

**Cultural Perceptions of Health and the Use of Health Care Services  
Among Migrant Farm Workers in Maine**

Undergraduate Research Opportunities Program (UROP) Report  
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The goal of this research project was to obtain a better understanding of how Hispanic migrant workers in Maine perceive health and health care, and the level to which they take advantage of various health-related social services. With the cooperation of the Maine Migrant Health Program (MMHP), I was able to conduct interviews with immigrant egg farmers in Turner, Maine to gain a better understanding of their current health situation and care, as well as to obtain comparative data of their health background in their home country.

Our findings show that relocating to Maine, and assuming the social condition of being an immigrant plays a significant part in the workers' social behavior and their overall wellness. Cultural beliefs and knowledge have a great influence on their perceptions of health and their decisions of whether to seek health care and treatment for illnesses. Definitions of health and sickness depend on many factors, including family, religion, working conditions and health care resources available. Since Maine experiences a growing number of migrant and immigrant workers every year, we hope to provide insight into a community that, though it plays an important part in the Maine culture, has been little acknowledged.

## Introduction

Being a recent immigrant to this country myself, working with migrant and immigrant populations has been a personal goal. Having visited other areas of this country before, at my arrival to Maine I was surprised to hear that it is considered by many to be one of the least culturally diverse states in the country. However, being introduced to nonprofits that provide services to culturally diverse communities in this state rapidly changed my perception of minority communities in Maine. Working as a volunteer with the Maine Migrant Health Program allowed me to get to know rural areas of Maine that are home to thousands of migrant and seasonal communities of farm workers.

In 2010, I applied for and received a fellowship from the Undergraduate Research Opportunities Program at the University of Southern Maine (USM) to lead a research project

focused on the how these migrant and seasonal communities view health and make use of health related services available to them. With the help of MMHP this research project was conducted between fall 2010 and spring 2011. The following information explains the methodology that was implemented, the outcomes of the study and final observations and analysis of the data collected from the researcher and advisor.

The context in which human migration occurs is very complex and the reasons why a particular person migrates can often be explained in broad terms such as pursuing a better quality of life by improving their material condition. Maine is host immigrant and seasonal populations; there are a growing number of migrant workers who come from different places to harvest the state's products. According to MMHP approximately 12,000 migrant farm workers live in the state year round and close to 8,000 seasonal workers come to Maine every year, primarily Mexicans, Pilipino, Jamaicans, Hondurans, Guatemalans and Haitians.<sup>1</sup>

The purpose of this study is to explore beliefs about health in a particular Hispanic migrant community in Turner Maine – most of whose members are egg farmers – and to identify the different factors that influence their beliefs. By doing so we hope to provide insight into a population that is part of Maine's society and that plays a role in the cultural diversity of the state. This was a qualitative research project that we hope will provide the basis on which standardized data can be formulated, which hopefully will happen in future projects. Our objective was not to generate final conclusions, but rather wider hypotheses that can be addressed in future studies. We have chosen to focus on health as the main cultural factor through which we examine the cultural diversity of the community. Although this was not a study about health care, we do however focus on concepts of sickness and health because we believe that these are not universal concepts, but rather are culturally relative.

## Methodology

Through ethnographic research we access research tools to inform ourselves about culturally diverse communities. Ethnography employs a holistic perspective and the use of comparative methods, with fieldwork as the primary means of data acquisition; we work with the populations directly and the information gathered is not based on assumptions, but on direct contact. All through our study, our research method was ethnographic and qualitative. Our

interest in the population at this site was based on that it is predominantly Latino, most of the workers live in Maine yearlong, and that it is demographically diverse in terms of country of origins.

#### Procedures and Recruitment.

The first step was preliminary field research. Thanks to the MMHP I was introduced to the community and started the preliminary fieldwork; by volunteering with the program I was able to make contact with the community of egg farmers in Turner, Maine and to get to know the community as a whole. In this first stage no data was collected.

This general introduction to the community helped us to establish our research questions. By identifying the information that we wanted to know, we were able to avoid asking vague questions to the participants and losing track of our main objective, which was to learn how this particular community perceives health and the level to which they take advantage of various health-related social services available to them. The aim of our research was to answer the following questions:

- Do cultural perceptions of health and health care change when migrant Hispanic farm workers establish themselves in Maine?
- How does cultural change influence the way that the workers perceive their own health and the use of services available to them?
- Do migrant farm workers treat their health problems differently here in Maine than in their home countries?

After formulating the main questions, we were able to design our interview format. We conducted interviews using informal or open-ended questions with several egg farmers. The Maine Migrant Health Program served as an intermediary between the researcher and the people interested in participating.

Each interview consisted of two sections, the first called *General Information* consisting of around twenty questions ranging from worker's country of origin to current cultural practices. The second was called *Health Pathways*, designed to learn more about the health history of the workers in approximately twenty questions. The interview process lasted almost two months.

Every interview lasted between one hour and an hour and thirty minutes and was conducted in their homes.

At the beginning of the interview each worker was given a consent form that explained the purpose of the study and gave an overview of the questions that were going to be asked. It also explained that all information gathered was confidential, and gave the measures that I was taking in order to protect their identity. Finally, it explained that they had the right to answer only the questions that they wanted to and it gave brief information about who the investigator was. Every document was presented in Spanish using clear and basic language.

Our sample consisted of sixteen workers in Turner, Maine, all of whom self-identified as Latino immigrants between the ages of twenty and sixty-one. Their countries of origin were Mexico, Honduras and Guatemala. Although our sample was smaller than we initially intended, the qualitative information gathered from the interviews (over twenty hours of recorded audio) allowed us to identify several common factors that emerged from our collected data, factors that allowed us to make general observations.

## Findings

We had two points of interest that became our two major features: (1) cultural perceptions of health and (2) the use of health care services. From the beginning we expected that both would correlate and influence each other. In order to answer our research questions, we needed to break down the information that people gave us into several variables and place them under our two key features. These variables also are interdependent but for the purpose of this research we decided to make these divisions. We identify the following variables as influential to the first feature, Cultural Perceptions of Health:

*Religion.* Although direct questions about religious beliefs were not asked, when it came to identifying cultural practices that were important, religion was among the first ones mentioned. All the people that we interviewed acknowledged either practicing or belonging to some specific religion. We were able to identify at least two ways in which religion is present in the worker's lives: church groups and religious convictions. Groups formed through Church provide a sense of community and a support system; close to seventy percent admitted that having that safety net creates trust and brings a sense of calm that if something bad happens they are not alone. Regarding the religious convictions, we distinguished some characteristics that

have been associated in other studies with religious upbringing in Latin America such as the idea of suffering and fatalism<sup>ii</sup>, when illness or health problems are perceived as a misfortune out of the person's control.

Seventy-five percent of our sample said that their and their family's health situations are God's will. The feeling that health problems are the work of God or that God is going to fix problems -if they are meant to fix-, was very recurrent among the people we talked to. The majority of the participants did not say they were being punished, but instead their faith was being tested. This variable is also related with the traditions and cultural behaviors variable.

*Access to resources.* Often the level to which the worker has access to health related services influences the person's perception of what requires medical or pharmaceutical attention, in other words what is sickness and what is health. For all the participants, economic resources at some point in their lives since living in Maine have determined what is a health issue instead of just an inconvenience. These resources are not solely monetary, but also relate to mobility (access to a vehicle or some sort of transportation) and social relations. Thirty-five percent of the participants have no personal vehicle or are unable to drive, and forty-five percent have to share transport with other members of the family. All spoke of to the high cost of gas and not knowing the roads well enough to get around. And socially, in terms of having a social network with the rest of the community that provides a support system to access the services available to them, fifty percent of the participants said that they do feel that support, while the other fifty stated the opposite. This variable also correlates with the time living in the host country, under the feature of the use of health care services.

*Working Conditions.* Direct questions about work conditions were not asked in the interview, but when mentioning past or present health issues, sixty-five percent of the workers identified their health issues -constant headaches, muscle pain, arthritis, and depression- as related to their working conditions. However, only fifteen percent recognized such conditions as a problem. The other eighty-five percent who experience discomforts told us that these symptoms are not indicative of bad health, but rather are the expected results from their job.

*Other traditions and cultural behavior.* There are many traditions or behaviors that can be considered part of people's cultures.<sup>iii</sup> When asked which are the cultural elements that they bring with them and make an effort to keep practicing in their households, over eighty-five percent of the participants mentioned the following:

- Traditional kinds of food;
- Religious beliefs and practices;
- Spanish language;
- Traditional holidays like the Day of the Dead, Three Wise men Day, etc; and
- Family relations within the household.

These participants gave high importance to the idea of maintaining these elements in order to keep their families together and remind their children and themselves of where they come from.

Family relations stood out second only to religion as being most important to the participants. More specifically, participants spoke of gender relations within the household, which several studies show to be, in many occasions, part of a cultural upbringing.<sup>iv</sup> Seventy-five percent of the participants live in Maine with their spouse, and forty-five percent of these admitted that their approach to health issues depends on how they believe their spouse will respond. Not wanting to worry or upset the partner (and in some cases the rest of the family) determines whether or not to recognize the headache, the cut, or muscle pain as a health problem. This variable can also be laced under the feature Use of health care services.

Our second feature was the use of health care services by this community. We approached this feature in the same way as the first: we broke down the collected data into variables and placed them accordingly. It is worth mentioning again that these two major features correlate with each other and some variables can be placed under both. The variables located under this feature are the following:

*Time lived in the host country.* The amount time lived in the United States and in Maine varied among the participants between three and twenty years. The people that have been living in the country and Maine for a longer period of time often are more familiar with the resources to which they have access. Some acquire a greater ability to travel and build more support systems

among their community, both of which influence whether they make use of the health services available to them and the level to which they use them. We observed the pattern that the more time spent living in Maine, more likely a worker is to have the ability and economy stability to acquire a vehicle, and at the same time the more strength they have in their social relations with their community. Regardless of the amount of time living in Maine, all of the participants live in this state full time - with the exception of the occasional holiday and family emergencies.

*Use of traditional or folk remedies.* Seventy-five percent of the participants make use -to varying levels- of traditional or folk remedies.<sup>v</sup> Family and friends bring some of the ingredients needed for such remedies from their home countries. Among these remedies we found:

- 7 Azares tea;
- A drink made of a mix of coke and bicarbonate;
- Different kinds of herbs from Mexico, like “Hierba de la Vivora;”
- Dry Eucalyptus leaves; and
- Different kinds of massages on throat, head, etc. ;

A few people mentioned occasions where they traveled to their home countries to have special “limpias” or cleansings. Although all of the participants acknowledged that the use of these remedies was complementary to other medications, they also pointed out that on several occasions, traditional remedies are their first choice. However, twenty-five percent of the participants stated that they have used traditional remedies because of a lack of access to medication.

*Social network and support systems.* When we asked the participants to tell us what was the most common way in which they learned about the services available, fifty percent said that it was both through outreach from different organizations and friends and people from the community. It is not surprising that this was the same fifty percent that acknowledged feeling a sense of support from the community. They also have stated that on more than one occasion members of the community have helped them reach services. Although these support systems are not always used, over fifty percent expressed that normally if they have health problems they prefer to keep it to themselves out of a feeling of not wanting to bother anybody else. The other half

acknowledged experiencing an ongoing feeling of loneliness and of not having anybody to whom to talk. This variable is also related with access of resources and time living in the U.S.

*Country of origin and the intention of returning.* In this study culture was of key importance for both of our features, one thing that underlies culture is the country of origin. We singled out this variable because we found it to be the standard measurement of what participants know about how health care should or should not be. When we ask people about services we refer to health care providers, nonprofits that provide health education, facilities, etc. Forty-three percent of the participants said that the services are much better here than in their home country, another forty-three percent said that the services are not as accessible as in their home country, and the remaining fourteen percent was indifferent or thought that the services are equally accessible. This perception influences the level to which they take advantage of the services available. We believe the intention of returning to the home country is important to the level in which the participants use health care services. While forty-three percent of participants admitted that they are more attentive to their health problems in the U.S. than in their home countries, the other fifty-seven percent (including the fourteen percent that was indifferent) said that since they were going to return to their home country someday, it did not really matter whether they use services here or not. Half of participants do not recognize Maine to be their home in any way.

## Conclusions

This research is based on the idea that health and sickness are internal concepts within a culture, and in order to understand them we need to look at their relation with the political and social factors that condition human relations. It is safe to assume that at their arrival, migrant and immigrant populations experience some degree of cultural shock.<sup>vi</sup> Some people deal with this shock by detaching themselves from their cultural heritage in order to fit in (a process of cultural assimilation), while others try to carry with them elements from their own cultures to cope with the social differences (a process of cultural resistance). These processes are hard to measure given the cultural differences within Hispanic communities, including different traditions, different reasons for migrating, and in some cases different languages. The process of cultural

assimilation or resistance can be influential on a person's perception of their life in this foreign country.

There were more aspects of life mentioned by the participants than could be classified or mentioned in this report. The participants did not explicitly acknowledge a linear relationship between their cultural perceptions and their use of services; the researcher and the project advisor used their discretion to classify the information gathered into variables in order to provide general conclusions. Some of the aspects that we found to be influential to the cultural perception of health and sickness were related to religion, access to resources, working conditions and other cultural or traditional traits. Regarding the use of health services among the workers, we found that the amount of time living in this country (which is also related to the access of resources), the use of traditional or folk remedies as a way to heal health problems, the relationship with the rest of the community and the intention to return to their home country influence the level to which the workers make use of such services.

According to our data, the reasoning behind what a person considers health and sickness and how they view and access the health services available to them reflects other elements of their lives. These elements include cultural and geographical isolation<sup>vii</sup>, fear of language barriers and cultural differences with the rest of the population, loneliness and being apart from family, difficulties of getting and maintaining a job, not having time or resources to engage in other activities besides work, intention of returning to the home country making everything here seem temporary (in some cases even sickness), etc. These contextual and cultural factors can result in social barriers to seeking help or in the creation of a heightened dependency on programs that provide health services in some way. But these factors can also result in a feeling of a need for self-reliance when addressing health issues, which some researchers have viewed to be a cultural trait among Latino populations<sup>viii</sup>. It is our hope that further extensive research can contribute to and challenge these general observations.

Migration has been a central issue for ongoing political and social debates. Little privilege comes from the immigrant/migrant status; good health and available health care is usually part of the rights that are left behind. The reason underlying the proposal for this study was our belief that migrant and immigrant populations should be included and taken into account in the ongoing national debates about healthcare.

We believe that the provision of culturally sensitive services to these populations is key to their development in this country. Thankfully, according to some of the workers' testimonies as well as my personal experience, already many health care providers and nonprofits take into account the person's beliefs and cultural values when addressing their health. We hope that the results of this research will make a small contribution to the general knowledge about health beliefs among Hispanic migrant farm workers, and that it can contribute in some small way to the services provided.

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i Maine Migrant Health Program (2010)

ii Caplan, Susan. Paris, Manuel. *Correlates of Religions, Supernatural and Psychosocial Casual Beliefs About Depression Among Latino Immigrants in Primary Care*. Routledge (2010)

iii Culture understood as the activities, ideas, beliefs, values, and knowledge, which constitute the shared bases of social action

iv In anthropological, gender identities and relations are considered to be cultural aspects because they shape our daily life. In other words; gender relations are shaped by our culture.

v Also known as Traditional medicine, is consider to be health practices, approaches, knowledge and beliefs that incorporate alternative resources, manual techniques and exercises.

vi A label for the resulting feeling of homesickness, disorientation, helplessness and frustration after the exposure to an unfamiliar culture.

vii Only a 2.8 percent of the population in Turner is of Hispanic descent

viii S. Caplan (2010)