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The Aggregated Influences of Poverty Impacting Dental Care Access and Oral Health among Migrant Farmworkers in Tampa, Florida

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by

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Abstract

Oral health is an important aspect of overall health, but many vulnerable populations such as migrant farmworkers are without access to oral healthcare. Although some non-government organizations such as faith-based organizations have attempted to fill gaps left by government and private sectors, a lack of a dental safety net creates limited access to oral health services for migrant farmworkers. Access to care is further constrained by structural factors including low wages, migration route, and high costs of care. Building off a critical medical anthropology approach in understanding oral healthcare access, I argue that limited oral health access for migrant workers in the Tampa Bay area is the result of economic constraints and not cultural beliefs or educational shortcomings. This research therefore demonstrates the social determinants of oral health, and how social disparities can become embodied in marginalized groups such as migrant farmworkers.

Chapter One: Introduction

In the United States, there are an estimated 4.2 million migrant and seasonal farmworkers (Arcury, Quandt, and Russell 2002) with more than 286,000 in the state of Florida (Larson 2000). These workers travel across the country harvesting produce that is ultimately packaged, shipped to grocery stores, and sold to consumers who rarely consider the labor behind the foods they purchase. In the Tampa Bay area, migrant laborers are predominately of Mexican origin, and their labor is utilized for large-scale harvesting of strawberries, tomatoes, citrus fruits, and other produce. As the second most dangerous industry in the United States (National Safety Council 2008), agricultural work poses great threats to workers who are exposed to numerous health risks that are directly related to their occupation. Despite labor-related health concerns, however, migrant farmworkers are often without access to medical or dental care and the low wages they earn through piecework are generally not enough to purchase adequate healthcare coverage. Furthermore, most migrants are ineligible for Medicaid and many are not comfortable visiting hospital emergency rooms, fearing deportation because of their immigration status, or not wanting to miss work and consequently lower their earnings. Although non-governmental organizations (NGOs) including faith-based organizations (FBOs) exist to help fill voids left by private health insurance corporations and government programs, they are unable to address all of the health concerns of the migrant population in the Tampa Bay region.

Dental health for migrant workers continues to be largely unaddressed by private, government, and non-profit agencies. Oral health is an important aspect of overall health

to consider, as research has indicated connections between dental disease and systemic health, especially cardiovascular disease (Loesche et al. 1998; Beck et al. 1996) and pancreatic cancer (Michaud et al. 2007). Furthermore, dental pain can interfere with sleep and speech patterns, and poor oral health has been tied to lung disease, stroke, and premature birth or low birth weight for pregnant women[1]. Limited access to dental care and poor oral health can therefore lead to syndemic (Singer 2003, 2010) health impacts. Oral health, therefore, can in this sense can create syndemic health impacts Oral health problems can also cause people to alter their diets and lead to nutritional problems (Quandt et al. 2007). Modified behavior has also been linked to poor oral health, which impacts a person's social interactions by limiting smiling or talking (Quandt et al. 2007). In addition to deleterious health affects of poor oral health, teeth carry a social significance with them as they are a component of the mouth, the "means by which we express ourselves," as Exley writes (2009: 1094). The mouth and the teeth are highly visible in social situations among many cultures, and are important in social interactions and can influence perceptions of self and how others respond to an individual (Exley 2009: 1094).

Access to healthcare for marginalized populations is a significant problem in the United States, and although dental care is an important component in maintaining good health, populations with limited resources may overlook dental care because of other health concerns or because care is inaccessible due to structural barriers. Migrant workers are particularly susceptible to structural hindrances preventing access to dental care,

[1] For more information on oral health and its connection to general health, see the document produced by the US Department of Health and Human Services (DHHS): 2000 Oral health in America: a report of the Surgeon General. Rockville, MD: US DHHS, National Institute of Dental and Craniofacial Research, National Institutes of Health.

including but not limited to migration route, low wages, and legal status, and availability of nutritious food. These and other barriers have been described as a "web of effects" (Heyman et al. 2009 19) that work aggregately to constrain access to healthcare.

To explore some of the barriers to accessing dental care, I collected 40 interviews with migrant farmworkers accessing medical care services at a faith-based organization's clinic near Tampa, Florida. Drawing from a larger research initiative led by Dr. Heide Castañeda, this thesis incorporates data I collected from October 2009 to February 2010, and focuses on perceptions of dental health while discussing structural factors endemic to migrant labor that prevent farmworkers from accessing dental care. Major findings demonstrate an overall lack of safety-net dental care providers, which is juxtaposed to a limited yet existing safety-net medical provider network. Furthermore, contrary to popular assumptions, the population interviewed demonstrated knowledge of the importance of oral health and dental care, generally did not prioritize medical care over dental, and found cost of care to be the biggest hindrance in accessing dental services rather than a lack of knowledge being the influencing factor in not seeking care**.** Literature on minority immigrants and oral health cites cultural beliefs, not understanding the importance of primary teeth, and not wanting to expose children to painful dental experiences as a component of oral health disparities (Hilton et al 2007). The data presented in this work show that cultural beliefs about teeth are not an influencing factor in not accessing care**,** emphasizing that dental care needs are related to material needs, as almost all participants in this research had low or very low levels of food security, which sheds light on the population's poverty circumstances.

In addition to describing barriers limiting access to dental care, this thesis contextualizes findings by discussing problems associated with market-based medicine in the United States, and underscores how "safety-net" programs such as Medicaid are not always viable options for populations in desperate need. Despite the assumed availability of "safety-net" medical care for everyone in the United States, many populations remain without access to any type of care. Migrant workers, many of whom are undocumented, are a contentiously discussed population in the current debates over healthcare reform in the United States. As a recent Wall Street Journal article noted, "in many ways, illegal immigration is at the nexus of two key health issues: the uninsured and ballooning costs" (2009 A4). For migrants, cost and legal status are major prohibitive forces to accessing medical or dental care.

Among marginal populations, oral health is not often considered a priority when compared to other health concerns. However, as Horton and Barker (2010) write "Oral health is a sensitive measure of the state of the health care safety net because oral health is often less of a public priority than general physical health" (2010: 17). With the data I collected, I argue that structural factors are greater influents in constraining access to dental care than individual factors by demonstrating that poverty, measured by food security, housing, and occupation, prevents access to dental services and is therefore a key social determinant of health. To analyze migrant farmworkers' disparate accesses to dental care, I utilize a political economy of healthcare framework, influenced by critical medical anthropology, which seeks to examine macro-level problems on a micro-level scale (Singer 1984). In this respect, I follow Singer's (1984) notion of system-challenging praxis in an effort to critique larger social structures while studying a small population.

This thesis builds upon the following objectives:

1. Examine how structural hindrances limit migrant worker access to dental care.

2. Determine if migrant workers have different perceptions of the importance of dental care for themselves and their children

3. Explore relationships between poverty and access to dental care by using three proxies of poverty: housing, occupation, and nutrition/food availability.

4. Provide beneficial data to a faith-based medical service provider for migrants, where data collection took place. This provider is Catholic Mobile Medical Services, and the information can assist with funding efforts and explore ways for the organization to obtain dental equipment needed to arrange dental appointments at the clinic.

These objectives were informed by previous research experiences described in greater detail in the following pages, and from the results of a survey that includes questions to address each research goal (see Tables 4 and 5 and attached survey). This project received funding from the Institute for the Study of Latin America and the Caribbean (ISLAC) at the University of South Florida to provide incentives as compensation for participants' time.

Ultimately, this research explores the connections between migrant labor, poverty and healthcare by focusing on dental health, one of the least accessible types of care for migrant farmworkers. Examining lack of access to oral health services from a critical medical anthropology perspective, I build upon research that explores social determinants of health, and how social inequalities are embodied among marginal populations (Krieger 2001 *in* Horton and Barker 2010).

Chapter Two: Research Setting

During one of my evenings conducting research, I had an unexpected interaction with a woman visiting the clinic I used as my recruitment site. This woman questioned my presence at the clinic, and was curious about my research agenda.

"Can I ask you what you're doing?" an overweight, blonde woman asked me in a thick Southern accent as she steps out of the Catholic Charities Mobile Medical Services (CMMS) waiting facility. The facility, a trailer located adjacent to another trailer used as a clinic, served as my recruitment site for this research.

"I just want to know why you're in there talkin' to all them [migrants] instead of talkin' to me," she asked, standing on the wooden stairs leading to the trailer as I stood below, at the foot of the steps, looking up at her.

"I'm a graduate student at the University of South Florida," I explained. "I'm doing a research project looking at migrant workers' access to dental care and talking to people who utilize services at this clinic."

"Uh-huh," she said, looking at me suspiciously. "Now why are you focusin' on them? I mean, I'm here and I see you only talkin' to them in Spanish and I don't know what's goin' on…I've been here waitin' and nobody's talkin' to me, and I come through here and all I see are signs in Spanish—nothing in English, and it's like, I was born here and I can't get anybody to talk to me." She then continued to express her frustration that the services offered at the CMMS clinic are targeted at Latino migrant workers.

"I was born here—I'm a Plant City native. I can't get any medical care, but then here's everything in Spanish and it's like they're takin' over. This is our country, we

were here first! My granddaddy was a farmer and worked all his life on farms, and you know I'm hurtin', I need help too, but it's like there's nothing out there for me…but I guess it's our fault since we're the ones who brought 'em over here to work cheaper. We did it to ourselves…"

This conversation occurred on one of my regular Monday night visits to the CMMS clinic in Dover Florida. In all the months I had been conducting fieldwork, this was the only non-Spanish speaking, U.S. native I encountered who utilized services; especially odd since the clinic is located within the San Jose mission, a residential community for Latino migrant workers. However, my interaction with the woman demonstrates some of the prevailing ideologies immigrants must challenge when attempting to access any type of healthcare service in the United States. Perceptions of "deserving" and "undeserving" poor that are sometimes linked to citizenship prevent peripheral populations from receiving assistance, including not only farmworkers but rural whites. This interaction also speaks to the lack of access to healthcare for large populations in the United States other than migrants. These groups of people are also vulnerable and actively seek out services.

Many marginalized groups such as migrant farmworkers rely on NGOs and FBOs for health care. One such organization is Catholic Charities, Diocese of St. Petersburg, which operates clinics for underserved populations through the organization's Catholic Mobile Medical Services division. The supervisor for the CMMS clinic at the San Jose Mission is Sister Sara Proctor, a Catholic nun and physician assistant. Sister Sara, a Florida native who took her vows in 1983, has worked in U.S. Naval and Catholic hospitals, refugee clinics in the Northeastern United States, and rural clinics in Malawi

(Weiner 2002). She has held her position with the Catholic Charities, Diocese of St. Petersburg migrant health task force since 2000.

I met Sister Sara during the Fall of 2008 while working as a research assistant on for Dr. Heide Castaneda's research initiative entitled, "Oral Health Literacy and Access to Dental Care for Migrant Families in the Greater Tampa Bay Region," funded by the USF Collaborative for Children, Families, and Communities. As a research assistant for this project, I gained insight on problems related to accessing oral health services among migrant families in the Tampa Bay area and interviewed migrants at the CMMS clinic and at a nearby Migrant Head Start facility. Through the interviews conducted at the Migrant Head Start facility, I discovered that many migrant workers have U.S.-born children with Medicaid, but despite their Medicaid coverage children are frequently unable to see a dentist because there are few children's providers in the region who accept Medicaid. Moreover, Medicaid reimbursement rates are lower than private insurance rates, which discourage providers from accepting Medicaid patients.

For adults, the situation becomes increasingly precarious, as they are often undocumented and thus ineligible for government health programs. These difficulties became apparent during the interviews I conducted as a research assistant, and as a result, I became motivated to further investigate how adult migrants access dental care, if at all. Although some children of migrant workers may have Medicaid, which is not always effective in addressing their health needs, parents are usually without any oral health resources, even in the case of emergencies. To explore the difficulties in accessing dental care for migrant populations in the Tampa Bay area, I chose the CMMS San Jose Mission site because of my familiarity with Sister Sara and accessibility to the population.

Once I determined the recruitment site, I decided to test it for research viability. During the Spring of 2009, I visited the mission weekly and conducted interviews with migrant workers for a graduate course research requirement. This course, "City and Community," taught by Dr. Margarethe Kusenbach, required a semester-long study of a place or group of people. I conducted 29 interviews with migrant workers at the San Jose mission, and our interviews focused on issues related to housing and community. Although questions regarding dental care were not a part of these interviews, many participants mentioned that they did not have access to dental services. Upon completing the graduate course research project, I determined that the CMMS clinic was an appropriate setting to conduct MA thesis-related research about access to dental care among migrant workers. The previous data collected for the graduate course and for the "Oral Health Literacy and Access to Dental Care for Migrant Families in the Greater Tampa Bay Region," project has contributed to my background knowledge of this population, and laid the foundation for me to design the appropriate methods for conducting the research I present here.

Chapter Three: Relevant Literature

Oral Health Disparities among Migrants and Latinos in the United States

Catherine Exley (2009) writing to sociologists, has discussed the dearth of social science literature critically examining oral health and healthcare, and Horton and Barker (2010) similarly comment on the lack of medical anthropological literature on oral health. Anthropological analysis of oral health can contribute to understanding how social inequalities impact health and how those impacts carry lifelong and generational affects. Because teeth are visible, Exley argues that "[teeth] may be used to make judgments about an individual (2009:1097)." Teeth are a "marker of social vulnerability" as Horton and Barker (2010) note, and teeth demonstrate ways in which people embody social inequalities (Horton and Barker 2010).

xley (2009) compares oral health disparities to medical care disparities by noting that those with the greatest need for preventative care are and will continue to be less likely to obtain oral health services. She notes that oral health intervention rather than prevention is the norm, which raises a question as to why oral health is not considered part of a more comprehensive preventive care system. Addressing this question requires, as Exley writes, "considering oral health and healthcare at a structural and policy level, [which] may provide sociologists with a real opportunity to address social inequities, and to engage with wider society and policy makers in debate about how to best reduce oral health inequalities" (2009:1100). Although she is writing to sociologists, Exley's call to examine oral health at a structural level to create change can easily mesh with the aims of applied anthropology, and this research in particular answers a call to examine structural

constraints impacting access to dental care. This research also contributes to the literature by examining how personal financial situations influence access to care, tracing the structural level of migrant labor to an individual level of what resources people have to purchase care. Few ethnographic studies have been conducted on oral health, and even fewer have focused on migrant populations.

For ethnic minorities in the United States, oral health disparities begin at childhood as minority children disproportionately suffer from early childhood caries (Hilton et al. 2007). Children of Mexican origin have the highest rates of oral disease (USDHHS 2000 *in* Horton and Barker 2010). Discussing Mexican American children's oral health concerns, Horton and Barker have traced how childhood oral health issues can create larger problems later in life, and draw from Nancy Krieger's (2001) concept of "embodiment." Embodiment is the process in which people "literally incorporate biologically, the social and material world in which we live" (2001: 627 *in* Horton and Barker 2010), and offers a way to examine how health disparities are the products of economic and political structures. I build upon Horton and Barker's incorporation of Krieger's concept of embodiment, which allows for a framework to understand how social factors impact oral health disparities. Although Horton and Barker discuss disparities themselves, I focus on the limited access to care, which contributes to oral health disparities.

One study about oral health among migrant children in Washington state has demonstrated that children of migrant workers experience twice the tooth decay rate of the general population (Koday et al. 1990). Numerous studies have demonstrated that oral health is one of the top health concerns for migrant farmworkers, yet there are few

oral health resources for this population (Quandt et al. 2007, Nurko et al. 1998, Call et al. 1987, Woolfolk et al. 1984, Chaffin et al. 2003, Lukes and Simon 2005). Although widely overlooked, dental disease can increase risks for heart disease (Loesche et al. 1998) and tooth loss can have a negative impact on quality of diet and nutrition (Ritchie et al. 2002 298). Moreover, studies have demonstrated a relationship between poverty, diet and nutrition, and dental health (Marshal et al. 2007).

An Invisible Population

Following Arcury and Quandt (2007), the study population for this research is defined as migrant farmworkers based on migration route: "The migration may be from farm to farm, within a state, interstate, or international" (2007: 346). Migrant farmworkers are at risk for developing chronic communicable diseases (Bechtel et al. 1995), and experience high risks of occupational hazards related to pesticide exposure, injury, eye trauma, skin disorders, and harmful environmental conditions (Arcury et al. 2001, Arcury et al. 2003, Arcury et al. 2005, Arcury and Quandt 2007, Marshall et al. 2001). Despite the many health concerns migrant workers face, however, they are often without access to health resources partly because they fall within the socially constructed category of "undeserving poor," (Coutin 2003) and because their legal status leaves many of them ineligible for assistance programs such Medicaid.

Furthermore, marginalized groups such as farmworkers frequently become associated with their suffering, and in the United States the broader public normalizes and legitimizes this suffering. Peter Benson (2008) describes this process, and specifically underscores how the public becomes apathetic to the hardships that marginalized populations endure. Drawing from Levinas's work about "the Other" and face-to-face

interactions, as well as Deleuze and Guattari's concept of faciality, Benson discusses how facility creates a process in which "people [see] each other as typified objects and, on that basis, [circumscribe] suffering as an event that belongs to or was even caused by the sufferer" (2008 595). Benson also asserts that "faciality is crucial to the constitution and perpetuation of structural violence because how people see others can help legitimize patterns of social subordination, economic exploitation, and spatial segregation" (2008 234).

Nutrition and Oral Health

High levels of food insecurity have been documented for migrant and seasonal farmworkers (Quandt et al. 2004, Wirth 2007), and some scholars have discussed how chronic food insecurity among migrant workers can lead to severe health problems (Weigel et al. 2007). Kowalski et al. have additionally noted that poverty, migrant labor, and poor nutrition interact to negatively influence health (1999). While this research examines the relationship between poverty, migrant labor, and food security, it specifically focuses on oral health rather than broader health problems. Nutrition and food security are not the central focus of this research, but lack of access to nutritious food is considered an indication of poverty, and thus it was important to ask questions about access to food when gauging the relationship between poverty, migrant labor, and oral health. Moreover, oral health and nutrition have a reciprocal relationship, as poor nutrition can harm teeth, and poor oral health can lead to nutritional deficiencies. This further demonstrates the syndemic impacts of limited access to oral health since poor dental care caused by a social inequity can lead to multiple negative health outcomes. Research on oral health and nutrition has demonstrated that oral health problems can

contribute to nutritional deficiencies and low body mass index (Mojon, Budtz-Jorgensen, and Rapin 1999), and some scholars have specifically stated there should be an emphasis on understanding how oral health mediates nutrition and nutrient intake (Ritchie et al. 2002). Furthermore, research on endentulism, speficically, has also oral health impacts on an individual's nutrition, as Medina-Solís et al. (2006) note in their study of endentulism among Mexican adults 35 and older. As Medina-Solís write, "Tooth loss has been associated with changes in food taste and food preferences and nutritional deficiency" (2007:10). Recent literature also suggests that an individual's tooth status will impact food choices leading to avoiding nutrient rich foods such as nuts, carrots, and apples (Sheiham et al 2008).

Theoretical Foundation: Political Economy of Healthcare/Critical Medical Anthropology, and Embodiment of Social Inequality

Drawing from the field of critical medical anthropology, this research employs the political economy of healthcare framework as discussed by Merrill Singer (1984), inspired by Morsy (1979) and Baer (1982). Critical medical anthropology utilizes a political economy of healthcare approach to understand human relationships through the growth of capitalism, especially as it permeates all aspects of life, including healthcare. In examining the global influence of capitalism on healthcare and medicine, critical medical anthropology aims to demystify confluent causes of poor health related to neoliberal economic ideals while embracing a holistic scope that examines health structures on both macro and micro levels (Singer 1984). Examining power structures is an integral component of critical medical anthropology, and Singer (1995), citing Navarro (1985), explains the dialectical relationship endemic in medical services. As

Navarro discusses, many Americans insist on more control over medical care by desiring national health services, but under capitalism, medical services will continue to largely benefit only the dominant class (1985 531 *in* Singer 1984 89). "In the same degree that the capitalist and working classes are intrinsically in conflict…these two functions—the dominating and usefulness in medicine—are also in contradiction" (1985 531 *in* Singer 1984 89).

The dialectical nature of medical care becomes increasingly evident when working with marginalized populations such as migrant farmworkers. As a largely undocumented population, migrant workers frequently fear medical services because of concerns about legal repercussions due to their immigration status. Conversely, migrant workers, like all human beings, must rely on medical care at various times in their lives, especially given their exceptionally dangerous occupation. In this respect medical care is something that is useful and desirable for migrant workers, but their immigration status and economic situation can prevent them from accessing care, demonstrating how medical care is not always accessible for those who need it, and can effectively reinforce social class positioning by excluding those who are unable to afford services. The dialectic of medicine as it relates to migrant workers is thus a structure that is useful and helpful but also dominating as it continues to reinforce class positions through exclusionary cost practices. Furthermore, medical care is widely inaccessible to migrant farmworkers because of structural impediments previously mentioned, and these structural impediments result in disparate access to health services.

Critical medical anthropology is the most appropriate theoretical lens through which to examine disproportionate access to health services because, as Scheper-Hughes

notes, critical medical anthropology combines the intersections of personal, social, and political bodies (1994: 232). Oral health, as a topic of study, affects each of these levels as Exley (2009) notes, since poor oral health can have individual biological consequences, result in social marginalization or withdraw, and can be the result of constrained agency due to larger political forces, Noting shortcomings in the work of social anthropologists such as Turner, Van Gennep, Lévi-Strauss, Douglas, and Geertz, Scheper-Hughes argues that social anthropology fails to explore the meaning of the body beyond a symbol upon which social meaning is inscribed (1994: 231). Similarly, Bourdieu, as Scheper-Hughes notes, writes of the body as a somatization of culture (1994: 231), and Foucault's work on biopower and the inseparability of the body from the will of the State describes the body in a way that is "devoid of subjectivity" (Scheper-Hughes 1994: 232). Critical medical anthropology, however, fills the voids left by earlier social anthropologists and cultural theorists by understanding that the body is the "terrain where social truths are forged and social contradictions played out, as well as the locus of personal resistance, activity, and struggle" (Scheper-Hughes 1994: 232). Critical medical anthropology thus understands structural forces acted upon the body, but also engages in the unique subjectivities in how those forces manifest themselves.

Understanding subjective experiences of illness or health care access builds upon the Marxist underpinnings of critical medical anthropology while also incorporating a new layer of understanding how capitalism and disproportionate allocations of wealth impact individuals and populations. Blending subjective accounts of disproportionate access to care with a critical evaluation of the production of health services allows for a powerful analytical tool to affect change.

When aiming to improve the circumstances of marginalized populations, applied anthropologists examining social problems can find critical medical anthropology to have an appropriate framework for advocacy or intervention. Medical anthropology, as Singer, borrowing from Pelto argues, is an applied field of anthropology because researchers critically question how situations for their research participants can be improved (Singer 1995: 82). Additionally, critical medical anthropology engages in what Singer terms system-challenging praxis (1995:90); that is, actions undertaken in order to challenge larger structures with the goal of producing a meaningful social change. Engaging in system-challenging praxis involves "unmasking the origins of social inequity" (90), a how social inequity relates to living and working conditions. Singer further borrows from Virchow to relate medicine and improvements in health fields to improved social conditions, asserting that medicine must be understand as an applied social science given its relationship to social conditions (Singer 1995: 90).

Influenced by Singer's concept of system-challenging praxis, through this research I critique the current medical system in the United States as a whole by examining one aspect of it—an underserved migrant farmworker population. By examining structural impediments and the perpetuation of structural violence among one population, I effectively demonstrate that dental care is not accessible for everyone, and that labor-related inequity that causes poverty (measured through food insecurity and housing) prevents populations from accessing critical preventative services such as oral health care. Structural violence is defined by Paul Farmer as historical and economically driven processes that constrain individual agency and contribute to the suffering of the disenfranchised (1999: 79; 2004: 307-308). Migrant farmworkers' marginalization is in

part due to this larger, often unseen process Although I do not use term frequently, this study is an examination of the perpetuation of structural violence among one population, and the social inequality that limits access to oral health care among this population is the direct result of structural violence.

This research also builds upon recent efforts to understand social contexts of illness and how illness is related to social, political, and economic forces (Singer 2003: 424). Combining biological inflictions (such as poor oral health related to limited access) and unequal social conditions (such as poverty, which constrains access to health services), this research examines the syndemics of oral health and poverty among migrant farmworkers in the Tampa Bay area. Syndemics, as Singer (2003) notes, is the existence of more than one health-related problem that synergistically impact a population (Singer 2003: 425). Organizations such as the Center for Disease Control (CDC) have adopted the concept of syndemics, and the concept further advances the biosocial aspects of illness and health (Singer 2010). As this research highlights, social processes impact health: labor conditions impact poverty which impacts access to oral healthcare, thereby demonstrating the interacting forces of poverty that contribute to constraints in accessing oral health care.

By focusing on broad relationships while interviewing individuals, I examine macro level structures through a micro level scenario, and I have witnessed how local level actors reinforce macro-level ideologies related to healthcare. One example of this was at a recent grand opening of a public clinic in Dover, Florida. A Republican state representative gave a speech to everyone in attendance for the grand opening, saying:

> Everyone talks about healthcare reform, but this is evidence that we don't need it! *This* is the place where *anybody* can come for affordable healthcare without being turned away…thank you all for being on the "*Right"* side of healthcare.

This representative's comments demonstrate an ideology of individual responsibility by highlighting that policy is not needed for healthcare reform as individuals should be and are able to manage their own health services. The representative's comment and intended pun about "right" (read: conservative) side of healthcare received boisterous applause and cheers, but her message of healthcare accessibility regardless of other factors is a fallacy. Research on marginal populations such as migrant farmworkers demonstrates that low incomes, inability to obtain insurance, and limited facilities in which to obtain care all constrain access to health services (Arcury and Quandt 2006). These findings are echoed in my data, as many of the participants in this research commented on the price of care at the local clinic, saying the $50 consultations were too expensive. The clinic that arguably provides services to everyone is therefore still not accessible to those who need the care because fees are often too high for people to afford and the range of care is limited. This example highlights how local government actors embrace ideas about healthcare, such as one clinic's ability to see any patient regardless of needs, and perpetuate these ideas even though they may not be accurate.

The process of examining the macro level structures on a local scale was not part of a research agenda, but rather inherent to the critical medical anthropological approach, which serves as the theoretical framework for this research. As Singer, borrowing from

Wolf, writes: "Critical medical anthropology is empowered by its understanding of local contexts in relationship to their location in encompassing world or national systems (Wolf 1982)" (1995: 99).

Critiques of critical medical anthropology include Barbara and John Ehrenreich's arguments that the political economy of health perspective views medicine as "a desirable but poorly distributed commodity" (Morgan 1987 133) despite the fact that biomedicine can have negative human impacts. While this critique is valid, it does not negate the usefulness of examining political economic structures influencing healthcare disparities in the United States since the market-based medicine approach to healthcare has been partly responsible for exacerbating healthcare inequalities. Moreover, a political economic understanding of healthcare allows for an understanding of how social inequality is related to health services, and how these inequalities become embodied realities for marginalized populations.

In addition to adopting a critical medical anthropology perspective to understand how structural forces influence individual situations, this research also examines ways in which individuals embody the inequalities created through structural inequality, thereby building upon literature that discusses social determinants of health. Horton and Barker weave together critical medical anthropology, social determinants of health, and embodiment when discusses oral health disparities among Latinos, writing:

> "the disadvantage produced by social stratification leaves its imprint on our physiologies and physiognomies in innumerable ways. It is incumbent upon critical medical anthropologists to contribute to the growing

> literature on health disparities and highlight these invisible pathways" (2010 forthcoming, no page number).

This research contributes to Horton and Barker's call for literature to highlight invisible pathways of social stratification's impact on health by showing how labor inequality constrains access to oral healthcare and how migrants embody the inequalities created through their labor, which is driven by neoliberal economic ideologies that demand cheap labor. In addition to demanding cheap labor provided by migrants, neoliberal economic ideologies have also pervaded healthcare, requiring a critical examination of health services are provided in the United States.

Critiquing Market-Based Medicine

As this research is largely influenced from the political economy of health perspective, it critiques market-based medical systems in the United States, which are greatly impacted by the neoliberal economic ideals. While some scholars such as Adler and Newman have discussed how socioeconomic status (SES) contributes to healthcare disparities (2002), it is also important to examine the nature of the macro level healthcare system in the United States. In addition to addressing disparities related to SES, researchers and advocates of healthcare reform must explore the failures of market-based medicine. Neoliberal economic ideals applied to healthcare have ultimately resulted in market pressures that have raised healthcare costs for patients and providers alike (Draper et al. 2002). Even safety-net organizations and Federally Qualified Health Centers (FQHCs) have suffered under recent market conditions as the federal government has relinquished control of Medicaid to managed care organizations (MCOs) in each state (Horton 2001, Boehm 2005). One of the results of this process, which yields a type of

care known as Medicaid Managed Care (MMC), is a counterintuitive increase of bureaucracy and cost on safety-net organizations and FQHCs. This process demonstrates the current healthcare system's inefficiency, and how one of the many problems with market-based medicine goes ignored because of a trust in corporatizing human services. Boehm writes that programs such as MMC "underscore inconsistencies in trying to guide public health care with neoliberal economic ideologies" (2005 61). In the Discussion, I provide commentary on the current healthcare system in United States and its limitations, which are currently being publicly debated. Some aspects of market-based medicine are being questioned through conversations regarding healthcare reform, but neoliberal economic discourse and corporate influence dissuade much of the public from challenging the current healthcare structure in United States.

Faith-Based Organizations and Health Services

Because their hardships are overlooked and they are seen as undeserving of assistance, many farmworkers must rely on charitable contributions to assist them with housing and medical needs. Faith-based organizations (FBOs) such as Catholic Mobile Medical Services (CMMS), the site for data collection for this thesis, attempt to address these needs, but many do not have the resources required to address inadequate oral healthcare access. Gaps are left open in the market-based medical system, and FQHCs and FBOs have attempted to address needs of underserved populations,. For example, CMMS often refers patients with dental needs to a local FQHC, the Tom Lee Community Health Center, operated by Suncoast Community Health Centers. Some public health discourse now encourages faith-based collaborative health projects (Kegler et al. 2007). In recent years, the influence of faith-based organizations has grown due to a

conservative and neoconservative agenda to promote "a sense of morality" in the United States (Chambré 2001:436), and the Bush administration further fostered faith-based organization expansion after creating the Office of Faith-Based and Community Initiatives. Despite the political beginnings of FBOs, they continue to garner support because of their access to willing volunteers (Chambré 2001:436; Hyatt 2001). Through their network of social connections, some FBOs have been successful in influencing positive health changes for populations they serve (Yanek et al. 2001), and faith-based organizations also provide healthcare services that can connect with patients' spirituality (Anderson 2004:125). As an organized whole, the Catholic Church has also had a role in health care debates in the United States, as Michael Angrosino has noted, and since the 1960s the Church has viewed poverty as a detrimental hindrance to what Angrosino refers to as "the development of full human potential" (1996:6).

Despite the aims and successes of many FBOs and religious movements, I do not intend to argue that FBOs are a solution to systemic healthcare inequity. FBOs may mitigate some health care disparities but should be evaluated on an individual basis for each situation, a lesson learned during a previous experience working with an FBO that emphasized its evangelical mission as well as providing health services (Kline 2010). Although this project does not specifically address themes related to FBOs as service providers, it is important to contextualize the service provider for the migrant workers who participated in this research.

The literature above provide a background about migrant's difficulties in accessing healthcare while also noting the need to examine oral health, which a marker of social status and a measure of inequalities (Horton and Barker 2010). The following

chapter discusses the methods of data collection for examining access to oral healthcare for migrant farmworkers in the Tampa Bay area, finding that cultural beliefs about oral health are not an impediment to accessing care for migrant farmworkers in the Tampa Bay area while highlighting how poverty impacts access to care.

Chapter Four: Methods of Data Collection

Manuel looked at me suspiciously after I asked if he wanted to participate in the research. "What exactly is the purpose of this study?" he asked me. I explained to him that I am student of anthropology at a University and am interested in learning more about difficulties accessing dental care for migrant workers in the Tampa Bay area. "I'd like to know more so I can try to do something that can help the situation," I explained. "And if you participate, I'll give you a $20 giftcard to Wal-Mart."

Manuel looked at me confused. "I pay you $20?"

"No, no!" I explained, "I give you a gift a card worth $20 for Wal-Mart just for answering the questions."

"Oh, okay! Well, talk to me," he answered, gesturing to the empty chair next to him.

My experience with Manuel demonstrates some of the unexpected moments of fieldwork, such as a participant who initially misunderstands part of the research process (in this scenario, compensating informants for time) as well as the importance of thorough explanation of the research objectives to ensure informed consent. Fortunately, during my data collection I had few such hindrances or problems. This chapter discusses data collection methods and details my prior experience with this population. I also discuss efforts to make this research design collaborative with volunteer medical service providers and some of the ethical dimensions of this research I considered before starting the project.

Prior Studies

The methods chosen for this study were intended to compliment existing data collected between October 1, 2008 and September 30, 2009 as part of a larger research initiative entitled "Oral Health Literacy and Access to Dental Care for Migrant Families in the Greater Tampa Bay Region." This project, for which I was a research assistant, utilized semi-structured interviews to obtain data about migrant families' access to dental care in the Tampa Bay area. I personally conducted seventeen of the parent interviews, translated, and transcribed them. The 40 semi-structured interviews conducted during this project yielded a great deal of qualitative data, which informed my data collection process for this project. The main findings of this previous project are located in an article currently under review (Castañeda et al. 2010).

The thesis project also incorporates participant observation data collected from exploratory observation and 29 surveys administered in early 2009 as part of the graduate level sociology course, "City and Community." The surveys administered for the course were a product of a significant amount of input from Sister Sara, program coordinator of Catholic Mobile Medical Services, and from Dr. Margarethe Kusenbach. Dr. Kusenbach lent her expertise in writing open-ended questions, and Sister Sara provided feedback on making each question more appropriate for the farmworker population. Greater detail on the survey is provided below, and as a result of the mutual input from Sister Sara and Dr. Kusenbach, the course-related research project was a success and informed the survey design for this research, while also providing the housing data discussed in the results section. Additionally, my advisor, Dr. Heide Castañeda provided helpful feedback on

how to word survey questions, and her experience was particularly useful given her expertise in working with undocumented populations.

The Importance of Collaborative Research and Mutually Beneficial Methods

Like many NGOs or FBOs, Sister Sara and the CMMS staff are often short-handed and have a myriad of time-consuming responsibilities. In our first interview together, she explained to me that she sees other medical providers who do not cater to migrants but are instead focused on treating one specific type of illness often get more financial resources than she does.

> [This group] got this grant for millions of dollars and they hired all this extra staff, and they outfitted the staff with their portable laptops and Blackberries and all this other stuff, and I'm sitting here without any kind of administrative support staff because I can't afford it, I can't hire one, not in our budget…

Their overwhelming schedules as a result of being short-staffed prevent CMMS staff and volunteers from conducting surveys to obtain pertinent information about the population they serve. For this reason, in March of 2009, I asked Sister Sara if I could assist her and her organization with their goals as part of my internship, and what type of information might be useful to her. Sister Sara asked me to design a survey around any topic I chose, but wanted me to incorporate questions about where migrants would access care if the CMMS clinic did not exist. Explaining that she must always justify her budget to her supervisors, she wanted me to provide this information because she would then be

able to quantify how much money the CMMS clinic saved other healthcare systems, such as local emergency rooms, by focusing on underserved populations.

Happy to comply with the request, I collected data regarding access to dental care while also gathering data useful to her. Although Sister Sara was not directly involved with the research being conducted, she guided the process and also benefited from having a researcher present. I involved Sister Sara in my data collection plans, and she reviewed and commented on all survey questions, many of which were altered to reflect her specific feedback. This process was beneficial in refining the methods for this project.

Survey Construction

Given the existing data from the previously discussed projects, this research primarily featured structured surveys for data collection that included primarily close-ended questions as well as a few open-ended questions. While a survey is not ideal for beginning research, at this stage, a survey can be considered acceptable because of the aforementioned endeavors preceding it (see Table 2). The survey I conducted is therefore an ethnographic survey as defined by Schensul, Schensul, and LeCompte (1999:169), drawing from existing qualitative data while also incorporating a theoretical underpinning: the critical medical anthropology approach to political economy of healthcare.

The survey uses multiple choice, rating, and categorical questions that yield nominal, ordinal, and interval measures. The rating questions use qualitative labels rather than numeric scales to make the questions more meaningful for participants. For example, in questions were participants were asked about the importance of care, such as "How important is it to visit the dentist regularly?" respondents were given choices of "very

important," "important," "somewhat important," and "not important." These ratings were determined to be easier to conceptualize than asking participants to chose on a scale from 1-5 about the importance of dental care. Multiple choice questions, such as asking where participants went for medical care, were developed after conducting pilot surveys as part of a graduate level sociology class titled "City and Community," and from feedback from Sister Sara Proctor. These data provided additional data to develop a comprehensive understanding of access to oral health care among migrant workers in the Tampa Bay area. Survey interviews were not audio-recorded, unlike the qualitative, semi-structured interviews in prior studies, in order to minimize potential discomfort during the survey interview process. Furthermore, recording the conversations was not necessary because the survey instrument/interview guide was already a structured document.

Each survey question was designed to address a research objective (see Table 3), and aimed at exploring the relationship between access to care and poverty examine poverty through the proxies of housing, occupation, and food security (see Table 4). Inadequate housing, lack of nutritious food, and low-wage jobs contribute to poverty, and for this survey occupation is not only a substitute for income level, but also for social class. Questions regarding food security were borrowed from the July 2008 version of the *U.S. Household Food Security Survey Module: Six-Item Short Form*. The six-item short form of the food security model was used to limit the burden of time on participants, since the entire survey with the six-item food security module typically took 15-25 minutes to complete.

The Economic Research Service of the USDA notes that the six-item food security survey is an appropriate substitute for the 18-item survey in cases where there is the

potential for a high participant burden (USDA Economic Research Service 2008). Since participants in this study were already asked to answer more than thirty questions, the six-item survey seemed more appropriate than the 18-item survey, in order to spare participants from possible frustration associated with being asked many questions. Moreover, interviews not exceeding 15-20 minutes were desired because participants were waiting for their medical appointments, and I did not want interviews to interfere with the clinic's operations. The six-item survey captures food security scores and highlights how limited financial resources influences availability of food. For example, the survey asks questions regarding how often participants had to skip meals, how long food lasted and if participants had money to buy more food once it ran it, if participants had enough money to buy balanced meals, and if participants ever went hungry because of not having enough money to purchase food.

Not having enough money to purchase food sheds light on the population's poverty circumstances as it connects to labor relationships and to constrained agency in accessing care. Low wages associated with migrant farmwork inhibit participants from having enough money for food, buying nutritious food, and results in skipping meals, all of which lead to low levels of food security. If participants do not have enough money for food, they are less likely to seek health services such as dental care because food is more of a priority. Additionally, poor nutrition status interacts syndemically with poor oral health as poor nutrition and poor oral health can influence one another as well as cause other health problems. A hierarchy of needs was echoed throughout research by both participants and by Sister Sara Proctor. To further ensure effectiveness and validity, the

survey with the six item food security questionnaire was pilot tested and given to Sister Sara for review.

Participants were provided with a $20 gift card to a major retailer as compensation for their time. These funds were provided through a grant from the USF Institute for the Study of Latin American and the Caribbean.

Table 1: List of survey questions that inform each research objective

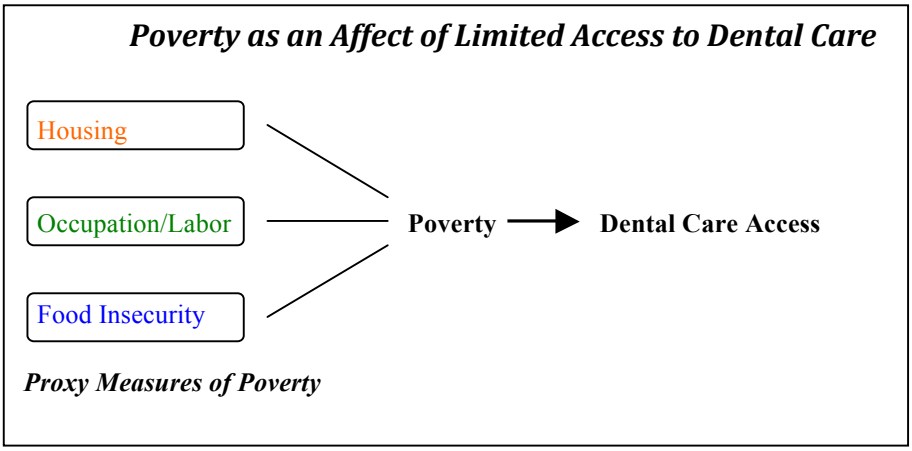
Research Objective	Corresponding Survey Questions
1. Examine how structural hindrances limit migrant worker access to dental care.	6,8,15-21, 27, 28
2. Determine if migrant workers have different perceptions of the importance of dental care for themselves and their children. Similarly, it would be necessary to then determine if migrant workers prioritize their children's dental health needs over their own, and if possible, find statistical significance demonstrating different oral health services usage rates between adults and children.	9-11, 13, 14, 18, 19, 22-28
3. Explore relationships between poverty and access to dental care by using three proxies of poverty: housing, occupation, and nutrition/food availability.	1-5, 12, 29-33
4. Provide beneficial data to internship supervisor, Sister Sara Proctor of Mobile Medical Services, to assist her with funding efforts and explore ways for her to obtain dental equipment needed to arrange dental appointments at her clinic.	7 & 8

Inclusion Criteria and Sampling

This research focuses on migrant farmworkers (following Arcury and Quandt's [2007] definition, as described earlier) and therefore only migrant farmworkers were eligible to participate in the survey. To assess eligibility, I introduced myself to potential participants, briefly explained the project, and asked 1) if the potential participant is currently a farmworker or has been a farmworker in past two years, and 2) if he/she

travels during the growing season. I located participants by sitting in the CMMS waiting room and asking every person in the waiting room the inclusion criteria questions. Since this study was conducted at a very specific site among a specific group of farmworkers utilizing CMMS services, it is a purposive sample and therefore does not necessarily represent all farmworkers in the state. It is instead representative of migrant farmworkers in the Tampa Bay area who utilize a CMMS clinic, and despite this very specific population, some of the broader implications about migrant health, labor, and poverty, can be extrapolated.

Figure 1: Lack of access to dental care as a result of poverty, measured by three proxies:



housing, occupation, and food availability.

Ethical Considerations

Working with marginal populations raises a series of ethical dilemmas, especially when the population is vulnerable because of unauthorized legal status. Many migrant workers are undocumented, and therefore may be guarded about talking to a researcher. For this reason, I excluded questions about immigration status, and I did not ask participants for their names. In agreement with Section 1, Paragraph C of the American Anthropological Association's Statement on Ethics, which maintains that informants have a right to remain anonymous, I maintained participant confidentiality and used pseudonyms for any narratives presented in this document.

In addition to maintaining confidentiality, I also compensated research participants in my study for their time, as they provided me with the service of information. Compensation for services is also addressed in the AAA Statement on Ethics; Section 1 Paragraph D asserts that researchers should minimize participant exploitation: "There should be no exploitation of individual informants for personal gain. Fair return should be given them for all services." Migrant workers are exploited for cheap labor and denied medical insurance despite working in a dangerous setting. Therefore, I felt it was fair to compensate them for their time as research participants. While working on farms, migrant workers are typically paid by how much produce they pick, thus their compensation fluctuates a great deal. By providing an incentive in the form of a $20 gift card to Wal-Mart (identified as the most frequently visited store for this population), I provided fair return for services as stated in the AAA Statement on Ethics, and avoided further exploiting an already over-exploited group of people. It should be noted that providing participant incentives is potentially problematic, as some

researchers may argue that using participant incentives can alter respondents' survey answers and compromise the quality of the data collected. In some scenarios I would agree with this assumption, however, for this research and this particular population, I argue that incentives are vital to offset the regular and legitimized exploitation of migrant workers. By compensating participants for their time, I demonstrated that their time is *always* valuable.

Additional factors I considered included literacy rates and possible feelings of coercion. Not all participants were literate, and some patients may have felt obligated to participate in the research because they were awaiting health services and could have feared that not participating would impact the quality of care received. To address these possible concerns and to avoid potential participant embarrassment or discomfort, I provided consent information and administered the survey verbally, while also stating in the consent form that not participating would have no impact on the services participants receive. Spatial considerations were also made to minimize possible feelings of coercion; all surveys were administered in the waiting area, which is located in a separate facility from where patients receive medical care, and thus there was no intentional connection to the medical care participants received and the survey I administered. Conducting the surveys in the separate waiting facility also minimized my exposure to patients' sensitive medical information.

Chapter Five: Results

As I walked outside with Xiomara to begin our interview, I noticed her hands were trembling. Her entire body shook slightly, but not so much to move her thin gray hair, and she looked at me eagerly, ready to answer my questions. "Thank you for doing this study," she said, "it's so important because no one knows how hard it is to see a dentist." As we began to speak, Xiomara started to explain some of her hardships. Like many of the farmworkers I interviewed, Xiomara, age 56, talked about not being able to access dental care because of not being able to find work, and when I asked her food security questions, her hardships became increasingly clear to me. "There's just not a lot of work here—when there's no work, there's no money; when there's no money, there's no food. Of course I have to skip meals…I go to bed and I'm hungry…but there's no work."

This chapter highlights the main findings of this research and demonstrates how labor and low wages impact access to care and food security. Xiomara's situation was unusual in the respect that she was one of the oldest participants of the study; despite her age, however, her story was similar to many other participants in this research. Like Xiomara, participants expressed difficulties finding work or earning enough money to cover basic expenses such as food and rent. Their labor situation directly impacted their economic situation, which resulted in limited means to secure medical and dental care. Low wages for many participants also translated to skipping meals, limiting their food intake, and going to bed hungry. Dental care or medical care were secondary after food

and shelter; as one participant told me "first the rent, then food, then we worry about dentists..."

This chapter presents data to highlight the relationship between poverty and access to dental care. Poverty is measured by proxy of housing conditions and occupational conditions, as well as food security scores.. Each proxy measure of poverty is represented in a different section of this chapter. The data are reported in six sections: demographics, housing and work, perceptions of care, access to oral health care and oral health habits, children's care, and finally, food security. Thirteen participants did not have children (even if they lived in households with children) and therefore the questions about children's care were not applicable. All of the names in this chapter and subsequent chapters are pseudonyms to protect the identity of the research participants.

Demographics

Figure 2: Participant gender

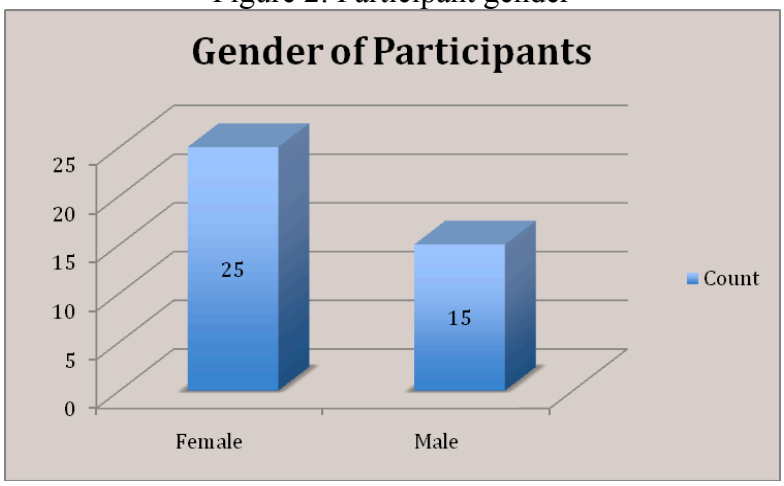


Figure 2 shows the gender of all participants involved in this study. The majority of participants, 62.5%, were female, and 37.5% of participants were male. Participants

were not specifically recruited by gender; this is an artifact of who was present at the recruitment site at the time of the study.

Figure 3: Participant age

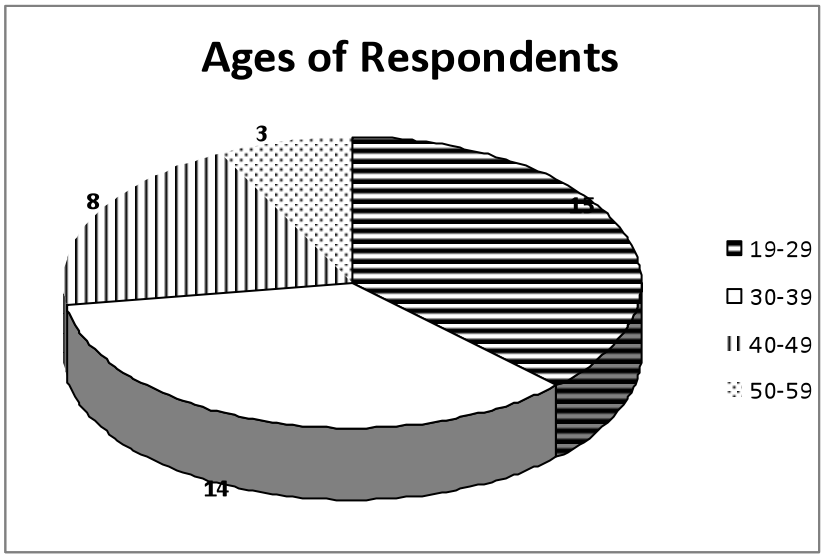


Figure 3 shows the ages of all participants. The majority of participants, 37.5%, were ages 19-29. 35% of participants were ages 30-39, 20% were ages 40-49, and 7.5% were 50-59. One of the older participants reflected on her age, since she was notably older than the other farmworkers, saying "It's difficult work in the fields, and at my age it's *very* difficult." This participant then showed me her hands, describing arthritis pain that she tries to ignore while working.

Table 2: Region of origin

Region in Mexico	Count
Oaxaca	13
Guerrero	5
Hidalgo	5
Tamaulipas	4
Veracruz	3
Guanajuato	2
Puebla	2
Chiapas	1
Distrito Federal	1
Jalisco	1
Baja California	1

All of the participants except for two were of Mexican origin; the two non-Mexican participants were from Honduras. Of all of the participants from Mexico, most were from the state of Oaxaca (13), followed by Guerrero (5) and Hidalgo (5), then Tamaulipas (4), Veracruz (3), followed by Guanajuato (2) and Puebla (2). One participant each came from Chiapas, the Distrito Federal, Jalisco, and Baja California. These findings are not typical, as Oaxaca is not typically a farmworker labor sending state. The National Center for Farmworker Health (2009) finds that 46% of farmworkers in the United States are from west Central Mexico, including states of Guanajuato, Jalisco, and Michocan, and the same study shows that only 19% of farmworkers are from southern Mexico, including Guerrero, Oaxaca, Chiapas, Puebla, and Veracruz. These data show that the majority of farmworkers in the utilizing the CMMS clinic are not from the traditional sending states in Mexico, but are instead from less typical sending states, such as Oaxaca. Additional research is needed to systematically explore whether the sending states reflected among those utilizing the CMMS clinic applies more broadly to the Tampa Bay area, and if so, whether or not sending states have changed and for what reasons.

Table 3: Language

Language	Count
Spanish only	26
Spanish and Mixtec	8
Spanish and English	4
Spanish, English, and Mixtec	1
Spanish and Otomí	1

The majority of participants spoke only Spanish, followed by Spanish and Mixtec speakers, followed by English speakers, and one participant spoke Spanish, English, and Mixtec, and another participant spoke Spanish and Otomí.

Housing and Work

Out of the the 40 participants interviewed, 11 participants currently stay in Florida year-round (but have migrated in the past two years, which was part of the inclusion criteria), and 29 participants migrate when the strawberry season ends. Participants travel to places such as North Carolina, Michigan, Ohio, and Georgia, and participants who stayed in Florida year-round had migrated in the past two years in accordance with recruitment criteria.

For all households, the mean and median number of adults for each household was 3 with a mode of 2. The mean number of children was approximately 2.23, the median number of children was 2, and the mode was 0. The mean total household size was 5.225, the median and mode total household sizes were both 5.

In the households where children were present (n=31) the mean number of adults was 2.77 with a median and mode of two. In these households, the mean number of children was 2.87 with a median of 3 and mode of 2. Not all participants who lived in

homes with children present considered themselves caregivers. When asked to answer questions about children's oral health, only 27 of the 31 participants interviewed felt comfortable answering questions about the children in their household. As one participant said to me: "The children aren't mine…they're my brother's. I don't know what he does for their teeth." Other participants commented on not knowing about children's care because they did not have children, and I did not ask participants to answer questions about children's care if they did not have children or lived in households with children but did not participate in the children's care.

For households without children (n=9), the mean number of adults was 3.78, the median was 3, and the mode was 2.

Table 4: Amount of rent paid (data collected during Spring 2008 for graduate course titled "City and Community")

Monthly Amount Paid for Rent	***Number of Responses***
$300.00	2
$350.00	2
$355.00	1
$360.00	2
$450.00	3
$455.00	3
$480.00	1
$550.00	6
$600.00	2
$620.00	1
$700.00	1
$800.00	2
$1,500.00	1

The data for Table 6 were collected during Spring 2008 and show the amount of rent each respondent paid (n=29). Most respondents (6) paid $550 a month in rent while two respondents paid the lowest reported amount, $300, and 1 person who shared a home with seven others, paid $1,500 a month.

Table 5: Average rent by dwelling (data collected during Spring 2008 for graduate course titled "City and Community")

Type of Dwelling	***Average Monthly Rent***
Apartment	$740
House	$895
Mission	$455
Mobile Home	$452

Table 5 shows the average monthly rent for respondents broken down by type of dwelling. Apartment renters paid an average of $740 a month, home renters paid an average of $895 a month, those who lived at the mission paid an average of $455 a month, and mobile home renters paid an average of $452 a month. Most of the units included the cost of water but did not include the cost of electricity, and an adequate calculation for electrical costs would require knowing the square footage of participants' homes. However, when taking into account the median gross rents (rent as well as cost of utilities) for the two cities where most migrant farmworkers interviewed live, Plant City and Dover, the average apartment rent reported above falls in between median rents of the two areas. The median gross rent for Plant City, Florida is $807 per month, and the median gross rent for vacant units in Dover, Florida is $691 per month. Living in the San Jose Mission and a mobile home are more affordable than living in houses or apartments, but the apartment data show that reported average rents are higher for apartments than the median gross rent in Dover but slightly lower than the median gross rent in Plant City.

Perceptions of Care

Table 6: Comparing dental and medical care

Is dental care more important, less important, or as important as medical care?	
Response	**Count**
As Important	31
More Important	6
Less Important	3

Table 6 shows the responses to the question "Is dental care more important, less important, or as important as medical care?" The majority of participants, 37, answered that dental care is either *as important* as or *more important* than medical care, while only three participants answered less important. These data are of particular interest because the responses demonstrate that this population does not privilege medical care over dental care. The importance of dental care is widely understood, and most respondents claimed dental care is equally important to medical care.

"They're both important," one participant answered when asked the question. "Good teeth are part of being healthy." Another participant noted that although dental care is important, it is not always easy to see a dentist: "It's very important to see a dentist but there aren't any dentists…and SunCoast is very expensive so there's no way to see a dentist."

Table 7: Importance of regular dental care

How important is it to go to the dentist regularly?	
Response	**Count**
Very Important	20
Important	17

Somewhat Important	2
Don't Know	1

Table 7 shows responses to the question "How important is it to go to the dentist regularly?" The overwhelming majority of participants (37) answered either "very important," or "important," while only three participants answered "somewhat important" or "I don't know." Although the data in Table 7 demonstrate that respondents understood the importance of dental care, the construction of the question regarding importance of dental care may have been flawed. The nature of the question "How important is it go to the dentist regularly?" may have produced answers that are either uncontested (most people would probably answer this question in much the same way, all things being equal) or socially desirable. In retrospect, asking participants to rank several items and services -- including dental care -- may have provided more insight regarding perceptions of importance of each. Despite the potential problems with this question, however, Table 6 demonstrates that respondents did not consider medical care more important than dental care. Both questions capture only perceived importance and not actual practice, and in fact respondents may have to prioritize needs and place dental needs below other types of needs.

As a final note about the data in table 7, it is important to highlight that since almost all of the participants rated regular care as important, education emphasizing the importance of dental visits may be ineffective. Education about flossing, however, could be beneficial for this population since many do not floss (as illustrated later).

Table 8: Visits per year

How often should one go to the dentist?	
Response	**Count**
Twice a year/every six months	16
3 or more times a year	9
Once a Year	8
For problems only	3
"Frequently"/"When needed"	2
Don't Know	2

When asked "How often should one go to the dentist?," as shown in Table 8, 16 respondents answered twice a year or every six months, 9 respondents answered 3 or more times a year, eight respondents answered once a year, three respondents said to go to the dentist only when dental problems arise, two respondents answered "frequently or when needed" and two respondents answered "I don't know." These understandings of when to visit the dentist overlap with recommended guidelines set by the American Academy of Pediatric Dentistry (AAPD) and the American Dental Association (ADA),[2] indicating that this population is not misguided about when to visit a dentist because of "cultural beliefs" or other factors. One participant described what she thought was an ideal scenario: "You should go every six months if you can…but sometimes you can't because there aren't any dentists or because it costs too much. That's why I wait to see a dentist in Michigan because a bus comes to the fields and I can pay $20 for a cleaning then."

[2] The ADA discusses nuanced recommendations for patients to receive care and will use phrasing such as "once every six months," or "twice a calendar year." These policies can be viewed in detail by accessing the ADA's electronic document on current policies at http://www.ada.org/sections/about/pdfs/doc_policies.pdf.

Table 9: Harmful substances to teeth

Are there any types of foods that are bad for your teeth?	
Response	**Count**
Sweets	25
Gum	6
No foods are bad	5
Chocolate	4
Cigarettes	4
Don't know	4
Soda	3
Sugar	3
Alcohol	2
Meat	2
Other	9
Other responses included acidic food, drugs, fatty food, hard items, ice, peanut butter, potatoes, food scraps, and spicy foods--each with one respondent.	

When asked to list substances that are harmful to teeth, participants listed numerous types of foods and other substances. All items mentioned during interviews are shown in Table 9, therefore the list of responses is greater than the list of participants. The largest response for the question "are there any types of food that are bad for your teeth?" was sweets, which 25 participants mentioned. Six participants mentioned chewing gum, five mentioned that there are not any foods that are bad for your teeth, four participants stated chocolate, cigarettes, and that they did not know what foods might be bad for teeth, while three participants listed soda and sugar. Two participants said alcohol and meat were bad for teeth, and nine participants listed one item each that others did not, including acidic food, drugs, fatty food, hard items, ice, peanut butter, potatoes, food scraps, and spicy foods. Overall, the answers given for this question demonstrate that participants are aware that certain foods can be harmful for teeth, and most participants identified sugary food items as harmful. This understanding of harmful

substances for teeth further demonstrates that this population has knowledge of what can cause dental caries.

Some participants commented on how foods directly impact their teeth and may require additional dental treatment. For example, Ines, a 43-year-old mother of four, mentioned that her children eat more sweets than she does, and because of this she felt they needed to see a dentist more often than she did. "I should go twice a year, but the children, they eat a lot of sweets, so they should go more often." Most participant responses were like Ines' and recognized that foods can be harmful for teeth, with children's consumptions of sweets requiring more frequent visits to a dentist. Her children are U.S.-born and have Medicaid, so they are eligible for dental visit, Ines however, is not. "I can only go to the dentist when I'm pregnant, so that's when I get my teeth cleaned."

Access to Oral Health Care and Oral Health Habits

Table 10: Brushing

How often do you brush your teeth?	
Response	**Count**
Twice a day	27
Three times a day	9
Once a day	4

Itzel, a Spanish and Mixtec speaker in her early 30s, stressed the importance of brushing her teeth. "You have to do it frequently to prevent carries," she exclaimed. Itzel, like other participants, was very savvy about the need to maintain oral hygiene. Table 10 demonstrates that the majority of respondents (27) brush their teeth twice a day, and nine respondents three times a day, and only four respondents once a day. None of the respondents answered that they did not brush their teeth, and while this could be

arguably an answer to please the researcher, the majority of participants had no problem admitting they did not floss, as demonstrated in the next table. These data also demonstrate that respondents were likely to own a toothbrush if they brushed their teeth often, therefore demonstrating that purchasing a toothbrush was understood as a necessity.

Table 11: Flossing

How often do you floss?	
Response	**Count**
I do not floss	21
A Few times a week	7
Once a day	4
Twice a day	2
Three times a day	2
Occasionally	2
Rarely	2

Flossing regularly was not as common as regularly brushing teeth, as highlighted in Table 11. 21 respondents reported not flossing at all, seven flossed a few times a week, four flossed once a day, and the remaining categories which included flossing twice a day, three times a day, occasionally, and rarely, each had two respondents. One of the providers interviewed for this project speculated that brushing and flossing were not seen as important as other necessities, but this table suggests perhaps flossing is not considered as high as a priority as brushing teeth. The flossing data, when compared to data on brushing and the importance of visiting the dentist, present a possible avenue of health education programs. Although participants were well aware of the importance of visiting a dentist and most brushed their teeth, a possible health education program could be designed to emphasize the usefulness of flossing.

To mitigate any potential embarrassment about not flossing their teeth, I told participants I also did not floss, and for those who did floss I explained that they were doing a better job of taking care of their teeth than I was. This typically elicited a smile or laugh.

The data on brushing and participants' flossing demonstrate that

Table 12: Last dental visit

When was the last time you went to a dentist?	
Response	**Count**
Between 1-5 years	14
During the past year but longer than one month ago.	11
Never	7
Don't know/don't remember	4
In the past month	3
More than 5 years	1

In Table 12, the data listed provide a snapshot for last dental visits. The majority of respondents (14) had visited the dentist in the past five years, 11 respondents had a dental visit in the past year but over one month ago, seven had never seen a dentist, four respondents did not remember, three visited the dentist in the past month, and one visited the dentist more than five years ago. Many participants reflected on their experiences in Mexico, saying it was easier to get an appointment and that they could go more frequently. "In Mexico we can go every month, whenever we want, and its free," Esme, a participant whose story I will explain in greater detail below, explained. In Mexico, the Instituto Mexicano del Seguro Social (IMSS) runs a federally-funded preventative dentistry program that covers children's oral health care (Segovia-Villanueva et al. 2006: 88). Moreover, the IMSS insures citizens who are not able to access healthcare insurance by obtaining coverage through their jobs or through more expensive private purchase (Pérez-Núñez et al. 2006: 903). Although IMSS covers dental procedures, studies of oral

health coverage in Mexico show that dental care can benefit from improvements because access to care is not ubiquitous, but rather varies depending on region and individual factors for each patient (Pérez-Núñez et al. 2006; de la Fuente-Hernández and Acosta-Gío 2007). Dental care in Mexico is considerably cheaper than in the United States and there is an organized dental tourism industry designed to persuade U.S. citizens to travel to Mexico specifically for dental care[3]. Turner (2008) notes that high costs of care, low prices of airline tickets, and internet advertising have all contributed to increases in dental tourism.

Table 13: Difficulty accessing care

Are there any factors that make it difficult for you to see a dentist?	
Cost of care	17
Personal finances	17
Length of time to get an appointment	5
Language barriers	3
Lack of dentists	3
Transportation	2

All respondents were given an opportunity to describe what they felt was a hindrance in accessing dental care. All responses fell into the categories related to cost of care, personal finances, length of time to obtain an appointment, language barriers, lack of dental providers, and transportation problems. Some respondents answered more than one barrier, and therefore the totals for this table do not equal the total number of participants.

[3] Dental tourism can be arranged through internet groups that advertise the significantly lower cost of dental care in Mexico compared to the U.S. See Dental Tourism Mexico, http://www.dentaltourismmexico.com/ and Mexican Dental Vacation, http://www.mexicandentalvacation.com/ as examples.

Cost of care and personal finances are separate categories because of how participants spoke of financial difficulties. Some participants claimed the cost of care was too expensive, which was their main difficulty in accessing care, while others claimed they personally did not have the money to afford the care. The principle difference between these two categories is how participants discussed economic components of care. For those saying the cost of care was too high, they were referring to the structural problem of costly care, while those who provided responses such as "I don't make enough money to go," or "I just don't have the money to see a dentist" discussed the problem of limited access to care on a more personal and individual level. The varied responses demonstrate how the problem in accessing dental care is both a macro- and micro-level issue tied to larger labor-related hardships. Dental care is expensive, and farm laborers wages are low, producing economic barriers on two spectrums. Ethnographic examples from fieldwork highlight this point.

Juan Carlos, a 39-year-old man from Guerrero, believed dental care is extremely important—"you should go to the dentist every month if you can," Juan Carlos asserted, "just to make sure everything is okay." Juan Carlos works on the strawberry farms and lives in a house with his wife, child, and two other family members with whom he splits the rent. When I asked Juan Carlos about the difficulties in accessing care, his response was immediately related to work.

> There's just not enough work to be able to miss a day. I'm only earning $30, $40, $60 a week and rent is $200-$300 [a week]. And right now there is less work because of the ice and a lot of strawberries have grown

> small and not really round, so people won't buy them because they don't like the ones that aren't perfectly round.

Adriana, 27, explained that sometimes she cannot leave work to go to a dental appointment, and that the costly appointment may result in her losing her job: "There's a lot of pressure at work if you want to leave to go to an appointment. I can' t leave because I don't want to lose my job, and I would have to pay $40-$100 just for a dental consultation." Rosalva, 32, explained that her wages cover her most basic needs first, such as food and shelter. Her statement echoed another participant's when she stated "Food first--then we worry about doctors, or not having glasses, or not going to the dentist."

For participants like Juan Carlos, Adriana, and Rosalva, access to care is directly related to labor and depends on how much money they have. If they have enough money to cover basic needs like rent and food, then any money left over can be used for medical or dental care. Juan Carlos and Rosalva's answers in particular demonstrate the precarious nature of their work and their vulnerability to market demands that react to consumer preferences. If forces beyond their control such as weather patterns cause crop damage that is undesirable, Juan Carlos, Adriana, and Rosalva suffer because consumers will not purchase the crop, therefore suppliers will not purchase the crop, and the growers will not hire laborers to pick the crop. Ultimately this translates into limited job opportunities and increasingly limited access to care.

These experiences are similar to Sara's, a 36-year-old woman from Tamaulipas. Sara, however, focuses on the costs of care instead of personal finances and wages. "Cost—that's the only thing. It's very costly to go to the dentist. Even if you have

Medicaid you still have to pay part of the visit. If it were less costly I would go." For Sara and many other participants the cost of care is the main hindrance. Lupe, a 43-year-old woman also from Tamaulipas echoed this point when talking about the importance of going to the dentist:

> It is important to go to the dentist two times a year but sometimes you just can't because it's too costly. People remove teeth because it's cheaper. It cost $500 for a root canal at SunCoast [clinic], but only $100 to remove a tooth. But just to go there is $50 for a consultation.

For many participants, extractions are a more cost effective way to manage their oral health rather than obtaining restorative care, which is more costly.

A third example highlights both the individual and structural themes expressed in these stories. Esme, a 47-year-old from Tamaulipas, worked on the farms last year but now runs a daycare in her home. Esme believes that dental care is even more important than medical care, and says that the costs and her personal financial situation prohibit from going the 3-4 times a year she would like to go.

> The cost is very high and I don't have a lot of money. If I had more money and I could afford it, I would go to the dentist. Imagine paying $100 for a dentist. If I earn $200 a week and then spend $100 on the dentist, how will I pay rent? If it were only $20 for a cleaning and $30 for a filling, I could do it.

Esme's story highlights both the high costs of care and the personal financial choices people must make when prioritizing their needs. Sister Sara once commented on the way in which people must consider finances before accessing care or engaging in preventative behaviors that may require any type of expense.

> How much is a toothbrush? Two bucks? If I have to decide if that two bucks is going to buy a toothbrush or flour, I'm going to choose flour because I make tortillas with the flour. I can feed my family with that two bucks. At that point a tooth brush is like a luxury item.

Table 14: Teeth condition

How would you describe the condition of your teeth—excellent, very good, good, okay, or bad?	
Response	**Count**
Excellent (*Excellente)*	1
Very Good *(Muy Bien)*	5
Good *(Bien)*	12
Okay/Fair *(Más o menos)*	13
Bad *(Mal)*	8
Don't know *(No Sé)*	1

When asked to describe their teeth, 13 respondents said their teeth were in "okay" condition, 12 said "good" condition, eight said "bad," five said "very good," and one respondent each answered "excellent" and "I don't know."

Some participants linked their teeth's condition to not being able to afford dental visits or a lack of providers, as exemplified by the story of Beatriz. "Why do you think your teeth are bad?" I asked Beatriz, a 30-year-old woman from Puebla. "Because," she answered, "they have lots of problems! There aren't any dentists here and if I go to one somewhere else they never understand me when I try to tell them I have sensitive teeth!"

Sympathizing with her teeth sensitivity, I suggested to Beatriz what to tell dental providers in English and also told her about special toothpaste specifically for sensitive teeth. She was unaware of sensitive teeth toothpaste and expressed gratitude for the advice.

All respondents were asked if they currently had dental pain and the majority of respondents, 28, answered “no.” Ten respondents answered “yes,” and two answered “sometimes.” Although most respondents did not currently experience pain, this question may not capture the entire scope of dental problems participants have because some participants like Juan Carlos have found short-term fixes for their pain. Juan Carlos said he was not in pain, but then explained “I went to the emergency room because my teeth were decayed and I was in pain. They gave me pills to help with the pain and now I'm okay." Another participant, Luís, a 27-year-old Honduran man, shared a similar response "I take a pill for the [tooth] infection and the pain goes away." Luís later explained to me that he takes amoxicillin for the infection.

Since many participants were not in pain, I was curious to discover where they would go if they suddenly experienced dental pain or had a dental emergency.

Table 15: Emergency resources

If you woke up with dental pain tomorrow or had a dental emergency, where would you go?	
Response	**Count**
Community clinic	19
I don't know where I would go	6
Emergency room	6
Catholic Charities clinic	3
Pharmacy	2
Dentist office	2
Urgent care clinic	1
"I'd look for a dentist"	1

When asked where they would go if suddenly experiencing dental pain or a dental emergency, 17 respondents said they would go to a community clinic like SunCoast Medical Center, six respondents answered emergency room as well as “I don’t know,” and three respondents said they would go to the Catholic Charities clinic. Two respondents said they would go to a pharmacy, another two respondents said they would go to a dentist’s office, and one respondent said “I would look for a dentist,” while another respondent said he/she would visit an urgent care clinic.

Although most people answered that they would go to a community clinic, many participants have highlighted that community clinic is unaffordable, explaining that a consultation alone cost $50. Others shared a more desperate feeling associated with emergency dental needs. Luís, for example said “I don't know where I would go for an emergency. We don't have other options” (other than the CMMS clinic and SunCoast Community centers). Josefa, a 38-year-old from Oaxaca, also stressed this point. "There's nowhere I can go to get help, and I have tooth pain right now." Others, such as Gracia, were hoping I could provide them with a place to get care. “I was hoping you could tell me!” Gracia exclaimed. Gracia’s comment, echoed by others, resonated with me throughout this research, which I will touch upon later.

Table 16: Improving access

What would make it easier to see a dentist?	
Don't know	14
Individual factors	5
Lower cost	5
Payment plan	5
Subsidized dental care	4
Higher wages	2
Referral source	2
Mobile dental unit	1
More community services	1
Shorter wait time	1
Walk-in dental clinic	1

I asked participants about their ideas on how to improve access to dental care, and many provided more than one suggestion, so that the totals for Table 17 do not equal the total number of participants. Many participants were unsure of what suggestions to offer. Others, however, suggested that dental costs should be lower: five participants suggested lower costs in dental care, while another five suggested a payment plan so that they could make monthly payments. This was a point Esme made, saying that making payments would increase her access to obtaining dental care. "If I could find someone to let me pay little by little I could get care, but you have to pay all or nothing." Five participants also gave responses that I have categorized as “Individual factors,” which are situational consequences that are solely focused on individuals and not structural problems. For example, one respondent said that “you just have to take better care of your teeth,” while another answered “go different places and find a better paying job.” One participant, Ybet, said “If I don't make enough money to pay the prices, I can't pay." Framing access to dental care in this way demonstrates the hegemonic discourse of individual responsibility in health care, including dental care. Rather than critiquing the structural determinants of health, these participants instead subscribed to an individualized reason

to why they were not able to access care, seeing personal shortcomings rather than seeing how forces beyond their control constrain their agency in having a choice to access care.

Four participants mentioned that a subsidized dental care program would be beneficial, and Esme asserted this as well: "we need some sort of campaign for those of us who don't have Medicaid, and whose children don't have Medicaid either." Esme points out that there are people who fall within gaps created by healthcare coverage, and for those who fall into these gaps there is little to assist them. Even the current healthcare reform initiatives prohibit unauthorized immigrants from using their own funds to purchase healthcare, continuing to widen healthcare coverage gaps (Associated Press 2010). Two participants said dental care would be more accessible if they had more money from working, and another two participants said they would like a referral source—an agency to tell them where they can go to get dental care. Some participants stated that mobile dental units would be helpful, while others said more community providers such as CMMS were needed. Some participants stated that shorter wait times at existing clinics would be helpful, and proposed a walk-in dental clinic as a suggestion.

Children's Care

Of the little migrant oral health literature that exists, much of it covers children's' oral health disparities and access to care. This research focuses on adults but also asked questions about children's care to provide a comparative component in the research. The goal in comparing answers to questions regarding adults and children is to examine whether or not participants felt children's care was more important than adults' care. Of the 40 adults interviewed, 13 did not have children and were therefore not asked

questions about children's oral health care since the questions were aimed at parents. In retrospect, it may have also been beneficial to see if non-parents had different perceptions than parents about children's oral healthcare, but not including non-parents did not impede the findings of this research.

When asked "how important is it for children to go the dentist regularly?" Twenty respondents answered "very important" and seven answered "important." Therefore 100% of eligible respondents answered that it was either important or very important for their children to go to the dentist.

Table 17: Ideas about children's and adults' frequency of visits

How often do you think your children/adults should go to a dentist?		
Response	**Children**	**Adults**
Once a year	5	6
Twice a year	7	9
Two or three times a year	4	1
Three times or more a year	7	6
If there's a problem	2	2
"Often"	0	1
Never Been	0	1
Don't Know	2	1

When asked how often respondents thought their children should go to the dentist, seven respondents answered twice a year, five respondents answered once a year, four answered two or three times a year, seven answered three or more times a year, two did not know, and two said "if there is a problem." When compared to how respondents with children answered about adults, results were similar.

One parent, 24-year-old Mario from Hidalgo, linked his child's care to access to Medicaid and the importance of taking his child to the dentist. "It's easier for children [to see a dentist] because they have Medicaid…it's less difficult because it's more important that they go." Mario's statement demonstrates a commonly-held belief that children's care is more important than adult care, reflecting also that children are considered to be more deserving of care than adults because they are not able to provide for themselves.

The data collected demonstrate the most adults believed dental care for themselves and for their children was important; therefore no substantial difference between perceptions of the need for care can be determined. However, two parents spontaneously said that they felt it was more important to take their children to the dentist

than it was to make an appointment for themselves. This may be an important question to ask parents systematically in future studies.

Table 18: Children's last visit

When was the last time your children went to a dentist?	
Response	**Count**
During the past year not the past month	14
In the past month	6
Between 1-5 years	4
Never	4

Each respondent was asked to report when their children last went to the dentist. Fourteen respondents answered "during the past year but not in the past month," six respondents' children had been to the dentist in the past year, four had been in the past 1-5 years, and four had never been.

Table 19: Children's reason for visit

What was the reason for their last visit?	
Response	**Count**
Checkup or cleaning	15
Emergency Visit/Pain	5
Never Been	3
Filling	2
Decay	1

When asked why their children last visited the dentist, 15 respondents said the appointment was for a checkup or cleaning, five said it because of pain or an emergency visit, three said their children had never been, two took their children to get fillings, and one answered that the children went for fillings.

Table 20: Condition of Children's teeth

How would you describe the condition of your children's teeth—excellent, very good, good, okay, or bad?	
Response	**Count**
Good	10
Excellent	6
Very Good	6
Bad	4
Okay	2
**Some participants answered differently for each child, therefore the total number of responses does not equal 40.*	

Table 20 shows the results of respondents' assessments of their children's teeth. Ten respondents said their children's teeth were in good condition, six said excellent, six answered "very good," four answered "bad," and two answered "okay."

In some families, the condition of teeth varied among children.

"The oldest has really bad teeth!" One parent exclaimed. "the other two, theirs are okay, but the eldest's are very bad. Last time we went they told me he had caries, but the two young ones are okay."

Table 21 Emergency resources for children

If one of your children woke up with dental pain tomorrow or had a dental emergency, where would you take them?	
Response	**Count**
Emergency Room	11
Community Clinic	7
Dentist Office	4
I don't know	2
I would look for a dentist	1
Catholic Charities Clinic	1
To Mexico	1

When asked where they would take their children for a dental emergency or pain, 11 respondents chose the emergency room, seven selected a community clinic, four said they would go to a dentist's office, two did not know, and "I would look for a dentist," "I would go here (to the Catholic Charities clinic), and "I would take them to Mexico" each received one response. Responses for where parents would take children for an emergency differed from where parents would go for their own dental emergencies. The majority of percipients answered they would go to a Community Clinic for their own dental emergency, whereas the majority of respondents with children answered they would take their children to an emergency room.

Each respondent was also asked if it was easier, more difficult, or the same difficulty in accessing dental care for themselves and their children. Twenty respondents said it was easier for their children to access dental care, 4 said it was easier for adults, and three said it was the same level of difficulty.

For many respondents who answered that children had an easier time accessing appointments, they explained it was because of children's eligibility for Medicaid. As Elicia, 26, points out "It's easier for my son to go to the dentist because he has Medicaid. When I go, I have to pay more." Expanding on Elicia's comment, Ruebén adds: "It's easier for the children because they have more resources…but there needs to be help for the parents, too." Another participant, Tomás, 27, linked citizenship to access to resources for healthcare. "It's much easier for the children because they were born here." In some families the citizenship avenue to care becomes more obvious as some children were born in the United States and others were not. This was evident during my interview with Rafael, a 42-year-old father of three. "For the one child it's easier because he has

Medicaid," Rafael explained, "but the others don't have Medicaid so it's hardest for them." Even if children have Medicaid it does necessarily cover all of the costs of their dental needs, as Sara pointed out. "Even though they have Medicaid, there are some things for the children that still cost a lot. For example, Medicaid doesn't cover braces, and the oldest is going to need them."

The answers to this question to some extent reflect its ambiguity. Asking for whom it is easier to go to the dentist allows participants to interpret the question as "for whom is it easier to obtain an appointment?" or "who has an easier time at the dentist's office?"

This is demonstrated by some parents' responses who said it was easier for adults to go, since their reasoning did not always relate to insurance or Medicaid. "It's easier for adults because they can put up with the pain, but you have to pay more for adults," Camila, 32, noted. Elba, 27, commented that it was easier for her to go to the dentist because her daughter needed anesthesia every time she went. The dental clinic encounter also played a role in how parents answered this question. Lourdes, who has two children, noted that "it's more difficult for the children [to go to the dentist] because they don't always understand what's going to happen when at the office."

Parents who answered that it was the same for children and themselves were either eligible for Medicaid because they were recently pregnant, or, conversely, neither they nor their children were eligible for Medicaid. This demonstrates that even though Medicaid has many flaws and cannot fulfill all of the needs of some people, it still has an impact on those who access Medicaid services. Those without Medicaid however are left without any options if their wages are too low to afford any type of medical or dental

care. As Rosalva explained, "Here we need more support for people without Medicaid." This has problematic implications as recent research has show that Medicaid reimbursement rates are lower than private insurance reimbursements, which discourage providers from accepting Medicaid (Horton and Barker 2010; Castañeda et al n.d.).

Food Security

Table 22: Food security

Totals	**Percent**	**Count**
Food Secure	17.5%	7
Marginal Food Security	10.0%	4
Low Food Security	37.5%	15
Very Low Food Security	35.0%	14

Table 22 captures the level of food security for participants. Food security levels were calculated using the *U.S. Household Food Security Survey Module: Six-Item Short Form.* Questions focused on whether or not participants had enough money to purchase food, skipped meals because they could not afford food, and went hungry because they did not have enough money to purchase food or they ran out of food. Each response was given a score of 0 or 1 depending on the answer, and the totals were calculated to determine under which category the participants fell. Scores of 5 or 6 indicates very low food security, 2-4 indicate low food security, a score of 1 indicates marginal food security, and a score of 0 indicates food security. The scores for each participant are not reported here, but rather the totals for each category of food security.

The majority of participants, 72.5%, experience low or very low food security (15 or 37.5%, and 14 or 35%, respectively). Ten percent, or 4 people experienced marginal food security, and seven participants were food secure. The connection between labor, wages and food security became evident during several conversations with participants.

Pilar, a 27-year-old Oaxacan, explained that the amount of food she can purchase is dependent on how much she works. "When there isn't any work it's difficult, and I only work 2-3 hours a day, 2-3 days a week, so you can't always buy all the food that you want." Reina, 29, also from Oaxaca, explained that her family sometimes does not eat because they cannot afford food. “We have to skip meals more often when there's no work." Lupe also expressed this point, but claimed that instead of skipping meals she just reduced the amount of food she consumed: "When we have work we don’t skip meals…when there isn't work you eat, but not as much as you want. The children get more than we do--we always give the children more."

For Juan Carlos, low wages meant fewer food options, especially when trying to work on weekends to earn more money: "All we can afford is beans…we have other expenses, too. If we work on the weekend we have to pay $12 a day for childcare, $24 a day for Saturday and Sunday."

Other participants, such as Alejandro, relied on family support to purchase food when wages were low: “We ask family members for loans so we don't have to buy less food.”

When relating the data on oral health habits by level of food security, it becomes increasingly clear that food security impacts access to oral health and is a good indicator of poverty impacting access to dental care in this particular population. For example, of all the participants who experience very low food security (n=14), 57.14% of respondents said their last reason for a dental visits was an emergency visit. 40% of respondents experiencing a low level of food security gave the same answer, but only 25% of respondents who experienced marginal food security said their last visits was because of

an emergency. By contrast, none of the participants who were food secure (n=7) answered that their last visits was due to pain.

Further illustrating this point was the percentage of respondents visited a dentist in the past month. Overall, 14.29% of food secure respondents answered they had visited the dentist in the past month, whereas only 7.14% of respondents with very low food security and 6.67% of respondents with low food security had visited the dentist in the past month.

Although these data could be critiqued because of the small sample size, these initial findings regarding food security and the percentage of responses regarding access to care are worth considering since preventative behaviors regarding care yielded similar results. The percentage of respondents who brushed their teeth twice a day (71.43%) was the same for food secure respondents those with low very low food security. Flossing data, however, is erratic, and no implications can be drawn from the small sample size. Future research on this topic can incorporate a sampling plan that requires a larger population from every level of food security.

Summary of Results

All of the data presented in this chapter highlight the ways in which oral health disparities can be attributed to social determinants. Neoliberal economic policies that have encouraged transnational labor migration result in people arriving to places like the United States in an effort to make a decent living wage. This research demonstrates how farm labor remuneration is kept low due to market forces, such as ideas regarding attractive fruit, and how job opportunities are not always predictable because of uncontrollable forces such as whether patterns. Furthermore, the low wages that laborers

earn are not always enough to support themselves or their families, as demonstrated by the high rates of food insecurity. When faced with low wages and not enough food, migrant laborers are not always able to afford the dental care they desire or need because the cost of care is out of reach for them. Additionally, this population is excluded from safety-net medical programs such as Medicaid because of their immigration status, and the broader healthcare structure in the United States does not incorporate affordable dental care in its conception of comprehensive preventative care, as demonstrated by a lack of dental clinics and the high cost of dental consultations at local community clinics. Lastly, the dental care system does not encourage restorative care, as extractions are less costly than restoration efforts. For this reason is it necessary to explore possible solutions to the problem migrant workers have in accessing dental care.

Chapter Six: Conclusions and Recommendations

All research on migrant workers and oral health highlight how the complexity of the problem, and some scholars have discussed multiple barriers to care. Hilton et al. (2007), for example, consider some migrants' cultural beliefs to be an important barrier to care, and Quandt et al. (2007), for example, discuss lack of education about oral health as one of the major impediments to accessing services. This research contributes to the discussion on the complexity of migrant workers' oral health problems by emphasizing some of the structural barriers to care. In this respect, for migrant farmworkers utilizing the CMMS clinic, education about oral health is not necessarily a complete solution to addressing oral health disparities, and cuttural barriers may not play as large a role in disparities as among other migrant populations. Moreover, the findings directly demonstrate how social inequalities constrain access to care, create difficulties in accessing health services, and ultimately affect the bodies of marginal populations. Labor-related inequity and insufficient compensation is a primary constraint relating to access to care for migrant farmworkers in Tampa. The problem in accessing oral health services is therefore related to problems surrounding migrant labor and insufficient compensation for agricultural work.

While structural impacts are large influencers in limiting access to oral healthcare, some farmworkers such as Ybet frame access to care in terms of individual factors, and this ideas is largely created from the hegemonic discourse of individual responsibility in health care, including dental care. For others, limited access is recognized as a structural

problem rather personal shortcomings or misunderstandings about recommended oral practices.

The data from this research further do not support an argument suggesting migrant farmworkers prioritize medical care over dental care because of cultural beliefs or a lack of understanding the importance of oral health care. On the contrary, these data suggest that migrant farmworkers are aware of the importance of dental care, but are unable to access care because of costs and other factors hindering access. Moreover, the population engages in good oral hygiene behaviors such as brushing their teeth (although flossing is largely neglected), even though some literature reports that oral health hygiene is a problem among migrant families (Quandt et al. 2007).

The labor-based inequality of migrant farmwork demonstrates ways in which populations embody inequity; low wages constrain access to preventative oral health services, which lead to larger oral health problems such as dental caries, and as Exley (2009) and Horton and Barker (2010) argue, oral health disparities have lasting social repercussions. Examining access to oral health services among migrant workers in the Tampa Bay area utilizing a critical medical anthropology approach allows for useful understanding structural hindrances in accessing care and how those structural problems manifest themselves in lives of individuals. Structural hindrances include the hardships concomitant to migrant labor such as low wages and occupational health hazards, but also the broader discourses surrounding immigration, healthcare, and deservingness of services for populations such as migrant farmworkers, many of whom are unauthorized immigrants. These structural factors hinder access to care and ultimately have negative health consequences on individuals, who are unable to access care due to structural

barriers. The structural impediments therefore create the "embodied inequalities" that Horton and Barker (2010) discuss, and provide another example of structural violence, which Paul Farmer (1999:79, 2004:307–308) defines as historical and economically driven processes that constrain individual agency and contribute to the suffering of the disenfranchised.

Given the population's understanding of good oral health practices, examining health disparities for migrant farmworkers in the Tampa Bay area necessitates an understanding of how medical and dental services are perceived in the United States. The current healthcare structure in the United States privileges medical care over dental care, as evident by the safety net medical clinics and absence of safety net dental providers. In an interview with a dental student who works on a mobile dental unit in Michigan, he told me his perspective on the situation:

> People don't get the importance of dental care because insurance doesn't cover it, so they don't think it's important. You can go to the emergency room if you break your foot but where can you go if you break a tooth? If you go to the E. R. for that, they might do an extraction and do a terrible job with it because they don't know what they're doing, and then how does that help your teeth?

Another dental provider interviewed for the Oral Health Literacy project shared similar sentiments: "Most people don't have dental insurance, and if you have it, it's probably not worth it."

The structural privileging of medical care over dental care is inconsistent with the Tampa-based migrant farmworkers' individual understandings of the importance of

dental care. As supported by the data collected from this research, cost is the main prohibitive factor of obtaining dental care for migrant farmworkers. Cost is often discussed as a barrier to care in the migrant health literature (Quant et al. 2007; Arcury and Quandt 2007), and participants in this research did not visit the dentist because they could not pay for dental visits. The food security data in this research emphasize this population's poverty circumstances, and although other food security studies of migrant populations have been conducted (Quandt et al. 2004; Kasper et al. 2000; Kowalski et al. 1999), this research specifically uses food security as a measure of poverty to demonstrate the limited material resources of the population. Dental care is thus an issue of material needs—wages are too low for this population to afford food, let alone a visit to the dentist.

Since this population is aware of the importance of dental care, oral health education for this particular migrant farmworker population in Tampa, Florida is not the primary answer to bettering oral health disparities. Instead, short term and long term solutions must be considered in how to improve oral health and access to dental care among migrant farm laborers.

Recommendations

Short-term and more immediate recommendations to address poor access to dental care among migrant workers in the Tampa Bay area build upon the existing oral health and medical infrastructure in the area. Many migrants interviewed suggested that that if they were able to make payments for dental care they would go to the dentist. Allowing migrant workers to make payments for care received would greater increase

their ability to obtain dental care. This, however, is undoubtedly a difficult task since frequent movement is intrinsic to migrant labor, and dental offices would be apprehensive to extend credit to migrants. Sister Sara also reflected on patients asking her about the ability to make payments:

> I've had people come to me for services I could not provide, and they say to me, 'Is there anyway we can arrange payments? We're willing to pay if we can make payments we can afford.' And unfortunately, even that, too often, is not available.

Sister Sara continued by reflecting how the medical structure in the United States is not designed to accommodate easy payment plans for uninsured patients:

> I had a gentleman come with a hernia. He is not eligible for squat. A hernia is not life threatening… it's considered elective surgery, but it was a significant hernia, it was impeding his lifestyle, his ability to work, things like that. And the only thing I told him was that if it ends up incarcerated and shows up in the emergency room, they'll fix it! And he kept saying, 'I'm willing to pay.'…In order to arrange that, there's number one, the surgeon, there's anesthesiology, there's the recovery room, the hospital bill, the lab bill, and all of those are subcontractors. So it's not simply going to a hospital and saying "can we arrange a payment plan for this man?" The system just got set up that way. So even people who want it, and are willing to make an effort, they're restricted, the barriers are put there for that, you can't negotiate for that.

Informal discussions with providers in both Florida and Michigan have shown that dental health providers are wary of offering services to migrants because they are not always accessible, due to the mobility associated with their occupation. To my knowledge, allowing payment plans on care has not been a practice among dentists serving migrant farmworkers. Since migrants are a transient population and providers would not be guaranteed to receive payment for services rendered, the most feasible short-term and immediate solution is to utilize networks in place through non-profit medical providers like faith-based organizations to address dental concerns. At the CMMS clinic Sister Sara has said if she obtained dental equipment she would be able to start providing dental services, and I am currently looking for ways to obtain a dental chair for her. While many FBOs are successful in their mission to mitigate disproportionate access to healthcare, they are not a solution to systemic healthcare inequity because they do not always address structural factors that exacerbate limited access to medical care. Additional knowledge about the political economy of health care and some of the injustices embedded in market-based medicine could provide the FBOs with a greater understanding of how to best utilize their influence to make social change to benefit underserved populations (Kline 2010).

Long term solutions include the need for policy solutions and incentives for dentists to provide services to underserved populations. Policy initiatives must be economic and humanitarian in scope. Economic policies must be aimed at controlling costs of care and increasing reimbursement rates for Medicare. Medicare reimbursement rates are particularly important to address to assist with limiting the generational impacts

of poor oral health in farmworker families, since recent research shows that even if children of migrant farmworkers have Medicare, they are not always guaranteed access to services because of the few providers who accept Medicare due to low reimbursement rates (Castañeda et al. 2010).

Humanitarian policy initiatives involve framing healthcare as a fundamental human right for which all people are eligible to obtain, regardless of immigration status. The humanitarian approach to health policy is unlikely to quickly gain traction in the United States given deeply embedded understandings of deservingness, but a labor-related humanitarian argument for healthcare may benefit migrant agricultural laborers. Raising awareness about low wages and concomitant economic hardship that leads to food insecurity may compel wider audiences to understand the suffering of migrant agricultural laborers. Further focusing on workplace hardships and abuses may also assist this cause.

Combining both economic and humanitarian aspects of providing healthcare coverage for immigrants, the creation of a "fifth stream" of healthcare access specifically for migrants is needed. I adopt this model from the National Health Care for the Homeless Council, which in 2005 published a document reviewing access to medical care for homeless men and women. Typically, medical streams (the way health care is delivered) can be divided in four ways: private health insurance, public health insurance (such as Medicaid and Medicare), safety-net healthcare providers (such as FQHCs, discussed earlier), and, in the case of homeless persons, the Federal Health Care for the Homeless Program, established by the McKinney-Vento Act (NHCHC 2005). The latter allocated federal funding to homeless shelters and established the Healthcare for the

Homeless program in recognition of safety-net programs' shortcomings. Similarly, in the case of farmworkers, a number of migrant health clinics have been established to serve this unique population. However, these currently serve only a small portion of the migrant farmworker population. Specific policy is needed to state how safety-net medical facilities do not reach migrant populations, and therefore federal funds are needed to address migrant health concerns. Policy initiatives can address increasing the scope of migrant clinics that operate under the Health Resources and Services Administration and funding for increasing clinics can come from federal and farm owner coffers. The HRSA estimates that its clinics address health needs of approximately one quarter of the migrant and seasonal farmworker population in the United States, but more health services are needed for this population and both federal and corporate funding can contribute to constructing additional HRSA clinics.

To provide additional services for migrants, more HRSA clinics could be constructed to serve the population. Funding for these clinics and their staff could be provided through a payment system backed by growers who hire migrant and seasonal farmworkers and through federal subsidies. In this model, growers would pay into the program based on the size of their farm and therefore the number of workers on the farm. To summarize, a good piece of legislation would accomplish the following aims:

1. State that FQHCs do not adequately address migrant health needs.
2. Create a a new stream specifically for migrants, since they are not able to access healthcare through any existing healthcare stream,
3. Build this new healthcare stream for which only migrants are eligible on existing clinic networks established by the HRSA.

4. Fund new clinics established by the HRSA through federal subsidies and tariffs imposed on growers, who must then contribute to the cost of care for their workers. Growers' fees will be assessed based on the size of their farms and amount of produce harvested.

Aside from policy initiatives, other long-term solutions include considering ways to increase access to current providers for marginalized populations. These solutions are also economic ways of addressing the problem of limited access to dentists, but are instead focused on the dental service providers rather than the State. Incentives for dentists to assist underserved populations are greatly needed, and these incentives may include ways to eliminate dental school debts for assisting populations such as migrant farmworkers, as a method of improving oral health disparities. Public health practitioners could encourage this type of structural impact to address disparities in health, rather than focusing on individual factors such as education. Education, as this research demonstrates, is not the main factor constraining care, but rather structural hardships related to labor and low wages.

Conclusion

The migrant farmworkers who participated in this research do not have access to oral health services, and this lack of access is a direct result of the hardships created by social inequality. Social inequality can be measured by the low compensation for migrant labor (which is not enough to afford basic needs such as enough food to maintain a level of food security), but also through more abstract ideas regarding citizenship and deservingness of health services, demonstrating how migrant labor is needed but also met

with opposition (Willen & Castañeda 2008). Labor, poverty, immigration, and access to healthcare are all interrelated when examining migrant healthcare access (Castañeda et al. 2010). When examining oral health, it becomes clear how social inequality plays a role in creating health disparities because teeth are highly visible (Exley 2009), and this visibility shows an inability to afford oral health services which has lasting social repercussions (Horton and Barker 2010) that can perpetuate inequality. This research also highlights a lack of oral health safety net providers, and how dental care is not considered a part of comprehensive preventative medical care in the United States.

Medical anthropologists attempting to address oral health disparities among migrant farmworkers must therefore advocate for dental care being incorporated into a holistic understandings of maintaining good health while also combating discourses surrounding citizenship and deservingness of health services. Additional advocacy work is also required for addressing low wages, and shining light on how low wages perpetuate inequality. Disproportionate access to health services is a concern that must be addressed on multiple levels, making it a difficult problem to address easily. For this reason, smaller more immediate solutions such as assisting existing faith-based service providers in obtaining ways to perform new services is a good way to begin mitigating disparate access to care, although faith-based organizations are in no way a preeminent solution to larger social inequalities. Small solutions, however, are a way to address concerns while utilizing networks put in place by advocates for marginalized populations, and these advocates may be able to obtain more resources through their organizations.

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Appendix A:

English Version of Survey Instrument

Date: _____ Participant ID _____

Demographics:

Male Female Age:_____ Country of Origin: _____

Languages spoken:
Spanish English Other (specify)_____

What is the zip code of where you are currently living? _____

Housing and Work:

1. ***Where do you work at the moment?*** Agriculture Not working Other (specify) :_____

If working in agriculture:

2. ***Do you leave Florida when the growing season is over, or do you stay here?***

Stay in FL year-round Travel elsewhere

3. ***How many people live in your household at the moment? Adults: _____ Children: _____***

4. ***How do you get to work?***

Walk (Live on site) (1) Bus (2) Carpool (3)

Drive and own vehicle (4) Drive and share vehicle (5) Not working (6)

Other:_____

5. ***How long does it take you to get to work?***

Comments:_____
_____

Access to Health Care:

6. ***When you feel sick, where do you usually go for healthcare?***

Community Clinic (e.g. Suncoast) (1) Hospital Emergency Room (2) Urgent Care Clinic (3)

Pharmacy (4) Doctor in an office (5) Curandero/a (6)

Catholic Charities Clinic (7) Nowhere/"I don't get sick" etc (8)

Other: _____

7. ***If this clinic did not exist, where would you have gone to receive treatment for your ailment?***

Centro médico (e.g. Suncoast) (1) Hóspital (2) Clinica urgente (3)

Farmacia (4) Doctor en una oficina (5) Curandero/a (6)

Clinica de catholic charities (7) Nowhere/"I don't get sick" etc (8)

Other: _____

8. ***In the past year, how often have you visited the Catholic Charities clinic?***

First visit (1) 2-3 visits (2) 4-6 visits (3) 7-8 visits (4) More than 8 visits (5)

Exact number of visits:_____

Perceptions of Care:

9. ***Would you consider dental care more important, less important, or just as important as medical care?***

More important Equally important Less important

Comments:_____
_____

10. ***How important is it for adults to go to the dentist regularly?***

Not Important Somewhat Important Important
Extremely Important

Comments:_____
_____

11. ***How often do you think you should go to a dentist?***

Comments:_____
_____

12. ***Are there any foods or beverages that you think have a negative effect on your teeth? If so, what are they?***

Comments:_____
_____

Access to Dental Care and Oral Health Habits:

13. ***How often do you brush your teeth?***

Once a day (1) Twice a day (2) Three times a day (3) A few times a week (4)

Occasionally (5) Rarely (6) I do not brush my teeth (7)

Other: _____

14. ***How often do you floss?***

Once a day (1) Twice a day (2) Three times a day (3) A few times a week (4)

Occasionally (5) Rarely (6) I do not floss (7)

Other: _____

15. ***When was the last time you went to a dentist?***

In the past month (1) During the past year but less than one month (2)

Between 1-5 years (3) More than 5 Years (4) Never (5)

No response (98) I don't know/remember (99

16. ***What was the reason for your last visit?***

Emergency Visit because of Pain (1) Appointment to remove or fill a tooth (2) A checkup (3)

I've never been (4) No response (98) I don't know/ remember (99)

Comments:_____
_____

17. ***Are there any factors that make it difficult for you to see a dentist?*** (Prompts: Cost, distance, waiting time for an appointment, language barrier)

Comments:_____
_____

18. How would you describe the condition of your teeth—excellent, very good, good, okay, or bad?

Excellent (1) Very Good (2) Good (3)

Okay (4) Bad (5) I don't have teeth/I have false teeth (6)

No Response (98) I don't know (99)

19. Do you currently have any dental pain?

Yes (1) No (2) Sometimes (3) Other (explain):_____

20. If you woke up with dental pain tomorrow or had a dental emergency, where would you go?

Community Clinic (e.g. Suncoast) (1) Hospital Emergency Room (2) Urgent Care Clinic (3)

Pharmacy (4) Dentist Office (5) Curandero/a (6)

Catholic Charities Clinic (7) I don't know where to go (8) I never have dental pain. (9)

21. What would make it easier to see a dentist?

Comments:_____
_____

Children's Care:

The following questions pertain just to your children.

22. How important is it for children to go to the dentist regularly?

Not Important Somewhat Important Important Extremely Important

Comments:_____
_____

23. How often do you think your children should go to a dentist?

Comments:_____
_____

24. When was the last time your Children went to a dentist?

In the past month (1) During the past year but less than one month (2) Between 1-5 years (3)

More than 5 Years (4) Never (5) No response (98) I don't know/remember (99)

25. What was the reason for their last visit?

Emergency Visit because of Pain (1) Appointment to remove or fill a tooth (2)

A checkup (3) They've never been (4) School Suggested (5)

Doctor/pediatrician recommended (6) No response (98) I don't know/ remember (99)

Comments:_____
_____

26. ***How would you describe the condition of your children's teeth—excellent, very good, good, okay, or bad?***

Excellent (1) Very Good (2) Good (3)

Okay (4) Bad (5) They don't have teeth/ have false teeth (6) No Response (98)

I don't know (99)

27. ***If one of your children woke up with dental pain tomorrow or had a dental emergency, where would you take them?***

Community Clinic (e.g. Suncoast) (1) Hospital Emergency Room (2) Urgent Care Clinic (3)

Pharmacy (4) Dentist Office (5) Curandero/a (6) Catholic Charities Clinic (7)

I don't know where to go (8) They never have dental pain (9)

28. ***Is it easier, more difficult, or the same for your children to see a dentist?***

Comments:_____
_____

Nutrition and Food Security Supplement[4]:

29. HH3. I'm going to read you several statements that people have made about their food situation. For these statements, please tell me whether the statement was often true, sometimes true, or never true for (you/your household) in the last 12 months—that is, since last (name of current month).

The first statement is, "The food that (I/we) bought just didn't last, and (I/we) didn't have money to get more." Was that often, sometimes, or never true for (you/your household) in the last 12 months?

[ ] Often true
[ ] Sometimes true
[ ] Never true
[ ] DK or Refused

30. HH4. "(I/we) couldn't afford to eat balanced meals." Was that often, sometimes, or never true for (you/your household) in the last 12 months?

[ ] Often true
[ ] Sometimes true
[ ] Never true
[ ] DK or Refused

31. AD1. In the last 12 months, since last (name of current month), did (you/you or other adults in your household) ever cut the size of your meals or skip meals because there wasn't enough money for food?

[ ] Yes
[ ] No (Skip AD1a)
[ ] DK (Skip AD1a)

31a. AD1a. [IF YES ABOVE, ASK] How often did this happen—almost every month, some months but not every month, or in only 1 or 2 months?

[ ] Almost every month
[ ] Some months but not every month
[ ] Only 1 or 2 months
[ ] DK

32. AD2. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?

[ ] Yes
[ ] No
[ ] DK

33. AD3. In the last 12 months, were you every hungry but didn't eat because there wasn't enough money for food?

[ ] Yes
[ ] No
[ ] DK

End of Survey

[4] Borrowed from U.S. Household Food Security Survey Module: Six-Item Short Form, July 2008