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Hypertension Management Among Haitian Immigrant Hotel Housekeepers Within the  
Context of their Transmigrant Life

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**ABSTRACT**

Hypertension Management Among Haitian Immigrant Hotel Housekeepers Within the Context of Their Transmigrant Life

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Little is known about how Haitian immigrants define and manage hypertension. Likewise, there is limited research about how Haitian immigrants' work and relationships within and across the U.S. and Haitian borders influence the way they manage hypertension. The purpose of this study was to explore how Haitian immigrant hotel housekeepers define and manage their hypertension within the context of their transmigrant life.

This critical ethnography study was conducted in Miami-Dade County, Florida. Data were collected among 31 Haitian immigrant hotel housekeepers. Study methods included (a) face-to-face individual interviews, (b) a demographic questionnaire, and (c) photo voice interviews. All 27 women and four men who were study participants had migrated in the U.S. within a 10-year period prior to the study. Thirty-one demographic questionnaires, 31 face-to-face interview transcripts, and 12 photo voice interview transcripts were analyzed.

Hypertension was also referred to mostly using the Haitian Creole word *tansyon* ( $n=27$ ). *Tansyon* was viewed both as an illness and as a normal body phenomenon. Western biomedical and non-Western biomedical approaches were used either as substitution or complimentary to each other to manage hypertension. Hotel housekeeping work influenced hypertension management both at the individual and system levels. The study found that the transmigrant life context, along with factors such as race, class, gender, and immigration status, had both positive and negative influences on the definition and management of hypertension.

This study can inform health care providers and researchers about Haitian immigrants' definition and management of hypertension. This study also describes how hypertension was influenced by their experiences in the U.S. and their relationships

across the U.S. and Haitian borders, along with their race, class, gender, and immigration status. This study may also stimulate the ongoing conversation about the influence of work on workers' health, adding to the literature specific information on how hotel housekeeping affects hypertension management.

## TABLE OF CONTENTS

	Page
List of Tables.....	iii
List of Figures.....	iv
List of Flow Charts.....	v
Chapter I: Introduction .....	1
Research Purpose and Aims .....	5
Study Significance .....	6
Summary .....	7
Chapter II: Literature Review .....	9
Hypertension.....	9
Hypertension Management.....	19
Critique of the Existing Literature on Hypertension Among Haitian Immigrants .....	27
Hotel Housekeepers .....	42
Summary .....	45
Chapter III: Theoretical Framework and Methodology.....	46
Transnationalism Theoretical Framework.....	46
Haitian Immigrants as Transmigrants .....	50
Critical Ethnography Methodology .....	53
Summary .....	56
Chapter IV: Research Study Design .....	57
Study Setting .....	57
Sampling.....	59
Data Collection .....	61
Data Analysis.....	68
Data Storage and Management.....	78
Scientific Rigor.....	78
Summary .....	84
Chapter V: Findings I: Definition and Management of Hypertension Among Haitian Immigrant Hotel Housekeepers .....	85
Abstract.....	85
Introduction .....	87
Methods .....	88
Participant Characteristics .....	90
Results.....	92
Definition of Hypertension .....	92
Management of Hypertension .....	94
Transmigrant Life Context: Consideration for Social Constructs.....	108

	Study Limitations .....	115
	Discussion .....	116
Chapter VI:	Findings II: Influences of Work on Hypertension Management Among Haitian Immigrant Hotel Housekeepers .....	119
	Abstract.....	119
	Introduction .....	121
	Methods .....	122
	Participant Characteristics .....	123
	Results.....	127
	Individual Level Influences of Work on Hypertension Management	137
	System Level Influences of Work on Hypertension Management ...	141
	Study Limitations .....	155
	Discussion .....	155
Chapter VII:	Summary .....	161
	Comparison and Contribution to Existing Literature .....	161
	Theoretical Framework .....	164
	Methodology .....	165
	Rigor .....	169
	Study Limitations.....	171
	Implications and Recommendations .....	172
	Conclusion .....	176
References	.....	177
Appendix A&B	Recruitment Flyers-English and Haitian Creole .....	201
Appendix C&D	Consent Forms-English and Haitian Creole .....	203
Appendix E&F	First Individual Interview Guides- English and Haitian Creole.....	210
Appendix G	Demographic Questionnaire .....	229
Appendix H	Interview Guide- Second Individual Interview and Photovoice.....	233
Appendix I&J	Field Notes- For First Individual Interview and Photovoice .....	235
Appendix L	Letter for Community Leaders and Business Owners .....	237
Appendix M&N	Screening of Potential Participants .....	238
Appendix O	Notation System for Interview Transcriptions.....	241
Appendix P	Support Letter from Church Leader.....	242
Appendix Q	An Experience to Learn more About Hotel Housekeeping Work.....	243
Appendix R	Text for Thank you Cards.....	246

## List of Tables

Table Number		Page
1.	2003 and 2009 Classification for Stages of Hypertension .....	13
2.	Percentage of Men and Women Diagnosed With Hypertension by Age Group	15
3.	Rationale for the Exclusion of 20 Participants .....	60
4.	Steps of Analysis of Individual Interviews.....	70
5.	Questions Revised for Clarity for Next Participants.....	73
6.	Sample Characteristics.....	91
7.	Reported Number of Rooms Cleaned Per Shift.....	141

## List of Figures

Figure Number		Page
1.	Blood Pressure Medications .....	95
2.	Checking Blood Pressure at Home.....	95
3.	Checking Blood Pressure at the Pharmacy .....	96
4.	Low Salt Diet .....	98
5.	Staying Away From Red Meat.....	100
6.	Papaya and Papaya Leaves.....	102
7.	Lwil Maskreti.....	103
8.	Fey Metsyen .....	103
9.	Fey Lougawou .....	104
10.	Dry Simen Kontra Leaves Imported From Haiti .....	104
11.	Garlic and Leaves- Boiled Concoction as Everyday Water Intake.....	105
12.	Garlic and Leaves- Boiled Concoction as Everyday Water Intake.....	105
13.	Finished Room Helps to Stay Calm.....	143
14.	Heavy Cart Leads to Tiredness .....	144

**List of Flow Charts**

Flow Chart Number

Page

1. Steps for Data Collection-----62

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## **Dedication**

I dedicate this work to my parents Amicar Coichy, and Wilner Sanon

## **Chapter I: Introduction, Significance, Purpose, and Aims**

### **Introduction**

Little is known about how hypertension (HTN) is defined and managed among Haitian immigrants. The few studies that explored hypertension among this population have noted that HTN is a major health concern with poor control and negative outcomes (Koch et al., 2005; Odell et al., 2006; Preston, Materson, Yoham, & Anapol, 1996). In their study conducted in Miami Florida, Preston and colleagues (1996) reviewed 88 charts of Haitian patients in multispecialty clinics at a teaching hospital. They found that 77 (85.5%) of the 88 patients had hypertension. Additionally, 63 of the 77 patients who were hypertensive were receiving treatment for hypertension. However, only 20 (26%) had the disease under control. Odell et al. (2006) conducted a retrospective cohort study with 4,320 Haitian and 12,258 African American maternity patients in Massachusetts and found that the Haitian women were more likely to have chronic hypertension compared to the African American women. They also found that chronic hypertension and preeclampsia were the greatest risks for delivering a low birth weight infant among Haitian immigrants. Koch and colleagues' retrospective study (2005) among 175 Haitian immigrants in Miami, Florida reported that hypertension was the single cardiovascular risk factor associated with small vessel infarction. Although studies have not fully explored the overall prevalence of hypertension among Haitian immigrants in the United States (U.S.), the findings from the aforementioned studies indicate that hypertension is a major health concern among Haitian immigrants. Therefore, researchers are compelled to investigate hypertension further.

A focus on how HTN is defined and managed among Haitian immigrants is important for a number of reasons. First, in order to reach the Healthy People 2020 goal to decrease the number of people with hypertension who have their blood pressure under control to 61.25% (U.S. Department of Health and Human Services, 2012a) more research is needed about hypertension management. Second, definitions about and ways to manage HTN vary across ethnic groups (Kramer et al., 2004; Li, Stewart, Stotts, & Froelicher, 2006; Wong, Mouanoutoua, Chen, Gray, & Tseng, 2005; Yeh, Wang, Wayne, & Phillips, 2008). Researchers and clinicians must understand how each ethnic group defines, and manages the disease to be effective in care provision. Third, Haitian immigrants are the second largest black immigrant population (N=881,488) in the U.S. (Prou, 2005; United States Census Bureau, 2010). Thus, U.S. health care providers are likely to have increased encounters with Haitian immigrants with hypertension. Fourth, researchers and clinicians are inspired to care for others considering the context of their everyday lives, cultural values, and socio-economic status. Yet, little is known about how these contextual factors affect Haitian immigrants' ability to manage hypertension and obtain effective care (Desrosiers & St Fleurose, 2002).

Haitian immigrants are a population that encounters cultural, socioeconomic, and political barriers that influence their everyday lives (Laguerre, 1999; Stepick, 1998; Zephir, 2004). As migrants from a developing country, Haitians in the U.S. often experience racism and discrimination (Stepick, 1998). Consequently, Haitian immigrants' employment opportunities are limited to blue-collar jobs such as hotel

housekeeping and restaurants. Studies have yet to explore the influence of such work on their HTN management.

In addition, many Haitian immigrants have a transnational identity (Basch, Glick-Schiller, & Szanton-Blanck, 1994; Charles, 1992). This identity enables them to maintain relationships and use resources in both Haiti and the U.S. Anchored within the critical paradigm, transnationalism questions inequities of power distribution that result in socio-economic, cultural, and political oppression (Guarnizo, 2003). Research guided by transnationalism focuses on the empowerment of immigrant groups against the existing socio-economic, cultural, and political barriers. These barriers and inequalities are outcomes of the constructs of race, class, gender, and immigration status. In seeking to understand and address these problems, pioneers of the transnationalism framework focus on the hegemonic relationship that exists between those people in control of production and those in the working class (Glick-Schiller & Fouron, 1999; Laguerre, 1999; Pierre-Louis, 2006). Any system that seeks to understand immigrants' everyday lives and health issues must also account for these constructs. Thus, an exploration of the definition and management of hypertension must also consider these constructs.

Immigrants who sustain these multi-stranded relations and create transnational identities are called transmigrants (Basch et al., 1994). Transmigrants' activities across geographical borders occur within social fields (Levitt & Glick-Schiller, 2004). Social fields refer to the space within which communications and exchange of resources across borders take place. These social fields include familial, social, economic, organizational, religious, political, and cultural relationships. There is constant back and forth movement of resources between two places within these social fields (Faist, 2000).

Not surprisingly, transmigrants use these resources within their social fields to manage their diseases (Gastaldo, Gooden, & Massaquoi, 2005). Gastaldo and colleague (2005) reported that Brazilian women use their family and friend networks, along with the goods such as herbs from both their home state and host country, to care for their HTN. Transnational identities empower transmigrants by allowing them to resist cultural, socio-economic, and political barriers. They do this by using their cultural-based networks, ideas, goods, and materials from both home state and host country to meet their needs (Basch et al., 1994; Glick-Schiller & Fouron, 1999). It is necessary to explore how transmigrant activities of communication and exchange of resources within social fields influence disease management such as hypertension among Haitian immigrants.

Work is also an important part of Haitian immigrant's transmigrant life (Basch et al., 1994). Work allows Haitian transmigrants to survive in their country of residence and to sustain relationships with family and friends from their home country, Haiti. Haitian immigrants are able to send remittances or monetary goods derived from working to support friends and family in Haiti (Charles, 1992; Laguerre, 1999).

In 2010, the total remittance flow from Haitians living abroad to Haiti amounted to \$1.3 billion (Orozco & Burgess, 2011). Those living in the U.S. sent an estimated \$842,184,000 in 2010 (Orozco & Burgess, 2011). According to the World Bank (2004), in 2004 remittance in U.S. dollars represented 19% of Haiti gross domestic product (GDP). Since work is central to Haitian immigrants' lives, it is imperative to explore what role work plays in their health maintenance, how they define illnesses such as hypertension, and how they manage the disease.

The context of transmigrant life is important to an understanding of Haitian immigrants' management of hypertension. Transmigrant life influences immigrants' attitudes and behaviors toward their socioeconomic and political status (Basch, Glick-Schiller, & Szanton-Blanck, 1994). However, to date, hypertension in particular or health in general has not been studied thoroughly using a transnationalism framework.

This critical ethnography study explored how Haitian immigrants defined and managed HTN. The study examined how the cultural, socioeconomic, and political aspects of Haitian transmigrant life influenced Haitians' definition and management of HTN. The study shed light on how Haitian transmigrants use resources within their social fields to manage HTN. The study also described how being a blue-collar (hotel housekeeper) immigrant experiencing discrimination affects HTN management.

### **Purpose and Aims**

The purpose of this study was to explore how Haitian immigrant hotel housekeepers define and manage hypertension within the context of their transmigrant life.

The specific research aims were as follows:

1. To describe how Haitian immigrant hotel housekeepers define hypertension
2. To identify strategies used by Haitian immigrant hotel housekeepers to manage hypertension
3. To explore the influences of transmigrant life on hypertension management among Haitian immigrant hotel housekeepers, focusing on:
  - a. Resources within their social fields
  - b. Work

## **Significance of the Study**

This study was significant for three main reasons. First, this study explored how Haitian immigrants defined and managed hypertension. This is an area, which is rarely investigated. The studies that do exist have reported HTN to be a rising health concern among this immigrant population leading to negative health outcomes (Koch et al., 2005; Odell et al., 2006; Preston et al., 1996). However, to the best of my knowledge, this is the first study exploring how Haitian immigrants view and define hypertension and what approaches they use to manage this disease.

Second, because over 90% of individuals will have hypertension in their lifetime, hypertension management remains a public health challenge in the U.S. (Ostchega et al., 2008; Wang & Vasani, 2005). As public awareness increases regarding hypertension, hypertension management is becoming a priority to improve individuals' quality of life and decrease negative outcomes. The goal of Healthy People 2020 is to have 61.2% of hypertensive adults treated and controlled (U.S. Department of Health and Human Services, 2012b). Therefore, a focus on hypertension management is necessary in order to reach optimum control.

Third, this study adds to the existing occupational health and hypertension literature by exploring how work influences the management of a chronic disease, especially among Haitian immigrants with transmigrant identities. Transnationalism has yet to be fully applied in research in general. No study was found using transnationalism in occupational health. Transmigrants use work as a means to survive in their country of residence and to sustain financial relationships with their friends and family in their home country (Basch et al., 1994; Charles, 1992; Laguerre, 1998, 1999).

Transnationalism helps researchers understand the socioeconomic and political attitudes and behaviors of immigrants. It has been used in the fields of anthropology (Basch et al., 1994; Glick-Schiller & Fouron 1990), and sociology (Faist, 2000; Gastaldo et al., 2005; Guarnizo, 2003; Portes, 2001). Few researchers have studied the influence of transnationalism of chronic disease management or workers' health. Because work is a significant part of Haitian transmigrants' life, it is important to address the ways work influences how HTN is defined and managed.

### **Summary**

Hypertension is a major health issue among Haitian immigrants. Scarce studies have explored how Haitian immigrants define hypertension, or the approaches they use to manage the disease. Few have examined these experiences within the context of their everyday lives.

Haitian immigrants comprise an immigrant group that experiences cultural, socioeconomic, and political discrimination in the U.S. Because of their immigrant and minority status, Haitian immigrants often participate in blue collar jobs. Additionally, their beliefs and approaches to HTN management are unknown. Immigrants use transmigrant identities to resist cultural, socioeconomic, and political discrimination experienced in their host country. Such identity, which includes resources within social fields that transcend national borders, can influence the management of diseases such as HTN. In order to address hypertension management among Haitian immigrants, their transmigrant life, and their work must be accounted for, because these factors are intertwined with the everyday life.

The purpose, aims, and significance of this dissertation research were introduced in this chapter. The study (a) described how Haitian immigrants define hypertension; (b) identified the strategies Haitian immigrant hotel housekeepers use to manage hypertension; and (c) explored the influence of transmigrant life on the management of hypertension among Haitian immigrant hotel housekeepers, focusing on the transmigrants' resources within their social fields, and work. The next chapter will highlight why the aims were important and review the literature in the field.

## **Chapter II: Literature Review**

In this chapter, the Western biomedical and non-biomedical definitions of hypertension and hypertension management are presented. Hypertension prevalence and approaches to hypertension management are discussed. In addition, the individual and social risk factors for hypertension development and hypertension management are described. A critique of the existing literature on hypertension and Haitian immigrants is provided, which explores the context of Haitian migration and describes the characteristics of Haitian immigrants living in the United States. Last, the chapter reviews research about hotel housekeeping work, focusing on the nature of the work and worker characteristics.

### **Hypertension**

#### **Hypertension Definitions**

**Western biomedical definition of hypertension.** Using the Western biomedical model, HTN is defined as a systolic blood pressure of 140 mmHg or higher and diastolic blood pressure of 90 mmHg or higher (American Heart Association, 2012). Also, according to the Western biomedical model, a person has hypertension if he/she is taking antihypertensive medications (Roger et al., 2012). In addition, a person is considered to have hypertension if he/she is told by a Western physician or other Western biomedical health professional that he/she has hypertension on at least two separate occasions (Roger et al., 2012). Hypertension and high blood pressure are often used interchangeably among health professionals and in the Western literature (Rosamond et al., 2007).

**Non- Western biomedical definition of hypertension.** Other definitions have been used to define hypertension that differ from those of the Western biomedical model (Connell, Mckevitt, & Wolfe, 2005; Luckoschek, 2003). For example, hypertension and high blood pressure are often believed to be separate illnesses with different etiologies (Luckoschek, 2003). A study of African Americans ( $N=42$ ) reported that they believed that hypertension was a result of thick blood (Luckoschek, 2003). Hypertension is also thought to be a result of emotions such as aggravation, impatience, stress, or worrying (Boutin-Foster, Ogedegbe, Ravenell, Robbins, & Charlson, 2007). Some define hypertension as a mental disorder that can be improved and managed by calming down or controlling one's temper (Luckoschek, 2003). Additionally, hypertensive individuals with a non-biomedical definition believed that having a normal blood pressure indicates that one has been cured of the disease (Connell et al., 2005). Because the Western biomedical and non-biomedical definitions of hypertension differ, it is important to understand how individuals define hypertension and its etiology.

### **Hypertension Prevalence Using the Western Biomedical Definition**

According to the Centers for Disease Control and Prevention (2012), hypertension is prevalent in one out of three Americans. Hypertension is considered the most important modifiable risk factor to prevent cardiovascular disease (Cutler et al., 2008). Hypertension affects nearly 73 million individuals in the U.S. and approximately one billion worldwide. If left untreated, hypertension can lead to a number of more serious conditions, including heart disease, strokes, and congestive heart failure (American Heart Association, 2012). The American Heart Association reported that

individuals with a blood pressure lower than 120/90 mmHg have half the lifetime risk of stroke of individuals with hypertension. The prevalence of hypertension is continuously increasing; it was projected that by 2025, 1.56 billion people worldwide will have hypertension (Kearney et al., 2005). In 2010, hypertension cost the U.S. an estimate of \$93.5 billion dollars for health care services, medication, and missed days of work (American Heart Association, 2011). Thus, this disease is both a health and economic burden. As hypertension becomes an increasingly important global health issue, it is not only important to understand the etiology, manifestation, and outcomes of the disease, but also its management.

### **Classification of Hypertension**

In the Western biomedical framework, there are three types of hypertension (a) essential hypertension (also called primary hypertension or idiopathic hypertension), (b) secondary hypertension, and (c) pregnancy-related hypertension (Centers for Disease Control and Prevention, 2012). With essential hypertension, the specific treatable etiology for the disease is unknown (Rosamond et al., 2007). Secondary hypertension occurs as an outcome of an existing disease such as a kidney disorder or congenital abnormality. Since secondary hypertension is due to another disease, it usually subsides after the primary disease is treated or managed (Rosamond et al. 2007). Two types of pregnancy-related hypertension that have been identified are pre-existing chronic hypertension and induced hypertension. Pre-existing chronic hypertension occurs when a woman has already been diagnosed with hypertension before pregnancy (Centers for Disease Control and Prevention, 2012).

The Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC) categorized adult hypertension into three stages (Joint National Committee, 2003) (see Table 1). Stage 1 involves a systolic blood pressure between 140 and 159 mmHg and a diastolic blood pressure that falls between 90 and 99 mmHg. For Stage 2, the range for systolic blood pressure is 160-179 mmHg, and the range for diastolic blood pressure is 100-109 mmHg. For Stage 3, the systolic blood pressure is above 180 mmHg, with the diastolic blood pressure being above 110 mmHg. About 69% of first heart attack cases and 77% of first stroke cases fall into the Stage 1 category of hypertension, with a blood pressure of 140/90 mmHg (Rosamond et al, 2007). In addition, 91 % of people who develop congestive heart failure had a prior diagnosis of hypertension (Rosamond et al. 2007). Hypertension is often called a silent killer, because it usually has no warning signs or symptoms until further complications are presented (American Heart Association, 2012).

Giles and colleagues (2009) further classified hypertension into three stages that differed from the Joint National Committee (JNC) report (see Table 1). Stage 1 refers to a systolic blood pressure reading of 115 mmHg and a diastolic pressure reading of 75 mmHg. People with Stage 1 are not believed to have organ damage (Giles et al., 2009). Stage 2, defined in 2009, corresponds to the first stage of JNC and occurs with a systolic blood pressure reading of 140 mmHg and above and a diastolic blood pressure reading of 90 mmHg and above. Giles et al. (2009) defined Stage 3 as a sustained resting blood pressure level of 140/90 mmHg and a marked elevation to 160/100 mmHg and above.

Table 1

*2003 and 2009 Classification for Stages of Hypertension*

Stages	2003		2009	
	Systolic Blood Pressure (SBP)	Diastolic Blood Pressure (DBP)	Systolic Blood Pressure (SBP)	Diastolic Blood Pressure (DBP)
1	140-159 mmHg	90-99 mmHg	115 mmHg	75 mmHg
2	160-179 mmHg	100-109 mmHg	140 mmHg	90 mmHg
3	>180 mmHg	>110 mmHg	>160 mmHg	>100 mmHg

*Note:* 2003 data from “Definition and Classification of Hypertension: An Update,” by T.B. Giles et al., (2009). *Journal of Clinical Hypertension*, 11, p.613. 2009 Data adapted from “The Seventh Report of the Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure,” by A.V. Chobanian et al., 2003, *Journal of the American Medical Association*, 289(19), 2560-2572.

Hypertension involves both the systolic and diastolic numbers. However, one can also have isolated systolic blood pressure (ISH), which occurs when the diastolic number is normal and the systolic number is elevated. ISH has been identified as the most common uncontrolled form of hypertension in older adults. In a recent study, Franklin and colleagues (2001) reported that 65% of their older adult subjects aged 50 to 59 had uncontrolled isolated systolic hypertension. Isolated diastolic hypertension (IDH) occurs when the bottom number of the blood pressure reading is elevated and the top number is normal (Franklin et al. 2001). Understanding the definitions and classifications of hypertension is important for addressing the needs of populations affected by HTN in general. However, this knowledge is especially important in helping individuals with hypertension understand their risks (such as stroke) when their HTN is not properly managed.

## **Individual Risk Factors for Hypertension Development**

Hypertension development is believed to be influenced by several individual factors using the Western Biomedical approach. These factors include age, diet, weight, physical activity, tobacco, alcohol consumption, and family history. Each factor is described in order below.

**Age.** Hypertension occurs in all age groups, including children (Ostchega et al., 2008). Children whose systolic blood pressure is 120 mmHg and above, and whose diastolic blood pressure is 80 mmHg and above are considered hypertensive (Ostchega et al., 2008; Sinaiko, 1996). Although both children and adults can be diagnosed with hypertension, people between the ages of 40 and 60 have an increased risk for the disease (Joint National Committee, 2004). The American Heart Association (2007) reported that 37% of men and 37.4% of women between the ages of 45 to 54 had hypertension. These percentages increased to 49.1% and 55.4%, respectively, for men and women who were between the ages of 55 and 64 (Rosamond et al. 2007) (see Table 2). Thus, age is an important factor to consider.

Table 2

*Percentage of Men and Women Diagnosed With Hypertension by Age Group*

Age Group	Men	Women
20-34	11.2%	6.4%
35-44	23.2%	18.3%
45-54	37.5%	37.4%
55-64	49.1%	55.4%
65-74	63.6%	73.9%
75+	69.5%	83.8%

*Note:* Adapted from "Heart Disease and Stroke Statistics-2007 Update: A Report From the American Heart Association Statistics Committee and Stroke Statistics Subcommittee" by Rosamond et al., 2007. *Circulation*. 115, e69-e171.

**Diet.** A diet with high fat, sodium, and dairy intake, and low consumption of fruits and vegetables is believed to increase the risk of hypertension (Conlin et al., 2000; Joint National Committee, 2004; Sacks et al., 2001). The study by Sacks and colleagues (2001) showed that a reduced sodium intake was associated with a 2.1 mmHg decrease in systolic blood pressure. Adequate potassium, calcium, magnesium, and protein intake were all shown to have an inverse relationship with blood pressure (Hermansen, 2000).

**Weight and physical activity.** Lack of physical activity also increases the risk for hypertension (Fagard, 2005). Pereira and colleagues (1999) conducted a study with 7,459 people. After adjusting for confounders such as age, baseline blood pressure, and family history, they found that those with higher levels of physical activities had a

34% lower risk of developing hypertension compared to these participants with lower physical activity levels (OR= 0.66, 95% CI = 0.47–0.94) (Pereira et al., 1999).

A body mass index (BMI) above 24.9 is considered overweight and is highly associated with an increased risk of hypertension (Joint National Committee, 2004). The increased prevalence in hypertension was shown to be directly related to the increased rate of obesity in the United States. The relationship between BMI and increased hypertension rates applied to all ethnic groups and both genders (Cutler et al., 2008).

**Tobacco and alcohol consumption.** Alcohol intake also increases the risk of hypertension development (Marmot, 2001a, 2001b; Marmot et al., 1994). The consumption of more than two alcoholic drinks a day—especially without food—increases the risk of hypertension (Stranges et al., 2004). Men who drink 300-499 ml of alcohol per week have an average systolic blood pressure of 2.7 mmHg higher and a diastolic blood pressure of 1.6 mmHg higher than those of nondrinkers (Marmot, 2001a, 2001b; Marmot et al., 1994). In a sample of 4,837 women and 4,844 men, those whose drinking level surpassed 500 ml of alcohol per week had a systolic blood and diastolic blood pressure reading of 4.6 and 3.0 mmHg, respectively, compared to non-drinkers (Marmot, 2001a, 2001b; Marmot, et al., 1994). Women who drank 300 ml per week had increases in their systolic and diastolic readings of 3.9 and 3.1 mmHg, respectively, compared to female non-drinkers (Marmot et al., 1994).

Smoking increases the risk of hypertension development (Boden-Albala & Sacco, 2000). A cross-sectional study of 12,417 men showed that the participants who had a history of smoking had a 13% increased risk for hypertension compared to the 8.8% risk in participants who did not have a smoking history (OR = 1.31; 95% CI = 1.13-1.52; p

<.001) (Halimi et al., 2002). Even after adjusting for age, BMI, social class, and alcohol consumption, smokers still had a higher blood pressure compared to non-smokers (Primatesta, Falaschetti, Gupta, Marmot, & Poulter, 2001).

**Family history.** A direct positive relationship has been established between family history and hypertension (Joint National Committee, 2004). About 20 to 40% of blood pressure variation in the general population is related to genetic factors (Beevers, Lip, & O'brian, 2001; Vidt, 2007). Individuals who had one parent with hypertension were twice as likely to develop hypertension (Beevers et al., 2001). Hypertension was 3.8 times more likely to be diagnosed before the age of 55 among individuals with a positive family history of hypertension (Williams et al., 1991).

### **Socio-Cultural Risk Factors For Hypertension Development**

In addition to individual risk factors, several social risk factors have been identified for hypertension development. These social risk factors include ethnicity, length of stay in the U.S. (for immigrants), and socioeconomic status. Each of these social factors is described below.

**Ethnicity.** Researchers have found that the rate of diagnosis of hypertension differs among ethnic groups (Kington & Smith, 1997; Kramer et al., 2004). Non-Hispanic Blacks had the highest rate of hypertension across gender and age, followed by Hispanics, and then Whites (Kington & Smith, 1997). Hypertension occurred in 46% of Blacks, compared to 29% of Hispanics and 32% of Whites ("Hypertension in America: A national reading," 2005). Blacks also had lower management rates for hypertension, as shown by their 42% control rates, compared to the 47% and 43% control rates for Whites and Hispanics, respectively (Thaker et al., 2005). This finding means that Blacks

with hypertension were less likely to have their blood pressure under control compared with their White and Hispanic counterparts. Additionally, Blacks were diagnosed with hypertension at a younger age, leading to a 1.3 times greater rate of nonfatal stroke. Blacks also had a 1.8 times greater rate of fatal stroke, 1.5 times greater rate of heart disease death, and 4.2 times greater rate of end-stage kidney disease than comparative rates for their white counterparts (Rosamond et al., 2007). In addition, hypertension was more prevalent among Afro-Caribbean groups compared to Whites (Lane & Lip, 2001). These studies consistently indicated that hypertension development varies among ethnic groups.

**Length of stay in the U.S.** Studies of U.S. immigrants have reported a positive correlation between length of stay in the U.S. and hypertension development (Moran et al., 2007; Singh & Siahpush, 2002). For example, Singh and Siahpush (2002) divided the length of stay in their study into increments of 1-5 years, 5-10 years, 10-15 years, and more than 15 years. Immigrants living in the U.S. for up to 5 years were 33% less likely to report high blood pressure than the U.S.-born individuals, compared to 35% less likely for those in years 5-10, 25% less likely for those in years 10-15, and 19% less likely for those who in the US over 15 years (Singh & Siahpush, 2002). Overall, the reporting of hypertension by immigrants increases as the length stay in the United States increases.

**Socioeconomic status.** Hypertension development is influenced by socioeconomic status (Muntaner, Sorlie, O'campo, Johnson, & Backlund, 2001). Measured as education level and/or occupational status, socioeconomic status has a direct positive relationship with hypertension development (Kaplan & Nunes, 2003).

Those with lower socioeconomic status are at a higher risk for hypertension development, and this holds true for Blacks, who have a lower socioeconomic position in society, relative to Whites (Geronimus, Bound, Keene, & Hicken, 2007; Matthews et al., 2002). Blacks and immigrants also tend to work lower paid jobs and have fewer years of education than Whites (Gradín, 2012). Low socioeconomic status puts Blacks and immigrants at a higher risk for hypertension and at a higher risk to encounter barriers to managing the disease (Bloch, Betancourt, & Green, 2008; Boutain, 1999; Joint National Committee, 2003, 2004). Muntaner and colleagues (2001) conducted a population survey of 375,000 people. In this survey, they compared income of non-professional workers to those who worked as professionals in the government and financial sectors. The non-professional workers had lower incomes than those in the professional sectors. The authors also reported that those with lower incomes had higher cardiovascular mortality than those with higher incomes (Muntaner et al., 2001).

### **Hypertension Management**

The literature review on hypertension management is presented in this section. The Western biomedical and non-biomedical definitions of hypertension management are also elaborated upon. The various approaches to hypertension management, including individual and socio-cultural influential factors are outlined.

#### **Western Biomedical Definition of Hypertension Management**

Hypertension management is defined as one's ability to control his/her hypertension by keeping the systolic blood pressure below 140 mmHg and the diastolic blood pressure below 90 mmHg (American Heart Association, 2009). The term control is used when determining effective hypertension management in the Western-

biomedical model (Krousel-Wood, 2009). Hypertensive individuals who are able to maintain recommended systolic and diastolic blood pressure levels are said to have their hypertension under control (Krousel-Wood, 2009). This control indicates effective management of hypertension (Schlomann & Schmitke, 2007).

About 69% of individuals with hypertension in the U.S. receive medication to help manage the disease (American Heart Association, 2009). However, nearly half (54.6%) of these individuals have blood pressure that is still poorly controlled (Chiong, 2008; Cutler et al., 2008; Krousel-Wood, 2009). This necessitates more research on strategies for proper management of the disease. Because hypertension is a major contributing factor for cardiovascular diseases, proper management of the disease is believed to lead to significant improvement in health outcomes.

### **Non-Biomedical Definitions of Hypertension Management**

Individuals use various definitions of hypertension management that differ from those of the biomedical model (Schlomann & Schmitke, 2007). For example, to some individuals, hypertension management is defined as one's ability to control their emotions, temper, anger, and everyday life stressors (Luckoschek, 2003; Schlomann & Schmitke, 2007). In Luckoschek's study (2003), the participants believed that while hypertension could be cured, and high blood pressure was incurable. Therefore, there was nothing they could do to lower their high blood pressure. Luckoschek's study also found that many individuals, when told that their blood pressure was high, did not take it seriously, because they were not experiencing any symptoms. Because of these differences in definitions of hypertension management between the Western biomedical

and the non-biomedical models, when addressing hypertension management, it is important to assess the individual's definition of the disease and its management.

### **Approaches to Hypertension Management**

**Western biomedical approaches to hypertension management.** Western biomedical approaches to hypertension management are twofold; there are pharmacological measures and non-pharmacological measures. The former measure includes anti-hypertensive drugs such as thiazide, beta blockers, calcium antagonists, angiotensin-converting enzyme inhibitors, and  $\alpha$  blockers (Wang & Vasan, 2005). The latter includes close monitoring of blood pressure by the patient at home, regular visits to the health care provider, and regular blood pressure measurement (Joint National Committee, 2003). Also included in non-pharmacological measures includes a diet, with reduced fat, sodium, and caloric intake, and increased intake of fruits and vegetables (Joint National Committee, 2003). The dietary approach to hypertension management was adopted from the guidelines of the Dietary Approaches to Stop Hypertension (DASH). The DASH diet is low in fat and high in fruits, vegetables, fiber, and minerals (particularly calcium, potassium, and magnesium) (Hermansen, 2000). The DASH guidelines also recommend decreased consumption of red meat, sweets, added sugar, and sugar-containing beverages (Sacks et al., 2001). The DASH diet has been studied in many randomized control trials and has shown effectiveness at reducing blood pressure (Conlin et al., 2000; Sacks et al., 2001).

Along with close blood pressure monitoring and proper diet, increased leisure-time physical activity is another non-pharmacological measure for hypertension management (Joint National Committee, 2003). Increased leisure-time physical activity

has been shown to improve blood pressure levels and hence to improve hypertension management (Ong, Cheung, Man, Lau, & Lam, 2007). Aerobic exercise training showed a reduction in blood of between 4 and 10 mmHg, and brisk walking was recommended for at least 30 minutes most days of the week (Joint National Committee, 2003).

Another non-pharmacological measure was limiting alcohol consumption (Xin et al., 2001). A decrease in alcohol consumption was found to lower blood pressure by 3.31 mmHg in systolic and 2.04 mmHg in diastolic blood pressure (Joint National Committee, 2003). Smoking cessation was also recommended for hypertension management (Joint National Committee, 2003).

**Non-biomedical approaches to hypertension management.** Several non-biological approaches were documented in the literature on hypertension management. They included the use of sea salt, weight loss, and culturally based medicines. Some individuals believed that the use of sea salt was beneficial for hypertension management (Luckoschek, 2003) because sea salt was not thought to be a source of sodium (Joint National Committee, 2003). In contrast to the Western biomedical model, many individuals in one study believed that weight loss could cure hypertension (Luckoschek, 2003). Weight loss was believed to be a substitute for Western medication as a means for managing hypertension.

In the non-biomedical approach, medications are often not believed to be effective for hypertension management (Boutin-Foster et al., 2007; Connell et al., 2005; Luckoschek, 2003). In some cases, medications were thought to be effective against high blood pressure but not hypertension (Luckoschek, 2003). Hypertension, by

contrast, was believed to be controllable by the individual simply through the control of temper and emotions (Luckoschek, 2003).

Culturally based approaches are also used by immigrant population to manage their hypertension (Connell et al., 2005). Tai Chi—a traditional Chinese approach to maintaining physical and psychological health—has been used to lower blood pressure in the Chinese population (Yeh, Wang, Wayne, & Phillips, 2008). A recent study on Filipino immigrants found that many of the participants used cultural remedies such as herbal teas, home-brewed mango leaves, garlic, and guava to manage their hypertension (Dela Cruz & Galang, 2008).

### **Individual Factors Influencing Hypertension Management**

**Medication adherence.** Medication adherence has been defined as a person's ability to follow a health practitioner's guidelines on the frequency and method of taking a given medication (Krousel-Wood, 2009). In Krousel-Wood's study, medication adherence was found to be the most significant modifiable individual barrier to achieving optimal control of high blood pressure. Lack of medical adherence to medications can be caused by factors such as patient's mistrust in the effectiveness of the medications and medication side effects (American Heart Association, 2009; Fongwa et al., 2008; Krousel-Wood, 2009). Conversely, facilitators of medication adherence include patient education and patient understanding of how to properly take medications (American Heart Association, 2009; Fongwa et al., 2008).

Medication adherence for hypertension management remains a concern, especially for immigrants. Several studies have noted how poor adherence leads to poor control of hypertension among immigrants living in the U.S. (Li et al., 2006; Li,

Stotts, & Froelicher, 2007; Wong et al., 2005). Immigrant groups often fail to adhere to their hypertension medication because of their cultural health beliefs and practices (Li et al., 2007). Lack of medication adherence can also result when immigrants combine Western biomedical medications with culturally based medications such as herbs (Li et al., 2007).

### **Socio-Cultural Factors Influencing Hypertension Management**

**Cultural beliefs and attitudes.** Cultural attitudes and behaviors toward a disease can influence the management of that disease (Han et al., 2007; Hill & Sutton, 2000; Li et al., 2006). For example, Li and colleagues (2006) reported that cultural beliefs in the effectiveness of Chinese herbs led to decreased adherence to Western medication and hence poor management of hypertension. Han and colleagues (2007) also reported that Korean immigrants' beliefs about the effectiveness of Western-style medications influenced their adherence to prescribed medications.

The American Heart Association (AHA) has recognized the influence of cultural beliefs on individuals' attitudes toward hypertension management (Joint National Committee, 2003). As a result, it has been recommended that cultural attitudes be understood and respected by health care practitioners. By demonstrating knowledge, understanding, and respect for cultural influences on hypertension, practitioners build trust and increase communication between themselves, their patients, and patient families (Joint National Committee, 2003). Improved trust and communication leads in turn to more appropriate, culturally based care, and hence, improved health outcomes.

The nature of transmigrant life is yet another factor influencing hypertension management among immigrant groups. Transmigrant life is experienced through the

constant back-and-forth travel (or communication) between the home and host country. This occurs for the purpose of socioeconomic and political involvement, cultural exchange, health maintenance, and disease management (Basch et al., 1994; Faist, 2000; Gastaldo et al., 2005; Glick-Schiller & Fouron, 1999; Guarnizo, 2003; Murphy & Mahalingam, 2004). Gastaldo and colleagues (2005) found that transmigrants believed that combining resources from their home and host countries would help improve their hypertension and their health overall. The influence of transmigrant life on hypertension management must be acknowledged. The special back-and-forth quality of this lifestyle influences immigrant attitudes and behaviors towards chronic disease management and health promotion in general.

**Health care costs.** Healthcare costs for hypertension in the U.S. were estimated to reach \$73.4 billion in 2009 and \$93.5 billion in 2010 (Centers for Disease Control and Prevention, 2012). The individual costs per year per patient for controlled hypertension was about \$124 (Li et al., 2007), while the average annual costs for uncontrolled hypertension, at \$691 per year per patient, was more than five times as high (Li et al., 2007). Health care costs represent a barrier to optimum hypertension management (American Heart Association, 2009; Fongwa et al., 2008; Joint National Committee, 2003). Following diagnosis, people with hypertension are asked to make routine doctor visits for the remainder of their lives, yet people who lack health insurance coverage or money for copayments may not be able to afford those visits (American Heart Association, 2009). Individuals unable to afford their medications may also have more difficulties managing their hypertension. Moreover, the lifestyle modifications recommended for improved hypertension outcomes may require patients

to spend additional money, and this can be a significant added burden on some individuals. For example, the eating plan for the Dash Diet requires dieters to buy fruits and vegetables, which can be more costly than fast food or food from the local non-organic grocery store (Joint National Committee, 2003). Costly health care expenditures therefore remain a major barrier to effective management of hypertension.

**Access to care.** Individuals with health care coverage were more likely to keep their disease under control (American Heart Association, 2009; Minor, Wofford, & Wyatt, 2008). Whether they had private or government-funded health insurance, individuals with some type of coverage had better ability to manage their hypertension, leading to better control of the disease (He et al., 2002). After adjusting for age, sex, race/ethnicity, education, smoking status, and alcohol and drug use, individuals with health care coverage were 3.5 times more likely to have their hypertension managed (Shea, Misra, Ehrlich, Field, & Francis, 1992)

## **Work**

### **Influence of Work on Disease Management**

Few studies explored the influence of work on hypertension management, and to date, no studies have explored how specific characteristics of paid employment influence hypertension management. These characteristics would include such things as work hours, income, co-worker support, and workload (Karasek & Theorell, 1990). Long and inflexible work hours, low-income work, high workload, and low co-worker support increased risk for HTN development (Greenlund et al., 1995; Grotto, Huerta, & Sharabi, 2008; Karasek & Theorell, 1990). However, these characteristics have not been explored when it comes to their specific influence upon HTN management. A

focus on the effect of work characteristics on hypertension management is thus important, because of the way these work characteristics can influence how the disease develops over time.

## **Influence of Work on Disease Management Within the Transnationalism**

### **Framework**

Anderson and colleagues (Anderson, Blue, & Holdbrook, 1993) assessed how the work of immigrants influenced chronic disease management. They found that often work had a negative influence on disease management. Because of their fear of losing their jobs, Chinese immigrants with diabetes did not discuss their disease with co-workers and employers. In addition, immigrant participants with a time restriction on their jobs were more likely to have poor disease management.

Transnationalism emphasizes the importance of work in transmigrant life (Basch et al., 1994). Transmigrants use work not just to survive but also to maintain their transnational relationships with friends and family members in the home country (Faist, 2000; Orozco & Burgess, 2011). Although many transmigrants work low-wage jobs, their income still allows them to send remittances home and to take care of their friends and family members both in their host state and in their home country (Orozco & Burgess, 2011). Work represents both a vital means of survival and advancement; thus, it is important to explore the influence of work on the transmigrants' health.

### **Critique of Existing Literature on Hypertension Among Haitian Immigrants**

#### **Hypertension Prevalence Among Haitian Immigrants**

Preston and colleagues (1996) were the first to explore hypertension among Haitian immigrants. Their goal was to estimate the prevalence and significance of

hypertension among Haitian immigrants in Miami, Florida. Guided by the positivist/empirical paradigm, researchers reviewed 88 charts from eight clinics within the Jackson Memorial Hospital system. The study revealed that 86% of the Haitian immigrants had hypertension, with only 21% having their hypertension under control. The study also reported that Stages 3 and 4 were more prevalent among the 88 patients at 33% and 23% of the total cases, respectively. Despite the small sample size ( $N=88$ ), the study findings raised awareness about HTN as a health issue among Haitian immigrants.

In their study, Koch et al. (2005) focused on Haitian immigrants living in the U.S. However, their primary goal was to determine the stroke subtypes among this immigrant group, rather than the prevalence of hypertension. The Koch study was guided by the positivist/empirical paradigm, and included a retrospective chart review of 175 discharged Haitian immigrant patients who were admitted with acute stroke at the Jackson Memorial Hospital between 1998 and 2002. Importantly, the study revealed that hypertension was the predominant risk factor for both hemorrhagic and ischemic stroke in Haitian immigrants. Koch and colleagues also reported that hypertension was the only significant factor for small-vessel strokes among those 175 cases.

Desilets and colleagues (2006) compared the body composition and other markers of cardiovascular disease risk of 40 Haitian-born immigrants and 40 Whites living in Quebec. The Haitian immigrant participants had significantly higher blood pressure than their White counterparts did. A study by Saint-Jean and Crandall (2005b) reported that hypertension was among the most prevalent health conditions mentioned by their adult Haitian immigrant participants. Odell and colleagues (2006) compared the

risk factors for low birth weight in Haitian women (n=4320) to that of African American women (n=12,258) living in Boston, Massachusetts. Their study revealed that chronic hypertension prior to pregnancy was the strongest risk factor associated with low-birth-weight infants among their Haitian participants.

A study by Jean-Baptiste and colleagues (2006) observed that Haitian participants reported the lowest awareness and control levels (30%) for hypertension compared to people of other Caribbean countries such as Jamaica (67%) and St. Lucia (55%). They recommended that further research explore the underlying causes for hypertension prevalence and poor control among this population.

The above studies attest that hypertension mismanagement can lead to several fatal outcomes among Haitian immigrants. Addressing the control and management of the hypertension are necessary. Existing studies on hypertension among Haitian immigrants all used an empiricist/positivist approach. Although this approach helped generate significant data such as prevalence and control percentages, it lacks the ability to give a full understanding of the individual and social factors influencing disease management. Studies using the empiricist/positivist approach filter the participants' voices through surveys, and do not account for the subjectivity and active participation of the researcher in the data generation process (Creswell, 2007; Denzin & Lincoln, 2005; Thorne, 1997). This may result in data that are not representative of the participants' voices and experiences (Denzin & Lincoln, 2005; Thorne, 1997). Additionally, the reviewed studies do not consider the socioeconomic, cultural, and political aspects of transmigrant life that can influence immigrants' HTN management.

Reports about hypertension among Haitian immigrants have only been retrospective studies using chart reviews (Koch et al., 2005; Odell et al., 2006; Preston et al., 1996). The issue with using data that already exist and that were not collected by the researcher is the increased the risk for missing data and data misinterpretation (Mcart & Mcdougal, 2007; Polit & Beck, 2004).

### **Hypertension Among Haitians Living in Haiti**

Hypertension remains one of the leading health problems affecting Haitian populations living in Haiti and abroad (Jean-Baptiste, et al., 2006; Pan American Health Organization, 2004, 2007). When addressing hypertension among Haitian immigrants, it is therefore important to understand their experience with this health condition both before and after immigration. Hypertension among Haitians in Haiti is discussed below.

A cross-sectional study of 1,620 Haitian adults older than 20 years of age conducted by the Haitian Foundation for Diabetes and Cardiovascular Disease (FHADIMAC) in Port-au-Prince Haiti revealed that 48.7% of the men and 46.5% of the women in the study had hypertension (Shipp, 2001). Moreover, according to FHADIMAC (2002), 70% of cardiovascular disease cases in Haiti are related to hypertension. Another study done in Haiti with 382 participants revealed that 24% had high blood pressure, with a mean systolic blood pressure greater than or equal to 140 mmHg and/or a mean diastolic blood pressure greater than or equal to 90 mmHg (Lluberas, Parrish, & Kling, 2000). Another study done in rural Haiti reported that 27% of the 315 participants were hypertensive (Niska, 2006). Thirty-nine percent of the men and 45.6% of the women in that study had high blood pressure. These studies on

Haitians living in Haiti, when combined with studies on Haitian immigrants in the U.S., show that the risk for hypertension development is high for both populations.

### **Context of Migration for Haitian Immigrants**

This section sets the context for the study to understand those aspects of the country of origin and the country of settlement that compel Haitian immigrants to create a transnational identity, and thus could influence their hypertension management. In this section, a brief description of Haiti is provided, along with a discussion of the migration patterns of Haitian immigrants. Characteristics of Haitian immigrants living in the United States U.S. are also discussed.

### **Description of Haiti**

Haiti is located on the western third of the island of Hispaniola in the West Indies. Haiti shares Hispaniola with the Dominican Republic, which occupies the eastern two thirds of the island. About the size of Maryland, Haiti is considered to be the poorest country in the Western Hemisphere, with over 80% of its population living below the poverty line, a 52% literacy rate, and a life expectancy of 48 years (Central Intelligence Agency, 2008). Haiti has a total population of about 8 million and an area of 27,750 square kilometers (Central Intelligence Agency, 2008). Some of the country's major cities include Port-au-Prince (the capital city), Cap-Haitien, Les Cayes, and Gonaives (Zephir, 2004). Most Haitians are of African descent; their ancestors were brought to the island by Spanish and French colonizers beginning in the sixteenth century. They were enslaved for labor on large plantations. Haitians experienced great hardship during the enslavement period and beyond (Pan American Health Organization, 2007).

Haiti, also called the land of mountains (Fick, 2000; Zephir, 1996), became the first free Black republic when it proclaimed its independence from France in 1804 (Central Intelligence Agency, 2008; Fick, 2000). This country's long colonial subjugation history is of great importance to its current economic and political status. The history influenced the migration of its population throughout the world (Buss & Gardner, 2008; World Bank, 2007).

During the pre-colonial era, Haiti was populated by indigenous tribes known as the Arawaks and the Tainos (Central Intelligence Agency, 2008; Fick, 2000). The country was first colonized in 1492 by Christopher Columbus (Buss & Gardner, 2008). The Arawaks and Tainos were eventually destroyed through a combination of genocide, diseases introduced by the Spaniards, and enslavement. With native populations extinct, the Spanish (and later French) who colonized the island imported slaves from West Africa to work the plantations.

French colonial involvement on the island began in 1625 and was not ended until the revolution led by Toussaint Louverture. The revolution culminated in independence in 1804. Since that time, Haiti has experienced periods of greater or lesser political freedom. In recent times, Haitians suffered under the dictatorship of president Francois "Papa Doc" Duvalier (1957-1971), who proclaimed himself "president for life" in 1964 and was succeeded upon his death by his son Jean-Claude "Baby Doc" Duvalier, who ruled the country from 1971 until he was overthrown by a popular uprising in 1986. Also in the twentieth century, Haiti endured a series of political interventions and occupations by the U.S. military, with the longest of these lasting from 1915 to 1934 (Buss & Gardner, 2008; Fick, 2000; Laguerre, 2005; Lundahl & Silie, 1998; Stepick & Portes,

1986; World Bank, 2007). Haiti's recent political history has seen a series of short-lived reform governments. This was typified by individuals such as Jean-Bertrand Aristide, a former Catholic priest who twice won the presidency and was twice ousted. The second time being forced into exile (possibly at the urging of the United States) in 2004 (World Bank, 2007).

In addition to the political unrests, Haiti has experienced a series of natural disasters affecting Haitians living in the country and abroad. In 2004, hurricane Jeanne killed an estimated 3,000 Haitians primarily in Gonaives (Beatty et al., 2007). Moreover, in 2010 a 7.0 earthquake struck Haiti killing over 250,000 and leaving more than 300,000 injured. These events worsened the health of the Haitian population (Brown, Ripp, & Kazura, 2012). For example, six weeks after the earthquake, about 10,813 individuals were sexually assaulted while living in tents (Kolbe et al., 2010). About ten months after the earthquake, 11,125 were hospitalized and 724 were dead as a result of cholera (Walton & Ivers, 2011). The earthquake also resulted in 1.3 million individuals left homeless (Green & Miles, 2011). These events also reinforced the creation and maintenance of transnational identity of those living abroad as they sustain strong ties and networks, and send remittance to help improve the lives of those left behind in Haiti (Fagen, 2009; Lundy, 2011; Orozco & Burgess, 2011).

Understanding the history of Haiti provides the context for the understanding of the migration patterns and cultural ties of Haitian immigrants. Such information will allow researchers to better understand why Haitian immigrants partake in certain behaviors throughout their transmigrant lives, including an ongoing participation in the economic and political activities of Haiti (Charles, 1992; Glick-Schiller & Fouron, 1999; Laguerre,

1998). Haiti's history of political repression and impoverishment is also one of the main reasons why Haitian immigrants feel such a strong connection with their homeland, and why they feel compelled to take care of their friends and family in Haiti by staying in their jobs and sending remittances home (Basch et al., 1994; Glick-Schiller & Fouron, 1999). Although many Haitian immigrants would like to eventually repatriate, continued political and economic instability in Haiti has influenced their decision to stay in the U.S. and work in low-wage jobs rather than return to their home country (Portes & Stepick, 1985; Stepick, 1998; Stepick & Portes, 1986).

### **Migration of Haitians to the United States**

The migration patterns of Haitian immigrants to the U.S. are a result of many factors. In one study, some immigrants expressed that they were evading the political chaos of Haiti (Laguerre, 2005; Zephir, 1996). Others said they were pursuing a better life, escaping the heavy poverty and misery that plagued Haiti (Laguerre, 1984, 2005; Prou, 2005). Although significant out-migration began as early as the 1920s, the large-scale migration of Haitians to the U.S. did not gain attention until the first massive influx in 1957, at the beginning of the Francois Duvalier regime in 1957 (Laguerre, 1984). The migration of this group occurred in a wavelike pattern, with the first wave composed of upper-middle-class intellectuals and professionals such as doctors, lawyers, teachers, and engineers.

The second wave of Haitian out-migration to the U.S. occurred following the inauguration of Francois Duvalier and was primarily middle class in composition. These individuals were fleeing Haiti to evade the mass slaughter initiated by Duvalier's private police force, commonly known as the tonton macoutes (Laguerre, 1998).

The third wave took place when Jean-Claude Duvalier, the son of Francois Duvalier, took power at the age of 19, after the death of his father in 1971 (Zephir, 2004). At this time, the term boat people was coined by Americans to describe the Haitians who arrived on U.S. shores after sailing across the Caribbean to Florida in small fishing boats (Hohl, 1982; Portes & Stepick, 1985; Stepick, 1998; Stepick & Portes, 1986; Zephir, 2004). The wave of boat people included individuals seeking political asylum and many others who were fleeing poverty (Hohl, 1982; Portes & Stepick, 1985; Stepick, 1998; Stepick & Portes, 1986; Zephir, 2004). Haitian-born immigrants of the third wave were mostly of the lower class (Laguerre, 1984, 1998, 2005). The migration of Haitian immigrants to the U.S. has continued in smaller waves since then, rising to a peak again during the overthrow of president Jean-Bertrand Aristide in 2004 (Opitz, 2004).

The official welcome Haitian immigrants have experienced in the U.S. is very different from that of other recent waves of immigrants. For example, Holcomb and colleagues (Holcomb, Parsons, Newman Giger, & Davidhizar, 1996) reported that, of the hundreds of thousands of Haitians who tried to enter the U.S. soil in the early 1990s, only 11,002 Haitian immigrants were allowed to stay compared to 213,802 Mexican immigrants and 77,735 Vietnamese immigrants for the same period. Haitian immigrants, regardless of whether they were considered to be asylum seekers or economic refugees, were more prone to be put in detention camps and deported than other immigrant groups (Charles, 2006; Lennox, 1993; Loescher & Scanlan, 1984; Opitz, 2004; Portes & Stepick, 1985). In addition, Haitian immigrants experienced the stigma of being perceived as carriers of HIV/AIDS (Santana & Dancy, 2000). In 1982, the U.S.

Food and Drug Administration (FDA) rejected any blood drawn from Haitians, because Haitians, as a group, were classified as one of the three H's (hemophiliacs, homosexuals, and Haitians) who were thought to be almost universally infected with HIV/AIDS (Stepick, 1998). Their unique migration history and struggles induced Haitian immigrants to create a unique and responsive transnational identity for it provides them a sense of security and belonging (Basch et al., 1994; Glick-Schiller & Fouron, 1999).

### **Characteristics of Haitian immigrants living in the United States**

Despite their history of migration difficulties, Haitians of all classes have continued to immigrate to the United States. An estimated 830,000 individuals of Haitian ancestry currently live in the U.S. (United States Census Bureau, 2010), and Haitians remain one of the fastest growing groups in the United States, as indicated by the jump from 289,521 Haitian immigrants in the U.S. in 1990 to 548,199 in 2000 (United States Census Bureau, 2000; United States Department of Commerce Bureau of Census, 1993). The reported increase in the number of Haitian immigrants in the country is believed to be lower than the actual number, because the census data fail to account for undocumented Haitian immigrants (Laguerre, 1984; Zephir, 2004). The undercounting of Haitian immigrants is also results because surveys often place Haitian immigrants in the same category as the non Hispanic Black population living in the U.S., despite their distinct ethnic and cultural differences (Pierre-Louis, 2006; Zephir, 2004).

The continuing growth of Haitian immigrants in the United States was described in the report from the United States Department of Homeland Security. It reported 22,583 individuals from Haiti obtained legal permanent residence for the fiscal year 2008 to 2010 (Monger & Yankay, 2011). This number was greater than that for other

black Caribbean immigrants, such as Jamaicans (19,825) (Monger & Yankay, 2011). The Haitian immigrant population has spread throughout the United States, with the majority residing in Florida (specifically Miami-Dade County), New York, and Boston (United State Census Bureau, 2010). According to the U.S. Census Bureau (2010), of the 800,000 Haitian-born immigrants living in the country, 376,000 resided in Florida and 191,000 lived in New York.

As Haitian immigrants have migrated and grown in the United States, they have experienced myriad hardships that have kept them on the lower rungs of the social ladder (Zephir, 1996). These hardships include, but are not limited to, discrimination, poverty, lower-wage employment, language barriers, and limited of access to services (Canales, 2007; Loomis, 2004; Saint-Jean & Crandall, 2005a, 2005b). Haitian immigrants are reported to have the lowest rates of health coverage compared to other immigrant groups (Carrasquillo, Carrasquillo, & Shea, 2000; Shipp, 2001). As noted above, many Haitian immigrants work in low-wage jobs (Canales, 2007). The majority (38.1 %) of Haitian-born immigrants are employed in the service industry, followed by the management and professional sector (24.7%) and sales and office occupations (20.8%) (United States Department of Labor Bureau of Labor Statistics, 2010). The U.S. Census Bureau (2010) reported that more than 19.3% of Haitian-born immigrants lived below the poverty level.

Even while facing these challenges, the Haitian immigrant population has shown great resilience. Many Haitian immigrants have participated in the economic growth of the U.S. (Stepick, Stepick, & Kretsedemas, 2001; Zephir, 2004). They have become taxpayers, business owners, and home owners (Stepick, 1998; Stepicket al., 2001;

Zephir, 2004). Businesses predominantly owned by this ethnic group include: money transfer agencies, travel agencies, food preparation businesses, and small corner grocery stores known as ti boutik (Loomis, 2004; Prou, 2005). Haitian immigrants are involved in politics and educational and community law-making forums, and they form strong communities such as little Haiti in Miami-Dade County, Florida (Prou, 2005; Stepick & Stepick, 1992; Stepick et al., 2001). Unlike previous decades, when they did not want to reveal their identity for fear of discrimination, modern Haitian immigrants take pride in their identity as Haitians (Stepick, 1998).

The term transnational has often been used to describe the status of Haitian immigrants and their ability to reside in the United States while at the same time maintaining a tight kinship with friends and family back home (Laguerre, 1998, 1999). As people who dwell in two cultures, Haitian immigrants sometimes find themselves playing double roles, which may require them to code switch. Code switching is an acquired skill used by Haitian immigrants to shift their attitudes and behavior based on their particular environment and desired perception projection (Oswald, 1999). For example, Haitian immigrants must sometimes use their native language (Haitian Creole or French) in order to demonstrate their multicultural skills and maintain close relationships with the Haitian community. Other times they must switch quickly to English in order to apply for a job, for example, or be viewed as an acceptable and promising resident of their new country (Oswald, 1999).

Researching and obtaining information about Haitian immigrants is often difficult because of the confusion between racial and ethnic classification systems. In surveys, the ethnic category choices often include only White, Asian, Hispanic, Black, and Other.

Although Haitian immigrants have distinctive characteristics as an ethnic group and differ from other African Americans in many ways, they have no choice but to list themselves as Black (Saint-Jean & Crandall, 2005a, 2005b). Few put themselves in the other category.

Nevertheless, Haitian immigrants remain a distinct ethnic group within the United States. Their history of migration and experiences in the United States distinguishes them from other immigrants. As their numbers in the labor force continue to increase, and as they continue to participate in the economic growth of the United States, Haitian immigrants have become an essential part of the U.S. economy. Researchers and health providers must therefore understand their history and current health issues. This will be conducive not only to the Haitians' well-being, but to that of the U.S. population as a whole.

**Religion.** The official religion of Haiti is Roman Catholicism. The African-based tradition of voodoo, another popular religion in the country, is practiced by mostly the lower economic classes in Haiti (Desrosiers & St Fleurose, 2002). Haitians practice voodoo as a medical tradition as well, since it offers explanations and treatments of various illnesses, including those affecting mental health (Desrosiers & St Fleurose, 2002; Miller, 2000). Other prominent religions of Haiti include evangelical Christian denominations, such as Baptists and Pentecostals (Pierce & Elisme, 1997). Religion plays a vital part in the Haitian immigrant life and has great influence on Haitians' beliefs, attitudes, and behaviors toward health and illness. Haitians consider the church to be a major support system for both legal and undocumented Haitian immigrants, providing religious, financial, medical, and social support. Because of the influence of

religion on Haitians' medical beliefs and practices, it is important to assess the role religion plays in their hypertension management.

**Language.** French and Creole are reported as the official languages of Haiti (Bernard et al., 1996; Purnell & Paulanka, 2005). Although all Haitians speak Creole, the ability to express oneself in French is considered an upper-class privilege and is employed by the elite as a form of oppression and a way to demonstrate power and prestige (Stepick, 1998). Haitian Creole was made the second official language of the country only in 1987 (Pierce & Elisme, 1997).

Language remains a major, if not the most prominent, barrier for Haitian-born immigrants. In one study, most Haitian immigrants claimed to use Haitian Creole at home and did not speak English. The inability to communicate with bosses and health care providers has resulted in longer stays in job immobility, misunderstanding, mistreatment, misdiagnoses, and lack of proper illness management for Haitian immigrants (Desrosiers & St Fleurose, 2002; Holcomb et al., 1996; Miller, 2000).

**General health and illness beliefs and practices.** Haitian immigrants employ a combination of Western medicine and home remedies to cope with and care for their illnesses (Holcomb et al., 1996). They define health as being physically, mentally, and spiritually/morally sound (Gany, Herrera, Avallone, & Changrani, 2006). The notion of hot-cold equilibrium, or cho-fret in the words of Haitians, is the basis for health and illness belief for this population (Holcomb et al., 1996). This same humoral dichotomy is also seen in several countries of Latin America (Foster, 1987). According to this belief, the body responds to internal and external stimuli with a change in temperature. An example of a behavior that reflects this belief was exhibited the reluctance of Haitian

women to take a bath right after giving birth. Haitian immigrants also believed that gaz (or gas) results in health issues such as headaches and back pain (Pierce & Elisme, 1997).

Among Haitians, the etiology of illness falls in two categories: (a) natural causes and (b) supernatural causes. Illnesses in the natural cause category are seen as being due to an imbalance in the hot-cold equilibrium. Such naturally caused illnesses are known as *maladi bondye* (disease of the Lord) (Purnell & Paulanka, 2005). By contrast, health issues attributed to supernatural causes are due to curses sent by someone who is either jealous or is in conflict with the ill person (Desrosiers & St Fleurose, 2002). As noted by Derosier and St. Fleurose (2002), these illnesses also result from chastisement of a voodoo spirit called *loas* who may be displeased with the ill person because of that person's lack of commitment and or reverence.

Haitians traditionally use six types of expression to describe the degree of their illness (Laguerre, 1987). These include *Kom pa bon* (I do not feel well); *De tan zan tan moin malad* (I feel sick from time to time), *Moin malad* (I am sick); *Moin malad anpil* (I am very sick); and *Moin pap refe* (I will never be well again), which indicates an expectation of death (Laguerre, 1987). Haitian immigrants use a combination of the Western medical system and their cultural folk system to care for their health. Included in the latter are folk healers such as *hounguns* (male voodoo priests), *munbos* (female voodoo priestesses), *shamans* (voodoo practitioners), *leaf doctors* (herbalists), *matrons* or *fam saj* (midwives), *docte zo* (bonesetters), and *pirkists* (injectionists) (Bishop, 1989; Holcomb et al., 1996; Miller, 2000).

Haitian immigrants who wish to use the Western medical system often encounter difficulties due language, legal status, education level, insurance coverage, and their cultural approaches to disease management (Saint-Jean & Crandall, 2005a). Governmental, institutional, and individual discrimination and lack of access to health care are also other known barriers (Saint-Jean & Crandall, 2005a, 2005b; Schantz, Charron, & Folden, 2003). Additional barriers include an overall misunderstanding of their health patterns and behaviors on the part of health practitioners (Saint-Jean & Crandall, 2005a)

Many researchers who are aware of the lack of understanding about the Haitian population have written reports and conducted studies on Haitian immigrants (Desantis, 1993; Desrosiers & St Fleurose, 2002; Holcomb et al., 1996; Menos, 2005; Miller, 2000). The goals of these reports and studies were to equip policymakers and health professionals with the proper tools and knowledge when working with this population (Desantis, 1993; Desrosiers & St Fleurose, 2002; Holcomb et al., 1996; Menos, 2005; Miller, 2000). Despite attempts, discrimination and misunderstanding of this group remains prominent in the U.S. health care system (Miller, 2000).

### **Hotel Housekeeping**

Hotel housekeeping is recognized as the second largest occupation in the hospitality industry (Lee & Krause, 2002). The housekeeping department typically accounts for 75% of the hotel permanent staff (Gray, 2004; Gray & Liguori, 2003). With an increased trend toward globalization, the hotel industry has become a global industry (Kandampully & Suhartanto, 2000). In 2000, Kandampully and Suhartanto reviewed hotel housekeeping services, reception, price, and food and beverage quality. They

determined that hotel housekeeping was the only key determinant factors to customer loyalty.

### **Worker Characteristics**

Hotel housekeepers are described as individuals who are responsible for the cleanliness of hotel rooms (United States Department of Labor Bureau of Labor Statistics, 2008). They are also referred to as hotel maids, housekeeping cleaners, and room attendants (United States Department of Labor Bureau of Labor Statistics, 2008). Both women and men are identified as hotel housekeepers. Women are called house maid and housekeepers. Men are called housemen and are usually responsible for deep cleaning carpets in the rooms, turning the mattresses, regrouting bathrooms, and bringing fresh supplies into the rooms (United States Department of Labor Bureau of Labor Statistics, 2008).

Hotel housekeepers are predominantly women of color and immigrants (Fruming et al., 2006; Gray, 2004). A study by Lee and Krause (2002) in San Francisco, reported that 95% of the hotel housekeepers had a primary language other than English. Fifty percent of new Americans in Los Angeles and Las Vegas were employed in the hospitality industry (Gray, 2004). The dominance of women of color and immigrants as hotel housekeepers is also shown in the hospitality industry in Florida. In 1998, it was reported that 67.4% of the hotel/motel labor force in Florida was composed of immigrants (Nissen & Grenier, 2001). Hotel employers favor immigrant employees for many reasons. Immigrants are perceived as hard working, more likely to accept low-skill and low-wage jobs, and less likely to complain (Waldinger, 1997).

## **Work Characteristics**

Because of a growing high demand for customer satisfaction and luxurious rooms, there has been a major change on the job characteristics of hotel housekeepers. According to Johnson (2008), today “hotels are being extensively remodeled through greater use of marble surfaces, mirrors, chrome, larger pillows, heavier mattresses, and more labor intensive bed linens and towels” (p.192). Despite these renovations, which bring with them a heavier workload, housekeeping workers are expected to perform at the same rate as before, and for the same compensation (Johnson, 2008).

Hotel housekeeping work is centered on the number rooms one can clean in a short period of time (George & Hancer, 2008). For example, some hotel housekeepers are expected to clean from 12 to 18 rooms in their 7.5 hour shift (Faulker & Patiar, 1997). The job involves strong physical output, because the workers have to lift heavy mattresses, kneel on floors, and perform repetitive movements such as tucking in bed sheets (Seifert & Messing, 2006). Hotel housekeepers are not allowed to drink water in the rooms nor use the bathrooms of the hotel rooms they are cleaning (Faulker & Patiar, 1997).

In addition to the rooms, hotel housekeepers are responsible for the cleanliness of the hotel lobbies and other departments of the hotel such as the food and beverage department and linen supply (Hayes & Ninemeier, 2004; Vallen & Vallen, 2005). Housekeepers interact on a daily basis with guests, which may increase their anxiety, as they worry about presentation of themselves as employees and as hotel representatives (George & Hancer, 2008). They are also responsible to report items to the Lost and Found and report which rooms are vacant.

Housekeeping staff typically have no control over the decision making process on what type of materials to include in the rooms, their workloads, or their work hours. To become part of the hotel housekeeping staff requires few qualifications (Finegold, Wagner, & Mason, 2000; United States Department of Labor Bureau of Labor Statistics, 2008). The work is so demanding that it offers little chance for personal and professional growth and few opportunities for promotion (Finegold et al. 2000; Gray, 2004). The typical income of hotel housekeepers places them below the poverty level with a median annual income of \$17,580 (United States Department of Labor Bureau of Labor Statistics, 2008). In addition, many hotels do not provide health insurance coverage to their housekeepers.

### **Summary**

This chapter defined Western biomedical and non-biomedical definitions and management strategies for hypertension. The chapter also described Western biomedical research about individual and social factors influencing the definition and management of hypertension. It then reviewed the literature on hypertension among Haitian immigrants. The chapter further discussed the migration history of Haitian immigrants in the United States. Lastly, the chapter described the worker and work characteristics of hotel housekeeping. The next chapter, Chapter 3, will describe the critical ethnography methodology and transnationalism theoretical framework that guided this study.

### **Chapter III: Theoretical Framework and Methodology**

This chapter describes the theoretical framework of transnationalism. It also outlines the study methodology of critical ethnography. A justification for using the transnationalism theoretical framework and critical ethnography methodology is given. The application of the theoretical framework to the research study and methodology concludes the chapter.

#### **Transnationalism Theoretical Framework**

The importance of the transnationalism theoretical framework has been established (Cordero-Guzman, Smith, & Grosfoguel, 2001; Olwig, 2007; Portes, Guarnizo, & Landolt, 1999; Vaquera & Aranda, 2011; Vertovec, 2009). Basch, Glick-Schiller, and Szanton-Blanc (1994) defined transnationalism as “the process by which immigrants forge and sustain multi-stranded social relations that link together their societies of origin and settlement” (p.7). Transnationalism knows no borders. It goes beyond physical spaces and involves the ongoing exchange of ideas, symbols, and socioeconomic, political, and cultural approaches. Transnationalism entails the maintenance, by immigrants, of a simultaneous relationship with both the home and the host countries. Based on this approach, immigrants are able to stay actively involved in and influenced by the social, political, cultural, economic, and cultural aspects of their home country as well as those of their host country (Glick-Schiller, Basch, & Szanton-Blanc, 1995).

Individuals who build social fields across borders are called transmigrants (Levitt, 2001; Levitt & Glick-Schiller, 2004). The term “social fields” refers to the multidimensional networks and social relationships in which ideas, practices, and

resources are shared. These social fields include familial, religious, emotional, cultural, social, economical, organizational, and political ties, and personal networks (Laguerre, 1998). Transmigrants maintain close relationships with their family members and friends still living in their home country (Basch et al., 1994; Laguerre, 1998). In this way, they aspire to contribute to the well-being of their home country. Many desire to go back to the home country at some point (Basch et al., 1994).

The transnationalism theoretical framework (TTF) emphasizes the constructed transnational identities of immigrants within their transnational social fields (Basch et al., 1994; Glick-Schiller, Basch, & Szanton Blanck, 1992; Kivisto, 2001). These transnational identities involve simultaneous relationships that occur between the home and the host countries and are used by immigrants to cope with their new environment, build resiliency, and sustain close contact with their home country (Basch et al., 1994; Glick-Schiller et al., 1992; Vertovec, 2004; Waldinger & Fitzgerald, 2004). TTF emphasizes the hegemonic relationship that exists between nation-states (i.e., the home and host countries of the transmigrants) vis-à-vis culture and practice (Basch et al., 1994).

TTF is guided by four premises (Basch et al., 1994). The first premise is that the occurrence of the contemporary migration phenomenon is concurrent with the rise of global capitalism. The second premise is that transnationalism is rooted in the identities and everyday lives of immigrants, where their relations transcend national boundaries. The third premise emphasizes that researchers must go beyond the boundaries of physical location and identity in order to fully understand the phenomena of transnationalism. The fourth premise posits that immigrants are actively involved in the

nation building process and that their identities are constructed around the hegemonic aspects of such a process. Each premise is explained in the following sections.

**Premise 1.** The contemporary migration phenomenon results from the global capitalist movement (Basch et al., 1994). The global capitalist movement allow for social networks and organizations across countries through communication (Lane, 2012). Through this movement, there are constant inter-country relations, imports, foreign investments, and political involvements. The parallel development of transnationalism and global capitalism determines the difference between current and previous immigrants (Guarnizo, 2003; Smith & Guarnizo 1998). An example of the parallel development of transnationalism and capitalism is the constant borrowing of money from organizations like the International Monetary Fund (IMF) by developing countries (Guarnizo, 2003). With the global capital and labor markets there are constant borrowing of loans from the International Monetary Fund (IMF) by third world countries (Basch et al., 1994). Transnationalism acknowledges that economic forces influence the influx of immigrants into developed countries, and that these forces, along with immigrants' cultural practices and identities affect their approach to survival in the host country. Economically, socially, and politically vulnerable, immigrants are induced to create and maintain a transnational lifestyle.

**Premise 2.** The representation and rootedness of transnationalism in the identities of transmigrants is exhibited by their everyday life actions. By remaining independent of technology booming around them, contemporary immigrants are able to maintain a close relationship with their dual nation-states and maintain social relations in both countries (Basch et al., 1994). Transmigrants' everyday life involves the

exchange of ideologies, and products. These exchanges are executed with more ease and fluidity because of increased avenues for communication between countries. For example, in any given day one might attend a meeting for the improvement of his/her current community and also maintain a conversation with a friend about an object he/she just sent back to their home state and about their mutual hope of going back to the home state to participate in elections. This opportunity to construct and maintain multiple identities on a national, racial, and ethnic level allows these immigrants to become resilient and cope with their complex environment and existence (Portes, 2001).

**Premise 3.** Basch and colleagues (1994) urged researchers to go beyond the boundaries of physical location and identity to fully understand the phenomena of transnationalism. They rejected previous concepts used by researchers to describe immigrants, concepts such as “remittance societies” and “assimilation.” “Remittance societies” refers to generations of immigrants who do not plan to return to their home state but rather intend to support their families indefinitely from abroad (Kivisto, 2001; Laguerre, 1998). Assimilation occurs when migrants adapt and are fully engaged in the cultural, social, economical, and political practices of their host country, leaving those of their home state behind (Laguerre, 1998). These concepts relate to finite geographic space and do not explore the spanned borders and multiple identities that transnational immigrants construct. In addition, the construct of assimilation incorporates the idea of America as a “melting pot” and does not look at class barriers and inequalities (Basch et al., 1994). Such an approach is not ideal for the global capitalist system, where inequalities and hegemonic constructs such as race and ethnicity still exist. With

assimilation, the “melting pot” point of view denies the fact that some groups have greater privileges than others do and that such privileges such as education and work opportunity influence individuals’ overall health and well-being.

**Premise 4.** Immigrants are actively involved in the nation building process during which their identities are constructed around the hegemonic aspects of such process (Levitt & Glick-Schiller, 2004). Transmigrants’ daily lives and consciousness are influenced by their current global and national hegemonic contexts (Basch et al., 1994). Because of social, political, economic, and labor related inequality experienced in their host country, immigrants create their transnational identity (Basch et al., 1994; Charles, 1992). This transnational identity sets apart transmigrants from those who are indigenous to the host country. The identities constructed by immigrants allow them to accommodate to and resist the hegemonic structure of their host country at the same time.

### **Haitian Immigrants as Transmigrants**

Many Haitian immigrants living in the U.S. maintain a strong familial, social, religious, economic, political, and cultural relationship with their home state, Haiti (Basch et al., 1994; Glick-Schiller & Fouron, 1999; Laguerre, 2005). Haiti’s former president, Jean-Bertrand Aristide coined the term *diziem departman-an* (meaning “the tenth department (or province) of Haiti”) to describe Haitians living abroad, the fact that they comprise a deterritorialized nation-state, and actively participate in the reconstruction of Haiti (Basch et al., 1994; Zephir, 2004). Surprisingly, considering their low-paying jobs, many Haitian immigrants have been able to buy homes and create communities in the U.S. and at the same time build homes and maintain their social,

political, economic, familial, and cultural ties with communities in Haiti (Glick-Schiller & Fouron, 1999; Zephir, 2004).

Although Haitians abroad do not constitute “remittance societies,” remittances have been a prominent aspect of transmigrant life and transnationalism identity creation (Vertovec, 2004). The term remittance pertains to any products or goods (often in monetary form) that immigrants send back home to fulfill their obligations of taking care of their family members in Haiti. Haitian-born immigrants are actively involved in sending remittance to their family members in Haiti, and Haitians living in Haiti are very dependent of these remittances (Glick-Schiller & Fouron, 1999; Guarnizo, 2003). In the year 2000, remittances constituted than 10% of the gross domestic product (GDP) of Haiti (Glick-Schiller & Fouron 1990; Glick-Schiller & Fouron, 1999; Pierre-Louis, 2006; Zephir, 1996, 2001, 2004). This number is nearly doubled (19%) in 2004 (World Bank, 2004).

Haitians have faced a long history of discrimination in the U.S. (Laguerre, 1989; Stepick, 1998; Stepick & Portes, 1986). Consequently, Haitian immigrants have forged transnational identities (building new networks and maintaining close home ties) partly to address these subordinating and hegemonic constructs and partly as a strategy for survival. This survival strategy provides Haitian immigrants a sense of security, improves their economic status, gives them a sense of social belonging, and increases their self-esteem (Basch et al., 1994).

### **Application of Transnationalism Theoretical Framework to the Research Study**

Two major aspects of the context of Haitian immigrants' transmigrant life were considered for the application of TTF to this research study. The first was that Haitian-

born immigrants' everyday life and experiences of the world and illnesses are influenced by the social constructs of race, class, gender, and immigration status. In this study, careful listening and dialogue with the participants was necessary for bringing out the participants' perspectives and experiences.

The second aspect of the context of transmigrant life was that both local and international networks are used in health promotion and disease management practices of Haitian-born immigrants who have constructed transnational social fields. This notion has been supported by research conducted with other immigrant groups. For example, Gastaldo and colleagues (2005) explored transnational health promotion among immigrant women living in Canada, and found that immigrant women used information from their social networks in their host country as well as from their home state to maintain and promote their health. In addition, Messias's study (2002) with Brazilian immigrants found that the participants were utilizing both pre-emigration and post-emigration (that is, transnational) resources and health practices in order to maintain their health. The Brazilian women in that study often requested remedies and medications from their home state to manage their illness in the U.S. These studies support the idea that many immigrants have constructed transnational identities. Within the transnational social fields, there are multidirectional flows of monetary, informational, goods, symbolic objects, and cultural value exchanges (Laguerre, 1998; Levitt & Glick-Schiller, 2004). Therefore, when exploring immigrants' health promotion and illness management behaviors, one must account for and inquire about their lives as immigrants, as well as their social networks in both their home state and host country.

In this study, TTF guided the sampling inclusion and exclusion criteria, the generation of interview questions (see Appendix C), and the analysis, interpretation and presentation of the data. For example, the study included first generation (foreign-born) immigrants. This inclusion criterion also adhered to the population of focus of TTF (Smith & Guarnizo 1998; Vertovec, 2004). There have been debates on whether second-generation immigrants construct transnational identities (Smith & Guarnizo 1998; Vertovec, 2004); however, the primary of focus of transnationalism and of this research study was on the first generation of Haitian-born immigrants.

### **Critical Ethnography Methodology**

Critical ethnography is a methodological approach that focuses on the different social processes that influence cultural knowledge (Thomas, 1993). These social processes are relationships within society that exist within the context of political agendas. Influenced by anthropology, history, philosophy, education, and sociology, critical ethnography is described as “a type of reflection that examines culture, knowledge, and action” (Thomas, 1993, p. 2). This methodological approach relies on the value-laden premises that social constraints exist and that these constraints need to be approached from an emancipatory standpoint. In this context, emancipatory refers to empowerment of Haitian immigrant hotel housekeepers.

With critical ethnography, epistemology the nature, foundation and acquisition of knowledge arises within the context of cultural practices and interactions among people (Meleis, 2007). People assign and interpret meanings based on their current and past experiences, along with their cultural knowledge (Charon 2001; Foley 2002; Thomas,

1993). These meanings influence one's everyday life and are exhibited through interactions, practices, beliefs, and actions.

Similar to the conventional sociological approach of ethnography, critical ethnography is influenced by symbolic interactionism (Atkinson, 2001; Madison 2005; Thomas, 1993). Symbolic interactionism emphasizes the social construction of ontology and urges the questioning of our notion of reality, identity, and social ideologies (Blumer, 1969; Charon 2001). These factors often are the root cause of our domination and influence our notion and belief of who we are, and how we ought to be (Charon, 2001; Thomas, 1993).

Critical ethnography emphasizes critical consciousness, which allows researchers to take responsibility for, and action toward, personal and environmental change (Thomas, 1993). In addition, critical ethnography challenges conventional sciences in their central metaphors (Kincheloe & McLaren, 1994). These central metaphors refer to the ways of viewing, approaching, and processing information. Critical ethnography takes into account the researcher's environment and sociopolitical influences. This approach uses cultural images to increase researchers' awareness of symbolic oppression, which takes place through social control (Thomas, 1993).

The emancipatory aspect of critical ethnography allows for the empowerment of socially marginalized and dominated groups. It raises consciousness about systems of unnecessary social domination in which only a particular group has access to resources leading to inequality (Thomas, 1993). The term "unnecessary social domination" refers to inequalities that exist as a result of cultural and social patterns that encourage the domination and access to resources by one group compared to another group (Thomas,

1993). Unlike a conventional anthropological approach to ethnography, which focuses on the subjective analysis and description of cultural traditions (Spradley, 1979), critical ethnography challenges sociopolitical, cultural, and research activities (Atkinson, 2001). The main goal of critical ethnography is to promote social change through knowledge.

The role of critical ethnographers is to bring to light hidden agendas or any other forces that could prevent or suppress cultural growth. Critical ethnographers speak on behalf of their study participants with the primary goal of empowering them and acknowledging their voices. Critical ethnographers also use knowledge to influence social change; while being mindful of their own social and political biases. This recognition allows for the invocation of social consciousness and societal change (Thomas, 1993).

The transnationalism theoretical framework (TTF) was well allied with the critical ethnography methodology in this study for several reasons. First, both transnationalism and critical ethnography bring a critical lens with which to explore aspects of domination (such as class) as they are embedded in the politics and the makeup of a society. Second, TTF and critical ethnography both emphasize the understanding of everyday life within the context of socioeconomic and political factors. Third, both consider the hegemonic constructs of race, class, and gender as major forces of domination, discrimination, and oppression. TTF merely added immigration status to these constructs. Other scholars have considered the application of TTF to research studies using ethnographic methodologies (Levitt & Glick-Schiller, 2004). For example, Levitt and Schiller (2004) stated that:

Ethnography is particularly suited for studying the creating and durability of transnational social fields. Participant observation and ethnographic interviewing allow researchers to document how persons simultaneously maintain and shed cultural repertoires and identities, interact within a location and across its boundaries, and act in ways that are in concert with or contract their values over time (p.1013)

In this study, the use of the transnationalism theoretical framework along with the critical ethnography methodology allowed the researcher to address practices of Haitian immigrants within the context of hegemonic constructs of race, class, gender, and immigration status as well as immigrants identity. Both the theoretical framework and methodology helped underscore how the historical context of migration and current socioeconomic and political status of Haitian individuals living as immigrants in the U.S. influenced their approach to hypertension management.

### **Summary**

This chapter discussed the theoretical framework and methodology that guided the study. The methodology of critical ethnography was ideal for this study because it allowed a critical exploration of how transmigrant life influences hypertension management among Haitian immigrants. The transnationalism theoretical framework in conjunction with critical ethnography was used to guide the study process and research study design. The next chapter (Chapter 4) of this dissertation discusses the research study design.

## **Chapter IV: Research Study Design**

This chapter describes the study setting, sampling and recruitment, and data collection and analysis process. In addition, the chapter details the study incentives, protection of the participants, and data management strategies. Finally, the chapter discusses how the researcher assured study rigor.

The purpose of this study was to explore how Haitian immigrant hotel housekeepers defined and managed hypertension within the context of their transmigrant lives. The specific research aims were as follows:

1. To describe how Haitian immigrant hotel housekeepers define hypertension
2. To identify strategies used by Haitian immigrant hotel housekeepers to manage hypertension
3. To explore the influences of transmigrant life on hypertension management among Haitian immigrant hotel housekeepers, focusing on
  - a. Resources within the immigrants' social fields
  - b. Work

### **Study Setting**

The study took place in Miami-Dade County, Florida. Miami-Dade County is located in the southeastern part of Florida. About 116,137 Haitian immigrants inhabit Miami-Dade County (United State Census Bureau, 2010). Service occupations are the major sources of revenue for Haitian immigrants living in the area (30.6%) compared to management and professional occupations (24.1%) and sales and office occupations (28.5%). Building, grounds cleaning, and maintenance make up the largest portion

(11.1%) of the service occupation category for Haitian immigrants in Miami-Dade County (United States Census Bureau, 2010).

## **Sampling**

**Sample size.** A total of 31 Haitian immigrant hotel housekeepers participated in this study. Sample size was determined based on the information needed and saturation (Polit & Beck, 2004). The researcher was able to reach the breadth and depth of information needed with this number of participants. Redundancy of the information indicated that data saturation had been reached.

**Inclusion criteria.** The transnationalism theoretical framework (TTF) indicates a focus on contemporary immigrants (that is, recent immigrants) with up to 10 years of residency in the host country of the United States. For the study inclusion criteria, the participants were required to: (a) self-identify as Haitian immigrants (having been born in Haiti and having migrated to the United States); (b) reside in the Miami-Dade County Florida area; (c) work as hotel housekeepers (including room cleaners or housemen); (d) have migrated to the United States within the past 10 years; (e) be at least 18 years of age; (f) be clinically diagnosed with hypertension by a health care provider; and g) be able to provide written informed consent to participate in the study.

**Exclusion criteria.** The transnationalism theoretical framework requires that immigrants maintain relationships with their home country. Therefore, during the recruitment, immigrants who said that they did not have any contact with their home country were excluded from the study. In addition, individuals who were working as private housekeepers were excluded. Two such interested individuals were excluded because they were not hotel housekeepers.

## **Sampling and Recruitment**

Purposive sampling was used for this study. Purposive sampling is a sampling method in which “the researcher selects participants based on personal judgment about which ones will be most representative or informative” (Polit & Beck, 2004, p. 729).

Purposive sampling was chosen for this study because the goal was to recruit Haitian immigrant hotel housekeepers who had hypertension and could articulate their experience. Participants were recruited based on the inclusion and exclusion criteria.

Study participants were recruited through four local churches, one barbershop, three restaurants, two boutiques, and one local organization that provided translation and employment services to the population. Church pastors and business owners (see Appendix L) serving the Haitian immigrant community in Miami-Dade County were asked to make announcements and post and distribute flyers in their establishments. The flyers were both in English and Haitian Creole (see Appendices A and B). Since Haitian immigrants usually form strong communities and gain support from their church and local businesses (Pierce & Elisme, 1997; Prou, 2005; Zephir, 2004), building trust through constant communication and collaboration with the leaders of these churches, organizations, and businesses was crucial for the recruitment process.

Lastly, the researcher used the “snowball” technique, in which individuals referred their friends or family members to participate in the study. This technique has been proven to be effective in recruiting participants who otherwise would not have been accessible (Streeton, Cooke, & Campbell, 2004). The researcher used a script (which was approved by the University of Washington’s Human Subjects Review Committee) to call individuals who were interested in the study (see Appendix N). Another script,

also approved by the University of Washington Human Subjects Review Committee, was used to talk to interested individuals who contacted the researcher about the study (see Appendix M).

Prior to the initiation of the first interview, the inclusion and exclusion criteria were reviewed with the participants again. The consent form was read to the participants, and their questions were answered. The researcher then obtained consent signatures. Fifty-one people were interested in the study, of whom 20 were excluded because they (a) did not meet the criteria (n=10), or (b) had other reasons not to participate in the study (see Table 3)

Table 3

*Rationale for the Exclusion of 20 Prospective Participants*

Exclusion Rationale	Number (n=20)
<b>Opted Out</b>	
No show to interview	1
No time	2
Fear of job loss *	2
No reason given	5
<b>Not Eligible</b>	
>10 years of residency	4
No Hypertension	4
Not hotel housekeepers	2

*Note.* \*Participants feared losing their job even after the researcher explained t they did not have to take pictures of their workplace if they did not feel comfortable doing so.

**Gaining Entry to the Study Sites**

On August 27, 2009, the researcher traveled to Miami-Dade County, Florida for 12 days to start building rapport in the Haitian community. During this visit, the

researcher went to local businesses, barbershops, and churches. The business owners and church leaders agreed to have the study flyers available in their facilities once they were approved. One church leader provided a letter of support (see Appendix P). The other church leaders and business owners were willing to give oral agreement for support but opted to not write a support letter.

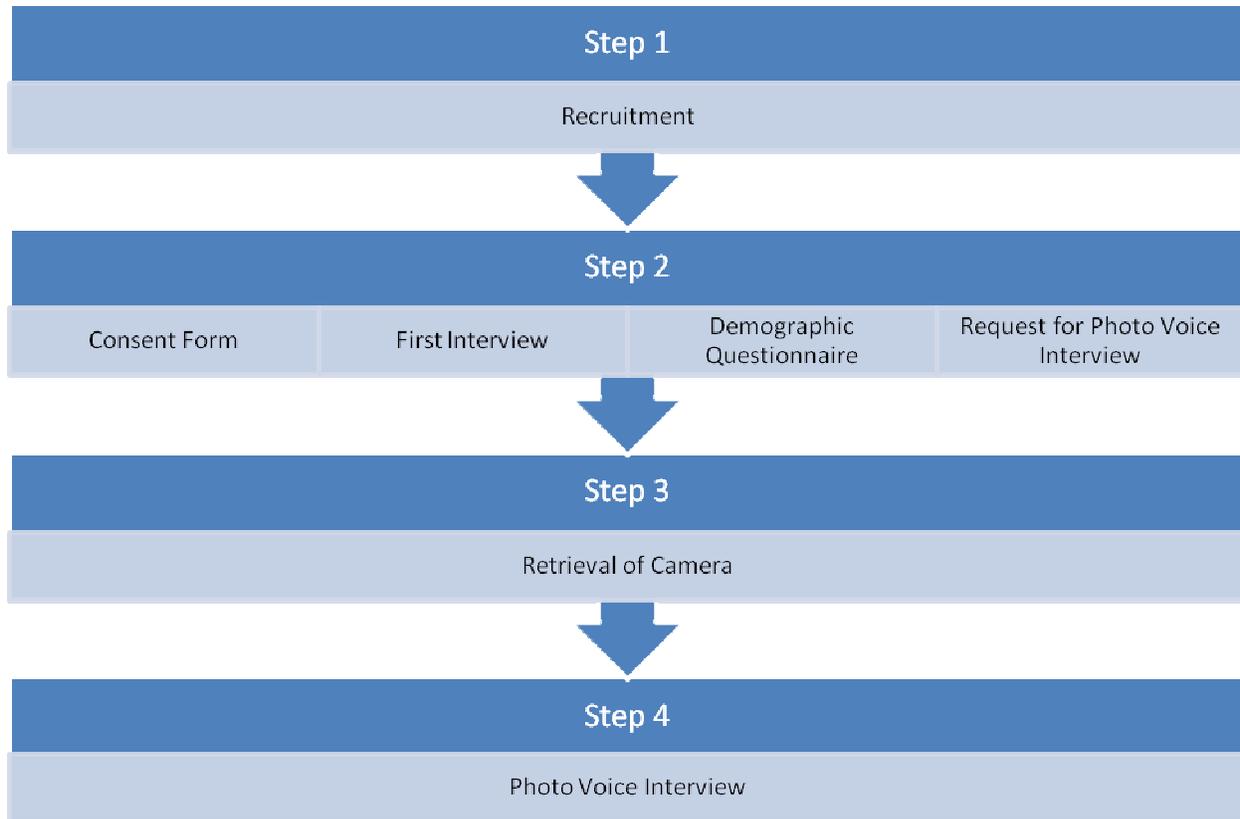
### **Data Collection**

A demographic questionnaire (see Appendix F), face-to-face individual and photo voice interviews (Appendix E and Appendix H), and notes from the researcher's journals (see Appendices I and J) were used to collect the data for this study. This approach, also known as data merging (using multiple sources of information), provided rich data, and produced robust findings (Fetterman, 1989; Schensul, Lecompte, Nastasi, & Borgatti, 1999). The four types of data yielded rich knowledge and a well-rounded understanding of Haitian immigrant hotel housekeepers' experience with hypertension as well as how they manage disease within the context of their immigrant life.

Data were collected between July 2010 and September 2010. When given the choice between English and Haitian Creole, all of the participants opted to do their interviews in Haitian Creole. Data were collected for each of the participants following the steps in the Flow Chart 1 below. Those who refused to participate in the photo voice interview stopped at Step 2.

## Flow Chart 1

### *Steps for Data Collection*



**First individual interview.** Upon establishment of eligibility, the researcher met with each of the participants at a time and location of their choice that would ensure safety and confidentiality. Prior to conducting the interview, the purpose and study procedure were discussed with each participant. Both verbal and written consent were obtained from each of the participants to ensure that they understood the study's purpose, agreed to participate in the study, and gave permission for their interviews to be recorded. The first individual interviews took place in participants' homes ( $n=23$ ), a church office ( $n=2$ ), a participant's vehicle ( $n=1$ ) and the researcher's vehicle ( $n=5$ ).

Each interview lasted between 20 and 90 minutes. After the interview, each participant received a \$20 gift card.

Guided by critical ethnography (Thomas, 1993), each interview was conducted with the mindset that the participants were expert in their own knowledge about hypertension and its management. The researcher remained aware at all times of her position as a graduate student, a nurse with knowledge of HTN and HTN management, and a researcher. Throughout the process, the researcher was also aware of how her own positions might influence the dynamics of the interview and the way participants answered the questions. For example, when participant 28 (P28) was asked what he thought of hypertension, he responded: "I should be asking you. When people have hypertension how is it?". This rerouting of the question suggested that the participant thought of the researcher as an expert on hypertension. The researcher clarified her interest and reiterated that there was no right or wrong answers to the interview questions.

As posited by critical ethnography, individual behavior is based on current and past experiences and cultural knowledge (Charon 2001; Foley 2002). Thus the interviews were conducted with the awareness that the way that Haitian immigrant hotel housekeepers defined and managed hypertension would be dependent upon their historical, cultural, and socio-economic experiences, both in Haiti and in their current place of residency (the U.S.) and the meanings they ascribed to these experiences.

**Demographic questionnaire.** The demographic questionnaire was completed immediately after the first individual interview. Examples of information obtained included sex, age, education, income, number of rooms cleaned per day, number of

trips back to Haiti, and remittance practices. Additionally, the demographic questionnaire had an open-ended section for the researcher to inquire about how each of the demographic characteristics (e.g., age, gender, and education) influenced participants' HTN management. This open-ended section yielded richer data regarding the participants' experiences with HTN and management of this health condition. It also addressed the critical ethnography methodology and transnationalism theoretical framework, because it placed the participants' definition of HTN management within the context of their political, socioeconomic, and cultural experiences. The process revealed the participants' experiences as men and women of certain age groups, as blue-collar workers of lower income status, and as an immigrant group with active relationships with individuals from back home.

It is important to note that the questions from the demographic questionnaires were not asked in a chronological manner. Many questions that were on the demographic questionnaire were already addressed during the first individual interview. The interview was designed to flow like a conversation, while using the questions approved by the Institutional Review Board for the conduct of the research. The conversation style allowed both the participants and the researcher to be comfortable and expand upon their experiences with HTN and HTN management. If, during the individual interview, a participant talked about the number of rooms they cleaned per day, the researcher proceeded to asking him/her about the number of rooms he/she cleaned and how that influenced their hypertension management. Consequently, a large amount of the demographic data was collected during the first individual interview.

**Photo voice Interview.** Before adjourning from the first meeting during which the first individual interview and demographic questionnaire took place, the participants were asked if they would feel comfortable taking pictures of anything and/or anyone that had an impact on the way they defined and managed their hypertension. This data collection method reflected: (a) the way participants defined and managed hypertension, (b) influences of work on HTN management, and (c) influences of transmigrant life on HTN management. Individuals who agreed to take pictures ( $n=12$ ) were provided with a disposable camera and made appointments with the researcher to return the camera for the photographs to be developed. They were told to: 1) take pictures of objects and/or individuals they believed played a role in their hypertension management; and 2) be sure they had permission from the individuals of whom they were taking the picture. Participants were also told that needed to take only pictures that they felt comfortable taking and to use as many if not all the spaces available on the camera. Pictures that identified individuals were returned to participants.

One week after the first interview, meetings were set up to retrieve the camera and follow-up appointments were made to discuss the photographs. The photos were developed immediately after the participants returned the cameras and were kept in the order they were taken by the participants. The researcher then met with the participants in their home ( $n=9$ ) and the researcher's car ( $n=3$ ) for the photo voice interviews. At these interviews, photographs were handed to the participants and they were asked which of the pictures best depicted: (a) the influence of work as a hotel housekeeper on their HTN management (b) the way they defined hypertension, and (c) the way they managed hypertension. They were also asked: "Why did you take this picture?" - [Pouki

sa ou pran foto sa?]; “What is happening in this picture?” - [Sakap pase nan foto sa?]; “How does this picture relate to how being a hotel housekeeper influence your hypertension management?” - [*Kijan foto sa montre jan lavi imigran ou ak travay ou enfliyanse jan ou kontrole tansyonw lan?*].

Each photo voice interview lasted between 20 to 30 minutes. It was important for the researcher to meet with the participants to discuss the pictures, because they might have had different personal meanings for each depiction (Musello, 1980). As a form of empowerment, photo voice was used in this study to give the participants another way of considering and describing the socioeconomic, political, and cultural determinants that influenced their hypertension management (Wang & Burris, 1997; Wang, 1999; Wang, 2006).

Surprisingly, all of the study participants felt uncomfortable with this process. Nineteen of the 31 study participants declined the opportunity to participate in the photo voice interview. The other 12 participants who chose to participate remained hesitant about taking photos, especially at the workplace. They were able to take photographs of things outside of the workplace; however, when it came to the workplace, they remained hesitant.

This hesitance was due to several factors. First, some of the participants ( $n=4$ ) did not want to be accused of stealing the disposable cameras. Second, some participants ( $n=5$ ) did not think that their supervisors would feel comfortable about them taking pictures at the workplace. Two participants' supervisor denied the permission for them to take pictures at the workplace. Third, some participants ( $n=8$ ) were worried about time constraints. Since the workers were under constant pressure to complete

each room and move on to the next, some did not even have a moment or two to stop and take pictures. Very few participants (n=4) were able to take pictures at the workplace, and they were mostly pictures of completed rooms (see Picture 1) or of their carts (see Picture 2).

Despite the participants' inability or reluctance to take pictures representing workplace influence on HTN management, participants who agreed to the photo voice interview were able to explain the pictures of what objects and/or person they would take. Upon completion of the second interview, each participant received another \$20 dollar gift card. The gift cards (two cards for a total of \$40) were not a form of coercion for participation. According to Erlen and colleagues (1999), "coercion is possible only if one person or group intentionally and successfully influences another person's decision by using threats so as to make it impossible to resist the threats" (p. 85). The gift cards were simply a form of thanks and appreciation for the study participants' willingness, time, and effort (Resnick, 2008).

**Notes from the researcher's journaling.** Journaling, or making field notes, is a viable method of data collection in ethnographic studies (Koch, 1998; Lecompte & Schensul, 1999; Munhall, 2003). For this study, the researcher kept a journal to record the participants' non-verbal cues and responses throughout the interviews. Journaling helped the researcher reflect through the research process and record what was learned and what was observed. Through journaling, the researcher also noted perplexing issues that required further discussion and clarifications before, during, and after the interviews. A journaling guide (see Appendices I and J) was used to provide cues for follow-up questions.

## **Instrument Translation**

The interview guides, demographic questionnaire, and consent form were translated into Haitian Creole so that the participants could choose the language they felt most comfortable with. As recommended, each instrument was translated from English to Haitian Creole and then back to English to ensure equivalence of the language for these instruments (Hilton & Skrutkowski, 2002). The researcher translated from English to Haitian Creole, and a colleague who is fluent in both English and Haitian Creole did the back translation. Each translation and back translation was completed independently, and then the researcher and translator consulted on the results for inconsistencies. This ensured that meanings were not lost from literal translation of words that have different cultural meanings.

## **Data Analysis**

Analysis of the data obtained from the individual interviews, photographs, and demographic questionnaire was guided by the transnationalism theoretical framework and critical ethnography. The analysis of the demographic questionnaire, the individual interviews, and the photo voice interviews is described in the respective order.

**Demographic questionnaire analysis.** The data analysis of the questionnaire was done on two levels. Level 1 involved the analysis of the closed-ended questions. Level 2 involved critical analysis of the demographic questionnaire, followed by open-ended questions on the participants' questionnaire answers. Each analysis level was described below.

*Level 1.* For this level of analysis, the researcher used the Statistical Package for the Social Sciences (SPSS) software for the descriptive analysis of the demographic

variables. The demographic characteristics of the participants were used to situate the participants within the context of their immigrant life in order to understand their views and approaches of HTN within that context. Gender was grouped as male and female. Age was grouped within the age range supported in the HTN literature of the American Heart Association. The age distribution was set to groups of 20-34, 35-44, 45-54, 55-64, 65-74, and 75+ years.

*Level 2.* The second level of data analysis of the demographic questionnaire involved analysis of the open-ended questions. The open-ended questions were transcribed and uploaded into the Atlas.ti software to be analyzed with the first individual interviews. Atlas.ti. is an analytical software package used for qualitative inquiries (Muhr & Friese, 2004). The historical, socio-cultural, economic, and political contexts were considered for this analysis to aid understanding of how Haitian immigrants described and managed HTN. For example, the economic context was considered through the participants' income, and education. Also considered was how the factors of social control (race, class, gender, and immigration status) influenced the participants' life, definition, and management of HTN. For example, one of the open-ended questions asked the participants how they believed their gender influenced their management of HTN. The open-ended section of the demographic questionnaire allowed the participants and researcher to question how their characteristics and everyday life influenced their HTN and its management. Participants' answers to the open-ended questions were relevant to each participant, as far as how they believed their own individual characteristics (such as age and gender) influenced their HTN and its management. Common words and phrases were noted and checked for patterns.

**First individual interview analysis.** Data analysis for the first individual interview occurred with three steps (see Table 4). The first step of analysis was preliminary and occurred throughout the data collection process. The second step of analysis involved identification of general themes and occurred during the coding process, after data collection. The third step of data analysis went deeper into the data to examine the context of transmigrant life with a critical lens.

Table 4

*Steps of Analysis of Individual Interviews*

Steps	Descriptions
Step 1	<ul style="list-style-type: none"> <li>- Listened to audio-recorded interviews</li> <li>- Reviewed field notes</li> <li>- Made notations about unclear questions and any remarks made by previous participants to clarify for second interview and future participants</li> </ul>
Step 2	<ul style="list-style-type: none"> <li>-Transcribed individual recorded interviews</li> <li>-Uploaded transcripts into Atlas.ti.</li> <li>- Read individual transcripts</li> <li>-Assigned key words and sentences to free quotations</li> <li>-Assigned codesto free quotations</li> <li>-Compared interview codes to determine themes</li> </ul>
Step 3	<ul style="list-style-type: none"> <li>-Re-read each trasncript for deeper understanding as influenced by Critical ethnography and TTF</li> </ul>

*Step 1* The first level of data analysis began immediately after the first interview. Critical ethnography requires flexibility to meet the needs of individuals (Thomas, 1993). After each interview, the recorded interviews were reviewed. Notes were also taken

about statements or words that caught the researcher's attention and that suggested more questions and other adjustments to the following interviews.

Several adjustments to the research questions were made as a result of this process (see Table 5). In addition to the adjustments made during this first level of analysis, the researcher was able to take notes about ideas and issues to revisit in the first interview with the other participants. For example, participant 14 (P14) associated exercising with the time pressure at her work. She mentioned "The work makes me exercise. When I work fast, I do exercise, water drips down on me".

Notes were made of this statement, and subsequent participants were asked whether they felt the same way about exercise and the time pressure of hotel housekeeping work. Field notes and the first interviews allowed the researcher to get clarifications and rethink some questions for the next participants. For example, when participant one (P1) was asked how she believed her income influenced the way she managed hypertension, she did not understand the question. The question was rephrased so that the next participant could better understand it. Table 5 shows all the questions from the first individual interview and open-ended questions from the demographic questionnaires that had to be revised.

This preliminary analysis for the first individual interviews also helped identify similarities and differences within and across individual interviews. For example, there was often an overlap between the definition and cause of hypertension. In this first level of data analysis, the researcher was able to listen to the interviews, and make this observation. She then specifically ask other participants what they thought about the different difinitions and causes of HTN discussed by the previous participants.

*Step 2.* The second level of data analysis for the first individual interviews involved coding and theme identification. All the recorded interviews were transcribed verbatim. The transcripts were then uploaded into Atlas.ti. In an ethnographic study, “coding involves organizing data into categories related to the framework and questions guiding the research so that they can be used to support analysis and interpretation” (Lecompte & Schensul, 1999, p. 45). Once uploaded into the software, the transcripts were coded in the following four stages. In Stage 1, each transcript was read, and free quotations were given to the important passages. Below is an example of a passage with a free quotation.

Researcher: *O, ok. kisaw panse ki bay tansyon an?*

Researcher: Oh, Ok. What do you think caused your hypertension?

P: tansyon ...*petèt strès.*

P: Hypertension....Maybe stress

Table 5

## Questions Revised for Clarity for Subsequent Participants

Original Question	Revised Question	Rationale
How do you think your income influences the management of your hypertension?  <i>Kijan ou panse kob wap fe chak ane enflyanse jan ou kontrole tansyonw?</i>	If you made more money than <b>participant's income</b> , do you think you would have more or less difficulty managing your hypertension? Why?  <i>-Si ou tap fe plis ke <b>participant's income</b> eske ou panse ou tap gen plis difikilte pouw kontrole tansyonw lan?</i>  If you made less money than <b>participant's income</b> do you think you would have more or less difficulty managing your hypertension? Why?  <i>-Si ou tap fe mwens ke <b>participant's income</b>, eske ou panse ou tap gen plis difikilte pouw kontrole tansyonw lan?</i>	The researcher wanted to know how the amount of money they made influenced their HTN management. The researcher wanted to know if they made more or less than the amount they are making now and if they believed that would make a difference in their HTN management.
How do you think being <b>stated age</b> influences the management of your hypertension?  <i>Kijan ou panse laj ----- an enflyanse jan ou kontrol tansyonw?</i>	If you were younger than <b>participant's age</b> do you think you would manage your HTN better?  <i>Si ou te pi piti ke <b>participant's age</b> eske ou panse ou tap kontrole tansyon w lan pi byen?</i>  If you were younger than <b>participant's age</b> do you think you would manage your HTN worse?  <i>Si ou te pi piti ke <b>participant's age</b> eske ou panse ou tap kontrole tansyon w lan pi mal?</i>  If you were older than <b>participant's age</b> do you think you would manage your HTN better?  <i>Si ou te pi gran ke <b>participant's age</b> eske ou panse ou tap kontrole tansyon w lan pi mal?</i>  If you were older than <b>participant's age</b> do you think you would manage your HTN worse?  <i>Si ou te pi gran ke <b>Participants' age</b> eske ou panse ou tap kontrole tansyon w lan pi mal?</i>	The researcher wanted to know how they think their age influence their approach to HTN management. If they were younger or older, would they do the same thing? Would they do a better job at managing their HTN? Would they do worse?
How do you think being an immigrant influences the way you manage your hypertension?	How do you think living in a country other than Haiti influences the way you manage hypertension?	Participants assigned negative connotation to the term "immigrant." Therefore, the researcher rephrased the question emphasizing "living in another country."

In Stage 2, the transcripts were read again and specific code names were assigned to the quotations. The code names were either “in vivo” (directly from the text/paragraph) or open coding (term chosen by the researcher) to best describe the meaning of the text. Code names were also chosen from the code list that included all the terms previously assigned to preceding texts. Below is an example of a passage with an “in vivo” code.

Researcher: *O, ok. kisaw panse ki bay tansyon an?*  
Researcher: Oh, Ok. What do you think caused your hypertension?  
P: *tansyon ...petèt strès.*  
P: Hypertension...Maybe stress

Stress

In Stage 3, each interview was compared. Themes then emerged. For example, for the passage above, the code “stress” would fall under the theme “cause.” The theme cause has different codes such as stress and diet. In addition to identifying codes and themes, the researcher used the memo pad on the tool bar of the Atlas.ti. software to make notes and write important observations that needed to be discussed in the results.

*Step 3.* For this third level of data analysis, the transcripts were read and re-read with the lens of critical ethnography (CE) and transnationalism theoretical framework (TTF). This allowed for a deeper exploration—beyond merely the “what is”—to an analysis of the “why” and the “how” embedded in the data (Thomas, 1993). Critical ethnography calls our attention to the influence of social control on reality and the creation of meaning. The researcher reflected on participants’ responses during the interviews: both on how they responded and why they responded the way they did.

The transcripts were explored beyond the “texts” to uncover the factors of social control that influenced the way Haitian immigrant hotel housekeepers defined and

managed hypertension (HTN). These factors of social control included race, class, gender, and immigration status. The researcher considered how these factors might have influenced the immigrants' perceptions, their experiences, and hence their responses to the way they managed hypertension. For example, when participant 26 (P26) talked about the influence of his work on hypertension management, he said he believed that his work was stressful because of his race. He thought that hypertension could be managed by relaxing and staying away from stress. He talked about racism at his workplace giving him stress and inhibiting him from managing his hypertension. He stated:

The manager is a woman who cannot stand Black people at all. She will give you one day of work and give the Whites five days. You see them all with the same skin color. Everyone who does not have the same skin color [as the manager] is no longer around. (P26)

*[Manajemm nan se yon fi ki pa vle we nwa menm. Li gen poul baw yon jou travay epi li bay ti blan yo senk jou. Ou we yo tout menm koule net ale. Tout mounn ki pa menm koule avek yo pa la anko].*

Data analysis revealed the oppressive system of the U.S., and that of the workplace in particular, and how, combined, they could influence the participants' perception or feelings of stress and thus management of hypertension. Data analysis also considered how being categorized as Black—which is associated with being at the lower socioeconomic ladder in the host country—influenced the participants' HTN

management. This lower economic class status, as well as the context of working in a lower position in the service industry as hotel housekeepers, was considered jointly as well, in order to understand their influence on the participants' HTN management. Moreover, the influenced of gender (being male or female) on the immigrants' everyday life and HTN management was considered as well.

**Photo voice interview analysis.** In this research study, photographs were used both as the actual documentation and also as a source of information (Dempsey & Tucker, 1990). Photo voice analysis occurred in three steps: (1) discussion of the pictures with the participants, (2) photograph comparison, and (3) discussion of the meanings of the photographs in terms of their influence on the immigrants' experiences as hotel housekeepers. Each of these steps is described below.

The first step of analysis took place during the data collection process. This involved looking at the photographs with the participants and discussing the participants' choice of the best depiction of how their work influenced HTN management. Participants were able to verbally explain the photographs, what they represented, and how the object/person represented in the picture influenced their HTN management.

For the second step of analysis, all the photographs that had been identified as defining HTN, managing HTN, and representing work influences on HTN management were reviewed. The researcher then compared the photographs with information from the first individual interview of each participant to see how they either supported or contradicted the participant's description about their experience with HTN and HTN management. Photos were also compared to see how they differed between

participants. The pictures that were kept (the ones not identifying individuals or hotel names) were scanned onto a computer.

For the third step, the recorded photo voice interview transcripts were uploaded into Atlas.ti. and coded using the existing code list. The researcher took into account the participants' perceptions and experiences as a transmigrant group in the U.S. working as hotel housekeepers, and how these influenced their HTN management. The researcher also considered how race, gender, class, and immigration status influenced the discussion about the photographs.

### **Reflexivity**

Reflexivity was the researcher's constant evaluation of how her personal and intellectual experiences and interactions with participants influenced her way of collecting, analyzing, and representing the data (Jordan & Yeomans, 1995; Thomas, 1993). Reflexivity is necessary for effective qualitative research (Muecke, 1994), especially critical ethnography research (Thomas, 1993). Jordan and Yeomans (1995) posited that "reflexivity operates on the basis of a dialectic, between the researcher, research process and its product" (p.394). Together, the participants and researcher constructed knowledge, and the participants became more aware and socially conscious of the various social forces (social domination and power imbalances) that influence their actions and well-being (Jordan & Yeomans, 1995).

For this study, the researcher considered her historical, social, and political background and position because they would have an influence on her reflections and the thought process and meanings she ascribed to the participants' accounts. She was also aware of the inequality in power relationships between the research participants

and herself. Throughout the research process, she asked herself the following questions: “How is my education influencing my interaction with the participants and the way I am collecting, analyzing, and representing the data?”; “How is my position as a researcher influencing my interaction with the participants?” As the researcher thought about these questions, she assured the participants that they were the experts in their own knowledge about their hypertension experiences..

### **Data Storage and Management**

The digitally recorded interviews and digitally recorded demographic questionnaires were uploaded onto a secured computer to which only the researcher had access. Separate folders were created on the computer for each of the participants. For example, the folder for participant 4 contained: the audio files of the two interviews, the demographic questionnaire, the transcripts of each interview, and demographic questionnaire open-ended section for that particular participant. The folders, the log, and the master list were copied onto a CD and an external hard drive. Both the CD and external hard drive were kept in a locked cabinet. Hard copies of the transcripts were also placed in a locked cabinet.

### **Scientific Rigor**

Rigor in qualitative research reflects the consistency of the study methods and accuracy of the representation of the population and phenomenon of interest (Lincoln & Guba, 1985; Thomas & Magilvy, 2011). Rigor calls for research transparency and allows the public to follow every step of the research study from proposal development and planning to data interpretation (Thomas & Magilvy, 2011). Rigor of a qualitative study is maintained by ensuring credibility, transferability, dependability, and

confirmability. Below is a description of how the researcher addressed each of these features of rigor in the study.

**Credibility.** Credibility refers to the accurate representation and understanding of a specific phenomenon with respect to participants' shared experiences (Golafshani, 2003). For this research study, credibility was achieved through: (a) comparisons, (b) photo voice interviews, and (c) member checking. First, participants' accounts about their experiences with HTN and HTN management were compared and contrasted. The transcripts were checked for similarities and differences within and across the participants, and it was determined that participants did experience similar issues with HTN and HTN management. Those who reported specific issues or beliefs that differed from the majority (for example, the person who thought that exercise could not help hypertension) were identified. Second, credibility was established through the photo voice interview, during which the researcher followed up on previous interviews. This was also an opportunity to clarify any questions or issues that were raised during the researcher's reflection and throughout the interview sessions. The photographs and transcripts from the photo voice interviews supported the participants' previous accounts of their experiences with HTN and HTN management. Third and finally, throughout the study process, the researcher maintained contact with members of her dissertation committee who were experts in some field of qualitative method inquiry, such as critical ethnography methodology. The researcher obtained feedback on the data analysis and coding process and made changes accordingly.

**Transferability.** Transferability is the ability to apply the research method in other population groups to address similar phenomena and collect similar data (Lincoln

& Guba, 1985). For this study, transferability was addressed through: (a) the demographic questionnaire, and (b) inclusion and exclusion criteria. A detailed demographic questionnaire allows for the audience and other researchers to have a clear idea of the characteristics of the study population. Additionally, the researcher had clear inclusion and exclusion criteria for participating in the study. Using concise demographic data and inclusion and exclusion criteria, one could replicate the study and some similarities in the findings would occur. Such findings certainly would depend on the population group. For example, the study participants discussed experiencing racism because of the color of their skins at the workplace, which in turn influenced their HTN management by preventing them from staying calm. Alongside several similarities such as workload and hiring process, the findings might differ if the participants themselves were different, for example, if they were White immigrant workers.

**Dependability.** Dependability refers to ensuring the transparency of the research process via an audit trail (Thomas & Magilvy, 2011) maintained throughout the entire research process (Morse, Barrett, Mayan, Olson, & Spiers, 2002). In this research study, dependability was achieved by obtaining a completed and approved proposal prior to data collection, Before the researcher traveled to Florida to collect data, she wrote the research proposal, which supported the significance of the study (through intensive review of the literature), had a clear research purpose, and detailed each step of the data collection and data analysis process. In completing the research proposal, the researcher was able to fully describe and get more comfortable with her decision making and analytical process leading to the research purpose and methods. Additionally, the researcher maintained ongoing contact with members of dissertation

committee as they helped her reduce and transform the data for analysis and write a concise results section. The audit trail was used to help the researcher track the research process.

**Confirmability.** Confirmability is reinforced through reflexivity (Thomas & Magilvy, 2011). Once credibility, transferability, and dependability are met, then confirmability can be achieved. In this research study, the researcher maintained a journal and field notes, which allowed her to reflect throughout the data collection and data analysis process. Additionally, she reflected on the findings as she compared them to the existing literature identifying similarities and specific areas where the study addressed the literature gap. As a qualitative methodology, critical ethnography calls for reflexivity, which stresses acknowledgement of one's position and experiences as influencing epistemology (Foley 2002; Jordan & Yeomans, 1995; Madison 2005; Thomas, 1993). Reflexivity was maintained throughout the dialectic between the research participants and the researcher. Knowledge was generated throughout the interaction between the participants and the researcher. Such knowledge generation was influenced by both the participants' and researcher's experiences, knowledge, and beliefs. The researcher journal allowed the researcher to reflect on her interactions with participants, and her observations during and after each interview. For example, in the second journal entry the researcher wrote the following: "[name] seemed offended when I brought up the word immigrant... advised to not say the word again with other people because they might not trust me in the future, it might be best to change the word immigrant and rephrase the question". Another journal entry read: "Husband present... husband answering a lot of the questions for participant." This participant whose

husband was present during the first interview participated in the photo voice interview. The husband was not present during the second interview. The questions that her husband answered, were redacted from the transcript to ensure that the data was her own information and not her husband's opinion.

Throughout the data collection and analysis process, the researcher considered the role that her experience and knowledge as a nurse in a doctoral program played in her approach to understanding and synthesizing the data. However, throughout this endeavor, she reported the participant's own voiced experiences, using their own words to support her findings discussions.

Reflexivity was also exhibited throughout the data collection process to ensure that the researcher addressed the study aims and at the same time gathered information about HTN management without losing rapport with participants. For example, some of the interview questions were re-formulated based on the responses received from the first few participants. The word "immigrant" made participants feel threatened and uncomfortable, for example, so it was changed to "someone living in a country other than Haiti."

Additionally, prior to going to Florida to collect the data the researcher was able to spend a day shadowing a Mexican immigrant hotel housekeeper in a hotel in Washington State. This provided an opportunity to experience first-hand what hotel housekeeping work entailed. The researcher was exposed to hotel housekeeping work and could relate to the participants' accounts about their work.

## **Protection of the Participants**

Approval of the human subjects application was obtained from the Human Subjects Review Committee of the University of Washington. Once potential participants for the study were identified, oral consent was obtained from them. The approved written consent forms (see Appendices C and D) with the researchers contact information and a detailed description of the purpose, procedures, risks, benefits of the study were provided to the participants in their preferred language (Haitian Creole) and signed prior to any form of data collection. The participants were told that they had the right to decline to answer any questions during the interviews or to stop participating in the study at any time. Before the interviews, participants were asked for permission to have the interviews audio recorded and notes taken. (All the participants agreed to have their interviews audio recorded.) The researcher addressed all questions and concerns of the participants throughout the study.

De-identified data were shared with the members of the researcher's dissertation committee. Each participant was assigned a number to maintain confidentiality during the study report and dissemination process. For example, the fourth participant was labeled as "P4." Each participant was asked for permission to use their audio recordings during the dissertation defense and at national conferences. The replay of the recordings will include only those sections that do not identify the participants. The digitally audio recorded interviews are projected to be destroyed within 10 years of the study completion.

A master list and a log were generated for this study. The master list included the participants' names, phone numbers, and assigned IDs. The phone numbers were

needed for the researcher to contact the participants about the camera for the photo voice interview. The master list was destroyed 6 months after data collection from the last participant was completed. A log was used to track the research process. The log identified participants only by their IDs without any identifiable information. It included information about the number of contacts that were made with each participant, as well as the time, date and content of the conversations with each individual. The log will be destroyed within 10 years of study completion.

### **Summary**

This chapter described the research design. Provided in the chapter was detailed information about the setting of the research project, sampling, inclusion and exclusion criteria, and recruitment process. The chapter also reviewed how the researcher ensured protection of the participants, collected the data, and analyzed the information for this study. The chapter additionally addressed issues of reflexivity, and means to achieve scientific rigor of this critical ethnography. The following two chapters (Chapters 4 and 5) report the study findings. Chapters 4 and 5 are written as future manuscripts.

## Chapter V- Definition and Management of Hypertension

### Chapter Abstract

**Purpose:** This chapter describes how Haitian immigrant hotel housekeepers defined and managed hypertension within the context of their transmigrant life.

**Background:** Transmigrants are individuals who maintain relationships that transcend geographical borders by using resources in both their host and home countries to survive. How Haitian immigrants define and manage hypertension has yet to be fully explored in general or in terms of their transmigrant identity. No study exists using a transmigrant analysis to understand chronic disease management among Haitian immigrants.

**Methodology, Methods and Sample:** A critical ethnography study exploring the definition and management of hypertension among 31 Haitian immigrants was conducted in Miami-Dade County, Florida. Data were collected using demographic questionnaires, individual and photo voice interviews. Data were analyzed with SPSS and Atlas.ti software.

**Results:** The Haitian Creole words “*tansyon*” ( $n=27$ ) was mostly used by participants instead of the word hypertension. *Tansyon* was thought of as a normal condition of the human body ( $n=3$ ) or as a *maladi* (illness) ( $n=28$ ). Both Western medicine ( $n=24$ ) and non-Western medicine approaches ( $n=25$ ) were used by the participants to manage hypertension. Transmigrant life context, along with factors such as gender and immigration status, influenced the definition and management of hypertension.

**Discussion:** The definition of hypertension shaped participants’ beliefs about its occurrence and the resulting management strategies used. Health care providers need

to be aware of how Haitian immigrants define and manage hypertension. In addition, more attention is needed on the role of transmigrant life context, gender, and immigration status on hypertension management among Haitian immigrants.

## Introduction

Knowledge about the definition and management of hypertension (HTN) among Haitian immigrants is sparse. Few studies have explored HTN among Haitian immigrants (Koch et al., 2005; Preston et al., 1996). These studies identified hypertension as a major health concern among Haitian immigrants leading to poor health outcomes. Little is known about how Haitian immigrants define and manage HTN. What is especially important to consider is the transmigrant life of most Haitians and its influence on their disease management.

Haitian immigrants have used transnational ties that are maintained with their home country to address health issues they experience in the U.S. For example, through transnational ties, injectable substances are procured in Haiti to be used by *picturists* (individuals who perform injections) (Rahill, Dawkins, & De La Rosa, 2011). Haitian picturist services are also used in the U.S. by Haitian immigrants lacking health insurance or otherwise lacking access to health care (Rahill et al., 2011). However, these important transmigrant issues have not been thoroughly researched.

Additional factors that need to be considered, in the exploration of definition and management of HTN among Haitian immigrants, include that of gender and immigrant status. This is important because gender and immigration status have shown to influence the health and disease management among immigrant groups (Belizaire & Fuertes, 2011; Gu, Burt, Paulose-Ram, & Dillon, 2008). The social construct of gender (Hoffman, 2006) has especially been explored concerning HTN among other ethnic groups (Gu et al., 2008; Keyhani, Scobie, Hebert & McLaughlin, 2008; Otschega et al.,

2008; Sharpe, Clark, & Janz, 1991). Studies have yet to determine the role gender plays in the definition and management of HTN among Haitian immigrants.

The influence of immigrant status on immigrants' health has also been explored in previous studies. For example, a recent study reported that, as their years of residency in the U.S. increase, the quality of life of Haitian immigrants decreased (Belizaire & Fuertes, 2011). Thus, it is important to determine the influence of immigration status on the definition and management of HTN among Haitian immigrants.

This result chapter reports how Haitian immigrant hotel housekeepers defined and managed hypertension within the context of their transmigrant life with special consideration for their gender and immigration status. The next section of the chapter will describe the study methods. Participants' characteristics will be described. Then the study results, limitations will follow. A discussion section will conclude this chapter.

## **Methods**

### **Sampling and Recruitment**

A detailed description of the study methods is found in Chapter 4 of this dissertation. Flyers were posted in four Haitian churches, one barbershop, three restaurants, two boutiques, and one local organization. Snowball techniques were also used to recruit additional participants. Study participants were 18 years of age or older, resided in Miami-Dade County, Florida, worked as hotel housekeepers, had migrated in the U.S. within the past 10 years, had been diagnosed with HTN by a medical doctor, and were able to provide oral and written consent. Recruitment resulted in the selection of a purposive sample of 31 Haitian immigrant hotel housekeepers.

## **Data Collection**

In-depth semi-structured interviews, demographic questionnaire, and photo voice interviews were conducted with the 31 participants between July 2010 and September 2010. Participants were given the choice of preferred language for the interviews: English or Haitian Creole. All 31 participants opted for Haitian Creole. Prior to the first interview, the purpose and study procedure were discussed with each participant. Consent forms (in Haitian Creole) were reviewed and signed. After completion of the first individual interview and demographic questionnaire, each individual was asked to participate in the photo voice interview. Those who agreed to participate in the photo voice interview ( $n=12$ ) were given a disposable camera and told to take pictures of anything and anyone (with permission from the targets) influencing their HTN management. One week after the first interview, the researcher met with participants to collect the disposable camera. The researcher made another appointment with them to discuss the developed photographs. Interviews were audio recorded. Field notes were compiled at the end of each interview.

## **Data Analysis**

The Statistical Package for the Social Sciences (SPSS) software was used to analyze the first part of the demographic questionnaire. This section included information about gender, age, education, income, number of rooms cleaned per day, length of time working as a hotel housekeeper, length of time in the U.S., number of voyages back to the home country of Haiti, and amount and frequency of remittances sent to Haiti. The second section of the demographic questionnaire placed the participant's accounts about HTN and HTN management within context by asking them

how they believed each of their characteristics (e.g., gender, age, and income) influenced their HTN management. The responses were audio recorded, transcribed, and analyzed, along with the individual interviews. The audio recorded interviews and field notes were transcribed and imported into Atlas.ti software. Transcripts were read and re-read to identify codes. Codes were then compared within and between individual transcripts and themes emerged. Lastly transcripts were read again with a critical lens to understand the context of transmigrant life and how it influences participants' HTN management, giving consideration to race, class, gender, and immigration status.

### **Participant Characteristics**

Table 6 shows the demographic characteristics of the participants. Both men ( $n=4$ ) and women ( $n=27$ ) participants were interviewed. The majority of participants ( $n=17$ ) ranged in age from 46 to 55. Participants were single ( $n=12$ ) or married ( $n=12$ ). While others were separated ( $n=4$ ), partnered ( $n=2$ ), or divorced ( $n=1$ ). Over half of the participants (58.1%) had an education level between the first and fifth grades. About 96% of the participants had an annual income level below \$20,000. Data from the open-ended section of the demographic questionnaire were used to understand the context within which participants defined and managed HTN.

Table 6

*Sample Characteristics (N=31)*

Variables	Frequency ( <i>n</i> )	Percentage (%)
Gender		
Male	4	12.9
Female	27	87.1
Age		
18-25	1	3.2
36-45	7	22.6
46-55	17	54.8
56-65	6	19.4
Marital Status		
Married	12	38.7
Divorce	1	3.2
Single	12	38.7
Separated	4	12.9
Partnered	2	6.5
Education		
1st-5th Grade	18	58.1
6th-9th Grade	7	22.6
High School	5	16.1
Missing	1	3.2
Income		
<\$10,000	4	12.9
\$11,000-\$15,000	10	32.3
\$16,000-\$20,000	6	19.4
\$21,000-\$30,000	6	19.4
\$31,000-\$40,000	1	3.2
Missing	4	12.9

## Results

### Definition of Hypertension

Participants used the word *tansyon* ( $n=27$ ) was mostly used for hypertension. Definitions of *tansyon* fell into two categories: a) *tansyon* as a natural body occurrence ( $n=3$ ) and b) *tansyon* as a *maladi* (illness) ( $n=28$ ). Each of these categories is described below.

***Tansyon as a natural body occurrence.*** Three participants (P5, P17, P27) thought of *tansyon* as a normal condition of the human body; therefore, it was not treated as an illness. The three participants who thought of *tansyon* as a natural body occurrence also reported not taking their prescribed medication. They believed that if they were not ill, there was no reason for them to take the medication. One participant commented that “*tansyon* is something natural. We all have *tansyon*” (P27). When asked about her prescribed medications, another participant stated:

Well that is for people with hypertension, sick people. But me, I already told you that I do not believe that I am sick. I do not believe what the doctor told me.

Everyone has *tansyon*. It is something normal. If I do not put in my head that I am sick, then I am not sick. (P17)

*[A sa se pou mounn ki fe tansyon, mounn ki malad. Mwen menm mwen deja diw ke mwen pa kwe mwen malad, mwen pa ke de sa dokte ya dim. Tout mounn gen tansyon. Se yon bagay nomal li ye. Sim pa met nan tet mwen ke mwen malad, mwen pa malad.]*

The three participants who thought that hypertension was a normal body phenomenon did not believe that they were sick. All three individuals were women. Two were between the ages of 36 and 45. Only one of the three participants had an education level surpassing 5<sup>th</sup> grade (6<sup>th</sup>- 9<sup>th</sup> grade). There were no specific characteristics that linked all three individuals together.

***Tansyon as a maladi.*** *Tansyon* was also thought of as a *maladi* (an illness) ( $n=28$ ). In this instance, *tansyon* was not a natural bodily occurrence. Participant 6 (P6) stated: “Well hypertension is an illness” [*ebyen tansyon an se yon maladi*]. *Tansyon* was considered to be an illness caused by factors such as stress ( $n=16$ ), everyday worries ( $n=15$ ), getting upset (*fe kole*) ( $n=8$ ), poor diet ( $n=10$ ), being shocked (*fe sezisman*) ( $n=23$ ), and family history of HTN ( $n=7$ ).

There were differences in the beliefs regarding whether or not HTN could be cured. Fourteen participants believed that their HTN could never be cured. For example, participant 4 (P4) stated: “It is not something that can be cured. Hypertension does not get cured. You can help with medication, but it cannot be cured”. Others ( $n=14$ ) thought that religious faith, absence of stress, or leaving the U.S. would help cure their HTN. Ten participants believed that God would cure their HTN. They believed that if they went to church, prayed and relied on faith, their HTN would be cured, as shown by this statement: “I don’t believe I have [HTN] for the rest of my life. I believe that one day God can take it away for me” (P8).

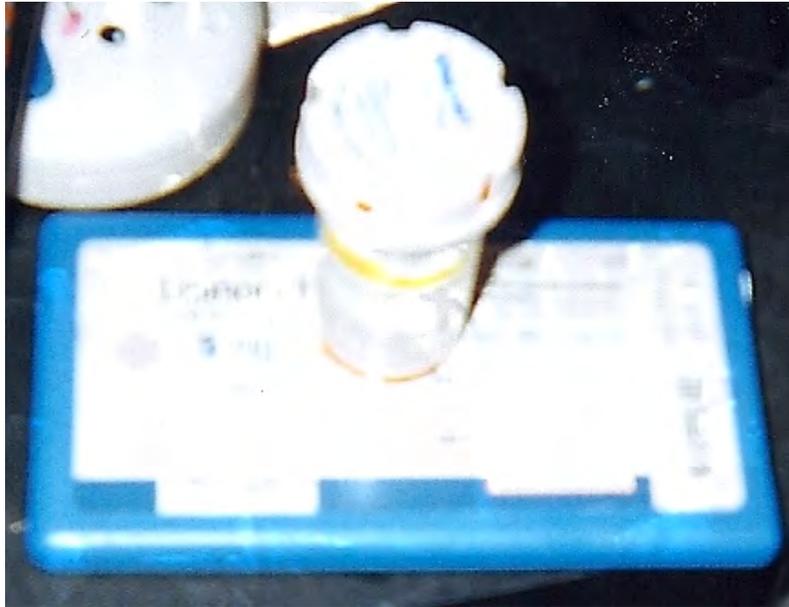
Of the 16 participants who believed that HTN was due to stress, six thought that if the source of stress were to vanish, so would their HTN. Participant 24 (P24) responded: “If I think stress causes it. And then I start to relax. And the things that used

to take over and make me always emotional, I think that hypertension can go away with all those things” (P24).

### **Management of *Tansyon* as a Maladi**

All the 28 individuals who thought of *tansyon* as a maladi took measures to manage the disease. Although 14 people believed that hypertension could be cured, they still took measures to take care of their hypertension while awaiting the cure. Both Western medicine ( $n=24$ ) and non-Western medicine measures ( $n=25$ ) were used to manage hypertension. Western approaches included Western medications ( $n=24$ ), exercise ( $n=1$ ), and a low-fat diet ( $n=10$ ). Non-western approaches included home-based remedies ( $n=25$ ) and Haitian cultural diet ( $n=9$ ). These non-Western approaches were reported to be used either as complementary to ( $n=18$ ) or as substitutions for ( $n=7$ ) the Western approaches.

**Western medicine approaches to manage *tansyon*.** Western approaches to HTN management varied. Participants used routine doctor visits ( $n=24$ ), and prescribed blood pressure medication (see Figure 1) ( $n=26$ ) to manage their *tansyon*. Two participants reported doing routine blood pressure checks at home (see Figure 2). While others ( $n=10$ ) checked their blood pressure at the pharmacy (see Figure 3). In addition, participant followed a low-fat ( $n=13$ ) or low-salt ( $n=12$ ) diet, eating fruits and vegetables ( $n=31$ ), and exercise ( $n=1$ ) to manage their *tansyon*. The photo voice method helped participants described their management strategies.



*Figure 1:* Blood pressure medications.



*Figure 2:* Checking blood pressure at home.



*Figure 3: Checking blood pressure at the pharmacy.*

Using the camera provided, one participant was able to depict her prescribed blood pressure medication. The other participant was able to take a picture of the blood pressure medication she used at home to check her blood pressure. The participant who took picture of the pharmacy discussed how she often goes to pharmacy to check her blood pressure. These participants followed the Western biomedical system, took their prescribed medication, routinely checked their blood pressure, and acted accordingly.

One factor influencing participants' ability to use the Western biomedical system to care for their hypertension was health insurance coverage. Making routine doctor visits and taking prescribed blood pressure medication were dependent upon the participants' access to medical insurance. Seven out of the thirty-one participants did

not have insurance coverage. Four of these seven people were hired via an agency and were not offered insurance benefits. The other three participants opted not to take insurance coverage, because they did not want to have monthly insurance money taken out of their paychecks. For example, one participant stated:

They pay me 8 dollars and 75 cents. But if I took insurance the money would have been less. When I get paid, if I work 40 hours, even if I worked 67 hours, they will give me my money. But with the insurance, if they have to take out 200 dollars, that is what they will take out and they will give you the rest. It is not enough. That is why I do not take their insurance. (P11)

*[Yo peyem 8 dola 75. Men simm tap pran asirans kob la tap mwens. Lemm toushe simm fe 40 awa, mwen met te fe 67 awa, yap banm koib mwen. Men avek asirans lan, si se 200 dola pou yo retire yap retire tout 200 dola a pou yo remet ou res la. Li pa ase. Se sak fe mwen pa pran asirans yo a.]*

The same seven individuals without insurance coverage reported not taking medication. One of these seven participants reported taking some of her husband's medication. Another of these seven non-insured participants reported taking her mother's blood pressure medication. Those with insurance coverage were able to maintain their routine doctor visits and refill their medication.

Some Haitian immigrants held beliefs similar to the Western biomedical model. They thought that a diet in high in fruit and vegetables and low in salt and fat would be helpful to them in controlling their blood pressure. Participant 31 stated: "I don't put a lot of salt in my food. And then I don't eat a lot of grease." One participant reported using

one particular type of salt. She believed that this salt did not have a lot of sodium and thus was good for her hypertension. She showed the researcher her package of salt and said:



Figure 4: Low-salt diet.

This is the salt. The other salt's sodium level is 490. This one is 430. The sodium level is lower in it. My doctor told me not to eat salt. And then I bought it and ate it. And then I notice the *tansyon* stays in its normal level. So I continue to buy it. The one I used to buy before did not have iodide in it. (P8)

*[Sa se sel la. Lot sodyom se 490 li ye, sa yo se 430 li ye. Sodyom nan pi piti landann. Pase dokte te dimm piga mwen manje sel. Epi kounyeya mwen ashtel mwen manje li, epi mwen we tansyon an toujou rete nomal, donk mwen kontinye ashtel. Men samm te konn ashte avann, pat gen iyodid ladann.]*

All but one participant believed that exercise was good for hypertension. However, despite their acknowledgement of the benefits of exercise, only a few participants reported taking actions related to exercising. Exercise examples reported included: walking in the park ( $n=1$ ), walking to and from the bus stop while coming or going to work ( $n=2$ ), and increasing the pace at which they cleaned the rooms at work as a form of exercise ( $n=5$ ).

**Non-Western biomedical approaches to manage *tansyon*.** Similar to the Western biomedical approach, the non-Western approach could use a low-fat, low-sodium diet along with high intake of fruits and vegetables to manage hypertension. Beyond that, however, additional culturally based measures were undertaken as a dietary approach to HTN management. For example, participants refrained from eating red meat ( $n=9$ ). Examples of red meats were pork, beef, and goat meat, which are all traditional foods in Haitian culture. These meats were avoided because participants believed that they have too much blood (*trop san*) and thus could raise one's blood pressure. One participant took the picture below to further reiterate her avoidance of red meat. She said:



*Figure 5: Staying away from red meat.*

This picture is a little fish that I cooked. I eat mostly fish and chicken. Fish is not the same as beef meat. The beef has too much blood. It has too much calories. It will bring your blood pressure up. Even it can kill you. (P31)

*[Foto sa se yon ti pwason mwen te kwit. Se plis pwason ak poul mwen manje. Pwason pa menm jan ak vyan bef. Bef la gen twop san. Li gen twop kalori. Lap monte tansyon an. Bon se li ki ka touyew.]*

Pictures captured through the photo voice method supported the participant's account about not eating red meat. This participant took a picture of a fish. This picture emphasized that eating fish was better for HTN management than red meat.

Other non-Western, culturally based approaches reported by the participants were: *5 kob wouj* ( $n=1$ ), baby aspirin ( $n=3$ ), *fey zanmann* ( $n=11$ ), papaya and papaya leaves ( $n=2$ ) (see Figure 6), oil of *lwil maskreti* (oil) ( $n=2$ ) (see Figure 7), *fey metsyen* ( $n=12$ ) (see Figure 8), *lay* (garlic) ( $n=12$ ), *fey lougawou* ( $n=4$ ) (see Figure 9), and *simen kontra* ( $n=22$ ). These herbal remedies were all imported from Haiti (see Figure 10) or came directly from the participants' backyards where participants had planted them for easy access. One participant said:

Oh. I can take *metsyen* leaf, *zanmann* leaf, *lougawou* leaf. I have my garden outside. Whenever I need I just go outside, I take and boil them. When I am done drinking these leaves, I pee a lot. It lowers my blood pressure. Papaya leaf, it lowers the blood pressure more than the pill. You can get addicted to the pill. You keep taking the pill the doctor gave you, but it is not good for your intestine. (P2)

*[O Mwen kon pran ti metsyen, fey zanman, fey lougarou. Mwen gen jadenm deyo a. Lem' bezwen mwen anik soti mal pran yo mwen bouyi. Lew fin bwe fey sa yo, le few pipi anpil. Li desan tansyon an, fey papay. Li desan tansyon an ke gren nan. Gren nan se yon adik li ye. Wap pede bwen gren dokte ya bawou a, men li pa bon pou entesten w.]*

This participant reiterated that she believed cultural based medicine worked in lowering blood pressure. She discussed her preference for the non Western medication. This preference was because of the potential addictive effects of prescribed medications.

The *5-kob wouj* (a red five-cent piece) was placed in the middle of the head along with the *lwil maskreti*. This was believed to lower blood pressure. Baby aspirin

was believed to enhance blood circulation. *Fey zanmann* was used as a tea and also applied straight to the forehead with the oil of *maskreti*. *Fey metsyen*, *fey lougarou*, and *simen kontra* were also prepared as a tea. Papaya was blended and drunk as a juice. Papaya leaf was smeared with *lwil maskreti* and placed on the forehead to lower blood pressure. Garlic bulb was used to make tea and was also boiled along with the other leaves and placed in the refrigerator to be consumed throughout the day for water intake (see Figures 11 and 12).



*Figure 6:* Papaya tree and leaves.



*Figure 7: Lwil maskreti.*



*Figure 8: Fey metsyen.*



*Figure 9: Fey lougawou.*



*Figure 10: Dry simen kontra leaves imported from Haiti.*



*Figure 11*



*Figure 12*

*Figures 11 and 12: Garlic and leaves—a boiled concoction used as everyday water intake.*

Through the photo voice method, participants explained the use of herbal medicines for hypertension management. Herbal medicines were imported from Haiti as seen in Figures 7 and 10. While others were grown in participants' backyards as depicted in Figures 8 and 9.

As seen, both Western biomedical and non-Western biomedical approaches were used to manage hypertension by study participants. Use of Western medical approaches depended upon a participant's access to services such as medical insurance and exercise equipment. Non-western medical approaches were made possible through access to culturally based medicines both from individuals living in the U.S. and Haiti.

**Combination or complimentary approaches.** Non-western approaches to HTN management were used both as a replacement for ( $n=14$ ) and complement to ( $n=11$ ) Western biomedical approaches. Six participants, all with health insurance coverage, reported using only Western approaches to manage their HTN. Those who used non-Western approaches as a replacement did so because of their cultural beliefs in the effectiveness of the herbal medicines and because of lack of trust of Western medical practitioners. For example, when asked if he took the medication prescribed by the doctor, participant 26 expressed his belief that the doctor was treating patients for HTN primarily for financial gain. He said:

No, I do not take [the medication] anymore. Because I came to understand. I do not go to the doctor anymore. What I realized is that the doctor is making a deal with me. They make this deal with all of us all the time and we do not even know it. You always have the same problem and you come. He does not even tell you that the hypertension is ok. He tells you that you have to take medication. You come back again, he gives it to you again. But the attitude you need towards the hypertension to treat it, it does not tell you about it. Because he is making a clientele. You understand? (P26)

*[Non mwen pa pran'l anko. Paske mwen vinn konpran. Mwen pa al kay dokte anko. Sann te vinn remake dokte a se yon dil li te fe avem. Yo fe dil la avèk nou tout tan nou pa menm konnen sa menm. Ou toujou gen menm pwoblem nan ou vini. Li pa menm diw o tansyon an pa bagay non. Li diw fow pran medikaman. Ou tounnen anko, li bawou'l anko. Men konpotman pouw ta genyen ak tansyon an*

*pouw ta tretel pouw pa konsa li pa diw li. Paske se yon klian lap fe avew. Ou konpran?]*

As viewed through the lenses of this participant, doctors are in need of clients. Hypertension creates a clientele. This participant did not want to be a part of that system. Lack of trust in the intention of the Western biomedical doctors resulted in sole usage of non-Western approaches for HTN management.

During their first interview, three participants reported using only the Western-biomedical based medication prescribed by their doctor. However, when provided with the camera to take pictures of objects and people that showed aspects of their life influencing their HTN management, these same participants took pictures of herbal medicines. For example, during her first interview, participant number 4 stated: “No, I only take the medication that my doctor prescribed to me.” However, for the photo voice interview, this same participant took pictures of *fey simen kontra*, *fey zanmann*, and *fey metsyen*. In the interview, she explained:

The *simen kontra* is good for all types of illness. It is not only good for hypertension. It is good for all types of illness. *Simen kontra* is a big medication. You boil it and you drink it with salt.

*[Simen kontra a li bon pou tout sot de maladi. Se pa pou tansyon an Selman li bon non. Li bon pou tout sot de maladi. Fey simen kontra se yon gwo medikaman li ye . ou bouyil ou bwel a sel.]*

She also mentioned:

You understand, sometimes you spend one or two days, you take the doctor's medication. You combine all of these together, you put garlic in it and you spend two days drinking it. I make sure I do not take it together with the doctor's medication. If you decide to make Haitian remedies, you spend the day you do not take the doctor's medication.

*[Ou konpran, ou gendwa fe yon jou ou byen 2 jou ou pa pran gren dokte. Ou mete tout say o ansanm ou mete lay ladan, ou mete tout ansanm epi ou fe 2 jou wap bwel . mwen mek shou mwen pa jan bwel ansam ak medikaman dokte yo. Si ou deside pouw fe medikaman ayisyen, ou fe jounen ou pa bwe medikaman dokte ya.]*

As shown, Western biomedical and non-Western biomedical approaches were used either as complementary or as substitute to manage hypertension. Those who reported using a non-Western medicine approach as a replacement for Western medicine did so because they lacked trust in the Western medical system. They concurrently, had confidence in the effectiveness of the culturally based medicines they consumed as treatment.

### **Transmigrant Life Context and Consideration for Social Constructs**

The influence of the transmigrant life context was evident in participants' behavior towards hypertension management. Participants' social fields encompassed the social networks and relationships where exchange of ideas, practices and resources between Haiti and the U.S. Their social fields enabled them to import herbal medicines

such as dried leaves and *lwil maskreti* oil from Haiti. Participants' networks in Haiti also provided them with medications both during their visits to Haiti and also through importation. As one participant stated:

Doctor [name] himself [who lives in Haiti] did an order for me. He told me that what he ordered was good for me. He told me it is good for *tansyon*. He ordered it from the Spanish people in Cuba. So the medication is good for the *tansyon* and also to help me lose weight. So I always take it. (P19)

*[Dokte [non] li menm te fe ode yon te pou mwen.li dim li bon pou mwen. Li di mwen li tou bon pou tansyon . Li ode li, nan menm moun spanish yo kiba. Egal la li tou bon poul desann tansyon an tou, epitou li bon pou l fem vinn piti. Egal mwen toujou pran li.]*

This participant used networks within her social fields where she was able to gain some information and medicine. Through her social fields, she obtained some medicines from other countries that were not found in the United States.

The transmigrant life context also provided participants with social networks across Haitian and U.S. borders, and these networks influenced their hypertension management. Almost half (45.2%) of the study participants reported going to Haiti every year. According to the participants, when they went to Haiti, their improved access to fresh food from the garden or market (as compared to processed foods available in the U.S.) helped with their blood pressure. During their visits in Haiti, their family members made herbal teas for them to help lower their blood pressure. Twelve of the participants stated that during their voyages back in Haiti they did not take their prescribed

medication with them because they believed that their blood pressure would stay at a normal level during their visit. One participant stated:

Well when you go to Haiti, you go get some fresh air. You do not have *tansyon*. The *tansyon* stays in Miami. This is true what I tell you. The *tansyon* stays in Miami. As soon as I arrive and I reach the airport, I start thinking about my bills and responsibilities, the *tansyon* comes right back. My *tansyon* goes up. (P15)

*[Ebyen le wal ayiti wal pran freshe. Ou pa menm fe tansyon menm. Tansyon an rete mayami. Se bon pawol wi map baw la. Tansyon an rete mayami. Koumm fe sa mwen rantre la mwen reve la nan epot la, mwen komanse panse ak bil mwen yo ak responsabilite m yo, tansyon an monte.]*

This participant associated life in the United States as triggering hypertension and hindering its management. When asked if she believed hypertension could be cured, this participant reported not believing that it could be cured. However she thought that being in the United States made the HTN worst and harder to manage.

Another participant also responded: “Well I always keep in contact with [people in Haiti]. They always tell me to make tea. Sometimes I send for them to buy medication for the *tansyon* in Haiti for me to take” (P25). When the researcher asked if the medication she sent for was different from what her doctor gave her in the U.S., she replied: “Yes [it is different]. I do not remember the name. It is a small, pink pill that is really flat. They get it for me in the Dominican Republic. There are different sizes.”

Nine participants thought that living in the United States helped their hypertension management because they had access to Western-based resources to care for their HTN. For example one participant stated:

Ok, in the medical branch [In the United States] we have more resources. They really help you. The doctors are more active. For example, if you have a problem, you can run to the hospital. When you have an emergency, they can care for you. But in Haiti we do not have some materials to do certain things. By the time you reach a hospital, you could already be dead. (P24)

*[Ok nan pati ki fe pati medikal la. Sa nou plis ankadre. Yo edew vreman. Dokte yo pi aktiv. Pa egzanp depi ou gen yon pwoblem ou kouri lopital, le ou gen emejansi, yo pranw. Men an ayiti, nou ka manke materyel, pou fe yon seri de bagay. Traje ou pral pakouri pouw ka jwen sa ou bezwen an ka koz ou gentan mouri.]*

This participant acknowledged that living in the U.S. provided more access to resources and Western biomedical medications to care for HTN. With this statement, she was aware of the shortcoming of Haiti's health system with less hospitals, doctors, and medical equipments. Therefore, as a transmigrant, she used the resources that were readily accessible to her in the U.S. and at the same time, the social networks in Haiti to manage her hypertension.

The study findings indicated that participants used resources within their social fields across Haiti and the U.S. to care for their hypertension. They imported herbal remedies to make culturally based remedies. Friends and family from Haiti also sent

them medications that they ordered from other countries such as Cuba and the Dominican Republic. However, at the same time, resources in the United States such as readily accessible hospitals and emergency rooms were thought to be helpful in the management of HTN, as P24 stated above.

### **Gender Consideration**

All but two female participants noted having more ease to care for their HTN than their male counterparts. They felt that they had greater motivation and more knowledge about cultural remedies, and were able to maintain their doctor appointments and take their medication. As participant 14 stated, “Women can take care of their hypertension better than men” [*Fi ka jere tansyon an pi byen ke gason an*].

Another participant stated:

The man will say “I am not sick, I do not need to go to the hospital.” But for me, I have to, I always keep my appointments. I think that women take better care of their *tansyon* (hypertension) than men. Because men never want to go the hospital. They never go check their *tansyon* (blood pressure) to find out if their *tansyon* (blood pressure) is high”. (P29)

*[Gason an ap di mwen pa malad, mwen pa bezwen al lopital. Men mwenmenm pou mwen mwen oblije, mwen toujou kenbe randevou mwen. Bon dapre mwen mwen we fi plis teke tansyon ke gason sitou. Paske gason yo pa janm vle al lopital. Yo pa janm al tcheke tansyon pou yo konnen si tansyon yo wo.]*

One of the four male participants reported taking his prescribed medication. Another male participant noted that his wife was the one who ensured that he ate well, took his medications, and took care of his HTN. He stated the following:

Well it is my wife that controls it for me. She does not give me a lot of salt. She does not give me food with a lot of fat. It is my wife. Well I cannot say that I control my *tansyon* (hypertension). When my *tansyon* (blood pressure) goes up, my wife boil *metsyen* leaf, and garlic, the *tansyon* goes down. (P21)

*[Bon se madanm mwen ki kontrolel pou mwen. Li pa banm apil sel. Li pa banm manje ki gen gres. Se madanm mwen. Bon mwen paka di se mwen ki kontrole tansyonm. Le tansyon mwen wo, madanm mwen bouyi fey metsyen pou mwen, ak lay ladan, tansyon an desan.]*

This participant acknowledged that his wife helped him manage his HTN. His wife handled his diet, and provided him with the herbal medicines. He thought that being a man was not helpful in his HTN management since his wife as a woman could take better care of the HTN than he could.

In this study, women were viewed in a positive role in HTN management role. Women reported keeping their doctors appointments, taking their medications, and making culturally based remedies. Both men and women believed that the women were more capable of managing their HTN. As seen in the statement by participant 14, she thought that as a woman, she could take better care of her HTN than a man could. While the male participants as seen in participant 21's statement, believe that the women could do a better job a managing HTN.

## Immigration Status

Study participants thought of *tansyon* as an illness associated with living in a country other than their own, and this relates to the context of their immigration status.

For example, participant 19 stated:

Sometimes they say it is stress that causes it. When you are living in a country that is not yours. In this country, there are so many problems you feel overwhelmed. When you leave children behind, you are thinking about them. When you cannot find jobs also. And then tiredness.

*[Pafwa yo konn di stres ki bawou li. Le wap viv nan yon peyi ki pa paw. Nan peyi sa telman gen pwoblem ladann tet ou sho. Lew kite timoun deye wap kalkile, lew paka jwen travay tou. Epi fatig.]*

All the study participants associated living in the United States either with their hypertension development ( $n=25$ ) or exacerbation ( $n=6$ ) of their hypertension.

Participant 4 stated: “When I was in Haiti, my *tansyon* was not [bad] like that.” Another participant reported: “As for the pressure in this country, if we are not careful, the *tansyon* will kill you, the way this country functions. Because you are always on the run. Everything you do, you are always under pressure” (P16). Being under pressure related to lack of time, financial strain, and bills.

As stated above, participants associated living in the United States as immigrants with more stress and more problems with life overall, and felt that it influenced their health. Lack of job opportunities, stress about bills, and the constant feeling of being on the run and under pressure, negatively impacted participants’ hypertension. The

researcher did not specifically ask each of the participants about this at the time of their diagnosis; however, six of the participants mentioned during their interviews that they already had hypertension before they migrated to the United States. They reported that their blood pressure increased after they migrated to the U.S. The remainder of the participants thought that being an immigrant living in the United States was the original cause of their HTN development and had influenced their ability to manage the disease.

### **Study Limitations**

Several study limitations could have influenced the findings and their interpretations. First, only four men participated in the study. Male participants appeared to be less likely to take their medications, maintain their routine visit and believe in the effectiveness of Western biomedical approaches to managing HTN. More studies are needed with a more representative number of Haitian men immigrants to address HTN management.

Second, the researcher did not assess the time since HTN diagnosis among participants. During the interviews, only six participants mentioned having received their diagnosis in Haiti. Acquiring such information could have strengthened the notion that increased length of stay in the U.S. is related to worsening of health among immigrants (Belizaire & Fuertes, 2011; Jasso, Massey, Rosenzweig, & Smith, 2004). Further research is needed to understand whether the meaning of, or management of, hypertension changed over time for Haitian immigrants.

Third, participants took pictures only of things that influenced how they managed hypertension. No participant was able to take pictures to illustrate how they defined hypertension and their experience with hypertension. Future research should consider

the effectiveness of the photo voice method of data collection among particular groups. The limitation was addressed by using multiple sources of data collection, including interviews during which participants were able to verbalize their definition of, and experiences with, HTN.

## **Discussion**

The study findings support the existing literature about the definitions and causes of hypertension. However, the results also showed that some individuals do not believe that hypertension is an illness and perceived it as a normal body occurrence. The relationship between family history of HTN and HTN development has been well established in previous literature. Previous studies have indicated that stress and worry were related to HTN (Boutain, 2000; Boutain, 2001). Boutain (2001) reported that African Americans associated stress with their tasks and the everyday pressures at work, and also associated it with worrying over everyday concerns about self, family, and community. Participants in this current study also related their stress level to their responsibilities. Worrying was also associated with their ability to pay their bills, take care of their households in the United States and providing for their friends and family members in Haiti.

This study is in accord with the existing literature about the factors influencing HTN management. As noted in the literature review, patient-related factors such as beliefs and behaviors towards HTN and HTN medications; access to resources, education, and income (Jaddou et al., 2011; Krousel-Wood, 2009; Minor, et al., 2008) all played a role in participants ability to control their HTN.

Previous studies have also noted African-Caribbean immigrants' lack of trust in Western medications and health professionals, specifically in relation to hypertension (Higginbottom, 2006; Morgan, 1995). Use of herbal medicines and non-compliance have also been documented (Harwood, 1971; Higginbottom & Mathers, 2006). Health providers need to account for these factors associated with various immigrant groups.

This study also supports the research showing that HTN definitions and HTN management strategies vary across cultural groups (Wong, et al., 2005; Yeh, et al., 2008). This study adds to the literature by bringing to light how Haitian immigrants think about HTN, and how they define and manage the disease. Their transmigrant life context was evidenced through their account about their active relationship and communication across Haiti and the U.S. It was also exhibited through the transfer of herbal remedies from Haiti to the U.S. for HTN management. Such transfer of resources for the purpose of disease management has been used in other immigrant groups (Messias 2002).

The findings also revealed why Haitian immigrants may have HTN mismanaged, as indicated in previous studies (Koch et al., 2005; Preston et al., 1996). The discordant beliefs of the participants in regards to the current Western biomedical approaches to HTN management promoted doubts about medication effectiveness.

Moreover, gender was shown to influence HTN management. There have been contradicting results about the role of gender in hypertension management. Some studies have found that women across all ethnic groups were less likely to manage their hypertension compared to men (Gu et al., 2008; Keyhani et al., 2008; Ostchega et al., 2008; Sharpe et al., 1991). For example, Ong and colleagues (2008) found that women

were more likely have their HTN poorly controlled than men when the results were adjusted for age. Other studies have reported that women tended to manage their hypertension better than men (Ong, et al., 2007; Ong, So, Lam, & Cheung, 2008). The current study helped further understand the role of gender in hypertension management from the (subjective) perspective of the participants. In the current study, all but two female participants noted having more ease to care for their HTN than their male counterparts. They felt that they had greater motivation and more knowledge about cultural remedies, and were able to maintain their doctor appointments and take their medication.

Participants' immigrant status also played a role in their HTN management. They reported that as their length of residency in the U.S. increase, they experience more stress, and are unable to remain calm. Thus they have more difficulties managing their HTN. This study findings supports the previous reports that increased number of years in a foreign country leads to poorer health outcomes (Belizaire & Fuyertes, 2011).

This study enabled the understanding of how Haitian immigrants defined and managed hypertension. This exploration was completed with consideration for the participants' transmigrant life context through which they were able to obtain resources in Haiti and the U.S. to manage their HTN. Gender and immigration status showed particular influence on the way participants managed hypertension. When caring for Haitian immigrants with hypertension, healthcare providers need account for their transmigrant life. Attention is also needed with regards to gender and immigration status.

## Chapter VI: Influence of Work on Hypertension Management Among Haitian Immigrant Hotel Housekeepers

### Chapter Abstract

**Purpose:** This chapter reports how work influences hypertension management among Haitian immigrant hotel housekeepers.

**Background:** Hotel housekeeping is one of the most common sources of employment for Haitian immigrants. It is important to explore the impact of such work along with its interaction with the constructs of race, class, gender, and immigration status on how they manage hypertension. Researchers do not often explore chronic disease management in the context of work.

**Methods:** This critical ethnography study was conducted in Miami-Dade County, Florida. Transnationalism was the theory guiding the study. Thirty-one Haitian immigrant hotel housekeepers were recruited. Demographic data and transcripts of face-to-face semi-structured interviews (individual and photo voice) were analyzed using SPSS and Atlas.ti software.

**Results:** The influences of work on HTN management arose at (a) the individual level and (b) the systems level. The individual level included co-worker dynamics and work that enabled the maintenance of the transmigrants' lives. The systems level included supervisory support, workload, work pace, and work hiring practices.

**Discussion:** Interventions at the workplace may be beneficial for effective hypertension management among Haitian immigrant hotel housekeepers. The study findings pinpoint several areas of work, both at the individual level and systems level that can be addressed to improve HTN management among workers. Further studies are needed to

determine whether such work influences on hypertension management also pertain to other types of work. Additionally, health care providers need to account for these work influences when determining effective methods for hypertension management among Haitian immigrant hotel housekeepers.

## Introduction

Information about how work influence HTN management among Haitian immigrants is sparse. Yet, hypertension is commonly diagnosed and mismanaged among Haitian immigrants (Koch et al., 2005; Preston et al., 1996), and work accounts for a considerable part of their daily life. What is especially important to explore is the influence of the interaction of work and the social constructs of class, race, gender, and immigration status on participants' hypertension management.

Haitian immigrants encounter hardships with respect to their class, race, gender, and immigration status in the United States (Basch et al., 1994; Laguerre, 1998; Prou, 2005; Zephir, 1996). The issue of class for Haitian immigrants is twofold: class as understood within the Haitian social system (Lobb, 1940) and class as explained by Marx (1894) and Weber (1958). Class within the Haitian system relates to the elites versus the *noires* (Lobb, 1940). Being categorized as an elite or a *noire* is dependent upon place of residence, physical appearance, family position, economic success, political and professional prominence, and education (Lobb, 1940). For example, the elites reside in the more prestigious areas of the country, are of lighter complexion, occupy important political positions, are economically stable, and are highly educated (Wingfield & Parenton, 1965). As they move to the United States, Haitian Immigrants operate Marx's and Weber's approach to class. That is when their class is determined by their socioeconomic status and position as workers in decision making in the labor process (Marx, 1894; Weber, 1958).

The other constructs of race, gender, and immigration status also impact Haitian immigrants' experience in the United States. Consequently they develop transnational

identities. Such identities foster maintaining relationships that transcend borders between their home country of Haiti and their host country, the U.S. (Basch et al., 1994). In order to survive in their host country and maintain these transnational relationships, Haitian immigrants are often required to take low-wage jobs such as hotel housekeeping (Canales, 2007; Loomis, 2004).

Moreover, the number of Haitian immigrants coming to the U.S. is constantly growing: 548,999 in 2000 compared to 289,521 in 1990 (United States Department of Commerce Bureau of Census, 1993; Us Census Bureau, 2000). Consequently, attention needs to be given to this immigrant group's contribution to the U.S. workforce and to immigrant health concerns such as HTN management. Careful consideration for the context of the Haitian immigrants' transmigrant life and work life is needed in research.

This chapter reports study findings regarding the influence of work on HTN management among Haitian immigrant hotel housekeepers. This influence was explored and described within the context of the Haitians' transmigrant life with consideration for class, race, gender, and immigration status. This study is significant because it is a first scholarly work to outline the influence of hotel housekeeping work on hypertension management. It also brings forth how the amalgamation of work experiences and transmigrant life experiences influence HTN management.

## **Methods**

### **Sampling and Recruitment**

A more detailed study description is found in Chapter 4 of this dissertation. This critical ethnography study took place in Miami Dade County, Florida. Purposive

sampling was used to recruit study participants through four local churches, one barber shop, three restaurants, two boutiques, and one local organization. The inclusion criteria required that participants: (a) were Haitian immigrants, (b) were residing in Miami-Dade County, Florida, (c) were working as hotel housekeepers, (d) had migrated to the United States within the past 10 years, (e) were at least 18 years old, (f) had been diagnosed with hypertension, and (g) were able to provide both verbal and written consent. Flyers were posted and distributed in the establishments named above. Interested individuals contacted the researcher and gave recommendations for other potential participants (“snowball sampling”).

### **Data Collection**

In-depth semi-structured face-to-face interviews, demographic questionnaires, and photo voice interviews were completed with 31 Haitian immigrant hotel housekeepers. All 31 participants completed the first interview and demographic questionnaire. Twelve individuals participated in the photo voice interviews.

### **Data Analysis**

SPSS software was used to analyze the closed-ended questions in the demographic questionnaire. Transcripts of open-ended questions in the demographic questionnaire and of the individual and face-to-face interviews were uploaded into Atlas.ti software. Analysis of the transcripts was done through coding, theme identification, and comparison across individual interviews.

### **Participant Characteristics**

A total of 31 individuals participated in the study. A majority of the participants were female ( $n=27$ , 87.1%) and four were males. Participants’ ages ranged between 46

and 55 years. There was an equal number of married ( $n=12$ ) and single participants ( $n=12$ ) followed by separated ( $n=4$ ), partnered ( $n=2$ ), and divorced ( $n=1$ ). About 60% of the participants had an education level ranging between first and fifth grade, and only five participants reported having completed high school. Additionally 64.6% ( $n=20$ ) of the participants reported an annual income of \$20,000 or less, with half of those participants making between \$11,000 and 15,000 dollars a year. Four participants declined to report their income. Table 6 (below) gives more demographic detail for the participants.

All of the participants ( $n=31$ ) were born in Haiti and had migrated to the United States within the past 10 years. The mean length of residency in the U.S. was 7.5 years ( $SD= 2.75$ ) with the shortest length being 2 years and the longest being 10 years. All except two participants had been living in Miami-Dade County, Florida since they moved in the United States. Nearly half of the participants ( $n=13$ ) had gone back to Haiti every year. Only two participants had been working as hotel housekeepers for less than 1 year; the remainder had been working as hotel housekeepers between 1 and 10 years. Ten participants reported cleaning over 18 rooms per day, and twelve participants reported cleaning between 11 and 15 rooms per day. The remainder were between 6 to 10 rooms ( $n=1$ ) and 16 to 18 rooms ( $n=4$ ) per day.

All 31 participants reported keeping in touch with friends and family in Haiti and sending remittances the varied between \$50 and \$300. Almost half of the participants ( $n=15$ ) could not give a specific amount of their remittances, and 18 could not give the frequency (that is, how often they sent remittances). The reason for this was that, since remittances had become such an everyday aspect of their lives, they would send

whatever money they could, whenever they could. A common response to the questions about the frequency and amount of money they sent to Haiti was: “It depends on what I have . . . and when I have it” (P11, P26, P4, P16, P19, P25).

Table 6

*Sample Characteristics (N=31)*

Variables	Frequency ( <i>n</i> )	Percentage (%)
Gender		
Male	4	12.9
Female	27	87.1
Age		
18-25	1	3.2
36-45	7	22.6
46-55	17	54.8
56-65	6	19.4
Marital Status		
Married	12	38.7
Divorce	1	3.2
Single	12	38.7
Separated	4	12.9
Partnered	2	6.5
Education		
1st-5th Grade	18	58.1
6th-9th Grade	7	22.6
High School	5	16.1
Missing	1	3.2
Income		
<\$10,000	4	12.9
\$11,000-\$15,000	10	32.3
\$16,000-\$20,000	6	19.4
\$21,000-\$30,000	6	19.4
\$31,000-\$40,000	1	3.2
Missing	4	12.9

## Results

### Individual Level Influences of Work on Hypertension Management

The individual level influences of work on HTN management included: (a) co-worker dynamics, and (b) maintenance of transmigrant life through work. Participants reported both positive and negative aspects of each of these influences. In this section, there will be a general discussion of co-worker dynamics and maintenance of transmigrant life through work as these two factors affect HTN management. The chapter will then describe how these two influences intersected with the hegemonic constructs of class and immigration status as these two constructs arose at the individual level to influence HTN management.

**Coworker dynamics.** Coworker dynamics encompassed the relationships and interactions between the participants and other hotel housekeepers. All 31 participants reported that the other hotel housekeepers influenced their HTN management. The positive and negative influences of hotel housekeeping work on HTN management are described below.

#### *Positive influences of coworker dynamics on hypertension management.*

Participants ( $n=11$ ) reported that their co-workers aided them in managing their hypertension. They aided each other by giving advice on remedies. Co-workers talked about hypertension before the meetings that preceded the start of their shifts, and during their breaks. During these discussions, they advised each other on which doctor to visit for their HTN. They also brought home-based remedies, such as *lay*, *fey lougawou*, *fey zanmann*, *fey gwo neg*, *fey metsyen*, to one another. All of these are herbs were remedies that Haitians both living in Haiti and the United States used to

manage hypertension. For Haitian immigrants, housekeeping work fit within the social fields of their transmigrant life and provided a forum where they could exchange ideas and resources (such as herbal remedies). Despite living in a country where Western-based medicine is practiced, some of the participants used their cultural non-Western home-based resources to manage HTN. Because of the exchange of ideas and resources at the workplace, the use of these non-Western approaches along with the Western practices for HTN management was reinforced. One participant stated:

Well you know we all at the work we are all one. Everyone would give ideas. We would ask each other what we do for our hypertension. Some people say to just go to the doctor so that the doctor can prescribe you medication. Others say to take 'lay'. 'lay' is good. Some say to take 'fey lougawou', 'fey zanmann' will help. Each person gives an idea. Drink a lot of water. It will come down. You understand? (P13)

[Ebyen ou konnen nou tout la nan travay la se yon sel la. Tout mounn konn ap bay ide. Nou konn ap mande lot kisa ou fe pou tansyon an. Gen mounn ki di jis al kay dokte pou dokte preskriw medikaman. Gen lot ki di pran ti lay la, ti lay la bon. Genyen ki di pran ti fey lougawou a, fey zanmann nan lap ede. Shak mounn bay yon ide. Bwe anpil dlo. Lap desann ou. Ou konprann?]

Co-workers were viewed as a support group. Participants ( $n=4$ ) mentioned that the majority of their co-workers experienced high blood pressure. Learning of a new HTN diagnosis from a co-worker was no surprise to the participants. Knowing that other

co-workers were experiencing similar issues helped each of them to better cope with the disease. One participant said:

Everyone is running. All the people are a bunch of sick people. Do you believe there is a hotel housekeeper who does not have hypertension? Well I have yet to see a hotel housekeeper who does not have hypertension. (P15)

[Tout mounn se kouri yap kouri. Tout mounn yo se yon paket bann mounn malad yo ye. Ou kwe gen yon awouskipin ki pa fe tansyon? Bon mwenmen mwen poko janm we yon awouskipin ki pa fe tansyon non.]

As seen, coworker dynamics positively influenced participants' management of hypertension. Through their interactions with their coworkers, participants obtained advice and tangible resources (such as leaves for home remedies) to share with one another for their hypertension. Co-workers also provided a sense of support and thus helped participants better cope with their hypertension.

*Negative influences of coworker dynamics on hypertension management.*

Conflicts among workers created a more stressful work environment, keeping participants' blood pressure at a constantly elevated state and thus exacerbating their hypertension. Conflicts about work hours and work shift were reported to increase tension between the workers and hinder HTN management.

All the participants ( $n=31$ ) reported working regularly three to four days and said they would like to work more hours to pay their bills. Participants said they deserved more work hours than their co-workers. They based their merit of more work hours on their perceived work ethic, seniority, and friendship with their managers. One participant

stated: “There is a seniority thing. Someone would say ‘Look they gave me four days, and look, this person just started and they gave her five days.’ You understand? When that happens you get stressed” (P6).

There were also conflicts between those working the morning shift and those working evening shifts. Participants (n=4) working evening shifts reported that their work was more demanding since they mostly got the “checkout” rooms and had to do a more thorough cleaning of the rooms. They also remarked that any unfinished work from the morning shift fell on them. As one participant explained:

People who work in the morning, if there are people in the room, they just tighten the bed sheets. But me I have to change everything. They just clean the bathroom and they are done. The evening people have more things to do. You know I am working the evening. In the morning, the work is easier. (P8)

[Mounn kap travay maten an, si gen mounn nan shanm nan, se jis detire yo detire kabann nan. men mwen menm fok mwen shanje tout bagay. Yo jis netwaye badwoum nan epi yo fini. Men mounn apre midi yo gen plis bagay pou yo fe. Ou konnen se apre midi map travay. Le maten yo travay pi izy.]

Those working the morning shift noted that they had more rooms to clean during the day and often did not have enough time to complete the rooms, unlike the evening shifts who had ample time. There was a pattern regarding the number of rooms cleaned between the two shifts. The four participants working the evening shift were more likely to report cleaning between 11 and 15 rooms whereas some of those who worked the morning shift reported cleaning over 18 rooms. This supported what the participants

reported, namely, that the morning shift had more rooms. However, because most of the rooms were occupied during the time, they had less work and were thus provided with a larger number of rooms to complete:

The evening people have a little thing. Morning people have more hardships. We have more hardships than the evening people. Some days, they can have some hardships too, but not the same way as the day people. And then it is during the day, the supervisor is here. (P15)

[Mounn aswe yo on tijan gen yon bagay. mounn maten an jwenn plis brimad. Nou pran plis brimad pase mounn aswe yo. Gendjou yo gendwa jwenn yon ti brimad tou wi, men se pa menm jan ak mounn lajounen yo. Epi se lajounen sipevize a la.]

These differences in shift workload and work hour led to a lack of trust among participants and their co-workers. Some participants ( $n=4$ ) reported not socializing with other co-workers at all. Participant 8 said, “Ah, I can only confide in God, because once you are done analyzing these people, you don’t really [pause]. Ah, I talk to some people at work, but I am not their friends. Because sometimes, there is jealousy at work” (P8). This findings showed that lack of support and collaboration between Haitian immigrant hotel housekeepers and their coworkers hindered their ability to manage their HTN.

**Work enabling maintenance of transmigrant life.** Maintenance of transmigrant life through work referred to the ways in which work provided monetary means for study participants. This allowed participants to survive in the U.S. and to also maintain their transmigrant relationships with friends and family members in Haiti. Maintenance of

transmigrant life through work had positive and negative influences on HTN management. Both are described below.

*Positive influences of maintenance of transmigrant life through work on HTN management.* All 31 participants reported using the money they made while working as hotel housekeepers to maintain their relationships between the U.S. and Haitian. With the money they made through work, they were able purchase phone cards and send remittances, including money and products or goods, to Haiti. Participant 24 said: “Whenever I send money to them, I know that even if they don’t have enough to eat for 30 days, at least they will eat for 15 days. I feel happy”. This participant associated her ability to send money and provide food for her family as positively influencing her hypertension management. She felt happy and was able to stay calm.

Additionally they mentioned that this responsibility of taking care of friends and family in Haiti obligated them to better take care of themselves and go to work. They had to keep their HTN under control so that they could work and continue to nurture these transmigrant relationships. One participant stated:

Ah girl, if I were to tell you the amount of money I send to Haiti, I cannot talk about that, girl. I can tell you everything I make where it goes is Haiti. Because all my soul is in Haiti. Six children in Haiti. If I were to let hypertension kill me who would take care of them? So I am obliged to take my medications. (P1)

[A piti si poumm ta palew kob mwen voye ayiti, mwen paka pale bagay sa pitit. Mwen met di tout samm fe kote lale se ayiti. Paske tout nanm mwen se ayiti, sis

timounn ayiti. Si mwen ta kite tansyon an finn touyemm kiyes kap okipe yo?

Donk mwen oblije pran ti medikamanm.]

This participant associated her remittance practices as positively influencing her hypertension management. Her responsibilities and sense of obligation to care for her children in Haiti prevented her from mismanaging her health. Maintaining blood pressure control became a germane not only to her health but also to the survival of her children. The remittance practices were made possible through the income she generated while working as a hotel housekeeper.

*Negative influences of maintenance of transmigrant life through work on HTN management.* Maintenance of transmigrant life through work also negatively influenced HTN management among some Haitian immigrant hotel housekeepers. The constant sending of remittances (e.g., money) made possible through work to Haiti hindered participants' ability to go to doctor visits and purchase their medication. Participant 18 stated:

Taking care of the children in Haiti I think it does not make the hypertension well. Because most of the times you do not have the economy even for your own self if you were to get sick while you do not have insurance. If you were to have a problem, an emergency, you do not even have a dollar to take something, to say let me run to Walgreens, let me run to CVS to go get some medication. Most of the time what you need that would be the best, you need to see a doctor to get it. But you need to have the money to go see the doctor. (P18)

[Teke timoun yo ayiti mwen panse ke li pa ka fe tansyon an pi byen non. Paske le pli souvan ou pa gen ekonomi ou menm pou tet ou pou si ou ta malad ou menm pandan ke ou pa gen asirans lan. Si ou ta gen yon pwoblem yon emejansi ou ta kouri. Ou pa menm gen yon dola pouw ta pran yon bagay, pouw di kitem kouri nan walgrinn nan, kitem kouri nan cvs la la pou mal deye yon medikaman. Le pli souvan saw ta bezwe ki pi bon an il fo ke ou we yon dokte pouw ta kab jwen ni. Men fow gen kob la pou wale kote dokte ya.]

Sending money home helped Haitian immigrants stay calm and manage their HTN. However, working to help sustain those transmigrant relationships also created a source of constant stress for participants. With the meager amount of money they made as hotel housekeepers, participants struggled to survive. Paying bills and buying food was already hard for them. Sending remittances to friends and family members in Haiti sometimes added to their burden, making it even more difficult for them to support themselves. It became more difficult to purchase medication, and pay for doctor visits.

**Compound effects of individual level influences of work with class.**The hegemonic construct of class arose at the individual level of work influences on HTN management. Study participants alluded to the two aspects of class: 1) class as explained by Marx (1894) and Weber (1958) which focuses on the differences in socioeconomic status, and worker's position in the decision-making process, and 2) class as indicated in the Haiti's societal system.

*Class based on Marx and Weber.* Over half (58%) of the participants reported a first- through fifth-grade education level. This lower education level indicated less intellectual assets and thus lower class and power (Marx, 1894; Marx & Engels, 1848;

Weber, 1958). Additionally, about 64.6% ( $n=20$ ) of the participants had an annual income of less than \$20,000 dollars. The Bureau of Labor Statistics identified a similar annual income of \$21,000 as being typical for individuals involved in housekeeping (United State Department of Labor Bureau of Labor Statistics, 2010). Participants' statements reflected their acknowledgement of being a subjugated group. They recognized that they had less opportunities and chances in the marketplace because of their lower education status. For example, Participant 6 said:

For example you, you go to school. You go to learn what you need. With that you will find a good job to work. You will see life is good for you. But when you come to this country and you have no English, you do not go to school. You only learn a few words by listening to people talk. I do not have to tell you. It is not the same job. The life is hard for you. It is not the same job.

[Tankou ou menm la wal lekòl. Wal aprann sa ou bezwen an. Avek sa wap jwenn yon bon ti job pou w travay. Ou ap we la via dous pou wou. Men le ou vinn isi pitit ou pa gen angle sou wou. Ou pa al lekòl. Se anba boush wap pran ti pawòl. Mwen pa bezwen diw. Se pa menm job. Lavia di pou wou. Se pa menm job.]

Individuals' class level in the United States is indicated by their education and socioeconomic status, and influenced their hypertension management. Participants were aware that having a higher education would help them have better knowledge about hypertension and be more apt to access resources such as the Internet to learn about how to best manage the disease. Participants were aware that as immigrants in the U.S., as hotel housekeepers, they had less assets, and had less power with

decision making. Participants' statements about the researcher having more opportunity because of her higher education and also their inability to have control over their work.

*Class as indicated by the Haitian' societal system.* The issue of class was brought up during the interviews. Five participants mentioned that they had moved from a higher-class level in Haiti compared to their co-workers. They attributed their higher-class level to their education, which they all reported to be high-school level.

Participants also believed that because of their circumstances in the U.S., they had to work with people who would be of a lower status in Haiti. One participant stated:

The people I work with, they are lower class people. I am not criticizing them.

They know I love them, I work with all of them. But they are so uneducated. I end up being treated the same as them. (P26)

Mounn nan travay sa yo, se yon seri de mounn ki telman ba, mwen pap kritike yo. Yo konnen mwen renmen yo, mwen sevi avek yo tout. Men yo telman pa edike. Eke mwen menm yo soti pou yo ta baleyem menm jan avek yo”.

By this statement, the participant acknowledged the power of the Haitian class structure, which values the more educated over the less educated (Lobb, 1940). Those who were perceived as being lower class (i.e., having less education) were treated differently than those with more education in Haiti. This participant (P26 above) believed that his class helped him with this HTN management. He believed that his higher class status was proven by his higher education level, since he had completed high school. He also reported being able to get information from the Internet about how to manage his HTN.

## **Systems Level Work Influences on Hypertension Management**

The systems level of work influences on HTN management included supervisor support, workload, work pace, and work hiring practices. At the systems level, participants brought up the issue of occupational systemic oppression. In this section, there will be a discussion of each of the categories that arose at the system level, followed by a discussion of the roles played by the hegemonic constructs of class, race, gender, and immigration status.

**Supervisor support.** Supervisor support referred to the sense of support that participants experienced from their supervisors. The words “manager” and “supervisor” were used interchangeably during the interviews to describe the person in charge of hotel housekeeping. Both positive and negative influences were reported.

*Positive influences of supervisor support on HTN management.* Supervisors were reported to play a significant role in the participants’ HTN management. Participants ( $n=5$ ) who reported having a supportive and friendly supervisor also felt that they had their hypertension under control. They reported that some of their supervisors showed concerns about their well-being by asking them how they were doing and asking about their blood pressure. Two participants mentioned that their managers had even lightened their workload after they had a crisis at the workplace and had to go to the hospital because of their increased blood pressure. One participant said: “My boss helps me with my hypertension, because if my blood pressure goes up and I don’t feel well, he sends someone else to help me and he tells me to sit down” (P14).

Two participants reported that their managers held informational meetings during which they discussed hypertension issues with the workers. These short meetings

usually took place right before or during the morning meetings for workload distribution, before the start of the new shift. During these meetings, their managers discussed with the participants how to take care of themselves and their hypertension. Information given included the importance of eating healthy (e.g. by eating more fruits and vegetables), and exercising. The researcher did not collect information on whether these two participants worked at the same hotel or had the same supervisor. Such information would have indicated whether or not it was just that one supervisor showing support. During the interview, Participant 30 stated: “The boss told me to do exercise, [and] not to eat just any type of food. Every morning he has a meeting with me. He tells me to eat apple a lot. To eat lots of fruits” .

*Negative influence of supervisory support on HTN management.* Study participants ( $n=7$ ) reported discrimination from their supervisor because of their race and country of origin. They compared themselves to the White Americans and other immigrants (such as those from Cuba) who also comprise a large number of hotel housekeepers. A feeling of isolation occurred, because as they walked into their break rooms, the only conversations they heard were in Spanish. They felt that their supervisor preferred their non-Haitian immigrant counterparts over them. As evidence, they said that they were given less work hours and more “write-ups” than their counterparts. They mentioned discrimination against them based on their skin color. Participant 24 said, “They look at this color,” [Yo gade sou koule sa]—as she pointed to the skin on her arm. Another participant stated:

The manager is a woman who cannot stand Black people at all. She will give you one day of work and give the Whites five days. You see them all with the same

skin color. Those who do not have the same skin color are no longer around.

(P26)

[Manajemm nan se yon fi ki pa vle we nwa menm. Li gen poul baw yon jou travay epi li bay ti blan yo senk jou. Ou we yo tout menm koule net ale. Tout mounn ki pa menm koule avek yo pa la anko.]

Through this statement, this participant was aware of the different treatment received as a result of skin color from the supervisor. Those who are in power (e.g. supervisors) are most likely White and thus treat the others (e.g. Blacks) differently and unfairly. Racism from the supervisor was imminent through the gradual change of worker composition.

Participants ( $n=3$ ) also discussed how their inability to communicate with their supervisor resulted in a constant state of stress for them. This lack of communication was due to their status as immigrants with a language barrier. They had difficulties understanding their manager and vice versa. For example, Participant 9 had recently come to the U.S. During her 4-year stay, she had not been able to go to school and learn English. She stated, "I have problems with the language at work. That makes me feel my blood pressure go up" (P9).

There were also reports of lack of support from supervisors. Many of the participants ( $n=25$ ) felt that their supervisors did not care about their well-being and that all they cared about was that the job was completed at a low cost. They discussed that their supervisor did not care or acquire about their hypertension:

I feel like I am a robot. If it were for the boss, the hypertension could kill me he would be more happy. Because if you are working for nine dollars, he would be

happy for the hypertension to kill you so that he could hire someone else to pay 7 dollars and 25 cents (P16).

[mwenn santim se yon robo. Si se pou bos travay la si tansyon an te ka pete tet ou pito li tap pi kontan. Paske si wap travay pou 9 dola, li tap kontan pou tansyon an tuyew poul ka pran yon mounn poul ka pye 7dola 25 santimm]

This participant felt as if she were not being viewed as a person. She was only considered as a labor tool. This statement shows that this participant did not feel valued at work. She understood that she could be easily replaced. She felt that the manager's agenda was not in her favor, but only in favor of organizational growth and increased revenues and profit.

**Workload.** Workload related to the work tasks participants had to complete. The workload of hotel housekeepers includes bringing requested items to hotel guests, pushing carts, moving furniture, fixing the beds, cleaning bathrooms, vacuuming, and dusting (Faulker & Patiar, 1997; United State Department of Labor Bureau of Labor Statistics, 2010). Typically, hotel housekeepers clean between 12 to 18 rooms in a 7.5-hour shift (Faulker & Patiar, 1997).

No participants reported positive influences of the workload on their hypertension management. All 31 participants discussed having too much to do at work, which gave them stress and hindered them from staying calm and lowering their blood pressure.

Table 9 reflects the number of rooms cleaned daily by participants.

Table 7

*Reported Number of Rooms Cleaned per Shift*

Number of Rooms Cleaned	Frequency ( <i>n</i> )	Percent (%)
Valid		
6-10	1	3.2
11-15	12	38.7
16-18	4	12.9
18 and over	10	32.3
Missing*	4	12.9

*Note.* \*Four participants working in hotel housekeeping were called housemen. There was no data on the four male participants, because they were housemen and did not clean rooms. Typically, housemen have tasks such as cleaning the halls and lobby and shampooing the hotel carpets. However, they did not clean rooms. Thus, the question about the number of rooms cleaned per shift did not apply to them.

Out of the 27 participants who reported a total number of rooms cleaned, 10 reported cleaning over 18 rooms in a 7.5-hour shift. This number exceeded typical numbers reported in the literature (Lee & Krause, 2002). Acknowledgement of the negative effects of workload on workers' health resulted in a modification of the requirement for the number of rooms to be cleaned from 15 per day to 14 per day in regions such as San Francisco (Lee & Krause, 2002). Yet, study participants still reported cleaning over 15 rooms per day. In their report, Lee and Krause discussed their modification in the requirements for the number of rooms cleaned related to active involvement of the local union in San Francisco. In this study, the researcher did not collect any information about whether participants were unionized. Although participants felt that they had too much to do, a bigger concern was around the fear of job loss and unemployment:

The housekeeping work now is a little harder. The work for three people, only you are doing it. There are no jobs. You end up working harder. Because before you used to do 15 rooms, 16 rooms. Now it's 18. Sometimes you do 19, 17. You have no choice because there are no jobs. Once you lose the job, you will not find another. (P7)

[Travay awouskipin nan kounyea li enpe di, paske pa gen travay. Travay pou 3 mounn ta fel, ou oblije se ou sel ki fel. Pa gren travay. Ou vinn travay pi di. Paske lontan ou te konn ap fe 15 shanm, 16 shanm. Kounyea se 18. Pafwa ou konn fe 19, 17. Ou oblije paske pa gen travay, depiw pedi job la ou pap jwen anko.]

Cleaning this large number of rooms hindered participants from keeping their blood pressure under control. Two participants mentioned that they knew it was against the law for managers to require that hotel housekeepers clean more than 17 rooms per day. However, because of group coercion and fear of reprisal and job loss, they had no power to refuse cleaning their assigned rooms. As one participant said:

The hotel is not supposed to give you more than 17 rooms. The 18th is an extra. But you have to do it, because there are no jobs. If you lose your job you will not find another. You are obliged to do it. Because if every time they give it to you, you say no, the boss will not be happy with you ( P3).

[Otel la pa sipoze baw plis ke 17 shanm. 18 la se yon ekstra li ye . Men ou oblije paske pa gen travay. Depiw pedi job la ou pap jwen anko. Ou oblije fel. Paske si tout tan yap bawou wap di non, bos la pap kontan avew.

Some rooms had one bed, while others had two. Participants ( $n=3$ ) noted that many of the rooms had double beds, which increased their workload and work pace. During the photo voice interview, one participant described the situation as follows (also see Figure 13):



*Figure 13: A finished room helped housekeepers stay calm.*

Well I took this picture of a room because it is these rooms that give me a little opportunity for when the boss comes to see the room is well represented. Whenever they ask for the room, you rush, rush. But when you are done with the room you see that it is well done even with all the rushing. It makes you a little calm. (P18)

*[Ebyen mwen pran foto shanm sa paske se shanm sa yo menm menm ki pou baw yon opotinite pou le bos la paret pou yo we shanm nan gen reprezantasyon. depi yo mandew shanm nan, ou wosh, wosh. Men le ou finn fe shanm nan ou gade ou we li byen fet malgre ou tap wosh la li fe ou ontijan kal.]*

When asked about why she took a picture of the cart (see Figure 14), Participant 7 discussed that the heaviness of the cart gave her more stress. She also mentioned that she wanted to show how much linen there had to be on the carts in order to do the work. The only positive notion associated with the cart was that if the linen was categorically arranged, it would make her job easier and she would be able to work faster and more efficiently. She said:



*Figure 14: A heavy-laden cart leads to tiredness.*

Starting from pushing the cart, you are already tired. You have a vacuum you are pushing, you have this you have that. Starting from pushing the cart, you are already tired I don't even have to tell you when you are done working. (P7)

*[Depi nan pouse kad la ou deja fatige. Ou gen vakyum wap pouse, ou gen dis ou gen dat. Depi nan pouse kad la ou gentan fatige mwen pa bezwen diw lew finn travay menm.]*

This participant expressed feeling overwhelmed. Through this statement, the participant reported feeling overworked. She felt overexertion at the end of her shift. Thus the report of workload influence on hypertension was not only associated with the number of rooms to cleaned, but also with the number of other overbearing tasks that need to be completed at the end of the shift. The four participants who did not report number of rooms cleaned were the male participants who were housemen. These housemen were not responsible for cleaning rooms. Their duties included cleaning and vacuuming the hallways, heavy shampooing the carpets, and re-stocking the carts. They did report that their workload did not influence their hypertension management. As one houseman reported:

No, I do not do rooms. For example, I do the hallway, I clean, wipe, and fix things. I turn the mattresses [...] Well, I like it. I have been working there for 2 years. It does not do anything to my hypertension. I work, I do not run, I am not in the sun, I take little rests. I do not work outside (P21)

Non mwen pa fe shanm. Tankou mwen fe hallway, netwaye , siye, yo bagay ki pa byen ranje tankou matla yo, poum vire yo... Bon mwen renmenl. mwen gen 2 an ladan li. Li pa fe tansyonm anyen. Mwen travay, mwen pa kouri, mwen pa nan soley, mwen pran ti repo mwen. Mwen pa nan travay deyo]

Another male participant stated: “Well for me I can’t say the work helps me with my hypertension. I cannot say the work helps me with anything” (P28).

These participants’ statement show that the men perceived their workload as not influencing their hypertension. As shown by the statement above by Participant 21, the housemen’s workload was perceived less stressful. They did not have to rush or work under pressure. They did not associate their work with their hypertension management.

**Work pace.** Work pace was the rapidity at which participants had to complete their tasks. Time pressure has been and remains a concern for hotel housekeepers (Pallesen, 2007). All but the four male participants, who were housemen, reported feeling rushed and said they had to work fast to complete their assignments. Work pace had both positive and negative influences on HTN management. Each is described below.

*Positive influence of work pace on HTN management.* Surprisingly, some participants ( $n=5$ ) considered the time pressure at work as aiding in their HTN management. They viewed having to run from room to room from the beginning to the end of their shift as a type of exercise. They associated exercising with positive approaches to hypertension management; therefore, they considered working fast and sweating as helping them manage their HTN. Participant 14 stated “The work makes me exercise. When I work fast, I do exercise, water drip down on me”. Another participant (P7) noted, “If you are working it is a form of exercise. It gives you courage. And when you have hypertension and you are working it is even four times better”

*Negative influence of work pace on HTN management.* Most participants ( $n=27$ ) started their shifts at 7:30 am and ended at 4:30 pm. They reported being under constant time pressure and unable to stay calm throughout the shift. These participants considered staying calm to be a way of controlling their blood pressure; therefore, cleaning many rooms and being in a time crunch to complete their tasks before the end of their shift was identified as hindering their ability to manage HTN. For example, because she had to complete 16 to 18 rooms by the end of her shift, Participant 2 reported that she had to work very fast throughout her shift:

When you are trying to be quick to finish your work. Well today I was under so much pressure I came home and had to lay down. I looked and realized that the rooms were not completed. I am supposed to finish at 4 and it was 2:40, and I had six rooms remaining. And if I don't go downstairs in time, I will get in trouble. I had to rush and work faster to see if I can finish. When I came home I had to lay down" (P2).

[Le ou tande wap fe vit pouw fe vit pouw travay pouw fini. Bon jodia la se pa ti preshe mwen te pran, mwen vinni se koushe mwen oblishe koushe. Mwen gade mwen we shanm yo rete nan menm. Mwen sipoze fini a 4 e, li te 2 ze 40 mwen gen 6 shanm ki rete. E simm pa desann a le a map pran baton wi. Se kouri wi pouw kouri, poum we si ma fini. Lemm vini lakay se koushe mwen koushe.]

Moreover, four participants reported that their water pill (diuretic medication) increased their urination frequency. Unfortunately, due to the time pressure at work and the location of the staff restroom (which was often on the first floor of the multi-story

hotels where they worked), the participants encountered a dilemma. They had to decide whether to keep cleaning the room they were working on (and which they were supposed to finish in 30 minutes) or take the elevator to go down to use the staff restroom. Workers were not allowed to use the restrooms in the rooms they were cleaning. Consequently, some participants chose not to take the prescribed diuretic medication, since it increased urination frequency and could have interfered with their work. Participant 14 said: "If I take the medication, I will pee a lot. Sometimes I do not take it because it makes me pee too much". Another participant stated:

Some days you have to go pee you need to go downstairs to go to the bathroom. You stand in front of the elevator, and you already pee on yourself, the elevator never opens. And going downstairs to go to the bathroom takes time. When you do go, you waste time while you need to complete the room. (P24)

[Gende jou ou gen pipi a ou bezwen desann anba pou wal nan twalet. Ou kanpe devan elevatè a, pipi a gentan grennen sou wou, elevatè a pa janm ouve. Lefini desann anba pou wal nan twalet pran tan. Le konsa se tan wap pedi pandan ke ou bezwen finn fe shanm nan.]

This participant's statement reflects a direct influence of her work pace on her hypertension management. Having to complete the rooms rapidly and the far location of the restrooms obligated her to make a choice. She chose not to take her blood pressure medication because it would increase her urinary frequency and thus take away from the little time she had to complete her work.

**Work hiring practice.** Work hiring practice alluded to whether a housekeeper was hired directly through the hotel or through an agency. Previous studies on work-hiring practices have focused on cost and economic impacts of such practices on the hotels and also the training and career development of hotel workers (Lai, Soltani, & Baum, 2008; Soltani & Wilkinson, 2010a, 2010b). These studies supported that agency-hired workers (also called flexible workers) were cheaper labor than the hotel-hired workers (Soltani & Wilkinson, 2010a, 2010b). Although workers hired through agencies received less training and had fewer avenues for career development, they did have more fringe benefits, compared to the hotel-hired workers (Soltani & Wilkinson, 2010b). Studies have yet to focus on the impact of such practices on the health of hotel housekeepers.

All study participants, including those hired through agencies ( $n=4$ ) and those hired directly through the hotels ( $n=27$ ), had favoritism for the hotel hire practice. No participants reported positive influences of work hiring process on HTN management. The negative influences of work hiring process on HTN management are described below.

Respondents reported that hotel housekeeping was shifting more towards agency hiring. Some study participants ( $n=4$ ) were hired by agencies and not by the hotels directly. They reported that their jobs were less secure compared to the other workers hired by the hotels. For example, Participant 19 stated:

It is an agency that hired me. They only pay me seven dollars. I have not made it anywhere because many times you find an agency that gives you a job and then you only go for one day (P19).

[Se yon ajanjsi ki ayem. Yo peyem selman seven dola. Mwen pat ko abouti anyen ansanm avek li paske le pli souvan ou konn jwen yon ajensi ki baw yon job epi wale yon sel jou].

Participants hired by agencies got paid less because the agencies retained a certain percentage of what they made. They also did not receive the same benefits as those who were directly employed through the hotel. Participants mentioned that this phenomenon of agency-hire versus hotel-hire created a conflict among them. The agency-hired workers stayed together and resented those who had been hired by the hotels because their jobs were more stable. Conversely, the hotel-hired workers resented the agency workers, because they believed that their employer would fire them to hire more people from the agencies, since there were fewer contractual obligations with the agency-hired workers. In addition, the participants believed that those hired through agencies got paid less and that the hotels preferred them over the hotel-hired employees who received benefits and represented a greater overall cost to the employers. As Participant 11 explained:

If I get paid eight dollars [an hour] and they fire me, they will hire someone at seven or six dollars. Now they hire more from agencies. The agencies pay less. And people from the agencies do not get all same benefits as I do as a hotel employee. For example, I am hired through the hotel, I get sick days, I can call in

sick, they will pay me, I get vacation they will pay me. But the agency doesn't have those things. And then if the people from the agencies work six days some will be for the hotel and some for the agency. The little rest is for the worker. That's why more hotels get agency workers because it works in their advantage (P11).

[Si mwen a eight dola yo revokem, yap pran yon mounn a seven ou six dola. Tankou kounyea a yo pran plis ajansi. Ajansi a peye mwens. Le fini le ou nan ajansi ou pa jwenn menm benefis avek mwen mnem ki anplwaye otel la. Tankou mwenmenm mwen anplwaye mwen jwen sik, mwen ka rele sik, yap peyem ni, mwen gen vakans, yap peyem ni. Men ajansi a pa gen sa yo. Lefini tou si mounn ajansi a travay 6 jou enpe pou otel la enpe pou ajansi a. Ti res la pou mounn nan. se sak fe plis otel bezwen pran ajansi paske li vinn nan avantaj yo].

This participant's statement reflects the impact of work hiring practice on hypertension management. As an employee hired through the hotel, she was aware that she had more benefits than another employee hired through an agency. She also believed that her status as a hotel-hire employee made her vulnerable to lose her job to a lesser paid co-worker.

Individuals hired through agencies often did not get health insurance. Lack of insurance was reported to influence hypertension management. These participants had the choice to purchase insurance; however, they opted not to do so because of their low income. Thus, they were unable to go to the doctor until they had a crisis, in which case they sometimes ended up in the emergency room. Lack of insurance also impeded

participants from purchasing and refilling medications that were required to help keep their blood pressure under control.

According to the study findings, individuals working through agencies were more likely to have difficulties managing their HTN. This is because they reported getting paid less and having conflicts with their co-workers. They also tended not to have health insurance coverage, so they were unable to go to doctor visits and purchase needed medication.

**Compound effects of systems-level influences with class.** The constructs of class, race, gender, and immigration status arose at the systems level. In this instance, the class approach was that of Marx and Weber and not of the Haitian societal system. As members of the working class, participants in this study discussed their inability to make decisions over production and vulnerability. Participants were aware of their lower class position as blue-collar workers that was reflected through their income and education. They acknowledged that their position on the organizational hierarchy was at the lowest level of the industry. The understanding of the relationship between education, social position, autonomy, and power in the workplace was reflected in the following statement:

If someone has a higher position at the job she does whatever she wants to you. You, you are obliged to stay in the job because others will take your place. she places people in a mental condition that is hard to deal with. Me, myself, I experience it [being mistreated and having a mental condition]. You see what I am saying? Everyone they have a eight dollar job. Of course I am talking about people of high level [higher class]. Someone who comes from a university, she

gets a job. That person too can lose a job, but when she gets a job she is much more stable. You will not find a nurse in the morning to just get fired. They don't do that. Nor a doctor, nor an accountant, nor an engineer. But you [speaking of self] they can send you away whenever they want, anyhow they want. Do you understand? (P16)

[Si yon mounn gen yon ti pozisyon nan job la li few sal vle. Ou menm ou oblije rete ladann pouw paske lot kontinye ap vini. Li vinn antrene mounn yo nan yon kondisyon mantal ki di. Mwen menm mwen ladanni. Ou we sa map diw. Tout mounn se job 8 dola yo genyen. Alo map pale natirelman pou mounn ki pa gen wo nivo. Yon mounn ki sot nan inivesite, li jwen yon job. Li pedi job tou wi, men le li jwen yon job li bokou pli stab. Ou pap jwen yon enfimye yon maten konsa pou yo voyel ale, yo pa fe sa. Ni yon dokte, ni yon kontab, ni yon enjenye. Men ou menm, yo ka voyew ale le yo vle, nimpot kijan. Ou konprann?]

This participant was aware of her position. She became aware that her education and income status influence the power/autonomy she has at work. She also perceived that this status affected the way she was treated at work.

**Compound effects of systems-level influences with race.** As noted in the general discussion of systems level influences, participants specifically reported that they were mistreated at work because of their black skin color. The statements by Participants 24 and 26 about being mistreated by their boss because of their skin color (described in previous sections of this result chapter) reflect these views. In this study, institutional and personally mediated racism were noted as being prominent throughout

hotel housekeeping work. Institutional racism was reflected through the preference hotel housekeeping industry managers exhibited for hiring particular racial and ethnic groups. Personally mediated racism was evidenced through the reported discriminatory behaviors of the supervisors toward the study participants.

**Compound effects of systems-level influences with gender.** In this study, the majority (87%) of the participants were female. Compared to their male counterparts, all the female participants reported that their tasks negatively influenced their hypertension. In contrast to the male participants (whose duties included cleaning the hallways, heavy carpet shampooing, and flipping mattresses) the female participants were more likely to experience time pressure and heavy workload, because the male participants did not have to worry about the number of rooms to clean. Since their workload and work pace prevented them from staying calm, and also from taking their blood pressure medication, the women participants appeared to be more vulnerable with respect to their ability to manage their hypertension, compared to the men.

**Compound effects of systems-level influences with immigration status.** The combined effect of immigrant status and their status as blue-collar workers influenced the participants' hypertension management. For example, the participants' language barrier impeded communication with supervisors, resulting in constant stress and an inability to stay calm, which in turn resulted in constantly elevated blood pressure. Moreover, there seemed to be a trend between the work hiring process and the immigration status of the participants. For example, the four participants (P3, P12, P19, and P27) who reported being hired through an agency had all migrated to the U.S. within the past 3 years. Thus, agency-hired participants were at their most vulnerable

state. They were new to the country, and as newcomers they experienced language barriers. Moreover, as agency-hired workers they were paid less and had no health benefits. Government benefits were of no help to them, since in the U.S. immigrants are not eligible for Medicaid if they have been in the country for less than 5 years (Angel, 2010; Dubard & Massing, 2007). These issues only accentuated the disparity among the agency-hired Haitian immigrant hotel housekeepers. The agency-hired individuals would thus have even greater difficulties managing their HTN.

### **Study Limitations**

Only four men participated in the study. Therefore, the study did not fully represent the Haitian immigrant housemen's perspectives about their experiences with HTN and HTN management. Moreover, the photo voice method was used to give the participants the opportunity to depict any factors influencing their hypertension management. Because of their lower position and fear of job loss, participants were hesitant about using this method. Consequently, only four participants were able to depict their work influences on HTN management using photo voice interviews. Interviews were the primary data collection method and indeed generated rich information. The first semi-structured interview and discussion about pictures that participants would have taken at the workplace remain vital sources for rich data.

### **Discussion**

Critical ethnography enables the understanding of both the why and the what is, with consideration for factors of social oppression (Riessman, 1993; Thomas, 1993). Since work was part of Haitian immigrants' everyday life experiences, it was important to explore the influence of their social context, such as work, on their health outcomes.

Previous studies have reported that HTN was poorly controlled among Haitian immigrants (Koch et al., 2005; Preston et al, 1996). Through critical ethnography, the researcher was able to address “why” HTN was so poorly managed among Haitian immigrants, specifically among those working in hotel housekeeping.

Existing literature supported that work such as that of hotel housekeeping—with high levels of stress and demands and low levels of control—increase the risk for HTN development among workers (Clays et al., 2007; Ducher, Cerutti, Chatellier, & Fauvel, 2006; Karasek, 1979; Karasek & Theorell, 1990; Rau, 2006; Rosenthal & Alter, 2011; Siegrist, 1996; Siegrist, Siegrist, & Weber, 1986). Despite this established relationship between work and HTN development, studies have yet to focus on how work influences hypertension management.

Previous studies on coworker dynamics also explored mutual support among coworkers (André-Petersson, Engstrom, Hedblad, Janzon, & Rosvall, 2007; Johnson & Hall, 1988). Research on work and co-worker support has examined the workplace atmosphere, sense of fellowship, mutual support among co-workers, and collaboration among co-workers (Ahlberg-Hultén, Theorell, & Sigala, 1995). When there is a low level of mutual support among co-workers, it can result in high level of stress and thus increase the risk for HTN development (André-Petersson, et al., 2007; Guimont et al., 2006). The findings from this study identified the same factors as influencing HTN management among Haitian immigrant hotel housekeepers.

The results of this study support existing literature on the relationship between work organization and workers’ health. Work organization accounts for workplace structure, workload, and interpersonal relationships at the workplace (National Institute

for Occupational Safety and Health, 2002). This study showed that high workload demand (i.e. number of rooms to clean), lack of support, and unstable work hours (for example, among agency-hired workers) all negatively impact participants' ability to manage their hypertension. Hotel housekeeping work leaves no autonomy or power in the decision making process regarding how many rooms to clean and in what length of time to complete the rooms. This pressure of high productivity within a short period resulted in the participants not taking their blood pressure medications. Work organization also lead to conflicts among the hotel housekeepers are they are constantly competing for work hours, and benefits.

This study expands the occupational health literature by exploring the role work plays in HTN management among immigrant workers. Especially this study identified several aspects of work that either hindered or fostered effective management of HTN. HTN is one of the 10 most expensive health conditions for employers in the United States (Goetzel, Hawkins, Ozminkowski, & Wang, 2003). Hypertension complications result in preventable absenteeism (days away from work), presenteeism (reduced productivity at the workplace), and disability (Goetzel et al., 2003). Having HTN under control is not only beneficial for the workers but also to their employers. Additionally, the U.S. has historically been, and is projected to continue being, a nation reliant on immigrant labor (Lee & Mather, 2008). Therefore, addressing the health and well-being of immigrant workers is beneficial for the country's labor force and global economic stance.

The National Institute for Occupational and Health (NIOSH) (2002) reported the occupational trend towards flexible staffing through agency-supplied workers. Flexible

employment allows employers to meet consumer demands with minimal obligations to their workforce, thus increasing worker's financial and health risks (Dinatale, 2001). NIOSH identified the health risks of agency-supplied workers as one of the research gaps that needs to be addressed in order to determine the effects of the such practices on workers' health (National Institute for Occupational Safety and Health, 2002). This study addressed this gap that had yet to be addressed. The results indicated that because agency-hired workers received no benefits and were paid less, they had more difficulties to maintain routine doctor visits and purchase medications to manage their hypertension.

Previous literature on transmigrant life has examined the impact of transnational identity on the political, economic and social stance of immigrants (Basch, et al., 1994; Glick-Schiller, Basch, & Stanzton-Blanck, 1995; Glick-Schiller, et al., 1992; Glick-Schiller & Fouron 1990; Glick-Schiller & Fouron, 1999; Levitt, 2001). This study adds to the literature by reporting the influences of work on the maintenance of transmigrant life. The findings in this chapter suggest that work enable immigrant workers to maintain relationships across borders, which in turn influence their hypertension management.

It is clear from the findings of this study that work has major influences on the way Haitian immigrant hotel housekeepers manage their hypertension. The context of workers' class, race, gender, and immigration status further complicate their experience with the disease. Because of their history with class in Haiti and the U.S., class remains an important aspect of the Haitian immigrants' experiences. The socioeconomic and political atmosphere of their home country puts a big emphasis on class (Deibert, 2011). The Whites and Mulattos, who comprise 5% of the population, dominate Haiti's

economic and political systems, while 80% of the population is living in abject poverty, over 50% are illiterate, and over 40% are unemployed (Central Intelligence Agency, 2011). Haitians moved to the U.S. with hopes of bettering their lives, only to experience similar disparity issues in their host country (Stepick, 1998). The majority (60%) of the participants in this study had completed only the first through fifth grades. Twenty participants reported an annual income of \$20 thousand or less, which also put them at a lower socioeconomic level. The class disparity created conflicts among the participants, their co-workers, and supervisors. These conditions hindered them from staying calm and kept their blood pressure at a constant elevated state.

The study findings also supported the notion that race remains a form of domination over participants' work experiences, and consequently HTN management. After they arrive in the United States, Haitian immigrants are classified within the Black race (Stepick, 1998; Zephir, 1996). Thus, they automatically experience similar hardships with that of the majority Blacks in their own country. Being confined to low income jobs and experiencing race-based discrimination are examples of such hardships. As stated in the section above, participants specifically reported feeling discriminated against in the workplace. This experience of discrimination was reported to hinder proper management of HTN.

Among all the categories across the individual and systems level influences, there were more reports of negative than positive work influences on HTN management. These findings call attention to the need to address the organizational structure of work in order to promote worker health. Moreover, the findings indicate the need for health professionals to take a holistic approach when caring for this population

group. HTN medications have been proven to improve the life of patients with HTN; however, just prescribing medications may not suffice. Factors such as type of work, workload, and sense of social support from co-workers and supervisors at the workplace all influenced participants' ability and willingness to take necessary measures to manage their HTN. It is critical for health care providers to be aware of work aspects that affect HTN management among this immigrant worker group. Moreover, more research is needed to further comprehend the influences of work hiring practices on worker health.

## **Chapter VII: Summary**

The purpose of this chapter is to discuss the study results with respect to the aims of this study, theoretical framework, methodology, and existing literature. The study aims were to a) describe how Haitian immigrant hotel housekeepers define hypertension, b) identify strategies used by Haitian immigrant hotel housekeepers to manage hypertension, c) explore the influences of transmigrant life on hypertension management among Haitian immigrant hotel housekeepers, focusing on: resources within their social fields and work. Through demographic questionnaires and interviews, various descriptions of hypertension were identified, a myriad of approaches to hypertension management were recognized, and aspects of work influencing hypertension management were learned.

Comparisons and contributions of the study to the existing literature are provided. Methodological and theoretical implications of this study are considered. The study limitations are described. Recommendations for future research and practice on immigrant health and occupational health in general, and specifically in hotel industry, are given. Finally, study conclusions are provided.

### **Comparison and Contribution to Existing literature**

Haitian immigrants' definition and management approaches to HTN were similar to those of other ethnic groups (Boutain, 2001; Dela Cruz & Galang, 2008; Han, et al., 2007). For example, Filipinos living in the U.S. associated stress as the cause of hypertension and used garlic, fish, and a low-salt and low-fat diet to help manage their hypertension (Dela Cruz & Galang, 2008). However, unlike the participants in the study

by Dela Cruz and Galang, many of the Haitian immigrants in this study did not believe in the effectiveness of their prescribed medication. Many participants focused more on herbal medicines to manage hypertension. In addition to low intake of salt and fat, Horowitz and colleagues (2004) reported that African Americans and Hispanics refrained from pork consumption as a way to manage their hypertension. However, they did not report the reason behind such practice. Avoidance of pork was also identified in this study among Haitian immigrants and the reasoning was that pork was categorized as one of the meats with “high blood.” Lamb and beef were also identified as “high blood” meat and were not consumed for that reason.

Similar to previous studies, participants in this study did not take their medications because of lack of access to insurance, the absence of symptoms, lack of time to used the restrooms at work, and lack of trust in the health care system (Kronish, Leventhal, & Horowitz, 2012; Luckoschek, 2003; Schlomann & Schmitke, 2007). The notion of a conspiracy on the part of health providers was elaborated upon. Participants lacked trust in the motives of the health care system, especially that of doctors. In this study, participants thought that even if there were a medication that could cure hypertension, their doctors would not give it to them because of the business aspects of patient care. Participants believed that their doctors prescribed them medications to ensure that they come back. They did not trust their doctor as they believed that the doctor’s goal was to make profit.

This study addresses the limitations of the current literature on hotel housekeeping work and worker health. Current literature on hotel housekeepers has mainly focused on their workload (Powella & Watson, 2006; Seifert & Messing, 2006),

growth of the industry (Kandampully & Suhartanto, 2000) and lack of avenues for growth (Powella & Watson, 2006). Additionally, there are studies about psychological outcomes such as stress, emotional distress and feelings of burnout (Faulker & Patiar, 1997; Ledgerwood, Crotts, & Everett, 1998; Pallesen, 2007) and physical health outcomes of musculoskeletal problems such as back pain (Fruming, et al., 2006; Krause, Scherzer, & Rugulies, 2005; Scherzer, Rugulies, & Krause, 2005) and injuries (Buchanan et al., 2010). Little is known about the influences of housekeeping on chronic disease management. This study shows that research about the health and safety of hotel housekeepers must account for their ability to take care of their chronic diseases, both within and outside of the workplace.

Additionally, this study adds to the literature about the effects of hiring practices on workers' health. Literature that explored contract labor agencies supplying workers to hotels have not fully reviewed it as the growing trend and a financial growth option for hotels (Lai, et al., 2008; Soltani & Wilkinson, 2010a, 2010b). Research needs to explore the impact of hiring practices on the health of workers. This study's results indicated that, because they did not receive benefits, agency-hired hotel workers had difficulties managing their HTN. Lack of benefits, offered through employment prevented them from having insurance coverage, maintaining routine doctor visits, and purchasing medications to care for their hypertension.

Moreover, the study findings relate to the existing literature about the role of the hegemonic constructs of class, race, gender, and immigration status on health outcomes. The literature notes a relationship between health and class, as measured by education level and income (Grotto, et al., 2008; Minor, et al., 2008); being a woman

(Cutler, Sorlie, Wolz, Thom, Fields, & Roccella, 2008; Engberding & Wenger, 2011; Zhang et al., 2011); being Black (Bloch, et al., 2008); and being an immigrant (Tsai & Bruck, 2009; Tsai, 2011). All these factors can be either health-damaging factors or health-protective factors, depending on one's position within those constructs. This study also found that being in a lower class, being categorized in a racial group that is considered inferior, and immigration status all played the role of health-damaging factors. They all impeded hypertension management among study participants. Interestingly, gender played both a protective role (on the cultural level) and a damaging role (on the occupational level) for HTN management.

As a subjugated group, Haitian immigrants' ability to manage their hypertension were suppressed by their social context. They experienced discrimination, racism, and lower social class grade. These experiences occurred in participants' everyday life both within and outside of their workplace. As such, approaches to disease management among this immigrant group must also account for their everyday life context.

### **Theoretical Framework**

Transnationalism was a useful framework for this study. Participants' transmigrant life was exhibited through their reported ongoing relationships with friends and family in Haiti. Transmigrant life was also evident through their utilization of culture-based remedies that were imported straight from Haiti or grown in their backyards to care for their hypertension and their sense of obligation to split their income to care for themselves in the U.S. and take care of their loved ones in Haiti.

Pioneers of the theory of transnationalism noted that immigrants create their transmigrant identity as a result of oppression and its associated negative outcomes

(Basch, et al., 1994). Such identity fosters social, economic, and political ties that transcend geographical borders (Levitt, 2001). Study participants acknowledged their negative experiences and factors of dominance, such as their lower education level, lower class grade, and positions as unskilled blue-collar workers with no autonomy and authority over their work (including work hours and workload). They also acknowledged the strong relationships they have with Haiti and the role such connections have on their health and well-being.

### **Methodology**

Critical ethnography connects social phenomena and broader social and historical events, thus revealing and challenging dominant structures, ideologies, and hidden assumptions (Cook, 2005; Madison 2005; Thomas, 1993). Critical ethnography enables the redefinition of social phenomena with a critical lens.. It allowed the researcher to explore not only how Haitian immigrant hotel housekeepers defined and managed hypertension but also why they managed their hypertension in such ways. In the course of the study, it became clear to the researcher how Haitian immigrant hotel housekeepers use a complex system of rules, meanings, and experiences as transmigrants and hotel housekeepers to influence their behaviors towards HTN management. Such exploration was conducted with consideration for the hegemonic constructs of class, race, gender, and immigration status that drive current ideologies and actions of oppression and domination.

Participants discussed the work-related dichotomies both at the individual and systems level, in the context of class, gender, and immigration status. Oppressive structures at the workplace influenced workers' health. The goal in capturing these

discussions was to reflect participants' experience in their own words and point of view. The goal was also to be able to explore the complex interaction between work, and participants' life context and its influence on HTN management. Critical ethnography allowed the researcher to achieve this goal.

### **Efficacy of Methods**

The researcher used a demographic questionnaire and face-to-face semi-structured individual and photo voice interviews. Using multiple sources of data collection conformed to critical ethnography. This approach also allowed the researcher to obtain more in-dept knowledge about HTN management that was specific to Haitian immigrant hotel housekeepers. Additionally, these methods of data collection gave participants the opportunity to share their experiences with HTN and the factors aiding or hindering HTN management, using both verbal and pictorial approaches.

### **Demographic Questionnaire**

The demographic questionnaire provided basic information about the participants, such as their age, gender, education, and income. The data from the demographic questionnaire set the context for the study. For example, data about participants' education and income supported their accounts about their experiences as a disenfranchised group. The data also provided better understanding of the participants' socioeconomic position and thus the potential influential factors for health and disease management. Some issues arose during analysis of the demographic questionnaire. Some demographic variables were collected as categorical variables. For example, participants were asked to provide information on age using four categorical options. As a result, the researcher was unable to determine actual ages, and so was

unable to calculate the mean and standard deviation for age. However, the data were collected in this unspecific way in order to gain the participants' trust and ensure their comfort level would be high. Participants felt comfortable giving ranges and estimates rather than specific answers.

Additionally, other demographic data that were not collected could have benefited a better understanding of the context for HTN management. Examples of these demographic data include time of HTN diagnosis and location of diagnosis (whether diagnosis was in Haiti or the United States). Time of diagnosis could have provided a better understanding of participants' behavior toward HTN. For example, perhaps those who were newly diagnosed would be more prone to adhere to their medication or vice versa compared to those who had been hypertensive for a long time. Knowing whether participants were diagnosed with HTN in Haiti or the U.S. would have provided a better understanding for the influence of transmigrant life on HTN and HTN management.

### **First Individual Interview**

During the first individual interview, the researcher was able to talk with the participants about their HTN and HTN management. The interview was done in a conversational manner during which participants were able to elaborate on their experiences. This face-to-face semi-structured interview was effective in that it allowed the researcher to gather data to address the study aims.

### **Photo Voice Interview**

Unlike the demographic questionnaire and the first individual interview, not all the study participants opted to partake in the photo voice interview. Only 12 out of the 31

participants participated in this second interview. Out of these 12 participants, only four took pictures at their workplace. As discussed in the methods section under data collection, participants had various reasons for not participating in the photo voice interviews. Some feared they would be accused of stealing the cameras at their workplace and others were concerned about not having enough time in their day to take pictures. Those who agreed took pictures only of things that were direct representations of how they managed hypertension, things such as herbal remedy leaves and family members. However, no one took pictures of things that could be seen as metaphoric representations of how their transmigrant life and how work influenced the way they managed hypertension. Despite a full explanation of the method, after they brought the cameras back, and also during the discussion of the pictures, participants seemed to still have some misunderstanding of the photo voice method.

The photo voice interview is an excellent approach with which to empower study participants (Carlson, Engebretson, & Chamberlain, 2006; Molloy, 2007) as it enables them to choose and share objects and people from their context with researchers so that we can see their world through their own eyes. However, such an approach might be effective for one group of people and not another. The study participants were unable to take pictures at the workplace because of the nature of their job, position, and status at work. Two participants asked their supervisors for permission to take pictures and were denied.

Despite these setbacks, photo voice strengthened the study in several ways. Through photo voice, participants were able to identify herbal medicines that they used to manage their hypertension. Discussions of the pictures supported the previous

accounts in the first interviews about management of hypertension. Discussion of the inability to take pictures also reinforced the fact that this immigrant worker group is marginalized and that research methods need to be selected with additional consideration and feasibility assessment.

### **Rigor**

The researcher took several measures to maintain the scientific rigor of this study. The researcher continuously consulted with and debriefed her dissertation committee members about all the steps of the research process. She also conducted the research as stated in this research proposal, and Human Subjects Review Committee at the University of Washington approved the procedures.

Mishler (1990) and Riessman (1993) used the term validation instead of validity for interpretative data. The term validation refers to an ongoing evaluation process that occurs during the participant-researcher-audience interaction throughout the research process (Mishler, 1990). Validation of a study does not focus on the truth of the data but rather on the flow of the research process (Riessman, 1993), hence the use of the term trustworthiness instead of truth. Validity was met by maintaining the trustworthiness of the “reported observations, interpretations, and generalizations” of the study (Mishler, 1990, p. 419). For example, the information collected during the interviews was not altered and was kept as recorded, and the results were supported with the participants’ own words extracted from the transcripts. Moreover, the researcher then asked for further clarification about anything that was unclear during the interviews. In addition, the use of the photographs during the photo voice interviews was another form of

validation, since the pictures were concrete examples of things the participants said had influenced their hypertension management.

Riessman (1993) used the term pragmatic use to determine if other people can detect the trustworthiness of a study. The research process and method for analysis were made visible in this dissertation. Data were presented in the form of text and were provided in a way that the audience could determine and clearly understand each step of the whole research process, from data collection to analysis and interpretation (Bailey, 1996). Therefore, the audience has enough information to evaluate the research process (data collection, analysis and interpretation) for themselves.

Cross-cultural language is another factor to consider when it comes to qualitative work with different cultural groups (Bhopal, 1995; Suh, Kagan, & Strumpf, 2009; Tsai et al., 2004). For this study, one strategy proposed by Suh and colleagues (2009) was employed. With this strategy, the interviews were analyzed in their original (non-translated) version. Interview analysis involved contextual comparison between meanings of English and Haitian-Creole. This allowed for the researcher to capture meanings without losing cultural aspects and expressions. Result dissemination was done in English. To ensure that meanings were captured, result dissemination followed an analytical process. For example, after each quote, the researcher described the context and meaning of the response. The researcher was aware that because of her heritage as a Haitian descendant, and being fluent in the language, she could be considered as an insider. However, being an insider because of familiarity with the culture runs the risk of misinterpretation (Bhopal, 1995; Tsai, et al., 2004). To address these issues, as recommended by Tsai and colleagues (2004), throughout data

collection, data analysis and dissemination, the researcher utilized reflexivity for constant awareness of her position, the interactions, and participants' responses.

### **Study Limitations**

Despite its significant findings, this study had several limitations. First, one might argue for the issue of transferability, because the study participants were a specific immigrant worker group. However, the goal for this study was to understand the experiences of that specific immigrant worker group: Haitian immigrant hotel housekeepers. The researcher was required to focus on this group in order to address the study purpose and study aims.

Second, only 31 individuals participated in the study. Because of this small sample size, one might argue that the study findings might not be generalizable. Qualitative research puts emphasis on the depth, breadth, and context of the data (Thomas & Magilvy, 2011). Validity of the data is not dependent upon sample size but on saturation and redundancy (Polit & Beck, 2004). Saturation was reached in the study as participants' accounts became redundant. A sample of 31 participants were deemed appropriate for this study because saturation was reached through this number of participants. Moreover, purposive sampling with appropriate sample criteria helped assure that the study address the study purpose regarding the specific phenomenon of hypertension management (Sandelowski, 1995). As stated by Thomas and Magilvy (2011):

The purpose of qualitative research is not to generalize to other subjects or settings, but to explore deeply a specific phenomenon or experience on which to

build further knowledge or to develop a more patient-focused practice that is sensitive to the research participants. (p.152)

Moreover, the use of photo voice was not very effective. Participants were not able to have pictorial descriptions of work influences on their HTN management. However, the information obtained from the first individual interviews gave rich information about work influences on HTN management.

Lastly, only four men participated in the study. It would have been helpful to have a roughly equal number of men and women so that the researcher could have made a better exploration of the men's experiences with HTN and as hotel housemen. However, during the recruitment and data collection, men did not come forward to show interest in the study. The researcher was provided with the name and phone number of two potential male participants; however, they did not want to participate in the study. Women are overrepresented in the housekeeping industry compared to men (Adib & Guerrier, 2003); therefore finding an equal number of female and male housekeepers to participate in this study was challenging.

### **Implications and Recommendations**

The growth of nursing science relies in part on continued knowledge generation about health and advocacy for human well-being. Among other things, nursing science tries to account for the interaction between individuals and their environment and the health outcomes of such interactions (Barrett, 2002). This study provides a better understanding of the experiences of Haitian immigrants with hypertension and its management. Existing literature acknowledged that HTN was poorly controlled among

Haitian immigrants, and the study findings reveal some reasons to explain why this has been the observed health outcome.

The study findings identified several aspects of the participants' transmigrant life, such as their socioeconomic grades that influenced their ability to manage hypertension. With their political, historical, socioeconomic, and migration experiences, Haitian immigrants remain a uniquely disenfranchised immigrant group in the U.S. Such experiences compel this immigrant group to create their transnational identities. The study shows that these transmigrant identities, although positively influencing the immigrants' psychosocial well-being, also impede their HTN management. Their continued placement in the blue-collar workforce, in jobs such as hotel housekeeping, intensifies their negative experiences and thus affects their HTN management. The results of this study identified several research gaps that must be further explored to foster immigrant health and address occupational health issues, as described below.

First, further research and interventions geared toward occupational health and safety and immigrant worker health are needed. Studies are needed, for example, to determine if and how the work factors (e.g., work hiring practices) identified in the study influence disease management differently for Haitian and non-Haitian worker groups in other industries. Further studies are also needed to determine whether such work influences on HTN management pertain only to hotel housekeeping or to other types of work as well. Worker interventions need to be implemented at the workplace to address worker health and chronic disease management. Additionally, although systems like worker compensation are already in place to address health risks and injuries on the job, not much is being done for workers who experience disease and health outcomes

that cannot be directly attributed to the workplace. Therefore, interventions are needed to establish a system that addresses the issue of chronic disease such as hypertension and diabetes in addition to government-regulated programs of worker compensation for work-related injuries.

Second, more research is needed to address the effective use of the photo voice methods in research for data collection. Photo voice has been used as a way to empower oppressed groups by giving them the opportunity to choose the objects or issues of interest to them and give these objects or issues a meaning (Carlson, et al., 2006). However, in this study, participants were unable to fully depict factors influencing their HTN management due to misunderstanding of the method and also because they were afraid of losing their jobs. More consideration is needed to determine whether the photo voice method is effective for all types of oppressed groups. Further research is needed to determine the outcomes of the photo voice method utilization on vulnerable populations.

Third, studies are needed to expand on the framework of transnationalism in relation to immigrant health. So far, the transnationalism framework has mostly been used to understand the social, economic, and political aspects of transmigrants in the fields of anthropology and sociology. However much work is needed to understand the effects of transmigrant identities on transmigrant health. As current global and technological developments facilitate increasing interactions and resource exchanges both inside and outside of the country, more attention to this area is needed if we are to understand the impacts of such interactions and resource exchanges on immigrants' attitudes and their behaviors towards health promotion and disease management.

Consideration for the transnationalism theoretical framework addresses this issue.

Transnationalism has been driving the current understanding of the socioeconomic and political context of the beliefs and behaviors of contemporary immigrants. It has been established that transnational identities and transnational connections have considerable economic, socio-cultural, and political impact on immigrants, their families, their communities and the home and host country. However, we need to extend this understanding even further to the realm of health care, because we know that the best care is provided within context. Previous studies have noted that transnational identities have aided in the psychological and mental health status of immigrants (Murphy & Mahalingam, 2004). However, this study's findings showed that such identity can be a strain on the immigrants' health and behaviors towards health promotion and disease management. More research is therefore needed to further explore the health consequences and effects of transnational identities on immigrants.

Fourth and finally, researchers and health providers need to consider how work and transmigrant life influence hypertension management among contemporary immigrants. Researchers need to conduct further research and establish interventions tailored both for the individuals and the workplace to help foster effective disease management for hypertension. Health care providers need to account for these work influences particularly when determining effective methods for HTN management among Haitian immigrants. Health professionals also need to consider and embrace the issue of transnationalism. We need to understand how transnational identities filter down through the transmigrants' life (for example, in their homes and at their workplaces) and impacts their behavior toward disease management. Such

considerations will contribute to our goals of health equity, healthy populations, and a healthy workforce.

### **Conclusion**

This study added to the literature by: (a) providing an understanding of Haitian immigrants' definition and management of HTN, (b) identifying effects of work hiring practices on chronic disease management, and 3) showing the potential negative outcomes of transnational identity on immigrants' health. This critical ethnography study shed light on the experiences of Haitian immigrant hotel housekeepers with HTN and HTN management. This study evidenced that despite the various efforts to address effective hypertension management, the underlying gradient of disparity for hypertension (including factors such as work, class, gender, and immigration status) still needs to be addressed in order to achieve optimal control. At issue is the need for effective interventions to address the underlying social, economic, and political factors leading to or intensifying hypertension disparity. Furthermore, this study addressed the recommendations to not only consider occupational health issues at the individual level but also at the organizational system level. Such considerations are pertinent to address the root issues of immigrant worker health.

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Marie- Anne Sanon, RN  
Envestigatè Prensipal



Mwen se yon etidyan Aisyen nan inivesite de Washington e mwen ta remen pale ak ou o sijè de jan ou kontrole tansyon/hi blod preshè ou

**Eske ou fèt an Ayiti?**

**Eske doktèw diw ke ou Fè Tansyon?**

**Eske Wap Travay Nan Fè Menaj Nan Otel?**

**Eske ou pi gran ke 18 an?**

Si ou repon wi pou tout kesyon sa yo. Ou gen opòtinite pou ou patisipe nan yon reshesh o sijè de Ayisyen kap travay nan fè menaj nan otèl e ki fè tension/hi blod preshè.

Nan proje sa wap fe: 2 entevyu, ak yon kesyone. Pandan premye entevyu a, map mandew pouw pran foto pou nou ka pale nan dezyem entevyuy a. Shak intevyu ap dire o mwen 2 zed tan edemi.

Ou jwen yon \$20 dola gif kat apre shak entevyu

Si ou interese, sil vou plè rele Marie-Anne:  
nan: (XXX)-XXX-XXXX

Haitians & Hypertension  
Marie-Anne Sanon

## **APPENDIX C: CONSENT FORM: ENGLISH**

### **UNIVERSITY OF WASHINGTON CONSENT FORM Haitian Immigrants Hotel Housekeepers & Hypertension Management**

Investigator: Marie-Anne Sanon, RN PhD Student  
School of Nursing  
University of Washington  
[V2@u.washington.edu](mailto:V2@u.washington.edu)  
(716)-903-7152

Faculty Sponsor: Dr. Doris Boutain, RN, PhD,  
Associate Professor, Psychosocial and Community Health  
School of Nursing  
University of Washington  
Box 357263, Seattle, WA 98195-7263  
[dboutain@u.washington.edu](mailto:dboutain@u.washington.edu)

#### **Researcher's Statement**

We are asking you to be in a research study. This form is called a consent form. It provides you with information about the study that you are being asked to participate in. As you read the content of this form, you will gain a thorough understanding of why I AM doing this study; why you are considered the best participant for the study, the study procedures, its benefits and the potential risk associated. The information of this form will allow you to make your decision to as to whether to participate in the study or not. After you read the form, you can ask us additional questions for more clarification. If you decide to participate in this research study, you will be asked to sign the bottom of this form and a copy of the signed form will be provided to you.

#### **PURPOSE OF THE STUDY**

I want to know about Haitian immigrants who are working as hotel housekeepers and the way they manage hypertension or high blood pressure. I also want to know how your immigrant life and your work as a hotel housekeeper influence the management of hypertension. I want to interview Haitians who were born in Haiti and are now living in Miami-Dade County.

#### **STUDY PROCEDURES**

If you chose to participate in this study, I will ask you to do three things:

- First you will meet with me to do an interview and fill out a short questionnaire that asks about things such as your age, the length of time since you moved to the United States from Haiti, your average income, your marital status, your education level, and your ability to write, read and understand English. During the interview I will ask you things like “Tell me about your high blood pressure?” “What do you do to keep your hypertension under control?” “How does being an immigrant influence your hypertension management?” “How does your work as a hotel housekeeper influence your management of hypertension?”

You have the right to refuse to answer any of the questions from both the questionnaire and interviews.

At the end of this first meeting, you will be given a disposable camera to take pictures of any objects or individuals that you think play a role in the management of your hypertension. Take pictures that you only feel comfortable taking. If you take pictures of people, make sure that you tell the person why you are taking the picture and make sure that they are comfortable with you taking their picture. Make sure to tell them that the picture will not be included in the study. Only pictures of objects and pictures that do not identify businesses or individuals will be included in the research report. You will be provided a prestamped envelope so that you can mail me the camera after you have taken the pictures.

- The second time we meet, we will discuss the pictures. During this meeting, I will also ask you about anything that wasn't clear during the first interview. The meeting date and times will be set at your convenience.

Each meeting time will go last up to 2 and a half hours depending on the amount of information you are giving. I will be traveling to the place of your choosing so you don't have to worry about transportation.

I would like to take written notes and audio record your interviews with a digital recorder so that I can catch all the important things that are mentioned. I will keep the recordings in a harddrive that only I will have access to. I will transcribe your interviews within 6 weeks of your interview; assign an identification code to the transcript. Please indicate below whether or not you give your permission for me to audio record your interview. Also I ask for your permission to use your audio recordings during my oral dissertation defense and at national conferences. The replay of the recordings will only include sections that will not identify you. The digitally audio recorded interviews will be destroyed within 10 years of the study completion. Please indicate below whether you give me permission to use your audio recorded interview at my dissertation defense and national conferences.

### **RISKS, STRESS, OR DISCOMFORT**

There are no direct physical risks for participating in this study. During the interviews, you might be at risk of experiencing some discomfort. If the questions asked cause you any discomfort you can stop the interview at anytime and withdraw from the study.

### **BENEFITS OF THE STUDY**

There are no direct benefits for participating in this study. However by participating in this study, you will help us understand how you management your hypertension and how your immigrant life and your work influence your management of the disease. This understanding could yield better patient-provider communication, better care and better health outcomes.

### **OTHER INFORMATION**

Taking part in this study is voluntary. You can choose to stop at any time. The information obtained about you will be kept confidential. To ensure that the information you provide from the questionnaire, the interviews, be kept confidential, only the person in charge of the study will conduct the interviews and know your name and information. An ID will be assigned to you. The link between your assigned ID and your direct contact information will be broken six months after our last meeting. A separate list will

be kept for your contact information. This list will be kept 6 months after the last meeting.

A total of \$ 40 dollars gift card will be given to you for completing the interviews. You will receive the first \$ 20 gift card after the first interview. You will receive the \$20 dollar gift card after the second interview about the pictures.

I may want to re-contact you in order to clarify information from your second interview. Please indicate below whether or not you give your permission for me to re-contact you. Giving your permission to re-contact you does not obligate you in any way.

---

Printed name of the Investigator	Signature of the Investigator	Date
----------------------------------	-------------------------------	------

Subject's statement

This study has been thoroughly explained to me. I volunteer to take part in this research. I have had a chance to ask questions. If I have questions later about the research, I can ask the researcher listed above. If I have questions about my rights as a research subject, I can call the Human Subjects Division at the University of Washington at (206) 543-0098. I will receive a copy of this consent form.

----- I give my permission for the researcher to audiotape my interview

----- I do NOT give my permission for the researcher to audiotape my interview

----- I give my permission for the researcher to re-contact me after the second interview to clarify information

----- I do NOT give my permission for the researcher to re-contact me after the second interview to clarify information

----- I give my permission for the researcher to use my audio-recorded interview for her dissertation defense

----- I do NOT give my permission for the researcher to use my audio-recorded interview for her dissertation defense

----- I give my permission for the researcher to use my audio-recorded interview at national conferences

----- I do NOT give my permission for the researcher to use my audio-recorded interview at national references

---

Printed name of subject                      Signature of subject                      Date

I certified that I was provided a copy of the consent form.

---

Printed name of subject                      Signature of subject                      Date

## **APPENDIX D: FOM KONSANTMAN**

### **Imigran Ki Fet An Ayiti Kap Travay Nan Fe Menaj Nan Hotel E Ki Fe Tansyon**

Envestigate: Marie-Anne Sanon, RN  
PhD Student  
School of Nursing  
University of Washington  
[V2@u.washington.edu](mailto:V2@u.washington.edu)  
(716)-903-7152

Sponse Dr. Doris Boutain, RN, PhD  
Associate Professor  
Psychosocial and Community Health  
University of Washington School of Nursing  
Box 357263  
Seattle, WA 98195-7263  
[dboutain@u.washington.edu](mailto:dboutain@u.washington.edu)

### **DEKLARASYON ENVESTIGATE YA**

Fom sa a rele on kosantman fom. Li pemet ou gen enfomasyon sou etid la yo mande ou pou patisipe a. Nan moman wap li fom nan, wap konpran poun kisa mwen ap fe etid sa a, pou kisa ou se pi bon kandida pou etid la, pwosedi etid la, benefis li genyen ak tout risk ki la dan. Enfomasyon ki nan fom nan ap pemet fe desizyon pou si ou vle ou non patisipe nan etid la. Apre ou fin li fom nan ou ka poze nou lot kesyon pou plis klarifikasyon. Si ou decide pou ou .

### **REZON ETID LA**

Mwen vle konnen o sije de imigran Ayisyen ki ap travay kom moun kap fe menaj, eki eksperyans ak kwayans yo o sije de maladi tansyon ou byen hi blod preshe. Mwen vle kesyone Ayisyen ki te fet an Ayiti e ki rete nan Miami-Dade County kounyea. Le ou patisipe nan etid la, wap ede nou gen pi bon enfomasyon sou imigran Ayisyen ki genyen maladi tansyon e koman yo jere maladi a. Enfomasyon sa yo ap ede moun ki ap bay la sante konpran Ayisyen natif natal pi byen e cheche tretman ki gen rapo ak kilti imigran Ayisyen ki gen maladi tansyon.

### **PROSE ETID LA**

Si ou chwazi patisipe nan etid la ou genyen twa bagay pou ou fe: Premyeman, map mande pou ou ranpli yon fom ki mande laj ou, depi ki le ou kite Ayiti pou vini Etazini, konbyen kob ou fe, eske ou marye ou non, ki nivo edikasyon, eske ou kap li, ekri ak konprann angle.

Dezyemman wap rankontre avek mwen pou yon entevyou. Randevou a ap fet nan dat ak le ki bon pou ou. Randevou a ka pran soti nan 1 e a 10 e de tan, sa depann de kantite enfomasyon ke ou geyen. Ou ka decide kibo pou nou rankontre donk ou pa bezwen bay tet ou pwoblem pou transpotasyon. Twazyemman nap diskite sou kondisyon travay ou , kijan on bon ou on move jounen ka afekte travay ou.

Map ekri ak anregistre entevyou sa a poum ka si ke mwen pran tout enfomasyon empotan ou bay. Men ki jan kesyon yo ap ye nan entevyou a.

- Palem de tansyon w?

- Kisa ou fe pou ou kontrole tansyonw?
- Kijan la viw antan ke yon imigran enflyianse jan ou kontrole tansyonw?
- Kijan travayi ou a antan ke moun kap fe menaj nan otel enflyianse jan ou kontrole tansyonw?

Ou gen dwa refize reponn nenpot kesyon ki nan kesyone ak entevyou a. Ou gen dwa kite etid la a nenpot ki le. Finalman, apre premye rankont nou an, mwen ap baw yon kamera pou ou ka pran foto de nimpot bagay ak moun ki ede avek tansyonw. Fe atansyon le wap pran foto yo. Pran foto ke ou konfotab pouw pran. Pa pran foto moun san yo pa konnen. Si wap pran foto yon moun di moun nan poukisa wap pran foto wa. Pou repot etid la, map Selman itilize foto ki pa identifiye moun ak biznis. Tout lot foto yo ap pou ou. Map bawou yon envolp ak stenp pou ou ka mel camera a pou mwen le ou fin pran foto yo.

- Nap rankontre yon dezyem faw pou yon lot entevyou pou nou ka diskite foto yo. Pandan rankont sa, map tou klarifiye lot kesyon ke mwen te geyen apre premye entevyou a.

Shak miting yo ap dire o plis dezeditan edmi selon kantite enfomasyon ou vle dim. Map vini kote ou vle pou nou fe entevyou a pou ou pa bay tet ou problem pou transpotasyon. Mwen ta renmen ekri ak rekode sa wap dim yo pou mwen ka asire ke mwen pran tout enfomasyon ke wap dim yo. Map sere intevyew sayo yon konte ke sel mwen ka ale. Map tape entevyou yo apre 6 semèn ke nou fin pale. Map bay yon nimeron nan sam tape ya pou non ou ka pa paret. Sil vou ple dim si ou banm pemission pou mwen fe sa. Mwen ta renmen mande pemisyon pou mwen itilize entevyou wa nan egzamen final mwen ak konferans. Pati ke map itilize yo pap gen non ou. Sil vou ple dim si ou dako pou mwen itilize rekod entevyou a pou sa.

### **RISK, TRES, AK MALEZ**

Pa gen okenn risk fizik pou patisipe nan etid la. Nan moman entevyou a ou ka santi depresyon. Si kesyon yo poze ou la fe ou malalez, ou gen dwa kite entevyou a nenpot kile e kite etid la. Enfomasyon as sipo ap disponib si ou bezwen konsiltasyon sikolojik paske ou gen malez pandan wap patisipe nan etid la. Enfomasyon ou bay la ap rete konfidansyel, sepandan moun ki ap fe rechek la sipoze rapote si ou reprezante on dajè pou tet ou ak lot moun.

Pou asire ke tout enfomasyon ou bay ap rete sekre se selman moun kap fe rechek la kap konnen non ou ak ki kalite enfomasyon ou te bay. Apre entevyou a yap mete yon kod pou dezye enfomasyon ou yo pou yo ka idantifiye yo san non ou pa paret.

Enfoamasyon ou pataje nan etid la ap rete nan achiv nou pou 10 an apre yap detwi yo.

### **BENEFIS ETID LA**

Pa gen okenn benefis direk pou patisipasyon'w nan etid la. Sepandan wap ede nou konpran kijan ayisyen kap viv o zeta zini panse de tansyon epi kijan yo trete malady sa. Epitou, wap ede nou konpran kijan travay ou an tan ke moun kap fe menaj nan hotel afekte tansyon e jan ou trante tansyon. Wap ede dokte ak infimye kompran kijan aysien define e trete tansyon. ansam enfomasyon sa yo ap rann fasil kominikasyon ant pasyan ak moun kap bay swen

### **LOT ENFOMASYON**

Ou pa oblije patisipan nan etid la. Ou ka stope nenpot le ou vle. Enfomasyon ke ou dim yo ap rete konfidansyel. Selman mwenmen ap konnen non ou. Apre sa, map baw yon

nimero pou peson lot moun pa ka identifyew. Infomasyon ak non ou ap afase 6 mwa apre nou fin rankontre dezyem fwa.

Wap jwen 40 dola gif kat pou patisi[asyon nan etid la. Premye 20 dola gif kat la wap jwen apre premye entevyu a. Lot 20 dola gif kat la, wap jwen ni apre dezyem entevyu a. Mwen ta renmen gen opotinity poum relew si mwen gen kesyon apre dezyem entevyu a. sil vou ple dim si ou dako pou mwen relew.

---

Non Investigate Ya <u>Deklarasyon Patisipan</u>	Sinyati Investigate ya	Dat
--	------------------------	-----

Yo Eksplike etid sa banmwen tre kleman. I decide pou mwen patisipe nan etid la. I te gen okazon pou mwen poze tout kesyon mwen te geyen o sije de etid la. Si nan lavni mwen gen plis kesyon sou rechek la, mwen ka mande investigate ya. Si mwen gen kesyon sou dwa mwen antan ke yon rechek patisipan, mwen ka rele Human Subject Division nan nimero (206) 543-0098. I ap resevwa yon kopi dokiman konsantman fom sa.

- Mwen bay pemisyon pou investigate rekode entevyou mwen an
- Mwen PA BAY pemisyon pou investigate rekode entevyou mwen an
- Mwen bay pemisyon pou investigate ya pran not pandan entevyou mwen an
- Mwen PA BAY pemisyon pou investigate ya pran not pandan entevyou mwen an
- Mwen bay pemisyon pou investigate ya rekontaktem pou plis klarifikasyon
- Mwen PA BAY pemisyon pou investigate ya rekontaktem pou plis klarifikasyon
- Mwen bay pemisyon pou investigate ya itilize rekod yo nan egzamen final li
- Mwen Pa Bay pemisyon pou investigate ya itilize rekod yo nan egzamen final li
- Mwen bay pemisyon pou investigate ya itilize rekod yo nan konferans
- Mwen Pa Bay pemisyon pou investigate ya itilize rekod yo nan konferans

---

Non Patisipa	Sinyati Patisipan	Dat
--------------	-------------------	-----

Mwen setifye ke mwen jwen yon kopi konsant fom sa

---

Non Patisipa	Sinyati Patisipan	Dat
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## APPENDIX E: INDIVIDUAL INTERVIEW GUIDE: ENGLISH

Date \_\_\_\_\_

Participant ID \_\_\_\_\_

**Marie-Anne Sanon, RN**  
**Principle Investigator**

Thank you very much for your willingness to participate in the study. As I mentioned to you before, the purpose of this study is to understand how you manage your hypertension and how your life as an immigrant and your work as a hotel housekeeper influence your management of the disease. Right now, we will go over the consent form and then we will proceed to the interview. This interview will last up to 2 and a half hours. Your responses will be kept confidential. Your responses will not be used for other purposes other than research. If there is a question that you do not feel comfortable answering, we can skip over that question. You can stop the interview at anytime. Do you still wish to participate in the study?

**If no, say:** thank you for your time and speaking with me.

**If yes, continue and say:** Before I begin, do you have any questions? **If yes, answer the question. If no continue**

Before I begin the interview, I need to confirm that you are able to participate in the study. I will repeat some questions that were previously asked of you.

Now I will read you the eligibility criteria. After each statement, please reply Yes or No.

<i><b>Inclusion Criteria</b></i>	<i><b>Response</b></i>	<i><b>Action</b></i>
Were you born in Haiti?	Y N	If no, Ineligible
Do you currently live in Miami Dade County, Florida?	Y N	If no, Ineligible
Do you currently work as a hotel housekeeper?	Y N	If no, Ineligible
Are you at least 18 years of age?	Y N	If no, Ineligible
Are you capable of providing oral and written informed consent?	Y N	If no, Ineligible
Have you been told by a medical doctor that you have hypertension?	Y N	If no, Ineligible

<i><b>Exclusion Criteria</b></i>	<i><b>Response</b></i>	<i><b>Action</b></i>
Have you been living in the U.S. for over 10 years?	Y N	If yes, Ineligible
Are you under 18 years of age?	Y N	If yes, Ineligible
Were you born in the United States?	Y N	If yes, Ineligible
Is your housekeeping work at a private home?	Y N	If yes, Ineligible

Do you keep in touch with your friends and family members in Haiti? | Y N | If No, Ineligible

**If ineligible, say:** “I am so sorry you cannot participate in the study because **state the reason.**” I apologize that this issue was missed during our last conversation

**If eligible, say:** Great! You are able to participate in the study. We can continue. First, I need to get your signed informed consent to conduct the interview.

**Informed Consent**

I will read you the consent form now. This form is used to give me permission to enroll you in the research study. I will then ask for your signature. **Get the signature and then begin the interview.**

**After getting informed consent, say:** Thank you for your signature.

Now, I wish to tell you more about the interview. This interview will have three parts: First, I will begin talking about your hypertension and how you manage your hypertension. Then I will ask you about how your immigrant life and your work influence your management of your hypertension. Lastly, I will ask you some background information about yourself

May I tape record the question and answer part of the interview?

If the participant says yes, take out the audiotape recorder, and say: I bought a pen and papers to take some notes to help me better remember what you are saying. May I have your permission to take notes for this part of the interview to be sure that I do not misrepresent what you tell me?

If the participant says no, do not take pen and pad out

If yes, take out notepad and pen.

**Remember to record interview starting time:** \_\_\_\_\_

**Turn the audiotape on.**

**Table 2: INTERVIEW QUESTIONS**

Aim	Primary/Required Questions	#	Good to Ask Questions	Application of Methodology & Theoretical Framework
Aim 1	<p>You are participating in this study because your doctor told you that you have hypertension or high blood pressure. What do you think you have? What does that mean to you?</p> <p><i>-Wap patisipe nan etid sa paske doktew te diw ke ou fe tansyon. Ki sa ou panse sa vle di?</i></p>	1.	<p>****a) You are participating in this study because your doctor told you that you have hypertension or high blood pressure. What do you think you have? What does that mean to you?</p> <p><i>-Wap patisipe nan etid sa paske doktew te diw ke ou fe tansyon. Ki sa ou panse sa vle di?</i></p> <p>Probes:</p> <p>****b) What do you think the word hypertension mean?</p> <p><i>-Ki sa ou panse tansyon vle di?</i></p>	Critical Ethnography & Transnationalism
	<p>Tell me about your- <b>participant's term-</b> <i>-Palem de participant's term</i></p> <p>What do you think causes your <b>participant's term -?</b> <i>-Kisa ou panse ki baw participant's term?</i></p>	2.	<p>a) Do you use another term for the word hypertension?</p> <p><i>-Eske ou itilize lot mo let wap pale de tansyon?</i></p> <p>Probes:</p> <p>b) What is that word?</p> <p><i>-Ki mo li ye?</i></p> <p>c) How did you learn about this word?</p> <p><i>-Ki jan ou fe apran de mo sa?</i></p> <p>Since you mentioned that that you use the word <b>-participant's term-</b> for your hypertension, I am going to use this term throughout the whole interview instead of the word hypertension)</p> <p><i>-Kom ou dim ke ou itilize participant's term let wap pale de tansyon, apati de kounye a, map itilize mo sa pandan entevyou a.</i></p>	Critical Ethnography & Transnationalism

		<p>3. *****a)Tell me about your-<b>participant's term</b>- -<i>Palem de participant's term</i></p> <p>Probes: b) Can you tell me more about that? -<i>eske ou ka palem plis de sa?</i></p>	Critical Ethnography & Transnationalism
		<p>4. ****What do you think causes your <b>participant's term</b> -? -<i>Kisa ou panse ki baw participant's term ?</i></p> <p>b)why do you think so? -<i>sak fe ou panse sa?</i></p>	Critical Ethnography & Transnationalism
		<p>5. From what I understand many Haitian immigrants think their illnesses can be due to supernatural causes such spirits and voodoo What do you think that? (probe: how so?) -<i>Mwen konpran ke anpil ayisyen panse ke maladi yo se resulta de rezon ki sipenaturel tankou vodou ak espri. Ki sa ou panse de sa?</i></p>	Critical Ethnography & Transnationalism
		<p>6. a)Can you tell when your <b>participant's term</b> is high? -<i>Eske ou konen ki le participant's term monte?</i></p> <p>b)when your <b>participant's term</b> is high what happens? -<i>le participant's term ki sa ke rive?</i></p> <p>c) When that happens how do you feel? <i>Le sa rive, kijan ou santiw</i></p> <p>d) What do you think about? <i>Ki sa ou santi?</i></p> <p>d)What do you do? -<i>Kisa ou fe?</i></p>	Critical Ethnography & Transnationalism

		7.	<p>a) Can you tell when your <b>participant's term</b> is low?  <i>-Eske ou konen ki le <b>participant's term</b> desan?</i></p> <p>b) when your <b>participant's term</b> is low what happens?  <i>-le <b>participant's term</b> ki sa ke rive?</i></p> <p>c) When that happens how do you feel?  <i>Le sa rive, kijan ou santiw</i></p> <p>d) What do you do?  <i>-Kisa ou fe?</i></p>	Critical Ethnography & Transnationalism
		8.	<p>a) When you talk to your friends and family members about your <b>participant's term</b> What do you tell them?  <i>-Le wap pale ak fanmi epi avek zanmiw o sije de <b>participant's term</b> , kisa ou di yo?</i></p> <p>b) What do they tell you?  <i>-Kisa yo diw?</i></p>	Critical Ethnography & Transnationalism
		9.	<p>a) How long do you think it will take to treat your <b>participant's term</b> (Probe: why do you think so?)  <i>-Konbyen tan ou panse lap pran pou geri <b>participant's term</b> ?</i></p> <p>b) Why do you think so?  <i>-Sak fe ou panse sa?</i></p>	Critical Ethnography & Transnationalism
Aim 2	What do you do to care for your <b>participant's term</b> ?	10	<p>How has it been for you since your diagnosis with - <b>participant's term</b> - ?  <i>-Depi kile out e fe dyagnostik <b>participant's term</b> ?</i></p>	Critical Ethnography & Transnationalism
	What do you think about the medications that your health care provider gave you?	11	<p>What do you think is the treatment for <b>participant's term</b>  <i>-Kisa ou panse ki ka trete <b>participant's term</b> ?</i></p>	Critical Ethnography & Transnationalism

<p><i>Ki sa ou panse de medikaman dokte ou ba ou?</i></p> <p>What other things do you take in addition to the medications your health provider gave you?  <i>Ki lot bagay an adisyon de medikaman dokte ou pran pou tansyon?</i></p>	12	<p>a) Do you think you have your <b>participant's term</b> under control?  <i>-Eske ou panse ke <b>participant's term</b> sou kontrol?</i></p> <p>b) How so?  <i>-Sak fe sa?</i></p>	Critical Ethnography & Transnationalism
	13	<p>a) The last time you went to the doctor and they measure your blood pressure, what numbers did the doctor tell you?  <i>Denye fwa out e ale kay dokte pou mezire tansyon, ki nimerò dokte a te diw?</i></p> <p>b) do you think that number was a good number?  <i>-eske ou panse nimerò sa se yon bon nimerò?</i></p>	Critical Ethnography & Transnationalism
	14	<p>a) What have you been doing since your diagnosis to care of your <b>participant's term</b>?  <i>-Kisa wap fe depi dyanostik ou wan pou kontrole <b>participant's term</b> ?</i></p> <p>b) how did you learn about this?  <i>-Kijan ou te fe apran de sa?</i></p> <p>c) are you still currently doing <b>participant's term</b>?  <i>-eske ou toujou ap fe sa?</i></p> <p>d) <b>if not:</b> what are you currently doing to care for you <b>participant's term</b>?  <i>-? -Kisa wap fe kounyea pou kontrole <b>participant's term</b> ?</i></p> <p>e) Why did you change to this approach?  <i>-Poukisa ou chanje fason?</i></p>	Critical Ethnography & Transnationalism
	15	<p>How is this approach helping you with your <b>participant's term</b>?  <i>-Kisa fason sa ap edew avek <b>participant's term</b> ?</i></p>	Critical Ethnography & Transnationalism

		<p>16 a)Did your doctor give you any medication for your <b>participant's term</b> ? -Eske doktew te baw medikaman?</p> <p>b)what are these medications? -Ki medicaman yo ye?</p> <p>c)How are they working for you? -Kisa ou panse de yo?</p> <p>d)how are they helping you with your <b>participant's term</b> -Kijan yo edew ak <b>participant's term</b> ?</p>	Critical Ethnography & Transnationalism
		<p>17 a)Which approach do you use the most to help you with your <b>participant's term</b> The medications that the doctor gave you or <b>participant's term</b> -Ki sa ki edew plis, medikaman dokte bawou oubyen <b>participant's term</b></p> <p>b)how so? -Sakfe sa?</p> <p>c)Can you give some examples? -eske ou ka banmwon kelke egzamp?</p>	Critical Ethnography & Transnationalism
		<p>18 What are the things that make it difficult for you to manage your <b>participant's term</b> -Ki sa ki ran li difisil pou ou kontrole <b>participant's term</b> ?</p>	Critical Ethnography & Transnationalism
		<p>19 a)I have heard that some people go to priest, to care for <b>participant's term</b> what do you think about these approaches? -Mwen tande ke gen moun ki itilize paste, prèt, oubyen vodou prèt, ki sa ou panse de sa?</p> <p>b)Can you tell me more about that? -Eski ou ka palem plis de sa?</p>	Critical Ethnography & Transnationalism

		20	<p>a)I have also heard that some people use prayers to care for their <b>participant's term</b> what do you think about this approach?  <i>-Mwen tande tou ke gen moun ki itilize pryè pou <b>participant's term</b> kisa ou panse de sa?</i></p> <p>b)Can you tell me more about that?  <i>-Eske ou ka pale plis de sa?</i></p>	Critical Ethnography & Transnationalism
		21	<p>a)what about those who use herbal doctors What do you think about that?  <i>- E moun ki itilize dokte fey, ki sa ou panse de sa?</i></p> <p>b) Can you tell me more about that?  <i>-eske ou ka pale plis de sa?</i></p>	Critical Ethnography & Transnationalism
Aim 3	<p>How do you think being an immigrant influences the way you manage your <b>participant's term</b>?</p> <p>What roles do your relationships with your friends and family in Haiti and in the U.S. play in your management of your <b>participant's term</b>?</p>	22	<p>a)We have just discussed your experience with your <b>participant's term</b> and what you have been doing to help manage it. Now I would like to talk to you about how being an immigrant in America and your connection with Haiti influence your management of you- <b>participant's term</b> Can you tell me when you moved to the United States?  <i>-Nou fenk fin pale de eksperyans ou ak epi de jan ou kontrole <b>participant's term</b> Kounye mwen ta renmen pale avek ou de jan lavi imigran nan etazini avek koneksyonw ak moun ayiti enflyen jan ou kontrole <b>participant's term</b> Eske ou ka dim ki le out e vin o zetazini?</i></p> <p>b)How was that transition for you moving from Haiti to the United States?  <i>-Ki jan li ti ye pou ou kite ayiti pou ou vini o zetazini?</i></p>	Critical Ethnography & Transnationalism
	How do you think working at a	23	<p>Why did you move to the United states?  <i>-Poukisa ou te vin viv o zetazini?</i></p>	Critical Ethnography & Transnationalism

<p>hotel as a housekeeper influences your management of your <b>participant's term</b>? How do you think being an immigrant influences the way you manage your <b>participant's term</b>?</p>	24	<p>a) Can you tell me more about your experience as an immigrant in the United States? -<i>Eske ou ka palem de eksperyans ou anta ke yon imigran kap viv o zetazini?</i></p> <p>b) Go on -<i>ou te met kontinye</i></p>	Critical Ethnography & Transnationalism
	25	<p>a) How do you think being an immigrant influences your management of your <b>participant's term</b>? -<i>Kijan ou pans eke lavi imigranw enflyuansè jan ou kontrol <b>participant's term</b>?</i></p> <p>b) Can you tell me more about that? -<i>Eske ou ka palem plis de sa?</i></p>	Critical Ethnography & Transnationalism
	26	<p>a) Were you diagnosed with <b>participant's term</b> ? -<i>Kile dokte te baw diagnostic ke or te fe <b>participant's term</b>?</i></p> <p>b) So that was after or before you moved to the United States? -<i>Donk sa te apre ou byen avan ou te vin o zetazini?</i></p>	Critical Ethnography & Transnationalism

		<p>27 a) Do you keep in touch with your friends and family in Haiti?  <i>-Ekse ou kenbe kontak ak zanmiw ak fanmiw an ayiti?</i></p> <p>b) How often do you communicate with them?  <i>-alo kijan ou kominike avek yo?</i></p> <p>c) Do you talk to them about your <b>participant's term</b> ?  <i>-Eske ou pale avek yo de <b>participant's term</b>?</i></p> <p>d) What do you say?  <i>-Ki sa ou di yo?</i></p> <p>c) What do they tell you?  <i>-Kisa yo diw?</i></p>	<p>Critical Ethnography &amp; Transnationalism</p>
		<p>28 a) Do your friends and family in Haiti ever send you medicine for your  <i>-Ekse zanmiw ak fanmiw an ayiti kon voye remed pou ou pou</i></p> <p>b) How do they send them?  <i>Kijan yo voye yo?</i></p>	<p>Critical Ethnography &amp; Transnationalism</p>

		<p>29 a) You mentioned that you keep in touch with friends and family in Haiti, Have you ever been back to Haiti since you moved to the United States?  <i>-Ou dim ke ou kenme kontak ak zanmi e fanmiw an ayiti, eske ou janm retounen ayiti depi le ou vini o zetazini?</i></p> <p>b) how often do you go?  <i>-Shak kile wale?</i></p> <p>c) How do these trips to Haiti influence your management of your <b>participant's term</b> ?  <i>-Kijan voyaj say o enflyuansè jan ou kontrole <b>participant's term</b>?</i></p> <p>d) Do you stop taking or replace any medications once you are in Haiti?  <i>-Eske ou diskontinye ou byen ramplase oken medikamen le ou rive an ayiti?</i></p> <p>e) Why?  <i>-Poukisa?</i></p>	<p>Critical Ethnography &amp; Transnationalism</p>
		<p>30 a) How would you describe your relationship with your friends and family in Haiti?  <i>-Kijan ou ta dekri relasyonw avek zanmiw ak fanmiw an ayiti?</i></p> <p>b) Can you tell me more about that?  <i>-Ekse ou ka palem plis de sa?</i></p>	<p>Critical Ethnography &amp; Transnationalism</p>
		<p>31 a) Do you send them money ?  <i>Eske ou kon voye lajan pou yo?</i></p> <p>b) How often?  <i>-Shak ki le?</i></p> <p>c) How much money would you say you send to Haiti every month?  <i>-Konbyen kob ou kadi ke ou voye ayiti shak mwa?</i></p>	<p>Critical Ethnography &amp; Transnationalism</p>

	32	As you know, I am not only interested in what you think about your <b>participant's term</b> and how being an immigrant and your friends and family in Haiti influence your management of you <b>participant's term</b> , I am also interested in understanding the role that your work play in the management of your <b>participant's term</b> <i>-Konm ou déjà konnen, mwen non Selman enterese de sa ou panse o sije de ak jan ou kontrol <b>participant's term</b> jan lavi imigranw ak relasyon ak zanmi ak fanmi enflyanse jan ou kontrole . Mwen enterese tou de jan travay ou enflyanse jan ou kontrole <b>participant's term</b></i>	Critical Ethnography & Transnationalism
	33	In order to participate in the study, you have to be working as a hotel housekeeper. Can you tell me about your work? <i>-Pou ou te ka patisipe nan etid sa, fok ou se yon moun kap travay nan fe menaj nan otel. Eske ou ka palem de travay ou?</i>	Critical Ethnography & Transnationalism
	34	a)What type of hotel are you working in? <i>-Nan ki otel wap travay?</i>	Critical Ethnography & Transnationalism
	35	a)How would you describe your work place? <i>-Kijan ou te ka dekri travay ou a?</i> b) How so? <i>-Sak fe sa?</i>	Critical Ethnography & Transnationalism
	36	How long have you been working there? <i>-Konbyen tan ou genyen wap travay la?</i>	Critical Ethnography & Transnationalism
	37	How did you find out about this work? <i>-Kijan ou te fe konnen de travay sa?</i>	Critical Ethnography & Transnationalism
	38	a)Can you walk me through a typical day at work for you? <i>-Eske ou ka palem de kijan yon regilye jounen nan travay ou ye pou ou?</i>	Critical Ethnography & Transnationalism
	39	a)what is your schedule like? <i>-Kijan skedil ou ye?</i>  b) How do you think this schedule influences your management of your <b>participant's term</b> <i>-Kijan ou panse skedil sa enflyanse jan ou kontrole <b>participant's term</b>?</i>	Critical Ethnography & Transnationalism

		<p>40 a)How do you think your work is with flexibility? -<i>Kijan ou panse travay ou ye ak fleksibilite?</i></p> <p>b)How do you think this <b>If flexible say: flexibility; if not flexible say: lack of flexibility</b> influence your management of your <b>participant's term</b> -<i>Kijan ou panse ke If flexible say: fleksibilite; if not flexible say:mank de flexibilite enflyanse jan ou kontrole participant's term ?</i></p>	Critical Ethnography & Transnationalism
		<p>41 a)How many rooms do you clean a day? -<i>Konbyen shanm ou netwaye shak jou?</i></p> <p>b) How do you think this responsibility of cleaning <b>State the number</b> rooms a day influences your management of your <b>participant's term</b> <i>Kijan ou panse responsabilite pou ou netwaye State the number shanm shak jou enflyanse jan ou kontrole participant's term</i></p>	Critical Ethnography & Transnationalism
		<p>42 a)I understand that many hotels have been renovated with new floors, countertops, and mattresses, are these renovations happening in your hotel? -<i>Mwen konpran ke yon ban otel ap renouvle sham yo ak kanban yo, eske otel ou a ap fe sa tou?</i></p> <p>b)What do you think about those renovations? -<i>Kisa ou panse de renouvelman sa yo?</i></p> <p>c)How do you think they influence your management of your <b>participant's term</b> -<i>Kijan ou pans eke renouvelman say o enflyanse jan ou kontrole participant's term</i></p>	Critical Ethnography & Transnationalism

		<p>43 a) If you have to take your medications for your <b>participant's term</b>, do you take them at work?  <i>-si pou ou pran medikaman pou <b>participant's term</b>, Eske ou pran medikaman yo nan travay ou?</i></p> <p>b)how is that for you?  <i>-Kijan sa mashe pou ou?</i></p>	<p>Critical Ethnography &amp; Transnationalism</p>
		<p>44 a)What resources are available to help you remember to take your medication while you are at work?  <i>-Ki resous ki gen nan travay ou ke edew sonje pou ou pran medicaman ou?</i></p>	<p>Critical Ethnography &amp; Transnationalism</p>
		<p>45 a)What inpeeds you from taking your medication at work?  <i>-Kisa ki anpeshew pran medikaman pou nan travay ou?</i></p> <p>b) Why do you think so?  <i>-Sak few panse sa?</i></p>	<p>Critical Ethnography &amp; Transnationalism</p>
		<p>46 a)I heard that many hotels do not provide insurance coverage to their hotel housekeepers. Is this the case in the hotel where you work?  <i>-Mwen tande eke anpil otel pay bay employe kap fe menaj yo asirans. Eske otel ou a bay asirans?</i></p> <p>b) Do you have other sources for insurance?  <i>-Ekse ou genyen lot sous pou asirans?</i></p> <p>b)How do you think <b>If insured say:</b> having health insurance influence your management of your <b>participant's term</b>? <b>If not insured say:</b> how do you think not having insurance influence your management of your <b>participant's term</b>?  <i>-Kijan ou panse <b>If insured say:</b> asirans enflyanse jan ou kontrole <b>participant's term</b>? <b>If not insured say:</b> Kijan ou panse ke san asirans enflyanse jan ou kontrole <b>participant's term</b>?</i></p>	<p>Critical Ethnography &amp; Transnationalism</p>

		<p>47 a) Do your co-workers and manager know about your <b>participant's term</b> ?  <i>-Eske kowoke ak manaje ou konnen de <b>participant's term</b>?</i></p> <p>b) how do they feel about you having <b>participant's term</b>  <i>-Kisa yo panse de oumen ki gen <b>participant's term</b></i></p> <p>c) What do they tell you?  <i>-kisa yo diw?</i></p> <p>d) Do they give you advise on how to manage your <b>participant's term</b>?  <i>-Eske yo kon baw konsey so kijan pou ou kontrole <b>participant's term</b>?</i></p>	<p>Critical Ethnography &amp; Transnationalism</p>
		<p>48 a) What other work do you currently have?  <i>-Ki lot travay ou genyen?</i></p> <p>b) What do you think the difference is between these two jobs and the way they influence your ability to manage your - <b>participant's term</b>  <i>-Ki diferans ou panse ki genyen ant de travay say o et jan yo enflyanse jan ou kontrole <b>participant's term</b>?</i></p> <p>c) How so?)  <i>-Sak fe sa?</i></p>	<p>Critical Ethnography &amp; Transnationalism</p>

Aims	Required Questions
<p>1.To explore how Haitian immigrant hotel housekeepers describe hypertension</p>	<p>You are participating in this study because your doctor told you that you have hypertension or high blood pressure. What do you think you have? What does that mean to you?  <i>-Wap patisipe nan etid sa paske dokte w te diw ke ou fe tansyon. Ki sa ou panse sa vle di?</i></p> <p>Tell me about your <b>participant's term</b>-  <i>-Palem de <b>participant's term</b></i></p> <p>What do you think causes your <b>participant's term</b> -?  <i>-Kisa ou panse ki baw <b>participant's term</b> ?</i></p>
<p>2. To identify strategies used by Haitian immigrant hotel housekeepers to manage hypertension</p>	<p>What do you do to care for your <b>participant's term</b>?</p> <p>What do you think about the medications that your health care provider gave you?  <i>Ki sa ou panse de medikaman dokte ou ba ou?</i></p> <p>What other things do you take in addition to the medications your health provider gave you?  <i>Ki lot bagay an adisyon de medikaman dokte ou pran pou tansyon?</i></p>
<p>3. To explore the influences of transnigrant life on hypertension management among Haitian immigrant hotel housekeepers focusing on resources within their social fields and employment opportunities.</p>	<p>How do you think being an immigrant influences the way you manage your <b>participant's term</b>?</p> <p>What roles do your relationships with your friends and family in Haiti and in the U.S. play in your management of your <b>participant's term</b>?</p> <p>How do you think working at a hotel as a housekeeper influences your management of your <b>participant's term</b>?</p>

**Closing**

**Say:** Thank you very much for taking time to talk to me today. Your information was very helpful in helping me understand how you manage your hypertension and how your immigrant life and your work influence your management of the disease.

**Turn the digital recorder off.**

**Remember to record interview end time:** \_\_\_\_\_

**Now Begin the Demographic Questionnaire**

## APPENDIX F: INDIVIDUAL INTERVIEW GUIDE: HAITIAN-CREOLE

Dat \_\_\_\_\_

Patisipan ID \_\_\_\_\_

**Marie-Anne Sanon, RN**  
**Envestigate Prinsipal**

Mesi anpil paske ou deside patisipe nan proje sa. Kom mwen te déjà diw, bi proje sa, se pou mwen konpran kijan ou kontrole tansyonw epi kijan laviw antan ke yon imigran e travay ou kom yon moun kap fe menaj nan otel infliyansè jan ou kontrole tansyonw. Entevyiu sa ap dire de 1 a dezedan. Repons o yo ap rete confidential. Mwen pap itilize repons ou yo pou lot rezon ke pou proje sa. Si gen yon kesyon ke ou pa tro konfotab pouw repon, nou ka sote kesyon an. Ou ka stopè entevyiu a nenpotle ou vle. Eske ou toujou enterese patisipe nan proje ya?

**If no, say:** Mesi pou tan ou ban mwne pou ou pale avek

**If yes, continue and say:** Avan mwen komanse, eske ou genyen oken kesyon? **If yes, answer the question. If no continue**

Avan mwne komanse entevyiu a, mwne bezwen konfime ke ou eligib pou patisipe nan proje ya. Mwen pral pose kesyon ke mwen te pozew déjà yo denye fwa.

Kounye a, mwen pral li krite yo. Apre shak fraz, sil vou ple di wi ou non

<i><b>Inclusion Criteria</b></i>	<i><b>Response</b></i>	<i><b>Action</b></i>
Eske out e fet an Ayiti?	Y N	If no, Ineligible
Eske wap viv nan Miami Dade County, Florida?	Y N	If no, Ineligible
Eske wap travay nan fe menaj nan otel?	Y N	If no, Ineligible
Eske ou gen o mwen 18 an?	Y N	If no, Ineligible
Eske ou ekri e di ak boush ou si ou dako pou patisipe nan proje sa/?	Y N	If no, Ineligible
Eske se yon dokte ki te diw ke ou fe tansyon?	Y N	If no, Ineligible

<i><b>Exclusion Criteria</b></i>	<i><b>Response</b></i>	<i><b>Action</b></i>
Eske ou genyen plis ke dizan depi wap viv o zeta zini?	Y N	If yes, Ineligible
Eske ou pi piti ke dizwitan?	Y N	If yes, Ineligible
Eske out e fet o zeta zini?	Y N	If yes, Ineligible
Ekse wap travay nan fe menaj kay moun/	Y N	If yes, Ineligible

**If ineligible, say:** Dezole men ou paka patisipe nan proje sa paske **state the reason.**” Mwen eskizem paske mwen pat realize sa denye fwa nou te pale

**If eligible, say:** Bon nouvel, you ka patisipe nan proje a. nou ka kontinye. Men avan mwen bezwen pou ou siyen fom konsantman pou nou ka fe entevyew a.

**Informed Consent**

Mwen pral li fom konsantman avek ou kounye a. Avek fom sa, wap banm pemisyon pou ou patisipe nan proje ya. Kounye a siyen fom nan. **Get the signature and then begin the interview.**

**After getting informed consent, say:** Mesi anpil pou siyati ya.

Kounye a, mwen ta renmen palew de entevyu a. entevyu sa ap genyen twa pati. Premyeman nap komanse pale te tansyonw lane pi kijan ou kontrolel. Apre sa, nap pale de komon la viw antan ke yon imigran ak travay ou enflyanse jan ou kontrole tansyonw. Epi map mandew lot enfomasyon tankou laj ou ak edikasyonw.

Eske mwen ka rekode kesyon ak repons nou yo pandan entevyu a?

**If the participant says yes, take out the audiotape recorder, and say:** Mwen pote yon plim ak yon ti kaye pou mwne ka pran not pout mwen pa blye sa wap dim yo. Eske mwne ka gen pemisyon pou mwne pran not?

**If the participant says no, do not take pen and pad out**

**If yes, take out notepad and pen.**

**Remember to record interview starting time:** \_\_\_\_\_

**Turn the audiotape on.**

**APPENDIX G: DEMOGRAPHIC DATA QUESTIONNAIRE**

Date \_\_\_\_\_

Participant ID \_\_\_\_\_

**Marie-Anne Sanon, RN**  
**Principle Investigator**

Now I would like to get some more information about your background. I will read each of the following questions to you and check your answer. Please feel free to skip the questions that you do not want to answer.

What is your gender?

*Ki sex ou?*

Female

Male

Other

How do you think being a (if male say: male; if female say female) influences the management of your **participant's term**?

*Antan ke yon----- kijan ou panse sex ou enflyanse jan ou kontrole.....?*

---

What is your age?

*Ki laj ou?*

18-25

26-35

36-45

46-55

56-65

How do you think being (being: state age) influences the management of your **participant's term**?

*Kijan ou panse laj ----- an enflyanse jan ou kontrol .....?*

---

What is your marital status?

*Eske ou marye?*

Single

Divorced

Separated

Partnered

How do you think being (state marital status) influences the management of your **participant's term**?

*Kijan ou panse..... enflyanse jan ou kontrole .....?*

---

How many people, including yourself, are there in your household?

*Konbyen moun kap viv avek ou nan kay?*

1       2       3       4       5        6-10       11-15      16+

How do you think living with **(state the number of people)** influences the management of your **participant's term?**

*Kijan ou panse viv avek ..... enflyanse jan ou kontrole .....?*

---

Is everyone in your household related to you?.....

*Eske tout moun kap viv avew se fanmi?.....*

How do you think living with .....influences the management of your **participant's term?**

*Kijan ou panse genyen .....nan kay you enflyanse jan ou kontrole.....?*

---

What is the highest level of education you have completed?

*Nan ki klas ou rive?*

1<sup>st</sup> – 5<sup>th</sup> Grade       6<sup>th</sup> – 9<sup>th</sup> Grade       High School

College       Masters       Doctorate

How do you think education influences the management of your **participant's term?**

*Kijan ou panse edikasyon enflyanse jan ou kontrole.....?*

---

What is your household's total annual income for the most recent calendar year?

*Konbyen kobo u fe shak ane?*

< \$ 10,000       \$11,000 - \$15,000       \$16,000- \$ 20,000

\$ 21,000- \$ 30,000       \$ 31,000- \$40,000       \$ 41,000- \$50,000

\$50,000+

How do you think your income influences the management of your **participant's term?**

*Kijan ou panse kob wap fe chak ane enflyanse jan ou kontrole.....?*

---

When did you come to the United States?-----

*Kile ou vini o zeta zini?-----*

How do you think living in the US since (**state number of years**) influences the management of your **participant's term**?

*Kijan ou panse la lavi o zeta zini enflyanse jan ou kontrole?*

When did you move to live in Miami-Dade County? -----

*Kile ou vini viv nan miyami? -----*

How do you think living in the Miami Dade County since (**state number of years**) influences the management of your **participant's term**?

*Kijan ou panse la lavi nan dade county enflyanse jan ou kontrole?*

How long have you been working as a hotel housekeeper? .....

*Konbyen tan wap travay nan fe menaj nan otel?.....*

How do you think working as hotel housekeeper for (**state number of years**) influences the management of your **participant's term**?

*Kijan ou panse job fe menaj sa enflyanse jan ou kontrole.....?*

How many rooms do you clean a day?

*-Konbyen shanm ou netwaye shak jou?*

3-5

6-10

11-15

16-18

18+

How do you think this responsibility of cleaning **State the number** rooms a day influences your management of your **participant's term**?

*Kijan ou panse responsabilite pou ou netwaye **State the number** shanm shak jou enflyanse jan ou kontrole **participant's term***

How often do you go back to Haiti?

*Shak ki le ou tounen an ayiti?*

Every 6 months

Every year

Every 2 years

Every 3 years

Every 4 years

Every 5 years

Every 6 years

Every 7-10 years

Every 10-15 years

How do you think going to Haiti every **State the number** influences your management of your **participant's term**

*Kijan ou panse ala ayiti shak....enfliyanse jan ou kontrole.....?*

---

Do you send money to friends and/or family members in Haiti?  
*Eske ou kon voye lajan bay zanmi w ou byen fanmiw an ayiti?*

Yes  No  (If no, skip to the end)

How do you think going to Haiti every **State the number** influences your management of your **participant's term**

---

How often do you send money to friends and/or family members in Haiti?-----  
*Shak ki le ou voye lajan bay zanmi ou byen fanmiw an ayiti?*

How do you think going to Haiti every **State the number** influences your management of your **participant's term**

---

How much monthly would you say you send to Haiti every month?-----  
*Konbyen kob ou voye shak mwa an ayiti?*

How do you think going to Haiti every **State the number** influences your management of your **participant's term**

---

**Say:** Thank you very much for taking the time to meet with me today. As a token of my appreciation for your time and help, I would like to offer you this \$20 dollar gift card. Do you know anyone who would be eligible and interested to participate in this study? **If yes say:** Would please give them my information for them to call me? **If yes: give the participant my contact information and say:** Thank you

Also would you feel comfortable taking pictures of anything or anyone from the United States, from Haiti, from work and from your everyday life as an immigrant that influence the way you define and manage your **Participant's term**? If you agree, I would give you this camera to take the picture within one week. After that I would take the camera from you and develop the pictures. This would involve me calling you back for a second interview after the pictures are developed. Just as before, you would tell me a time and place that would best work for you.

## APPENDIX H: PHOTOVOICE INTERVIEW GUIDE

Date \_\_\_\_\_

**Marie-Anne Sanon, RN**

**Principle Investigator**

Thank you very much for your willingness to meet with me again to discuss the pictures of what you think play a role in your **use the participant's term from previous interview** management. During this interview, I will ask you to tell me about the pictures you took This interview will last up to 2 hours, depending on how much you have to say.

Before we began: Is there anything that any of you would like to mention or ask about?

**If yes, answer the question. If no continue**

**If no, say:** thank you for your time and speaking with me.

<p><u>Aim I:</u> To describe how Haitian Immigrant Hotel Housekeepers Define Hypertension</p>	<p>Which of these pictures best depict how you define your HTN?</p> <p><i>Ki es nan foto sayo montre sa ou panse de participant's term?</i></p>	<p>For each individual picture chosen, I will ask:</p> <p>-Why did you take this picture? <i>Pouki sa ou pran foto sa?</i></p> <p>-What is really happening in this picture? <i>Sakap pase nan foto sa?</i></p> <p>-How does this picture relate to how you describe your <b>participant's term</b>? <i>Kijan foto sa montre sa ou panse de participant's term?</i></p>	<p>Other Questions to Ask:</p> <p>Was there any particular picture that you wanted to take but could not? Why? Why not?</p> <p><i>Eske te gen lot foto ke ou te vle pran men ou pat kapab? Poukisa?</i></p>
<p><u>Aim II:</u> To identify strategies used by Haitian immigrant hotel housekeepers to manage hypertension</p>	<p>Which of these pictures best depict how you take care of your HTN?</p> <p><i>Ki es nan foto sayo montre jan ou controle participant's term?</i></p>	<p>For each individual picture chosen, I will ask:</p> <p>-Why did you take this picture? <i>Pouki sa ou pran foto sa?</i></p> <p>-What is really happening in this picture? <i>Sakap pase nan foto sa?</i></p> <p>-How does this picture relate to how you take care of your <b>participant's term</b>? <i>Kijan foto sa montre jan ou controle participant's term?</i></p>	<p>“other study participants have stated that ..... What do you think about that?”,</p> <p><i>Lot patisipan yo dim ke .....ki sa ou panse de sa? “</i></p> <p>“when we met the last time, you mentioned that..... can you elaborate on that please? How does this picture that you are showing me depicts what you told me?”.</p>
<p><u>Aim III:</u> To explore the influences of transmigrant life on HTN management among Haitian immigrant hotel housekeepers focusing on resources within their social field, and employment</p>	<p>Which of these pictures best depict the influence of your immigrant life and work as a hotel housekeeper on your HTN?</p> <p><i>Ki es nan foto sayo montre jan la vi imigran ou ak travayou</i></p>	<p>For each individual picture chosen, I will ask:</p> <p>-Why did you take this picture? <i>Pouki sa ou pran foto sa?</i></p> <p>-What is happening in this picture? <i>Sakap pase nan foto sa?</i></p> <p>-How does this picture relate to how being an immigrant and a hotel housekeeper influence <b>participant's term</b>? <i>Kijan foto sa montre jan lavi imigran ou ak travay ou enfluyanse jan ou kontrole participant's term?</i></p>	<p>How does this picture that you are showing me depicts what you told me?”.</p> <p><i>denye fwa nou te rancontre, ou te dim ke..... eske ou ka palem de sa plis? Kijan foto sa ke wap montrem kounye a pale de sa ou te dim nan?;I</i></p>

	<i>enfliyanse jan ou controle</i> participant's term?		
--	---	--	--

## APPENDIX I: FIELD NOTES FOR INDIVIDUAL INTERVIEW

Date \_\_\_\_\_

Participant ID \_\_\_\_\_

**Marie-Anne Sanon, RN**  
**Principle Investigator**

I already received permission from the participants to take notes before we began the interview.

	<i><b>Interview Process Check List</b></i>	<i><b>Notes</b></i>
Establishing Rapport	<ul style="list-style-type: none"> <li>- How were the interviewer and the participant positioned during the interview session? Did the positioning reflect power difference? Was the positioning changed during the interview session?</li> <li>- Did the participant look relaxed during the interview? If not, note when did the participant looked not relaxed? Indicate the length of non-relaxed period.</li> <li>- Was the participant comfortable with the questions being asked? If not, note the non-verbal cues.</li> <li>- Was the interview environment private throughout the interview? If not, note what caused the invasion of privacy? What did the interviewer do to ensure privacy?</li> </ul>	
Interview Questions Aim 1:	<ul style="list-style-type: none"> <li>- Did the researcher ask all the required questions on the interview guide? If not, please note what was added or what was deleted? Why the change occurred?</li> <li>-Did the participant understand all the questions? If not, which questions were misunderstood?</li> </ul>	
Aim 2:	<ul style="list-style-type: none"> <li>- Did the researcher ask all the required questions on the interview guide? If not, please note what was added or what was deleted? Why the change occurred?</li> <li>-Did the participant understand all the questions? If not, which questions were misunderstood?</li> </ul>	
Aim 3:	<ul style="list-style-type: none"> <li>- Did the researcher ask all the required questions on the interview guide? If not, please note what was added or what was deleted? Why the change occurred?</li> <li>-Did the participant understand all the questions? If not, which questions were misunderstood?</li> </ul>	

**APPENDIX J: FIELD NOTES FOR PHOTOVOICE INTERVIEW**

Date \_\_\_\_\_

Participant ID \_\_\_\_\_

**Marie-Anne Sanon, RN**

**Principle Investigator**

I already received permission from the participants to take notes before we began the interview. In addition, I have already listen to the digitally recoreded interview of each participants before I meet with them a second time for the photovoice interview.

	<b><i>Interview Process Check List</i></b>	<b><i>Notes</i></b>
Pictures	-Is the participant able to discuss why he/she took the picture?	
Comparison from individual interview	-Did any of the pictures and discussion of the pictures generate different data compared to their individual interviews? -Did the pictures and discussion of the pictures generate any new information about the topic? If so note which new information?	
Aim 1	Which pictures did the participants show as depicting how they describe hypertension?	
Aim 2	Which pictures did the participants show as depicting the way they manage their hypertension?	
Aim 3	Which pictures did the participants show as depicting how being an immigrant influence the way they manage their hypertension? Relating to resources within social fields?  Relating to employment opportunities as hotel housekeepers?	

**APPENDIX L: Letters for the Community Leaders & Business Owners for Recruitment**



Name of leader or Business Owner  
Name of Organization  
Address

Greetings (Name of Leader or Business Owner)

My name is Marie-Anne Sanon. I am pursuing my doctorate at the University of Washington, School of Nursing. Thank you for helping me with my study. My goal with this study is to understand how Haitians who were born in Haiti and are now living in Miami Dade County and are working as hotel housekeepers manage their hypertension.

I understand that as a (community leader or business owner), you have regular interactions with these individuals and I was wondering if you could help get the word around about my study. I would like to also get your permission to post flyers in your facility about the study.

Thank you very much for your help. Please do not hesitate to contact me if you have any question.

Sincerely,

Marie-Anne Sanon, RN

Principal Investigator  
University of Washington  
School of Nursing  
(716)-903-7152  
V2@.u.washington.edu

## APPENDIX M: Screening the Potential Participants

Date \_\_\_\_\_  
 Participant ID \_\_\_\_\_  
**Marie-Anne Sanon, RN**  
**Principal Investigator**

Hello, this is Marie-Anne Sanon. Thank you for calling me and taking an interest in my study. As you may already know, I am a student at the School of Nursing at the University of Washington. I am pursuing my doctorate degree. I am conducting a research study to understand how you manage their hypertension. I am interested in knowing about your work as a hotel housekeeper and how you think it might affect your management of your hypertension. Finally I would like to know about how your family and your friends both in the United States and from Haiti influence your management of your hypertension.

If you agree to participate in the study, I will ask you to meet with me face to face to do an individual interview. After the interview, I will ask you some information about your background. Lastly, I will give you a camera to take pictures and will meet with you again to discuss the pictures and how they influence your hypertension management. Both the individual interviews are expected to last up to 2 and a half hours. The interviews will audiotaped. I will also take notes during the interviews.

Would you be interested in participating in this study?

**If No Say:** thank you for your time and for calling me

**If Yes Say:** Now I will go over the eligibility criteria with you. Please say yes or no after each statement

<i><b>Inclusion Criteria</b></i>	<i><b>Response</b></i>	<i><b>Action</b></i>
Were you born in Haiti?	Y N	If no, Ineligible
Do you currently live in Miami Dade County, Florida?	Y N	If no, Ineligible
Do you currently work as a hotel housekeeper?	Y N	If no, Ineligible
Are you at least 18 years of age?	Y N	If no, Ineligible
Are you capable of providing oral and written informed consent?	Y N	If no, Ineligible
Have you been told by a medical doctor that you have hypertension?	Y N	If no, Ineligible
<i><b>Exclusion Criteria</b></i>	<i><b>Response</b></i>	<i><b>Action</b></i>
Have you been living in the U.S. for over 10 years?	Y N	If yes, Ineligible
Are you under 18 years of age?	Y N	If yes, Ineligible
Were you born in the United States?	Y N	If yes, Ineligible
Is your housekeeping work at a private home?	Y N	If yes, Ineligible

**If ineligible, say:** “I am so sorry you cannot participate in the study because **state the reason.**”  
 Thank you very much for calling me.

**If eligible, say:** Great! You are eligible. Now we can set a time and place that would work for you to do the individual interview.

Date \_\_\_\_\_ Time \_\_\_\_\_ Place \_\_\_\_\_

**APPENDIX N: Screening the Potential Participants for Recruitment**

Date \_\_\_\_\_  
 Participant ID \_\_\_\_\_  
**Marie-Anne Sanon, RN**  
**Principal Investigator**

Hello, this is Marie-Anne Sanon. Thank you for giving me your phone number and taking an interest in my study. As you may already know, I am a student at the School of Nursing at the University of Washington. I am pursuing my doctorate degree. I am conducting a research study to understand how you manage their hypertension. I am interested in knowing about your work as a hotel housekeeper and how you think it might affect your management of your hypertension. Finally I would like to know about how your family and your friends both in the United States and from Haiti influence your management of your hypertension.

If you agree to participate in the study, I will ask you to meet with me face to face to do an individual interview. After the interview, I will ask you some information about your background. Lastly, I will give you a camera to take pictures and will meet with you again to discuss the pictures and how they influence your hypertension management.. Both the individual interviews are expected to last up to 2 and a half hours. The interviews will audiotaped. I will also take notes during the interviews.

Would you be interested in participating in this study?

**If No Say:** thank you for your time and for calling me

**If Yes Say:** Now I will go over the eligibility criteria with you. Please say yes or no after each statement

<i><b>Inclusion Criteria</b></i>	<i><b>Response</b></i>	<i><b>Action</b></i>
Were you born in Haiti?	Y N	If no, Ineligible
Do you currently live in Miami Dade County, Florida?	Y N	If no, Ineligible
Do you currently work as a hotel housekeeper?	Y N	If no, Ineligible
Are you at least 18 years of age?	Y N	If no, Ineligible
Are you capable of providing oral and written informed consent?	Y N	If no, Ineligible
Have you been told by a medical doctor that you have hypertension?	Y N	If no, Ineligible
<i><b>Exclusion Criteria</b></i>	<i><b>Response</b></i>	<i><b>Action</b></i>
Have you been living in the U.S. for over 10 years?	Y N	If yes, Ineligible
Are you under 18 years of age?	Y N	If yes, Ineligible
Were you born in the United States?	Y N	If yes, Ineligible
Is your housekeeping work at a private home?	Y N	If yes, Ineligible

**If ineligible, say:** “I am so sorry you cannot participate in the study because **state the reason.**”  
 Thank you very much for calling me.

**If eligible, say:** Great! You are eligible. Now we can set a time and place that would work for you to do the individual interview.

Date \_\_\_\_\_ Time \_\_\_\_\_ Place \_\_\_\_\_

## **APPENDIX O: Notation System for Interview Transcriptions**

This notation system will be used to transcribe the interviews for the study. It will help capture the interaction and meaning-making process between the participant and the researcher. The notation system will incorporate emotions, tones and hesitations throughout the interactions. This notation system was adopted and modified from Mishler's transcription notations.

<b>Symbols/Notations</b>	<b>Signification</b>
	Creole word in a English Conversation
Italics	Signifies the use of gestures to accentuate words
...	Incomplete Sentences
(...)	Inaudible/unclear (unable to understand the words)
P	Pause
[bp]	Brief Pause
[lp]	Long Pause
[l]	Laughing
[=]	Overlapping (two people talk at the same time)
I	Interviewer/Researcher

APPENDIX P: Support Letter From Church Leader

NEW VISION WORSHIP CENTER, INC.

9900 NW 7<sup>TH</sup> AVENUE

MIAMI, FLORIDA 33150.

PH: (305) 335-5103.

FAX:(305) 694-0026.

E-mail: [pastorpeterson@bellsouth.net](mailto:pastorpeterson@bellsouth.net).

501© (3) organization.

TAX ID #: 34-2034966.

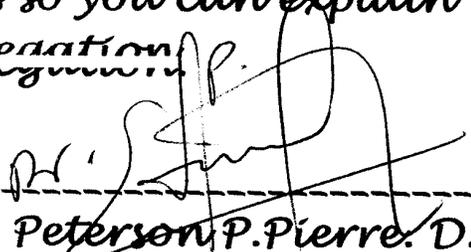
STATUS: Public charity 170(b) (1) (A) (1).

Attn: Ms. Marie Anne Sanon, RN.

*Greetings in the name of the Lord;*

*I was delighted to meet you and we will be more than happy to help you in your research project concerning how the Haitians who were born in Haiti and are now living in Miami Dade county, Florida and are working as hotel housekeepers manage their hypertension.*

*You are free to post your flyers in our facility and we are willing to invite you to speak at one of our meetings so you can explain your project to the congregation.*

  
-----  
Rev. Peterson P. Pierre, D.DIV.

Senior Pastor/Teacher/Chaplain.

## **Appendix Q. An Experience To Learn More About Hotel Housekeeping Work**

*Disclaimer:* No data or information learned from this educational experience will be used as data for the research study. This was an experience for a course where I chose a specific industry to spend a day and learn about the work. I was able to gain a better prospective of the characteristics of hotel housekeepers and their work.

On Monday April 20th, 2009, I was able to spend a day at a hotel in Federal Way, Washington to observe and learn how hotel housekeepers work. This preliminary field work took place in Washington and not Florida. This preliminary field also had Hispanic immigrants and not Haitian immigrants. However this field work opportunity gave me a better sense and understanding of what hotel housekeeping is all about and what the job entails. This ability to observe, learn and be exposed to the context of hotel housekeepers is a great source of data and knowledge for ethnographic research (Faulker & Patiar, 1997). A month ago, I contacted the housekeeping manager of the hotel who finally gave me her approval. Per our conversation, my goal was to come and get a better understanding of hotel housekeeping. I arrived at the hotel at 7:30 AM. The manager I spoke with was on vacation but a supervisor was present.

The supervisor spoke very minimal English and someone from the front desk had to translate in Spanish for her the purpose of my visit to the hotel. I was then left alone with her in the room while she was filling out paper work. Although I do not speak Spanish fluently, I can pick up some words. Therefore the supervisor was able to explain to me what she was doing. For example she had to fill out a form which was the assignment form to tell the housekeepers which room was vacant, which was still occupied, which rooms do not need sheet changes. She also showed me the schedule sheet which is done every week. The

typical work hours for the housekeepers in this particular hotel were 7 hours (8 am to 3 pm). They do not get paid for lunch and do not receive medical insurance. They are not part of a union.

At around 8:00 the supervisor met with everyone (housekeepers-women, and the houseman) to give them their room and floor assignments. Each person had between 13-14 rooms to clean within those 7 hours. The amount of room assigned and the time frame they had to clean those rooms matched the reports from the existing literature on hotel housekeeping (Fruming et al., 2006; Krause, Scherzer, & Rugulies, 2005; Waldinger, 1997). There was only one houseman that day and he was in charge of vacuuming and shampooing the floors along with the task of bring towels and emptying the carts filled with dirty laundry and waste.

I was not surprised to notice that the entire housekeeping staff of the hotel was composed immigrants. When I asked, I was told that they were from Mexico and that they referred the job to one another. This observation also matches what is reported in the existing literature that housekeepers are primarily immigrants and women of color (Atkinson, 2001; Thomas, 1993).

The supervisor assigned me to follow someone who I will call Maria. Maria spoke a little English. I was able to stand and watch how she did the work. One particular thing I noticed was that housekeeping work was similar to a science as everything had to be systematic. Maria used her card to knock on the door and told me that using the card protected her knuckles because she has to do the knocking all day. She knocked three times every time for each room and said "housekeeping" before she made an entry. Some rooms had the "do not disturb" sign on the door knob and were skipped for later. The bathroom had

to be clean a specific way using different types of chemicals. The shower curtain and towels had to be arranged in a design that was taught upon hiring. The bed had to be made in a very specific way along with the pillow arrangements. Maria admitted to me that she did not use many of the chemicals that they give her because she sneezes, coughs, and her eyes burn when she sprays them.

After watching Maria clean 3 rooms, I was able to learn to do the work myself. It was challenging for me for many reasons: My knees started hurting after kneeling on the floor to clean the bathtub. When I tried not to lean, I would slip. The chemicals were indeed difficult to breathe in once they were sprayed. I was sweating and got thirsty very quickly. One time I had to use the restroom and I had to go from the 5th floor to the 1st floor to the housekeeping break room to use it. This made me realize the stress that these workers are under because they only have a certain amount of time (not more than 30 minutes) to clean each room. The pillows had to be put in the pillow cases in a particular way and I was having a little hard time making them look the way they were supposed to. The mattresses were heavy, and they had to be lifted each time to fix the corner of the sheets. A big part of the work involved bending down which can easily lead to back problems. The cart (see picture 1) was heavy and difficult to maneuver within the narrow hallways. Carrying the big vacuum while handling the cart made it even much more challenging for me. The work is very isolated. Maria told me that she usually turns on the radio in the alarm clocks in the room so that she does not feel so lonely. At 12:30, we took our 30 minutes break, which is not paid for. Then we returned to the finish the rest of the rooms. By the time the shift was over at 3:00 PM I was really exhausted. I gave flowers to "Maria" and the supervisor as an appreciation for having me for the day.

## **Appendix R: Text for Thank You Cards**

Dear Mr. or Mrs. or Ms. (participant's name).

I would like to thank you very much for your time and support of my dissertation research on Hypertension management among Haitian immigrant hotel housekeepers within the context of their transmigrant life. Thank you very much for sharing your stories and experiences about your hypertension, and your work.

Again thank you,

Sincerely,

Marie-Anne Sanon

## Vitae

Marie-Anne Sanon, PhD, MN, RN

### **EDUCATION**

Doctor of Philosophy in Nursing, 2012

University of Washington, School of Nursing, Seattle, WA

Masters of Nursing in Communities, Populations and Health, 2010

University of Washington, Tacoma, WA

Bachelors of Science in Nursing, 2006

University at Buffalo, Buffalo, NY

### **FUNDING**

Hester McLaws Nursing Scholarship Award, School of Nursing, University of Washington  
2010

Sigma Theta Tau International- Psi Chapter-at-Large Grant, 2010

### **SCHOLARSHIP**

*Manuscripts- Accepted*

**Sanon, M.A.** (2012). Application of Transnationalism Theoretical Framework to Nursing  
Practice and Research. *Nursing Science Quarterly*

*Manuscripts- Under Review*

**Sanon, M.A.** & Watkins, S. Bugs on uniforms: is this a public health Concern?

*Book Chapter-Invited*

Evans-Agnew, R., **Sanon, M.A.**, & Boutain, D. (2013). Critical research methodologies and  
social justice issues: A methodological example using photovoice. In *Social Justice as  
Praxis: Philosophies and Practices of Emancipatory Nursing*. Routledge.