FEMALE MIGRANT FARMWORKERS: THE MEANING OF HEALTH WITHIN THE CULTURE OF TRANSIENCE

A DISSERTATION

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BY

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Date

To the Associate Vice President for Research and Dean of the Graduate School:

I am submitting herewith a dissertation written by Rachel Rodriguez entitled "Female Migrant Farmworkers: The meaning of health within the culture of transience." I have examined the final copy of this dissertation and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy with a major in Nursing.

Judith McFarlane
Major Professor

We have read this dissertation and recommend its acceptance:

Anne Young

John Fehir

Accepted

Leslie M Thompson
Associate Vice President for Research and Dean of the Graduate School

DEDICATION

This work is dedicated to all migrant farmworker women and their struggle for health and the nurses who join them in that struggle.

"God smiles on us when he sends a nurse here, and we all pray she'll keep coming."

migrant farmworker woman
to PHS official
(Johnston, 1985)

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And always, thanks to my family, especially Mom and Dad, for believing in me and teaching me to believe in myself.

FEMALE MIGRANT FARMWORKERS: THE MEANING OF HEALTH WITHIN THE CULTURE OF TRANSIENCE

ABSTRACT

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Hispanic, female migrant farmworkers' definition of health was described through an ethnographic study. Previous studies regarding definitions of health have routinely asked persons to rate their state of health within an undefined category. For this study, thirty-two migrant farmworker women working in the midwestern migrant stream were interviewed using a semi-structured questionnaire to describe their definitions of health. Data were collected and analyzed using the logic of grounded theory to identify the central theme and document these women's definition of health. The central theme was identified as creating peace. The respondents defined health as the ability the live in peace. The study indicated that the female migrant farmworkers interviewed had a broader description of health than the traditional biomedical model used by nurses and other health care workers. This broad definition has implications for further research into the culture of transience and the development of health policies for transient populations.

TABLE OF CONTENTS

LIST OF TABLES

Table

LIST OF FIGURES

Figure

CHAPTER 1

INTRODUCTION

Migrant farmworkers travel thousands of miles each year in search of work in some of the most hazardous occupations in this country. Dangerous working conditions, exposure to pesticides, and the potential for infectious disease are only a few of the risks associated with migrant farmwork Wilk, 1986). Low wages and harsh living conditions contribute to the potential for poor health that is virtually inevitable for the migrant farmworker (Slesinger, 1992).

A migrant farmworker is described by the federal government as "an individual whose principal employment within the last 24 months is in agriculture on a seasonal basis...and establishes a temporary abode for employment purposes" (Migrant Health Program, 1992, p. 1). Farmworkers travel through three main streams or routes. The western stream encompasses southern California and Arizona to northern California, Oregon, and Washington. The midwestern stream includes southern Texas and progresses to Illinois, Michigan, Wisconsin, Colorado, and most of the midwestern states. The eastern stream begins in Florida, moves through

the Carolinas, and ends in upstate New York (Martaus, 1986).

Migrant farmworkers routinely leave their permanent home (homebase) and live in temporary housing (labor camps) for approximately six months out of the year while working in northern states. Some men leave their families at the homebase and travel alone to work. Many times families, even extended families, travel together.

Migrant farmworkers are a multi-ethnic group. Hispanics make up the largest segment (60%), with most being Mexican or Mexican-American. Puerto Ricans, Central Americans, Haitians, and African-Americans are also among those doing farmwork throughout the country (Zuroweste, 1991; Office of Migrant Health, 1992).

It is estimated that 70% of migrant women work in the fields (National Advisory Council on Migrant Health, 1992). Life in the camps is particularly difficult for women. After working 10 to 12 hours in the field, their work day continues with housework and child care (Rodriguez, in press).

Problem of Study

The physical strain inherent in the migrant woman's daily life, combined with frequent moves and poor living conditions, create a unique lifestyle for the migrant woman. The impact of the migrant lifestyle on migrant women's

perceptions of health has not been examined. Most studies in migrant health to date (Dever, 1991; Arbab and Weidner, 1986; Chi, 1985) have not specifically targeted migrant women's health. These studies have focused on illness and medical utilization rates. The way migrant women have come to define and experience health has not been documented.

Rationale for Study

In light of the current state of research and the existing lack of data regarding migrant health, a qualitative method of inquiry describing the meaning of health for Hispanic, female migrant farmworkers is proposed for this study. It is essential to document the meaning of health for this high-risk population in order for effective health strategies and health policies to be developed and evaluated.

In order to truly serve migrant women, these strategies must transcend the typical references to maternal/child health. The literature shows that questions about migrant women's health are related only to their ability to conceive and bear children (Slesinger, Christensen, & Cautley, 1986; Rust, 1990; Meister, 1991). Research that focuses on female migrant farmworkers' definitions of health will provide insight into a broad scope of issues that are important to migrant women as individuals.

This research will also provide a foundation on which to begin building nursing theory focusing on the care of transient populations. It is proposed that transient populations develop a unique culture that surpasses the bounds of ethnicity and geographic location. The impact of this lifestyle on women's health is the focus of this research.

Conceptual/Theoretical Framework

The research question for this study will not be derived from a pre-determined theory since it is qualitative in nature. Using an inductive approach allows for theory to develop from the data (Morse, 1992). According to Strauss and Corbin (1990), a qualitative method is used for research that attempts to uncover the nature of persons experience with a phenomenon. It can be used to uncover and understand what lies behind any phenomenon about which little is yet known.

The health of migrant farmworker women is an area about which little is known. There have been no comprehensive studies focusing specifically on the health of migrant women. In fact, studies about the health of migrant farmworkers are rare and, in many cases, date back over 15 years. Acccording to Meister (1991), available data documenting the health needs of migrant farmworkers are

sparse, incomplete, or inconclusive. Rust (1990) also illustrates the lack of reliable data through a review of the literature covering a period from 1966 to 1989. Of 485 articles identified over this 23-year period, only 152 were found to relate specifically to migrant families.

Rust (1990) identifies a long list of unanswered questions relating to the health of migrant farmworkers. Examples of these unanswered questions include population characteristics, mortality and survival data, perinatal outcome data, chronic diseases, health-related behaviors (including domestic violence), and accessibility to health care.

Research Question

To describe the meaning of health for Hispanic female migrant farmworkers, the following research question was proposed: How do female Hispanic migrant farmworkers define health?

Definition of Terms

Since this is a qualitative study, there are no pre-defined terms. The meaning of health will be defined by the migrant farmworker women interviewed. Codes, categories, and constructs will be developed and defined based on the words of the respondents.

Limitations

The results of this study cannot be generalized to other farmworker women populations. The qualitative nature of this study precludes a focus on generalization. According to Brink (1989), qualitative studies describe and explain phenomenon, therefore, generalizability is not an aim.

Summary

To describe the meaning of health for female migrant farmworkers, an ethnographic study was conducted. It was important that a qualitative approach be used since knowledge of this topic was unavailable. The little that is known about the health perceptions of female migrant farmworkers has been studied within the context of illness forcing respondents to categorize their state of health into terms that have not been operationally or empirically defined. The results of this research provide a beginning framework within which nurses and other health professionals working with migrant farmworker women can develop and evaluate realistic health strategies and health policies for health care delivery.

CHAPTER 2

REVIEW OF THE LITERATURE

The concept of health was reviewed beginning with definitions of health then proceeded to discussion of both quantitative and qualitative studies that have examined perceptions of health. Finally, studies focusing on migrant health were reviewed. It is important to note that documentation regarding the health status of migrant farmworkers is lacking. Although there is regional and anectdotal information suggesting that farmworkers are at risk for poor health, there is a paucity of reliable research data. Moreover, studies focusing specifically on perceptions of health for migrant farmworkers were not found in the literature.

Definitions of Health

The word health was not used in common language until approximately 1000 A.D. It was derived from the Old English word "hoelth" which implied a state or condition of being sound or whole. Obviously, this allowed for a very generalized use of the word. Over time, health took on a physical connotation meaning soundness or wholeness of the body. It has since become further qualified by adjectives

such as excellent, good, fair, and poor (Dolfmann, 1973).

Modern use of the word health has placed it within the context of illness. Much of today's work defines health as the absence of illness. For example, health is defined as "freedom from bodily or mental pain, disorder and disease...." (Pocket Webster School & Office Dictionary, 1990, p. 332). Rene Dubos in Man Adapting (1965) defined health as a "physical and mental state fairly free of discomfort and pain, which permits the person concerned to function as effectively and as long as possible in the environment where chance or choice has placed him" (p. 351). Talcott Parsons (1978) discussed health in terms of the sick role. He talked about the effects of health and illness on the actors and their respective roles in society. Parsons believed that health and illness could only be defined by physicians.

Halbert Dunn (1961) was one of the few who called for a definition of health to turn away from a focus on illness and disease. He coined the term "high-level wellness" (p. 4). He elaborated on the definition of health by the World Health Organization stating that complete well-being could only occur when all three states (physical, mental, and social) were at their peak, incorporating the ideas of self-actualization and maximum human potential.

Judith Smith (1981) synthesized the works of Dubos,

Dunn, and others into what she called the four models of health. The first was the eudiamonistic model. Here, health was viewed as a condition of self-actualization or the realization of one's full potential. The adaptive model stated that health occurred when the individual was able to adapt to the existing environment. Role performance was defined as a common sense criterion of health. If a person was able to perform their role, then s/he was considered to be healthy. The last model was the clinical. Within this framework, health was defined as the absence of signs and symptoms of disease as defined by medical science. While it may appear on the surface that these models incorporated multiple frameworks, Smith acknowledged that ultimately there was an overall health-illness continuum underlying each model (Smith, 1981). Consequently, health was identified as a gradation of "non-illness" within a particular model.

Although health has been discussed extensively within the context of illness, it appears that a generalized, universal definition of health is impossible. Dubos (1965) stated that the words "health" and "disease" could never be universally defined because a person's evaluation of health was conditioned by her/his unique character, including aspirations and personal values. Furthermore, he stated that each person, functioning within a particular physical

and social environment, would develop their own meanings for health. Dolfmann (1973) expanded on Parson's concept that health was culturally determined by hypothesizing that, in any heterogenous society, definitions of health would vary within subgroups of that society or culture. Dunn (1961) also supported the individuality of health. In his discussion of high-level wellness, Dunn referred to the uniqueness of the total individual. The implication was that the complete integration of physical, mental, and social well-being must be defined by each person.

Perceptions of Health

There are a number of quantitative and qualitative studies that have examined perceptions of health. For example, Parse (Parse, Coyne, & Smith, 1985) conducted a phenomenological study for the purpose of constructing definitions of health for various age groups. She asked 400 persons to describe (in written form) a time when they felt healthy. Informants were placed in one of four age categories (n=100 for each category) with 50 female and 50 males in each group. The sample was drawn from colleges, universities, community agencies, and the school system. Based on the data, Parse developed four hypothetical definitions of health.

Lakores, Jeffers, and Moss (1991) conducted a

descriptive study to identify perceptions of health for homeless men. This quantitative study was illness-focused as men had to document present illnesses and respond to statements grounded in an illness perspective, e.g. "when I'm sick, I just have to let nature run its course" (p. 2). Respondents were asked to rate their state of health from 1 (very poor) to 10 (excellent). Definitions of the ratings were not included in the instrument. The authors noted that the individuals generally perceived themselves to be in good health (mean of 6.5 on the scale) even though they were experiencing a current illness.

Skelly, Getty, Kemsley, Hunter, and Shipman (1990) studied health perceptions of homeless persons in Buffalo, New York. This study was also illness-focused. Perceptions of health were reported as the percentage of subjects experiencing health problems, i.e. dental, gastrointestinal, cardiovascular. The sample consisted primarily of white males which was noted as a limitation of the study by the authors. Results indicated that the questions were male oriented and did not address the special needs of women and children. La Rosa (1990) used a 73-item self-administered questionnaire to study health perceptions and practices of executive women. Once again, an illness orientation was noted in the aim of the study as it was attempting to identify risk factors for disease. The sample of 545

consisted predominantly of White females (90%) who were middle-aged, well-educated, and highly paid (mean annual salary was greater than $100,000). When asked about their perceived health status, they were to rate it as excellent, good, fair, or poor. Definitions of these terms were not included.

In a study of Egyptian agricultural women, Lane and Meleis (1991) used a triangulated qualitative approach to describe women's perceptions of health within the context of the lifecycle. They obtained data from multiple sources, including participant observation, informal interviews, and structured observations in randomly selected households. Using content analysis, the data were analyzed and perceptions of health were elicited. Illnesses such as headaches, frequent chronic infections, and enlarged spleens were used to describe and discuss health for these respondents.

Based on the review of relevant literature, several points emerge. First (with the exception of Parse), health is studied from an illness perspective and subjects are questioned about the presence or absence of illness or risk factors for illness. Second, instruments asking the individual to rate her/his state of health, i.e. excellent, poor, etc., force a response into categories that are not defined, and as a result, subject to the interpretation of

the investigator. Parse has stated that health is a synthesis of values and cannot be defined in linear terms such as good, bad, more, or less (Parse, 1981). Finally, descriptions of the subjects are not representative of the population of interest for this study.

Health of Migrant Farmworkers

Literature focusing specifically on migrant health reveals the following. A recent review by Dever (1991) of 6,969 patient charts from migrant health centers across the country revealed a listing of the most common health problems encountered by migrant workers using migrant clinics. He found that migrant farmworkers suffered from a number of complex health problems such as infectious diseases, diabetes, hypertension, and contact dermatitis. He also found that 40% of migrant farmworkers who visited health clinics suffered from multiple health problems. Another chart review (n = 936) by Arbab and Weidner (1986) focused on clinic utilization rates and the prevalence of infectious diseases in migrant farmworkers. The study focused on migrant farmworkers without access to water and sanitation facilities. An audit of 936 clinic charts found that farmworkers had a clinic utilization rate for diarrhea that was 20 times higher than that of the urban poor (control group). Fevers of unknown origin were 120 times

higher than the control group. Medical utilization patterns were also examined by Chi (1985). In this study, he included a self-assessed health status based on state of health two years prior, i.e. subjects were to rate their health as 1 = worse than today or 2 = same as or better than today. Elaboration on these ratings was not offered. While the data are important, it is also of significance to note that, of the estimated three to five million migrant farmworkers, only 12-15% use migrant health clinics (Migrant Clinicians Network, 1992).

Martaus (1986) conducted a descriptive study of the health-seeking process of migrant farmworkers. The study included a sample of 20 Mexican or Mexican-Americans working in northwest Ohio. She offered an illness-focused model beginning with symptom definition and ending with adherence to treatment. Martaus found that migrant farmworkers explanations for illness could be summarized in three ways. Hot/cold imbalance, germ theory, and emotional origin seemed to explain illnesses in her study population. Sudden onsent of symptoms was considered highly credible and was considered a measure of real illness. There were two factors which influenced a person's choice of treatment. First, the most important outcome of the treatment should be quick and effective relief of symptoms. Second, trust in the source of advice for the treatment was the most

influential factor in one's use of a remedy.

Finally, the Health Promotion Lifestyle Profile was used by Kerr and Ritchey (1990) to assess the health behaviors and lifestyles of migrant farmworkers. Once again, subjects were asked to rate their perceived state of health as excellent, good, fair, or poor. The majority of the sample (n = 62) rated their health as good or fair (43.5% and 35.5%, respectively). Kerr and Ritchey state that perceptions of health are subjective and depend on one's definition of health. They propose that describing migrant farmworkers' definitions of health may be more effective than comparing perceptions of health, i.e. good, fair, etc., to other groups whose definitions of health may be different. In this study, no description or definition of the terms excellent, good, fair, and poor, was offered by the researchers.

Data on pregnancy outcomes and infant mortality rates are also scarce. A study in California (Slesinger, Christensen, & Cautley, 1986) found an infant mortality rate of 29 per 1000 among migrant farmworkers compared to 14 per 1000 in the general U.S. population. This same 1977 study reported a mortality rate of 46 per 1000 migrant children under the age of five. De la Torre & Rush (1989) found that 24% of women in their sample (n = 148) experienced one or more miscarriages and/or stillbirths. A survey of migrant

farmworkers in Colorado (Littlefield & Stout, 1987) documented 32.5% of their sample (n = 120) experienced at least one miscarriage or abortion. Infant mortality for this sample was reported as 12.5%.

Summary

The literature validates the illness-based perspective of health research, particularly with migrant farmworkers, to date. Furthermore, while women were included in these studies, no study focused specifically on migrant women's interpretations of health. When health perceptions were included, the researchers directed the respondents to answer to an undefined category.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

An ethnographic approach was used to describe the meaning of health within a population of female Hispanic migrant farmworkers. Ethnography was the method of choice as it provided a cultural description; a way for people to describe and structure their world (Marshall & Rossman, 1989). This method was particularly important to the study of female migrant farmworkers because of the unique nature of their lifestyle. Ethnography provided the researcher with insight into the culture of the migrant lifestyle and its influence on health.

Setting

Individual interviews were conducted in the women's homes at their convenience. Only one woman, who was not able to meet in her home, was interviewed in private at the investigator's office. The focus groups met in the home of a migrant woman. To protect their privacy and confidentiality, interviews were conducted with only the investigator and respondent(s) present. Husbands were not present. Also, children, with the exception of infants, were not in the room during the interview. Institutional

Human Subjects Review Approval, including permission to audiotape, was obtained prior to initiation of the taped interviews. The interviews lasted from 30 minutes to one hour.

Population and Sample

To qualify for the study, participants had to be over the age of 18, Mexican or Mexican-American and currently working (over the last 12 months) within the midwestern migrant stream. Mexican and Mexican-American women were selected as they comprise the majority of migrant farmworkers today (Martaus, 1986; Smith & Gonzales, 1992).

Nominated sampling was used to identify the study population (Morse, 1989). This method of sampling identified persons who could be key informants; those who would be able to provide insight into the culture of the study population. Based on the investigator's previous experience as a nurse working with the Colorado Migrant Health Program, it was anticipated that this method would be the most successful for sample selection as, many times, farmworkers are mistrusting of "outsiders".

The researcher called upon previous contacts within the migrant community to identify potential migrant women respondents. Five key informants were identified. Two of the key informants did not nominate respondents, but three

were able to nominate several respondents. A total of 32 migrant women were interviewed.

Protection of Human Subjects

The protection of human subjects was addressed through the use of informed consent. Respondents were asked to sign consent forms for the interviews and tape-recordings. Consent form were translated into Spanish for those respondents who could not read or understand English. Consent forms were read to those respondents who could not read. In order to maintain confidentiality, respondents were not named in the transcripts or tape-recordings. Findings were presented as a group. Once data analysis was completed, the tape-recordings were destroyed. Respondents were assured that they could stop the interview at any time without affecting their access to health services.

Instrument

A semi-structured interview guide was used to conduct the interviews (appendix A). Since the study was qualitative in nature, pilot testing of the instrument and quantitative measurements of reliability and validity were not appropriate. Issues of reliability and validity are addressed in the sections on data collection and treatment of the data.

Data Collection

Individual, semi-structured interviews and focus groups were conducted for data collection. The researcher had an interview guide that included basic demographic data. This data was used to describe the sample. The interviewer began with a grand tour question, i.e. how did you feel yesterday?, (Fetterman, 1989). From here, she followed the lead of the respondent(s) regarding direction and further questioning keeping in mind the research question. All of the interviews were tape-recorded and transcribed by the investigator. Three of the interviews were conducted in English. The remaining interviews were conducted in Spanish and translated by the investigator. Data collection was continued until saturation was achieved and no new categories were identified.

Reliability during data collection was addressed through the use of two forms of equivalence. According to Brink (1989), equivalence is the reliability check of choice. For this study, equivalence was achieved by using alternate forms of similar questions. The tape-recordings and the investigator's field notes served as a second form of equivalence.

The use of key-informants for sampling provided self-evident validity during data collection. This form of validity implies that, for anyone in the culture group,

informants are assumed knowledgeable by virtue of their selection (Brink, 1989). For this study, key informants were Hispanic women who were currently working as migrant farmworkers in the midwestern stream.

Treatment of Data

Data were collected and simultaneously analyzed using the logic of grounded theory (Hutchinson, 1986). This method was appropriate for use with an ethnographic approach because the investigator was interested in understanding the culture of the group; using their description of how they experienced and ordered their world. Codes, categories, and constructs emerged that were specific to the population under study.

Open coding was used to identify first level codes using the words of the respondents. Level one codes broke the data into smaller pieces. Codes were then collapsed into categories (level two coding) with some codes being subsumed by others. Categories were carefully analyzed to assure they were mutually exclusive. Finally, the theoretical construct (level 3 codes) was derived by combining academic and theoretical knowledge (Hutchinson, 1986).

A test-retest form of reliability was used during data analysis (Brink, 1989). The investigator coded the data,

left it for several days without review, then re-coded it. The two sets of codes were compared. Similar codes were identified through this process.

Validity during data analysis was addressed in two ways. The first was the use of experts to validate the data analysis (Patton, 1990). With this method of inquiry, accuracy, not generalizability, is the issue of concern. Codes and categories were reviewed with migrant women, i.e. experts, for verification of the analysis. The women agreed with the investigator's analysis and emerging definition of health. They also agreed with the evolving description of the conceptual model regarding the culture of transience.

Triangulation of theories (Patton, 1990) constituted the second form of validity. Results were compared to Smith's (1981) models of health. One of Smith's models is role performance in which one is considered healthy if s/he can perform the duties of her/his assigned role. Although the migrant women talked about being able to work when they were healthy, role performance was described as a consequence of health, not as a definition of health.

Suffering through difficult living conditions was also described by the women and is related to Smith's adaptive model of health, i.e. health occurs when the individual is able to adapt to the existing environment. Even though their transient lifestyle was difficult, women attempted to adapt

to their changing environment. The eudiamonistic and clinical models of health were not related to the women's descriptions of their perceptions of health.

CHAPTER 4

ANALYSIS OF DATA

To identify the meaning of health for female migrant farmworkers, an ethnographic study was conducted. Hispanic women working in the midwestern migrant stream were interviewed. Ethnography was the method of choice as it allowed for a description of the culture of the migrant lifestyle. The impact of this culture on migrant women's definitions of health was described. Focus groups were conducted in addition to the individual interviews because the literature supports the use of both methods as a way to gain a more complete description of the studied phenomena (Morgan, 1988).

Data were collected and analyzed simultaneously using the logic of grounded theory (Strauss & Corbin, 1990). As the interviews were completed, the tapes were transcribed and analyzed to identify common themes. Three levels of codes were used based on Hutchinson's (1986) coding methodology.

Level one codes were derived from the words of the respondents. Direct quotes were used most often to identify predominating areas of concern for the migrant women. Level two coding consisted of collapsing and combining level one

codes into categories. The categories were reviewed to be sure they were mutually exclusive. The categories (level two codes) were then analyzed at a more abstract level in order to develop the theoretical construct.

Description of Sample

A total of 32 women were interviewed. Twelve individual interviews and 6 focus groups were conducted in 3 states within the midwestern migrant stream. The mean age of the women was 37.5 with a range of 18 to 61. All of the women were of Mexican or Mexican-American descent. One woman was separated, one was divorced, and all of the remaining women were married. The range for years of farmwork was 4 to 31 with a median of 15. A median was used as many women could not remember the exact number of years they had been migrating.

Findings

The findings are presented according to the major themes (categories) identified that answer the research question: How do Hispanic female migrant farmworkers define health? The respondents also described the culture of the migrant lifestyle. It is important to note that during the interviews women often did not speak of problems in their own lives, rather they talked about migrant women in the third person.

Responses from those participating in focus group interviews are separated from those who were individually interviewed. The women interviewed individually generally gave longer, more detailed descriptions. Semi-colons were used to separate the comments made by different women in the group interviews and an ellipsis was used to indicate the separation of phrases or thoughts by the women who were individually interviewed.

Living in Peace

One of the major themes identified was **living in peace.** In the group interviews, women explained what health meant to them in the following ways:

> no problems; have no problems; to be at peace, not have so many problems; ... moral, something you have inside you like your family, if you don't have a lot of problems in your family, to be tranquil; if you have problems or many things in your head, you don't feel comfortable, you won't wash dishes comfortably.

In the individual interviews, the respondents expanded on the theme of living in peace. For example, women described health in this way:

> Feeling happy, well I'm happy but when you have problems, I think if you have problems in the family, women's problems are diverse, sometimes it's the money because there are times when, in these months it's more

because when you come back from the jobs, you have the money that you brought back from there (upstream) to pay your bills here or if you've borrowed money when you left and you pay all that, but at this time when the money has finished and you are ready to go and your insurance bill's due, like for us its the truck and the van, and the license plates and it all piles up, you worry...for there to be harmony in the family, if, for example, you don't need anything, but you're not happy in the family, you still won't feel happy if there is something wrong.

It's a lot about your state of energy, for me, problems take a lot out of me, not my problems, but my family's, my mother, my mother-in-law, like my mother needed surgery and she's older and I was worried that something could go wrong, all that worried me, you can't tell it affects me, but my hair falls out, I get nervous, I can't sleep.

Be OK with your mind, that you are fine, you don't have problems, not here or over there; up there women have problems among themselves or with their husbands; women have problems among themselves, jealousy for those working in the plant, especially if you are new and the boss chooses you over other people who have been coming longer, the women won't talk to you if you

are chosen to work in the plant.

Dealing with the Locals

A theme that was also identified from the descriptions of the women's lives was **dealing with the locals.** Respondents in the group sessions did not discuss this issue, only the women in the individual interviews.

> A lot of times, I guess they generally blame everybody on one incident from whatever happened with a family or whatever, what usually bothers them is that we get food stamps and when we go to the groceries and they're paying with their cash and here we are with, you know, that bothers them because they think that's all we go for, it's even come out in the newspaper in the little newspaper in the area, that we're always there for the freebies, like daycare and health, because their health clinic is being used for migrants, too, they don't like that...they don't like it that in the summer their schools are being used for the migrants...they think we're getting freebies, I don't think so because what we go up there is to work and gosh, we give them most of our earnings, it all practically stays there.
>
> The Mexican people (in town) talk to us, they ask us where we're from and we get to talking, some of the Anglos talk to us, some are friendly, but there are

some who say they don't like us, but they need us.

There's people that you can tell they really don't like us, they'll make like faces, they'll turn away and I don't know, it's the looks of them, you can tell, you can sense it, we don't have problems with the owners of the stores, I think the problem would be the people that live there, the people that shop where we shop, they're all Americanos (Anglos)...one time I felt so bad because I was in the laundramat and I didn't even use that machine, but she (an Anglo woman) opened it and it was dirty and she looked at me and she called the man that worked there to have that machine cleaned because she was gonna use it and I felt so bad because she looked at me, but I didn't even use that one, so those little things make you feel bad.

Most of them are nice (people in town), there's a few that you can tell they don't like you, they don't smile at you, they sort of like ignore you, most of the stores are becoming nice...I was in K-Mart and I remember I was walking there, I heard this man behind me say something of Mexicans and I heard that and I knew that he was referring to me, I wanted to say that my money was as good as his, I was gonna say that but he left right away.

Some I don't think they get treated right, in this

way that you know when you go to the groceries, right, the Anglos, they put your food to the side or when they're catching (sacking) your food, they're like throwing it, I've noticed that and I can feel it right away, when you go to eat, they kinda stare, you go to the Pizza Hut and they're like staring, it doesn't make me feel good, I feel out of place.

(respondent related what the principal of the school said to a teacher) Don't bother to give the Mexicans (migrants) grades, they don't care anyway.

Life in Transience

Another major theme was **life in transience.** Individually, women described the theme of life in transience by saying the following:

...the risk, like I would say going up there, driving up there so many hours, the road hazards, you never know, you're so far away and yet you have people like my family, something happens to them you're so far away you can't be here at that time.

I'd say that you risk your life, maybe having an accident on the way, like we always try to travel with my sister in case something happens to her vehicle or our vehicle, but there's families they just take off by themselves, maybe out in the middle of nowhere they have a problem and who knows what's gonna happen to

those families.

Sometimes we stop at the rest stop for awhile, but if we are going during the day, we can't stop there, two of my brothers go, but they go in their own car, one brother follows us...sometimes we pay a hotel if we see that is no place safe, it's dangerous (the road), a lot of things have happened, people say, I've never seen, that people have even been killed on the side of the road.

The life we have, if they fall asleep (the drivers), my husband wouldn't stop to sleep and on highway 77 he was falling asleep and we were almost there and he couldn't make it...so that's the risk of the road.

In the camp there are many little houses, about 50, it's just one room and there is the stove and the refrigerator and a small table sometimes, and the beds...it's just one room and they rent it for $10.00 a week...there is one family that has eight children and they are all in that room...the bathrooms, for all the people that are there on the ranch, there are only two, one for the men and one for the women, they are holes...to take a bath, there are three showers for the women and three for the men, there are plenty of people and we need to take a bath.

She suffers when she has to leave her things (in the homebase), they will be stolen, its cost me so much and then I'm going to close up my house and someone else will open it up and take my things...when we're working over there (upstream) they say, "well, they've called so-and-so, they robbed his house" and another one and another one, they work so hard for the things they buy...when we're packing we say what could we leave, something that I don't care if they take.

The crew leader can move you when he feels like it, he doesn't have a reason, is it legal?, is it fair?, you have to suffer at the will of the crew leader, if he's nice, he'll worry about his people, but there's many crew leaders who worry about the money, the money he can get from the people he takes up.

We have to look from place to place, with new doctors, new clinics and everything that we need, we don't have a house to stay, we have to rent here and there, we have a house, then we have to go look for another one, we have to do everything all over, if we didn't travel we could be more tranquil in one house.

Respondents in the group session described life in transience in the following ways:

When you come over here you are risking yourself on the

road; to better yourself, to risk yourself and your health because even if you are in Texas you always have to work.

She has a pretty house back home, it's clear that you come to suffer, it's impossible to have things here; to suffer with your children, you have them in the sun, they are suffering and you suffer because you see them, but many times you are used to this, you come here to suffer, the bottle has flies; because you are so far to be caring for your children; I mean we do suffer but we have more money than those who stay, they are poorer; we suffer to have what we need; we suffer here too, we can buy things here.

This life is more active, more unknown, the women over there (homebase) already know what they have to do; you may work, but work is not sure because sometimes it rains and all that and sometimes the crops don't give, you know if there's hail and all of that, it spoils.

Trust

Another major theme identified was **trust.** Respondents spoke about the need for trust and talking only to those who could be trusted. Women in the group interviews identified those with whom they spoke about health concerns or other personal issues in the following manner:

(talk to) no one; women don't talk to other women, but with their mothers; sister-in-law sometimes; no one, I just go and I just do it all by myself; I talk to my husband; (talk to) husband; I talk to my husband first about my health; I talk to my daughter.

In the individual interviews, respondents described the theme of trust in this way:

I do talk to my neighbor when I feel bad, yes we talk, I have a lot of "confiansa" (trust) with my neighbor...(in the camps) it depends on the person, you start talking and you understand each other really well, if you see that that person can be trusted, then you can confide in her, but if you see that the person can't be trusted, then you won't confide in her...if she won't talk to you, right? then you're not going to say anything to her, if you see that she is too reserved, but if you see that she can be trusted.

It's very hard to get these women to trust you...we go and introduce ourselves and we talk to them, try to gain their trust, you know for them to feel confident with you, but still it's kind of a block right there, "maybe this woman's gonna go and talk to the whole camp about my problems", there's a lot of gossip, so I guess that's the main reason, everybody in the camps gonna find out.

It depends on how old their relationship is, if they're close friends and they want to confide in somebody, they probably would tell somebody else, but like I'm talking about the camps, like in Michigan or wherever, a lot of people don't know each other so they don't even share their problems with other people because they don't really know them...I would look for somebody that doesn't gossip, it's hard though because in the camp a lot of people like to gossip and they go from house to house.

(talk with) my sister-in-law, I've always counted on her since I was dating her brother, I've always trusted her, I'm the type of person that looks for friends, I talk with them (other women), I like to talk, I see the people, if they are like me, we'll continue, if not, well no, they stay alone, I know many women in the plant who stay apart, just do their work.

Time

Time is a major theme that was also identified in the interviews. This theme is predominant in the descriptions the respondents gave of their lives in the camps. Group participants described the theme of time and the demands on their time in the following ways:

Sometimes you can't wait for the appointment they give you, when you're sick you need to be seen; it's

hard to keep an appointment if they give it to you in the evening because you have to come home and cook supper and take care of the family; sometimes we can't get the medicines because we get out too late from our appointment and can't get to the pharmacy because it is already closed, we have to make another trip; they just tell us to come at a certain time and sometimes we can't make it, if we tell them we would like an appointment for a certain day, sometimes they try to do it, but we never really ask; if you go to a private doctor it will cost you a lot of money, just with the migrant programs, but for example, in Texas there is a clinic in Mercedes, you have to make an appointment 1 to 3 months in advance before they can see you...if your really sick; I don't use the clinic because you have to wait so long; I use the clinic here, but you also have to wait a long time, they don't even go by the appointment you are given, they just go by the sign-in sheet.

It's different (the migrant lifestyle) because they're struggling more, I don't know, they're constantly working 24 hours a day, they don't rest; the migrant workers work 24 hours a day; we (migrant workers) work harder (than women who do not migrate); the woman who isn't working (in the fields) dedicates

herself to her home, she gets up at a normal time and doesn't live running around like us, and us, well no because we always work in the fields, you are always...life is very pressured.

I imagine that they have more time to dedicate themselves to their children (women who do not migrate), to have a more normal life than ours, because we have less time with them, you see them when they come home from school so they are always alone, in the morning you have to leave them alone, because you have to go to the fields so early before they have to leave and you are just waiting because you are not home all day until very late and if you go in early you get to see them for a little while and when you get home late, well, what is it that you have?

Respondents in the individual interviews described the theme of time in the following way:

People need a lot of help there (in the camp) because you don't have the help of a doctor...general check-ups, people go but don't check themselves for cancer, diabetes, nothing...I think that was what was needed, counseling for this and for the women to check themselves regularly because they don't have time, if they have something else to do, they don't give themselves time...because she wants to get her work

done and get some rest, it's more important to wash the dishes or the clothes to finish quickly and get some rest.

You have to wait a long time (at the clinic), you're just sitting there thinking of all the things you have to do when you get home, that's what would happen to me, I would take the children to their immunizations, I didn't get my exam for cancer that I needed, I left without my birth control pills, I didn't go, I was supposed to, then I thought no, I'll just go over there (homebase) because I had little children, I had to take care of them, I would take them, but I wouldn't make time for me to go, I did go to take out a tooth, only because I couldn't stand it anymore, I was there early in the morning until 3 or 4 in the afternoon, it takes a long time, you lose work time and then you have problems with your husband, he wants to know where you were.

Sometimes there is (time), but sometimes there is not, there are times when one has to make the time, but many people would rather not go, they say "no, I'll miss work or the boss doesn't want me to miss", that's the reason they give for not going (to the clinic).

Personal Involvement

Personal involvement was also identified as an

important theme. The theme of personal involvement was identified in the following statements by women in the group interviews:

> ...(nurses could) come to visit us and be attentive to us; it is better when the nurse comes to remind us, it is good to know that the nurse is thinking of you; things are very different here, everything related to migrants here they attend to you right away, they help you right away to go to the doctor and over there (homebase) all the migrant things are secondary or the last resource and you have to wait and see if they will attend to you.
>
> The nurse could come out to the camp and make a list of everyone who needed an examination, then we could set aside a block of time to see women for these things; to have a mobile clinic, get checked here in the camp, have (health care workers) come to us; I give her (the nurse) a list of all the people that need to be seen, if they feel bad, when the nurse comes she knows who needs an appointment, she comes twice a week, it is OK like that.

The respondents in the individual interviews gave these descriptions of personal involvement:

> They come (the health care workers) and make the appointments for you, if we need anything they bring it

to us, they bring us medicines, sometimes the ones who come out here take us to the clinic.

Like the nurse that we had last year, she would do a lot of outreach, a lot of outreach, and she would go knocking on doors, everybody's doors and so she earned the trust from those ladies, and people would go to the clinic and they wouldn't know her by name, but they would say "I wanna talk to the Mexican nurse", all these migrants they asked for Helen, for the Mexican nurse, so I think earning the trust from the people, she would go and introduce herself and explain what she was there for and if she knew of a little problem, she especially went to that door.

In Michigan it's easier (than in the homebase) because we work with the clinic and its easier to communicate with the nurses and here (in the homebase) the nurses don't treat you the same, it's very different here...like they're more interested in health (in Michigan), maybe because it's a migrant clinic, but it's also a migrant clinic here (homebase) and it's very different, over there if you ask for an appointment or you feel bad, you go and the nurse checks you and sees what problem you have and if she sees that it's a problem that requires immediate attention they send you, they immediately make you an

appointment with a specialist if a specialist is required and they send you, and if you don't go, they are insistent or they call you or they even go to the camps.

I think lots of things could be done, one thing that would be very good would be if there was a mobile clinic and more transportation, but if there was a mobile clinic, then that wouldn't be needed...go to the camps, the last year's nurse has been going to the camps, she checks the children and the people who want her to.

Relationships with Men

The last major theme to be identified was **relationships with men**. Examples of these relationships are also evident in women's descriptions of the themes living in peace and life in transience. Respondents in the group interviews described their relationships with men in this way:

When I was working I noticed some girls, ladies talking about that, that there's times when they felt tired, but their husbands say no, that there's times when they're really sick and they need to go to the doctor, but their husbands just really don't want them to; many times the men don't give them permission, they don't care about the woman's health; my husband was one of those, he wouldn't let me go because I just wanted a

man to see me; the husband won't let them because he doesn't want them to and he doesn't have time and won't give them permission and if she doesn't have permission she can't go.

Individual interviews with the respondents revealed the following about their relationships with men:

Well, the first thing that comes to my mind is there was a couple in Michigan last year and we would invite her to come to the group sessions but the husband didn't let her, I mean "your place is right here inside the house" (respondent uses husband's words), and if she wanted to go and hang up some clothes on the clothes line he would go with her, so I think most of that is the husband...because there was more people in the camp, like men, you know, looking through the windows or whatever and maybe they think they're looking at the wife.

We had this lady in the camp, that's why I'm talking, we did, we went inviting, we say it's like prenatal, it's only women, you can come and join us, she was pregnant, and she was "no, my husband don't let me."

I've noticed there's a lot of alcohol use, a lot of the men they drink a lot, they're always outside drinking, other guys come in from other camps and

drink, and they have their music loud and the wives, I don't think they like it, at least I don't, I don't like it at all.

...women don't get much rest, and then they have to care for the children, the men don't help with the children, if the children are big that's OK, but when they are little it is very difficult.

Their husbands get there (to the camp) they drink and mistreat them and there is nothing they can do...they hit them, they get there (the men) and then go drink, you know because they are men they can get beer in the little towns and then they come back (to the camp), like on Sundays that we have a day off, they go and drink and they make comotion.

Summary of Findings

The following table summarizes the findings based on the first and second levels of coding. The table begins with the categories and proceeds downward identifying the dimensions (characteristics) of the categories. These dimensions are reflective of the first level codes.

Table 1

Common Themes in the Definition of Health

Living in Peace
- Having no problems
  - Problems with family
  - Problems with money

Dealing with the locals
- Feeling unliked
- Feeling out of place

Life in Transience
- Risking yourself
- Suffering
- Life is unknown

Trust
- People you can trust
  - No one
  - Family
    - Husband

Time
- Going to the clinic
- Checking yourself
- Dedicating time to children

Personal Involvement
- Coming to see us
- Being able to help

Relationships with men

These categories summarize the findings of this ethnographic study of 32 migrant farmworker women's discussion of health.

CHAPTER 5

SUMMARY OF THE STUDY

The purpose of this study was to describe Hispanic, female migrant farmworkers definition of health. Previous studies have asked migrant farmworkers to rate their state of health within a set of categories that have not been empirically or operationally defined. A qualitative method was selected for this study in order to document what health meant to these migrant farmworker women.

Summary

An ethnographic study was conducted using focus groups and individual interviews. The study was conducted in three states within the midwestern migrant stream where adult, Hispanic, female migrant farmworkers were working. A semi-structured interview guide was used to conduct the interviews. Respondents could answer the questions in either English or Spanish. The interviews were tape-recorded. They were translated into English (as necessary) and transcribed by the investigator. A total of 32 women were interviewed.

Nominated sampling was used to collect the data. Data were collected and simultaneously analyzed. Data analysis

followed the logic of grounded theory and began with the identification of level one codes. These codes were derived from the words of the respondents. As the process continued, level two codes, or categories were determined. The categories were created by subsuming common level one codes. The theoretical construct evolved from the analysis of level one and level two codes.

Discussion of Findings

Based on the analysis of the data, health is defined as the ability to live in peace. This peaceful life can be created by migrant women by understanding which circumstances can be altered by direct action and which cannot be altered. This understanding enables migrant women to live in peace and, therefore, be healthy.

Living in Peace

The first major theme to be described was living in peace. Women's perceptions of health often revolved around this theme. They spoke frequently about the relationship between health and a peaceful family life. They talked about health in terms of happiness.

Living in peace evolved from the first level code having no problems. The dimensions (or characteristics) of this code were described as problems with family and problems with money. Family problems often included

problems with husbands. When these problems were described by the women, it was apparent that they were associated with the migrant lifestyle.

Migrant women's problems with husbands often involved drinking (alcohol) and domestic violence. While drinking alcohol is not unique to migrant farmworker life, the situations described by the women were specific to their life in the camps. They described how men sat outside and drank in the evenings when in the migrant camps. Men often came from other camps to solicit drinking partners. Their drinking made the women unhappy and led to problems in their relationship.

Money also created many problems for migrant women. When they arrived in Texas after working the fields up north they had money to pay bills, but this money did not last long. A serious financial strain was also evident as the family prepared to migrate. They had to have money for the trip (food, lodging, and gas for the 2 to 3 day trip), make sure the car insurance was paid, and all of their other bills were paid prior to leaving home. Another concern for the women regarding economics was the availability of work once they arrived in the labor camps. If weather or other circumstances had interfered with the growth of the crops, they may arrive and find there is no work, i.e. no money, for several days or weeks. Families sometimes paid a small

amount of rent and/or utility bills for housing in the camps in addition to their bills from home.

Having problems, whether they were intrafamilial or economic, impacted on the migrant woman's perception of health. If she had too many worries or problems, she believed that she could not be at peace. Living in peace was described by the women as the key to being healthy.

Based on this description, level two coding proceeded to the development of the category of living in peace. Living in peace became the most encompassing of the descriptions of how migrant women defined health. Therefore, the **definition of health for Hispanic, female migrant farmworkers is the ability to live in peace.**

Dealing with the Locals

During the individual interviews, the respondents talked about their lives as members of the upstream communities. Their descriptions gave way to the category of dealing with the locals. Women discussed incidents where their ethnicity was the obvious reason for the comments or behaviors directed toward them by the local townspeople. The level one codes, feeling unliked and feeling out of place, were apparent in the descriptions women gave of their experiences while doing business in the towns close to the migrant camps. These feeling were apparent in the descriptions the women gave of their experiences while doing

business in a town where they knew they were not accepted because of their ethnicity. The category, or level two code, became dealing with the locals.

Life in Transience

Life in transience was another theme that emerged from the data. As the respondents described their lifestyle, three level one codes were evident. The first was risking yourself. Women talked about the risks inherent in this lifestyle, i.e. the risks of the road. Another level one code was suffering. This word was frequently mentioned as the respondents talked about their lives in the camps. Although they suffered, it was not without purpose. The women acknowledged that there was a purpose to this suffering - the ability to earn more money and make a better life for their families. They stated that, if they did not migrate, they could not provide for the needs of their families.

The third level one code descriptive of their transient lifestyle was life is unknown. Women described the difficulty in having to start fresh with every move; never knowing what they would encounter in their new location. Even those that went to the same camp every year did not know if there would be work, i.e. if the weather was bad and the crops were spoiled.

The category (level two code) that evolved from these

first level codes was life in transience. These level one codes were all descriptors of the transient lifestyle of these migrant farmworker women. These descriptions were reflective of the constant movement in their lives.

Trust

The next theme identified was trust. Level one coding revealed two codes. The first code was no one. The second code was family with a subcode of husband. It is important to mention this subcode because, although women identified other family members, i.e. sister or mother, it was often the husband with whom they spoke when they had a concern about health. If a woman did not speak with her husband, she usually spoke to a female family member. The women stated that often it was difficult to find someone with whom they could speak in confidence.

The reason given for this reluctance to speak about personal problems or health concerns was related to the gossip that was pervasive in the camps. Respondents described how some women would go from house to house talking about the problems of other women in the camps. As a result, the migrant women stated that it was very difficult to find someone to trust.

According to the respondents, there were two ways to identify someone who was trustworthy. First, the person must not be prone to gossiping. Second, that person must

also be willing to share some personal information. Consequently, trust became the second-level code. This category included people who could be trusted such as the family, as well as the fact that there may be no one that can be trusted.

In the Spanish interviews respondents used the word "confiansa." Translated literally, "confiansa" means confidence. In the present context, "confiansa" is an attribute ascribed to another person and infers trust. The phrase used by the migrant women, "alguen en que le tienes confiansa" would mean that she has confidence in that person; she can trust that person; she can be relaxed around that person. This is the person who was the most difficult for migrant women to find in the labor camps.

Time

Time was another important themes to emerge from this data. This theme was predominant in the descriptions the respondents gave of their lives in the camps. They also discussed time in terms of their ability to access health clinics and their ability to stay (or become) healthy.

Going to the clinic was a level one code that illustrated the importance of time in the lives of the respondents. Women often discussed the time they spent waiting at the clinic. They related this waiting time to its impact on their ability to work. They were also

disturbed about the long time that they had to wait before being given an appointment.

Another level one code was checking yourself. Respondents knew that it was important to get pap smears and general check-ups, but there was usually no time to go for examinations. Women felt they did not have time to go for preventive care even though they knew of its importance.

One final level one code contributed to the development of the category of time. Dedicating time to children was derived from the women's descriptions of the migrant lifestyle. They compared themselves to women who did not migrate and talked about how those women had more time to dedicate to their children. Time spent away from their children was a major concern for these women.

These three level one codes gave rise to the category of time (level two code). Respondents described the demands placed on their time that were inherent in their lifestyle. They also described how these demands impacted their ability to use health services. Based on this analysis of the data, time was an important factor in the respondents' definition of health.

Personal Involvement

Respondents felt that nurses could help migrant women stay/become healthy through personal involvement. This category was derived from the level one codes of coming to

see us and being able to help. Respondents routinely talked about how they needed help. They felt it was important to identify someone who would be helpful. One of the most helpful things was having the nurse come out to the camp. Women described how having mobile clinics and bringing medications to the camp would be very helpful. They also stated that it was helpful when the nurse came to the camp and made appointments for them.

These level one codes were categorized (level two coding) as personal involvement, i.e. the nurse investing time and showing interest in the lives of migrant women. While these activities would be traditionally termed outreach activities, they were interpreted by the respondents as the nurse paying attention and becoming personally involoved with them. (The woman who used the term "outreach" had receiving training within the framework of the biomedical model of health teaching.)

Relationships with Men

The last theme to be identified was the migrant women's relationships with men. This theme was difficult to dissect into three levels of coding as this was simply a description of the relationship. Consequently, the three levels of coding were not be used.

Respondents unequivocally stated that men had a definite influence over the woman's ability to achieve

health. They discussed the problems women often have with their male partners. They also described how men often did not allow women to access health care. The women also described their relationships with the men they live with in other ways. Respondents stated that, after the work in the fields was completed for the day, the men sat down to rest while the women continued with housework and child care. They talked about the fact that men did not help with housework or child care.

The respondents' relationships with men were significant influencing factors in their lives. Relationships with men were frequently mentioned in all of the interviews as the women described their lives. These relationships were also reflected in the themes of living in peace and life in transience.

Following the logic of grounded theory (Strauss & Corbin, 1990), the categories identified in the data were linked around a central theme or theoretical construct. This theoretical construct became the level III code described in Hutchinson's (1986) recommendations for analysis of qualitative data. The theoretical construct around which the categories revolve is **creating peace.** Creating peace, therefore, is the construct from which the definition of health is derived.

Respondents created peace in both active and passive

ways. Table 2 identifies the categories from the data that relate to creating peace.

Table 2

Creating Peace

Situations Requiring Action	Situations to be Accepted
Trust	Relationships w/men
Time	Life in Transience
	Dealing with locals

The migrant woman's lifestyle offered situations in which the respondents took action as well as those where no action was taken. The category of trust is an excellent example of a situation in which action taken could contribute to the creation of peace. Identifying those who could be trusted and steering clear of those who gossip in the camps were specific actions the migrant woman could take to create peace.

Time is also another area where the respondents made conscious decisions that impacted their ability to live in peace. The women placed time spent at work above the time spent with children and on personal health care activities. Even though they acknowledged that they would rather spend less time at work in the fields or in the packing plants, they knew that the income they earned would help the family to earn more money and assist with some of their financial

constraints.

The women also identified situations that were implicitly accepted as a part of their lifestyle. These situations were not necessarily acceptable, but actions were taken by the respondents regarding these situations. Their relationships with men reflect this acceptance. For the most part, women accept men's behavior despite the fact that they may not like it. Men have a definite influence over women's behavior in the camps, from deciding with whom she may speak to whether or not she is able to access health care services.

The circumstances surrounding their transient lifestyle were described as realities of migrant life. Once again, these realities were not necessarily acceptable, but nonetheless, were accepted as a means to an end, i.e. suffering through difficult circumstances in order to earn a living. The money they earned addressed some of their money problems and, therefore, helped her to create peace. The respondents way of dealing with the locals implicitly helped her to create peace. Once again, the women described this as part of the migrant lifestyle and did not take action against those who mistreated them.

Application of Findings to Theory Construction

The emergence of a beginning theory describing the culture of transience is presented within the four

metaparadigms of nursing. Of significance is the fact that this theory is grounded in the voices of women who are migrant farmworkers. These farmworker women described their transient lifestyle and the impact of this lifestyle on health.

Before describing the theory, a definition of the term transience is warranted. The Oxford dictionary (1989) defines transience as "passing by or away with time, temporary; introduced in passing, not belonging to the harmony; a person who passes through a place, or stays in it only for a short time; a traveller, a tramp, a migrant worker" (p. 404). This definition is important because of its significance to the emerging theory and its apparent validation in the data.

Description of the emerging theory within the four metaparadigms of nursing reveals the following. The **person** is the migrant farmworker woman. She has a permanent residence in her homebase. Without the income gained by working upstream, the migrant woman cannot maintain her home or support her family. She feels the suffering of her transient life is worthwhile in order to be able to give her family a chance at a better life. Time is a major factor is her life. This phenomenon has a serious impact on her ability to achieve health. The demands of her lifestyle leave little time for her to care for herself.

Health is defined as "the eye of the storm." The woman defines health as the ability to live in peace. This includes freedom from problems with money or family, especially the man in her life. Although her life appears to be somewhat chaotic with the constant moving across the country, the woman believes that she can find peace in her life. If she lives in peace, she is healthy.

The **environment** can be classified into two parts. The external environment is perilous, "stormy". It is described by the women as risky, unknown, and a place where one suffers. Women talk about the difficulty of their transient lifestyle. It is difficult to find someone that can be trusted.

With each move, she must repeat the process of identifying resources, e.g. stores, social services, clinics. Housing is often difficult to find. When housing is located, it is often substandard. Many times there is no running water, no fans to cool in the summer and no heat in the winter. Overcrowding is common. There can be as many as 20 people living in one house (usually two rooms). Migrant farmworkers face discrimination from the local residents upstream. It is obvious in the local schools and stores. This contributes to a hostile external environment.

The internal environment is a paradox. On the one hand, it is a safe haven; a place where she can find someone

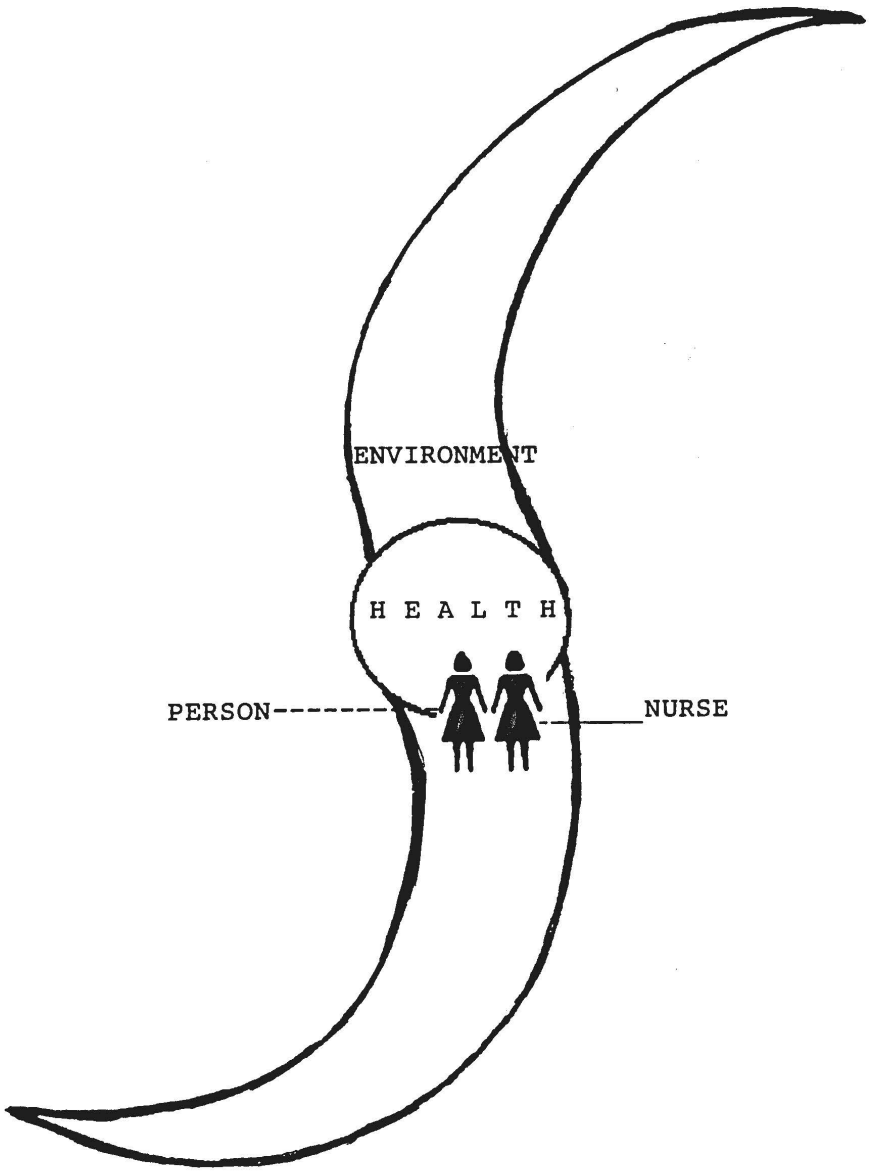
to trust. For many women though, the internal environment can be even more dangerous than the outside world. For women who are being physically or emotionally abused, the unavailability of a confidant can leave her in a very dangerous situation. Because of the lack of trust inherent in the migrant lifestyle, there may be no one to whom she can turn for assistance. Often, the only person she has ever confided in has been her husband. This safe haven can evolve into dangerous isolation.

Personal involvement is the construct that guides the metaparadigm of **nursing**. This includes going out to the camps and helping women in a variety of ways. Examples of helpful nursing activities include bringing a mobile clinic to the camp, bringing medications to the women, triaging health problems and making clinic appointments. Coming out to the camps is most important to the women as evidence that the nurse is paying attention to them. The nurses who are the most effective are those who share their lives with the women. The migrant women come to know these nurses as "real people" and not just a person who comes to take blood pressures or ask questions. If the nurse is cognizant of this fact, she may eventually earn the trust of the women.

The conceptual model that best illustrates the theory of the culture of transience is a hurricane. The model follows.

Figure 1

Culture of Transience Conceptual Model



The outer sections of the hurricane are reflective of the environment. The nature of hurricanes is such that they are dangerous and unpredictable. This is analagous to the description given by the respondents of their transient lifestyle. Health is defined as the "eye of the storm" because the eye of a hurricane is peaceful and calm. Finding peace within a seemingly chaotic existence is one of the ways these migrant women have defined health.

The migrant woman and the nurse are linked indicating the interdependent nature of their relationship. Bateson (1989) uses the term interdependence in describing relationships of interlocking needs; relationships containing elements of difference as well as elements of commonality. The primary element of commonality for the nurse and the migrant woman is the goal of attaining and sustaining the health of female migrant farmworkers. The elements of difference are signaled by the differing perspectives from which nurses and migrant women view health.

As the migrant woman and the nurse develop their interdependent relationship, they move closer to the eye of the storm, i.e. finding peace, attaining health. The transient nature of the migrant woman's lifestyle will contribute to her movement into and out of the eye of the storm. It is proposed that her interdependent relationship

with the nurse will enhance her ability to attain and sustain health.

Nurses have traditionally been educated within a biomedical framework or model that is based on western European cultural values. In The Health of Women, Brems & Griffiths (1993), describe biomedicine as dividing the human being into the "somatic body and intangible mind" (p. 260). The authors describe how the biomedical medical model separates the mind from the body and further dissects the body into systems and organs, emphasizing areas of specialization for health care practioners. Brems & Griffiths further state that, "...biomedicine has a...tendency to divide health from the setting that produces it" (p.260).

The migrant women interviewed for this study did not separate the mind from the body nor did they define health from a biomedical, illness-based perspective. The data indicate that the respondents' definitions of health could not be separated from their lifestyle or their environment, i.e. the setting that produced it. The culture of their transient lifestyle clearly had an impact on the way these women described and ordered their world and, consequently, could not be separated from how they described and defined health.

The way these migrant farmworker women described and

defined health is illustrative of the ethnomedical perspective of health and health care. The ethnomedical perspective gives meaning and context to perceptions of health and illness that are not necessarily based on Western medical standards of health and illness, but rather on the culture and values of the people with whom the health care professionals are working (Brems & Griffiths, 1993).

The respondents' definition of health also supports Dubos' (1965) contention that there can never be a universal definition of health or illness. According to Dubos, each of these terms are inextricably tied to the unique physical and social environment of the people from which the definition is derived. Dolfmann (1973) also proposed that health was culturally determined. He further stated that, even within subgroups of a society or culture, definitions of health would vary.

The results of this study are also somewhat consistent with Dunn's concept of high-level wellness. This concept provides for a definition of health that includes the mental and social states, as well as the physical state of being. According to Dunn (1961), health is only possible when all three of these states are at their peak. While self-actualization was not addressed, the migrant women in this study supported Dunn's perspective in their definition of health as the ability to live in peace.

Conclusions and Implications

The qualitative nature of this study does not allow for generalization of the findings. However, it is important to note that the conclusions presented are grounded in the voices of the migrant farmworker women interviewed for this study. While these respondents may not speak for all migrant women, they have made a significant contribution to understanding how migrant farmworker women view health. Their views must be incorporated into the development of future health strategies and policies. Brems & Griffiths (1993) recommend that listening and talking with women become a fundamental organizing prinicple in the development of women's health programs. They further state that health professionals cannot isolate health as a distinct entity apart from the everyday lives of women.

Health is culture and lifestyle, it is not a consequence of it. Rodriguez-Trias discusses this point in her editorial, "Women's Health, Women's Lives, Women's Rights" (1992). She states that, while factors such as access to health care and reproductive rights are significant factors in determining the health of women, health care professionals need to consider the importance of the socioeconomic and cultural factors that also determine health. According to Rodriguez-Trias, "women live in households, communities, and cities, and in times, places,

and circumstances that spell health or disease, life or death, with greater certainty than does access to health care" (p.663).

In examining the existing literature and reviewing the data from the current study, the following conclusions and associated implications are presented.

1. **Migrant farmworker women describe health in terms that are broader than the traditional perspectives of health professionals.** Respondents incorporated many aspects of their lives, e.g. family responsibilities and relationships, into their definition of health. For these women, health could not be separated from their daily existence and survival. These broad perspectives must be incorporated into all aspects of nursing practice, education, and research. These broad perspectives should also give direction to the development of health policy. In other words, health policy should not be developed in isolation. It should instead be incorporated into all areas of policy development such as economics, education, housing, transportation, and the environment.
2. **Migrant farmworker women need interdependent relationships** with nurses. Interdependent relationships are based on personal involvement.

The nurse must be willing to go out to the people, listen as they tell her/him about their priorities for health, and develop health strategies that are consistent with the culture and values of the population. At federal, state, and local levels, funds are needed for development of outreach programs for migrant farmworkers. One example of a successful program is the Camp Health Aide Program (1991) developed by the Midwest Migrant Health Information Office. This program trains migrant women in labor camps to provide basic health care and referral for migrant farmworker families within a culturally-acceptable framework. The Camp Health Aide works in partnership with a community health nurse to form a bridge between health care providers and migrant farmworkers.

3. **The transient nature of the migrant lifestyle has an influence on the way migrant women define and describe health.** In this study, migrant women identified problems associated with their lifestyle that determined whether or not they could live in peace and, as a result, be healthy. They also described the nature of their lifestyle as impacting the time they could spend on health care activities as well as the availability of support

systems for health. The risks associated with traveling to work sites and the harsh living condition associated with the migrant lifestyle contributed to their determinations of health.

As strategies for health care are developed, nurses must listen to and work with migrant farmworker women to develop innovative programs for health that will consider such issues as the time constraints inherent in their lifestyle. Simply offering evening clinic hours is not sufficient. Also, as much as possible, eligibility guidelines should be uniform across states. This strategy would facilitate the accessibility of resources for farmworkers as they move to find work.

Recommendations for Further Study

The following recommendations are made:

1. Further study of the theory of the culture of transience and its impact on the health of women and men through a) replication and b) application to additional aggregates is recommended. This study focused on Mexican and Mexican-American female migrant farmworkers. Persons of other ethnicities that make-up the migrant farmworker population in the United States should be included in future studies. For example, the eastern migrant

stream consists of African-Americans, Haitians, and Guatemalans. Their perspectives of health and the culture of transience must be incorporated into the development of this theory. Related aggregates of resettled people, i.e. refugees, are also recommended for further study.

2. Studies with populations outside of the United States are essential to the development of the theory of the culture of transience. It is proposed that, all over the world, there are people who must set up households apart from their usual environments in order to make a living. These perspectives should also be an integral component of future research.
3. Further study is also recommended regarding culturally-sensitive models of health care delivery to aggregates in transience. Studies that document the effect of community-generated health care planning and program development are needed to identify effective outreach models for these populations.
4. Analysis of existing health policy for populations in transience and recommendations for revisions based on field research is also a recommendation for further study. The merging of research and

policy into the development of legislation that is responsive to the needs of the people would lead to programs that are truly representative of health for the people.

A theory of the culture of transience and its impact on health is significant for the twenty-first century. With the development of a global economy, the borders of individual nations will eventually disappear and people from all walks of life will be migrating to find work. This theory will provide a framework from which effective health strategies and policies can be developed.

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APPENDIX A

INTERVIEW GUIDE

INTERVIEW GUIDE

Demographic Data:

Age_____

Marital Status_____

Ethnicity_____

Years as farmworker_____

Interview Guide:

1. Tell me how you felt yesterday.
2. What does health mean to you?
3. Who do you talk to about health?
4. How do you stay healthy?
5. What can nurses do to help migrant women be healthy?

APPENDIX B

CONSENT FORM

CONSENT FORM

I hereby authorize Rachel Rodriguez, RN to enlist me as a subject in her study to identify the health needs of female migrant farmworkers. I understand that I will be answering questions and that these are questions of a personal nature about my health. I understand that the whole session will be tape recorded. The session will last approximately 1 hour. The procedure has been explained to me by Rachel Rodriguez and an offer to answer all of my questions, at any point, has been made.

I understand that this study involves the following possible risks or discomforts:

1. I may feel uncomfortable answering the questions.
2. A loss of confidentiality may occur.

I understand that this study has the following potential benefits to myself and/or others:

1. It will help to identify what things are important to female migrant farmworkers regarding their health.
2. It will help nurses to develop health programs for female migrant farmworkers.

I understand that in the event of physical injury resulting from this research, Texas Woman's University is not able to offer financial compensation nor to absorb the costs of medical treatment. However, first aid will be provided as necessary. If a major health problem is discovered, and I so desire, referrals to appropriate health services may be made. I can withdraw from the study at any time without affecting the health care that I am now recieving at any clinic or other health care facility.

I understand that my answers will be confidential and will be reported as a group. My name and any other identifying factors will not be used.

I know that I may call Rachel Rodriguez, at 223-2120 should I need more information.

Signed:

_____ _____

Subject Date

_____ _____

Witness Date

CONSENT TO AUDIOTAPE

I, _____, consent to the recording of my voice by Rachel Rodriguez, RN, acting on this date under the authority of Texas Woman's University. I understand that the material recorded today is for educational and/or research purposes and I do hereby consent to such use.

Respondent:_____
Date:_____

****

The above consent was read, discussed and signed in my presence. In my opinion, the person signing said consent form did so freely and with full knowledge and understanding of its contents.

_____
Date:_____
authorized representative of
Texas Woman's University

CONSENT FORM

I hereby authorize Rachel Rodriguez, RN, to enlist me as a subject in her study to identify the health needs of female migrant farmworkers. I understand that I will be answering questions with a group of other people and that these are questions of a personal nature about my health. I understand that the whole session will be tape-recorded. The session will last from 1 to 3 hours. I understand that I may also be asked to participate in a personal interview that will provide more information. The personal interview may also last from 1 to 1 1/2 hours. The procedure has been explained to me by Rachel Rodriguez and an offer to answer all of my questions, at any point, has been made. I understand that this study involves the following possible risks or discomforts:

1. I may feel uncomfortable answering the questions.
2. A loss of confidentiality may occur.
3. Participants may reveal information to those outside the group once they leave.

I understand that this study has no direct personal benefits but has the following potential benefits to myself and/or others:

1. It will help to identify what things are important to female migrant farmworkers regarding their health.
2. It will help nurses to develop health programs for female migrant farmworkers in the future.

I understand that in the event of physical injury resulting from this research, Texas Woman's University is not able to offer financial compensation nor to absorb the costs of medical treatment. However, first aid will be provided as necessary. If a major health problem is discovered, and I so desire, referrals to appropriate health services may be made. I can withdraw from the study at any time without affecting the health care that I am now receiving at any clinic or other health care facility.

I understand that my answers will be confidential and will be reported as a group. My name and any other identifying factors will not be used. I understand that I am not to discuss these conversations outside of this group to protect the confidentiality of the group.

I know that I may call Rachel Rodriguez, collect at (713) 223-2120 should I need more information.

Signed:

_____ _____

Subject Date

_____ _____

Witness Date

CONSENT TO AUDIOTAPE

We, the undersigned, do hereby consent to the recording of our voices and/or images by Rachel Rodriguez, RN, acting on this date under the authority of the Texas Woman's University. We understand that the material recorded today may be made available for educational, informational, and/or research purposes; and we do hereby consent to such use.

SIGNATURES OF PARTICIPANTS

_____
Date

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

***

The above consent form was read, discussed, and signed in my presence. In my opinion, the person signing said consent form did so freely and with full knowledge and understanding of its contents.

_____	_____
Authorized representative of the Texas Woman's University	Date