use Among Mexican-Origin Farmworkers Served by a Federally-Qualified Health Center—Faith-Based Partnership: An Exploratory Study

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Abstract Migrant and seasonal farmworkers face many health risks with limited access to health care and promotion services. This study explored whether fear of deportation (as a barrier), and church attendance (as an enabling factor), were associated with medical and dental care use among Mexican-origin farmworkers. Interviews were conducted with 179 farmworkers who attended mobile services provided by a local federally-qualified health center (FQHC) in partnership with area churches, during the 2007 agricultural season. The majority of respondents (87 %) were afraid of being deported, and many (74 %) attended church. Although about half of participants reported poor/fair physical (49 %) and dental (58 %) health, only 37 % of farmworkers used medical care and 20 % used dental care during the previous year. Fear of deportation was not associated with use of medical or dental care; while church attendance was associated with use of dental care. Findings suggest that despite high prevalence of fear of deportation, support by FQHCs and churches may enable farmworkers to access health care services.

Keywords Fear of deportation · Church attendance · Health care use · Health centers · Faith-based organizations · Farmworkers

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Introduction

Migrant and seasonal farmworkers (MSFWs) are key contributors to the sustained growth of agriculture in the United States. In Oregon, the estimated 170,000 MSFWs and their dependents create over $3 billion in annual agricultural economic activity [1]. Despite their substantial economic contributions, MSFWs suffer a myriad of social disadvantages (e.g. low socioeconomic and undocumented immigration status; limited English proficiency; unsafe occupational and housing conditions; stigma and marginalization), which have a direct impact on their health [2–5]. The few studies that have examined health care utilization among this vulnerable population find that despite their marked disease burden, use of medical and dental care services remain significantly low [6–9]. Mainly linked to documentation status, fear of deportation has been considered a major barrier for using health care among immigrant populations, including farmworkers [3, 4, 10–12]. However, few studies have actually measured the prevalence of fear of deportation and its effect on use of health care services. In two studies, 39 % of participants mentioned that fear of deportation limited their ability to seek health care services [13, 14]. In turn, another study

found that although 20 % of participants were undocumented, only 6 % feared that accessing health care services would lead to problems with immigration authorities [15]. One of the reasons for this low level of fear of deportation may be that health care services are provided by "trusted" providers, such as federally-qualified community health centers (FQHCs) [16, 17].

Other "trusted" institutions for immigrant and farmworker communities may include churches, some of which go beyond strictly spiritual to more "tangible" forms of support (e.g. providing food, clothing) for their members. Church attendance (a topic widely studied among African-Americans) is considered a relevant factor of positive health care practices, particularly for uninsured and chronically ill populations [18, 19]. Recent research shows that tangible forms of church-based support (e.g. health-related programs/screenings, educational materials) may facilitate health care access [20, 21] and health promotion efforts [20, 22, 23] among Latinos. However, very little research has examined the support churches may provide to rural Latino immigrant populations, including MSFWs [24].

The purpose of this study was to explore the associations between fear of deportation, and church attendance with utilization of medical and dental care among Mexican-origin farmworkers in Oregon who attended mobile services offered by a local FQHC in partnership with area churches.

Methods

Study Design and Participants

In this IRB-approved cross-sectional study, interviews were conducted with 179 Mexican-origin indigenous and *mestizo* migrant farmworkers as part of the Migrant Health Outreach Project (MHOP) in rural Northwest Oregon during the 2007 agricultural season. In Mexico, *mestizos* (people of mixed European/Caucasian and Native American/Indigenous ancestry), are viewed as mainstream (majority), unlike in the US where the mainstream is understood as white [25].

Migrant Health Outreach Project partnered with Virginia Garcia Memorial Health Center (VGMHC)'s Migrant Camp Outreach Program, which provides medical treatment and health education to MSFWs living and working in local migrant labor camps. From May through August, the Center sends a team of providers, nurses, and health educators to the camps to provide on-site treatment and education. Health Educators provide education on sexually transmitted diseases, pesticide exposure, and prevention of work related injuries. As needed, patients are referred to one of VGMHC centers and connected to other resources. More recently, VGMHC has partnered with local area churches to provide additional resources (e.g. food, clothing) to MSFWs.

Participants (ages 18 or older) were recruited at eight labor camps served by the outreach program. After workers accessed mobile services, trained interviewers (who worked for the outreach program) described the study and invited them to participate. Per IRB guidelines, approval did not allow us to recruit participants at workers' residences. The number of participants ranged from five at one of the smaller camps to over 40 at the largest camp.

Bilingual/bicultural researchers and health practitioners worked together in the translation and back-translation of the survey questionnaire that utilized culturally and linguistically meaningful terms appropriate for use with a rural, Mexican-origin population with little formal education. All interviews were conducted in Spanish. Participants were offered a stipend of $20 to a local grocery store as compensation for taking part in the interviews, which averaged approximately 75 min in length.

Measures

Two outcome measures were included: (a) Use of medical care, measured by the question "Have you been to the doctor in the last twelve months?" (Yes/No); and (b) Use of dental services, measured by the question "Have you been to the dentist in the last twelve months?" (Yes/No). Both measures excluded use of screening services at the time of interviews. The conceptual framework for this study is the Behavioral Model of Access to Care for Vulnerable Populations (BMVP) [26]. Following the BMVP model, covariates were classified as predisposing (female, age, indigenous, educational level, married, family members living in the US); enabling (fear of deportation, church attendance, having health insurance, home ownership) and need factors (poor/fair physical health and poor/fair dental health, respectively) [26]. Indigenous Mexican status was assigned through asking participants if they self-identified as indigenous, or if they, their parents, or their grandparents, spoke any indigenous Mexican languages (e.g., Mixteco, Zapoteco, Triqui) [27]. *Fear of deportation* was measured using a single-item that inquired to what extent study participants experienced fear of the consequences of deportation ranging from 0 (not at all) to 3 (very much). *Church attendance* was measured using a 4-point Likert item asking, "How often do you attend religious services?" (ranging from 0 = not at all to 3 = very much). Both fear of deportation and church attendance were dichotomized (0 = not at all, 1 = all other values) for bivariate analyses.

Statistical Analysis

Summary statistics were calculated for all study variables. Chi square (categorical variables) and two-tailed *t* test (continuous variables) were used to explore bivariate associations with use of medical and dental care services. All analyses were conducted using the PASW 18 statistical software (SPSS Inc., Chicago, IL).

Results

As depicted on Fig. 1, the majority of workers (87 %) were afraid of deportation; while three out of four workers (74 %) attended religious services. Almost half of the workers (49 %) said they had poor/fair physical health; while 58 % said they had poor/fair dental health. Only over a third of farmworkers (37 %) used medical care and even less (20 %) used dental care in the previous 12 months. In addition, very few workers had health insurance (13 %). Table 1 shows the summary statistics for all study variables. Over two-thirds of farmworkers interviewed were male (71 %), indigenous (69 %), and married (69 %), with an average age of 31 years. On average, respondents had 5 years of formal education and four family members living in the US.

Table 2 shows the bivariate associations of predisposing, enabling and need factors by use of medical and dental care, respectively. Fear of deportation was not associated with use of medical or dental care. Female gender ($\chi^2 = 18.19$, $p < .01$), education ($t = 1.99$, $p < .05$), and health insurance ($\chi^2 = 4.68$, $p < .05$) were significantly associated with use of medical care; while church attendance ($\chi^2 = 9.21$, $p < .01$) was significantly associated with use of dental care.

Discussion

The present study explored the associations between fear of deportation and church attendance with use of medical and dental care among Mexican-origin farmworkers in rural Oregon who attended mobile services offered by a local FQHC in partnership with area churches. The most significant finding was that although fear of deportation was highly prevalent in this population (87 %), fear of deportation was not significantly associated with use of medical and dental care among study participants. This finding may be explained by the systematic and culturally appropriate outreach the local FQHC has provided to MSFW labor camps in the area over the past three decades. In other words, despite high levels of fear of deportation in general, workers did not perceive that accessing services provided by the FQHC would get them in trouble with immigration

Table 1 Profile of Mexican-origin farmworkers, MHOP, Oregon, 2007 ($n = 179$)

Variables	Mean (SD)	*n* (%)
Predisposing factors		
Male		127 (70.9)
Age (years)	30.6 (10.7)	
Education (years)	4.9 (3.1)	
Marital status		
Married		123 (68.7)
Number of family members living in US	3.8 (4.4)	
Ethnicity		
Indigenous		123 (68.7)
Mestizo		56 (31.3)
Enabling factors		
Having fear of deportation		155 (86.6)
Attending church		133 (74.3)
Having health insurance		23 (12.8)
Need factors		
Poor/fair physical health		88 (49.2)
Poor/fair dental health		104 (58.1)
Health care utilization		
Used medical care in last 12 months		67 (37.4)
Used dental care in last 12 months		35 (19.6)

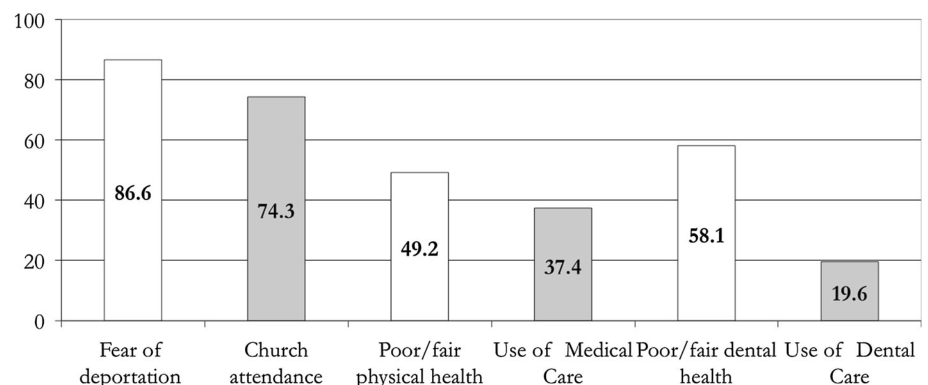

Fig. 1 Fear of deportation, church attendance, self-reported health, and use of medical and dental care services (%), MHOP-2007

Table 2 Bivariate associations with medical and dental care use, MHOP-2007 (n = 179)

	Use of medical care			Use of dental care		
	No	Yes	Statistical comparison	No	Yes	Statistical comparison
Predisposing factors						
Sex						
Female (*n*, %)	20 (38 %)	32 (62 %)	$\chi^2 = 18.19$**	38 (73 %)	14 (27 %)	ns
Male (*n*, %)	92 (72 %)	35 (28 %)		106 (84 %)	21 (16 %)	
Age (years, *n*, %)						
18–44	103 (65 %)	56 (35 %)	ns	130 (82 %)	29 (18 %)	ns
45 or older	9 (45 %)	11 (55 %)		14 (70 %)	6 (30 %)	
Education (years: M, SD)	5.3 (3.2)	4.4 (2.6)	$t = 1.99$*	4.9 (3.1)	5.1 (3.0)	ns
Marital status (*n*, %)						
Married	74 (60 %)	49 (40 %)	ns	98 (80 %)	25 (20 %)	ns
Not married	38 (68 %)	18 (32 %)		46 (82 %)	10 (18 %)	
Number of family members living in US (M, SD)	3.8 (4.4)	3.8 (4.4)	ns	3.6 (3.8)	4.7 (6.2)	ns
Ethnicity (*n*, %)						
Indigenous	76 (62 %)	47 (38 %)	ns	101 (82 %)	22 (18 %)	ns
Mestizo	36 (64 %)	20 (36 %)		43 (77 %)	13 (23 %)	
Enabling factors						
Having fear of deportation (n, %)						
0 = not at all	18 (78 %)	5 (22 %)	ns	17 (74 %)	6 (26 %)	ns
1 = a little—a lot	94 (60 %)	62 (40 %)		127 (81 %)	29 (19 %)	
Attending church (*n*, %)						
0 = not at all	33 (72 %)	13 (28 %)	ns	44 (96 %)	2 (4 %)	$\chi^2 = 9.21$**
1 = a little—very much	79 (59 %)	54 (41 %)		100 (75 %)	33 (25 %)	
Health insurance (*n*, %)						
Yes	5 (36 %)	9 (64 %)	$\chi^2 = 4.68$*	12 (86 %)	2 (14 %)	ns
No	107 (65 %)	58 (35 %)		132 (80 %)	33 (20 %)	
Need factors						
Physical health (*n*, %)						
Good/very good health	58 (64 %)	33 (36 %)	ns	–	–	
Poor/fair health	54 (61 %)	34 (39 %)		–	–	
Dental health (*n*, %)						
Good/very good health	–	–		61 (81 %)	14 (19 %)	ns
Poor/fair health	–	–		83 (80 %)	21 (20 %)	

M mean, *SD* standard deviation, *ns* not significant

* $p < .05$; ** $p < .01$

authorities. This finding is similar to a qualitative study in El Paso, TX, which found that trusted community-oriented health care services may enable undocumented Mexican immigrants to connect with such services [28]; and other studies that highlight the importance of "trusted" providers, such as local FQHCs or free clinics [16, 17], to provide health care services for this population.

In general, the percentage of workers using medical (37 %) and dental (20 %) care during the previous 12 months was low, comparable to previous studies [7–9]. As shown on Fig. 1, the higher levels of fair/poor physical and dental health and the comparatively lower levels of use of medical or dental care may be indicative of the reality of farmworkers who often work sick rather than miss work, and face out-of-pocket expenses and other challenges [2, 3, 29].

Similar to recent research [20, 24, 30], church attendance was a significant enabling factor for using dental services among this sample of Mexican-origin farmworkers. This effect may be explained by the support various local church groups provided to farmworker families at the study sites.

However, the same was not true for medical care. A possible explanation for this effect is that basic medical services were indeed offered by the FQHC serving the labor camps. However, dental services for adults were not provided by the FQHC. It is understandable then, that churches focused their efforts on supporting access to dental services. We observed that each of the labor camps, where these workers were interviewed and temporarily resided, had a "sponsoring" church that served as a support group. Representatives from these churches were observed visiting the labor camps and offering various basic necessities.

Results from this study should be considered in the context of its limitations. First, due to funding and staffing constraints, we were not able to provide an interpreter for indigenous workers who did not speak Spanish. Therefore, only indigenous and mestizo workers who spoke Spanish were interviewed for this study. Second, the relatively small sample prevented us from carrying out meaningful inferential analyses (a table with multivariate logistic regression results is available from the authors upon request). Third, given the cross-sectional study design, cause-effect relationships should be interpreted with caution. Fourth, measuring key variables (fear of deportation and church attendance) with single questions may have limited their validity and reliability. However, previous studies have measured fear of deportation with a single question [13, 14]. Fifth, our non-probability sample was limited to Mexican-origin farmworkers located in a small geographic area in Northwest Oregon who attended mobile screenings provided by a local FQHC. Therefore, findings may be biased (due to sample self-selection) and not be generalizable to farmworkers who did not attend the mobile screenings in the study area, or to other farmworker populations elsewhere.

Nevertheless, this exploratory study contributes to the literature in two relevant ways: (1) it proposes that the association between fear of deportation and use of health care services may be weakened or even non-existent when services are offered by a "trusted" local provider, such as an FQHC; (2) other community-based organizations, such as churches, may be able to supplement the support offered by FQHCs to expand use of health care services for MSFWs. Future research should explore the fear of deportation-use of health care link with more robust sample sizes and on diverse settings. The same should be true for the church attendance-use of health care link. For instance, we found that while only 22 % of those who did not fear deportation used medical care, 40 % who did fear deportation used medical care. Although the difference was not statistically significant, future research should explore this "paradox" further. Also, developing multi-item scales should be considered for more comprehensively capturing both the fear of deportation and the church attendance/support constructs.

From a policy perspective, it is important for various stakeholders (e.g. policy makers; health care providers; the agriculture industry) to collaboratively develop alternatives for expanding coverage for this population. This is particularly relevant since the recently upheld federal health care law excludes undocumented workers from receiving any health insurance benefits or even purchasing health insurance on their own [11, 12]. As health reform implementation is developed at the state level, relevant insurance and health care schemes should consider provisions to increase health care coverage to farmworkers [11]. Finally, reinforcing the role of FQHCs [4, 7, 8] and its articulation with mobile clinics [11] and other non-profits' outreach efforts [9], including faith-based organizations [20–23], may be instrumental in strengthening and expanding health care services to this vulnerable population.

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