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Afro-American migrant farmworkers: a culture in isolation

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Abstract *Increasing rates of HIV infection have been found in migrant farmworkers in the USA over the past decade. By virtue of lifestyle, language and culture, these workers are not exposed to the typical media HIV prevention messages. To determine their level of knowledge about this disease for use in prevention messages targeted specifically to this population, five gender specific focus groups were conducted among Haitian, Jamaican and African-American migrant farmworkers in upstate New York. The focus groups revealed that the health belief system of these Afro-American migrant workers primarily reflects that of their indigenous culture. This impacts their interpretation and utilization of risk aversive behaviours. The data also suggest that the culture of migrancy itself affects the extent of risky behaviours practised, but further studies are needed to examine this phenomenon.*

Introduction

Migrant farmworkers are an ethnically diverse group employed seasonally in agricultural labour. Most of the workers come from Caribbean islands such as Haiti and Jamaica, and from several Latin American countries. Farmworkers employed in upstate New York are part of both the eastern and mid-western streams. They travel 'upstream' from their home bases in Florida, Texas, Latin America and the Caribbean islands, while harvesting crops along the eastern and mid-western states. African-American workers provided the bulk of manpower in the region until the late 1970s, when immigrants from southern American countries entered the 'stream'. Migrant culture is a culture of poverty; the average annual income for a worker varies between $6000 and $8000. Yet these workers, even those legally in the USA, are largely unentitled to traditional governmental social supports offered at this income level. The economic deprivation, in addition to the residential instability and lack of adequate social supports, create serious health and social problems for this group.

Migrant farmworkers are not a healthy population. Disease and mortality rates exceed those of comparable native indigent populations. The life expectancy of a migrant farmworker is 49 years, compared to a 75 average nationally (Wilk, 1986). The geographic and cultural isolation inherent to the migrant lifestyle contribute to ill health. Both up-and downstream, migrants live in substandard housing under unsanitary conditions. Information is transmitted more commonly by word of mouth than through the media. High illiteracy

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rates, language barriers and adherence to folk medicine traditions further impede risk averse education from reaching this group.

The characteristics of the migrant lifestyle, with frequent changes in residence and social network, are isolating for migrant farmworkers. Single males in particular have few venues for socializing and sex workers are used frequently (Organista & Organista, 1997). Traditional STDs (sexually transmitted disease) are common and often go untreated (Nolan & O'Barr, 1993) and HIV infection is of increasing concern among migrant farmworkers throughout the country (Lyons, 1992). HIV risk from exposure upstream is compounded by high rates of HIV prevalence in their countries of origin of the farmworkers (WHO, 1994). A recent review of HIV disease among migrant farmworkers in the USA indicates that prevalence rates vary by ethnicity (Organista & Organista, 1997), from 0% in Latino males in the western stream, to 13% in a group of single African-American males in South Carolina. These numbers need to be interpreted in the context of the difficulty of conducting disease surveillance in a population that resists identification and tracking, but they also suggest that sub-groups of migrant farmworkers are at high risk of HIV infection. Support for the high rate of prevalence comes from the high incidence of other sexually transmitted disease found in health assessments of migrant farmworkers across the nation (Nolan & O'Barr, 1993).

HIV education programmes have classically targeted high risk urban groups. The potential for widespread dissemination of HIV disease in a migratory population with high risk sexual behaviour has prompted public health programmes to focus on these workers at an early stage in disease prevalence. The challenge to creating effective HIV prevention educational programmes for migrant farmworkers has been to tailor these efforts to migrant culture in general, as well as to the specific ethnic groups that make up this population.

In 1995, the New York State AIDS Institute provided funding to determine the level of knowledge about HIV infection as well as optimal means of reaching the State's refugee and migrant populations. The goal of this initiative was to utilize the information collected to design more effective and culturally relevant educational materials about HIV infection and AIDS.

To this end, gender- and ethnic-specific focus groups were conducted in the native language of the participants. Discussions focused on knowledge about health and HIV disease, relationships and family, and sources of health information. Questions addressed included: how do these workers face issues of personal risk? How do ethnic and migrant cultures integrate to influence attitudes and behaviour towards HIV infection? This paper is a summary and interpretation of data obtained from five focus groups conducted with Haitian and Jamaican immigrants and African-American farmworkers. Interviewing each ethnic group separately provided an opportunity to explore the ways in which attitudes and behaviours are uniquely attributable to a migrant lifestyle. Other groups interviewed included migrants from Central and South America, and East and Southeast Asia. Results from these groups are reported elsewhere (Latino Alliance for AIDS, personal communication).

Methods

Five focus groups were held between October 1996 and January 1997. Groups were composed of seven Haitian males, five Haitian females, five Jamaican males, five African-American females and six African-American males. Several of the Haitians and all of the African-Americans had settled permanently in the area and were not true migrants. Nevertheless, they shared the migrant culture and worked together over the harvest season. There was no Jamaican women focus group as Jamaican males travel upstream alone on *H2 visas*[1]. Outcomes of four of these five focus groups are analyzed in this paper. The fifth group, with

African-American males, did not yield sufficient information and is not included in this report.

Each participant was asked to complete a *uniform* written survey. Data was collected in four categories: demographic information, knowledge of HIV, risky behaviours and self concept. Questions covered social activities, health beliefs and practices, and participants' understanding of HIV infection (survey detailed in Appendix 1). Since most participants were illiterate, the surveys were completed within the focus group session with the help of a moderator. As a result the surveys do not reveal more private and personal information than the focus groups themselves. The questioning in the surveys however, was more direct and the data from these surveys supplemented that obtained in open discussion.

Results

Demographic details

Haitian males. Seven men attended the focus group. Their ages ranged from 31–57. All the men were seasonally employed. Two had multiple jobs. Six of the seven lived in group housing with other workers, and one lived in a multiple family unit. Only one lived with a partner. All had children (from two–six), but these were currently residing in Haiti. All seven had some primary school education, but only three had completed high school, and four had attended trade school (completion data unavailable).

Haitian females. Five Haitian women participated in the focus group. Their ages ranged from 20–50 years and all worked seasonally. Two of the women had been in the USA since 1980, while the others had arrived later, one as recently as two years ago. Two of the women lived in New York State year round while the others lived in migrant camps during the migrant season and returned to Florida after the harvest. Four of the women had children, and three had steady partners with whom they lived. Three of the five had a primary school education and one was currently enrolled in high school. The other did not complete primary school.

Jamaican males. Five Jamaican males attended the focus group. They ranged in age from 34–62. Although they all claimed Jamaican ethnicity, three out of five stated that they were US citizens. All were currently unemployed, but had been employed during the previous harvest season, and all considered themselves farmworkers. Only one lived with a partner (as well as 'non-relatives'), one with children and 'non-relatives' and the others lived with 'non-relatives'(2) or alone (2). The data on education was evidently misunderstood as four indicated grade school, some trade school and/or some college as their highest level of education completed. Only one stated that grade school was his highest level. All stated that they had children.

African-American women. Five African-American women, 33 to 59 years old, participated in the focus group. These women originally migrated to upstate New York as farmworkers from southern states *but* no longer returned to the South after the harvest season. All were born in the USA of African-American parents. They did seasonal farm work and during the harvest season lived in a housing complex with a group of Caribbean migrant farmworkers where 'everybody is family'. All of the women had children. Four out of five had steady partners with whom they lived. All the women had started high school, although only two had completed it.

HIV: knowledge and awareness

Origins and transmission of HIV disease.

Haitian males. Haitian male migrants, who strongly maintain their cultural identity and associated folk beliefs, attribute HIV infection to *desobeyisans* (disobedience) of social and religious rules: 'If you're going to get it, you're gonna get it.' 'You got to be careful.' If the rules of monogamy are followed, you can avoid infection: 'I don't mess with people I don't know. I don't mess with anyone besides my wife.' One male did acknowledge however, 'You can still get HIV even if going with only one person, if they have it.' Oral sex is considered taboo: 'God gives us a mouth to eat with.' Therefore, although they described an association between HIV and oral sex, none admitted to practising it. All the Haitian males did in fact show some understanding of the scientific, as well as the spiritual, link between promiscuity and unprotected sex and AIDS. Condoms were considered protective: 'If you don't use a condom, then you don't have much of a chance of not getting HIV.' 'I use condoms now' (since learning more recently about HIV disease).

Jamaican males. HIV and AIDS are caused by 'germs' and 'dirty blood'. Jamaicans said that the disease had been prophesied in the Bible and was linked to 'filthy living'. 'If you're poor and in the hospital, you can get it from blood.' One can also catch it by sharing drinking containers. Oral sex was considered taboo for most of the farmworkers: 'You don't know what you are putting in your mouth.' Risk of catching AIDS could be reduced if 'you don't suck, 'cause you suck germs.'

The issue of control is also clearly linked to HIV transmission. Ejaculation is imbued with cessation of control to women: 'You can have sex, but if you don't come, you don't have risk.' HIV infection can be spread 'when you go with women who sleep around' or 'you drink with women'. However, 'drinking won't spread it if we don't pass the cup between each other.' These men professed a certain fatalism about HIV disease transmission, although they voiced an understanding that condoms could protect one if used properly: 'You got to hold it to a certain level. You got to know how to use it. If there are germs there you could get it.' Or 'if you don't use it right.'

Haitian females. The females interviewed had at least a basic understanding of HIV/AIDS but were not as well educated about STDs although they easily described the symptoms of STDs. Haitian women did identify sexual transmission with syphilis and HIV but also indicated that handsome men were more likely to contract the disease because they attracted a larger number of female partners. In their answers to the focus group questions, there was no clear understanding of what comprised 'risky sexual behaviour'. Oral sex is a taboo but hot sex which they defined as deep kissing and biting could be considered dangerous practices. None admitted to the practice of risky behaviours, yet none used condoms during sex. However, the women stressed their personal responsibility to protect themselves from the disease—'se ou menm ki pou kembe tet ou'—it's up to you to protect yourself, by choosing appropriate partners. The youngest woman in the group said that she was in control during intercourse and made sure that her partner wore a condom and would even slip it on herself.

Folk beliefs were used to explain the spread of these diseases. According to Haitian women, a jealous *matlot* (mistress) could be responsible for sending *chank* (STD) through her lover to his wife and that one can catch AIDS by sitting on dirty toilet seats. The women indicated that it was important to have access to information even if they get confused because of the language barrier.

Control was important, but not sufficient, for full protection from infection. It is also the

woman's responsibility to keep HIV away. Spouses and partners are not readily trusted because men are known to 'trennen zel'—run around. They regard AIDS as a curse of modern times, 'se yon malediksyon li ye'. The disease carries a strong stigma in the community. They would prefer to die rather than live with the disease although they were hopeful that a cure would be found and early detection would guarantee a better quality of life.

African-American females. These women had a higher level of education than the Haitians and Jamaican migrants. They were also more familiar with the biomedical model of HIV/AIDS, of risk factors and of modes of transmission. However, they also associated the disease with evil. It is 'sent'; 'God is involved. It is God against Satan and one will win!' There is ample proof, according to one woman, that 'the Bible speaks of it. It is the fulfillment of prophecies.' Others view AIDS as a conspiracy, it 'comes from chemicals' which 'got out of hand'. 'AIDS is a government cover-up, like the nerve sickness of the Gulf war.' Yet, simultaneously, they professed belief that condoms could protect them against the virus, and permit them to safely continue sexual activity. 'Sex is one of the best things in life,' said one participant. It plays an important part in the lives of these women, keeping them 'still alive, not dead'. The inherent contradiction was not obvious to them, and was not commented upon by the focus group leaders.

HIV/AIDS has touched all these women's lives. One lost a son to the disease and her boyfriend is an IV drug user. Another woman's son-in-law has died and now her 22-year-old daughter has tested positive. They say that AIDS is so widespread that it has become 'part of life' and 'you gotta be careful.'

Connotations of HIV infection and disease.

Haitian males. Haitian males expressed concern about reported high incidence of HIV infection and AIDS in Haitian communities. Yet none admitted to knowing anyone with the disease. Three said that they could detect a person who is infected with HIV from the way they looked. Haitian males alluded to evil and death when questioned about the significance of HIV. The men indicated strong reactions to the possibility of an HIV or AIDS diagnosis: 'I will go to the doctor and wait for death to come [if I have the disease].' They associated living with AIDS as like: 'I'm "mache" (living and moving around), but I never know where I'm going to end up. If I am positive, I will go to hell. So I will go to church.'

For these men, sex is a source of frustration and guilt; it is fraught with problems. Their aversion to oral sex was clearly expressed, 'God gave me a mouth to eat with', and homosexuality is an abomination.

Jamaican males. Pollution and degradation rather than fear of mortality are the chief connotations of HIV infection and AIDS for Jamaican farmworkers. Jamaican males were very dramatic about the idea of personal infection: 'If I find out I am HIV positive, I will drink and get killed by a truck', 'I would seek out medical help', I would seek 'God, because science wouldn't help.' None said they had tested positive. One knew of someone who had. In general, they will 'fight for health, look for cures', try to find some spiritual option and 'get help from God'. Western medicine was viewed as relatively useless. 'Science' does not have the answers, 'God, religion, perhaps.' When prompted, however, one of the men stated that AIDS was a significant problem but regular life could continue, at least for a while: 'Lots of people who have it know they got it and are still working places.'

Haitian females. The female focus groups varied in their interest and concern about HIV

infection. HIV/AIDS was not a major personal health concern to the Haitian female participants, although all of the participants had at least a basic understanding that transmission of the disease occurred through sexual intercourse. They stressed that HIV infection could be passed between partners in the same way that syphilis is spread. They voiced an understanding of risk factors and of the progression from HIV to AIDS. (The level of understanding varied with age and the level of fluency with English.) Their understanding, however, was coloured with folk beliefs. Two women noted that: 'women die faster than men from the disease because they lose blood during menstruation.' They claimed to be able to tell when someone has AIDS, 'their hair turns funny like someone who has a permanent'. The women were also very aware of the stigma associated with AIDS in their community. It is like 'maladi lanmo' (the kiss of death). One of the women said she would rather kill herself than live with AIDS, and another said, 'I would eat myself to death.'

African-American females. African-American women were better informed about the potential implications of infection as well as of the progression from HIV to AIDS. AIDS is a much dreaded disease, it is 'a grim reaper'. However folk beliefs still coloured their interpretations: 'You can tell when someone has the disease because their skin shines.' The AIDS epidemic is a topic of great interest to these women, 'it is there for a reason, to keep everybody from having sex with everybody.' While one woman said that if she tested positive she would 'just lie and die' another said that 'she would seek medical attention' to find the status of the disease and what treatment might would be available to her.

Risky behaviour. The focus groups provided information on both awareness and practice of risky behaviours. Sexual promiscuity was present among all three ethnic groups. The number of sexual partners in the past two years varied across ethnic groups, and ranged from zero to five. As noted above, all the migrants in this study acknowledged the potential risks of unprotected hetero- and homosexual sex and needle sharing for HIV infection. However, by their own admission, they did not always act to protect themselves. Both Jamaican and Haitian males appeared reluctant to discuss personal sexual activity openly with the group.

Haitian males. Unprotected intercourse was the most significant risk factor for HIV transmission identified among all four groups. Four/seven Haitian males reported using condoms 'frequently', 2/7 'sometimes' and 2/7 'never'. Five/six (5/6) Haitian men admitted to having sex outside of their primary relationship. In the past, single male migrants frequently used female sex workers. The men evaded this issue in the focus groups. The degree to which this custom persists is unclear, although Haitian male workers were clear about women and the sexual temptation they represent. They claimed to ward off the temptation by spending their evenings 'at home with TV' or 'playing dominoes' and by the avoidance of heavy alcohol or drugs, which they stated led to 'tet pati' (loss of control).

Jamaican males. Three of the Jamaican males stated that they were sexually monogamous (although one said subsequently that he did have sex occasionally outside of the relationship); the other two admitted to having several partners, compared to one out of five Jamaicans, who claimed to be a 'frequent' user, and 4/5 who claimed 'never'. The three Jamaican males with a regular partner stated that they were 'monogamous' but were unsure about this quality among their women. (One of the three, however, stated that he had sex

outside of the relationship in addition to defining himself as monogamous.) Condom use varied from 'never' (2) to 'always' (1), with the others claiming 'occasionally'.

Jamaican males voiced concerns similar to Haitian males about the loss of control. Drugs make you 'go down'. However, as opposed to the Haitians, night-time activities are less restricted to the camp. At night we 'ride, eat, drink ... we do everything'. Women were desired, but feared: 'You keep to yourself as much as you can. Right now you feel like you want to go with her, when you look back, you're sorry.'

Haitian females. Haitian women expressed the need for finding, and the difficulty of keeping, a male partner to 'chache lavi' (make a living) and find cultural acceptance. Women suspect that their partners have encounters outside the relationship yet often feel that they have to accept unprotected sex in order to keep a man's support, especially when they cannot work or are out of work. On the other hand, they also indicated that it is up to a woman to protect herself, 'se ou menm ki pou kembe tet ou', (each one is responsible to protect themselves) because it is man's nature to trennen zel and a woman's lot to raise and care for children. Three of the Haitian women had one steady partner. However, this does not imply that these women are monogamous themselves. Another had had multiple partners, and the fifth described herself as a virgin. Haitian women spoke in the focus group of chache lavi (prostitution, having to find a man) to make ends meet. These women, like Haitian men, also denied heavy drinking or drug use to avoid 'tete pati' or loss of control, which would increase their risk of infection.

African-American females. African-American females stated that their partners only occasionally used barrier protection yet they indicated that, 'people get infected because they are ignorant or they didn't think they'd get it.' These women say that 'years ago I didn't know or consider' the link between risk behaviour and infection, 'yah! Now I do. Don't be messing around' is the best protection, condom or not because 'everyone, man or woman' is at risk 'one way or another, period!'

All focus group participants vigorously denied intravenous drug use or homosexual contacts. It is unclear how open the participants were about their behaviours, as statements made regarding promiscuity differed between survey responses and group discussions. Males and females also attributed promiscuity to one another, without proof, while denying it for themselves.

In contrast to the males, the females interviewed spoke openly about their sexual activity. Their concerns focused on the suspected infidelity of their partners. Trust is a prominent issue for these women. One stated that men tend 'to graze on other grass', and another, that 'if you know your mate, you know whether he is lying or not' and 'if they get mad (when asked to wear a condom,) then you know they doin' something' wrong!' These women felt more empowered to take care of their needs, 'do I look like I let a man run the show?', 'don't let anybody use your body like a trash can'.

Discussion

The focus groups illustrated that most of the participants are aware of HIV and of its lethality and its modes of transmission. Farmworkers from the three ethnic groups clearly link promiscuity and HIV infection. However, despite an understanding of the connection between behaviour and disease, the link between cause and effect remains fluid. Although most of the farmworkers had had significant exposure to western medicine and its principles, they did not view disease uniquely in these terms. Their concepts of health and illness reflect

specific cultural beliefs and are imbued to varying degrees with folk mythologies. The focus groups illustrated that farmworkers largely held true to their indigenous belief systems despite their migratory lifestyle and the exposure to American culture and American health care system.

The groups interviewed, Haitians, Jamaicans and African Americans, are all Afro-Americans[2] and share similar cultural roots. Migrant farmworkers traditionally come from poor rural areas in their native countries and the southern USA, where modern western medicine is not readily accessible. Their health culture consists of a system of health beliefs that is widely shared among Afro-Americans and 'provides an explanatory system concerning health problems that is consistent with their world view' (Snow, 1993). It reflects a mixture of cultural beliefs and medical practices derived from a variety of sources—knowledge brought to the New World by slaves and European colonists during the colonial era, as well as the knowledge of indigenous inhabitants of the region (Brodwin, 1996; Farmer, 1992; Laguerre, 1987; Snow, 1993). More recently, the diffusion of western medicine has created new ways to think about the body and introduced new disease categories (Brodwin, 1996). Thus, illness narratives and explanatory models of disease 'draw freely on biomedical symbols and therapies' (ibid, p. 77) as well as on more traditional etiologies and nosologies. 'This intertwining of traditional, popular, and biomedical ideas results in a system that is constantly evolving to accommodate changing needs—it is broad enough to include pathological agents as diverse as sorcery and viruses in the etiology of illness and it is flexible enough to incorporate a new problem such as AIDS when it appears' (Snow, 1993 p. 33). By example, in their explanatory models of HIV/AIDS, Haitian, Jamaican and African-American farmworkers offer critiques linking lived experience of migrant life, poverty and marginality with specific forms of political and economic violence.

In this plural context, western concepts are redefined, adapted and incorporated into the traditional health culture. Although illness and belief systems differ subtly between islanders and African-Americans, and vary even within a particular group, they show strong similarities. Core beliefs shared by all the participants include notions on causality of illness and the function of blood as a parameter of one's health status. In *Medicine and Morality in Haiti*, Brodwin (1996) explains that etiologic and moral distinctions between illness of God, *maladi Bondye*, and illness of Satan, *maladi Satan*, are crucial in explaining traditional Haitian concepts of illness and healing. Snow (1993) elaborates on a similar distinction in African-American traditional medicine. While unnatural illnesses are caused by 'malignant intentions of another', or by Satan, there are also illnesses that are caused by natural processes.

According to Snow, blood is considered by many to be the 'health cultural focus' for most Afro-Caribbeans (Snow, 1993). Great attention is given to the volume and quality of the blood, which can be influenced by natural and environmental causes, as well as by human and spiritual ones (Laguerre, 1987). Blood is a substance in constant flux; it responds to a variety of stimuli in a variety of ways (Snow, 1993). To maintain health one must be attentive to its purity, colour, consistency, temperature, location and rate of motion as it curses through the body.

In Afro-American health culture, notions of health and healing are embedded in a complex nexus of competing religious, social and political discourses. In this system, western medicine and scientific explanations of health and healing compete with traditional constructions based on different perceptions of the body and of the person. This is a dynamic system that easily accommodates changing needs and incorporates new disease categories, such as HIV/AIDS. More often than not, patients use western cures in conjunction with folk methods. They consult a wide range of practitioners at the same time: physicians; religious healers, root doctors, leaf doctors, as well as midwives and bone setters.

Religion and the belief in God's will are fundamental values in Afro-Caribbean culture. The tension between health and sickness is similar to the opposition between God and Satan, goodness and evil, and moral life and dissolute living. Each person's response to illness and affliction reflects a unique blend of religious, cultural and personal influences and experiences (Huffard, 1992). Some African-Americans think that God can be angry at human transgressions and show displeasure by inflicting sickness (Snow, 1993). Brodwin claims that he never heard Haitians say 'that God sends illnesses upon people or that God is responsible for human afflictions' (Brodwin, 1996). On the other hand, beliefs in sorcery abound. Humans can be agents of illnesses. Farmer reports that human agency 'is the dominant leitmotiv' (Farmer, 1992) in the etiology of AIDS among Haitians. Malevolent people can send a *maladi mo*, an illness caused by the spirit of a dead person (Brodwin, 1996), or a *mo sida*, AIDS death, with the assistance of a sorcerer (Brodwin, 1996; Farmer, 1992; Snow, 1993).

Explanations of the origins of HIV disease varied widely among the three ethnic groups. This may be attributed in part to the level of exposure to health education messages promoted by the American government, *as well as* the level of integration into the host culture. The interpretation of HIV infection by Haitian farmworkers is strongly influenced by the belief in the role of blood in illness propagation and by the magical origins of disease. Illness is traditionally attributable to *desobeyisans* or 'bad' behaviour. Several of the male and female Haitians who participated in the focus groups believed that HIV infection was 'sent' *as punishment* to the *desobeyisan*. Ignorance is often blamed for lack of prevention, 'people get infected because they are ignorant or they didn't think they would get it.' According to the African-American women, men and women alike 'flaunt their thing everywhere and ignore the connection' between risky behaviours and infection. *Haitians also indicated that the lack of information in their native language added to the confusion.* There was an element of fatalism about the disease, yet also a belief that other factors, not precisely defined in these focus groups, could prevent infection. Haitians stress the need for 'control'; a person in control is centred and will act with risk aversion. 'Control' is fundamental to the sense of self. Many Haitian males fear that women will manipulate them and take charge in bed. They believe that manipulation by females can be avoided in part by strict limitations on alcohol intake and through hard work. Throughout the focus groups, participants emphasized that they were in New York to make money. To earn money one has to work, and steady work requires good health. By actively working, Haitian men are able to keep women *'off their backs'* and to send money back to their families, and consequently avoid illness.

The information gained through the focus groups with Haitian migrant farmworkers differs little from that obtained in interviews with HIV-infected Haitian immigrants in a major US city. A qualitative study of nine HIV-infected Haitians who lived in Boston, Massachusetts at the time of their disease, notes a similar integration of traditional folk illness beliefs with modern medical concepts. All nine informants had used both spiritual and folk healing practices. Although none mentioned that they had tried Vodou as an alternative cure, four did attribute their disease to *malediksyon* or a hot/cold disequilibrium (Martin *et al.*, 1995).

The Jamaican sense of self derives from a notion of cleanliness and balance. The body is an open system that requires equilibrium and permeability to maintain a state of health. Although a robust and corpulent physique is associated with good health, overindulgence and waste of any kind are viewed as sinful and illness producing. Good health comes from proper attention to nutrition and to the 'nature of blood'. Figueroa's (1995) ethnographic study of Jamaicans documents their understandings of sexually transmitted diseases (STDs), including HIV disease. STDs reflect *bad* blood. AIDS is *dirty* blood; it is spread by contact with

decaying matter. *Dirty blood* implies an *unnatural* affliction, induced from without, which leads to disequilibrium and signs and symptoms of illness. Jamaican understandings of HIV transmission reflect both western and folk medicine concepts. For example, HIV infection is propagated by anal intercourse because semen does not drain from the rectum and stays in the body as waste. Regular vaginal intercourse, however, is viewed as necessary to equalize and cleanse the body. Sperm is 'health enhancing'. Only sex that leads to procreation is acceptable. This belief explains Jamaican males' strong resistance to condom use (Sobo, 1993).

The Jamaican migrants mirrored these beliefs in the focus groups. All linked HIV infection and AIDS with contaminated, *dirty* blood. Infection required intimate human contact and intake of bodily fluids. Although the farmworkers did not associate the infection with sexual intercourse, they expressed an understanding that condom use could prevent it. The distinction with the western scientific concept of disease transmission is inherent in the conception of a *germ* as a spiritual, as well as a physically pathological, agent of disease. There seems to be some understanding that caution decreases with intoxication, and that the loss of inhibition from heavy alcohol use could lead to increased risk of HIV disease. However the direct link between alcohol, decreased condom use and an increased risk of HIV transmission/acquisition was not always clear to them.

The Afro-Caribbean understanding of disease permeates the native African-American culture as well. Patricia Turner examines the role of folklore in a geographically and socio-economically wide range of African-Americans in her book, *I Heard it Through the Grapevine* (Turner, 1993). She found that current health beliefs were often imbued with folk legends which date back more than 400 years. Themes of conspiracy, contamination, cannibalism and castration permeate thinking about modern sociologic phenomena, including the AIDS epidemic. Rumours about the origin of AIDS are found in all sectors of society. However, the conspiracy and contamination theories have been particularly evident among African-Americans who imply that AIDS was purposely disseminated to eradicate or at least diminish their population. These theories were evident among the African-American farmworkers interviewed who attributed AIDS to 'chemicals' which 'got out of hand'. These notions are consistent with Afro-Caribbean explanatory models of the origin of the disease (on conspiracy theories and AIDS, see Farrer, 1992; Snow, 1993). Some also viewed HIV infection as 'people sent' retribution for sinful wrongdoing.

It is evident from this discussion that attitudes and knowledge about HIV infection and AIDS among migrant farmworkers are deeply rooted in Afro-American health culture. Although HIV is not understood purely in scientific terms, the message that a decrease in certain behaviours will also decrease the risk of infection is now commonly accepted. However, this knowledge is not necessarily translated into a change in behaviour, possibly because of competing needs. Often condoms are not used in part because the desire for conception takes precedence over the need to protect oneself from HIV transmission. In this case, interest in procreation supersedes safety concerns. Additionally women are reluctant to demand condom use by their partners. The inherent implication here is that they distrust their male partners. Furthermore, since women are often dependent on men as a source of financial support, their main concern is to keep men satisfied. As is often the case with behaviour, *knowledge* of adverse consequences is insufficient to induce a change.

The disparity between knowledge and behaviour is better understood in the context of the distinct culture of migrancy. This culture is marked by unpredictability, impermanence and capriciousness. In a study of farmworkers in upstate New York, Nelkin (1970) found that migrants live within a world of perpetual chaos. Nelkin postulates that migrant farmworkers, unable to control the features which preclude order and unable to create a world in which

the unexpected does not occur, take safety by adapting to this disorder.' In this context, chaos becomes order (Friedland & Nelkin, 1971). In her initial study, Nelkin analyzes the 'classic' behaviours of migrant workers with regard to heavy drinking, promiscuity, and lack of concern for health and hygiene, as a means of adapting to the arbitrary nature of the workers' daily lives. In the setting of 'little predictable relationship between their actions and consequences' (ibid, p. 29), living is present oriented and self-focused and little attention is given to long-term adverse consequences of behaviour. She goes on to note that migrant farmworkers do not perceive themselves as empowered to make changes which would impact their personal health or social circumstances. Although Nelkin studied this population over 30 years ago, and conditions at migrant work sites and camps have improved substantially during this time, the sense that one has little control over life does appear to persist with this population (Rothenberg, 1998, personal observations).

It could be argued that migrant farmworkers share only a common work culture, and that it is inappropriate to attribute shared social experiences to a set of coworkers. This statement, however, connotes a lack of understanding of the intertwinement of the work and social life of migrant farmworkers. Migrant *work* culture is the *social* culture of this population. Migrant farmworkers generally live and work in close proximity 24 hours per day, geographically and ethnically isolated from the local rural society. Migrancy connotes isolation—isolation from the local culture as well as isolation from their home culture (Presidential Commission on Mental Health, 1978; Mull, 1994a). Discrimination, educational deficiencies, and low wages are defining characteristics of this culture (Mull, 1994b). Migrants attempt to diffuse this isolation through rapid bonding with other coworkers they meet at each site. African-American women spoke of their multi-ethnic community as an extended family: 'We are our own family since we do not have much family up here.' Workers generally form strong support networks, helping each other through crises, sharing food and each other's cultures. Migrant farmwork appears often to be selected over other work options because it preserves freedom and independence, and because it is often the only lifestyle known (Mull 1994a; Rothenberg, 1998). 'Migrancy becomes a habit. Sometime you just want to move' (Rothenberg, 1998, p. 280). Migrant labour is also often the best option for refugees and immigrants who have little education and English speaking skills.

Migrant culture, as experienced by these workers, usually over a lifetime, overlays a variety of *indigenous* folk cultures in which disease is viewed in terms of inherent good and evil and health status is contingent on a variety of factors such as limited economic means, social isolation, language and cultural barriers. These factors often impede the migrants' ability to affect the very changes in lifestyle and behaviour which would improve their health status. Migrants perceive and experience their lives as sites of contradictions and conflicts between local and global perspectives, folk and biomedical explanations, survival and need for protection. These dilemmas tend to be misunderstood in mainstream health culture which labels migrants as non-compliant or unable to make rational choices (Nelki, 1970). There has been little documented continuity of care between upstream and downstream residences. From a western medical perspective, migrant farmworkers traditionally have taken little responsibility for their personal health care, a judgement based largely on lack of follow-up care and over use of urgent care. It is more likely that the failure to take advantage of primary care offered to them is due either to poor faith in the system to provide care, or due to the fact that these workers live in the present. The concept of behavioural changes today, leading to better health in the distant future, is not consistent with their daily mode of existence (Utting 1988). Yet, as noted above, there was evidence that the migrant farmworkers interviewed did grasp somewhat that the avoidance of alcohol or other activities which lead to sexual disinhibition and promiscuity could protect them in part from

HIV transmission. Many admitted to altering their previous behaviour and mode of socializing. Further studies with larger numbers of migrant farmworkes are needed to understand the reasons for this behavioural change. It should be noted as well that the lack of interest in western medical notions does not preclude the use of indigenous health and healing methods.

When interpreting these focus group findings, it is important to consider several factors. The number of migrant farmworkers interviewed for this study was small, migratory habits were individualized and the migrants interviewed may not be representative of the population. Although some of the farmworkers were actually resettled rather than 'true migrants', all farmworkers studied did share a similar social culture, occupation and residence. This can be attributed to the fact that even resettled farmworkers never, for the most part, had the opportunity to assimilate. Resettled migrants may live in one home base, but they do not retain a fixed work association with an employer, and they retain their social ties with other resettled migrants of similar ethnic background, rather than with the local culture (Mull, 1994a; Environmental Protection Agency, 1992).

The focus groups were conducted by three different moderators. Language barriers and concern about matching groups and moderators by gender, as well as the sensitivity of the material, precluded finding one individual to cover all groups. The project design presented further difficulties. Because of the type of issues being discussed, written surveys were developed to supplement the focus group data. However, since the majority of the farmworkers were either illiterate or had limited command of English, and because of time restrictions, a number of surveys were completed in a group setting by the focus group moderator. Therefore, the accuracy of the information obtained about personal habits should be interpreted in this light.

Despite these limitations, the following conclusions are suggested by the data. The health belief system of the average migrant farmworker strongly reflects that of his or her indigenous culture. A strong interplay exists between traditional beliefs, western medicine and cultural notions about the self and the role of individuals in society. The western medical message of risk avoidance is interpreted and practised in this context, although it is clear that HIV education efforts to date have led to some alteration of risky behaviours. The data also suggest that migrancy, as a distinct culture, may play a part in the risk behaviours practiced. Lastly, the participants indicated that community health workers were a valuable source of health education.

Additional funding for these programmes could lead to increased education and decreased HIV transmission. Further studies, in which a larger sample size were to be employed, would be useful to assess the extent to which both migrant and indigenous cultures contribute to health/illness belief systems and to health behaviour. It is hoped that this data will be useful for AIDS prevention programmes as well as more generic health promotion activities for migrant farmworkers. Despite their relatively low numbers across the country, these workers are vital to an economically viable fruit and vegetable industry. It is in our best interests as both consumers and health providers to strive for the optimal health of this population.

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Notes

[1] H2 visas are short-term visas for seasonal employment within the USA and are for the worker only. Family is not included.

[2] The term '*Afro-American*' is used to refer to all people of African origin in the New World. Conversely, the term '*African-American*' is used specifically when referring to people of African heritage who were born in the USA. '*Afro-Carribeans*' are people of African descent who were born on one of the Carribean islands.

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