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An Ethnographic Exploration of Parental Beliefs of Migrant Farm Worker Parents

Alexis Marie Newton

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**AN ETHNOGRAPHIC EXPLORATION OF THE HEALTH BELIEFS OF
MIGRANT FARM WORKER PARENTS**

BY

ALEXIS MARIE NEWTON

B.S.N., Fairleigh Dickinson University, 1977
M.S.N., University of Cincinnati, 1983

DISSERTATION

Submitted in Partial Fulfillment of the
Requirements for the Degree of

**Doctor of Philosophy
Nursing**

The University of New Mexico
Albuquerque, New Mexico

July, 2010

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DEDICATION

This dissertation is dedicated to my maternal and paternal grandparents who came to Ellis Island as immigrants. Their hard work and perseverance provided my parents with a loving environment of family support, respect and loyalty. My parents are first generation Americans who instilled in me a sense of pride, determination and tenacity. Without these qualities, this project would not have been possible. Thank you for your love and unending support. I also dedicate this project to all of the migrant farm worker parents who participated in this study. Your voices will continue to be heard.

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The unwavering support and confidence bestowed upon me by my husband Wylie, my son Lucas and my parents, Alexander and Gilda has been absolutely vital to my ability to complete this program, conduct my research and the writing of this dissertation. Thank you so much. I also wish to thank my friends and co-workers who lived through this challenge with me when I was unavailable to them. I welcome back my life.

My progress and successful completion of this program would not have been possible without the support and expertise of my committee chair, Dr. Jennifer Averill. Dr. Averill has been a role-model and a true inspiration to me. Thank you also to Dr. Schuster for his ability to provide his scholarly insights into my study proposal. Thank you to UNM for having such professional and esteemed graduate faculty members.

My deepest congratulations to my fellow friends and cohorts and I wish you the best of luck in your future endeavors.

I also wish to thank my Aunt Constance for her editing contributions and emotional support and the Salud Clinic in Fort Lupton, Colorado for their endorsement of my research and the migrant farm worker parents who participated in my study.

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ABSTRACT

The purpose of this study was to explore and describe the health beliefs of migrant farm worker parents in their own words. The concepts of health beliefs were explored using the qualitative research design of ethnography. A purposive sample consisted of twenty migrant farm worker parents ranging in age from 19 to 50 working in Weld County in north central Colorado. Data collection took place over a 2 month period during growing season. Data were generated using the following techniques: interviews, field notes, and journaling. Ethnographic analysis yielded themes and sub-themes from the data. The overarching theme is the migrant farm worker parent's pride in having healthy children. Four dominant themes were derived from the data using ethnographic analysis: (1) kinship (2) respect, (3) a matter of convenience, and (4) inhibition/suppression. The major findings were: (1) the emergence of a nonstereotypical image of migrant farm worker parents; (2) the identification of a community within a community; and (3) the importance of respect over cultural or spiritual considerations.

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Chapter I: Introduction

Purpose of Study

The purpose of this study was to explore the health beliefs of migrant farm worker parents by approaching and interviewing the sample population in two locations: the health clinic where they seek care for their children and the mobile unit that travels to farms offering health care to families. Collecting data in locations historically proven to generate trust and respect supported the objectives of this research study and promoted direct engagement with a group that is often misunderstood and marginalized.

Specific Aims and Research Questions

This study explored the health beliefs of a sample of migrant farm worker parents in the largely agricultural setting of Weld County, Colorado. I was interested in learning about the variables/phenomena that determine parental decision-making regarding children's health maintenance, injury prevention, and health care. Using an ethnographic approach, the study explored and described the health beliefs of migrant farm worker parents from their perspectives, in their own words. A qualitative ethnographic design was utilized to explore the following Specific Aims:

1. To describe the health beliefs of migrant farm worker parents from their perspective, in their own words; and
2. To describe the relevant psychosocial characteristics of migrant farm worker parents.

To address these aims, the research questions included the following:

1. What are the health beliefs of migrant farm worker parents?
2. What characteristics of migrant farm workers affect their parental health beliefs?

3. Do age, gender, ethnicity, family structure, religious beliefs, and number of years in the US affect parental health beliefs? What do migrant farm worker parents believe is the most important determinant of their children's health? Are their beliefs informed by their religious beliefs, cultural norms, family, traditions, or other factors?

Background and Significance

Statement of the problem. Migrant farm workers' health issues and inferior health status have often made news headlines, stimulating debates over immigration and health care responsibility. Children's health issues spark emotions within health care professionals and politicians who recoil at the reports of poor sanitation and exposure to pesticides and other environmental health hazards, along with inadequate access to health care. Mainstream society is shielded from awareness of the plight of the children within the vulnerable population of migrant farm workers, for their health situations have been difficult to document due to follow-up challenges that are frequently related to the migrant farm workers' seasonal and migratory lifestyle. Because agriculture exists in geographical regions of low population density, *rurality* itself appears to be a key factor in migrant children's health. Rural racial/ethnic minorities are known to experience major public health problems, as well as comprise the most understudied and under-served of all US populations.

The National Rural Health Association (2002) states that rural children are more likely to demonstrate delayed dental care, higher traumatic fatalities, and more neonatal deaths. Rurality has been said to exacerbate the effects of socio-economic disadvantage, ethnicity, poorer service availability, higher levels of personal risk, and more hazardous environmental, occupational, and transportation conditions (Braithwaite & Taylor, 1992; Williams, Lavizzo-Mourey, & Warren, 1994; Mueller, Ortega, Parker, Patel, & Askenazi,

1999; and Probst, Moore, Glover, & Samuels, 2004). On the brighter side, rurality has been documented to have strengths and assets, as well: it encourages traditional health beliefs, alternative practices, a sense of community, and a strong family structure (Averill, 2003).

Since nurses provide care to the migrant population, the discipline of nursing is positioned to lead the exploration of migrant farm worker health, with nursing researchers uncovering cultural elements of health outcomes and health beliefs. Some of the questions considered essential to understanding these focal areas include the following: Do migrant farm worker parents believe that prevention and education can reverse an illness or prevent injuries? Do migrant farm worker parents believe that health versus illness is within their control, or is it controlled by others, such as the universe or a supreme being? What are the connections among age, gender, family presence and length of time in the US, and health beliefs for migrant farm worker parents?

Although parents have the most influence on their children's health, the marginalized, oppressed, and vulnerable migrant parents may have health beliefs that are generally unidentified by health care providers. Thus, gaining the knowledge and understanding of these beliefs will ultimately improve health outcomes of migrant farm worker children.

Although much information is available concerning health disparities, marginalization in vulnerable populations and rural health inequities, health care researchers have scarce data about the health beliefs of migrant farm worker parents. It is understood that culture is an important major determinant of beliefs, but other factors must be considered as well. Uncovering migrant farm worker parents' health beliefs will also serve to validate and honor their perceptions and opinions, and help them trust in health care providers. As children of migrant farm workers are vulnerable to social, environmental, chemical, and

biological hazards and as health behaviors are passed from generation to generation, health care must understand and adapt to the culture, language, social standing, and geographical hindrances unique to this population. Findings to date, although limited in scope and currency, support the need to improve communication with migrant farm worker parents and understand their beliefs, in order to facilitate essential and favorable health care encounters.

Thus, in order to understand how to provide culturally congruent, quality health care for the children of migrant farm workers, it is critical to explore and document parental health beliefs, specifically personal, family, social, and cultural beliefs about health and illness (Kleinman, Eisenberg, & Good, 1978; Leininger, 1984, 1990; Anderson, Wood, & Sherbourne, 1992; Levine & Adelman, 1993; McGoldrick, 1993; Agar, 1996, 2006; Lipson, Dibble, & Minarik, 1996; Bechtel, Davidhizar, & Spurlock, 2000; Canales, 2000; Aday, 2001; Mirowsky & Ross, 2003; and Yehieli & Grey, 2005). Given that the majority of migrant families working in northeastern Colorado originate from Mexico, understanding Mexican family structure and function is uniquely important to understanding the migrant families' childrearing values and hence their attitudes about health care.

Cultural and religious beliefs influence health prevention and maintenance, decision-making, prioritization of children's needs, information gathering, and control and delegation of responsibility. Leininger (1984) identified ten cultural care actions within the Mexican-American population: (1) direct family aid, (2) involvement with extended family, (3) lovingness, (4) respect for authority, (5) mother as care decision-maker, (6) protective male care, (7) acceptance of God's will, (8) use of folk lore practices, (9) healing with foods, and (10) touching. Given that Hispanics are the fastest-growing ethnic minority group in the US (US Census Bureau, 2005), the literature is rich with studies exploring cultural differences

among Hispanics in the US. Recently, nursing and the social science researchers have studied diverse areas of illnesses, as evidenced by the following sample: Hispanics' health decision-making and illness recognition (Zwirs, Burger, Buitelaar, & Schulpen, 2008); parental locus of control and externalizing behaviors in preschoolers (Maniadaki, Sonnuga-Barke, Kakouros, & Karaba 2007); McCabe, Goegring, Yeh, & Lau, 2008); acculturation among Latinos with diabetes (Mainous, Diaz, & Geesey, 2008); Mexican Americans and hospice care (Taxis, Keller, & Cruz, 2008); Latino patients living with HIV/AIDS (Acevedo, 2008); and the study of risk information in migrant farm work (Vaughan & Dunton, 2007).

With children's health fundamentally dependent upon the decisions and choices of their parents, health beliefs of parents for children directly influence health decisions, (Soliday & Hoeksel, 2001). Parental health beliefs differ among cultures, ethnicities, and geographical locations. Additionally, health disparities and inequalities among economically depressed populations greatly contribute to children's overall health status. *Health disparities* are defined by Carter-Pokras and Baquet (2002) as differences in the quality of health care on the basis of the client's racial or ethnic group. *Inequality* is defined as a measure of welfare that is considered, in relative terms, the evaluation of the endowments such as the income of one population in comparison to the endowments of another (Mooney & Fohltling, 2008). While observing migrant farm workers in the fields of Boulder and Weld Counties during work experience, I experienced both concern and uncertainty. My concerns were rooted in questions of migrant farm worker survival, strength, and options. I asked myself if their lifestyle was one of personal choice or necessity, and I wondered what the consequences might be for their children. Attending to migrant farm worker children's health status became the focus of my interest and research while I explored health disparities

and inequalities in the population relevant to illness, injury prevention, and health maintenance. With growing national interest level in exploring, reducing, and eliminating health disparities and searching for means to improve children's health care delivery, I hope for changes to be instituted by health care workers, policy makers, and advocates. For me, it is both a personal and professional goal to participate in this important task.

Despite researchers' examinations of the main determinants of poverty and inequality of the migrant farm worker population, ultimately migrant farm worker parents themselves determine the fate of their children's health. At the fundamental level, parental health beliefs take into account social, cultural, and economic decision-making variables. The literature contains studies that document the status of children's health among various economically depressed and geographically isolated rural populations (Williams, Lavizzo-Mourey, & Warren, 1994; Mueller, Ortega, Parker, Patel, & Askenazi, 1999; Hargraves, 2002; and Probst, Moore, Glover, & Samuels, 2004). According to a report from the Institute of Healthcare Inequities (2008), the studies of geography and demographics are useful in determining health care access, distribution of providers, and prevalence of populations.

As they promote health maintenance and illness prevention, increasing numbers of nurses are developing innovative research programs to describe, document, and impact health outcomes for underserved children. Health beliefs of parents, the ultimate decision-makers regarding children's health care, appear to be the critical ingredient of children's health status. Nurses are unable to plan, implement care, or create health care delivery models without research about health beliefs. An understanding of parental health beliefs in the vulnerable population of migrant farm workers will assure a more informed nursing approach

to health matters of their children, while also improving health care delivery and providing culturally specific health care models.

I have chosen the migrant farm worker population this study partly due to the increasing numbers of migratory workers in the agricultural industries, and partly because my clinical and research interests support measures to improve the health status of these workers and their families. Without the labor of migrant farm workers, it would not be possible to support the multi-billion dollar fruit and vegetable industry in this nation (National Center for Farm Worker Health, 2008). Over 85% of fruits and vegetables produced in the US are hand-harvested and/or cultivated by migrant farm workers.

Although there are approximately 45,000 migrant farm workers in Colorado, they constitute one of the least powerful populations in the state (Colorado Migrant and Rural Coalition [CMRC], 2004). The CMRC (2004) documents that the greatest concentration of migrant farm workers appears in the northeastern counties of Adams, Larimer, and Weld. The CMRC is responsible for establishing initiatives to protect the migrant farm worker. In 2002, the Environmental Justice Program's Migrant Farm Worker Initiative found that some of the drinking water wells located in northeastern Colorado migrant camps contained excessive concentrations of nitrates. Although this initiative has assumed the task of reducing exposure to nitrate-contaminated water, the group's work continues to face many challenges from many sources, in spite of the Safe Drinking Water Act (SDWA) and the Colorado Rural Water Association (CRWA). The most recent initiative was established in 2004 to reduce exposure to pesticides and contaminated water in migrant farm worker communities (Migrant Farmworkers Protection Initiative, 2004).

For the past four years, the Colorado Legal Services Corporation (2008) has been procuring resources to expand the Promotora Project, whereby migrant farm workers are educated by members of their own population about their worker rights and exposures to pesticides. The Northern Colorado Area Migrant Coalition (2008) continues to address issues such as housing, working conditions, and health. In essence, although Colorado has gained incredible insight into the plight of the migrant farm worker, movements to improve conditions for this population continues to encounter opposition and uncertainty by powerful major stakeholders such as, growers, workers, and regulators (Migrant Farm Workers Protection Initiative, 2008).

According to the Migrant Legal Action Program (2004), migrant farm workers are the poorest of America's working poor and are exposed to a variety of indignities on a daily basis. An important study by Littlefield and Stout (1989) documented particular illnesses within the migrant farm worker population, including general malnutrition, maternal malnutrition, dental problems, parasitic infections, hypertension, diabetes, respiratory infections, and sexually transmitted diseases. Also documented were mental health problems, including depression, anxiety, and substance abuse, linked somewhat to isolation, financial hardship, and frequency of relocation. Compared to the general population, migrant families suffer disproportionately higher rates of all of these conditions (Littlefield & Stout, 1989).

Along with health-related and economic health disparities, the migrant farm worker family in agriculture also faces geographic and cultural isolation, which affects access to health care, and includes language barriers and marginalization by mainstream society. While location and language may further marginalize the migrant farm worker population,

isolation reinforces differences and inequities via challenges in transportation and fear of deportation (American Farm Bureau Federation, 2007; Weathers, Minkovitz, & Diener-West, 2004; Purnell, 1998; Sandhaus, 1998). It may be perceived by the migrant farm worker family that immersion into the culture of their temporary location can actually endanger their family's safety.

In the context of this study, the following variables/phenomena are known to impact health status: health beliefs, culture, social alliances, community conformity, folklore, geography, and climate. Any attempts to intervene in health inequities are futile without the acknowledgement and understanding of these factors. Before modifying health care delivery to migrant farm worker families, further analysis of those variables that contribute to their overall health status is warranted. First and foremost, health care delivery should reflect the population's desires and priorities regarding health care. The Institute of Medicine (IOM) (1998) contended that the quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and remain consistent with current professional knowledge. A new perspective will enhance our relationships with migrant farm worker parents, which may have a positive effect on health care planning for them and their children. Consequently, exploring parental health beliefs will generate knowledge necessary for health care providers to initiate health care delivery models specifically designed for migrant farm workers.

Theoretical Framework or Orientation

In this study, theoretical orientation is based on ethnography as a way of visualizing, exploring, and understanding, since "The resolution of the nexus between setting and problem is always recursive and dialogical" (Wolcott, 1999, p. 40). Agar (1996) further

noted, “To the extent that ethnography can complicate the simplified and often incorrect notions that one group has of another, it can play an important role in present and future worlds” (p. 252).

Ethnography is an approach to the discovery and investigation of social and cultural patterns in a community, institution, or specific population (Schensul, Schensul, & LeCompte, 1999). Ethnographic research begins with a question. As the research process progresses, the researcher learns more and more about the population, which allows a view beyond the initial question. Although ethnography does not build or test theory, it can uncover the associations among phenomena, which in turn generates new information within a specific focus. Schensul, et al. (1999) argued that ethnographic researchers seek to generate useful information about culturally patterned beliefs and behaviors and reasons accounting for behaviors within diverse groups over a specific time period. These behaviors occur naturally and assist with the prediction of events in another time and place within the same population. Flick (2006) affirmed that theory becomes people’s perceptions of their world in their own words, which becomes a preliminary and relative version of their worldview. Careful and sensitive regard for migrant farm worker ethnicity supported this study’s cultural perspective and generated its foundational framework.

Propositions

The following propositions comprised the foundation of this study: (1) The human aspect of nursing has enabled nurses to establish knowledge and practice within a realm of consciousness of social, spiritual, and artistic expansion. Furthermore, our concerns reach out to humankind, and we share the responsibility for determining what specific populations require from our research. (2) There is value to the telling of original stories in the words of

those who have lived the experiences, for storytelling provides a source of understanding and mutual presence. (3) Respectful presence (being at hand for the right reason and showing respect for the population under study) was my priority while studying this vulnerable population.

Summary of Chapter 1

As the migrant farm worker population has generated interest and concern in researchers focused on resolving poor living situations and initiating immigration discourse, this vulnerable population's health issues have been widely publicized in the national media. Ethnographic research represents a respectful strategy for deepening our understanding about the migrant farm worker perspective, particularly parents' beliefs and stories about how they care for their children. Since questions that guide this exploratory study are related to an analysis of the health beliefs of migrant farm worker parents, my work addressed the key concerns that have emerged from the inquiry. As the next chapter found in its review of the literature relevant to migrant farm worker parents, gaps exist in our understanding of this population and how they approach health care.

Chapter II: Literature Review

Introduction

This chapter presents a synthesis of nursing and extant literature relevant to the issue of migrant farm worker health status and health beliefs. For purposes of flow and organization, the review is divided into the following topics: (1) Migrant Farm Worker Population, (2) Migrant Farm Worker Health Status, (3) Migrant Farm Worker Children's Health, (4) Health Beliefs of Migrant Farm Worker Parents, (5) Health Locus of Control, and (6) Rural and Work Environment for the migrant farm worker. Reasons for examining the health beliefs of migrant farm worker parents include the lack of existing studies and the profound influence of parental health beliefs on children's health status. The literature search involved the exploration of published studies and federal/state government organizational websites related to health beliefs and health locus of control of migrant farm worker parents. The chapter concludes with a summary of knowledge gaps in current nursing literature and research related to migrant farm worker parental health beliefs and health locus of control.

Key Terms, Concepts, and Definitions

For purposes of this dissertation, key definitions are as follows: *migrant farm workers* are defined as a diverse and mostly minority population who periodically relocate their residence during a growing season in order to follow and manage crops. Their work includes preparing the soil for planting, sowing seed, irrigating crops, fertilizing crops, pest/weed control, and harvesting of crops (National Center for Farmworker Health (NCFH), 2007; U.S. Department of Labor, 2000). *Health beliefs* are defined by the Center for Disease Control (CDC) (2009) as an individual or group's attitude or understanding of the cause or cure of an illness or condition. *Culture*, as described by Lipson, Dibble & Minarik (1996),

includes norms, practices, and values of a population, and it is shared, learned, and passed on through generations as a dynamic, ongoing process, rather than a static entity. According to Meleis (1995), *culturally competent nursing care* is sensitivity to issues related to culture, race, gender, sexual orientation, social class, and economic situations, and other factors. A *cultural perspective in nursing care* includes objective, subjective contextual dimensions cross-cultural encounters (Lipson & Steiger, 1996). This perspective corresponds to my intent and lens in this study. The U.S. Census Bureau (2005) and the U.S. Department of Agriculture define *rural* as an area outside an urban environment with fewer than 2,500 persons, or 7-99 persons per square mile.

Migrant Farm Worker Population

Multiple sources have estimated that there are between 4 and 5 million seasonal and migrant farm workers in the U.S. (Cafferty & Engstrom, 2000; Boucher & Schenker, 2002; Carrol, Simardick, Bernard, Gabbard, & Hernandez, 2005; National Agricultural Worker's Survey, 2005). While some farm workers stay in one geographical area over an entire agricultural or growing season, approximately 42% of them migrate, according to Carrol, et al. (2005). The challenge for researchers is this migration, which complicates identification and counting among states. Current data suggest that migrant farm workers are impoverished, uninsured, medically underserved, and, remain one of the country's most socially and economically vulnerable populations, they, not surprisingly, experience disproportionate health disparities (National Advisory Council on Migrant Health, 2004; Cooper, Heitman, Fox, Quill, Knudson, & Zahm, 2004; Carrol, et al., 2005; Parra-Cardona, Bullock, Imig, Villarruel, & Gold, 2006; Villarejo, 2003). Demographically, the migrant farm worker population is diverse and regionally varied. The National Center for Farm Worker Health (NCFH) (2009) indicates

that migrant farm workers are predominantly Hispanic (83%), including Mexican or Mexican American, Puerto Rican, Cuban, and Central and South American workers. Also included in the migrant farm worker population are African Americans, Jamaicans, Haitians, and Laotians. Farm workers are typically authorized (56%) or documented (39%) (Carroll, et al., 2005). The NCFH (2009) reports that many migrant farm workers have a permanent residence or a home base in the US/Mexico border regions of the southwest, most often in Texas and California or in Florida.

According to Dalla and Christensen (2005), more farm worker mothers (91%) migrate with their children than do fathers (42%), and 2/3 of all migrant farm workers travel with their dependent children. Using a situation-specific theory of migration transition, Clingerman (2006) has found that migrant farm worker women attribute both employment, health needs, and health management to variations in climate. Significantly, Clingerman's study also registered women's reports of an increased likelihood of conversing with their husbands inside their household while others are not watching. This observed dynamic leads to the question of who is the decision maker in the family regarding health care.

These complex social, political, and cultural factors intersect to influence the health of farm workers as they migrate. Uncovering and examining these factors may more clearly delineate an understanding of their health and encourage development and coordination of evidence-based interventions for migrant farm worker children. Personal, community, and societal conditions can facilitate or hinder a person's smooth passage leading to a healthy outcome. This means that cultural beliefs and attitudes, socioeconomic status, preparation, and knowledge are personal attributes that can alter the way people respond to a transition experience (Meleis & DeLeon Santz, 2007; Meleis, Sawyer, Im, & Schumacker, 2000). Other

similar effects may be exerted by societal and community factors. For example, overcrowding and structural deficiencies of housing are well documented among migrant farm workers, with 80% living in poverty (Early, Davis, Quandt, Rao, Snively, & Arcury, 2006).

Migrant Farm Worker Health Status

The numerous health care challenges faced by migrant farm worker families are directly influenced by socioeconomic, geographic, historical, and cultural barriers. In addition, seasonal migrant farm workers experience health challenges unique to agriculture such as weather-related dangers, exposures to chemicals, and/or distance from bathrooms, water, and eating facilities. Rust's (1990) literature review of the health status of migrant farm workers concluded that studies have been more concentrated on illnesses arising from pesticide exposure and infectious diseases than anything else because a noted gap in evidence for this complex group involves missing and inaccurate population numbers. Rust (1990) called for research about migrant farm worker-specific variables, such as their personal lifestyles and occupations. He also identified a need for comparative studies with other groups experiencing poverty and helplessness in order to identify similarities and differences for this marginalized segment of the community.

Larson (2002) identified agriculture as the occupation with the highest morbidity and mortality, and recent data contend that agriculture surpasses mining as the most dangerous occupation in the country (U.S. Department of Labor, 2006). According to Sandhaus (1998), migrant farm workers have some of the highest work-related injury, morbidity and mortality rates in the US, with an average life expectancy of just 49 years, compared to the national average of 77.3 years. Infant mortality rates among migrant farm workers are nearly twice that of national rates (Slesinger, 1992). Infectious diseases including tuberculosis, parasites, and

bacterial gastroenteritis have been identified as a direct result of poor sanitation, overcrowded housing, and unsanitary drinking water. Furthermore, prolonged exposure to sun places the migrant farm worker at risk for dehydration, heat exhaustion, and skin cancer. Consistent with such work conditions, dehydration, heat stroke, and other problems were linked to urinary retention as well.

Exposure to respiratory irritants including pesticides, dusts, pollens, and molds are another health concern of migrant farm workers. Skin problems remain a recurrent health problem, especially those resulting from wet tobacco, (NCFH, 2002). Green tobacco sickness results from direct skin exposure to the nicotine in wet leaves, producing symptoms similar to heat exhaustion or pesticide exposure (North Carolina Department of Labor, 2009). Direct exposure to causative agents is the primary cause of visits to migrant health centers among male adult farm workers.

The Environmental Protection Agency (EPA) (2007) estimates that in 2005, 300,000 farm workers suffered acute pesticide poisoning, and 40% of the cases were associated with complex infectious diseases. A seminal study by Littlefield and Stout (1989) identified hunger, poverty, and environmental hazards as factors that increase the risks for illness. Littlefield and Stout (1989) documented additional illnesses within the migrant farm worker population including malnutrition, maternal malnutrition, dental problems, parasitic infections, hypertension, diabetes, respiratory infections, and sexually transmitted diseases. There are also documented mental health problems, including depression, anxiety, and substance abuse, all of which are linked at least in part to isolation, financial hardship, and frequency of relocation. Many or most of these issues remain in 2009, as the current literature indicates.

Several studies have attempted to identify populations with access barriers. Using reports of unmet needs as a measure of poor health care access, one in particular (Mayer, Slifkin, and Skinner, 2005) finds that rural residence and other social vulnerabilities are associated with decreased perceptions of need, adding bias to subjective measurements of unmet needs for these populations. A study of these topics (Bechtel, Shepherd, & Rogers 2005), found that multiple health problems, minimal resources, limited accessibility to other health specialists, and multigenerational and interfamilial factors create a difficult framework for change.

Numerous studies about migrant workers have come from that state due to the high percentage of farm worker labor within Minnesota. Garces, Scarinci, and Harrison (2006) in an examination of sociocultural factors related to health care among the Latino immigrants, demonstrated that women play an important role in the health of the family, primarily due to their reproductive medical needs, which necessitate access to health care more frequently and also allow them to gain trust in traditional health care.

Another study by Mikhail, Wali, & Ziment (2004) found that among Latino immigrants, alternative/complementary health and medicinal practice (e.g., home remedies, traditional practices, use of herbs, etc.) is higher for women (75%) than men (25%). Over 80% do not inform their primary care providers of this practice. Mikhail, et al. (2004) find that more women than men report having no control over their health, and attribute this to “the system”, including lack of information, language barriers, and lack of access to care and medications. Reporting “family” as their sole support system and provider of health care, some women identify embarrassment about being undressed or being touched by a stranger (a medical provider) as a barrier to seeking care. Berk, Schur, Chavez, and Frankel (2000)

concurred that 33 – 50% of undocumented immigrants are afraid to seek health care due to their immigration status, which is similarly found in research on other ethnic-specific indigent populations across the US (e.g., Haitians, South American Indians, etc.).

A qualitative study examined nutritional habits and the high incidence of obesity, cardiovascular disease, diabetes, and anemia among migrant farm workers (Fishman, Pearson, & Reicks, 1999). It featured interviews that cited choices of food, inadequate food handling and preparation, and a lack of understanding of required nutrients and a balanced diet as contributing to disease. Nutritional status has also been linked to poor dental and oral health. In a similar study based on the nutritional status of migrant farm workers, Quandt, Clark, Rao, and Arcury (2007) found that oral health issues are one of the greatest unmet health needs of all. Researchers have also found that migrant farm workers do not seek oral care due to lack of time and/or access, money and poor education about dental health (Lukes, 2002; Lukes & Simon, 2005).

A phenomenological study by Magana and Hovey (2003) identified 18 stressors, all resulting from lack of communication with and information dissemination to migrant farm worker families, along with their perceptions of health care providers. Hiott, Grzywacz, Davis, Quandt and Arcury (2008) identified significant levels of stress contributing to mental illness. In this study, the following stressor domains were identified: legality/logistics, social isolation, work conditions, family concerns, and substance abuse. These stressors are associated with the inception or occurrence of mental illness in migrant farm workers. A similar phenomenological study of perceptions of living with diabetes (Heuer & Lausch, 2006) revealed themes centered on fear and folklore. Recurring themes of fear and folklore may also emerge in other health beliefs. Both phenomenological studies of migrant farm

workers' lived experiences are a rarity in the literature review, suggesting that the majority of studies involving this complex group have been purely descriptive and quantitative. A need exists to establish a clearer understanding of the farm workers from their own perspective, in their own words.

Cultural assumptions regarding the migrant farm worker family were found in studies by Caudle (1993); Lipson, Dibble, and Minarik (1996); and Purnell (1998). Assumptions arising from an analysis of their work included the following: (1) the extended family provides structure and strength, while the elders hold the wisdom, (2) adaptation into a new community is secondary to the importance of an opportunity for financial prospect in a growing season, (3) maintenance of traditional culture and values are more important than acculturation into a new community, (4) distinct gender roles are common, (5) many people believe in folk healing practices, and (6) the needs of the family supersede those of individuals. The comparison of these assumptions with the findings of this parental health belief study will enrich the overall knowledge and context of migrant family health.

The U.S. Department of Agriculture (2005) identified agriculture as having a mortality rate of more than eight times the average of other industries, and suggested a need for further research in agriculture occupational safety. In 2007, Farquehar, Samples, Ventura, Davis, Abernathy, McCauley, Culrich, and Sharbeh conducted a qualitative study of occupational health issues, using focus groups of migrant farm workers. The analysis of the focus group responses identified two primary areas of concern for the farm workers: (1) disrespect and discrimination based on the unique languages and cultures of the indigenous farm workers, and (2) a lack of basic occupational health and safety information and equipment for the workers. Although this study identified concerns from the migrant farm

workers' perspective, it is limited to a small convenience sample. Moreover, the participating farm workers were interviewed while working, a situation that may have added to stress related to time away from work and possible repercussion from employers or supervisors.

Migrant Farm Worker Children's Health

In 1998, the Institute of Medicine (IOM) reported a significant gap in the scientific research on children of migrant farm workers, especially undocumented workers. Berman (2003) later identified just four research studies published in pediatric journals over the past 54 years that address topics of acute and chronic medical conditions of migrant farm worker children. These studies highlighted nutritional deficiencies, vitamin and trace mineral deficiencies, and pesticide exposure. Further exploration of barriers to health care and ethics of health care inequities is therefore needed and indicated. The NCFH (2005) contends that 66% of migrant farm workers migrate with their children, a statistic that points to an estimated 250,000 children migrating with their parents annually. This high mobility inhibits long-term relationships with health care providers and creates barriers to continuous and follow-up care. Migrant clinics have twice as many visits with children under the age of 15 as do ambulatory clinics in general, with the highest rate of co-morbidity in patients below 5 years of age (NCFH, 2005). A mobile lifestyle, income inconsistencies, a possible lack of citizenship, and knowledge deficits (regarding available programs) influence the migrant farm workers' abilities to obtain health care for their children. In a qualitative study of Mexican mothers' expectations for children's health services, Clark & Redman (2007) found that listening and cultural respect were the women's highest priority.

According to the NCFH (2005), children as young as 10 years old perform an estimated 25-40% of all farm work. Children of migrant farm workers are therefore at risk for illness and injury while working in the fields, when playing within close proximity to dangerous farm machinery, or when exposed to respiratory irritants. Another area for concern is motor vehicle crashes occurring in poorly conditioned and overcrowded vehicles not equipped with seat belts or child restraint seats. Along similar lines, there have been incidents of severe injuries to children who ride in truck beds. The NCFH (2005) estimate that 61% of migrant farm worker children have at least one health problem, while 43% have two or more health issues or problems. More than 33% of these children also suffer from intestinal parasites, severe asthma, chronic diarrhea, Vitamin A deficiency, chemical poisoning, or chronic otitis media (NCFH, 2005).

Two studies have been conducted over the past four years relating to migrant farm worker children's health status. Assessing the correlates of unmet need for medical care among migrant farm worker children, Weathers, Minkovitz, and Diener-West (2004) find that pre-school-aged migrant children experience disproportionate unmet medical needs. This study further maintained that, among all children, unmet need for care is consistently associated with poverty and a lack of insurance, whereas in migrant children, the primary barrier is not financial, but instead a lack of transportation, a lack of knowledge of where to go for care, and very high caretaker work pressure (Weathers, et al. 2004). Kilanowski and Ryan-Wenger (2007) reported a dearth of studies specifically focused on migrant farm worker children. Studying the health status of carnival and migrant farm worker children, with the purpose of evaluating health status indicators in these children from birth to 12 years of age, Kilanowski et al. (2007) compared their findings to national averages to identify

health disparities. Results were as follows: 61% of carnival parents and 8% of migrant farm worker parents rated their children's health as fair to poor. Sixteen percent of the carnival parents and 27% of migrant parents stated that they delay health care because of cost.

Presenting health status information on the socially invisible and vulnerable children who are migratory and mobile for several months out of the year, this was the only study to focus on parental assessment of children's health.

Nutritional status has also been specifically studied in migrant children. Examining household food insecurity and health outcomes in the seasonal migrant farm worker, Weigel, Armijos, Hall, Ramirez and Orozco (2007) reported that the high incidence of learning disabilities in farm worker homes is due in part to the lack of consistent food supplies and lack of education regarding nutrition. These same children have multiple GI symptoms and infectious diseases. Further research is needed to determine other causes of learning disabilities. While current knowledge identifies nutritional imbalance as one factor among many in the development of learning disabilities, educators might focus their research on other causes of learning disabilities, such as language barriers, prenatal health care, or poor school attendance, to learn whether these issues are modifiable and whether behavioral patterns can be influenced by educating parents.

Health Beliefs of Migrant Farm Workers

Determining the influence of attitudes, spiritual beliefs, cultural beliefs, social beliefs, and health-seeking behaviors among migrant farm workers is a complex work in progress. Over the past two years, studies have emerged that focus on the beliefs of specific international ethnicities regarding health conditions ranging from HIV to sleep apnea. Research has focused on health beliefs associated with prevention, adherence, provision of

care, interventional strategies, knowledge, self-efficacy, socioeconomics, geographical locations, gender, and age-related issues among specific cultures and ethnicities.

Health beliefs related to diabetes have been specifically studied in Mexican Americans, migrant farm workers, and international border-area populations (Parchman & Byrd, 2001; Brown, Becker, Garcia, Barton & Harris, 2002; Hartwig & Garcia, 2007; Howes, Guerra, & Zucker, 2007; and Lujan, 2008). This is likely due to the very high prevalence of diabetes in these groups, relative to national norms.

Focusing upon beliefs about medication compliance and latent tuberculosis among migrant farm workers, Wyss (2004) studied the effects of the environment and an overall belief system. This work painted a picture of farm workers who have a strong sense of cultural heritage, self-perceptions of being healthy, and the disbelief/denial of any serious health threats. Furthermore, Wyss found that migrant farm worker men believe that work and job responsibilities take priority over everything else in their lives. This study created external changes in a migrant tuberculosis program geared to testing, treatment, and medication adherence.

In their study of migrant farm worker conceptualizations of health, Kelsey (2005) and Clingerman (2006) found the following themes: 1) health-promoting behaviors are recognized and valued, but are economically and legally influenced; 2) traditional gender roles of migrant farm workers are influenced by family structure; 3) health worker caring is perceived by migrant farm workers as respect, demonstrated by the use of Spanish and the acceptance of traditional cultural values, beliefs, and practices; and 4) health behavior is influenced both by tradition and by knowledge acquired by formal and/or informal means. Overall, it is apparent that studying the health beliefs of the migrant farm worker population

has impacted the nature and provision of migrant health programs, as well as the overall knowledge of health care strategies for this specific vulnerable group.

Perceptions of Control

Perceived personal control is a learned expectation that outcomes are the direct result of one's own decisions and actions (Rotter, 1966,1990; Ross, Mirowsky, & Cockerham, 1983; Mirowsky & Ross, 2003; Wallston, Wallston, DeVallis, Stein & Smith, 1996).

Persons who believe that they are in control of their own lives look for information that will guide them to the best health-related choices. These people believe that through their own informed choices, they are able to master, control, and alter their lives. This perceived control is the cognitive awareness of a link between efforts and outcomes (Mirowsky & Ross, 2003). Mirowsky et al. (2003) also described those at the opposite end of the spectrum, individuals who have a sense of powerlessness or who believe that their actions do not affect outcomes, but instead that outcomes are determined by other forces such as powerful others, luck, fate, or chance.

Parental Perceptions of Control and Health Beliefs

Tinsley and Holtgrove (1989) explored the hypothesis that utilization of preventative health services for children was directly related to specific maternal beliefs and perceptions concerning control of children's health, and that relationships exist between parental health beliefs/attitudes and health behavior. The literature is rich with studies that focus upon child health care and socioeconomic status, while eluding preventative pediatric healthcare related to mothers' health beliefs and their stress related to financial status (Mouton & Tuma, 1988; Roy, Torrez & Dale, 2003; Rodriguez & Olswang, 2004).

A study by Boyce (2005) examined the tension experienced by health care providers over whether to help immigrant families maintain their cultural heritage and/or to help them assimilate, as stated in parent's beliefs. All of the statements, to some extent or another, reflected the providers' belief that both the nation and the immigrants themselves would be best served if immigrant families assimilate as much as possible into the majority culture. The more flexible that providers and others were in applying a range of educational ideologies and assimilation models, the better able they were to address the native culture of those receiving their parenting advice.

Numerous studies suggested that children with a foreign-born parent have worse perceived health and are more likely to experience health barriers than to children whose parents were both born in the U.S. (Bates, Fitzgerald, & Wolinsky, 1994; Guendelman, English, Chavez, Hernandez & Charney, 1998; Capps, Fix, Ost, Grandados, Puvvula, Berman, & Dowling, 2001; Guendelman, Schauffler, & Pearl, 2001; Burgos, Schetzina, Dixon, & Mendoza, 2005). Children's health outcomes are linked to their parents' ability to speak English, the number of previous family generations immigrating to the U.S., and the child's birth and citizenship. All factors considered clearly indicate the vulnerability of the migrant farm worker child.

According to the U.S. Census Bureau (2005), the American Community Survey results show that 1 in 5 children in the US has at least one foreign-born parent. Other studies exploring health insurance and migrant children by Palloni and Moenoff, (2001), and Weathers, Minkowitz, Diener-West & O'Campo (2008) concluded that children in the U.S. are more likely to lack health insurance when they or their parents lack U.S. citizenship. Weathers et al. (2008) attributed this to a lack of familiarity with U.S. health and social

service agencies, as opposed to immigration authorization. Findings also indicate that insured migrant children have more need for care than the uninsured, despite their otherwise relatively greater resources and socio-demographic advantages. With this finding differing from other published findings, Weathers et al. (2008) offered the following propositions: (1) higher proportions of insured immigrant migrant children are pre-schoolers with chronic respiratory and GI illnesses and (2) most uninsured migrant children are foreign-born and may be selected (legally) for migration based upon the basis of good health. A recent study of Latino mothers' beliefs about food and nutrition (Gomel & Zamora, 2007) concluded that mothers incorrectly estimated the weight of their children, and did not consider weight (or underweight) to be a health risk factor.

Rural and Work Environment

In addition to remaining one of the most vulnerable populations, migrant farm workers are working and temporarily residing in rural farming communities where more challenges emerge, such as overall access to health care, scarce or unavailable health/social resources, and the presence of rural traditional belief systems that often marginalize seasonal workers as outsiders. Bushy (2000) referred to the sociocultural features of a rural community as informal daily face-to-face interactions, more frequent access to extended family members, informal support systems, population homogeneity, generational stability among residents, and a strong preference for local control. These features, coupled with the migrant farm workers' perceptions of disenfranchisement or marginalization, produce further sociocultural stress for them. Already separated by mainstream society through language barriers, education, literacy, economic oppression, and possibly undocumented immigration status, the rural environment factor creates additional burden, disparity and loss of control.

Farm workers represent a rural minority population with multiple, complex health care needs, who earn low wages, and who are forced to live in crowded and often structurally-deteriorating, difficult-to-access housing. They frequently lack transportation, work long distances from inadequately staffed health care agencies, and are susceptible to the challenges of weather and climate (Division of Health & Human Services (DHHS), 2002; Ward & Atav, 2004; Institute of Medicine (IOM), 2005). This hard-working, vulnerable population faces challenges that are highly predictive of their health and well-being.

In conclusion, over the past ten years, eighteen studies about migrant farm worker children's health have been conducted. The literature included a lifestyle questionnaire, limited measurement of health disparities in vulnerable children, provision of care to children of migrant farm workers, access to care, use of health services for children for migrant farm workers, migrant children's demographic fact sheets, nutrition and Body Mass Index (BMI) of migrant farm worker children, health status and barriers to care, and national averages for immunization status. To review, barriers for care have been addressed with focus on socioeconomic barriers and access to care. Noting the link between parental health beliefs and children's health status, I note the absence of studies that address the beliefs of migrant farm worker parents relative to their children's health. This finding in the literature supported the need for the research conducted here.

Summary of Literature Review

Several closing points can be made regarding the literature about migrant farm worker families and their health beliefs. There is a paucity of information regarding the impact of observed disparities on migrant children's health outcomes, although key factors

likely include nativity, immigrant generations and citizenship or characteristics of migrant farm worker parents.

Exploring racial and ethnic differences in health beliefs of parents will advance knowledge about disparities and poor outcomes in migrant children's health while also serving to identify those children who are the most vulnerable. The exploration of migrant farm worker parental health beliefs examined the associations among health beliefs, perceptions of control, and various demographic variables. This study provided important information concerning the potential improvement and positive outlook for the provision of migrant children's health services, basing its findings on the parents' perceptions and perspectives. In the context of this literature review, the next chapter will focus on the specific research design and methods used to address the research questions about migrant farm worker parental health beliefs.

Chapter III: Methods

Purpose and Specific Aims

The overall purpose of this study was to explore the health beliefs and attitudes of migrant farm worker parents. The organizing theoretical framework for the qualitative, ethnographic methods chosen was the Qualitative Research Process, as depicted by Miller and Crabtree (2003). Chapter 3 presents the specific aims, research questions, research design, sample and setting, methods, and procedures used in this study follow the Miller and Crabtree framework. Procedures included strategies for data collection, including research instruments, ethical conduct of study, data management, data analysis, and methodological rigor.

The study's Specific Aims were:

1. To describe the health beliefs of migrant farm worker parents from their perspective, in their own words; and
2. To describe the relevant psychosocial characteristics of migrant farm worker parents.

To address these aims, the research questions included the following:

1. What are the health beliefs of migrant farm worker parents?
2. What characteristics of migrant farm workers affect their parental health beliefs?
3. Do age, gender, ethnicity, family structure, religious beliefs, and number of years in the US affect parental health beliefs? What do migrant farm worker parents believe is the most important determinant of their children's health? Are their beliefs informed by their religious beliefs, cultural norms, family, traditions, or other factors?

Research Design

Consistent with the research questions and limited extant literature, an exploratory, ethnographic design was selected. Complemented by demographic information in the form of a short survey, an ethnographic design accomplishes the following goals:

1. Explores the values and priorities informing parental health beliefs, from their perspective.
2. Interprets and explains personal experiences that shape health beliefs, in the parents' own words.

This ethnographic approach was appropriate for the following reasons:

1. The migrant farm worker parents could be approached and interviewed in everyday settings and contexts, such as work locations in agricultural areas.
2. Data could be generated from multiple sources.
3. Ethnography is flexible and adaptable to the activities and rhythms of daily life.
4. The focus on a single group in a specific setting offers depth of understanding.
5. Verbal descriptions of the participants' perceptions and beliefs become situated in lived experience, in surroundings familiar to them.
6. Listening by the researcher offered validation and power to migrant farm worker parents who are seldom asked questions.
7. The respectful and ongoing presence of the researcher helped build trust and rapport among the participants and between the researcher and the participants.

Theoretical drive is defined by Morse (2003) as “the overall direction of the project as determined from the original questions or purpose and is primarily inductive or deductive” (p. 190). The theoretical drive of this study was inductive, discovery-based, and exploratory.

Congruent with the qualitative design and ethnographic approach, at the core of this study were the research participants. According to Harris and Johnson (1999), *ethnography* means “a portrait of the people” (p. 64), a written description of customs, beliefs, and behavior based on information collected in the setting where people live and work. Agar (1996) counseled that ethnography relies on a variety of methods to generate data. For this study, methods include interviews with migrant farm worker parents, a demographic survey, observations, field notes, and a reflective journal.

Throughout the research process, I experienced changing roles, from being the research instrument (during interviews), to being a participant (assisting in the clinic patient flow), to being an observer of parents seeking care for their children. A common ethnographic challenge or tension is functioning simultaneously an outsider and an insider. Narayan (1993) referred to this as a “shared subjective experience”. Although demanding, the ability to be accurate in one’s observations may be assisted by the use of journaling. A researcher’s journal reflects critical thinking, judgments, and decisions about the process and construction of unique social realities in the field (Flick, 2006). Journaling also captured whatever feelings, discourse, or troubling events arose during the course of the study, while gathering data from various sources served to cross-validate and reinforce information. Another important facet of ethnography was the observation and evaluation of the researcher by participants. Emphasizing the need in this study for the researcher to be both immersed in and aware of her surroundings and interactions, this bidirectional observation also supported the ethnographic dialogue that lead to shared meaning and understanding.

Concerns prior to this study were what to do when misinterpretations occurred in the course of interactions. For instance, when observing pauses, changes in body language, or a

participant's lingering difficulty finding the words to answer questions, I needed to provide verbal feedback. I further needed to reconsider all my initial thoughts about guiding the interview while remaining flexible. Being open to suggestions from my research assistant/interpreter while simultaneously remaining true to the research questions was also a priority. This need for objectivity and distance included constant self-appraisal to assess whether or not I was overstating my personal agenda boundaries. This was accomplished by evaluating every word and response elicited by participants. With these ideas in mind, I challenged myself to remain unbiased and authentic, while my reflections remained attuned to the day's experiences. Patton (2002) stressed the importance of keeping centered upon the aim of the research while guiding the interview process and to establishing/maintaining rapport and a sense of mutual interest with participants. Needing to de-emphasize differences and emphasize our connectedness as parents, I identified myself to participants not only as a nurse researcher, but also as a mother. Finding similarities between us as parents tended to lessen any powerful images associated with me due to my education or research and data collection.

Figure 1 depicts the Qualitative Research Process developed by Miller and Crabtree (2003). It helps visually represent the overall activities of gathering/exploration, reflexivity, interpretation/finding common ground, representation/documentation, and analysis/understanding. My data collection, management, and analysis followed this guide in sequence. The stages are intended to be descriptive and explanatory. They do not test relationships between/among the various procedures.

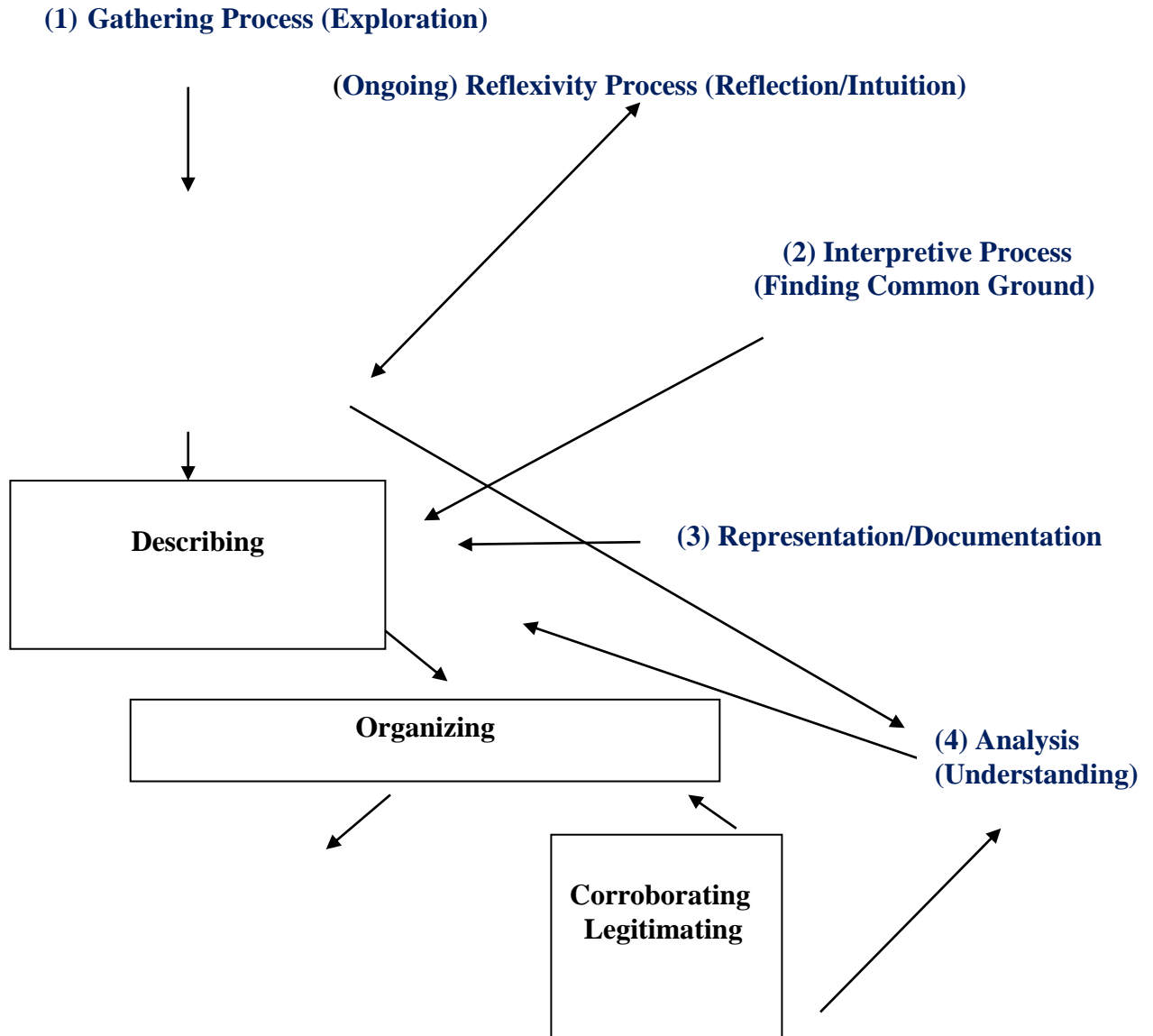


Figure 1: Qualitative Research Process

From Miller, W. & Crabtree, B. (2003). Clinical Research, In N. Denzin & Y. Lincoln (Eds.) *Strategies of Qualitative Inquiry* (p. 415). London: Sage. Permission of the authors and Sage Publications obtained.

The health beliefs of migrant farm worker parents were the primary focus in this exploratory study, with an emphasis on capturing and describing those beliefs in the participants' own words. Charmaz and Olsen (1995) posited that being in the place or scene

of the research assists the researcher in knowing the participants and contextualizing the process. Qualitative methods pull out those findings that are grounded in the real world without a pre-determined hypothesis, allowing ideas to develop further through participation, dialogue, and observation. There was no actual problem to be studied, as migrant farm worker health beliefs are not problematic per se; instead the goal was to understand how those beliefs influence health planning for children. Exploring those health beliefs in an environment of trust and cultural respect complimented my ethnographic perspective, while writing in the voice of the participants spoke directly to the reader. The interpretative process of qualitative ethnographic research was both artistic and political, as described by Denzin and Lincoln (2003). Perhaps this choice reflected my basic nature, as I discovered in pre-research reflection and journaling. To create the story as told by migrant farm worker parents became for me a natural, personal, and scholarly endeavor.

Qualitative research recognizes the researcher as the instrument, taking into account the experiences and perspectives of the researcher as valuable and meaningful to the study (Lincoln & Guba, 1985). A purpose of interviewing, one strategy for exploring others' perspectives is to obtain "here and now constructions" and "reconstructions" of "persons, events, activities, organizations, feelings, motivations, claims, concerns, and other entities" (Lincoln & Guba, 1985, p.268).

Gathering Process (Exploration): Sample and Setting

The potential study sample consisted of migrant farm worker parents presenting to the Salud Clinic in Brighton and Fort Lupton and the Salud Mobile Unit located in Fort Lupton, Colorado (See Appendix A for a map illustrating location of clinics). The sample was determined by demographics, culture, and status (migrant farm worker parents residing in

Weld County, Colorado) during planting and growing season 2009. Participants were comprised of a purposive sample of migrant farm worker parents who presented to the clinic with their child or children at the time of data collection and who provided informed consent to participate and be interviewed. A copy of the consent form can be seen in Appendix C. A *purposive sample* is defined as nonrandom, composed of cases (participants) that match the study purpose, as well as unusual cases, typical cases, and cases that display maximum variation in the group of interest (Lincoln & Guba, 1985). A purposive sample was selected deliberately to identify participants with characteristics or situations that pertain specifically to the research question and were selected for the purpose of gathering the most appropriate and valid data (Patton, 2002; Polit & Beck, 2008). At the start, 20 participants were anticipated to compose the sample size. This number was based upon previous exploratory ethnographic studies of health related beliefs of migrant farm workers (Poss, 1998, 2000; Wyss, 2004).

The largest agricultural county in Colorado, Weld County is the home of the Fort Lupton Salud Clinic, the original migrant worker clinic, which has been served the needs of migrant farm worker families since 1979. Inclusion criteria for the study were: parent or parents who presented with their child or children at the Salud Clinic or Salud Mobile Clinic, migrant farm workers, parents who were 18 or older, and parents of children who were not gravely ill (requiring a higher level of care). Exclusion criteria included: parents who were non-migrant farm workers, children who were accompanied by family members or guardians other than their parents, gravely ill children, parents less than 18 years of age, parents who were related to the research assistant, and migrant farm worker parents who demonstrated perceived stress (crying, nervousness, anxiety about time, inability to focus on questions).

The Salud system provides a full spectrum of high-quality, comprehensive, culturally competent, primary medical and dental care to more than 66,000 residents and migrant and seasonal farm workers in north central and northeast Colorado. Salud also operates a mobile clinic in Fort Lupton that serves to increase access to health care by migrant and seasonal farm workers. With nearly 400 employees, Salud currently receives more than 225,000 annual visits in northeastern Colorado.

As I traveled with the mobile unit, parents were told of the study by me, by my research assistant, or by nurses staffing the mobile unit and by other participants. I anticipated that some individuals might ask to participate as my research assistant or I would approach. The mobile clinic experience further enhanced my observation of the migrant farm workers in their environment, defined by Patton (2002) as “going into the field” (p. 48), and who also described the objectivity and neutrality of the investigator as learning through empathy. Patton referred to this as “empathetic neutrality” (p. 50).

I contacted the director of the migrant farm worker health program and the **Medical Services** Salud offers a full spectrum of primary care services at its family practice, adolescent and pediatric clinics including: director of research and education at Salud prior to my research, and then met with them to explain the study and answer questions. The study was met with both positive feedback and an interest in the potential benefits of the results. Background information, demographic survey and interview questions were left with the directors to promote their further understanding of the study, and they granted me permission to perform the study at the free-standing clinic and mobile units in Fort Lupton and Brighton, Colorado. A copy of the letter of permission appears in Appendix B. The director, with whom I continued to share updates, suggested data collection begin in the growing season

and continue until the number of participants needed for the study was achieved. Because Fort Lupton's population increases by an estimated 6500 migrant farm workers each growing and harvesting season, the clinic sees over 100 patients on a busy day, and we anticipated reaching sample size by mid-season.

In support of the ethnographic design and to address both Specific Aims, procedures for data management, collection and analysis will follow.

Exploration and Reflexivity: Data Collection

I collected research data with my research assistant present for translation and collection of demographic surveys. Three two-hour workshops were facilitated for the staff of the Salud Clinic. Workshops were scheduled to include nursing, management, and clerical staff at their convenience. Clinic personnel were familiarized with the study, demographic survey, and interview questions. Each session included an overview of data collection methods, protection of human participants, and potential benefits of the study. Attendees were ensured of the confidentiality processes with ample time allotted at each meeting for questions and answers. A notebook was assembled and remained at the site for reference. At timely intervals during the data collection process, informal meetings were held daily to ensure staff understanding and to answer questions and address any concerns. These meetings also served to ensure trustworthiness, a qualitative analogue of reliability.

Time spent in the clinic and with the mobile unit (128 hours over the course of three months) served to establish trust between staff and myself prior to data collection. A copy of the demographic survey may be viewed in Appendix D. Although migrant farm worker parents were approached in the pediatric waiting room at the Salud Clinic, a small conference room located adjacent to the waiting room had been designated for interviewing. Mobile unit

parents were told about the study on our arrival to the farm, and were approached outside of the unit. A small table and chairs were available outside of the mobile unit. Permission was obtained for audio taping of interviews. For participants who agreed to be interviewed, but did not agree to be audio taped, the following procedure was followed: The interview was conducted as a guided conversation (based on the research questions and follow-up questions), and I recorded occasional brief notes. Following the actual interview, I documented detailed field notes, emphasizing major points of information or perspective from the participants. At a later time, I recorded reflections and additional comments in my journal. The process was standardized according to the following steps:

1. I introduced myself as a Registered Nurse in graduate school conducting a research study and the research assistant as a Registered Nurse assisting with data collection and translation.
2. The informed consent process preceded all data collection for each participant. I emphasized that the consent was voluntary, and applied only to this study. Additional information was provided upon request to clarify the meaning of informed consent and the nature of the study. Participants were also told, “There will be no effect upon your child’s care whether you consent or choose not to be involved.” Unrestricted time was allocated for questions and answers; anonymity was assured and maintained by reminding participants to omit their name on the survey and instrument. Consent forms, completed demographic survey, interviews (written or taped), field notes, and journal were identically coded to guarantee association in case of separation. This coding for later analysis was devised and known only to me, so as to preserve the identities of participants.

3. Participants had the option of English or Spanish consent forms and demographic surveys. Participants also had the option to stop the interview if time was a constraint. If participants were not literate, my research assistant or I read the question aloud and documented the answer.
4. An honorarium in the form of a \$20 gift card was given to all participants who completed all or any portion of the study.
5. Patton (2002) and Sandelowski (2000) contend that saturation of qualitative data determines sample size, with saturation resulting as themes and responses become repetitive and no further conceptual categories emerge in the data. As saturation occurred, data collection was ended.

Both the Salud Clinic and the mobile clinic sites supported and cultivated conversations. Due to their reputations as “being safe” for migrant workers, nevertheless, there were unique differences between the Salud free-standing clinic and the mobile unit. While adherence to the above procedures was maintained, flexibility was essential to accommodate mobile unit participants. Because the mobile unit traveled to the farms, privacy was planned differently. Interviews were conducted outside and away from the mobile unit to ensure privacy. A small table and easily folded chairs were brought along. In the event of adverse weather conditions, an umbrella was kept on hand.

Demographic Data Collection

A short demographic survey (see Appendix E) provided descriptive characteristics of the sample and determined frequency and variability of the demographic characteristics of migrant farm worker parents residing in Weld County, Colorado. This demographic survey

was completed immediately after consent was obtained. Items addressing demographic information included age, gender, marital status, family structure, and religious preference.

Translation of Tools

All forms and surveys were translated into Spanish. To manage methodological issues involved in the use of translation, the back-translation method was used to obtain the most culturally equivalent instrument (Kim, 1999). My research assistant performed the initial translation of all instruments to Spanish, and the back-translation was performed by a faculty member of the foreign language department at Front Range Community College, Boulder County Campus, Boulder, CO (to be described in further detail).

In addition to helping distribute and collect demographic surveys, my research assistant helped with translation during the consent process and throughout the structured interviews. A Unit Coordinator for the family care unit at Boulder Community Hospital, she has worked as a Spanish translator for both campuses of the hospital for the past six years. She is a certified translator, and her experience in written translation includes medical and surgical consent forms, discharge notes for adult and pediatric patients, and other miscellaneous paper work at the hospital. Born in Mexico, she migrated with her migrant farm worker parents to California at the age of 6 years. She has lived in Colorado for 20 years. Over the course of one month, I oriented her to the study purpose and protocols. Her training included the following:

- How to introduce the study.
- How to administer the demographic survey
- How to obtain informed consent.
- How to respond to participants' questions.

- How to protect participant privacy.
- How to manage and maintain the data for the investigator.

Ethnographic Data Collection

Interviews. In this Reflexivity Process (Miller & Crabtree, 2003), health beliefs were described not through a theoretical framework but instead through the words and interpreted meanings shared by the participants living the experience. Each interview consisted of 6 semi-structured questions created for this specific study to identify thoughts and attitudes related to child health care, with emphasis on events that occurred prior to presentation at the clinic. A copy of the open-ended questions appears in Appendix E. Questions are original and have not been asked in prior studies. They were conceptually driven by the literature and developed by the investigator. Participant responses and elaborations for the questions were encouraged. Acknowledgment of the investigator as the research instrument supported the ongoing direct observation of participants and their situations, especially while I traveled with the mobile unit. Lassiter (2004) defined this approach as ethnography based on the following practices: participating in the lives of others, observing behaviors, taking field notes, and conducting interviews.

I also utilized a reflective journal as part of the qualitative data collection process. Reflective journaling allows for personal observations and cultural assumptions, and assists in analyzing personal experiences that inevitably shape the research process and outcomes (e.g., I have worked as a migrant nurse for a similar population in Colorado). Greene (2007) maintained that a reflective, thoughtful standpoint of intentional engagement with the premises, perspectives, outlooks and commitments of one's mental model is especially important in social inquiry, so did I find that my written words pushed me to acknowledge

my own thoughts, motivations, and speculations? Actually initiated prior to the study (to help me consider how and why I might choose a qualitative and ethnographic approach), the answer was yes. The reflective journal assisted me in focusing my attention and intention for the work. Freshwater and Rolfe (2001), Horsburgh (2003), Hand (2003), Fontana (2001), and Lipp (2003), all defined and recommended the use of reflection as an essential component of qualitative research methodology. All agreed that reflection assists in raising the researcher's awareness of personal ideals of how her research acts on the world and how the world acts on her research, and of how to be flexible in her interactions and actions.

Interpretive Process (Finding Common Ground), Representation/Documentation: Data Management and Data Analysis

Within the Miller and Crabtree (2003) framework, data management, and analysis, and understanding incorporated the following steps (Agar, 1996; Harris & Johnson, 1999; Miller & Crabtree, 2003):

1. All data, including interviews (transcribed), field notes and reflective journal, were entered into Word, then organized and meticulously read. I reflected critically on the meanings of data in individual components (e.g., separate interviews), and then as a whole (e.g., group data). This process was repeated for consistency, and a back-up folder of all data was also generated.
2. All textual data were next entered into a qualitative software package (E-Z Text (CDC software,)), for ease of numbering lines of text and further analysis. Benefits of this software included assistance with the coding process, allowance for the compact storage of transcription materials, and management and presentation of multiple data sources for the ease of analysis and conclusion drawing.

3. Text was synthesized and reduced as I searched for recurrent ideas and conceptual themes. Preliminary coding was initiated by developing potential names of categories (e.g., fear of deportation, inadequate financial resources).
4. Rereading all data sources identified repeated instances that supported preliminary interpretations. I looked for complex interpretations and alternative explanations to account for variations in data, employing intuition, analysis, description, and deep reflection throughout the process.
5. I composed research memos alongside categories/preliminary codes to capture the developing conceptual content and thinking.
6. From the initially coded documents, new documents were assembled with clustered data organized into commonly coded segments. Pieces not assigned were uncoupled from usable data and kept in a separate file.
7. Notes were read, coded again, and reconsidered for depth and/or additional information. Reflective journaling was selectively coded for relevance to migrant farm worker health beliefs. Codes were grouped into categories (data revealing similar meanings). From the categories, and through the process of repeated reflection, larger units of conceptual meaning (themes) emerged as linkages between or among distinct codes. Themes were presented as short sentences or descriptive phrases. This step represents synthesis of emergent findings across the collective/group data.
8. A codebook was assembled to define/describe final coding categories of distinct conceptual ideas. The codebook assisted in identifying relational patterns that became

the central themes. For example, the code for “obstacles to coming here today” was defined as Barriers. (Codebook may be viewed in Appendix F.)

Ethnography deploys researchers, either marginally or deeply into the lives of others. In ethnographic research, the most important activity is the interaction among participants in their own environments and contexts. It often becomes impossible for the researcher to separate the participants from the environment while analyzing data and considering themes. As this is the essence of ethnography, this separation is not problematic but instead descriptive of the participants in the contexts of their daily lives. Culture, environment, and beliefs are the pieces that create the whole picture of the individual and population being interviewed. As Agar (2006) explained, one challenge in ethnography becomes the question of what is meaning and what is context? He believes that findings can be both, depending on how the researcher perceives and interprets what she discovers. Therefore, reflection and further analysis may change one’s perspective as time evolves. Meanings of the findings may also translate differently with individual audiences.

Descriptive Analysis of Demographics

Demographic data analysis was performed by using SPSS 17.0 for Windows. Analysis included mean, medians, standard deviation, frequency counts and percentages, calculated to characterize the population. The results and summary of this analysis can be seen in Table 4.1.

Corroborating and Legitimizing: Methodologic Rigor

The criteria for ensuring the rigor of this ethnographic study were identified by Lincoln and Guba (1985), Morse and Field (1995), Watson and Girard (2004), and Guba and Lincoln (2000). The standards for rigor were: credibility/dependability, adequacy,

confirmability, authenticity, and the audit trail. Guba and Lincoln (2000) referred to this process as establishing and ensuring trustworthiness. Trustworthiness for this study was addressed by the following criteria: credibility, transferability, dependability, and confirmability. Each is explained below relative to this study.

Credibility. *Credibility* refers to the level of confidence the researcher has in the study findings. In quantitative studies credibility is referred to as internal validity. For this study, credibility was achieved through field notes and observations that augmented interviews. Lincoln and Guba (1985), (2005) judged credibility by the researcher's sustained engagement and observation during the interview process and other interactions with participants. The ability to access the same informants a second time in this population of migrant farm workers posed the greatest challenge in this study since the migrant population is frequently mobile in response to harvest requirements and growers' preferences. Member checks, defined as validating emergent findings with some of the same or very similar individuals, was accomplished by verbally repeating participant responses and by verifying emergent findings with individuals similar to the actual participants. It was important not to make any assumptions about the data, but to simply allow it to inform the findings.

Supported by Guba and Lincoln (2005), this strategy is referred to as "the participatory/cooperative paradigm" (p. 192) and "basic beliefs" (p. 197) for qualitative research participants. Credibility was also checked with a bilingual research assistant, especially for this study population. Proposing that relationship is the key to qualitative validity, Kahn (1993) explained that a methodologically convincing story addresses the following relationships: the investigator's relationship with the participants (how does each address the other during the study?), the investigator's relationship with the data, iterative

aspects of the research experience (how does the investigator relate, respond to and reflect upon, the data?) and the investigator's relationship with the readers (assuring intent). I documented and preserved all of this information in my reflective journal.

Transferability. In qualitative research, *transferability* refers to the probability that findings have meaning to others in comparable situations (Streubert & Carpenter, 1999). It was my responsibility to provide finely detailed descriptions in order for the reader or other researchers to judge transferability (Lincoln & Guba, 1985).

Dependability. Defined by Lincoln and Guba (1985) as an assessment of the quality of the integrated processes of data collection, data analysis, and theory generation, *dependability* is established with the demonstration of credibility. Procedures to ensure dependability in my study included a detailed audit trail of all research activities and outcomes (Lincoln & Guba, 1985), for the process was as important as the product. The product consisted of the demographic survey, semi-structured interviews, field notes, and a reflective journal. I used an independent reviewer (a faculty member at Front Range Community College who is PhD-prepared and familiar with qualitative research) to examine the audit trail, which consisted of the original transcripts, data analysis documents, field notes, reflective journal, and the dissertation text. He was also able to assess the completeness and availability of documents and the degree and significance of researcher influence.

Confirmability. Lincoln and Guba (1985) defined *confirmability* as a measure of how well a study's findings are supported by the data collected. It may also be determined by the extent to which findings are adequately portrayed as the participants' ideas and not the priorities of the investigators. Confirmability may be threatened as investigator biases,

motivations, or personal perspectives are imparted into the findings. In order to compensate for this likelihood, I acknowledged and documented personal biases and ideations, and confirmed that these biases might serve to co-create interpretations. These interpretations, along with the participants' responses, are integrated into research findings.

Ponteratto (2005) argued that investigator triangulation and peer debriefing should be accessed in the transcription, translation, and analysis of qualitative data to account for and neutralize bias and to ensure methodological rigor. To address this, my research assistant translated and transcribed Spanish interviews into English. Taped interviews were simultaneously compared to written transcripts. If coding did not allow for consensus, coding was re-analyzed, and specific content and findings were excluded from the analysis when a lack of consensus resulted. Peer debriefing about process, preliminary findings, and early conclusions was accomplished by debriefing another student in the dissertation phase of the PhD program at the University of New Mexico, along with my colleague PhD prepared faculty member at Front Range Community College, and my dissertation chair (a qualitative researcher). Regular communication was also maintained throughout this process with my dissertation committee.

Protection of Human Participants and Ethical Conduct of Study

The proposal and copies of the consent form (English and Spanish) were submitted to the University of New Mexico Health Science Center Institutional Review Board and HRRC for approval. Approval was received prior to contact with study participants.

I monitored the study protocol and the safety of all participants. All efforts supported the requirements set by the University of New Mexico Health Sciences Center Human Research Review Committee (HSC HRRC) or Institutional Review Board. There were no

benefits to participants. I anticipated that participation in this study would not cause any more discomfort than what migrant farm workers' typically encounter in their daily lives. Throughout the study, confidentiality and privacy were maintained by the following procedures: there was no documentation/recording of the participants' names on any record; interviewing took place in a room or an area set aside from human traffic; and participants were told that they could withdraw from the study or refuse to answer questions at any time, with no penalty regarding the care of their children.

Congruent with Patton (2002), Flick (2006), and Cavillo (2007), we monitored the potential distress of the participants, remaining attuned to any verbal or non-verbal cues. For the migrant farm workers, stress most likely centered on time away from work, fear of repercussion from employers, or possible legal issues surrounding immigration status. In order to address issues concerning immigration or fear of employer retribution, I utilized the following opening script (with translation as indicated by my research assistant):

I am a graduate student at the University of New Mexico and I am studying beliefs about the health care of children and how parents decide to seek medical care.

Nothing that you say will ever be identified with you personally. Your name will not be written on paper. As we progress through the interview, if you have questions about why I am asking something, please feel free to ask me. If there is anything that you do not want to answer on the survey, just say so. I will respect your time, and if you are concerned about returning to work, just let me know. Any questions before we begin?

Soy una estudiante de doctorado en la Universidad de Nuevo México y estoy estudiando las creencias en torno a el cuidado de la salud de los niños y cómo deciden

los padres buscar cuidado médico. Nada de lo que usted diga será identificado con usted personalmente, nunca. Su nombre no será escrito en ningún papel. Conforme avanzamos en la entrevista, si tuene preguntas sobre por qué le estoy preguntando algo, favor de interrumpirme y preguntarme. Si hay algo que no quiere contestar, no lo haga. Respetaré su tiempo y si está preocupado por volver al trabajo, déjemelo saber. ¿Tiene preguntas antes de que comencemos?

Potential Risks

Migrant farm worker parents may have lacked openness due to the fear of repercussion for their children or themselves from the medical/nursing staff or their employers. With self-examination of my own values and motivation assisting my personal ethical consciousness, I periodically examined my personal outlook, as I was the research instrument. Cross-checking values and motivations from my position provided the foundation for what I did and said as a researcher. Taylor (1993) contends that the willingness to explore the truth of our own motivations, desires, and fears determines our ability to be caring, flexible, and ethical: “When both researcher and study participant neither deny nor exploit, but rather acknowledge and honor, their relationship it naturally becomes ethical” (Taylor, 1993, p. 8).

Procedures to Minimize Risk

All identifying information was removed from audiotapes and notes prior to transcription, and no distinguishing information remained on surveys or notes. Instead, I developed a numeric code to identify sites and participants. The first two numbers reflect the site, and the last two numbers indicate the numbering of participants. For example, the

number “0102” identifies the Salud Clinic and the second participant, while “0203” represents the mobile unit and the third participant.

A log with consent letter, interview date/time, code number and survey number was stored in a locked file cabinet at the clinic and was accessible only to me. Another log of unique identifiers linking survey and interview participants to audiotapes was locked in the same file cabinet. Information was stored in my password-protected laptop computer, which can be accessed only by me. All surveys, tapes, and instruments will be destroyed at the completion of the study and after the dissertation defense.

Potential Benefits

Although there were no direct benefits to the participants in this study, potential gains include an increased understanding of the health beliefs of migrant farm worker parents. Data from this study may be useful to nurse researchers, health care providers, and migrant clinic administrators. I consistently monitored for unanticipated complications of my study (stress or anxiety in participants, exposure of identity), which would have resulted in the study’s immediate suspension, and a subsequent report to the University of New Mexico HSC HRRC.

Study Limitations and Potential Bias

The potential bias in qualitative research lies within the investigator as instrument. Early on in this research journey, I identified my personal and professional biases. As the process continued, I made regular entries into a reflective journal, and in this journal and in field notes, I explored and analyzed my potential biases. Denzin and Lincoln (2003) maintained that a bias or value-free research design does not exist; however, a qualitative researcher must tell the truth when telling stories of a population under study and be true to

the research questions. As potential biases were revealed, I noticed and recorded them, then considered their impact on analysis and/or interpretation. The major idea in qualitative research is that everyone sees things differently, and what is truth to the observer may not be the truth to the participant. Addressing issues of engagement vs. attachment in bias monitoring, Patton (2002) proposed that empathy and sympathetic introspection help reduce bias in qualitative research. My presence among participants assisted in building trust and rapport and provided a sense of connectedness. The specific potential biases in this study included the following:

1. In all qualitative data collection the researcher is the instrument and therefore is subject to preconception and prejudgment, possibly as the result of data expectations.
2. Sampling may have been biased, since word of mouth throughout the migrant farm worker community may have encouraged participation to obtain a gift card.
3. According to Patton (2002), the researcher's use of reflexivity data collection and data analysis may be affected by personal values. As one reflects, he or she becomes more in tune with personal feelings, which can potentially impact interpretation and meaning.

As the Salud clinic has the reputation of being safe for the migrant farm worker population, it was vital for me to maintain professionalism, respect, and gratitude for the ability to conduct this study. Appropriate safeguards were employed to protect participants throughout the course of my study.

Summary

In summary, I chose an exploratory ethnographic design to gain understanding of migrant farm worker parental health beliefs. Data were collected using (a) a short

demographic survey, (b) a 6-item semi-structured interview tool, (c) reflective journal, and (d) field notes. I kept field notes during the process to include impressions about sites and participants and to note questions asked by the participants. Field notes and reflective journaling generated additional data, and were included in the formal analysis. Rather than blocking out worldviews, reflection upon the interpersonal subjective process helped create further knowledge related to this study and augmented standard data analysis procedures. Data analysis procedures consisted of sequential coding, thematic analysis, and specific procedures for methodological rigor or trustworthiness. As the next chapter demonstrates, the completed study yielded both expected and unexpected findings.

Chapter IV: FINDINGS

Overview of Major Themes

Introduction. The purpose of this chapter is to provide the results of the study. A qualitative ethnographic design was utilized to explore the following specific aims:

1. To describe the health beliefs of migrant farm worker parents from their perspective, in their own words; and
2. To describe the relevant psychosocial characteristics of migrant farm worker parents.

To address these aims, the research questions were presented in earlier chapters.

Data consisted of demographic information to portray the study participants, interviews consisting of five semi-structured questions, field notes and journal entries. In reporting the findings, I incorporated informant responses alongside key points from my field notes and reflective journal. This decision honors the view that all of these items represent data that impacted the results and implications, especially in ethnographic research. All interviews took place at the Salud Clinic in Fort Lupton, Colorado, which has a reputation for long incorporating the Mexican migrant farm worker culture into its philosophy of care. As earlier noted, Salud provides family health and dental services to all age groups, with patients entrusting their entire families to Salud's care.

Descriptions of the migrant farm worker parents will be shared, in the context of detailed narratives they offered in response to specific questions regarding their health beliefs. These stories were both current and reminiscent, while the participants spoke of their farm-working health challenges and their commitments to their children and extended families. They often spoke of their ability to endure hard work and socio-economic struggles. True to their humility and cultural characteristics, the participants in this study

were both timid and trusting. I often felt that the farm worker parents were concerned about my comfort, given my novice conversational Spanish and obvious desire to demonstrate respect. In turn, I was simultaneously concerned about their comfort in engaging in a conversation with me. Mutual respect was shared among the research assistant, clinic staff and participants. A disquieting concern also began to permeate the environment as the waiting room filled with parents and children. Although I approached data collection with some trepidation, my anxiety dissipated with the completion of just one interview. Speaking with this special population was both humbling and gratifying for me as I was drawn further into their world.

Preparation for Study and Gaining Acceptance

Spending time at the Salud Clinic prior to collecting data was invaluable for the following reasons: 1) familiarization with the patient flow, 2) knowing staff members by name, 3) experiencing the uniqueness of Salud in comparison to other family health centers, and 4) determining the most feasible area in the facility to conduct interviews. At the onset of this journey, I thought the Salud Mobile Clinic would best allow me to access the migrant farm workers. After visiting with the mobile clinic on two occasions, however, it became apparent that the mobile unit was most frequently accessed by single male migrant farm workers, not whole families. The field notes I wrote while observing the mobile unit provide the following insights: 1) the mobile unit has a standard schedule that is agreed upon by the clinic director and the employers (farm manager or owner), 2) the mobile unit conducts business at a fast pace so as to limit the farm workers' time away from the fields, 3) the migrant farm worker men who require care appear to be rushed, and 4) some remaining farm owners have yet to consent to visits. As a result, cultural immersion and interviewing were

accomplished at the standing Salud Clinic in Fort Lupton, Colorado. The following is an excerpt from my field notes:

I spent my first day at the Salud Clinic with the medical director. On this day I met the staff and became familiar with the different departments. The staff was proud of their clinic and did not hesitate to show me around. I was struck by the wonderful posters on the walls. They were vibrant in color and filled with scenes of migrant farm workers in the field and with their children. I could not help but look at each and every one. I met all staff and wrote down their names. I wanted to ensure that they knew who I was prior to beginning data collection.

Nevertheless, a sense of uneasiness dominated my first day of data collection. A little uncertain about how I should position myself in order to be unobtrusive; I sat in the waiting room observing until my research assistant arrived. Seeking to remain humble and polite, I also needed to stay out of the way so as not to interfere with the patient flow. On the first day of data collection, I met with the clinic staff prior to the clinic's opening. After thoroughly reviewing the study with the staff, I incorporated all their suggestions. Involving the staff was a good decision, as they appeared to know that their opinions were taken seriously. The following is a paragraph from my field notes on this first day:

This morning, one of the younger clinic cashiers tentatively approached me and asked about my research. I explained to her that I was seeking information about the health beliefs of migrant farm worker parents. She proceeded to tell me that her grandparents and parents had been migrant farm workers for many years. She remembered being a little girl in South Texas and packing her things to come to Colorado during cantaloupe season. I listened intently to her story and was acutely aware of her respect for her

family. She made a point of telling me how special the farm workers are and how hard they work. This conversation provided me with new insight regarding the staff. I believe that she had become one of my fervent advocates.

It was the staff's recommendation that the cashier mention the study to patients at discharge if they met the initial criteria of: 1) being 18 years of age or over and 2) being a migrant farm worker parent. I was then notified to provide details about the study. If the patient did not speak English, the research assistant accompanied me. If the patient demonstrated an interest, he/she was accompanied to the office that was assigned to me for interviewing. After introductions, the consent letter was presented in either English or Spanish. After providing at least ten minutes for reading or being read to, we asked for additional questions or clarification of concerns. When we sensed any hesitation or uncertainty, we encouraged patients to consult with the Salud staff or with other family members. This occurred once, and the participant returned later in the day to complete the study. Some consistencies noted in participant responses were: positive outlook about the study, willingness to contribute, and the lack of questions from them as participants. Some noteworthy comments made after reading the consent letter were:

"Thank you for asking me to do this and to answer questions."

"It is nice of you to ask my thoughts."

"No one has ever asked my opinion before."

"I will do this for all the farm workers."

"It is important for you to talk to us."

"I am happy that you are here to talk to us."

"I have no questions, let's talk."

With each introduction, my research assistant or I clearly explained that identifiers were not necessary; however, participants consistently provided their first names and the names of their children. I attribute this to the respect and politeness inherent or natural to their culture. We encouraged the use of our first names as well. My initial discomfort quickly turned into relief. The following is a passage from my journal:

I am feeling so very fortunate, honored, and relieved that these wonderful people are sharing their thoughts with me, a stranger. Although I am a nurse, they don't know me, and yet they are smiling, warm, and willing to tell me stories of such personal depth. I am deeply aware that I am doing the study that I need to be doing.

By the second day of data collection, I was feeling more comfortable, as my field notes written that afternoon demonstrate:

By the second day of data collection, we were greeted by name and given badges that were programmed to open doors that were initially closed to us. It was as though we were members of the staff. I was very pleased but at the same time I remained aware that I was a guest and needed to act like one.

Description of Participants

Twenty migrant farm worker parents were interviewed for this study. The majority of participants were younger, married Catholic women with 2 or more children, accompanied by their mothers or mother-in-laws (See Table 4.1).

Table 4.1: Sample Demographics (N=20)

Gender	Marital Status	Age	Children	Family Members in Household	Years of Education	Religion
Males = 2	M=17	19-25= 2	1=1	3=2	0=1	Catholic=18
Females= 18	D=1	26-34=9	2=2	4=3	3=1	Unity=1
	S=2	35-40=8	3=10	5=4	4=1	Christian=1
		41-50=1	4=7	6=6	6=3	
				7=3	8=7	
				8=2	9=3	
					10=1	
					12=3	

In qualitative research, it is imperative that data accurately describe and portray the population's lived experiences. I promoted *trustworthiness* and rigor of data by ensuring lengthy interviews and encouraging depth in answers through repetition of responses, emphasizing key points and asking for more details. Being open to any suggestions by the research assistant serving as a translator was very important for me. I acknowledged her comments in the understanding verbal or non-verbal innuendos. Constant self-appraisal was necessary to insure that I was not crossing boundaries due to my research agenda. My field notes and journal enabled me to reflect on my daily ability to accomplish a non-biased attitude and to keep from becoming too emotionally involved. I also corresponded every few days with my dissertation chair in a kind of debriefing mode. Since the purpose of this study was to explore the health beliefs of migrant farm worker parents; its *trustworthiness* assessed how accurately and clearly the participants' words were described and interpreted. As indicated within the Miller and Crabtree (2003) framework, all transcripts were entered into

first into Word. The research assistant/translator assisted in reading and re-reading the first transcripts to insure that interpretations were not opposing. A Spanish instructor also read through transcripts of conversations to look for any mistakes in transference of data and/or interpretations from Spanish to English. He also examined the audit trail, consisting of the original transcripts, data analysis documents, field notes, reflective journal and the dissertation text. Field notes and observations augmenting interviews serve as credibility for this study. Verifying information by repeating answers to interview questions also served to validate findings. Finding additional insights and meanings in field notes and journal, along with comparing and contrasting interview responses, strengthened the results. The self-reflective of the journaling helped to keep me grounded and focused as I was interpreting the meanings of my interview texts.

Results

This study was concluded after conceptual saturation or redundancy (Lincoln & Guba, 1985) was met with the successful completion of 20 interviews. I followed the specific methods and procedures detailed in Chapter 3. Despite an abundance of dialogue, there was often an absence of words. Indeed, quiet intervals became not silence; but meaningful pauses in conversation. I often used silence when I believed that my words could not do justice to the spoken words of a participant. Sometimes a particularly moving response from a participant could not lend itself to being further captured and reduced without losing some of its meaning. These reflections were noted in my journaling as prompting silence on my part instead of additional words. At other times, participants would say that they could not describe in words what they were feeling. This may have been due to the translation of Spanish to English and English to Spanish. At the same time, though, some

of the participants were anxious to share every detail of their life experiences. In field notes, whenever possible I utilized words offered by the participant, and not my own words as a participant observer.

Midway through my first day of data collection, I had completed two interviews of migrant farm worker parents. Interviews seemed to be progressing slowly, which I attributed to my lack of experience. At first, I attempted to take notes that were as complete as possible during interviews especially during interviews that were not taped. I soon realized that my writing was taking away from my engagement with participants. It was also difficult and uncomfortable to unobtrusively write down every word. So, I put my pen and paper away and decided to concentrate on the conversation. I found that my truck provided a quiet place to reflect and write before and after each interview. The following is an excerpt from my journal:

It is a beautiful fall day, a slight breeze and about 52 degrees. I decided to sit in my truck and write. There are also small picnic tables for the staff. I love being outside. I can smell the crispness of the air and the smell of cattle. Sitting here in this rural farming community keeps me focused. I look across the field perpendicular to the clinic and I see some workers picking pumpkins. This landscape has made my writing easy.

The staff was consistently compassionate with their patients. As each new day of data collection began, I felt more comfortable. The staff addressed me by name and was beginning to visit me in between interviews. As my time at the clinic lengthened, I began to notice links and commonalities between and among participant responses. Although I waited until my data collection was finished to transcribe interviews and review notes, I began

making brief entries of obvious connections among interviews. Also noted in my field notes were interviews that captured more than words and responses to interview questions, they also tugged at my consciousness on a more political level. After my first day in the field, I found myself thinking: Why do they continue to endure such harsh conditions? Why are they always smiling? Why are they thanking me for asking them questions? I should be thanking them (which I did), but it never seemed to be enough. I began to uncover answers to these questions after several days of data collection.

I reflected upon the migrant farm worker parents' work ethics, family ties, desire to provide for their families (sending money to Mexico), care and concern for their children's health status, and appreciation for health care for themselves and their children. In my quest to remain an outsider and yet become part of the clinic environment, I struggled to keep my emotions under control while not appearing too reticent during interviews. Clearly, my past experiences as a clinician and rural connectedness played a central role in this scene. Reflecting on this point, I was apprehensive that my empathetic responses to the migrant farm worker parents would color descriptions in some distorted way. Well into my study, I discovered that any attempt to write notes without personal feelings would have further distorted my perceptions and discounted important insights. This realization supports the idea of researcher-as-instrument in qualitative inquiry, and it is appropriate to acknowledge this fact.

As data analysis progressed, patterns of relationships between pieces of data emerged, thereby creating themes (see Table 4.2 for Data Analysis Procedures).

Table 4.2: *Data Analysis Procedures*

1	All data were entered into Word, including transcripts, field notes, & journal
2	Data were organized and read with critical reflection (separately and as a whole)
3	All data were entered into an ethnographic software package (CDC EZ Text)
4	Text was synthesized and reduced, and preliminary codes were written
5	Text was reread and interpreted with alternative explanations for variations
6	Research memos were composed alongside categories/preliminary codes to capture the developing conceptual content and thinking
7	From initially coded documents, new documents were assembled with clustered data and organized into commonly coded segments
8	Notes were read and coded again (see Appendix F for listing of final codes), and codes were grouped into categories with larger conceptual units or themes emerging as links between or among codes. Data on health beliefs were reviewed and compared to all other transcripts through constant comparison, and codes were then developed into themes. Themes were presented as descriptive phrases or sentences
9	A chart was assembled to assist in identifying central themes and sub-themes

(Agar, 1996; Harris & Johnson, 1999; Miller & Crabtree, 2003)

Themes concerning healthy children, strength through family, respect, and trust permeated each participant's story. In the majority of instances, because these data could not be prioritized, they were included in their entirety in no particular sequence. Themes directly related to parental health beliefs were developed from coding synthesis and integration, and emerged by reflecting on the following questions: 1) What is the importance of this piece of data? and 2) How does it relate to the other pieces of data? An overarching theme was described as "Pride in having healthy children", which permeates all the major themes and threads itself throughout interviews. Some pertinent comments from parents follow:

I am proud to have 4 kids that are healthy. I am careful what I let them eat and they don't drink a lot of soda, which we can't afford anyway. Sometimes not having money is good!

We're only here for the season, our children are healthy. We're so much proud of this. Other farm workers like us are not much lucky. They wonder why they don't have always-healthy kids. For us, their health is the much more important gift we have as a family.

My surprise was generated not by their happiness that their children were healthy but instead by their pride and ability to put into words the intensity of their feelings, as noted in this passage from field notes:

As I listened to this mother and father speaking about their own healthy children, I noted a gleam in their eyes. They spoke of other children who were not as fortunate and they became tearful. They want to speak of health in a way that emphasized their pride. I noticed that they were grateful but took full responsibility for obtaining both preventative and acute care for their children. Both parents hugged me and thanked me for listening to them. Once again, I thanked them, for it was through listening to their story that I became fully aware of the significance of having healthy children to the migrant farm worker parents.

I tried to express in my journal the level of my emotions, but the more I reflected on the farm workers' pride in having healthy children, in the context of poverty and limited power, the more I felt sad. I could not write an entry.

As analysis proceeded, four major themes describing parental health beliefs emerged: *sense of kinship, a matter of convenience, respect as parents, and inhibition/suppression.*

The following paragraphs will assist in explaining the emergence of each theme, validated by direct quotations from the participants, as well as excerpts from my field notes and journal.

THEME 1: A SENSE OF KINSHIP: “I know everyone here and they know me, even the waiting room turns in to a group hug.”

A strong sense of community exists between clinic staff members (doctors, nurse practitioners, medical assistants, and clerical staff) and their patients (all races). This sense of community and close kinship was quite obvious among the farm worker parents and the staff. Comments made by several participants strengthened this theme:

They help me and my children whenever we need them.

I can walk in without an appointment and they see them.

I know that they will take care of my children, just like my family does.

Every time I come here, I see someone else in the waiting room that I know.

Everyone that I know comes here for their health care.

It usually turns into a group hug.

Sustained *sense of kinship* is evident in the long-term employment of staff and the patients’ ability to know staff by name, and the staff’s familiarity with their patients. All staff is bilingual and initiate all conversations in Spanish. If the patient responds in English, the conversation turns to English. The staff and personnel at Salud have been employed a long time and demonstrate their bond through their teamwork and familiarity in conversations. At the outset of this study, this obvious sense of community added to my discomfort, since I was an outsider. I soon realized, however, that the staff believed my study to be important, as evidenced by their interest and assistance. Because migrant farm worker parents demonstrate an almost naïve trust in the staff, I wondered if there were too

much trust. As a stranger, I was overwhelmed by the innate trust shown specifically to me. The question became whether the trust arose from my presence at Salud or from my being a nurse. Was this dynamic a positive or a negative, and could it have influenced my research?

I was sitting in the waiting room awaiting our first interview of the morning. A young mother with 2 toddlers and a new baby were sitting across from me. She asked me (in Spanish) what I was doing and if I worked there. I explained to her that I am a nurse but I do not work there; I am a student at the University of New Mexico and I am conducting a study about migrant farm worker parents and their health beliefs. She asked if she could help me with my study and I said of course, but let's wait until you and your children are seen by the doctor. When you are seen by the cashier, she will call me and we can talk. I asked if that was OK with her. She said yes. I added that I would not want to keep her if she had another appointment. She said no, I want to do this. She then asked if I would watch her baby while she took her 2 children to the bathroom. I said that I would. The baby was asleep on her lap and did not wake while she placed him into his infant seat. I waited for her to return to her seat. She thanked me and told me that she looked forward to talking to me later. I was not sure that she would find me to follow-up but about 1 hour later, the cashier called me and stated that there was someone at her desk who asked to see me. I was pleased. She came to the office and after discussing the study and clarifying questions, the interview began.

The sense of kinship that developed so quickly at the clinic helped me focus on assessing the number of family members living together and hence allowed me to determine the decision-making power of the parent. In most cases, a mother made the primary decision

to take a child to the clinic: in nine instances, the mother made the primary decision to bring the child to the clinic, whereas seven decisions were made by either the parent's mother or mother-in-law. Two parents consulted their mothers and fathers, and two parents consulted their fathers. Of the 20 participants, 15 parents stated that they consulted with their mother or mother-in-law with all family decisions. Some parents seemed surprised by this question, as noted in the following dialogue:

Participant (P): "I make all the decisions about the health care of my family. My husband, her (the baby's) grandfather certainly doesn't make any decisions, and if he did they would not be right with me."

Researcher (R): *Laughing*. "So, do you consult with him at all when a child is ill?"

P: "No. *said in a loud voice*, He does not know and if I don't take them, no one will."

R: "Do you drive?"

P: "I do everything. I have been working in the fields for 20 years." *She is wringing her hands and rubbing her wrists*. I notice that both of her wrists are very swollen and slightly deformed.

R: "I notice your wrists are swollen. Are they painful?"

P: "Si, it's how you say something tunnel."

R: "Carpel Tunnel? In both wrists?"

P: "Si, but I want no surgery, it is just from picking potatoes for so many years"

Laughs and smiles at me.

R: "It looks like you are in a lot of pain." *Long Pause. The baby starts to cry. She reaches on the floor for her grand baby's car seat and cannot lift it. She again attempts with both hands but cannot lift.* "Can I help you with that?"

P: “Please sweetheart, could you hold the baby for me while we talk?”

R: “Of course I will. How could I not hold a baby?”

She smiles at me and says thank you.

After reflecting that night, I realized the significance of this woman’s entrusting me with her grand baby. I could not stop thinking of her and how much pain she was in at the time. I am forever thankful to have met her, and I worry about how she continues to work and care for her grandchildren. I ask in my journal:

How many more women have a similar story? How many women suffer in silence? I need to understand what drives them to be so accepting of their situation and yet remain stoic. Although I may never see her again, she will be forever in my thoughts.

THEME 2: A MATTER OF CONVENIENCE: “I wait to come when someone I know is coming.”

The socio-economic status of parents emerged as having the most negative impact on migrant farm worker parental health beliefs, most specifically, the lack of transportation. Parents prioritized their children’s needs over their own needs, such as taking advantage of rides with others whenever the opportunity arose, including trips to the clinic.

With flu season having just began and with the looming threat of H1N1, the clinic waiting room was full of parents and children. It was also nearing the end of farming season, when many migrant farm worker families were either returning to Mexico or following the migration to warmer climates. As some families were visiting the clinic for the last time prior to returning to Mexico, their reliance on the convenient healthcare available at Salud became clear:

P: "If I don't get my children seen before Thursday, they will have to travel sick, and I don't want that. I have 4 children and 3 of them have colds and fevers."

R: "Do you travel to the same farms each year?"

P: "Yes, the children, my mother, and my father-in-law will be going back to southern Texas, but my husband and oldest son are going to Florida."

R: "How old is your oldest son?"

P: "He is 19, and he wishes to stay with his father and work. I am praying to God that this will be the last time for him, and he will change his mind about school."

Another mother was returning to Mexico the following day with her mother and infant, who was "spitting up too much":

P: "I hate to leave but my mother wants to get back to Mexico, my brother is there and he is expecting his first baby any day."

R: "How will you travel?"

P: "We have saved enough to take a bus to Texas; there we will meet up with my cousin who will drive us. I just want to make sure that he (the infant) isn't sick."

Although a majority of parents had children with symptoms, one mother was acting on the side of prevention:

P: "Both of my children have been in classes where someone has had the new flu. I want to see if there is anything I can give them to protect them from getting it. I heard there was a new shot and I want to see if it is here."

R: "Do your children go to school here?"

P: "Yes, one is in kindergarten and one is in 2nd grade."

R: "Oh, so you live here all year?"

P: “Yes, I decided to stay here with the children and my mother, but my husband has already left to work in Arizona. He got a job on a ranch to work with horses.”

R: “Oh, it will be cold here soon. Will you be able to go there too?” *Pause*
(interrupted by cashier)

P: “He is going to see if the owner has a place for families to live. For right now, he will be living in a bunkhouse with many ranch hands so I doubt that will happen. I like it here though, and my children go to a nice school.”

Another woman asked her daughter-in-law to take her to the clinic to have her blood pressure checked, and the daughter-in-law decided to take her baby along and get her vaccinated at the same time.

P: “I don’t always have a ride so I decided to take the baby as well, and get her vaccinated.”

R: “How old is your daughter?”

P: “She just turned 2 months.”

R: “She is beautiful. You take very good care of her.”

P: “I have to make sure she stays healthy. I lost a baby 2 years ago to pneumonia so I am a bit too much worried.”

R: “I am so sorry for your loss. You are a very good mother and I don’t think that we can worry enough about our children, *laughing*, I am a worried Mom, too.”

P: *Laughing* “Good, then I am not alone as a crazy mother.”

R: “No, you are not.”

P: *Smiling and touching my hand.* “Thank you.”

Related to this theme, were the transportation issues that parents described.

P: "I really wanted to come 2 days ago when my 2-year-old first became ill."

R: "You sound upset about that. Why couldn't you come?"

P: "I had no way to get here." *She is visibly upset and tearful.*

R: "Here is a tissue. I am sorry that I upset you."

P: "It's OK, I just worry about my son and I am here today." *Smiling.*

R: "Well, I am glad that you are here. How did you get here today?"

P: "My brother had an appointment today, so I decided to come along. It was more convenient for me to come with him and he did not mind. He said he would give us his appointment if we could not be seen."

R: "You are lucky to have such a nice brother."

P: "Yes, I am very lucky."

One migrant farm worker mother stated:

If someone in my family has an appointment or is coming to the clinic, I try to make an appointment for the same day or I go with them. This way we don't have to worry about finding many rides. Even if my children are just a little sick, I will come and have them checked.

An observation recorded in my field notes:

This morning I heard the children crying and screaming as though all were not feeling well. We entered the clinic and walked through the waiting area. As we walked by the concerned mothers holding their children, we were met by pleasant faces. Once in awhile, someone would smile and say "hello or good morning". It was as if they were waiting for one of us to assist them. Some mothers appeared to be holding their children tightly while struggling to smile. There is a small area of the waiting room

set up for children to play. Many toys and children's books written in Spanish and English are camouflaging a brightly colored rug. I wondered why there were no children playing, but as I looked about the waiting room, I realized that it was better that they were staying close to their families due to the threat of spreading infection. There were many signs instructing patients to use hand sanitizers that were strategically placed about the waiting area. I finally began to hear some laughter among the patients. It appeared that many of the women knew one another, especially the older women who accompanied their children and grandchildren. At one point, all eyes were focused on the door, as patients waited for their names to be called.

THEME 3: RESPECT: "They listen to me and don't act like I'm stupid."

Sixteen of the 20 participants rated *respect* as the most important determinant of choosing health care for their children. How is respect demonstrated? Many participants mentioned health care providers listening, greeting them by name, engaging in conversation, and allowing family members to remain in treatment areas. Allowing family member access to treatment rooms was professed as being vital to overall parental decision-making, for it demonstrates respect for the family unit. Following are some responses from informants on this theme:

It is important that my family is involved in the care of my children and that their being there is seen.

I need my family to help me make important decisions.

Although I make the final decision, I need to ask my family's opinions and everyone needs to know this.

Listening is paramount to feeling respected:

They hear what me and my kids say, every word.

It's the listening, they listen to me here, and it makes me feel like I'm a good mom.

It's very important that they listen to my children. Children are different and they can't explain things. My 4y/o told the doctor that he felt crabs scratching his throat, a doctor at another clinic didn't even listen to him but here they knew that meant he had a sore throat.

I would walk out of the room if I thought that someone was pretending to listen.

It is respectful to listen to what someone is saying to you, just as I listen to the doctors and nurses.

I was explaining to the doctors my worries about my son's slow language and the doctor said, "Oh it's OK, it'll all be OK", without really listening to my concerns. I am happy when they listen to my worries. Here, they talk to me, they look at me.

I may be a young mother and I need help but I also want to be respected as a mom, sometimes doctors and nurses talk to my mom instead of me, but here they talk to me.

I would rather have a doctor respect me as their father than attempt to speak to me in Spanish.

They respect me as a mom.

Don't think I don't understand what you're saying if I am quiet. I show respect by being quiet and listening and I want the same.

Clearly being respected as parents by clinic personnel impacts significantly the parents' choice of health care provision for their children. I do not believe that respect is primarily indigenous to the migrant farm worker population because in patient care satisfaction surveys, respect is a recurring theme on pediatric units; parents often relay anger when they are not listened to or acknowledged. Although respect for parents may be a collective expectation of care, respect is nevertheless a major factor in migrant farm worker parental health beliefs.

THEME 4: INHIBITION AND SUPPRESSION: “Why would I tell a doctor or nurse what to do?”

In every interview, I asked the question, if you could give advice on the care of your children, what would you tell the doctors and nurses? This question raised the most discomfort for participants. At times, I was taken aback by the body language and responses that I received. The following responses, interspersed with field notes, will reveal the intensity of the participants' replies:

Why would you ask me this? I would never question a doctor.

Field Notes: I attempted to stimulate further conversation by asking, “Perhaps there was something that you wanted done in addition to the present care provided?” I did not get the response that I intended but instead: “You’re a nurse; would you want me to tell you what to do?” I reiterated that I would because it would be important for me to know that your needs as a parent were being met. The response was: “I could not do that; it is disrespectful.” I thanked her for her honesty and proceeded to the next question. It was apparent that this mother had strong convictions of respect.

They never do anything wrong and if they did, I wouldn't know it. It is considered disrespectful in my culture to question someone of a higher status than we are.

Field Notes: I asked; If they needed anything would they ask for it? Their answer was, "Yes I would, but I wouldn't question anything." Again, although hopeful for continued dialogue, I was met with silence. I respected their silence and moved on.

I am comfortable here; why would I say anything to hurt this?

Field Notes: This father averted his eyes to the floor when speaking. He spoke very quickly in Spanish and was difficult to follow. He kept his hand over his mouth while speaking. As we continued with the interview, he was quite verbal in all responses with the exception of this particular question. He had a genuine presence coupled with bright, gleaming eyes. At the end of the interview, he thanked us and apologized for his teeth. He ended by saying, "Thank you for listening to me. My teeth are in bad shape and I am much embarrassed, but I am not here for me; I am here for my children."

I don't know why you are asking me this.

Field Notes: I told her that I was asking because I wanted to know if there was anything that could be done better. She said "No, they do everything for me and my children here. There is nothing that could be done better." I believed that she understood why I was asking, but she would not provide any suggestions.

I don't know their job and they don't know mine.

Field Notes: I asked: Even if you don't know their job, would you tell them if you needed something additional in the care of your children. She replied; "Oh yes, I would ask them anything and they would do it; I just wouldn't make suggestions about something I know nothing about."

I was painfully aware that this question did not provide me with any substantial insight about migrant farm worker child care. However, it did provide me with a vast understanding of their level of reverence for health care providers. This reverence was unwavering and cemented into their cultural beliefs. The following is a passage from my journal:

If participants were given time to ruminate, would they become more relaxed with this question? Would they find some suggestions for care? Or, would they become irritated that I asked them to think about it? I need to think about my future research. Would there have been different responses if the question had been asked outside of the clinic, in a neutral but familiar area?

The Cultural Factor

Although respect is the most looked-for characteristic in a health care provider, at least 50% of the participants appreciated the fact that Salud was familiar with their culture and language.

I had my baby at the hospital and there was nobody that spoke Spanish in the ER. After my baby was born, there was a housekeeper that spoke to me in Spanish. It was not good until my family came to my room. I wouldn't go anywhere but here for me and my kids.

It is great to know people who understand my needs.

I understand what they are doing to my children and I can ask questions, even if they sound stupid.

They do much more than explain the drugs and they do it in Spanish.

Surprised, however, that cultural factors were minimized by some participants, I wondered whether this was due to the consistent cultural humility demonstrated by the Salud clinic staff. Familiar with Salud, participants in my study considered it their sole health provider, even as the growing season came to a close. The patients also demonstrated an unspoken appreciation for staff who spoke Spanish, as evidenced by the familiar chatting and socialization between staff and patients. Whatever the case, one participant did not see knowledge of his language as an important factor:

It's not so much the Spanish, I don't care about that. I just want things explained to me.

For one participant, the Mexican culture was seen as a mechanism for comfort and support especially when western explanations failed:

When I do not understand all of the words about medicine or care by the doctor, even if they speak Spanish, I rely on my parents to help me.

Sometimes, I go to my great-grandmother for old-fashioned remedies.

They really work, you know, and it makes me feel like I did when I was little.

Although one migrant farm worker father had a negative perspective of his culture, he had an impressive ability to share his sense of identity and self-esteem:

I am trying to fit in, to be an American and not a Mexican farm worker. Some of my people don't have any hope for the future. I must have hope and I must encourage my children to have hope. I come to Salud, not because they speak Spanish and are familiar with my culture. I come because the doctors are good. I don't care that they speak to me in Spanish; I would rather speak English. I am not

an illegal immigrant. I live and work here all year on a large farm. I don't need any protection.

How to Use a Gift Card

"I don't know what this is"

Gift cards were met with both surprise and gratitude. After the completion of several interviews, one parent asked, "What do I do with this if you don't mind?" Her softer voice and her downward gaze to the floor indicated that she was embarrassed to ask. As she averted her eyes, I said to her, "I am sorry that I did not explain. This card is just like having twenty dollars in cash, but you must use this one at Wal-Mart. I also have one for Safeway, if you would prefer." She responded "oh thank you very much; this one will be fine and I will use it tomorrow." I felt bad that I had not explained in enough detail to the previous parents. Fortunately, a staff member told me that she was explaining to the farm workers how to use the card because they were embarrassed to ask me. I continued to ensure that I provided clear instructions on how to use the gift card.

SUBSIDIARY THEMES

In reflecting on the major themes just presented, I also derived some secondary or subsidiary themes—subthemes—that echo through the study with a little less frequency than the major themes, and through the interviews with many of the participants. The six subsidiary themes follow:

Why Salud? : "We'd all be dead without them."

When asked why they chose Salud over other clinics or urgent care, only two participants mentioned that the care was free.

I do not have to worry about money. If my children need care, I can worry about them and not the money.

I hate to borrow money and I have no insurance. I don't have to worry about it and I don't need to have an appointment.

When asked about the fact that Salud's program is based on cultural needs, responses were again bewildering.

It's not the Spanish; I don't care too much about that. It's the listening. They listen to me here, and it makes me feel like I'm a good Mom.

Only one respondent spoke to legal issues:

They are good to me and my children and they don't ask questions about my family's legal status.

In God's hands. Although all participants had strong religious affiliations and 80% of the participants were Catholic, only two referred to her children's health as being influenced by God and prayer.

I know that my children's health is covered because I pray for them all of the time.

My family also prays for all of the children around us in all of the fields.

I can only do so much for my children. If they become sick, I take them here, but God decides if they should get better. My faith in God helps me deal with everything in my life, no matter how bad. God helps me get through everything that is hard for me and my family. If God decides that my children must get sick, then so be it.

Giving Good Medicine. "I never feel like my kids are treated unless they get medicine."

They give good medicine here, not just tests and lots of questions.

If I don't get medicine, I visit my Abuela. She gives my children tea and herbs but here they always give good medicine. [Note: Abuela means grandmother.]

Family Matters: "Our whole family helps with the children"

The entire family matters in terms of both their presence and opinions. Because a close relational fabric exists within migrant farm worker families and among seasonal migrant worker families, parents neither refuse assistance nor hesitate to ask for it when their children need help. In particular, families seek assistance in caring for children, request help in making decisions, and look for emotional support. Most often this assistance comes from grandparents or in-laws. One half of the migrant farm worker mothers were accompanied by either their mothers or mothers-in-law, and in two cases, both were present. One woman asked her mother if she should answer study questions. Her mother replied "Si, muy importante."

The migrant farm worker family experiences a sense of shared responsibility for children's health and well-being. One young mother addressed the daily contact that she maintains with her mother-in-law:

We don't live with my husband's parents. My father-in-law still works in the fields, so my mother-in-law and I chat everyday over breakfast at her apartment. I always help her to make her bed and do some cleaning. She looks forward to my visits and I think it keeps her healthy."

It was not uncommon to learn that many family members live together; indeed three generations living together appears to be the preferred situation rather than one of convenience.

We have lived with our parents every season. We want to be together to support each other in the care of the children and cooking. I never want to live by myself.

My parents and my husband's parents all live with us. Sometimes my brothers and sisters live with us also, depending on where they end up working, but the 6 of us are always together. We clean together, cook together, and go to church together.

Family values have a strong correlation with work ethics. During season the majority of migrant farm workers are forced to leave their families behind in order to follow work opportunities, although some families travel together for part of the season. With workers continuing to provide for their families by sending money to Mexico, the support of the family is matter-of-factly mentioned by all participants.

No matter where we go, my family is the most important thing to me. I would not survive without them.

My mother is my rock, and I cannot imagine my life without her.

Elders of the family especially grandparents and godparents, are considered responsible for caring for children if at any time parents are unable to do so. Sometimes grandparents assume direct parental roles, as noted by one "Abuela":

I am the children's Abuela. My daughter is being seen. I am always with them.

They give me a reason to continue to live. There will always be work to do for my family.

Staying Positive

Throughout this study, I never experienced negativity from the participants. Satisfied to have found work in Colorado, they loved working with their families in the outdoors. No

one frowned, and they were particularly thankful for the health care provided by Salud.

Believing in strength and survival, they attributed these qualities to being employed, working outside, and having large families.

The Value of Education

Some of the workers sacrificed so their children might attend school and not have a future in the fields, while others felt a special bond and deep pride for field work:

My parents were both migrant farm workers in Texas. I worked in the fields until I was 12 years old. My parents wanted more for me so they made me learn English and sent me to school. My husband's family are all migrant farm workers but he works in construction. Some of them do not approve of this decision. Working in the fields teaches you very much. No one should look down on us. We work very hard. I do not want my children to do this work. I worry much of the time about this. Their education is important to me but they must be healthy to go to school.

A migrant farm worker father stated, "If it is good enough for my parents, it is good enough for me and my children." Taking great pride in their work, many parents seemed to feel as one mother did:

I worked in the fields for 10 years and I just got my first job at Wal-Mart. I miss the work you know. We were all so close. We had fun even though we were working in the hot sun. We worked from sunrise to sunset and we made the best of it. I will always remember my family working together and laughing. They never complain and are thankful to have work. I do not feel that anymore. I have no friends here and no one smiles. To tell you the truth, I would rather be outside working again. I would not care if my children decide to work in the fields. If it was good enough for my

parents and grandparents, it is good enough for me and my children. It would be disrespectful of me to do this. But if they want to go to school to become something else that is fine too. I will not push them either way.

Although each participant's response was unique, all participants shared one attribute of all themes and subsidiary themes: strong relational linkages.

Critical Analysis and Synthesis of Themes

This qualitative study informed by ethnography provides an in-depth understanding of the health beliefs and characteristics of migrant farm worker parents. The overarching theme identified and threaded throughout all other themes and subthemes, is parental pride in having healthy children. The four major themes identified during the process of data analysis represent the migrant farm worker parents' views of their children's health and preferred attributes of children's health care provision. The four major themes are: a sense of kinship, a matter of convenience, respect, and inhibition/suppression. The following table (4.3) organizes and summarizes themes, categories, and subsidiary themes.

Table 4.3: Themes, Categories of Themes and Subsidiary Themes

Themes	Categories of Themes	Subsidiary Themes
Over Arching Theme: Migrant Farm Worker Parents Demonstrate Pride in Having Healthy Children		
Theme I: Sense of Kinship	A. Salud as community B. Familiarity among migrant farm worker parents in the waiting room C. Familiarity among staff members D. Familiarity between staff and patient population	<ul style="list-style-type: none"> • Staying positive • Support • Comfort • Seeking Help
Theme II: A Matter of Convenience	A. Taking advantage of transportation when available B. Socio-economic depression influencing lack of transportation C. When health care is not necessarily acute, taking advantage of preventative care or impromptu check-up D. Appointments are not always necessary	<ul style="list-style-type: none"> • Flexibility • Strength

Table 4.3: Continued

Theme III: Respect is the most desired attribute in medical personnel	A. Respect for parents B. Respect of extended family members C. Respect and care for children D. Listening to parents E. Listening to children F. Ensuring the understanding in any language G. Not making assumptions about language	<ul style="list-style-type: none"> • Family Matters • Cultural Priorities • Acknowledgement
Theme IV: Inhibition and Suppression	A. Innate and unquestioning respect for medical personnel B. Fear of retribution related to care of children C. Voicing complaints D. Holding back E. Doctors and Nurses know best	<ul style="list-style-type: none"> • Innate trust • Reverence for health care providers • Love of Salud

Sense of kinship emerged as a major theme in the study results. It became apparent from the first day of data collection that the Salud staff is close knit, involved in one another's lives, and were consistently demonstrative of teamwork and familiarity. Coinciding with the staff's familiarity with one another is the familiarity between the staff and their patients, who regularly greeted one another with first names and hugs. Staff also inquired politely about the well-being of patient's other family members. The community

environment within the clinic was overshadowed only by the camaraderie among the waiting patients. As evidenced by interview responses and other observations, waiting room patients either knew one another or knew of one another. Multiple ongoing conversations sometimes were louder than crying babies and playful (but ill) children. Most patients were so comfortable in their surroundings that the waiting room appeared to be the site of a social event rather than a health care visit. When migrant farm worker parents described Salud as “comfortable” they were referring to the familiarity of staff and the congregation of friends in the waiting room.

Participants referred to clinic visits as occurring as a *matter of convenience*. With their socio-economic status often preventing the acquisition of desirable transportation, parents often stated that they took their children to Salud whenever the opportunity arose. When a family member had an appointment, parents went along even if the child was not ill. Migrant farm worker parents considering preventative health care to be vital to their children’s well-being, would use a visit as a check-up. Parents prioritized the care of their children above any of their personal needs, including securing income, having food, and having a clinic that they trust.

Respect was the most important of spiritual and cultural need in health care provision and a significant and unexpected finding of this study, for an environment of cultural awareness, especially bilingual abilities. I had predicted of this study, that an environment of cultural awareness, especially bilingual abilities, would have been the most important factor to the migrant farm worker parent. But respect for and acknowledgment of the migrant farm workers as parents became the most important and revealing factor. In some instances, parents regarded listening as being more important than speaking their language. An

interesting and significant finding was the farm worker parents' desire for additional respect for their extended family who help care for children, assist in decision-making and provide overall emotional support. With family including all extended family members, even those related through marriage, not one participant mentioned any desire to be independent of family or to move away from family (unless the family could not perform seasonal migration). Respect for the child and listening to the child were also mentioned as important. Although surprisingly, there was no mention of children being translators for parents. Parents alluded to cultural perceptions, but not in the context of their importance to decisions about health care provision; rather culture was included in the theme of respect, and not as a separate entity. There were some negative references to cultural perceptions about migrant farm workers, particularly health care providers making assumptions about workers' indicated that abilities to understand and speak English.

Findings indicate that in the migrant farm worker parental culture, patients do not inform health care providers about their wishes and preferences. This inhibition and suppression regarding any desired changes in health care provision was both overshadowed and produced, significantly by respect and reverence for the health care providers. This discovery is meaningful in many ways. It serves to weaken the relevance of traditional patient care satisfaction surveys to the migrant farm worker population, for it is doubtful that migrant farm worker parents would comment on their care, even if they understood all of the questions. It is also a significant factor in proposing further studies involving migrant farm worker parents in order to discover/determine their wishes for care based on negative responses to the question of "what can we do better?"

Fundamental beliefs include parental pride related to having healthy children, mothers' sense of efficacy regarding decision-making, and a deep regard for opinions and reactions of extended family members. Migrant farm worker parents did not express a desire to control any factors related to the provision of their children's health care, but instead demonstrated the intent to follow any and all recommendations made by the doctors and nurses at the clinic.

Characteristics of Migrant Farm Worker Parents

The characteristics of migrant farm worker parents as revealed throughout this study are: politeness, humbleness, positive attitudes, innate trust and reverence for health care providers, and a deep regard for family. They are grateful for having secured work (even though temporary and often seasonal), and for having Salud as a provider of health care. The most significant characteristic is their pride in having healthy children.

This study was rich with in-depth conversations with migrant farm worker parents. In order to portray the results of this ethnographic exploration, numerous quotations were chosen to illustrate major themes arising from this study.

Consistency of Findings with Existing Literature and Criteria for Rigor

This study is the first to specifically explore migrant farm worker parental health beliefs. There have been several studies conducted over the past ten years that have focused on health beliefs of migrant farm workers addressing specific health conditions including diabetes, tuberculosis, pesticide exposure with resulting integumentary and respiratory conditions and the effects of sun exposure. Studies by Kelsey (2005) and Clingerman (2006) looked at conceptualizations of health and found that health-promoting behaviors are valued, but are economically and legally influenced and that traditional gender roles are influenced

by family structure. Clingerman's (2006) study found that health care worker's caring was perceived by respect that was demonstrated by cultural competence in the use of Spanish and acceptance of cultural values. This study found that migrant farm worker parents value respect as well, but do not value the cultural competence and use of the Spanish language as much as they value listening and respect as parents. Other studies such as Mirowsky & Ross (2003) Gomel & Zomora (2007), and Weathers, Minkovitz, Diener-West and O'Campo (2008), demonstrated that migrant farm worker parents perceive their children to have poor health, and did not consider any health risks from nutrition and underestimated outcomes of good health for their children. This exploration of migrant farm worker parental health beliefs demonstrated the opposite finding and reasons for the difference remain to be examined. Parents illustrated deep pride in having healthy children, were optimistic about outcomes of medical care and were knowledgeable about signs and symptoms of childhood illnesses.

Summary

This chapter provided results of the study, drawn from multiple sources of data and derived from ethnographic data analysis. Results and emergence of themes were detailed and identified. The findings of this study are pertinent to the provision of health care to migrant farm worker parents in this country. The results are also timely given the current political health care environment and state of agriculture in the United States. The overall process followed the general scheme for clinical research set down in Figure 1 in Chapter 3, as suggested by Miller and Crabtree (2003): gathering (exploration), interpretive process (finding common ground), representation/documentation, and analysis (understanding). Building on these findings, the next chapter will provide meaningful conclusions about the

overall investigation, study strengths and weaknesses, implications for nursing practice and education, and potential future research.

Chapter V: Discussion

In the context of findings presented in Chapter 4, the purpose of this chapter is to set forth the major conclusions and implications of the investigation. In order to summarize the dissertation and bring closure to the project, a brief synthesis of the findings will open this chapter. Following that will come a section on interpretation of the findings and study conclusions. Study limitations and strengths will also be presented. Finally, a section on important implications of this work will complete the discussion.

Overarching Theme

One recurrent meta-theme permeates all of the others: migrant farm worker parents greatly value having healthy children. This parental pride is intrinsically threaded among the four major themes of the study: kinship, a matter of convenience, respect, and inhibition/suppression. Social support within the community of migrant farm worker families and within the community of the Salud Clinic was a significant factor affecting health care attainment. Because socio-economic status and the linked problem of transportation are key issues, reliance on others for travel to and from the clinic emerges as the prime determinant of when health care is sought. Support of family and friends related to transportation appears to influence health care beliefs. Aside from transportation, other socio-economic factors do not appear to influence health beliefs. Socio-cultural influences, socio-economic conditions, personal insecurity, and the United States' current international border policies seem not to affect parents' ability to seek or obtain health care for their children. Just a fraction of the participants briefly mentioned money as a factor in choosing Salud as their health care provider. This may be associated with the fact that Salud provides health care to all of the migrant farm workers in the area regardless of financial status. With

family support consistently regarded as vital to children's health, family members are most deeply appreciated for their role in the care and well-being of the children and parents do not hesitate to request or receive assistance from family members. Often employed by the same or neighboring farms, family members convey a sense of responsibility for all of the children, regardless of blood relationship. Surprisingly, parents' culture-specific beliefs were secondary to issues of respect. Informed by the overarching theme of pride in having healthy children, four distinct themes emerged from the data analysis: 1) kinship, 2) a matter of convenience, 3) respect and, 4) inhibition/suppression.

Summary of Themes

1. Kinship: A sense of community was evident between and among patients who were observed in the waiting area. Patients were either acquaintances of or related to one another. Children played together. A strong working relationship existed between and among staff members including doctors, nurse practitioners, medical assistants, and clerical staff, as demonstrated by the familiar tone of conversations and their ability to work as a team when treating patients. Kinship was obviously sustained in their consistent ability to recognize their patients and their patients' family members and to address them by name (many were on a first-name basis). The staff had a long employment history with Salud, and it was not unusual to see hugs between staff and patients or between patients in the waiting room.
2. A Matter of Convenience: The only outward indication of socio-economic deprivation was manifested in the lack of transportation available to many of the farm worker parents. Parents set priorities for their children based on the availability of rides. It was common to hear stories of parents visiting Salud when a friend,

neighbor, or family member also had an appointment. Occasionally the timing was not appropriate as the child may have been ill for days prior to transportation becoming available. In some cases, parents brought their children just for the convenience of getting them evaluated for questionable symptoms of H1N1 or to seek immunizations for H1N1 prevention. Moreover, as farming season drew to a close and many parents were leaving for warmer climates or bound for “home” they mentioned the importance of visiting Salud for the last time before traveling. However, a last visit of this type took place only when the potential for a ride presented itself.

3. Respect: Sixteen of the twenty migrant farm worker parents rated respect for them as people as the most important determinant when choosing health care providers for their children. Respect from others was said to include the following: listening, being greeted by name, engaging in conversation with them and their children, and allowing all family members access to treatment areas. Listening to and respecting the parents was paramount in their love and praise of Salud.
4. Inhibition and Suppression: This theme was demonstrated by the migrant farm workers’ reaction to the question about best practice in the care of their children, and whether they questioned what the providers said or decided. It was quite apparent that parents were uncomfortable with the question, and possibly with questioning providers who had higher levels of literacy and education, and who enjoyed more official authority in society than any of them. Yet it provided great insight into the level of respect and even reverence with which migrant farm worker parents approached all health care providers.

Interpretation of Findings

An outcome of all the themes is the importance and strength of *community* at Salud. The parents shared a community inside the clinic with the health care providers and outside the clinic with other farm workers employed by the same or neighboring farms. This community within a community provided the parents with a sense of belonging and cohesiveness. Sharing membership in this special community added to their overall sense of comfort and trust in Salud.

Secondly, nurses have traditionally focused on the planning and provision of care with only a nod to cultural awareness and humility towards patients, including migrant farm workers. The migrant farm worker parents who participated in this study told us something different about what mattered most to them. Although cultural awareness is certainly important, it is not the farm worker parents' primary concern. Instead, providers' respect for the hard-working parents emerges as their major priority and preference. It is feasible to think that respect and cultural humility are similar concepts worth keeping for all providers. Parents want to be heard, and they want their concerns addressed, regardless of language. Although they appreciate people who speak their language, neither culture nor spirituality was voiced as a priority. While Salud is known for its culturally sensitive care and in-depth understanding of migrant farm worker health needs, this study identifies other priorities affecting the health beliefs of parents.

The characteristics of migrant farm worker parents include politeness, respect for medical personnel, a sense of family honor, and appreciation for health care. Participating parents were thoughtful, gracious, and willing to do anything for their children, extended families and other migrant farm worker children. Stoic and quiet people, they exhibited

strong family values and performed their work with pride and purpose. Unexpectedly, there was little mention from participants in this study of socio-economic and/or legal status. Paramount to migrant farm worker parents is having healthy children and obtaining care from health care providers who respect them as parents and provide a sense of community. Transportation was the only challenge mentioned that related to seeking health care for their children, but parents managed to take advantage of rides with others, even if an appointment was not necessary.

Findings suggest that migrant farm worker parents do not take the initiative to inform health care providers of their wishes and preferences; instead, respect and reverence for health care providers over shadowed the expression of any desired changes in health care provision. It is not known whether parents may have feared losing health care access if they spoke out about these things.

This discovery has important implications, for it calls into question strategies to elicit satisfaction surveys from the migrant farm worker parents when those surveys do not even begin to account for the farm worker parents' unique health care beliefs. Indeed, rather than expressing any desire to control health care provision migrant farm worker parents demonstrated the intent to follow all instructions from the doctors and nurses at the clinic. Clearly, cultural and other differences remain to be understood in these interactions.

Implications for Future Research

The extent to which kinship affects health care beliefs among migrant farm worker parents is a research area that deserves attention and exploration. Other studies involving this population suggest that relational dynamics are important cultural norm. Once the effect of kinship is identified and analyzed, it could be used as an underlying model of migrant

farm worker pediatric health care provision. In addition, studying the effects and attributes of a respectful health care environment as an over-riding characteristic might also inform and improve health outcomes.

Exploring the factors that affect parental responses to questions regarding satisfaction in care is a third research area that would help guide efforts to improve health care provision. This would include further inquiry into factors that inhibit or suppress parents' ability to speak freely about possible weaknesses or the offering of suggestions to enhance their children's health care. Admittedly, this is a complex issue with historical, social, and cultural dimensions.

A fourth and related research area might be the perceptions of internal and external locus of control that drive determination and behavior regarding children's health care practices. Investigating locus of control might assist researchers in understanding why certain interventions work and others do not, although as for other potential interest areas, it is a probably influenced by contextual and cultural factors.

A fifth potential research question is the extent of familial influence and social support on the health and well-being of children. Perhaps we need to explore further family roles, including whether the mother is the primary decision-maker, and what role the grandmother plays in health/other decisions. To whom are we gearing our patient education? Other studies have supported the idea that the family is a vital underpinning for this group of parents. More insight and clarity are needed on these topics.

In order truly to understand migrant farm worker parental health beliefs, more research is needed to define their true perceptions of health care providers. Because respectful conversation and behavior appear inherent to their culture, what do they really

think and how do we uncover these truths? A community based participatory approach, using multiple methods, might be feasible, if appropriate partners (from all stakeholder groups) could be identified and were interested in taking part.

Implications for Practice

It is an expectation that nurses apply research findings when planning health care provision for migrant farm worker children, special attention should be given not only to the major themes, but to the subsidiary themes as well. Conversations with respected insiders in the migrant farm worker community and others may assist in planning and evaluating the outcomes and effectiveness of care.

Nurses should continually assess resources and roles to tailor interventions in the health care provided to the migrant farm worker children and their families. Recognizing the dynamics of and relationships among the migrant families and communities would enhance the provision of health care as well, as would utilizing the evidence provided in this study in particular, honoring parents' pride in having healthy children. Applying these findings when providing education to parents, nurses could demonstrate respect for the parents and ask for parental preferences and requests. Finally, since family members have a significant role in the health and care of migrant farm worker children, all providers should include extended family members in care planning. However, it is recognized that this action may not be feasible in all situations.

Implications for Nursing Education

Nurse educators facilitate and disseminate research findings and evidence pertaining to deprived and vulnerable populations, including how to utilize findings in practice. Educational strategies include guiding students (at all levels) to integrate research findings

into patient education and delivery of health care. Nursing students who prepare teaching sessions for migrant farm worker parents should use these findings to guide their educational needs assessments, as well as educational resources and outcomes.

Limitations and Strengths of Study

This study has both limitations and strengths. A potential limitation is that the population was accessed through a migrant health clinic familiar with the migrant farm worker culture, and known throughout Colorado as the primary provider of migrant farm worker health care. Integrating the migrant farm worker culture into health care provision, Salud offers many programs to ensure the health of children belonging to this vulnerable population without regard to socio-economic or immigration status. If this study had been conducted at a clinic that is neither culturally aware nor bilingual, the results might have been quite different, especially those findings that relate to the sense of community among staff members and among waiting patients. It was difficult to assess whether parents were simply pleased with their care at Salud, or whether their inhibition produced a lack of feedback or whether another clinic or provider site might have produced different results. Whether this characteristic is culturally mediated or situational, it is clear that it is not well understood.

The second limitation of this study is my status as a novice researcher, which may have prevented deeper probing during the interview. Although I felt at ease with the population and the environment, my priority of being respectful may have impeded my ability to stimulate further responses by asking follow-up questions. Even so, I found these questions slightly easier to ask by the close of the interviews.

This study exhibited some important strengths, as well. The first strength was the sample size of twenty in a population considered difficult to reach, even for qualitative

research. Moreover, there was a good variation of age within the sample, and study participants were representative of the migrant farm worker population, for some were seasonal, and others were permanent residents of the area. This representative population served to enhance and deepen descriptive findings.

The second strength is found in qualitative interview questions themselves. Although one question was more challenging for participants (“If you could tell the doctors and nurses how to better care for your child, what would you tell them?”), the responses yielded significant insight into and information about health beliefs and migrant farm worker parental characteristics. Overall, as the nature of the interview questions invited and received stories from the hearts of the people, those stories created reflective opportunities for me as a researcher and underscored the importance of having healthy children among the migrant farm worker parents.

The third strength of this study is the innate trust that the study participants had for me, making possible more detailed interviews than otherwise might have developed. Although I was a stranger, participants’ trust was demonstrated and expressed as respect and faith in the medical profession. This trust enabled me to be accepted by the migrant farm worker parents and allowed them to speak openly with me about their health beliefs. Moreover, trust in health care professionals is crucial to their confidence in obtaining health care for their children.

An unexpected strength of the study is the migrant farm worker parents’ interest in and willingness to participate in the study and their overall perception (verbal) that the study was important to their population. Coupled with this was an interest in and acknowledgment

of the study by the Salud staff. The welcoming environment and efforts to assist me in the work of data collection overwhelmed me.

The last noteworthy strength involves the rich verbatim quotes offered by participants and the blending of field notes and reflective journaling. Gathering data from various sources served to cross-validate and reinforce information. Credibility was enhanced by translation and back translation by an outside expert, member checking (validation of findings) between myself and my research assistant, and the congruence between perceptions of participants and staff members. This study is one of the first ethnographic studies conducted primarily to explore the health beliefs of migrant farm worker parents. The qualitative design of this study informed by ethnography is the prominent strength, for it has produced new and relevant results from a group who is seldom invited into discussion.

Summary

This study explores the health care beliefs of migrant farm worker parents. Preliminary findings demonstrate the overarching theme of parental pride in healthy children. Four additional major themes are also documented: a sense of kinship, a matter of convenience, respect and inhibition and suppression. In order to plan appropriate care for migrant farm worker children, health professionals must understand and integrate the viewpoints of the children's parents and all other factors influencing their health care beliefs (e.g., extended family members' ideas, traditions, etc.).

Results from this study offer implications for nursing research, education, and practice. Nursing research recommendations include further exploration of migrant farm worker health beliefs in different settings with different probing questions. It is my belief that a study based on the methods of Community Based Participatory Research (CBPR)

would provide the most beneficial way of exploring areas of perceived reluctance, but only if all partners in the process were willing to address these issues. Other topics worth studying are the extent to which kinship affects health care beliefs, the differences between providers who are culturally aware versus those who are not (because cultural awareness does not emerge in this study as a major factor for parents), further inquiry into factors that inhibit, suppress, or encourage their ability to speak freely; future exploration of internal and external locus of control that drive determination and behavior regarding children's health care practice; and, lastly, further analysis about family roles directly related to the health and well-being of the children. Nursing leaders are positioned to positively impact health care policy regarding factors impeding the health care of migrant farm worker children, while doctoral prepared nurses should be leading research efforts related to health beliefs of all vulnerable and oppressed populations, including these children.

This study is one of the first to explore the health beliefs of migrant farm worker parents. Nurses involved with rural health and migrant farm worker pediatric health care are faced with multiple challenges, including U.S. political and economic struggles, health care policies regarding migrant groups, and marginalization and stigma for anyone outside the mainstream. These findings enrich the foundations of nursing practice and research involving migrant farm workers. In the conflicted political environment of health care provision, negative public images of migrant farm workers, and the generally depressed economics of agriculture, this study may awaken interest in and action for this underserved population.

Something in the Rain

by Trish Hinojosa

Mom and Dad have worked in the fields
I don't know how many years
I'm just a boy but I know how
I go to school when work is slow.

We have seen our country's roads
Bakersfield to Illinois
But when troubles come our way
Oh yes, I've seen my Daddy pray.

There's something wrong with little sister
I hear her crying by my side
Mama's shaking as she holds her
I try to hold them through the night.

There must be something in the rain
I don't know just what that means
"Aguelita" talks of sins of man
and dust that's in our hands.
There must be something in the rain
what else could cause this pain
Airplanes cure those plants so things can grow
I guess there's something in the rain

Now little sister's gone away
Mama is working hard all day
And me - I guess I understand
About our life - about our land
Talkers talk and dreamers dream.
We must find a place between.

Cause there's something in the rain
And there's more here in our hands
"Aguelita's" right about those sins of man
Whose profits rape the land.
And those rains keep pouring down
from the growers to the town and
until we break that killing chain
there's something in the rain.

This poem speaks of pesticide spray from a migrant farm worker child's perspective. From Buirski (1994). *Earth Angels, Migrant Children in America*. California: Pomegranate Artbooks.

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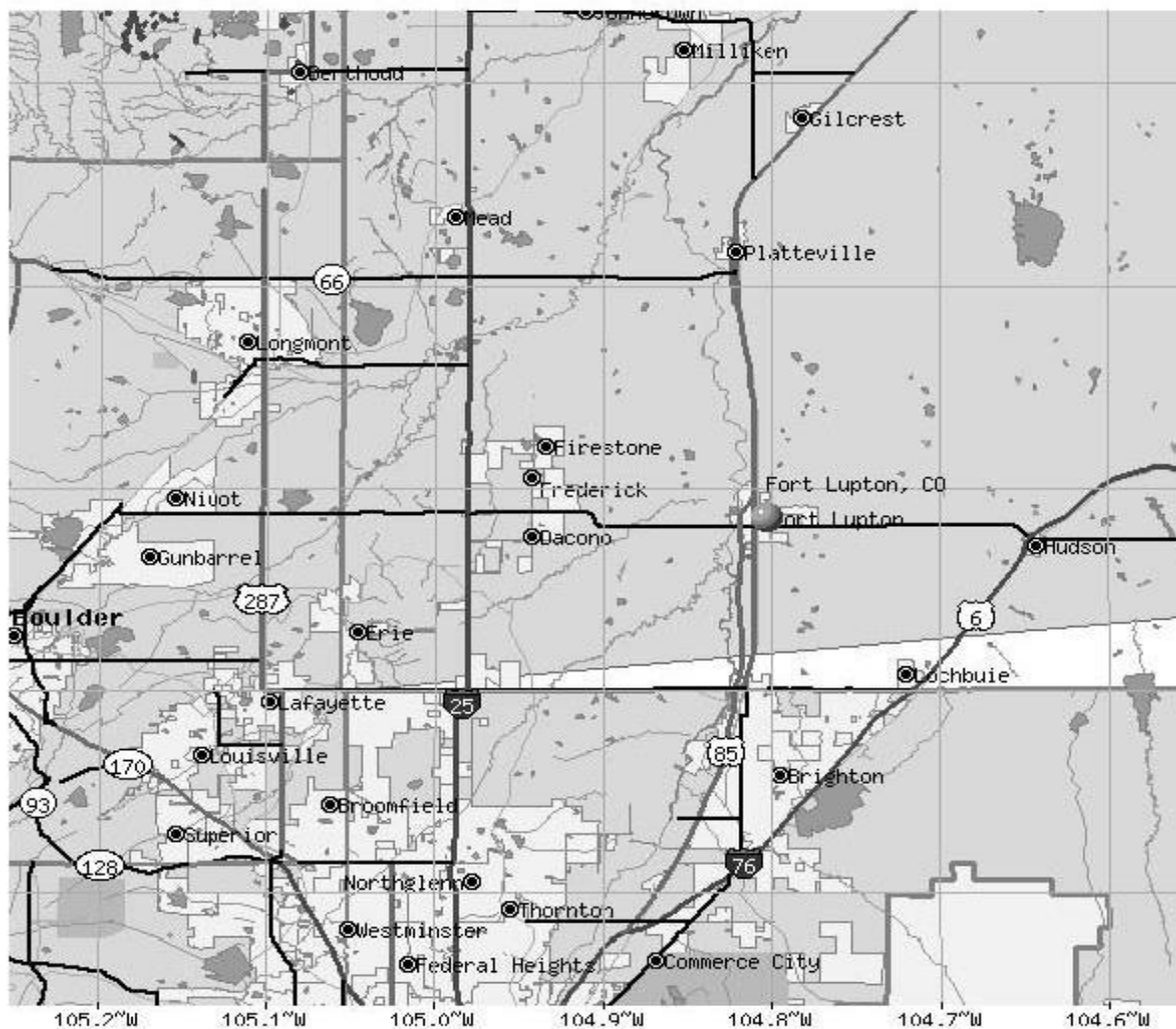
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Appendices

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Appendix A
Map of Weld County



Appendix B

Letters of Approval from Salud Clinic



ADMINISTRATIVE OFFICES

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HEALTH CENTERS

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STERLING

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Accredited by the Joint
Commission on Accreditation
of Healthcare Organizations

July 14, 2009


To Whom It May Concern:

The purpose of this letter is to offer strong support for the Ethnographic Exploration of the Health Beliefs of Migrant Farm Worker Parents dissertation proposal being submitted by Alexis Newton. This study will explore the health beliefs and attitudes of migrant farm worker parents. Hopefully, the result of this project will be to translate those research findings into practice. This has the potential to expand and extend the understanding of parents and their children who obtain services as farm workers in a migrant/community health center; giving opportunities to improve the services available.

The objectives of this project fit well within the mission of Salud Family Health Centers (Salud). Salud provides high quality comprehensive primary health care services to the poor, near-poor, uninsured populations, including migrant and seasonal farm workers, across northeastern Colorado. A large part of our effort is to improve the overall health of the communities we serve by reducing barriers to health care, including: ability to pay, transportation, and language.

In support of the proposal, Salud is glad to work with Ms. Newton to provide her access to our Mobile Unit patients who wish to participate in the qualitative portion of this study.

Sincerely,


Clara Cabanis, MS.
Migrant Health Director
Salud Family Health Centers



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of Healthcare Organizations

November 20th, 2009

*Alexis Newton RN PhDc CNS
Chair of Nursing Programs
Front Range Community College
Boulder County Campus
Longmont, Colorado*

Dear Ms. Newton:

The purpose of this letter is to express our support for your doctoral dissertation project entitled "An Ethnographic Exploration of the Health Beliefs of Migrant Farm Worker Parents".

The objectives of this project fit well within the mission of Salud Family Health Centers (Salud). Salud provides high quality comprehensive primary health care services to the poor, near-poor, uninsured populations across northeastern Colorado. Salud is particularly sensitive to the cultural needs of the migrant and seasonal farmworkers and their families.

In support of the proposal, Salud is glad to work with you by allowing access in the Fort Lupton clinic to migrant farm worker parents who wish to participate in your research study.

Sincerely,

Kelet Robinson, MD
Fort Lupton Medical Center Director

Appendix C
UNM HSC HRRC Approval



THE UNIVERSITY OF NEW MEXICO
HEALTH SCIENCES CENTER

Human Research Review Committee
MSC 08 4560 BMSB Room B71
1 University of New Mexico~Albuquerque, NM 87131-0001
(505) 272-1129 Facsimile (505) 272-0803
<http://hsc.unm.edu/som/research/hrrc/>

01-Sep-2009

Averill, Jennifer B, Ph.D.
College of Nursing

SUBJECT: HRRC Approval of New Research Protocol
HRRC#: 09-382
Study Title: An Ethnographic Exploration of Migrant Farm Worker Parental Health Beliefs.
Type of Review: Expedited Review
Approval Date: 01-Sep-2009
Expiration Date: 31-Aug-2010

Dear Dr. Averill:

The Human Research Review Committee (HRRC) has reviewed and approved* the above-mentioned research protocol including the following:

1. UNM HSC Expedited Review Application received 8/31/09
2. Attachment 1 and 8 received 8/31/09
3. Protocol "An Ethnographic Exploration of Health Beliefs of Migrant Farm Worker Parents" version 8/12/09
4. UNM HSC Consent Cover Letter for Anonymous Survey and Interviews (English) version 8/31/09
5. UNM HSC Consent Cover Letter for Anonymous Survey and Interviews (Spanish) version 8/31/09
6. Appendix A Questions for semi-structured Interview (English and Spanish versions) received 8/13/09
7. Appendix B Demographic Information questionnaire (English and Spanish versions) received 8/13/09

Consent decision:
Signature waived; requires written statement about research
HIPAA Authorization Addendum not applicable

This study is approved to enroll only the number of subjects listed in the application, protocol and consentform(s). If the PI wants to enroll additional subjects, it is the responsibility of the PI to submit an Amendment/Change to the HRRC before the approved number of enrolled subjects is exceeded. If increased enrollment is requested, the application, protocol and/or consent form(s) must also be amended to include the new target.

Sincerely,

Mark Holdsworth, Pharm.D., BCOP
Executive Chair
Human Research Review Committee

* Under the provisions of this institution's Federal Wide Assurance (FWA00003255), the HRRC has determined that this proposal provides adequate safeguards for protecting the rights and welfare of the subjects involved in the study and is in compliance with HHS Regulations (45 CFR 46), FDA Regulations (21 CFR 50, 56).

Appendix D
Informed Consent Cover Letters

University of New Mexico Health Sciences Center
Informed Consent Cover Letter for Anonymous Surveys and Interviews

STUDY TITLE
An Ethnographic Exploration of Health Beliefs of Migrant Farm Worker Parents

Jennifer B. Averill, PhD and Alexis Newton are from the University of New Mexico College of Nursing. They are doing a research study to find out what you think is important about the health care of your children. The purpose of the study is to obtain information about your health beliefs as parents and present them in your own words. You are being asked to take part in this study because you are a migrant farm worker parent.

Your participation will involve completing a short survey and a short interview.. The survey should take about 5-10 minutes to complete and the interview about 15-20 minutes to complete. Your involvement in the study is voluntary, and you may choose not to participate. We will not request your name or any other information from you that could show that you agreed to be in this study. There will be about 20 people participating in this study. The survey includes questions such as where you live, your age, who you live with, how many children you have, and the importance of your religion. You will also be asked 5 questions about who you ask for help when your child is sick, how you make decisions and what you want us to know about how you care for your child. You can refuse to answer any of the questions at any time. To help with this, you will be asked if we may tape your answers to our questions. This will make sure that we have your exact words. You may say no if you are uncomfortable with taping. If you say yes, we will destroy tape recordings immediately after we write what you have said. It is not necessary to provide your name on tape. There are no known risks in this study, but some people may have discomfort about some questions. All information will be kept on the researcher's personal computer at her home to insure the safety of the information. No one will know that you have been in this study.

The findings from this project will provide information on your health beliefs in your words. If published, results will be presented in summary form only. You may choose not to participate or stop the study at any time without any affect on you or your child being seen in the clinic either now or in the future.

If you have any questions about this research project, please feel free to call Alexis Newton, researcher at 720-281-7965. If you have questions regarding your legal rights as a research subject, you may call the UNMHSC Office of Human Research Protections at (505) 272-1129.

A copy of this consent form will be given to you. In order to protect your identity your signature will not be obtained.

Thank you for your consideration.

Sincerely,

Researcher's Name
Alexis Newton RN
Researcher's Title
Student College of Nursing

Page 1 of 1

HRRC# 09-382
Version Date 08/31/09

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The University of New Mexico Human Research Review Committee			

Salud de la Universidad de nuevo México Centro de Ciencias

Consentimiento informado Carta de cubierta para encuestas anónimos y entrevistas

TÍTULO DE ESTUDIO

Un Exploración Etnográfico de creencias de salud de migrantes Farm trabajadores padres

Jennifer B. Averill, doctorado y Alexis Newton proceden de la Universidad de nuevo México College de enfermería. Son haciendo un estudio de investigación para averiguar qué piensa que es importante acerca de la salud cuidado de sus hijos. el propósito de la el estudio es para obtener información acerca de sus creencias de salud, con sus padres y presentarlas en su propio palabras . Se le solicita a tomar parte en este estudio porque le son un padre de trabajadores agrícolas migrantes.

Su participación será involucrar a completar una breve encuesta y una breve entrevista. . El encuesta debería tener acerca de 5-10 minutos para completar y la entrevista sobre de 15-20 minutos para completar. Su participación en el estudio es voluntaria, y usted puede elegir no participar. Nosotros no solicitará su nombre o cualquier otra información de usted que podría mostrar que usted de acuerdo en estar en Este estudio. Hay alrededor de 20 personas participan en este estudio. El encuesta incluye preguntas tales como donde usted vive, su edad, que vive con, cuántos los niños que tiene y la importancia de su religión. También se le pedirá 5 preguntas acerca de quién pide ayuda cuando su hijo está enfermo, cómo realizar las decisiones y lo que se desea que nosotros saber acerca de cómo cuidar su hijo. Usted puede negarse a responder a cualquiera de las preguntas en cualquier tiempo. Para ayudar con esto, usted será preguntado si nos podemos cinta sus respuestas a nuestras preguntas. Esto se asegurará de que disponemos de sus palabras exactas. Usted puede decir que no Si usted es incómodo con vendaje. Si dice que sí, nos destruirá cinta grabaciones inmediatamente después de escribir lo que ha dicho. No es necesario para proporcionar su nombre en cinta. Hay sin riesgos conocidos en este estudio, pero algunos personas pueden tener incomodidad acerca de algunas preguntas. Se conservará toda la información en equipo de personal del investigador en su casa para garantizar la seguridad de la información. Nadie sabrá que usted ha sido en este estudio.

Los resultados de este proyecto proporcionarán la información en su creencia de la salud en sus palabras. Si publicado, resultados se presentarán en forma resumida sólo. Usted puede elegir no participar o detener el estudio en cualquier momento y sin ningún efecto sobre usted o su niño que se observa en la clínica ya sea ahora o en el futuro.

Si tiene cualquier pregunta sobre este proyecto de investigación, no dude en llamar Alexis Newton, investigador en 720-281-7965. Si usted tiene preguntas en relación con sus derechos legales como un tema de investigación se puede llamar la Oficina UNMHFC del humano protecciones de investigaciones en 505-272-1129.

Una copia de este formulario de consentimiento se dará a usted. En orden para proteger su identidad no se obtendrá su firma.

Gracias por tu examen.

Sinceramente,

Nombre del investigador
Alexis Newton RN
Título del investigador
Estudiante Colegio de enfermería

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Appendix E
Semi-Structured Interview Questions

Questions for semi-structured interview

1. Why is your child (children) being seen at the clinic today?
2. Did you make the primary decision to have your child seen today? If not, who made this decision?
3. Who is the first person you go to for advice about your child's health? Who is the second person you go to for advice?
4. What is most important to you when receiving health care for your child (children): cultural needs, spiritual needs or respect of you as a parent?
5. If you could give doctors and nurses advice on how to best care for your child (children), what would you tell them?

Preguntas para la entrevista semi-estructurada:

1. ¿Por qué vino su hijo/a (o sus hijos) a la clínica hoy?
2. ¿Fue usted quien tomó la decisión de venir a la clínica hoy? Si no fue usted, ¿quién tomó la decisión?
3. ¿Quién es la primera persona a la que usted va para pedir consejo sobre la salud de su hijo/a? ¿Quién es la segunda persona a la que va para pedir consejo?
4. ¿Qué es lo más importante para usted cuando recibe cuidado de la salud de su hijo/a (o sus hijos): necesidades culturales, necesidades espirituales, o que le respeten a usted como padre?
5. Si usted pudiera darle consejos a los doctores y enfermeras sobre cómo cuidar a su hijo/a, ¿qué les diría?

Appendix F
Demographic Survey

Demographic Information

Please complete the following information about yourself by filling in the blank or checking the square that describes your opinion.

Age at your last birthday was _____ years.

Sex: ☐ Male ☐ Female

Marital Status: ☐ Married
☐ Single
☐ Divorced
☐ Separated
☐ Living with Partner
☐ Widowed

How many family members live with you?

Children _____
Brothers and Sisters _____
Mother or Mother-in-Law _____
Father or Father-in-Law _____
Grandparents _____
Aunts _____
Uncles _____
Cousins _____

Amount of Formal Education: ☐ None
☐ 4th grade
☐ 8th grade
☐ some high school
☐ high school graduate

Religious Preference: _____

Importance of Religion in your life: ☐ Not Important
☐ Slightly Important
☐ Moderately Important
☐ Very Important

Your children's general health is: ☐ Excellent
☐ Very Good
☐ Good
☐ Fair
☐ Poor

Thank you for participating in this study.

Date: _____

Información Demográfica

Favor de completar la siguiente información sobre usted relleno los espacios en blanco o marcando lo que mejor describa su opinión.

En mi último cumpleaños cumplí _____ años

Sexo: ☐ Hombre ☐ Mujer

Estado civil: ☐ Casado/a
☐ Soltero/a
☐ Divorciado/a
☐ Separado/a
☐ Vivo con pareja
☐ Viudo/a

¿Cuántos miembros de su familia viven con usted?

Niños _____

Hermanos y hermanas _____

Madre o suegra _____

Padre o suegro _____

Abuelos _____

Tías _____

Tíos _____

Primos _____

Nivel de educación formal: ☐ Ninguna
☐ 4º grado
☐ 8º grado
☐ Algo de secundaria
☐ Terminé la secundaria

Preferencia religiosa: _____

Importancia de la religión en su vida: ☐ No es importante
☐ Poco importante
☐ Moderadamente importante
☐ Muy importante

En general, la salud de sus hijos es: ☐ Excelente
☐ Muy buena
☐ Buena
☐ Normal
☐ Mala

Gracias por participar en este estudio.

Fecha: _____

Appendix G

Coding Book

P-Re-Q	Participants Reactions to Questions
P-Re-I	Participants Reactions to Investigator
P-Re-RA	Participants Reactions to Research Assistant
Ob-B-SP	Observations between Staff and Participants
Ob-B-SM	Observations between Staff Members
Ob-B-P	Observations between participants in waiting area
FRDec	Family Roles in Decision Making
Ref CL	References to Culture and Language
Ref Rel	References to Religion
Ref I	References to Immigration Status
Ref \$	References to socio-economic status
BAR	Barriers
QFP	Questions from Participants
ExF	Expressions of Feelings from Participants
REF	Reflections of Investigator
S-Re-ST	Staff reactions to study
S-Re- I	Staff reactions to Investigator
P-VW	Participants view of their work
P-VS	Participants view of Salud
Imp of Res	Importance of Respect
Imp of Tr	Importance of Trust
Imp of CH	Importance of Children's Health

Appendix H
Letters of Copyright Permission

Newton, Alexis

From: Hutchinson, Adele [Adele.Hutchinson@sagepub.com] on behalf of permissions (US) [permissions@sagepub.com]
Sent: Tuesday, March 02, 2010 5:05 PM
To: Newton, Alexis
Subject: RE: permission to use chart in doctoral dissertation

Dear Alexis,

Thank you for your request. Please consider this written permission to use the material detailed below in your dissertation. Proper attribution to the original source should be included. The permission does not include any 3rd party material found within the work. Please contact us for any future usage or publication of your dissertation.

Best,
Adele

From: Newton, Alexis [mailto:Alexis.Newton@frontrange.edu]
Sent: Tuesday, March 02, 2010 10:38 AM
To: permissions (US)
Subject: permission to use chart in doctoral dissertation

To Whom It May Concern:

I am requesting permission to use a chart found in:
Denzin, N. & Lincoln, Y. (Eds.) (2003). Strategies of Qualitative Inquiry. This chart was in the chapter by W. Miller and B. Crabtree entitled "Clinical Research" (pg. 415). I have obtained permission by Dr.'s Miller and Crabtree via e-mail. I believe that I need to have Sage Publications permission as well. I am using this chart in my dissertation entitled "An Ethnographic Exploration of Health Beliefs of Migrant Farm Worker Parents" for the University of New Mexico College of Nursing PhD program. Would you please advise? Thank you so much.

Sincerely,
Alexis M. Newton

Date: Tue, 17 Mar 2009 08:39:54 -0400
To: anewton@unm.edu
From: Davida_M.Leayman@lvh.com **Block Address**
Subject: **request to use chart**

 Reply  Reply All  Forward  Print  Delete

Hi Alexis,

Dr. William Miller asked that I respond to your request, asking for permission to use his chart for qualitative clinical research in Denzin and Lincoln's Strategies of Qualitative Inquiry. He said that would be fine.

Best of luck with your dissertation!

Thank you,

Davida Leayman
Executive Secretary for Will Miller, MD, MA
Department of Family Medicine
LEHIGH VALLEY HEALTH NETWORK
1628 W. Chew Street, SON, 1st Floor
Allentown, PA 18105-7017
PH 610 969 4954
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