CE 2.3 contact hours

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By Jean C. Bokinskie and Tracy A. Evanson

Brenda and her family have been migrating from Texas to harvest broccoli in Maine since she was a little girl. Now Brenda is 25 and having second thoughts about migrating with her young daughter and ailing mother who was recently diagnosed with cancer.

Brenda says, "They (the workers) keep themselves strong and not go to the doctor. It would be between $30 and $50 without the medicine; the medicine would be $80. And we can't afford that" (Migrant Clinicians Network [MCN]*, 2008a).*

Did you know that over 85% of fruits and vegetables produced in the United States require hand-picking or cultivation (National Center for Farmworker Health, Inc [NCFH], 2002c)? The agricultural industry is dependent upon the manual labor provided by migrant farmworkers like Brenda and her family.

Somewhere between three to five million migrant farmworkers and their families travel throughout the United States (NCFH, 2002c) as they follow crops or shuttle within a 75-mile radius from their homes (Acury & Quandt, 2007). The conditions and discrimination experienced by these workers contribute to multiple health

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The Stranger Among Us: *Ministering Health to Migrants*

problems and disparities. Nurses in the faith community, especially parish nurses (PNs), can help meet the health needs of migrant farmworkers, workers, and their families. This article focuses on farmworkers; however, knowledge of Mexican-American culture, cultural competence, and ideas for health ministry could be used to help migrant workers employed in other types of work.

WHO ARE MIGRANT FARMWORKERS?

According to the 2001-2002 National Agricultural Workers Survey (U.S. Department of Labor, 2005), migrant farmworkers are employed in over 75% of U.S. states. Less than one-half were U.S. citizens or legal residents; 84% were Hispanic and 75% were born in Mexico. Spanish was the native language for 81% of the farmworkers, and 44% reported they could not speak English; on average, the highest grade completed was seventh. Most were male (79%) and married (58%) with an average of two children. The average total family income was from $15,000 to $17,499; 30% had total family incomes below the poverty guidelines. Only 23% had health insurance. These families have multiple barriers to health benefits and support services, and those who are undocumented face constant fear of deportation.

Agriculture is one of the most dangerous occupations in the United States (NCFH, 2002a). Migrant farmworkers are exposed to physical stressors from nature's elements (rain, hail, heat, lightning strikes, wind), and chemicals/pesticides. The strain of long hours of manual labor, mental and emotional stressors of separation from family members, unemployment, and long work hours add to the health risks. Substandard housing is a health threat for migrant families (Gentry, Grzywacz, Quandt, Davis, & Arcury, 2007; Magaña & Hovey, 2003). Housing concerns include close proximity to farm fields and pesticides, vermin, lack of window screens, poor insulation, and leaking roofs. Labor camps frequently lack adequate shower, toilet, and laundry facilities. Pesticide-contaminated clothing often is washed near food preparation areas or bathing areas (Hansen & Donohoe, 2003). Work demands, poor housing conditions, isolation, lack of recreational

Terms Used in this Article

Hispanic: individuals who are Mexican Americans, Mexicans, Puerto Ricans, Cubans or from Central and South America (NCFH, 2002c)

Migrant and migrant workers: migrant (those following crops or shuttling from a home base) and seasonal (those assisting with farm work during the tilling or harvesting seasons) farmworkers

Family: a single individual or a married/partnered couple with child(ren)/grandchild(ren)

Parish or Faith Community Nurse: an RN who serves the faith community by focusing on the needs of the parishioner, faith community, and surrounding geographic area with attention to spiritual needs

Faith community: churches, parishes, synagogues, or mosques

Clergy: ordained and lay faith community leaders

a Glance

- **Agricultural industry** *in the United States is dependent on migrant farmworkers who are predominately Hispanic*
- **The lifestyle** *experienced by migrant families contributes to obesity, cancer, stroke, diabetes, and heart disease*
- **The ministry** *of parish nursing is an excellent way to offer health support to migrant families*
- **A Biblically Based Model of Cultural Competence** *is vital to provision of culturally sensitive nursing care*
- **The seven** *established roles of parish nursing practice give guidance for developing health programs for migrant families*

activities, and poverty have been associated with high levels of anxiety, depression, substance abuse, and domestic violence in this population (Magaña & Hovey; NCFH, 2002c).

Hispanic migrant families experience an elevated risk for obesity, cancer, stroke, diabetes, heart disease, asthma, tuberculosis, and dental problems (Acury & Quandt, 2007; MCN, 2008b; U.S. Department of Health and Human Services [DHHS], 2008). In 2003-2004 the prevalence of obesity in Hispanic adults was 36.8%, compared with approximately 30% of non-Hispanic white adults (DHHS, 2007b). Hispanics are 1.7 times more likely to have diabetes as non-Hispanic whites of similar age (National Diabetes Information Clearinghouse [NDIC], 2005). Low levels of exercise, unhealthy diets, and stress contribute to obesity, type II diabetes, and hypertension (DHHS, 2007a).

CULTURAL CHARACTERISTICS

Most migrants come from Spanish-speaking countries of Mexico, Cuba, Puerto Rico, and Central or South America (NCFH, 2002c), where similar cultural beliefs exist, although diversity exists within groups. Healthcare providers (HCPs) should avoid stereotyping entire cultural groups based on information provided by select group members as there may actually be more diversity within the culture than between cultures. In order to provide culturally sensitive and personalized care, HCPs must spend time with individuals to understand their unique needs.

Family life in the Mexican American culture is centered on the extended family, patriarchal hierarchy, and distinct family roles (Lausch, Heuer, Guasasco, & Bengiamin, 2003). Migrant families may have some common cultural characteristics which could impede or enhance the implementation of healthy behaviors. Physical activity is a part of the culture; however, exercise is accomplished through manual labor or walking to the grocery store rather than through organized physical activities (Van Duyn et al., 2007). Heredity, obesity, poor nutrition, and stress are believed to cause diabetes in this population (Adams, 2003; Cartwright et al., 2006). Personal stressors may come from worrying about family members back in Mexico, fears of deportation, and discrimination. Obesity rates for Hispanics may be elevated due to poverty and cultural traditions. It is sad irony that migrant families usually cannot afford to buy the expensive fruits and vegetables they harvest, relying instead on less expensive high-fat, high-calorie, and processed foods. Childhood experiences of hunger may contribute to the desire to eat until satiety is achieved (Cartwright et al.). In the Mexican culture, not engaging in celebrations by eating may be seen as being inhospitable and weight loss has been perceived as an "act of vanity which was not consistent with having humility before God" (p. 103).

Illnesses have a body, mind, spiritual, and family connection in the Mexican culture. *Nervios* is a nervous state of insomnia or anxiety believed to be caused from chronic stress, whereas *sustos* is a condition resulting from a frightening event and manifests as insomnia, appetite changes, and malaise (Weigel, Armijos, Hall, Ramirez & Orozco, 2007). Formal religious beliefs (primarily Catholicism) are blended with traditional folk beliefs in the culture's healing practices, through traditional healers or *curanderos* (Hovey & Magaña, 2000; Mull & Mull, 1983). Surrounded by religious icons, the curandero employs traditional folk medicines of massage, herbs, egg, and teas to diagnose and treat illnesses (Mull & Mull). Having received the healing gift (*don*) from God, the curandero may use prayer as a part of treatment.

ADDRESSING HEALTH NEEDS

Diabetes, heart disease, and obesity are chronic diseases that require close

management by HCPs and self-management by the client in order to prevent long-term complications. Health promotion activities that increase physical activity and promote weight loss and selection of healthy food choices have been shown to delay or prevent type II diabetes (NDIC, 2005). In a study on diabetes self-management, Latino patients were able to state a number of specific strategies related to diet, exercise, medication use, and personal care. Explanations for lack of self-care included lack of control over cultural influences, limited understanding of health related information, and financial concerns (Carbone, Rosal, Torres, Goins, & Bermudez, 2007).

The provision of healthcare services to migrant families is a major concern (Acury & Quandt, 2007). Migrant families usually do not have insurance or finances to pay for diagnostic tests or treatments, release time from work to attend health provider appointments, or reliable transportation (NCFH, 2002a). Work hours must accommodate the crops, therefore most migrants are not able to access routine health services during traditional hours.

Language and cultural barriers are an issue when accessing services. It is estimated that 85% of migrant workers have difficulty processing written information regardless of the language in which it is presented (NCFH, 2002b). Exemplar programs have been developed throughout the United States to address the healthcare needs of migrant families. For example, Migrant Health Services, Inc., a private nonprofit organization serving migrants in the upper Midwest, has implemented a diabetes lay education program to provide diabetes education and support from the spring to fall. From fall to spring, the diabetes lay educator continues providing services to the same population when they return home to southern Texas (Bergland, Heuer, & Lausch, 2006).

Literature related to migrant workers' health lacks information about the positive attributes and abilities of migrant families beyond the cultural strength of family support (Lausch et al., 2003). The focus is on disabilities rather than abilities; offering services to care for because of need, rather than supporting self-care out of cultural desire, reflecting caring *for*, rather than caring *about*. Another model, using HCPs in creative and supportive ways, is needed. Providers can best serve migrant families by developing programs built upon the population's strengths. Faith communities support a sense of community that promotes healthy lifestyles and positive health behaviors (White, 2001). In a study on migrant farmworker acculturative stress, anxiety, and depression, Hovey and Magaña (2000) noted that religious affiliation fostered social support, church attendance increased coping abilities, and enhanced religiosity decreased distress.

PARISH NURSING

The ministry of parish nursing is modeled on the work of Jesus, who spent his life preaching, teaching, and healing. The PN functions within seven areas of health and healing ministry: health educator, personal health counselor, volunteer coordinator, community liaison/referral agent, developer of support groups, health advocate, and integrator of faith and health (Solari-Twadell & McDermott, 1999). Activities within the PN role may include organizing health screenings/fairs, referring parishioners to HCPs and services, actively listening to parishioners' life stories, advocating for access to healthcare and healthy lifestyles and behaviors, and offering prayer and spiritual support. The PN is well-suited to provide culturally competent care for migrant families who are both members and guests of the faith community, and can be assisted by other nurses in the faith community. In order to do so, nurses need a strong biblically based foundation in which to guide ministry and enter into a process of growth in cultural competence.

BIBLICALLY BASED CULTURAL COMPETENCE

According to transcultural nurse expert, Josepha Campinha-Bacote, "if healthcare professionals understood the truth that all human beings are made in the image of God, it would set them free from racism and allow them to care for culturally and ethnically diverse clients in a moral and ethical manner" (Transcultural C.A.R.E. Associates, 2008). *A Biblically Based Model of Cultural Competence in the Delivery of Healthcare Services* integrates intellectual and moral virtues and provides a framework for the provision of culturally sensitive nursing care. This model, based on Campinha-Bacote's (1999) original model of cultural competence, defines cultural competence as an ongoing process. There are five interdependent constructs that must be addressed to becoming culturally competent.

The lifestyle, living and working conditions, and discrimination experienced by these workers contribute to multiple health problems and disparities.

Cultural awareness means that the provider goes beyond personal bias and appreciates the unique beliefs and practices of others. The nurse needs to acknowledge his or her own perspectives of migrant families' beliefs and attitudes, in order to gain new perspectives. *Cultural knowledge* requires the provider to explore and understand the client's emic perspective through sharing of one's life story. This allows the nurse to gain insights into the client's physical, emotional, and spiritual strengths and weaknesses. Cultural knowledge requires an attention to learning about the individual as much as the culture. *Cultural skill* is the ability to gather information from the client with sensitivity toward the client's culture and individuality. Through multiple *cultural encounters*, the nurse gains insight into the individual's needs beyond the cultural norms. Multiple encounters may help in supporting self-care behaviors of the individual. The ability to speak the native language may not be an issue when gathering information (Kim-Godwin, Alexander, Felton, Mackey, & Kasakoff, 2006), rather it is the ability of the nurse to show unconditional acceptance of the client. *Cultural desire* is the internal drive to continue in the ongoing process of cultural competence. Desire is the unconditional love and caring that is foundational in Christian teaching (Transcultural C.A.R.E. Associates, 2008).

DEVELOPING CULTURAL AWARENESS

To begin the process of cultural competence, the PN and other nurses in the faith community need to become aware of the presence of migrant families. The PN needs to work with faith community members and clergy to welcome new and returning families. Hispanic art, wall hangings, and blankets may be placed in the church setting as a way to provide a welcoming atmosphere (Lausch et al., 2003). Bulletin boards and brochures in Spanish are an inviting gesture.

Clergy and nurses can meet with migrant families to assess their spiritual needs, understand their cultural practices, and hear their individual stories. In a study on health needs of immigrants and refugees, a provider stated "Number 1: listening, number 2: listening, and number 3: listening. Learning their stories, knowing what makes them function, what touches their hearts and souls is important in order to help them…" (Fennelly, 2006, p.199). Respecting and understanding others is important in developing trusting relationships in this population (Kim-Godwin et al., 2006). In close collaboration with leaders in the migrant community, the PN and clergy can develop programs to meet expressed needs. Multiple ongoing encounters with faith community members may help to develop relationships and provide a more open opportunity for migrant families to request assistance (Clingerman, 2007a). Ideally, it would be beneficial to have a Hispanic nurse who has in-depth understanding of the cultural values, beliefs, and practices. In the absence of such an individual, Spanish-speaking non-Hispanic nurses or others could be used to assist with interpreting, developing, and implementing programs.

PROGRAM IDEAS

Ideas for programs that could be implemented with migrant families are limited only by the faith community's beliefs and nurses' creative limitations. Health-related programs should be offered during nondaylight hours, when migrant families can access them. Annual evaluations of programs are necessary to make changes before the next season and should include the input and perspectives of the participants, in order to effectively identify successes and areas for improvement. Furthermore, it is essential to publish information about effective programs to the greater healthcare community since the evidence base in this area is limited.

Because of the large number of illegal immigrants among migrant farmworkers, churches can have concerns about the legalities of assisting migrant families. Information about legal and illegal support to illegal immigrants is available as supplement digital content, "Helping Illegal Immigrants: What Is the Law?" at http://links.lww.com/NCF-JCN/A1.

Specific programs that might be offered within the PN role to support migrant families include the following:

Integrator of Faith and Health. Working in collaboration with a local *curandero* and clergy, the PN can provide culturally appropriate care that supports traditional folk and religious beliefs. Offering healing and worship services and prayer groups in Spanish may reduce feelings of sadness or homesickness experienced by non–English-speaking church-goers (Clingerman, 2007b). The PN could sponsor education focusing on the importance of developing balance in life; the relationships between physical, emotional, and spiritual symptoms and various disease states; and ways to promote wholeness when cure is not possible.

Developer of Support Groups & Volunteer Coordinator. The work season for migrants may last a few weeks to a few months. Regardless of the time spent in one location, a sense of safety and belonging are important. Social support provides a sense of belonging and identity among Mexican American farmworkers (Hovey & Magaña, 2000). The PN can provide opportunities for parents and children to discuss concerns about transient lifestyles, parenting concerns, and stress from leaving family members (Magaña & Hovey, 2003). Clingerman (2007a) found that migrant women attributed importance to the time required to prepare physically, emotionally, financially, and spiritually for the next phase of migration. Support for the women could be provided through opportunities to discuss their feelings, or by engaging the help of other nurses and faith community members to assist with childcare or preparations for the move.

In order to foster cultural awareness in the larger faith community, the PN can sponsor education regarding Mexican American culture for faith community members. Education on unique needs, faith beliefs, and values can assist the community in developing comfort when working as volunteers and enhance a welcoming environment. Spanish classes could be taught by those fluent in the language or by individuals from the migrant community. The PN could facilitate discussions between migrant families and members of the larger faith community, helping both groups better understand each other's beliefs and values.

Community Liaison/Referral Agent. PNs work in close partnerships with local organizations and are well suited to assist migrant families in locating health services. The PN may assist families by connecting them with the NCFH's Call for Health program, which locates health services information and referral resources in a region (see Web Resources). The program also provides financial assistance for healthcare once all other local resources have been exhausted.

Personal Health Counselor. The PN may offer a listening ear and provide a supportive environment for migrant families. Depression, substance abuse, and domestic violence are reported risks, often due to isolation and economic hardship (MCN, 2008b), and personal health counseling should include screening for these conditions. Interactions may allow the nurse to form lasting and trusting relationships regardless of episodic lapses related to the population's transient lifestyle (Lausch et al., 2003).

Health Advocate. There are multiple ways in which PNs and other nurses can serve as health advocates for migrants. For example, advocating for safe housing by encouraging local housing authorities to enforce quality standards. Faith community members can be enlisted to help families find affordable housing free from rodents, mold, and pollutants. The PN can advocate for improved living and working conditions with faith community members who employ migrants.

On a larger scale, the PN can educate and encourage faith community members to serve as advocates beyond the local community. Advocates can encourage city councils and legislators to develop policies that address environmental issues, healthcare coverage, and farmworker safety and support national organizations focused on the plight of migrants (see Web Resources).

Health Educator. The faith community is an effective location for the provision of health promotion activities to assist in chronic disease management and to reduce the risks of obesity, diabetes, and hypertension in migrant families. Van Duyn et al. (2007) found that strategies that increase social support reduce barriers to physical activity in minority populations. Additionally, they found that Latina women desired church-based exercise programs because of the safe

For information about assisting illegal immigrants and current law, see http://links.lww.com/NCF-JCN/A1.

location. Existing exercise and nutrition programs can be adapted by adding culturally appropriate music, food selections, and teaching materials in Spanish. For example, the *Faithfully Fit Forever* program, a faith-based health promotion program developed by the Parish Nurse Ministry and Cardiovascular Rehabilitation Services, MeritCare Health Systems (2003), could be adapted. Hispanic lay leaders could serve as trained volunteer leaders and implement the program.

Many faith communities host weekly meals and fellowship hours, or other food-related events. These offer an opportunity for nutritional education and role modeling. The PN could implement a culturally appropriate version of the *Nurturing Youth Through Faith, Fitness and Food* program. This program developed through the Concordia College Parish Nurse Center (2005), addresses nutrition and activity issues of preteen children. The devotional materials and menus could be adapted to the cultural and dietary patterns of the migrant population. Culturally appropriate food models that reflect the portion size and types of foods commonly consumed by Hispanic populations are available. Balanced nutrition on a budget, safe food handling, and information on how to access local food assistance programs also can be addressed.

Health fairs are a common source of preventive care for Hispanic migrant families (Goertz, Calderón, & Goodwin, 2007). Health promotion and screening related to hypertension, heart disease, diabetes, dental, musculoskeletal health and vision can be included at a single time and location. Culturally appropriate educational resources in English and Spanish on health and safety issues are available from governmental or national organizations (see Web Resources). The PN also can use this information to develop bulletin boards on health promotion topics. Since literacy rates are low in this population, it is important to utilize pictures and graphics as much as possible, rather than relying on written materials. The faith community could be used as a clinical education site for nursing and other allied health professions. Students could develop educational materials, provide workshops, or lead exercise sessions, while gaining valuable experiences and developing cultural competence.

Intergenerational programs or dances can nurture relationships within the migrant population. These activities combine group socialization with exercise, thereby decreasing social isolation and improving physical activity. Music should reflect appropriate culture for all age groups. Multicultural programs can educate about the culture diversity and similarities among groups within the entire faith community.

In an effort to enhance continuity of care for migrant families, the PN can network with other health ministries throughout the U.S. Lay leaders, who are respected members of their communities, can be trained to facilitate programs as well. In a manner similar to Migrant Health Service's diabetes lay educator program (Bergland et al., 2006), education and support of the lay leader would need to occur prior to migration from the area. The PN and lay leader could maintain long distance communication to share insights, discuss strengths and weaknesses, and make program revisions on an ongoing basis.

PNs can coordinate with local schools to offer English as a second language to help empower members of the migrant population. In addition, health career fairs can help recruit minority students into health professions. The PN, as a caring role model, can serve as the impetus for further education for migrant families.

CONCLUSION

The United States relies on migrant workers to provide a valuable service; therefore we have a responsibility to provide support to these individuals and their families. As believers in Jesus, followers of his teachings, and members of faith communities, we are

Web Resources

- Farmworker Justice, Inc.—http://www.fwjustice.org/
- Migrant Clinicians Network, Inc.—http://www.migrantclinician.org/
- National Center for Farmworker Health, Inc.—http://www.ncfh.org/
- Call for Health - 1-800-377-9968 (a program of NCFH)
- Immigration Basics Fact Sheet—http://www.justiceforimmigrants.org/ParishKit/ImmigrationBasics.pdf

called to care for others. The "calling to care" goes beyond the comforts of the local faith community. Jesus spent much of his ministry with the poor, ill, and outcasts—namely, the vulnerable. Parish and other nurses are well equipped to assist the faith community in providing culturally competent care for migrant families through various roles. In communities served by migrant farmworkers, nurses can play a significant role in reducing health disparities in this vulnerable population.

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