Listening to the Quiet Voices of Hispanic Migrant Children About Health

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There is a paucity of literature related to school-aged migrant children's perceptions of their own health. To best provide culturally competent care, more information is needed about migrant children's experiences. Focus-group methodology allowed the voices of migrant children to be heard by primary health care providers at a summer school program for children of migrant farm workers in south Georgia. Seventy-three children participated in 14 focus-group sessions. Six themes emerged from the data that were analyzed by using a qualitative software system. They are healthy behaviors, acculturation issues, environmental influences, health care actions, health behavior outcomes, and learning needs. Emerging patterns within each theme render insight about these migrant children. The findings suggest implications for pediatric nurses related to culturally competent care.
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ACCULTURATION CAN BE stressful to children when entering the United States. One aspect of acculturation important to health care providers is that of health practices. Being healthy has positive implications for growth and development, learning, and the creation of healthy adult lifestyles. Migrant children are at greater risk for delays in the areas of growth and development, as well as learning, because of the transient nature of their family life. Hispanic migrant farm workers in the U.S. have been difficult to study because of their mobility associated with the change of seasonal crops and locations for employment. Children in migrant families are at high risk for many health problems because of their living conditions and limited access to health care. In addition, they are often exposed to infectious diseases (like tuberculosis [TB]), parasites, and pesticides; they also suffer from malnutrition, upper respiratory infections, gastroenteritis, dental caries, inadequate immunizations, accidents, and limited access to education and rehabilitation programs (Gwyther & Jenkins, 1998). Most of the information about migrant farm workers and their families has been obtained through databases, and there remains little literature related to school-aged migrant children's perceptions of their own health. To best provide culturally competent care, more information is needed about migrant children's experiences. Thus, the purpose of this qualitative study was to explore Hispanic migrant children's perceptions of their health, health practices, and access to health care.

CONCEPT OF HEALTH

For more than a century, the concept of health has been at the core of many theories tied to the health professions. With the advent of managed care over the last decade, many professionals have scrambled to define the concept in such a way that captures direction for the development of health-promotion programs that yield positive outcomes. However, the evolving concept of health has caused many programs to have only limited usefulness over time and to often yield only short-term outcomes.

To most, the definition of health is individual and subjective, in that it "exists in the mind and body of the individual" (Watson, 1979, p. 222). The World Health Organization (WHO) has defined health as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity." Although this definition is considered

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0882-5963/00/1503-0002$10.00/0
doi:10.1053/jn.2000.6018

broad, its universality depicts health as influenced by all environmental influences. This WHO definition takes into account not only the physical condition of the body, but also the state of mind. It has been noted that the mental processes are perhaps the most important influences on one's health, for they determine one's attitude about life, one's interaction with others, and how one deals with physical and social surroundings.

Thus, seeing health as the totality of one's existence is the holistic view of health. Such a view recognizes the interrelatedness of the physical, psychological, emotional, social, spiritual, and environmental factors that contribute to the overall quality of a person's life. In other words, no part of the mind, body, and environment is truly separate and independent. Thus, holistic health is hardly a revolutionary idea—even the Old English root of our word *health* (*hal,* meaning sound or whole) implies that there is more to health than freedom from sickness. In essence, health is known by the experiencing person.

Interest in health is rapidly moving into the community with heightened concerns about the health care needs of underserved populations. The migrant farm worker population is one such population. Most of the information gathered about migrant farm workers has been derived from databases and portrayed by outsiders in literary pieces and films rather than directly from the migrant farm workers themselves. The integral role of the migrant farm worker in everyday American life mandates attention to their health needs, which can be best accomplished by actively engaging them in studies in which their voices can be heard. One such study was conducted in south Georgia by using a focus-group methodology in which migrant farm workers had the opportunity to voice their health concerns (Perilla, Wilson, Wold & Spencer, 1998). Three themes emerged from their voices: health care issues, living and working conditions, and social and community issues. More specifically, they voiced concern about the lack of health care services available, poor living and working conditions, their fear of immigration officers, the drug and alcohol use among the farm workers, and racism and prejudice. The participants identified priority issues, which began with the need for English classes, and included educational needs, parenting classes, and tutoring for migrant children. The participants in this study were adults who voiced their health concerns, but their children's voices about health concerns were not known.

CHILDREN'S UNDERSTANDING OF HEALTH

Studies among children began in the mid-1960s and primarily focused on their understanding of the concept of health (Rashkis, 1965; Natapoff, 1978). It was during the early 1980s that a number of studies devoted to children's concepts of health and illness and their implications for health education were initiated (Gochman, Bruhn, & Parcel, 1982; Perrin & Gerrity, 1981). These studies used frameworks that were predominantly "cognitive" (such as the health belief model), "behavioral" (emphasizing external reinforcement of overt actions), and "developmental" (exploring the impact of age and experience). The domains of children's health-related beliefs and behaviors were noted to be related to a broad spectrum of personal events, such as nutrition and exercise patterns. Furthermore, most of the studies did not rely on information from children, but multiple adult informants in each child's circle of influence, such as parents, teachers, and physicians (Eisen, Donald, & Ware, 1980). Additionally, much of the earlier research on children's health was gathered through the use of quantitative methods with questionnaires and surveys.

A child's understanding of health depends on the organization and interpretation he or she gives to perceptions of his or her body, to the response of others to his or her body, and to the effects of the environment on his or her body (Rashkis, 1965). Results of studies have consistently suggested that children view health as a positive-toned feeling-state and view health as feeling good and being able to participate in desired activities (Rashkis, 1965; Natapoff, 1978; Lasky & Eichelberger, 1985). Young children generally view health as a positive, enabling concept unassociated with illness, whereas older children associate health and illness but see health as long-term and sickness as short-term (Natapoff, 1982). Ideas about health also mature with age as evidenced by abstract qualities of mental health that enter into the concept as the child enters adolescence (Natapoff, 1978).

The definition of health through children's eyes was broadened beyond the traditional concepts of health, such as nutrition, exercise, sleep, and safety, during the late 1980s and 1990s. The expanded view of health included social influences, environment, and distinction by gender and age. School-aged children's perceptions and concerns about health were studied, and the findings suggested the strong social influences of parents, family members, and school personnel on the child's perception

of health. Specifically, family roles and responsibilities and relationships with key adults in the school-aged child's life had a significant influence on their view of health (Hester, 1987a, 1987b).

Changing family roles, such as single-parent and two-working-parent households, during the 1990s have influenced children's perceptions of health. In the context of the changing family roles, more prepared meals are being purchased, and there is an increase in eating in fast food restaurants. School-aged children were found to have a knowledge of healthy foods; however, they were unable to consistently select healthier items when asked. The same children reported snack foods consumed in their homes, and many of those foods included chips, cookies, and cheese (Colizzo & Colvin, 1995).

Other studies related to school-aged children's perceptions of health focused on factors that influence health behaviors and identified gender differences (Ferrand & Cox, 1993; Graham & Uphold, 1992). The findings from these studies indicated that most boys and girls perceived themselves as healthy and able to participate in self-care activities such as seat-belt use, exercise, and dental health. In one study, boys reported more regular dental visits than girls (Graham & Uphold, 1992). Also, the gender of the child and the educational levels of the parents were factors found to contribute to children's health behavior (Ferrand & Cox, 1993).

Despite what is known about the concept of health, a universal definition does not exist because of the multidimensionality of the concept of health. Thus, it is difficult to measure health because health and wellness attributes are not well defined, the cultural determinacy of health varies, and the value of health is a derivative of cognition and ideas (Natapoff, 1978).

There remains a gap in the literature about migrant children's perceptions of health. Most of the literature related to Hispanic children of migrant farm families is focused on health status and barriers to care and has been generated from databases (Gwyther & Jenkins, 1998). There are no reports in the literature at this time about health perceptions that have been generated from migrant children themselves. In addition, there is a great need to learn more about migrant school-aged children's perceptions of issues related to health and acculturation. The voices of Hispanic migrant children can provide new information useful in nursing practice. Children's responses can be viewed within Piagetian theory.

CONCEPTUAL FRAMEWORK

The development of the concept of health seems to follow a progression similar to Piagetian theory of cognitive development, which includes an understanding of cause and effect, the ability to conserve ideas and reverse thinking, and considerations of the future (Natapoff, 1982). Children less than 7 years of age are in the pre-operational stage whereby they are egocentric, intuitive, present oriented, and unable to consider the whole and part simultaneously. These younger children likely view health as doing desired activities and feeling good, do not see health and illness as related, and do not consider cause and effect. For the child between the ages of 7 and 10 years of age who is in the concrete operational stage, cause and effect is considered. Conservation develops. (The child can consider original and changed state.) Reversibility develops. (Thinking processes can take place in opposite directions.) He or she can think through a chain of events and can classify objects and concrete ideas into a hierarchical arrangement. These young school-aged children view health as being able to perform desired activities and believe it is possible to be partially healthy and partially unhealthy at the same time. In addition, they are able to understand the relationship between cause and effect—action and health status; they can understand the concept of reversibility in health and sickness. For the late school-aged to adolescent child who is in the formal operational stage, future orientation is noted. Hypotheses can begin to be formulated. Abstractions can be considered, and deductive reasoning develops. These older children also view health as performing desired activities but view health as long-term and illness as short-term. They begin to consider mental health, as well as future health (Natapoff, 1982; Perrin & Gerrity, 1983; Piaget, 1963; Piaget & Inhelder, 1969).

METHOD

Design

The purpose of this study was to answer three research questions related to Hispanic migrant school aged children's perceptions of their health needs, learning needs, and concerns about health and access to health care. A qualitative approach was selected because of the lack of studies in which migrant children themselves participated. Qualitative methods are useful when studying under represented groups at risk for health problems. Also, insight can be gained about cultural issues relevant to health and illness by using the qualita-

tive method (Fiese & Bickman, 1998). Of utmost importance to this study is that qualitative inquiry can provide a better understanding of how the perceptions of health and illness of Hispanic children of migrant farm worker families can influence their participation with the health care system in the U.S.

Focus-Group Methodology

Much remains to be learned about the relationships between culture, socioeconomic status, and health that transcend the methods of quantitative research. The value of inductive reasoning, observation, unstructured interviews, focus-group methodology, and triangulation of qualitative and quantitative methods is shaping the discovery of influential variables that ultimately lead to theory generation and policy action. Focus groups allow participants the opportunity to comment, explain, and share information, unlike the structured and directive interview led by the researcher. Children are able to participate in research by using the focus-group method, and the method is an effective way to enter and understand children's perspectives (Charlesworth & Rodwell, 1997). The focus-group methodology allowed the voices of Hispanic migrant children to be heard by primary preventive health care providers in this study.

PROCEDURE

An explanation of the study was given, and permission to approach parents and children attending a summer-school program for children of migrant farm workers in south Georgia was granted by school officials. Informed consent was granted by a parent, and verbal assent was obtained from each child participating. We met with the teachers of grades 3 through 8 and arranged a convenient time to talk with students. An explanation of the study was given to the children, and those children who had parental permission and wanted to join a group went with us to the designated room. Before beginning each focus-group session, we developed a rapport with the children by allowing each child to say something into the tape recorder. When their voices were played back, some children seemed surprised at hearing their voices. Some laughed, and others were intrigued at hearing their friends' voices. Each child was asked if he or she still wanted to participate in the group, and his or her "yes" on the tape was the assent to participate. None of the children's names was recorded on the tape, to assure confidentiality, and all results were reported as group data. Structured questions were used to guide the focus groups (Table 1); however, we allowed the children the opportunity to expand on any of the topics covered. At the end of each focus group, we asked the question, "Is there anything else you would like to tell us about your health or learning needs?" The purpose of this final question was to continue to provide an opportunity for any child in the group to share additional information and to elicit any new information not previously discussed in the focus group.

RESULTS

Sample

Fourteen focus-group sessions consisting of 4 to 8 school-aged children (n = 73) enrolled in a summer-school program for children of migrant farm workers in south Georgia were conducted. The children's ages ranged from 8 to 14 years, and they were enrolled in grades 3 through 8. All of the children were fluent in English with the exception of six who had limited English-speaking skills. There were more boys (60%) than girls. The children had been in the U.S. from 2 months to 12 years. Most of the children were born in Mexico, and the others were born in Texas, Florida, California, and Michigan. All of the children's parents were born in Mexico, except for one child who reported that his mother was born in Texas.

Data Analysis

The qualitative data captured on audio tapes were transcribed verbatim and imported into a multifunctional software computer program referred to as Non Numerical Unstructured Data Indexing Searching and Theory-building (QSR Nud*IST, 1997, Qualitative Solutions & Research Pty Ltd, Melborne, Victoria, Australia). This computerized software program facilitated the management of the qualitatively derived unstructured focus-group data through the various phases of data entry, indexing, searching, and theorizing. Nud*IST analysis allows researchers to remain close to the data, while preserving its contextual aspects, and permits

Table 1. Focus-Group Questions

1. What does it mean for children to be healthy?
2. What do children need to learn about health?
3. What do you need to be healthy in school?
4. What makes you interested in health?
5. Tell us about how you get your health checks?
6. Take a moment and think about what you would want the nurses here to do to help you with your health.
7. Is there anything else you would like to tell us about your health or learning needs?

the opportunity to observe the emerging themes and patterns.

The data entry phase consisted of importing into the Nud*IST program the transcribed focus-group sessions, which were on disk. The second phase, indexing, creates an index system.

Results

Six themes emerged from the qualitative analysis (Table 2). They were as follows: healthy behaviors, acculturation issues, environmental influences, health care actions, health behavior outcomes, and learning needs. Examples from each theme are presented, exemplifying the voices of the children (Table 3).

HEALTHY BEHAVIORS

Healthy behaviors were identified by the children as selecting healthy foods, exercise, sleep/rest, dental care, cleanliness, avoiding alcohol/cigarettes, and getting along with people. The children identified milk, fruits (apples, bananas), vegetables (spinach, corn beans), juice, fish, chicken, and rice as healthy foods to eat. They stressed the importance of having breakfast every day and eating healthy foods for lunch at school. They also stated that it was important to avoid eating lots of eggs and candy.

Table 2. Emergent Themes

Major Themes	Secondary Themes
Healthy behavior	Selecting healthy foods
	Exercise
	Sleep/rest
	Dental care
	Cleanliness
	Avoiding alcohol/cigarettes
	Getting along with people
Acculturation issues	Positive aspects
	Friendships
	Educational opportunity
	Safety
	Negative aspects
	Conflict
	Resource acquisition difficulty
Environmental influences on health	Support systems
	Parental involvement
	Parental role modeling
Health care actions	Health maintenance responses
	Alternative health care practices
Health behavior outcomes	Perceptions of health care
	Expectations of health care
	Health care recommendations
Health learning needs	Healthy diet
	Exercise
	Water intake
	Cleanliness

The children talked about exercise as a healthy behavior and told us that riding a bike, playing outdoors, playing soccer, walking, and running were some ways they exercise. The children in all groups agreed among themselves that it was important to exercise and that they liked to exercise. They were able to associate health with keeping their bodies in good shape by exercising. Some children talked about their parents exercising. None of the children associated their parents farm work as exercise.

Getting sleep and rest were described as important health behaviors by the children in this study. They identified 8 to 10 hours of sleep each night as being good for children their ages. Some children thought that taking a nap during the day was helpful to health. They talked about being very busy at times and not getting enough sleep at night. The remedy for lost sleep was to catch up on the weekend.

The children also talked about taking care of their teeth as a health behavior. They identified cavities as something to avoid and talked about going to the dentist. They were knowledgeable about how and when to brush their teeth. One child even talked about brushing his tongue. The children identified fruits and vegetables and the avoidance of sugars and candy in their diet, as ways to have better teeth.

Cleanliness was an important topic to the children. The children in all the focus-group sessions appeared to be clean and wore clean clothes. They knew about head lice and prevention strategies such as combing and brushing their hair daily, no sharing of hats, and having their heads checked for lice.

The children in this study were aware of drug and alcohol use in their communities. Some children even spoke of family members who drank too much alcohol. Their views of using drugs, alcohol, or smoking were negative. None of the children reported wanting to use drugs or alcohol or smoke themselves. The children in grades 6 through 8 thought it was important to teach younger children to avoid drug and alcohol use. Some children related experiences about people using drugs or alcohol and associated these behaviors as undesirable and unhealthy.

Getting along with people was associated with health. The children talked about the importance of interacting with their family members in their daily lives so they could learn about health. In addition, they emphasized the need for friends in their lives

Table 3. Migrant Children's Voices Illuminating Major Themes

Theme	Children's Voices
Healthy behaviors	Selecting healthy foods
	"You should always drink a lot of milk because it is healthy for you."
	"It's important to select fruits and vegetables for lunch at school."
	"You have to eat a good breakfast everyday."
	"Apples, fruits, vegetables, bananas, bread, milk, juice, fish, and rice are healthy foods." "Chicken."
	"I don't eat a lot of eggs."
	"Do not eat a lot of candy."
	Exercise
	"Health means to keep your body in good shape."
	"I exercise because my mom walks every day."
	"My mom walks around the flowers, and she likes to look at things that are pretty while doing her exercise."
	"I ride my bike."
	"I like to play soccer with my friends."
	"I run around outside my house."
	"Playing in your yard."
	Sleep/rest
	"Get a good night sleep; 8-10 hours."
	"Sometimes your body just needs time to catch up."
	"Sometimes your schedule is so busy that you can't get enough rest during the week so you have to catch up on the weekend."
	"Take a good nap every day so your brain can rest."
	Dental care
	"Brush your teeth after every meal so you don't get cavities."
	"And brush your tongue every day."
	"You should go to the dentist three times a year."
	Cleanliness
	"Comb your hair, clean your face, take a bath, put your shoes on each and every day."
	"Have clean clothes. Then get your clothes laid out. What I mean is to get yourself organized."
	"Brush your hair every day so you don't get lices."
	"Check your head about once a month."
	Avoiding drugs and cigarettes
	"Dont' use drugs." "Don't smoke." "Don't drink alcohol."
	"Don't stand on railroad tracks when a train is coming, because I saw three boys on a railroad track and some boy got struck by the train, and they should not have been drinking on the tracks."
	Getting along with people
	"Friends and relationships are valuable to health."
	"Being healthy means having your friends and family around you."
	"Listening is being open to what other people tell you to help you be healthy."
Acculturation Issues	"Having lots of friends because we don't know anyone else but those of us from Mexico."
	"You get to know each other well because we have a lot in common being from Mexico."
	"Being with friends while our parents are at work."
	"I like it here in the United States because I get to go to school, but in Mexico, some of my cousins have to work instead of going to school."
	"Going to good schools [in the U.S.] because our schools in Mexico don't help us to learn much."
	"I like going to school here [U.S.] because we get to take classes like P.E. where we play soccer and learn to speak English."
	"Here [U.S.] we get school supplies when we go to school, but in Mexico we get nothing."
	"Being safe in good schools making us able to learn better."
	"Having someone to go to when you're afraid like a teacher or a coach," "Learning new ways to solve our problems without fighting."
	"You [people in the U.S.] have lots of violence."
	"Some of the people . . . different groups of people don't get along."
	"The police are a problem." "They take you back to Mexico. This is true especially when you have no papers."
	"When we see the police coming, we go into the house so they can't get us, and we lock our doors."
	"Sometimes we have to stay inside a lot because we have to hide from the police; our mother is not home to help us but tells us we have to stay inside."
	"Buying food that we like from Mexico is not easy for us in this country." "We don't get the paper regularly."
	"Access to health care professionals is different in America."

Table 3. Migrant Children's Voices Illuminating Major Themes (Cont'd)

Theme	Children's Voices
Environmental influences on health	"On the weekends we all get together with our friends, uncles, aunts, and cousins to eat and visit as a family."
	"I like to get together with my family to talk about times together in Mexico."
	"In our family we talk about things that are important to make decisions for our family so that we will be safe and healthy."
	"My mom gets up too early in the morning to help us get ready for school."
	"When I come home from school, my mom is there and always has something for us to eat."
	"Some of the kids come to our house because my mom is home, and she helps us do things that are fun and safe."
	"I like walking because my mom walks every day. She likes to take walks where she can see flowers."
	"My dad jogs; running is good for you."
Health care actions	Health maintenance responses
	"I make my own food. I cook steak, chicken, rice, and beans."
	"In the morning, I get myself ready for school even though my mother is home and my dad is already gone to work."
	"I choose to eat vegetables, fruits, and juice."
	"I try to tell my brother the best food for him to eat so he can learn."
	"I woke up at 5 so I can be ready for school on time."
	Alternative health care practices
	"One day I got something in my throat, and my momma didn't know what it was, so my mom put a cloth around my neck and tied it at the top. She then put something in the cloth. It was like a cream but it stinks."
	"My mom uses a plant when I'm sick. She do something with the plant, I don't know what, and she'll put it . . . I think she put it in your hand or something."
	"She [mother] and her friend plants them and grows them 'cause you need to pour some water on it."
	"You put the green plant in water and boil it."
	"You can make a paste and put it on your eyes and then some boys and girls said they have to drink it."
	"Some teas are for stomach and some for coughs, some for if your head hurts."
	"It feels real good to drink the teas. Probably you tell your mother if you can go outside and play with your friends because you are really feeling good and sometimes you sleep some when you drink it. When you wake up then you can play."
Health behavior outcomes	Perceptions of health care
	"When you have a health check, they check to see if you are clean. And they inject you in your finger, and it started to bleed a little bit."
	"They prick your finger to get your blood to see your cells."
	"They check your teeth, your heart."
	"They didn't check my eyes because I didn't bring my glasses since they call me four-eyes. My momma says that four eyes are better than two yes."
	"The nurses check your body to make sure everything is working. They check how big you are and how small you are."
	"The nurses check your body. They take all your clothes off, and they talk to you about going outside to play and not to sit too close to the TV and if you don't wear your glasses, you will go blind."
	Recommendations for health care
	"The nurses teach you how to stay healthy, like good things to eat, how to stay safe, and how to learn in school."
	"The nurse told me never to take any medicine unless my mother gives it to me."
	"The nurse also taught me how to wear a helmet and knee pads when riding a bike."
	"The nurses also told us how to stay safe in our neighborhood, like staying away from people who drink and take drugs."
Health learning needs	"I always eat breakfast."
	"When you eat good, it makes you fast."
	"You have to have a balanced diet, a little bit of every food group."

to be healthy and the need to be good listeners to learn about health.

ACCULTURATION ISSUES

Acculturation issues encompassed both positive and negative aspects of adjusting to life in the U.S. The positive aspects of living in the U.S. manifested themselves in three themes: friendships, educational opportunity, and safety. The children talked about their Hispanic migrant friends as being a positive support system when migrating to the U.S. The friendships seemed to have real substance to the children because of their common migrant background.

All the children in the focus groups voiced excitement about the educational opportunities in the U.S. They enjoyed going to school and learning. Most of the children in the focus groups were able to articulate the English language well for their ages. They valued the resources available in the schools in the U.S. and spoke of the lack of resources in classrooms in Mexico. The children

made it very clear that one of the best things about being in the U.S. was going to school. While attending the focus groups, the children demonstrated very polite behavior and showed genuine appreciation for their education.

The theme of safety was linked to learning and school opportunities. The children spoke of school as a safe haven—a place where learning could take place. They valued learning new ways to solve problems to avoid fighting. Their coaches and teachers were consulted to discuss problems.

In contrast to the positive comments about living in the U.S., two negative themes emerged. They were conflict and resource-acquisition difficulty. The children talked about seeing more violence in the U.S. than Mexico. They voiced concern about having to stay in their homes a lot when authorities (police) were present in the communities. The children also voiced concerns about not having access to many resources they wanted, including local newspapers and health care.

ENVIRONMENTAL INFLUENCES

Environmental influences on health included support systems, parental involvement, and parental role modeling. The children talked about their strong family bonds and the importance of extended family members. During the focus groups, most children shared the idea that their parents talked a great deal about life in Mexico. Those children in the study who were born in the U.S. shared stories of visiting Mexico on holidays and of hearing stories from their parents about what life was like in Mexico. The children who were born in Mexico reflected back on their recollections of their homeland.

Parental involvement was reported by the children. They told us that their mothers were instrumental in helping them get ready for school. Their mothers cooked, and many mothers were home after school when the children got off the bus. None of the children talked about being latch-key kids. All of the children either had a parent or older sibling at home, or they stayed in another home in the community until their parents came home from work.

Parental role modeling was evident as the children talked in the focus groups. Most of the role modeling was related to exercise. Some of the children became interested in exercise because their parents walked and jogged.

HEALTH CARE ACTIONS

Health care actions comprised health maintenance responses and alternative health care practices. The children in this study talked about the importance of actions that would maintain their health. They talked with pride about their abilities to prepare meals for themselves and get themselves ready for school. Some of the children also talked about teaching younger siblings how to care for themselves.

Alternative health care practices were reported by the children. They eagerly shared ways they were treated other than by going to a doctor. Most of the children talked about their mothers using teas to help them get better when they were sick. None of the children could give the exact name of teas used, but they knew there were different teas for treating the stomach and coughs. They also talked about plants that were grown and used by their mothers when they were sick. Again, none of the children could state the name of the plant, but they were able to describe the plant in detail and tell how the plant was used. Some mothers boiled the plant in water and made a drink. Others made a paste of the plant. There was consensus among children in all the focus groups that the plant and teas really made them feel better.

HEALTH BEHAVIOR OUTCOMES

Health behavior outcomes involve perceptions and expectations of health care and health care recommendations. The children talked about the role of nurses in their health care. They perceived nurses as providing health examinations and being good teachers. They accurately described activities that occurred during their health checkups. The children in all groups agreed among themselves that nurses were very important in their health, as well as, health checks. Their descriptions of health checks included physical activities and psychosocial aspects of health.

The children voiced recommendations for health care that they received from nurses. The children discussed many of the topics that were important to health, such as good-eating habits, how to be safe when playing outside, how to take medicines, and the need to be healthy to learn. They valued the teaching of nurses and recommended that children should listen to nurses.

HEALTH LEARNING NEEDS

The children talked about the importance of being healthy in order to learn in school. They identified good healthy diets, exercise, water in-

take, and cleanliness as important learning needs. They also talked about the importance of acceptance, attentiveness, honesty, integrity, and communication with adults as factors contributing to learning in school.

DISCUSSION

The Hispanic migrant children participating in this study were eager to voice their ideas about health and learning needs. In response to the focus-group questions, the children stimulated candid and thoughtful discussion about their personal experiences in the U.S. These findings support Charlesworth and Rodwell's (1997) notion that children are able to participate in focus groups, and the method is an effective way to enter and understand children's perspectives. Throughout the group discussions, the children reflected on their family life experiences both in Mexico and after their migration to the U.S. Their voices about health and acculturation were interwoven between two cultures.

Also, the children's thoughts and ideas indicated that they were in the concrete operational stage of thought. They were able to understand cause and effect–action and health status, such as drinking milk because it is healthy and brushing teeth to avoid cavities. The children also could think through a chain of events, such as not desiring to use alcohol or drugs because those substances could hurt them. The older children provided more complete descriptions of their ideas and even discussed teaching younger siblings. These findings lend support to the works of Natapoff (1982), Piaget (1963), and Piaget and Inhelder (1969).

The children in this study had a multidimensional view of health similar to the World Health Organization's definition of health. It was evident that the children viewed health as well-being and could share important things to do to be healthy, such as eating the right foods, keeping their bodies in good shape, and even resting their brains by taking naps. None of the children in this study associated health as being without a disease or illness. However, the children did depict health as having environmental influences such as parents serving as role models for positive health behaviors, access to health care being different in the U.S., and the threat of deportation. These findings support the work of Ferrand and Cox (1993).

Health was viewed as a positive-toned feeling-state by the children in this study, and they reported being able to participate in desired activities, which supports the previous work of Lasky and Eichelberger (1983), Natapoff (1978), and Rashkis (1965). Also, the children in this study engaged in exercise activities and believed exercise was an important health behavior. The children provided examples of exercise in which they participated and viewed their physical education class as a good way to get exercise. These findings support the works of Ferrand and Cox (1993) and Graham and Uphold (1992), whose findings indicated that children are able to participate in self-care activities such as exercise.

The findings suggest implications for health care providers related to culturally competent care. The children in this study reported using both Western health care and alternative health care. They talked about having examinations from nurses and going to the doctor when they were sick. They may have focused on the role of nurses in health care because nursing faculty and students from Georgia State University were providing health assessments in conjunction with the Migrant Family Health Program at the school during the same weeks the focus groups were held.

The children identified their mothers as the primary persons that care for them when they are sick. There was consensus in all the focus-group sessions that their mothers used alternative methods when caring for them, such as teas and plants for healing. Frequently, their mothers would treat them first and then seek medical health care if needed. The children in this study valued the outcome of the teas and plants even though they may have tasted bad or even had an unpleasant odor.

The children in the focus groups spoke freely about their adjustments to living in the U.S. Some of the difficulties they voiced were fears, longing for Mexico, and not having access to ethnic foods and even newspapers. The findings from this study also support some of the concerns voiced by adult migrant farm workers in south Georgia (Perilla, Wilson, Wold, & Spencer, 1998). Although the adults reflected on lack of services, information, and poor living and working conditions, their concerns about deportation, prejudice, and drug and alcohol use were echoed by the children in this study. Surprisingly, the children did not voice concerns about their living conditions, which was a theme identified by the adults. English classes were the highest priority identified by the adult migrant farm workers, whereas most of the children in this study had an age-appropriate command of the English language.

This qualitative study with 73 Hispanic migrant

children attending a summer school program located in south Georgia adds new knowledge about the health and learning needs of these children. It is not the intent of the authors to generalize these findings to all Hispanic migrant children, but rather, this work is the beginning of a deeper understanding of the daily complexities encountered by these children in transition. Further research is needed to explore other groups of Hispanic migrant children and their health and learning needs, as well as the stress associated with acculturation.

IMPLICATIONS FOR PEDIATRIC NURSES

The quiet voices of the Hispanic migrant children in this study speak loudly to pediatric faculty, nurses, and practitioners in practice. Pediatric nurses are important to the health of migrant children because of the education these nurses can provide. The children talked about the importance of listening to nurses because, in their own words, "they could help you learn about your health."

Piagetian theory (1969) can provide a theoretical underpinning that will enable pediatric faculty, nurses, and practitioners to be prepared to work with school-aged Hispanic migrant children. These children are in the concrete operational stage of thought and are able to understand cause and effect–action and health status, such as exercising because it is healthy. They are capable of voicing their own ideas about health and can implement self-care activities. They value health care received by nurses and can be quite knowledgeable about the procedures in their health checkups. Information should be provided in language that is consistent with the concrete operational stage of thought.

The challenge is to know important cultural aspects of Hispanic migrant children. Most of the children in this study could speak English, because of the educational opportunities afforded these children in the U.S.; therefore, there was no language barrier. Spanish fluency is an asset to all health care providers interacting with migrant children and families who only speak Spanish. During the initial health assessment in addition to the physical examination, it is important that nurses ask questions that will elicit any health and/or acculturation concerns. These are questions such as the following: Does the child have correct health information? Does the child have fears of being deported? Any mental health concerns that arise should be referred for follow-up with available Psychiatric Mental Health Child and Adolescent Clinical Nurse specialists, clinical psychologists, or other appropriate counselors.

Another area to be explored with the children is the use of alternative medicines in their home. It is important to ascertain what types of teas, plants, or other home remedies are used when anyone is sick in the family. Further exploration is needed about the children's mothers'—mothers were identified as the primary caregivers—appropriate use of alternative medicines. The information is necessary to determine whether or not a mother is using teas and other home remedies in a safe manner; however, pediatric nurses and practitioners must respect Hispanic mothers' desire to incorporate their traditional practices when caring for their children. The children in this study did talk about the effectiveness of teas and plants in their care.

It is important to be aware of the unique needs and responses from the children in this study. They valued education and had a strong interest in learning about health, which should make them receptive to health teaching. Another important contribution to these children could be the positive influence of nurses as role models, which has the potential of even influencing career choices. An increase in Hispanic migrant children choosing nursing as a career could lead to an increase in the number of Hispanic health care providers and better health for migrant farm workers and their families.

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