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Articles

Women's Roles and Women's Health: The Effect of Immigration on Latina Women

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Several articles in the literature address the health beliefs and practices of immigrant Latinos. It is well established that a woman's roles, and her ability to carry them out, have a significant effect on her health and the health of her family. As a clinician caring for immigrant women from Mexico, I sought to consider how Latina women's health and the health of their families may be impacted by the immigration process itself.

Data on the effects of international migration are scant.[1] In the United States, female immigrants outnumber male immigrants. These women face a number of barriers, including language difficulties, nationality differences, gender bias, limited skills or resources, physical dangers, and the absence of family or other social support networks.

Overcoming these barriers requires women to make numerous adjustments in their many roles and has been identified as an area in which additional research is needed.[2] The necessity for further research is evident when one considers that most health concerns of women are enmeshed with the financial and social aspects of their lives. Social science research relating to women's health must continue and must be complemented by traditional biomedical model approaches.

I draw from clinic experiences and present selected research findings in order to illustrate the implications of immigration on the roles of Mexican women in the United States. With the effects of immigration becoming a growing concern, my goal is to affirm the importance of this type of research and to encourage clinicians and planners to consider socioeconomic issues when developing health programs targeting women.

SEVEN ROLES OF WOMEN

An emphasis on family planning has focused attention on women's roles as child bearers and child care providers. In actuality, there are three major family roles women play—their reproductive and child care role, their role of maintaining the household, and their role in generating income for the household—and as many as seven roles have been identified.[3] The seven roles described by Oppong are considered in this discussion of the effects of immigration.

1049-3867/95/$9.50
1049-3867(94)0058-X

The *parental* role includes childbearing as well as socialization of children. A key issue in the parental role is a woman's degree of control over her fertility. The *occupational* role refers to those activities outside the home that contribute to the economic productivity of the household. This may include unpaid, informal work such as exchanging babysitting or refer to paid employment. The parental and occupational roles often compete for women's time and energy.

As a sexual partner, companion, and support person, women fill their *conjugal* roles, and the *domestic* role refers to a woman's maintenance of a home. Women's roles as *kin* are lived out as daughters and granddaughters, sisters, nieces, and in-laws. These relationships provide support for women but also carry expectations and obligations.

As a *community member*, women participate in church, political, voluntary, and other groups where they live. These are their contributions to communal well-being. Finally, as an *individual* woman, the desire for a sense of self as an individual, for personal growth, for self-expression, and for privacy are manifest.

Immigration may increase or decrease the number of roles women have. Challenges in enacting each of the roles in a new environment can follow immigration. The rapidity of role change as a result of immigration is stressful for women and their families. Indeed, some believe that "the issue of changing roles . . . seems to be a major contributor to psychological conflict and the development of symptomatology."[4]

THE EFFECT OF IMMIGRATION

Women who immigrate tend to fall into one of three groups. Young single women cross the border to escape unpleasant situations at home or are in search of an improved life situation. Married women often immigrate to accompany or join a spouse already in the United States. A third group of older women come to the United States to follow their grown children. Given that the groups are at varied points in their lives, immigration will affect the health of each age group differently.

The Parental Role

Immigrant women can have difficulty accessing the health care system. Not only must a woman realize there is a need to access the system for perinatal or pediatric care, for example, but she must then find a place to go, at a time she can get there, using transportation available to her, at a cost she can afford. These problems are compounded by language barriers and culturally unfamiliar or unacceptable practices. In addition, undocumented women fear discovery of their illegal immigrant status.

As parents, women may feel guilty about removing children from their familiar environment,[5] particularly if they move to an unsafe neighborhood in the United States. Immigrant parents must locate and enroll children in school, and access appropriate and timely pediatric and dental care. Alternatively, some women leave children behind in Mexico with relatives, send back remittances to help support them, and see their children only infrequently.

Occupational Role

Mexican families may pool funds to help a woman move to the United States if her perceived earning power in the United States offsets the initial expense to the family.[6] Such immigrants are unlikely to be heads of households, tend

to come from families with many adult members, and often have familial connections in the United States. Once working in the United States, the money sent back to families can be three times that which could be made locally in Mexico.

Women who work long hours as domestics may live some distance away from their familiars. The isolation, minimal job security, low pay, and lack of advancement all make it difficult for women to fulfill their other family roles.[7]

In a study of Mexican women who immigrated for seasonal employment,[8] work in the United States represented their first paid employment, which indicates that immigration had a significant impact on their occupational role. Women earned significantly less than their spouses. Women also tended to work fewer hours than men, using the time to meet the demands of their other roles. Compared with the immigrants who did not work, women wage-earners reported an increased sense of autonomy, more accomplishment, more confidence, and enjoyed buying previously unaffordable items.

Others[4] report that because it is sometimes easier for women to find work, women may experience a degree of role reversal and have "added pressures to perform multiple roles: to conform to traditional roles, fulfill the housewife role, accomplish occupational or career goals, and achieve personal growth."

Conjugal and Domestic Roles

Seasonal workers who have lived in both countries note that women can fulfill their expected conjugal and domestic roles in Mexico, even if not receiving paid employment. Women in the United States, however, find the lack of paid employment more of a problem. Such women become more dependent upon a partner or spouse for money, transportation, and assistance in fulfilling the domestic role. For these women, their inability to independently fulfill the domestic role created a loss of a role and put stress on the conjugal relationship. They not only had fewer roles than working women, but the few they had became more difficult to fulfill.

Some immigrant women with few supports may find themselves learning "to use sex and self to avoid a variety of frightening situations like emotional abandonment, physical harm, [and] extreme loneliness. . . . She may adapt to using sex as a strategy to avoid losing material goods, food stamps, money, belongings, or to avoid losing the protection of a man." The implications of increased risk of pregnancy, sexually transmitted disease, increased dependency, and decreased self-esteem are obvious.

Kin Role

Once Mexican families decide to immigrate, the decision about location is largely dependent upon the location of other family members. The importance of the kin role in women's lives is also reflected in the immigration pattern of older Mexican women. Those over 50 are three times more likely to immigrate to the United States than older men, and often immigrate to care for grandchildren.[8] Older Hispanic immigrants tend to have a more difficult time adjusting than do younger immigrants, and social networks such as church become important to maintaining emotional and physical health.[10]

The presence of existing family in the United States eases the emotional aspects of immigrating Mexicans,[6] but the sense of mutual obligations in assisting the new arrivals can be burdensome. Women may find they share crowded living environments with extended family members and acquaintances who are more hindrance than help.

Community Member

In their new setting, women fulfill their role of community member by connecting with church or becoming involved in their children's school or other community organizations. Little has been written about this component of the lives of immigrant women, but lack of familiarity with what is available, and unfamiliarity with norms can make this process difficult. Particularly for older immigrants, however, these ties outside the family are important for well-being.[10]

Individual Woman

Although economic considerations contribute to a Latina woman's decision to immigrate, economics are a more significant issue for her partner. That is, women who immigrated seasonally reported doing so out of a sense of adventure and out of a desire to keep the family together.

Studies among non-Hispanic women suggest that immigrants face a variety of conflicts.[11] These include the type of involvement and depth of relationships to form with those outside the family, employment and educational decisions, redefining one's normative way of dress or behavior, and deciding on one's degree of permanence in the new culture.

EFFECTS ON HEALTH

Stress

Authors studying other immigrant groups in the United States have suggested four stressors that affect health.[2] The first is the type or location of work. Women who are from a rural or more agrarian location and possess few job skills can experience an increase in stress via lack of job security. They may experience more conflict in a structured work environment as they juggle the demands of their various roles. Secondly, the development of a larger, expanded social network may be stressful if accompanied by increased obligations. Third, immigrants may have increased exposure to alcohol, which contributes to anger and aggression. Finally, the authors felt that altered perception of foods and developing food cravings was a stressful part of the acculturation process.

Mental Health

In a literature review of acculturation and mental health, women experience stress or loss whether or not they acculturate. Poorly acculturated Latina women may remain isolated from the dominant culture, and those who adapt more readily may find that they can no longer draw on their traditional cultural support.[13] The authors believe that women must find the middle ground, retain those cultural components that are affirming, and yet learn the new country's ways. Studies among Samoan immigrants[12] suggest that, although feeling lonely was common, those in the United States were more likely to have positive feelings about being in control and experience well being than those not immigrating.

Perinatal Care

Immigrant women have many demographic risk factors associated with lack of prenatal care. These include minority status, little education, and poverty.

Obtaining early prenatal care is less likely if women live in inner cities with little access to care or are unmarried.[14]

Other Issues

The health of Latina women is influenced by where she was born, her degree of permanence in the United States (is she a seasonal worker?), and her documentation status because this may affect her ability or willingness to seek access to health care in the United States. Many Latinos coming to the United States are from areas where they experienced the health problems associated with the inadequate public health of underdeveloped countries. Once in the United States lifestyle diseases become more pronounced. Mexican Americans experience more obesity, gallstones, and diabetes than do Anglos.[16] Mexican-Americans seem to have a genetic predisposition for these conditions, which is exacerbated by environmental factors such as diet.

Another health care issue is the lack of Hispanic providers. Hispanics constitute 9% of the total U.S. population and more than 25% of the populations of New Mexico, California, and Texas.[17] Yet nationally, only 4% of physicians and 3% of nurses are Hispanic.[8]

IMPLICATIONS FOR HEALTH CARE PROVIDERS

Different experiences in colonization are still reflected in differing views of health care. In the United States, the destruction of the indigenous Indian cultures coupled with the values of the colonizers resulted in a Protestant work ethic and a belief in the value of science. In contrast, Mexico retains elements of indigenous Indian medicine and belief systems mixed with Catholicism. It is not uncommon for symptoms to reflect a spiritual tension or be attributed to emotional upset or interpersonal stress.

Therefore, it is often helpful and enlightening to a clinician to elicit a woman's understanding of the etiology of her symptoms and any treatments used. The health provider and patient may not share a similar view of causality, but once familiar with the woman's point of view, the clinician can make an attempt to bridge the gap between the two. Information about treatments enables the clinician to affirm those which are helpful or neutral, and advise against those which may be harmful.

Because immigrant women are often finding their way within an unfamiliar community and within a confusing health care system, information offered by providers can be helpful. Work from the developing world suggests that the health of women and their families is improved when women's time conflicts caused by juggling multiple roles are minimized, education and training are offered, and income improved. Health care planners, by integrating services, can also help.[19] Women's health care services can be offered at the same time and location as pediatric services or combined with other social services, perhaps conveniently located at or near a school, densely populated area, or a worksite employing a large number of women.

For U.S. providers this translates into providing information about recommended routine health care schedules, healthy behaviors, and contraceptive and menopausal information when appropriate. Women need to be guided into other useful resources with which they may be unfamiliar, such as preschools and Head Start programs for children. Early and Periodical Screening, Diagnostic, and Testing is a federal program that offers free health screening for children from birth through 18 years. Office or clinic staff should be familiar with referrals to special educational or training opportunities such

as adult schools and other educational services and agencies assisting with financial issues, mental health, and legal problems.

However, the key is not referrals. The key is integration. Care and services must be available to women, accessible by women (linguistically and geographically), and affordable. Care and services must also be acceptable if the goal is to maximize their use by and benefit to women.

The young and robust Latino population stands in contrast to aging baby boomers. Latinos comprise a large percentage of the future work force and their health and education are important from an economic standpoint. Yet little is known about the special health care needs of Latino children and the contributions women make towards educating and ensuring the health of the next generation,[15] and even less is known about the experience of immigrant women and menopause, aging, and adjusting to altered roles.

Thus, women's roles are intertwined with their physical and mental health and that of their children and other family members. How these two concepts influence one another is worth exploring both quantitatively and particularly from a qualitative viewpoint. This is especially true for Latina women as their numbers and impact on the health care system will continue to increase into the next century.

ACKNOWLEDGMENT

The author wishes to recognize the significant contribution of Joanne Leslie, ScD, in the development of this article.

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