Over the past decade, the Hispanic population has increased in the United States. In 1990, Hispanics of all races numbered 22.4 million and composed roughly 9.0% of total U.S. population. In 2000, Hispanics of all races numbered over 35.3 million, approximately 12.6% of the total U.S. population (U.S. Bureau of the Census, 2000c).

Although a majority of the U.S. Hispanic population resides in the Southwestern United States, the Hispanic population in the Midwest doubled from 1990 to 2000. In 1990, Hispanics numbered 1.7 million in the Midwest region. By 2000, that population rose to 3.1 million. Hispanics now represent 7.7% of the total Midwest population (Ramirez & de la Cruz, 2002). Table 1 identifies the breakdown...
The largest Hispanic subgroup are people of Mexican descent. Mexicans represent 58.5% of those who identify themselves as Hispanic, or 7.3% of the total U.S. population. Puerto Ricans represent 9.6% of the Hispanic population. Other smaller Hispanic populations include Cubans, Dominicans, Costa Ricans, Guatemalans, Hondurans, Nicaraguans, Panamanians, Salvadorans, Argentinians, Bolivians, Chilenos, Colombians, Ecuadorians, Paraguayans, Peruvians, and Venezuelans.

One out of every 14 counties in the United States has a foreign-born population that increased by more than 50% from 1991 to 1998. Seventy-five of those counties are located in the Midwest, where community leaders are grappling with the challenges presented by a rapidly changing cultural landscape (U.S. Bureau of the Census, 2000b).

**Background**

This study replicates the focus group method described by Blewett, Smaida, Fuentes, and Zuehlke (2003). Their community-collaborative-based approach was central to the success of this research, as it depended on involvement of the community leaders. Blewett agreed to share her focus group protocol for this study, and these group meetings can encourage full and open disclosure by participants. Participants were asked to respond to structured questions regarding eight key themes: (a) moving to the Midwest, (b) migration patterns, (c) length of time in communities, (d) where health care is sought, (e) visits to primary care providers, (f) payment of health care and insurance coverage, (g) current occupation, and (h) illnesses. Participants were also asked similar questions about their families. Results appear reliable as these themes correlate positively with other existing studies (Bechtel, Davidhizar, & Spurlock, 2000; Blewett et al., 2003; Casey, Blewett, & Call, 2004; Marshall, Urrutia-Rojas, Mas, & Coggin, 2005; Parchman & Byrd, 2001; Sandhaus, 1998).

In spite of increased representation of the Hispanic minority in the United States, Hispanics continue to be under-represented in health care professions, as do most minorities. The Sullivan Commission’s Report on Health Professions Diversity states that the representation of minorities within health professions is “far below their representation in the general population,” and it is necessary to increase diversity among health professionals because “evidence indicates that diversity is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better educational experiences for health professions students, among many other benefits” (Smedley, Butler, & Bristow, 2004, p. 1). The remarkable growth in the Hispanic population has, specifically, contributed to the severe disparity between the percentage of Hispanics in the population and the percentage of Hispanics in the nurse force. Although African Americans, Hispanics, and Native Americans together make up more than 25% of the U.S. population, they account for only 9% of nurses, 6% of physicians, and 5% of dentists (Phillips, 2006). Numerous related barriers exist which distance minorities from adequate health care services and education:

- Language barriers for non-English speaking minorities. Non-English speaking minorities avoid seeking health care, do not access preventative services, and are less compliant with medication treatments due to basic misunderstanding.
- Financial burdens force students into work, rather than seek post-secondary education.
- Absence of minority health care providers in the personal lives of minority individuals often leaves the individual feeling uncomfortable, such that they avoid seeking treatment.
- Minimal minority recruitment efforts at colleges and universities.
- Cultural differences including schedules, values, and priorities.

Underlying several of these barriers are socio-economic factors that hinder health care education and access. Poverty significantly impacts human development, par-

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**Table 1. Year 2000 Data for Hispanic Populations in Midwestern States**

<table>
<thead>
<tr>
<th>State</th>
<th>Total Population</th>
<th>Hispanic Population</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minnesota</td>
<td>4,919,979</td>
<td>143,382</td>
<td>2.9</td>
</tr>
<tr>
<td>Nebraska</td>
<td>1,711,263</td>
<td>94,425</td>
<td>5.5</td>
</tr>
<tr>
<td>Iowa</td>
<td>2,926,324</td>
<td>82,473</td>
<td>2.8</td>
</tr>
<tr>
<td>Indiana</td>
<td>6,080,485</td>
<td>214,536</td>
<td>3.5</td>
</tr>
<tr>
<td>South Dakota</td>
<td>755,844</td>
<td>192,291</td>
<td>1.4</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>5,363,675</td>
<td>118,592</td>
<td>1.7</td>
</tr>
<tr>
<td>Kansas</td>
<td>2,688,418</td>
<td>118,592</td>
<td>4.3</td>
</tr>
<tr>
<td>Missouri</td>
<td>5,595,211</td>
<td>1,530,262</td>
<td>12.3</td>
</tr>
<tr>
<td>Illinois</td>
<td>12,419,293</td>
<td>217,123</td>
<td>1.9</td>
</tr>
<tr>
<td>North Dakota</td>
<td>642,200</td>
<td>82,473</td>
<td>10.9</td>
</tr>
<tr>
<td>Michigan</td>
<td>9,938,444</td>
<td>323,877</td>
<td>3.3</td>
</tr>
<tr>
<td>Ohio</td>
<td>11,353,140</td>
<td>217,123</td>
<td>1.9</td>
</tr>
</tbody>
</table>

**Source:** U.S. Bureau of Census, 2000c.
particularly as it relates to physical health and wellness as demonstrated within the Hispanic population in the United States. Hispanics are over-represented among the poverty stricken. Out of 6.6 million families living below the poverty level in the United States, 1.5 million or 22.7% are Hispanic (U.S. Bureau of the Census, 2000a).

Integrating diversity and cultural competence throughout the workforce is a strategic goal in many health care professions. As minorities become better represented in the field, the presumption is that overall education and access to health care for the total population will improve. The potential of nursing professionals to help foster a future of increased diversity in the health care workforce is considered in this article.

The profession of nursing increasingly reflects the population it serves. [It] derives strength from its ethnic, cultural, social, economic, and gender diversity, thereby enhancing its capacity to respond to the health care needs of a diverse nation. Nursing is a model for other professions in demonstrating the value of diversity (American Nurses Association, 2002).

This vision has established strategies to achieve increased diversity in the nursing workforce that include the following:

- Increase health system leadership that reflects and values diversity.
- Create diversity and cultural competence through educational programs and standards in the workplace.
- Increase diversity of faculty, students, and curricula in all academic and continuing education.
- Focus recruitment and retention programs to greatly increase diversity.
- Target legislation and funding for diversity initiatives.

In addition to the nursing profession, other organizations have acknowledged the necessity for diversifying the health care workforce for the benefit of all populations. For example, the Pew Health Professions Commission recommended that future health care professionals reflect the diversity of the nation's total population (O’Neil & Pew Health Professions Commission, 1998).

As professional organizations and associations continue to strategize ways to facilitate a diversified health care workforce, individual institutions must take necessary steps to ensure that health care is received by all persons requiring services. Many U.S. citizens in need of health care do not receive services, often because they lack insurance and/or proper access — a direct result of their socio-economic status (Blewett, Davern, & Rodin, 2005). Hispanics “represented 12% of the total population (in 1999) but constituted 23.1% of the population living in poverty” (Therrien & Ramirez, 2000). According to a report from DeNavas-Walt, Proctor, and Mills (2004), approximately 15.6% of the population, or 45 million people, did not have health insurance coverage in 2003, an increase from the year prior. For the same year, 32.7% of Hispanics did not have health insurance coverage. This rate is double that of the general population.

Health insurance coverage rates are significantly lower than the general population for foreign-born residents, though the rate of coverage increases significantly with length of residency and citizenship status. Foreign-born noncitizens who have resided in the United States for less than 10 years are covered at 58.3%. However, those who have been in country for 40 years or more are covered at 91.1%. With an uninsured rate of 33.4%, Hispanics are the least covered minority group with rates three times that of white non-Hispanics who are uninsured at a rate of 11%. The uninsured rate for Hispanic children is 27.2%, which again is significantly higher than the 8.9% rate for white non-Hispanic children. There are some positive elements to these statistics in that these uninsured rates declined in 1999 for the first time in 12 years (U.S. Bureau of the Census, 2000a).

The connection between health and poverty within the Hispanic population, specifically among migrant workers, is well documented in the literature. For decades, Hispanic workers have been “providing an economic foundation for rural America,” and will likely continue to provide that foundation for decades to come (Blewett et al., 2005, p. 193). Yet, in the middle of the 20th century, health care for migrant and immigrant workers was inconsistent at best and nonexistent at worst. Many employers (namely meat-packing and processing plants), as well as those in health care professions, have started to recognize that lack of health care is “a pressing problem for Latinos in the United States,” particularly for those living and working in rural settings (Blewett et al., 2005, p. 181). The problem will remain pressing since Hispanics are the “fastest growing minority population in the United States,” and Latinos account for the largest percentage of the Hispanic population (Sobralske, 2006, p. 129).

**Purpose**

The purpose of this article is to facilitate discussion regarding health needs of migrant workers living in America’s heartland. A focus group with interview methodology was used to identify the health needs of Hispanic agricultural workers. This study was designed to assess such needs and discuss barriers to health services for migrant workers, as well as suggest possible solutions to the barriers.

In addition to current data regarding the needs of this rapidly growing segment of the U.S. population, a narrative vignette of one couple’s experiences growing up as second-generation Hispanic immigrants — one of whom was raised in a migrant worker family — is presented. The vignette is offered to achieve the affective goal of inspiring identification and insight among health care
providers into the thoughts and lives of migrant workers. The narratives in this article are illustrative of the challenges involved in issues of migrant worker health. This story exemplifies the need for continued study of Hispanic health care service.

Health issues are complex in any given sociocultural context. Population worldview, which is influenced by cultural, social, and spiritual factors, as well as access and availability of health care, are factors that are intimately related to overall health and wellness (Sobralske, 2006). The following vignette, told from a first-person perspective, highlights these complex factors related to poverty and health care. The story paints a vivid picture of growing up as second-generation Mexican-American immigrants. Spanish is the first language for the married couple, but English proficiency was acquired during childhood. Their stories have been converged and condensed, but the details have been carefully preserved for the purpose of inviting the reader into the world of the Hispanic immigrant. Identifying with people is a necessary step to providing adequate and meaningful health care (see “Meet Mr. and Mrs. A”).

Narrative Analysis

The account of treatment in a tuberculosis ward may be far removed from health care experiences today, but the account

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**Meet Mr. and Mrs. A**

Our grandparents came to America by train and wagon around 1890. We have ten siblings between us (one sibling died in infancy). Our mothers gave birth to most of their children at home, but a few were birthed in hospitals. A doctor friend once told us that we should leave our small southwestern town to have opportunities to succeed. Our family heeded the warning, since a young boy had recently been murdered because he had been dating an Anglo girl. We moved West shortly after that.

**Mr. A** My entire family worked as farm laborers. Father and mother worked a combined 90 years in the fields. Depending on the season, a typical work week was 60 hours long. At times, we children worked before school, on weekends, and most of the summer. We picked a lot of cotton, carrying 8 to 12 foot long sacks which were often larger than we were! After pulling the cotton, we climbed a ladder to empty the sack into trailers. My father would sometimes pick as much as 450 pounds of cotton in a day. The typical wage then was about $4.00 per 100 pounds picked. We also used four-inch blades to cut grape bunches off of the vine. They were placed in a wooden box or in tin pans. Thompson grapes were spread on butcher paper to dry; whereas other varieties of grapes required filling pre-positioned wooden boxes for pick-up. We frequently had to fight off the bees while working with this fruit.

To pick plums, peaches, and nectarines, we climbed 12-foot ladders, picked the fruit, and deposited it in a bucket which hung on the ladder. After we filled the bucket, we descended the ladder and placed the fruit in a wooden box. Peaches were a particular bother since the peach fuzz, mixed with heat and sweat, made you itch all day. We picked a variety of other fruits and vegetables, including oranges, potatoes, and tomatoes. We climbed high ladders, dragged and filled boxes and bags, and often applied pesticides by hand.

Since we worked in the fields in order to survive, my parents did not focus much on education. Nonetheless, we attended school nearly everyday, as often as possible. We often worked before school to help out my parents, as well as after school, summers, and during holiday breaks. Schools were segregated at the time, but one I attended was integrated, and this is where I began to learn English. We were sometimes punished for speaking Spanish in school.

My brothers left the fields by joining military service at early ages (16 or 17 years old). Two of us went to college, worked hard, climbed the ladder, and had successful careers. Other siblings did not fully realize their potential. One in particular had great potential in the medical field but was never encouraged. He did work alongside many doctors in surgery and in emergency rooms in several hospitals. He was involved in many emergency surgeries in rural areas. Many of the daughters became pregnant at young ages, and many continued to struggle with low wages until they returned to school or left our town. The youngest completed a masters degree in education and is now a vice-principal. I had a successful career in the department of corrections, and retired recently as the warden of a large and notorious prison.

**(Mrs. A)** We had minor health issues in our families growing up. Mother endured traumatic menopausal symptoms and several kidney infections without a physician’s care. We often employed home remedies for accidents and illnesses. Once I was taken to a lady who massaged my injured arm back into place. She rubbed some sort of oil on it and placed it in a sling. I actually got well!

Another time I had a fainting spell and was subsequently diagnosed with tuberculosis. I was placed in a sanatorium. I do not remember being treated specifically, but I was given several shots, which I am sure contributed to my present phobia of needles. I believe I was there for about 1 year, so of course, I missed school. I don’t recall anyone taking lessons while in the sanatorium! I was 8 or 9 years old and about 120 miles from home. My family had little money for travel, and my siblings were not permitted in the sanatorium at all. They once came, and I waved at them from my window. Most of the girls in my ward were Hispanic. Our suspicion was that the gringos [white people] were experimenting with us! I do remember the name of one roommate who was taken out for surgery. She was about 15 or 16 years old, but she never returned to our ward. We were told she had not survived the surgery. That was buried deep in my soul. Most of the nurses had little bedside manner, but after I complained once to my mother, I was treated much better.
described in “Meet Mr. and Mrs. A” highlights many issues that remain current for minority communities requiring health care. The patient’s mother was unusual in her lack of inhibition in addressing concerns with health personnel treating her child, but there was nonetheless a lack of communication and knowledge regarding the treatment procedures. The story illustrates how language and cultural barriers, as well as lack of education, prevent many from acquiring and understanding treatment. Many Hispanics seek folk remedies, as Mrs. A. shared, and many times they are more confident in the ability of a folk healer than a formally trained health care provider to administer adequate care. Mr. A’s description of farm labor illustrates the health risks involved in the work, which requires bending over, heavy lifting, and utilizing tools that could cause injury.

Adequate health care is one critical consideration in the process of human development, and as every person is intrinsically worthy of care, it is contingent upon health care providers to invite collaboration among health ministry professionals, other clergy, political and community leaders, and employers to seek solutions to the lack of health care epidemic among America’s working poor.

Method

Qualitative research methods, namely the transcribed and analyzed interviews of participants, had remarkable value to this project’s goals. The qualitative research approach was the most reliable way to capture the actual, lived experiences of participants. The study was specifically designed to assess the level of understanding of health needs. How people make sense of their health needs and how health structures their daily routines can become affirmations for developing health services at the community level. This descriptive approach used through interview offered a more intimate understanding within a personal context. Descriptive notes were taken during the group interview. Group interview facilitated discussion and cohesiveness among all participants and also allowed for researcher monitoring of the line of questioning (Creswell, 1998). A structured group interview process was used to collect data. Data were mediated through a language translation process. Casual links and themes relevant to existing literature were identified.

Setting. This study was conducted in Omaha, in Douglas County, NE, which has the largest Hispanic population of any county in the state. Nebraska has lower than national average cost of living rates and unemployment rates. The growth rate of its Hispanic population is one of the three highest in the Midwest. In 2000, 5.5% of Nebraska’s population was of Hispanic origin. The 2005 Hispanic population estimate for Nebraska was 7.1%, with Douglas County exceeding that to a percentage of 8.7% in 2005 (U.S. Bureau of the Census, 2000b).

The focus groups occurred at the Chicano Awareness Center, the Latino community outreach service organization that serves as the primary provider of cultural transition and crisis services to the Latino community and its families within the city of Omaha.

Participants. Parameters for selecting participants required that they be of Hispanic origin, have worked in agricultural-related occupations in Nebraska or Iowa within the past 2 years, and be willing to participate in the study. The participant profile was established through an agreement with an external funding source, thus requiring all persons to be living in either Nebraska or Iowa and having worked agricultural occupations (farm workers, ranch laborers, detersellers) within the past 2 years. Individuals were asked to participate and were approached directly through Nebraska’s chapter of the National Association of Farm Workers (NAF) in Omaha. This technique was useful as individuals were more likely to participate in a program if incorporated into their own community (Blewett et al., 2003). Six focus groups with five to seven individuals each occurred between August 2003 and April 2004. A cumulative total of 40 men and women of Hispanic origin attended the groups in the evenings. Child care was made available as some participants brought their children. Transportation was not provided.

The participants’ residency in Nebraska or Iowa ranged from 2 weeks to 13 years. Prior to moving to the heartland, 24% lived in Mexico, 69% moved from border states (California, Texas), and 7% came from other states (Missouri, Colorado, North Carolina). Ninety-seven percent of participants reported moving here for work-related opportunities. All participants worked in agricultural occupations within the past 2 years, with 62% being unemployed at the time of the study.

All participants, the recruiter, the moderator, and the recorder received a small monetary stipend at the end of each focus group.

Design and Procedure

The research proposal was reviewed by a human subjects review committee at a Midwestern health sciences college, and received approval prior to implementation. Confidentiality of all participants, including transcribers and recruiters, has been maintained. Once the participants agreed to participate through NAF-Omaha, they were invited to a focus group. Prior to the start of the focus group, the study’s intent and consent forms were explained in Spanish. Each participant signed a consent form. The research process was explained during each focus group. Focus group methodology allowed for all participants to establish a rapport and comfort level with the study’s facilitators. The groups were facilitated in Spanish to promote native language use among the members. Multiple studies acknowledge the benefit of culture-appropriate focus groups (Blewett et al., 2003; Ruppenthal, Tuck, & Gagnon, 2005). The research team comprised the prin-
Principal investigator, one bilingual communication moderator, and one bilingual data recorder. The latter two were of Hispanic origin, and were trained in data collection. To ensure anonymity, handwritten notes were taken and no audio recorder was used. Focus group questions were asked in Spanish by two Hispanic social service workers, and then responses were translated from Spanish to English during transcription by this same team. After each focus group, the moderator and recorder joined together to transcribe the focus group content. A similar process was used by Ruppenthal et al. (2005). The same set of structured questions was asked during each focus group that lasted 1 hour.

Results

General demographic questions were asked at the start of each group, followed by questions generalized to their community to determine their understanding of health. When asked what they see as health concerns for Hispanics in general, responses ranged from “Too long of a wait,” to “No insurance” to “Doctors don’t speak Spanish.” Each group was then asked what they like about their health care. Responses included “I like that they respect you,” and “The doctors won’t turn you away.”

Participants’ responses were compiled into categories and percentage of frequency rate of response. At the conclusion of each focus group, participants were given the opportunity to offer their suggestions, comments, or thoughts on anything that may or may not have been discussed. The following list identifies suggestions expressed by participants regarding their health needs: (a) increase health information printed in Spanish, (b) control television media that affects children’s minds, (c) improve parent education, (d) provide education on nutrition and personal hygiene, (e) increase English as a second language programs, (f) provide sexual disease prevention education, and (g) dental care.

Analysis of Focus Group

As anticipated, the data from this Midwestern study show trends relevant to health care needs among Hispanic agricultural production workers which are comparable with other existing studies (Becthel et al., 2000; Blewett et al., 2003; Casey et al., 2004; Marshall et al., 2005; Parchman & Byrd, 2001; Sandhaus, 1998). The significant themes that emerged from this particular study suggest:

- Employment opportunities determine relocation of Hispanic workers.
- Most participants do not have health insurance, nor have they heard of Medicaid for children.
- Majority of participants do not seek preventive health care services.
- Health fairs are the common source of preventive care.
- Majority of participants do not have a primary care provider.
- Majority of participants do not seek dental or mental health care.
- Hospital emergency rooms and health clinics are the primary sources for necessary health care.
- Communication barriers, prohibitive costs, and lack of knowledge regarding how to access health care are barriers to services.
- Majority is interested in pursuing health care careers if given the opportunity.
- Many know that the hospitals will not turn them away if they are sick, even if they can not pay.

The data reveal a marked lack of understanding regarding health insurance. Of the 24% of respondents who indicated they possess some type of insurance, many indicated that they did not know the name or type of coverage they possessed (43%). Eighty percent were unaware of Medicaid and the children’s health insurance program. However, 48% indicated they go to a hospital emergency room for care when needed. The data imply the necessity of making health care and insurance education more readily available for this population so they may understand all health care options available to them.

There were two primary limitations of the study: (a) participants resided in one geographic location (Eastern Nebraska or Western Iowa); and (b) transcription of data took extra time, approximately 2 to 4 weeks post group, and such resulted in a delayed report of findings for each group.

The results of this study were used to develop Hispanic nursing education at a Midwestern college by preparing health professionals to serve the Hispanic population and attract students of Hispanic origin into health care careers. The variation of health care access, insurance, and education for Hispanic-Americans varies from state to state (Blewett, Davern, & Rodin, 2004).

Future Implications

The results of this study may be useful in facilitating discussion about health needs of migrant workers living in the United States. By assessing such needs and discussing barriers to health services we can generate dialogue toward possible solutions. Further studies should examine the effectiveness of program initiatives such as:

- Offer English as second language-medical terminology programs for Hispanics interested in pursuing health care careers.
- Prepare students to work their way up the health care career ladder, beginning at the nurse aide level and progressing to their chosen health care career.
- Improve access to higher education for Hispanic students by giving them exposure to health care careers beginning at the middle school, high school, and adult-learner levels.
- Offer hands-on service-learning experiences for students, such as college field trips and job shadowing.
- Encourage college, health, and community institutions
to collaborate in hosting health events such as community health fairs, health screenings, and prevention services for local Hispanic populations.

To attract minority students into health professions, it is critical to ensure they are offered realistic opportunities through education. Providing an academic course that prepares students to pursue health careers and guides them through the first steps of becoming a health care provider is vital to bridging the health disparity gap that exists in this country. Health professionals continue to strive toward empowering Hispanic citizens to become gainfully employed as health care providers within their communities, in a manner that enables them to also continue their education while working. By increasing the number of minority health care providers, we will increase the number of minority individuals that access health care, ultimately reducing the minority health care disparities that exist. Collaboration is critical if we are to understand and affect health care within the Hispanic community. Education is necessary to prepare the fastest growing population in America with adequate health care.

Increasing Awareness Through Service-Learning

Service-learning is one avenue that can be utilized within health care education settings to facilitate both cognitive and affective learning outcomes regarding the actual needs and concerns of particular persons in the community. Service-learning opportunities provide a link between academic learning and community involvement. Service-learning is defined by the National Service Learning Clearing House (n.d.) as “a teaching and learning strategy that integrates meaningful community service with instruction and reflection to enrich the learning experience, teach civic responsibility, and strengthen communities.” It is differentiated from volunteerism in that the student engages in guided formal reflection on the service project for the purpose of gaining further understanding of the course content, as well as an enhanced sense of civic responsibility.

Service-learning projects may provide ideal opportunities for health care students to engage the Hispanic immigrant population for the purpose of identifying and understanding needs. Perhaps more importantly, they may provide the opportunity for students to identify with people rather than only with their health concerns and needs. Service-learning reminds students that health care is about the person rather than the person’s disease or treatment.

The following is one health care student’s reflection on meeting and serving a new Hispanic friend (a Guatemalan immigrant to the United States) when involved in a service-learning course relating to health promotion. The reflection, used with permission, provides an honest example of the steep learning curve and positive outcomes available for health care students involved in service-learning opportunities among Hispanic people.

My field experience has definitely been a challenging but valuable part of my education...I was nervous because I wasn’t sure how I would get beyond the communication barrier and cultural differences, but I was eager to learn...I was really struck by all the color in the room — both skin color and clothing...Initially, there was just a lot of smiling and not so much talking, which was a little uncomfortable, but also kind of beautiful. When I asked questions, I didn’t feel like he really understood me. He didn’t answer me nor did he answer no. I became frustrated and was wracking my brain trying to think of ways to communicate and get him to understand and open up. At one point, I kind of became hopeless...Then we engaged in an activity, and he asked me to help him with a simple task...He actually asked me to help...Then it dawned on me that his English had really improved since I first met him 2 months prior. I think he is warming up to me a bit, and there is still hope for developing a relationship. He smiles more and likes to play card games together. I hear some of the other students talk about their countries. They talk about people being killed or dying from disease. I can’t even fathom the things he’s been through. As different as he and I are, I think we are really after the same things in life. We both enjoy sports, we are both immersed in education, and we both want the best for our family and friends. This experience will not only help me be a better practitioner, but I believe it will also help me relate to others in every day interactions, as well. I will try to understand what is normal for my future patients, even if it appears different from what is normal for me.

Analysis of Health Care Student Reflection

True success in service-learning is experiencing transformative learning and thinking among students. This student is exemplary in embracing differences and serving as an agent for community empowerment. To adequately meet the health needs of Hispanic immigrants, it will be necessary for providers to feel comfortable with differences while identifying commonalities they have with their patients. The student was able to
accomplish this, while recognizing that normalcy is different between their two cultures. The transformative learning is identifiable in the statement that her normal is not necessarily normal for others.

The student recognized that her worldview perceptions, created by her own life experiences, will not necessarily be shared by her patients. She acknowledges that what she has learned will help her in daily interactions, even with people who are like herself in many ways.

Service-learning opportunities will help prevent the temptation of health care professionals to presume upon their patients a manner of objectivity patients may not share regarding their own health. Service-learning can help students understand how Hispanic people see their world, understanding that it will not necessarily be a uniform picture within the community.

**Conclusion**

In this article, the aim was not only to highlight the health care needs and understanding of Hispanic migrant workers, but to illuminate ways to address the health disparity within this population. The two narratives provide first-person perspectives which add to the cognitive goals for understanding migrant health, while also addressing affective learning objectives. This allows the reader to enter into the thoughts, perceptions, and experiences of one former migrant worker and one future health care worker attempting to connect meaningfully with a member of the Hispanic community.

The qualitative approach to the focus group study facilitated greater insight and understanding to the lived experiences of individuals within the Hispanic community. The results of the study reveal that health insurance coverage among migrant workers interviewed was far lower than the average, even for the Hispanic community at large. Understanding of health insurance coverage was minimal and the majority of people asked do not receive regular preventive care. Most participants seek care through the costly avenue of hospital emergency rooms, often at the hospital’s expense.

The pressing need for improved education and care in the arena of migrant worker health may be addressed in a variety of ways. Service-learning opportunities for health care students could raise understanding and awareness of health care needs and thereby improve patient care. Providing viable educational alternatives for Hispanics who formerly worked as health care providers in their previous countries is also a possible solution. By increasing the number of Hispanics in health care professions, the health care disparity for this population may be decreased.

The pressing needs within the migrant worker community require collaborative efforts between health care professionals, health care educators, health ministry professionals, members of the clergy, colleges, and community organizations for the purpose of identifying issues and generating and implementing solutions.

**References**


Yet, migrant workers often benefit from inadequate social protection and are vulnerable to exploitation and human trafficking. Skilled migrant workers are less vulnerable to exploitation, but their departure deprives some developing countries of the valuable labour needed for their own economies. ILO standards on migration provide tools for both countries of origin and of destination to manage migration flows and ensure adequate protection for this vulnerable category of workers. Advice and guidance on the health needs of migrant patients for healthcare practitioners. Although most migrants will not suffer from mental health problems, some may be at increased risk as a result of their experiences prior to, during, or after migration to the UK. Issues such as ‘home sickness’, anxiety or sleep disorders may arise for anyone who is separated from family and friends, or integrating into a new community or culture. Health issues affecting female internal migrant workers: A systematic review. Perceptions and experiences of health care access amongst foreign migrant workers in Sri Lanka: A scoping study. Survey on assisted voluntary returnees to Sri Lanka: analysis of survey data on assisted voluntary returnees from Canada. The challenge of establishing a migrant sensitive, rights-based approach to. It advances our understanding and analysis of factors that impact the health of migrants, and reminds us on the need for a shared multi-sectoral response. Migration is a determinant of health: it does not have a systemic association with public health security threats to host communities but migrants do face distinctive vulnerabilities to poor health. Development of data collection, monitoring and surveillance mechanisms is needed to understand migrant health needs. Migration can have a positive effect on the development of health systems if the International Code of Practice is adhered to and if there is strong coordination between home and diaspora systems and professionals.