

Cross-cultural issues in women's health care

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SUMMARY

In the 1990s explosion of women's health research, some populations have still received limited attention, specifically, immigrant women. There is insufficient data on immigrant women's health that we need for public health services and there is almost no policy. It is difficult to learn about the magnitude of the problem across the U.S. because there is no national data base that documents the location and numbers of the many immigrant populations. Problems faced by immigrants are described mainly anecdotally or for selected immigrant or refugee groups, such as the Hmong in Minnesota or Mexicans in California. Until very recently, federal and state agencies have shown a lack of awareness and interest in these populations. And during the past decade we have seen legislation that actively discriminates against immigrants and immigration.

While my focus today is on immigrant women's health, much of what I will talk about applies to women who represent many kinds of diversity, in particular, ethnicity and socioeconomic status.

Key words: *Stressors (risk factor), Women's health, Immigrants women, United state, Women, Politics.*

Major Issues in Immigrant Women's Health

Immigrant and refugee women's health issues are both complex and global. They are global because of the enormous number of people who move across national boundaries for a variety of reasons. As of the end of 1998, there were 13.5 million refugees and asylum seekers worldwide and nearly 3.5 million others in refugee-like situations (U.S Committee on Refugees, 1999). Some 80% of refugees are thought to be women and children.

The Immigration and Naturalization Service (INS) defines an immigrant as a nonresident alien admitted for permanent residence. In contrast, a refugee is someone who is admitted outside normal quota restrictions based on a well

founded fear of persecution because of race, religion, nationality, social group, or political opinion. An asylum seeker arrives here and then applies for refugee status. The 4th category is "Illegal Alien," a term with negative connotations. Instead, I used "undocumented," which means the person does not possess documents allowing him or her to reside in the U.S.

The number of people admitted from any one nation is influenced by the U.S. Government's political relationship with that specific nation. For example, during the 1980s, Central Americans were not considered refugees despite the probability that the great majority would have been classified as refugees because they fled to save their lives.



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Before the former Soviet Union pulled out, Afghanistan was the largest source of refugees in the world. Since then, it has been difficult for Afghans to immigrate to the U.S. despite the deplorable conditions in that country, while El Salvadorans and Guatemalans now comprise the majority of the 651,000 refugees and asylum seekers admitted to the U.S. last year. California far and away has the largest number of immigrants and refugees.

Theoretical frameworks

Three frameworks help us view the health of immigrant women: acculturative stress, transition theory, and marginalization. Briefly, acculturative stress can affect health status with include physical, psychological and social aspects (Williams & Berry, 1991). Transitions cause significant changes in both person and environment over a period of time in which there is a loss of social support, a sense of disequilibrium and uncertainty about the future (Schumacher & Meleis, 1994), and feelings of loss of identity, vulnerability, being uprooted and having to function in a new setting in which women feel emotionally and culturally unprepared (Stevens, Hall, & Meleis, 1992).

Hall, Stevens and Meleis (1994) define marginalization as being "distinguished from the norm in a situation with negative attribution associated with being different. Immigrant women share the situation of being marginalized with impoverished women and women of color. Their accents or appearance set them apart in the eyes of people from the dominant culture, who may express anything from mild disrespect to virulent prejudice. Marginalized people lack power in many realms. In health and social services, marginalized

people tend to guard information that may expose their differences or further marginalize them; they disclose personal information only to those they trust. They face many types of institutional barriers to health-care. Marginalization is created and enforced by societal values, which influence the philosophy upon which health care systems are built. These systems tend to perpetuate these myths and stereotypes (Meleis, Lipson & Muecke, 1995).

Because immigrant women's health issues are highly complex. I will use a framework to help us categorize some factors that influence their health. I want to emphasize strongly that most of these issues are not unique to immigrant women - a few are common to all women and more are common to minority and poor women.

A Framework for Examining Major Issues in Immigrant Women's Health

There are a number of ways of categorizing influences on the health of women immigrants. For example, Afghan refugees in the United States experience three types of stressors: (1) the traumas people faced in Afghanistan, like having observed atrocities, imprisonment/torture of self or family members, difficult escapes, and loss of family, property, culture, and social status; (2) current daily concerns engendered by news and information from Afghanistan; and (3) current resettlement and adjustment issues in U.S. society (Lipson & Omidian, in review). This framework divides stressors into five major areas: (1) social risk factors, (2) psychological risk factors, (3) physical risk factors, (4) environmental risk factors, and (5) health care access problems. Obviously, there is a great deal of overlap and interaction between these issues, and different risk factors are highlighted for different women. In listing risk factors, we do not want to emphasize only risks or pathology. Women vary in their strength and coping mechanisms, and many develop great strengths through coping effectively with these stressors.

1. Social risk factors

Multiple roles and responsibility overload: Because of economic need, many immigrant women have two jobs; they are also homemakers and many care for other relatives. In one example, a woman accompanied her brother to the DMV



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to help him get his driver's license because he cannot speak English, made a doctor's appointment and interpreted for her sister, did the paperwork to sponsor her oldest sister's immigration to the U.S., and took care of her when she arrived. This woman works in a restaurant, making salads for minimum wage, cooks the family meals and does all the housework. If a woman is the only family member who drives, she may not be able to keep a job because she cannot refuse when family members ask her to drive them to appointments and school.

Jobs with low pay and no benefits. Immigrant women often work in situations that tend to oppress them more. They tend to be in dead-end, low status and low prestige occupations, and often work triple shifts in their daily lives (Lipson & Miller, 1993; Weitzman & Berry, 1992). They are often more able and willing than are their husbands to take jobs like fast food clerk, domestic work, hotel maid, or family owned small grocery store attendant. In some instances, they have limited control over the money they earn. Their work is not reflected in statistics, and they are considered non-productive (Meleis, Lipson & Muecke, in press).

Poverty and lack of education. Education among women immigrants varies widely, but in many of the countries from which the women came, girls have less access to education than do boys; in some refugee groups, such as Afghans and Hmong, older women may have had no education at all. In general, refugees who were professionals in their own countries are downwardly mobile and rarely regain their former social status. Other families improve their economic situation in the U.S., usually because everyone in the family is working very hard at two or more jobs. But the women often do not have access to the money they earn; even if the woman is the main wage earner, her check goes to the family. Many immigrant women lack financial security and governmental support. Relevant questions are "What kind of governmental support should immigrants or refugees receive? What kinds of help? Training? English classes? Money? Does financial support or welfare reinforce dependency?"

Language. Inadequate English is one of the strongest barriers to integration into the U.S. It blocks communication with neighbors, keeps women from learning the "rules" and easier ways of accomplishing their everyday needs, and keeps them from better paying jobs. Some immigrant women speak adequate, if accented, English, but do not read or write it. A related topic is the recent heavy discussion of *ebonics* in the schools, and last week's Chronicle article on Hawaiians use of pidgen English.

Lack of social support, isolation. Immigrant women with children at home are often very isolated and lonely. Many do not live near immigrants from their home country, and may not be able to speak enough English to relate to neighbors. In patriarchal societies, husbands may insist that they not leave the house. Their former social support systems, consisting of female relatives and other extended family members, neighbors, and old friends, are not available, and they cannot socialize in the customary way. Many women describe missing most the opportunity to drop in on each other daily, which they cannot do in the U.S. where people make appointments to visit and there is little available leisure time for informal socializing.

Ethnic bias, public and legislative xenophobia. Immigrant women suffer because of unfriendly neighbors and outright hostility in their immediate communities. They are frustrated and saddened by constant reminders that they do not belong, which make their integration into the mainstream even more difficult (Hattar-Pollara & Meleis, in press). Immigrants feel stereotyped, misunderstood and set apart. They work hard at creating a more familiar atmosphere in which they can relate to other people by finding some common ground, which also takes energy. People in host societies are rarely sufficiently patient to accommodate the time it takes to find common ground.

Bias is a source of stress. The general public does not discriminate between a legally admitted refugee or immigrant and an undocumented person, or an American citizen with an accent and dark skin. Everyone who was born elsewhere must bear the brunt of the current anti-immigrant wave. Beginning with Proposition 187 and continuing with welfare reform, legislation and current events promote visible discrimination. Newcomers in particular may be afraid to seek health care, not understanding that they are entitled to such services, even when they have appropriate documents. Even oldtimers with Green Cards were panicking until the regulations were softened. Example: old women in Fremont.

Risks for undocumented women. Undocumented women experience legitimate paranoia; they limit their activities for fear of discovery, deportation, only seeking health care in acute crisis. They are at risk for spousal abuse, health problems, poverty, and many other problems (DeSantis, 1992).

2. Psychological risk factors

Immigrant women have often lost family members, property, their country and culture. Many experience an undercurrent of unresolved grief attached to their losses, particularly refugees who have experienced many such losses and would not have chosen to leave their homes had they a choice.

Post-traumatic stress disorder. PTSD is a serious health outcome of refugee flight. Many refugee women who seek health care do so for symptoms of PTSD, such as nightmares, sleep disorders and somatic complaints. Psychological complaints include depression, withdrawal, avoidance, loneliness, persecution reactions, apathy, hopelessness, death/dying themes, loss of self-confidence (Boehnlein, 1987; Kinzie et al, 1984; Shepard & Faust, 1993), reexperiencing the traumatic event, and numbing of responsiveness to, or reduced involvement with, the external world. PTSD can be chronic and last several years or emerge after a long delay. It is frequently misdiagnosed.

Home country conflict. Mainstream health providers rarely recognize the impact of ongoing preoccupation with home among immigrants from war-torn countries; they cannot imagine the power of news and worry about relatives who remain. Frequently, immigrants' mood, stress level and symptoms change as the news changes, sometimes on a daily basis when they come from countries that are highly unstable politically. Thus, the concept of transnationalism is very important in considering the situation of immigrant women who are strongly tied to home through events and visits back and forth (Lipson & Omidian, 1996).

Culture conflict. This stressor is a common issue for immigrant women; the work of managing daily life with inadequate English, money and transportation make life doubly difficult. Those of us who have lived in other countries will remember our initial exhaustion from just attempting to function effectively from day to day, even if we knew the language. A more subtle issue is the North American value of individualism and individual rights, which conflicts with the collectivist cultures from which many immigrant women come. The very fabric of Euro-American life emphasizes individual choices and rights, which confuses women who have a difficult time perceiving themselves as individuals –instead, they see themselves as family members. Being asked to make decisions for themselves in health care when they expect that their family will make this decision illustrates this conflict.

Family role change. Immigrant women's puzzle about their proper roles in the U.S.. In some immigrant groups, women seem to acculturate more quickly than men do; they become caught between the immigrant community's expectations that they behave traditionally and their desire for American-style freedom and independence. Because women often get jobs more easily than their spouses can, there may be family conflict when the husband is not working. Disturbing the traditional patriarchal role can cause marital problems. Children acculturate much more rapidly than their parents do; they come home from school asserting their individual rights learned from teachers and peers. Women are often more tolerant of their children's acculturation than are men. The women are the culture brokers; they are the family mediators between husband and children, children and school, and perhaps other relatives and social and health care agencies. They are the ones who integrate the family into the new culture and yet they are expected to maintain their cultural heritage, its values and norms (Meleis, 1991; Hattar-Pollara & Meleis, 1995).

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Domestic violence. Although we know that family violence crosses cultural, economic and educational lines, we have little trustworthy hard data on rates for immigrant women. A current study being conducted by Ayuda, a domestic violence program for Latino women, is finding that 60% of undocumented Latina women have been battered by their intimate partners, and 77% married to U.S. citizens and permanent residents batter their women (National Council for Research on Women, 1995). In addition to not fully understanding the prevalence of abuse, we have little knowledge of interventions that might be culturally sensitive. For example, women might ask whether it is not easier to find ways to live with the violence than to escape to homelessness.

These are areas of needed research (Frye & D'Avanzo, 1994). We do know that many patriarchal cultures condone husbands "disciplining" their wives when they are not properly submissive. We also know that many immigrant husbands' self-esteem is shattered by their inability to obtain a decent job or any job at all, to perform their accustomed roles of supporting the family and representing it to the outside world. These men may become very depressed, angry or abuse substances which may be related to abusing their wives and children.

Most immigrant women, regardless of their legal status, fear the legal system. Even documented women often believe that reporting domestic violence can lead to their deportation. In many cases, the batterer never filed immigration papers for his immigrant spouse and many batterers use immigration law as a tool to hold their wives and children in violent homes. In addition to fear, in many immigrant groups it is culturally unacceptable to divulge such private information as family relationships to an outsider. Cross-culturally, however, women's shame and feeling that they may be responsible is extremely common.

3. Physical risk factors:

Pathogens from home or transit countries. Immigrants have higher rates of Tuberculosis and Hepatitis B than does the general population (USDHHS, 1990). They may arrive in the U.S. with parasites, such as schistosomiasis and other diseases, that are not readily recognized in primary care. Genetic problems also may not be recognized, like Glucose 6 phosphate dehydrogenase deficiency or Thalassemia common in Mediterranean people, which causes anemia.

Numerous pregnancies. Many immigrant women have married very young and have borne many children. Numerous pregnancies cause wear and tear on women's bodies and such immigrant women in their 40's may appear to be much older than their chronological age. For example, prolapsed uterus is more common at a young age.

Poor past nutritional status. Poor nutrition may have been associated with poverty, long stays in refugee camps, or countries in which men and children are always served first. Current nutritional status may be negatively affected by adoption of a high sugar, fat and salt fast food diet, or food preparation methods that are unhealthy, such as using excessive oil or overcooking vegetables.

Specific practices. Some women come from countries in which specific practices can pose health risks, such as female circumcision or chewing betel nuts, which leads to gum and tooth damage. Health providers may not recognize

Many immigrant women are taken advantage of because only a few jobs are available to them, such as workshops run by people from their own countries. For example, there have been occasional newspaper articles describing local sweatshops, like a group of Thai women who had been promised good jobs if they came to the United States;

such practices or may greet such women with fear and loathing, further traumatizing them. Yewoubdar Beyene has been working to teach health providers about how their attitudes impede access to care for many African refugee and immigrant women.

Poor prevention. health promotion practices. While engaging in adequate physical activity is becoming more commonplace among Euro-American women, it is rarely practiced by women in many immigrant groups. Many factors interfere, such as lack of knowledge of the importance of physical activity for health, work/family responsibilities that allow no time for self-enhancing activities, transportation or financial problems, modesty, and cultural viewpoints about the inappropriateness of exercise for women. Diet, however, is much more commonly regarded as part of health promotion, and this is an area where women immigrants can change and reduce their own health risks and those of their family members. Example: Bosnians and Pap and self-breast exam.

4. Environmental risk factors

Neighborhood violence. In some areas in which new immigrants and refugees settle, poverty, drugs and gangs are part of the everyday reality. For example, in some neighborhoods, women and children remain imprisoned in their houses for safety all day until the father or adult gong come borne to take them out. This is definitely the case in North Richmond. Two of my students did a community assessment of the Laotian community there and this was an enormous problem for women and young children.

Poor housing and crowding. Related to the above, immigrant women who live in impoverished neighborhoods often live in polluted environments,

including exposure to lead in paint or from traffic and industry pollutants. Their houses may be inadequately insulated, and they may face other environmental hazards associated with poor housing. The high price of housing causes enormous crowding in some immigrant populations. For example, in the Canal District of San Rafael, there may be as many as 20 undocumented Central Americans living in 2 bedroom apartments. In our recent study of Bosnian refugees in Santa Clara County, we met many extended families sharing small apartments.

Worksite hazards. Many immigrant women are taken advantage of because only a few jobs are available to them, such as workshops run by people from their own countries. For example, there have been occasional newspaper articles describing local sweatshops, like a group of Thai women who had been promised good jobs if they came to the United States; however, when they arrived, they were imprisoned in the sweatshop, worked at slave labor for almost no money, and threatened with arrest and deportation if they complained to anyone.

5. Health care risks

Legislation. There continues to be fallout from California's Proposition 187 and its counterparts in terms of psychological effects on immigrants, particularly in California, but elsewhere as well. In California, it is still common for many permanent and legal residents to avoid seeking health care because they misunderstand the implications of this legislation or do not know that it has not yet been implemented. Others are afraid of being suspected, discriminated against, or provided poor quality care because they think that health care providers are arms of the INS. This kind of legislation has many implications for health care providers, for example, how will we know who is suspected of not being a legal resident? Language? Skin color? Should health care providers be placed in the position of being police?

No insurance/financial barriers. Not having sufficient money to pay for health care is a barrier common to poor or minority women in general. Some refugee populations had access to Medicaid, but in some areas, few physicians now accepting; in other areas, conversion of Medicaid to HMOs or managed care has effectively blocked access to immigrant women for some the reasons described below. Lack of health insurance was one of the biggest concerns voiced by the Bosnians we interviewed recently. Of course, the high percentage of uninsured people in the U.S. is a national disgrace.



Language barriers. Language is a major barrier to access to health care. A quote from an Afghan woman depicts this well: "It's very hard to get to the doctor. One person has to find the right kind of doctor and one who takes Medi-Cal. Another person has to make the appointment. One has to drive us there. One has to translate" (Lipson & Omidian, 1992). Using family members as interpreters is fraught with issues; often, a child is the only family member who speaks enough English but does not have the maturity or vocabulary to interpret adequately. Picture a 12 year boy from a strongly modest culture and social separation of men and women being asked to interpret for his mother at a GYN appointment. Often, children or family members withhold from health providers information that may show a parent in a negative light. Gender matching is important in many cultures.

Transportation, child care. These issues, as well as the last two, are common to poor women of any background. Transportation is a bigger issue in the suburbs than it is in central cities. A child care complication is in new immigrant communities where it is culturally inappropriate to leave one's children with strangers or even to leave them home at all. I was amazed by an Afghan wedding that began in the evening and the last guests, including babies and toddlers, left at 4 a.m. Kids accompany their parents wherever they go, including women's health care appointments. Or, 3 or 4 kids at home will keep women from leaving.

Clinic structure/hours. Many immigrant women cannot obtain health care because clinic hours are the same as working hours, or if long waits preclude being able to be seen during a lunch hour. They may be at risk of losing their jobs if they take time off if ill or seek care for themselves or family members.

Health providers' lack of knowledge. Health providers from the dominant culture often do not understand immigrant women's experiences, explanatory frameworks of illness, or communication patterns. Examples are victims of torture or war who experience post-traumatic stress disorder or other symptoms related to what they have gone through, or different ways of describing the body, e.g., telling a health provider that "my kidney is hot." ⑤

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Appendix

Selected Resources on Immigrants and Refugees

Journals

Journal of Refugee Studies

Quarterly, research, programs, subscription
Oxford University Press Walton Street
Oxford OX2 6DP United Kingdom
+44(0)186556767
FAX +44(0)1865 267782

International Migration Review

Quarterly, research, programs, subscription
Center for Migration Studies of New York,
Inc. 209 Flagg Place
Staten Island, NY 10304-1199
(718)351-8800
FAX (718) 667-4598

Refugees

Monthly, programs, news, free
United Nations High Commissioner for Refugees
P.O. Box 2500
CH 1211. Geneva 2 Depot
Switzerland
(022) 739-81 11
FAX (public information) (022) 739 84-49

Refugee Reports

Monthly, statistics, news, subscription
U.S. Committee for Refugees News Service
1717 Massachusetts Ave., NW, Suite 701
Washington, DC 20036
Subscriptions: Sunbelt Fulfillment Services
P.O. Box 5026
Brentwood. TN 37024 (615) 377-3322

Migration and Health

Quarterly, newsletter, free
IOM International Organization for Migration
17, Route Des Morillons
CH-1211 Geneva 19
Switzerland

Migration and Mental Health Newsletter Newsletter, free

WIAD
Wissenschaftliches Institut der Ärzte
Deutschlands e. V.
Godesberger Allee 54
D-53175 Bonn, Germany
+49-228-8104-172
FAX +49-228-8104-155

Journal of Immigrant Health

Books (numerous)

See especially CORI PUBLICATIONS
(American Anthropological Association)
1992 Selected Papers on Refugees and Immigrants. Volume I *Pamela A. Devoe*, ed.
1993 Refugee Empowerment and Organizational Change: A Systems Perspective. *Peter W. Van Arsdale*
1993 Selected Papers on Refugees and Immigrants. Volume II *MaryCarol Hopkins and Nancy D. Donnelly*, eds.
1994 Selected Papers on Refugees and Immigrants. Volume III *Amy Zaharlick and Jeffrey L. MacDonald*, eds.
1996 Selected Papers on Refugees and Immigrants.. Volume IV *Ann Rynearson and James Phillips*, eds.
1997 Beyond Boundaries: Selected Papers on Refugees and Immigrants. Volume V *Diane Baxter and Ruth Krufeld*, eds.
1998 Diasporic Identity. Selected Papers on Refugees and Immigrants. Volume VI

Carol Mortland, ed.

1999 Negotiating Power and Place at the Margins: Selected Papers on Refugees and Immigrants. Volume VII. *Juliene Lipson and Lucia Ann McSpadden*, eds.

Organizations

U .S. Committee for Refugees
1025 Vermont Ave. NW, Suite 920
Washington, DC 20005
(202) 347-3507

Amnesty International, USA
322 Eighth Ave.
New York, NY 10001

InterAction

1717 Massachusetts Ave, NW, Suite 801
Washington, DC 20036
(202) 667-8236

Websites

UNHCR: <http://www.unhcr.ch/>
Bureau of Population, Refugees and Migration:
<http://www.state.gov/www/global/prm/index.html>
Immigration and Naturalization Service:
<http://www.ins.usdoj.gov/graphics/>
Committee on Refugees and Immigrants
(American Anthropological Association):
<http://www.ameranthassn.org/corihead.htm>
Center for Immigration Studies: <http://www.cis.org/>
Migration Dialogue: <http://migration.ucdavis.edu/>
Refugee Health Website: http://www.baylor.edu/~Charles_Kemp/refugee_health.htm

U.S.Census Bureau: www.census.gov