

Conducting Surveys among Immigrants: Methodology and Implementation of a Health Needs Assessment in the Haitian Community of Miami, Florida

Gilbert Saint-Jean, MD, MPH, PhD
Lee A. Crandall, PhD

Abstract

Lack of reliable data about foreign-born groups creates gaps in demographic measurement methodology leading to a cycle of misinformed policy development. Haitian immigrants represent one of the largest foreign-born groups in Florida. Only limited information is available on the health care issues that they face. This paper describes the methodological design and strategies employed for the implementation of a study whose primary purpose was to identify and evaluate basic health care needs and barriers to health care access for the Haitian immigrant population of Miami, Florida. Information was collected during face-to-face interviews on demographic characteristic and health needs and access from a probability sample of county residents of Haitian origin. The community's response was overwhelmingly positive. Out of the 210 households contacted, only six refused to participate. Study findings suggest that the study population is confronted with serious socio-economic difficulties with limited formal education and limited financial resources; an enormous need for health services; and daunting challenges to meet those needs. This study demonstrated that properly planned and culturally appropriate scientific investigations may succeed in accessing immigrants and other 'hard-to-reach' populations.

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Background

In 1995, 23 million foreign-born persons, 9% of the U.S. population, were living in this country. It is expected that by 2040 when the population is projected to reach 351 million, one in four residents will be immigrants and their offspring (Keuffel & Pemberton, 1996). Lack of reliable data about foreign-born groups creates gaps in demographic measurement methodology leading to a cycle of misinformed policy development. Difficulties in locating and accessing potential study participants, building trust and rapport with them, and ensuring an acceptable degree of reliability and validity of collected data are challenges currently facing researchers working with and advocating for immigrants. Some researchers even advise against conducting research among undocumented immigrants by asserting that a reliable sampling methodology does not exist to capture adequate information from underground groups (Cornelius, 1982). Others have proposed innovative methods such as the "Ethnosurvey" method (Massey, 1987), which combines elements of both ethnographic and quantitative designs. Stepick and Stepick (1990) adapted a variant of this methodology to conduct a series of successful longitudinal studies among South Florida's Cuban and Haitian populations between 1983 and 1987.

Haitian immigrants reside in almost every state, but are mostly concentrated in major cities including New York, Miami, Boston, Chicago, and Washington, D.C. (5). In Florida, Haitian immigrants represent one of the largest foreign-born groups. The 2000 census counted 233,881 people of Haitian

descent in Florida (U.S. Bureau of the Census, 2000). Experts believe this statistic to be a gross underestimate, which resulted partly from a low level of census participation by Haitians (Marcelin & Marcelin, 2001).

Despite the sizeable Haitian population in the U.S. and specifically Florida, only limited information is available on the health status and unique health care issues currently confronting this group. Publicly financed data collection enterprises such as the U.S. Census Bureau and the National Center for Health Statistics have produced little data specific to Haitians, whom they lump with other "Blacks," ranging from West Indians to African Americans.

In 2001, we conducted a health survey among Haitians living in Miami-Dade County, Florida. The primary purpose was to identify and evaluate basic health care needs and barriers to health care access for this population. This paper describes the study's methodological design and strategies employed for its implementation.

Methods

Selection of study participants

The sample was selected by adapting a multistage random sampling method originally developed by the CDC and recommended by the World Health Organization (WHO)'s Expanded Programme on Immunization (Abramson & Abramson, 1999). Authors credit this methodology with producing estimates with accuracy and precision levels similar to standard cluster sampling (Brogan, Flagg, Deming, et al., 1994). For immunization

coverage estimation purposes, WHO recommends a sample size of 210 households, (30 clusters of 7 households each). We opted for a similar sample size after our power analysis indicated that a sample of 184 would allow for detection within a 95% confidence interval, conservative prevalence estimates of 50% for health services utilization, insurance coverage, and for various health conditions being studied, within 10 percentage points of the true proportions.

We employed data from the 1990 census and the Miami-Dade County Property Appraisal Unit to locate accurately the study population. Census data available at the time the study was designed did not offer a specific category for Haitians, but did enumerate approximately 50,000 Miami-Dade County residents who “speak Creole or French Creole at home.” These data indicated that Haitians and Haitian Americans reside everywhere in the county, but were concentrated in the Northeast section of the county, formerly known as Edison/Little River. Now called Little Haiti, this is the community where newly arrived Haitian immigrants settled in the 1980s and 1990s. Subsequently, members of this initial wave who experienced economic success have moved north toward North Miami, North Miami Beach, and

Broward County. As a result of this flight, Little Haiti is now an underdeveloped community with some of the lowest socio-economic indices in the county. We chose to focus on residents of Little Haiti because it would have been much more costly and complex to cover a population sparsely distributed over a wide area. Additionally, because the Haitians who are clustered within this ethnic enclave are likely to be the group not covered through mainstream health coverage, and to be more socio-economically homogenous and more representative of recent Haitian immigrants than the more acculturated Haitians who now reside in more integrated neighborhoods.

We identified 20 census tracts with the highest concentrations of Creole speakers from which 30 block-groups were randomly selected. From each of these block-groups we then selected three city blocks. Finally, we visited the Miami-Dade County Property Appraisal Unit website (<http://www.co.miami-dade.fl.us/pa/home.asp>), which lists detailed information on all the county’s real-estate properties, including owner names and rental status. This listing was employed to randomly select for interview, within each selected city block, two or three households owned by someone with a Haitian surname or that were rental properties.

Table 1. Census Tracts with Highest Concentrations of Haitians and Haitian-Americans (Source: 1990 U.S. Census)

Census Tract	Total Population	Creole Speakers		Census Tract	Total Population	Creole Speakers	
		No.	%			No.	%
3.04	8654	1509	17.44	12.03	6412	100	17.16
4.04	6565	1118	17.03	13.01	5403	1743	32.26
4.05	4259	1031	24.21	13.02	6452	2112	32.73
4.06	7495	1982	26.40	14.01	5361	2184	40.74
4.07	5716	1089	19.05	14.02	4207	2278	54.15
4.08	5521	1290	23.37	20.01	5110	2149	42.05
10.01	6758	1181	17.48	20.03	4450	1655	37.19
11.01	4374	864	19.75	20.04	3494	2092	59.87
11.02	4611	1187	25.74	22.02	7109	1721	24.21
11.03	4254	1329	31.24				

Instrument Development

We developed a survey instrument with standardized questions published by the National Center for Health Statistics' National Health Interview Survey. The instrument and the corresponding study protocol received approval by the University of Miami's Institutional Review Board (IRB). The IRB approved administration of the survey with oral consent, since a written consent form would constitute the only threat to the anonymity of the respondents. The instrument was field tested through initial interviews with five potential study participants. The items included in the instrument cover four domains: demographic characteristics, need for health services, health care access, and utilization of health care services.

Survey Implementation

Due to their difficult history in the U.S., Haitian immigrants were expected to be particularly difficult to access. This was the opinion of several local investigators that had experience conducting surveys among this population. Additionally, Haitians tend to be discreet when discussing their health concerns with strangers, except in a health care setting with a health care professional. Language also creates a barrier to methodological accuracy as researchers are often unsure as to which of three languages, Creole, French, or English, might be most appropriate to respondents comfort levels and cultural ideation (Stepick & Stepick, 1990).

To address these challenges and increase the study's acceptability among the target population, the Principal Investigator, a Haitian-trained physician, designed and implemented a mini media campaign, before starting to administer the survey, to inform the community about survey objectives and his impending visits. IRB approval was obtained in January 2001 and interviews were conducted during the subsequent five months through June 2001. Live interviews were broadcast on two popular Creole radio programs. The first interview was conducted with a publicly financed program affiliated with National Public Radio (NPR), which sponsors a daily 15-minute program in Creole. This program is popular among Haitian parents with small children since it offers information on school-related issues, jobs, and community events. The principal investigator conducted the second interview on a real estate program that airs weekdays early in the morning. He also held a taped one-hour interview on the Haitian Television Network (HTN), the most popular Haitian television program in South Florida. The interview was broadcast three times over four weeks.

To facilitate household access during each visit, the principal investigator carried a University-

issued identification badge and a letter of introduction signed by a University official explaining the purpose of the study and soliciting the community's cooperation. After obtaining proper informed consent, the interviewer asked an adult resident, the person most "knowledgeable" about the family's health issues, to provide information on a maximum of 6 randomly selected occupants: the respondent and another adult (25-64 years old); one adolescent (18-24 years old); one elderly (65 years and older); and 2 children younger than 18 years old. The investigator methodically prepared each field visit by selecting a day in advance at least five households and three backups to be used, in case one of the pre-selected households was inaccessible. At the beginning, the investigator planned for five new households from a single block-group. As the survey progressed and the investigator was forced to make return visits due to absence of household members or requests from respondents, he tried to adapt his itinerary so as to minimize driving time while optimizing probability of contact with targeted participants. Typically, three visits were scheduled for mornings and two for afternoons, Monday through Friday. Following the first visit, when no one was available, a second visit would be scheduled later that day or the next. A third visit would follow when the second was unsuccessful. The investigator returned on Saturdays to follow-up on a third unsuccessful attempt, first in the morning, and then in the afternoon. After five attempts to contact a member of a selected household, the investigator selected a backup household from the same block, repeated the same steps and, if unsuccessful, would pick the next household to the right or the left by flipping a coin. Sundays and evenings were reserved for appointments when, on a few occasions, potential respondents made a special request for the investigator to return. In two instances, at a respondent's request, interviews were conducted over the phone.

The community's response was overwhelmingly positive. Out of the 210 households contacted, only six refused to participate. One of the refusals, a middle-age man, claimed that his non-Haitian wife did not want him to "divulge private information about the household." Another potential participant cited his negative experiences at the university-affiliated teaching hospital as the reason for his refusal. A female respondent requested that her husband be present, and since his return was not scheduled for two weeks, another household was selected. In three households, occupants refused to participate without providing reasons. Twenty-nine of the originally selected households were replaced over the course of the field study. On eight separate

occasions, household members were not eligible for the study for being non-Haitian. In the remainder, the first five attempted visits were unsuccessful, or no eligible respondent was present; the dwelling was abandoned or empty, or it housed a commercial enterprise, a day care center, or a church.

In nearly every household surveyed, the investigator was warmly received. He met old acquaintances in several places, in a host of others the residents heard about the investigator either in Haiti, or on one of the media presentations. For many participants, and for the investigator, the visit meant more than a survey. For some, it was a rare opportunity to share health and other social concerns, and obtain advice; for others it was a time to share family success stories. Pictures of deceased husbands, wives and children, children who were attending college or who were performing military service, and respondents or household members' weddings or school graduations were presented to the investigator. Several participants also inquired about the contribution of the study to the community and/or their families. Others requested assistance to access social services. For instance, an elderly respondent wanted to know about a new 'county-sponsored home program for elders'. In most cases, the interviews went beyond the scheduled 45 minutes and, in a few, the investigator had to tactically excuse himself after the conversation had gone much longer than anticipated.

While almost all respondents were knowledgeable about Medicaid and Medicare, the great majority never heard about Kidscare or Medikids, one of Florida versions of the State Children Health Insurance Program (SCHIP). This prompted the investigator to alert participating households with young children to the benefits of these programs by downloading and distributing, after completing the interview, basic information from the Internet.

Two specific cases are worthy of mention. One was a homebound female respondent living alone and suffering from hypertension, a heart condition, and diabetes. She had had open-heart surgery, but because her health insurance policy lapsed she felt could not go to the area's only public hospital or a similar facility. She was using all her life savings to pay for private physician visits and fill expensive prescriptions. Another case was a middle-aged man who had multiple surgeries following a near fatal car accident. He could not get Medicare or Medicaid because of his immigration status and relied on family members for financial help.

Results and Conclusions

Detailed study results were published elsewhere (Saint-Jean & Crandall 2005a; Saint-Jean & Crandall, 2005b). Findings suggest that the study population is confronted with serious socio-economic difficulties with limited formal education and limited financial resources, an enormous need for health services, and daunting challenges to meet those needs. The findings also point to the issue of accessibility as distinct from availability. In the case of Medikids or SCHIP, people had not received information about programs that they might otherwise consider. The traditional methods of communicating health care information are obviously not working for this community, thus the dual problem of not enough health care available and services that are available not being accessible.

The most prevalent health conditions mentioned by adults were back, neck, and bone or joint problems, vision problems, hypertension, arthritis, and diabetes. Only half of the study population was covered by health insurance and 72% were able to identify a usual place of care, which confirms findings from previous studies (Carrasquillo, Carrasquillo, & Shea, 2000). Between 36% and 39% of participants did not report having an annual physical examination. Barriers to having an annual physical included language, low rate of citizenship, low educational level, low English proficiency, low income, age, and short duration of residence in the U.S. Of the 72 respondents that were aware of a serious health condition affecting them, 65 (90%) had received care for that condition during the year preceding the interview. All those who did not receive care did not complete high school, lived in a household with low annual income, were between the ages of 18 through 34, and were foreign-born. Those without insurance were 2.5 and 3 times as likely not to have had a physical exam or receive care, respectively, as those with insurance. Multivariate analyses showed that non-citizens and those without a high school diploma were more likely to have gone without a physical examination or to receive care for their serious health conditions than citizens and more educated persons.

This study used a population-based sample to evaluate the ability of Miami-Dade County's Haitian community to access the health care system. There are several advantages to such an approach and the methods employed. The target population is a growing segment of the community with distinct cultural and ethnic characteristics. Major gaps in publications and research exist regarding the health needs of that community and its ability (or inability) to access appropriate care. Findings should be utilized for planning and evaluation purposes, as well

as for more culturally sound policy development methods. Additionally, the methods employed may easily be replicated by others sensitive to the needs and concerns of this community to assess similar issues in other so-called “isolated” or “inaccessible” populations. As census projections predict that foreign-born individuals will increasingly constitute a greater proportion of the U.S. population, it is important to develop novel approaches to study these communities. The approaches and techniques explored could be applied to similar immigrant groups that share cultural, legal, socioeconomic, and demographic characteristics with Haitians. Hundreds of copies of the report on study findings were distributed throughout the Haitian community and to relevant government and community organization offices. Several researchers and other professionals interested in using the data have requested copies of the report. Moreover, the investigator participated in several radio and television interviews to discuss and disseminate the study’s major findings.

Limitations of the study include those inherent in the data’s cross-sectional character with a resulting ability to draw causal inferences from observed associations. The use of a listing of homeowners to select the study sample may have caused an under-representation of renters. This technique is useful in studying special populations of immigrants that are characterized by residential proximity, recent arrival, and distinct cultural differences from the larger populations of the community. The Stata statistical (StataCorp, 2003) software package used for the analysis projects all results to the entire study population. While this has allowed for more accurate adjustment for sampling variations, it may have also introduced additional sources of error, the extent of which was difficult to determine accurately. Despite these caveats, this study constituted the first step toward understanding the issues affecting access to health care for the Haitian population of Miami-Dade County.

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Gilbert Saint-Jean (corresponding author) is Research Assistant Professor, Department of Epidemiology and Public Health, University of Miami Miller School of Medicine, Miami, FL GSaint@med.miami.edu. Lee A. Crandall is Professor, Department of Epidemiology and Public Health, University of Miami Miller School of Medicine, Miami, FL. Copyright 2006 by the *Florida Public Health Review*.