

**THE IMPACT OF INTERNATIONAL MIGRATION ON THE HEALTH OF
BRAZILIAN WOMEN LIVING IN AUSTRALIA**
**O IMPACTO DA MIGRAÇÃO INTERNACIONAL NA SAÚDE DE MULHERES BRASILEIRAS NA AUS-
TRÁLIA**
**EL IMPACTO DE LA MIGRACIÓN INTERNACIONAL EN LA SALUD DE LAS MUJERES BRASILEÑAS
EN AUSTRALIA**

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KEYWORDS:

International migration.
Woman's health. Qualitative
research.

ABSTRACT: The aim of this study was to give an account of the impact of international migration on the health of Brazilian women living in Melbourne, Australia. Based on a descriptive exploratory design, qualitative data was generated through participant observation, in-depth interviews and focus groups with 33 Brazilian women. Data analysis was done using QSR Nvivo. The main emerging themes were related to women's health problems, the lack of social support; and sociopolitical, sociocultural and socioeconomic barriers to access the healthcare services. The results of this study made evident that Brazilian women faced a diversified range of problems in the migration process to Australia. Such results proved to be consistent with those found in the literature.

PALAVRAS-CHAVE:

Migração internacional.
Saúde da mulher.
Pesquisa qualitativa.

RESUMO: Este estudo teve por objetivo investigar impactos da imigração internacional na saúde de mulheres brasileiras, que vivem em Melbourne, Austrália. Com base em uma abordagem exploratória descritiva, dados qualitativos foram obtidos com 33 mulheres, através da observação participante, entrevistas e grupos focais. A análise dos dados foi realizada através do QSR Nvivo. Os principais temas emergentes foram: problemas de saúde das mulheres, falta de apoio social e barreiras sócio-política, sócio-cultural e sócio-econômica para acessar os serviços de saúde. Os resultados deste estudo evidenciaram que as mulheres enfrentaram uma gama diversificada de problemas no processo de migração para a Austrália. Estes resultados foram consistentes com os encontrados na literatura.

PALABRAS CLAVE:

Migración internacional.
Salud de la mujer.
Investigación cualitativa.

RESUMEN: Este estudio tuvo como objetivo investigar los impactos de la migración internacional en la salud de las mujeres brasileñas que viven en Melbourne, Australia. Con base en un abordaje exploratorio descriptivo, datos cualitativos fueron obtenidos a través de la observación participante, entrevistas y grupos focales con 33 mujeres. En el análisis de los datos fue empleado QSR Nvivo. Los principales temas emergentes fueron relacionados a: problemas de salud de las mujeres, falta de apoyo social y barreras sócio-políticas, sócio-culturales y sócio-económicas como acceso a los servicios de salud. Los resultados del estudio evidenciaron que las mujeres enfrentaron una gama diversa de problemas en el proceso de migración para Australia. Los resultados obtenidos fueron consistentes con los encontrados en la literatura.

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INTRODUCTION

This paper gives an account of some of the findings of a larger study carried out with a group of Brazilian immigrant women living in and around Melbourne, capital city of Victoria, Australia. The interest in this study emerged from the Brazilian researcher's experience of living in different cultures and, mainly, from knowing of the experience of other Latin American and Brazilian women in different countries, such as, the United States, Canada and Sweden. Turned into marginalized ethnic minorities their lives undergo dramatic changes, which greatly impact their health and their access to health care services. Many of them consider the low English skill and low professional qualifications as barriers to social integration in the new country and to accessing social services, including health care services. The lack of studies on Brazilian immigrant women's health also called the Brazilian researcher's attention.

Brazilian women constitute an important immigrant group that deserves scholarly attention. The complexity and specificity of Brazilian women's health needs call for studies in different approaches that would provide a better understanding of the impact of international migration on women's health and on their family life. Acknowledgement of this complexity is crucial to encourage more effective, humanistic and comprehensively grounded approaches to women's health issues by health care professionals. It is also vital to guide education and research, as well as support the advance and effectiveness of health care policies appropriate for Brazilian migrant populations.

BACKGROUND

Several studies have shown the complexity and the specificity of the challenges faced by women in the international migration process, and the impact of migration in family life and society as a whole¹⁻². In spite of the well-documented international literature on women's migration, very little information and research exist in the area of international migration and minority women's health³⁻⁴. Studies in this area have documented that the health status of many new voluntary immigrant women is better than the population in the country from which they emigrated, as well as the country to which they immigrated⁴⁻⁷. This occurs as a result of the self-selected process of migration. Nevertheless, that health status of migrants often begins to deteriorate after arrival in the new

country⁶⁻⁸. The deterioration of women's health status has been related to many factors, such as, the uprooting period, differences in culture, lack of language skills, loss of extended family and a supportive community, change of economic and social status⁵⁻⁹, discrimination and intolerance, and parenting dilemmas⁹. To these factors must be added the poor access to appropriate health care and inability to negotiate health care needs, which may result in delays in seeking care⁶.

In the field of international migration's studies, Brazilian immigrant women's health remains under-researched. The only study found in literature is related to the domestic work of Brazilian immigrant women in the United States¹⁰. In this study the author concludes, "[...] physical and emotional overload and stress associated with domestic work and employment were identified as factors that diminished their health and quality of life"^{10:19}. One important reason for this gap in the literature is due to the fact that international migration of Brazilians is a recent phenomenon. The Brazilian emigration flow started to gain visibility during the second half of the 1980s, when the Brazilian economy underwent an economic crisis¹¹⁻⁵. Before that period there was no significant Brazilian emigration to other countries.

The crisis years of the mid-1980s worsened the position of Brazil's middle class contributing to a massive exodus of Brazilians to search for better opportunities elsewhere¹¹⁻⁵. In only three years (1985-1988) about 1.250.000 Brazilians left the country and did not return¹³. According to the report from the Foreign Affairs Ministry, in 1996, this figure increased to 1.560.162; the main destination countries of Brazilians immigrants were the United States (598.526), Paraguay (460.846) and Japan (201.139)¹⁶.

While Brazil has not been a traditional country of emigration and immigration, Australia is considered a traditional receiving country. Australia is one of the most multicultural nations with well over 100 different language and cultural groups making up its citizenry¹⁷. Melbourne is a remarkably diverse multicultural society, with a large proportion of British and continental European immigrants. However, in recent years Asian immigrants have added an important contribution to the cultural fabric of the Australian society.

Brazilian contribution to the total immigrant flow in Australia has been relatively small. The latest Census in 2001 recorded 4,704 Brazilian immigrants in Australia¹⁸. Victoria had, in 2001, the second largest number of Brazilian people (805), only exceeded by

New South Wales (2,518). Victoria was followed by Queensland (657) and West Australia (398)¹⁸. According to this data, Brazilian immigrants are still a largely unrecognised group in Australia.

The modest contribution of Brazilians to the total immigrant pool makes this group invisible and, consequently, scarcely noticed by policy-makers, demographers or the popular press¹¹⁻². In relation to Brazilian women's health, this invisibility may keep them on the margins of the receiving society not having access to health promotion and advances in health care. Brazilian women's socio-cultural background guides their beliefs about sickness and health. Professionals developing health care intervention and health-promotion activities should consider these cultural differences before implementing programs and projects for and with this group.

THE STUDY

Aim and research questions of the study

This paper is part of a large study, carried out between 2002 and 2003, which aimed to understand the context and cause(s) of Brazilian immigrant women's health problems in Australia and to build spaces for health promotion. The aim of this paper is to give an account of the impact of international migration on Brazilian women's health. The research questions in this study were:

- a) How does international migration affect Brazilian women's health?
- b) What health care problems have they faced since they arrived in Australia?
- c) How are they looked after in terms of health care services?

METHOD

This is a qualitative study in which a multi-method participatory research was used in order to answer the research questions.

Participants

Thirty-three women were recruited using a predominantly snowball sampling strategy proposed¹⁹. The initial contact with the women was made by telephone when the research goal, purpose and process were explained to them. All women contacted showed great interest in participating in this study.

Data collection

Qualitative data was generated through several related methods including participant observation, in depth individual interviews and focus groups.

Participant observation

Participant observation is an overall approach to inquiry and a data gathering method. Participant observation demands the researcher's involvement in the social world chosen for study, where she or he is able to experience the reality as the participants do²⁰. Participant observation was undertaken during the interviews, at focus groups and at all events carried out by the women's group during the research process²¹. Significant actions were described in details in the researcher's field notes, providing data for analysis.

In-depth individual interview

In-depth interviews were conducted between June 23 and August 28 2002, with 33 Brazilian women, 30 in their homes and three at the university. They were questioned about their preference to speak in English or Portuguese. According to their preference, 19 were conducted in English and 14 in Portuguese.

A semi-structured schedule for the interview included the following questions to guide the approach to the participants:

- a) Could you please tell me a brief history of your life experience in Australia?
- b) What health problems have you faced since you arrived in Australia?
- c) Why do you think that such problems exist?
- d) How you are looked after here in terms of Australian health care services?

The interviews were developed through an informal dialogue in which the participants were encouraged to reflect about their daily lives and identify their own needs or issues, primarily related to their health when living in Australia. The interviews lasted about 90 minutes and were tape recorded with the participant's consent. The interview transcripts were returned to the participants for validation of the information.

Focus groups

Focus groups are an inductive method of qualitative research, used to obtain information from participants' points of view²². Focus groups were

conducted using Wilkinson's²³ two key features, which position this approach as: 1) a contextual procedure, that avoid focusing on the participant devoid of social context, or separate from interactions with others; 2) relatively non-hierarchical procedure, which shifts the balance of power away from the researcher towards the research participants.

In this study, eighteen women participated in eight focus groups held in participants' houses. Thirteen women refused to participate in this stage of the research and two women returned to Brazil during this phase of the research. Among the reasons given to not participate were: the overload of demands with their professional or occupational life, household duties and the caring for children, and the lack of intention to be mixed up with Brazilians.

The focus groups lasted around 3 ½ – 4 hours. The focus groups were tape recorded, transcribed, analysed and later validated by the participants.

Data analysis

The data analysis was based on all contents audio-taped during the interviews, focus groups, as well as the researcher's personal field notes. The tapes containing the interviews were listened to several times before starting the transcription process. After the transcriptions were completed, the interviews in Portuguese were translated to English by the researcher. Then, the contents were read with the intention of achieving a sense of the data as a whole.

The data was analysed using open, selective and axial coding proposed²⁴, and managed by a computer program for the analysis of qualitative data - QSR Nvivo²⁵. The analysis was given to women for further discussion and clarification. Through this interactive process the participants validated the contents of the analysis. This process allowed for the emergence of new information related to the themes. The validation of the data was also carried out by sending the written research report to the participants.

Research rigour

The trustworthiness and credibility of this study were supported through: 1) triangulation by different yet complementary methods of data collection, such as, participant observation, in-depth individual interview and focus groups; 2) validation of all data collected from interviews and focus groups, the contents of analysis and a written research report given to

participants.

Ethical considerations

The proposal for this study was approved by the La Trobe University's Ethics Committee. The information provided by the participants remained confidential and anonymity was maintained through the use of code names chosen by the participants. The research started after participants were given a broad explanation about the research goal, purpose and process, and after formal written consent was obtained. Women were assured that they had the right to refuse to participate or to withdraw from the study at any time, and that confidentiality and anonymity were to be maintained throughout the study.

FINDINGS

Socio-demographic characteristics of participants

The 33 Brazilian immigrants ranged in age from 24 to 57 (the average age was 44), and had been in Australia for 3 to 33 years (the average was 15 years). The great majority of the participants came to Australia following their husbands (n=21) or partners (n=7), as compared to only five who decided to migrate on their own. The nationalities of their husbands or partners were Brazilian (n=20), Australian (n=4), Lebanese-Australian (n=2), Greek-Australian (n=1), and Italian (n=1). Among them, 20 had no children and 13 had one or two children. At the time of the study, 31 women were married or living with their partners, and just 2 reported being divorced. Almost all (n=28/33) had children.

Participants came from big- to middle-sized families. Eighteen women had more than four siblings, 14 had one to three siblings, and just one had none. They were born in different regions of Brazil, with a predominance of the Southeast Region (n=23), followed by Mid-West (n=5), South (n=2), Northeast (n=2), and North (n=1). From the total, 18 had previous migration experience (six as domestic migration and four as international migration). The reason to immigrate was for most of them to search for a better livelihood. The great majority of participants came to Australia with their family as a temporary immigrant and with the financial support of the Australian government. However, they ended up staying and currently almost all of them have acquired Australian citizenship.

At the time of migration, all of the participants possessed some form of education or occupational skill (15 had complete university degrees, 4 had incomplete university degrees, and 14 had vocational training). Nevertheless, like many other immigrants, they were not able to exercise their profession because their overseas university degrees had not been recognized in Australia. The lack of language fluency and the absence of Australian working experience were also factors that contributed to the change in their professional status.

Participants classified themselves as belonging to a middle-class group in Brazil, as well as in Australia. Almost all of them (n=25) were employed in Brazil before their departure, four were studying, and four were housewives. With the exception of one who came to Australia to work at the Brazilian Embassy, all of them were out of work for a short or long period after their arrival in Australia. At the time of the study, six women were out of formal work, helping their husbands, and five were housewives. Three of them were engaged in undergraduate courses. After migrating some women could not continue working in the same professional field as that of their previous education, and to work in another field required them to engage in new training courses. The women's professional or occupational activities were: maid (n=4), community service worker (n=3), computer programmer (n=2), employment consultant (n=2), childcare worker (n=2), receptionist (n=2), teacher (n=1), support access worker (n=1), librarian (n=1), travel agent (n=1), and ceramist (n=1).

The great majority of women (n=25) owned their houses. On average each house had 3-5 rooms (kitchen and bathroom not included). All houses were masonry, supplied with electricity, piped drinking water, and were connected with the public sewage and rubbish collection system. The main household appliances found in the women's homes were television sets, washing machines, refrigerators, microwave ovens, gas stoves, heaters and radios.

Emerging themes

The themes emerging from the data collected in this study were related to women's health problems, the lack of social support and barriers to access health care services.

Women's health problems

Brazilian women in this study reported good

health status at the time of the immigration to Australia. However, in this study, cancer (n=5), hay fever (n=5), hypertension (n=5), asthma (n=4), arthritis (n=3), and panic attack (n=2) were the most frequent health problems mentioned by the participants. Overweight (n=7) was another issue which, according to them, was associated with depression, anxiety disorders and changes in the diet and lifestyle. The feelings of emotional and social loneliness, depression and anxiety disorders were viewed as paramount concerns in Brazilian women's lives. Loneliness emerged as a result of the absence of a close intimate attachment, and social isolation as a response to the absence of an accessible social network²⁶. These conditions were present even after having lived in Australia for many years.

After a couple of years living here, I suffered from panic attacks and depression. I had no control over my thoughts. It was a very difficult time for me, as well as for my family. I had a thousand reasons to be happy but I wasn't. I was always very sad, and would often say, "I won't make it". I think that you can die of sadness. It wounds your heart and you feel like your body is giving in (Silvia).

Depression. I think that is the thing most Brazilian women have here. Being away from your family and your country can make you depressed. And there are a lot of people here with depression, a lot of Brazilian women here with depression (Carol).

Some of the participants seemed concerned about depression as they considered it a favourable condition for the emergence of other health problems. The causes most frequently related to depression were: nostalgia for being away from home, the sense of not belonging to Australian society, loneliness, lack of family support in Brazil, lack of a social network and lack of goals to fulfill their lives.

I find that the Brazilian community in general suffers from depression, which in my opinion is the cause of a chain of medical related problems (Cláudia).

I think depression is a symptom of not belonging here. The fact that you have to adapt, there are so many changes to make. Some of my friends have not been able to make the change because they have not had the support of their close family. The women tend to be unhappy, they cannot go home, they don't feel like they belong here. Some women go back and then return because of the economic situation. I know 2 or 3 families who tried to go back (Lena).

The lack of a social support to help them face health problems emerged as something which made the participants' lives more difficult.

The lack of social support

The lack of social support was referred to as a factor which generated insecurity, especially since they knew that growing old may sometimes be accompanied by even greater difficulties. Such insecurity seems to become stronger when they are informed that someone in the community is ill. This situation was observed during the time when this study was undertaken. A participant who had been diagnosed with cancer passed away. According to most of the participants, the need for support to overcome "hard times" goes against the lack of solidarity in the community. Participants' statements made evident the representation of Brazilians as naturally sympathetic people, but who change upon migration. According to them, such a perception is based on the disappointments experienced within the community.

I don't feel supported by the Brazilian community. Unfortunately, I don't know why, people here change from day to night. I think that if we were more united, a closer-knit group, it would be much better. Unfortunately, I've suffered a lot in that department. Now, my old age is teaching me how to live; I know I can't count on any friends. It's sad, to me, it's really sad because when I know someone, I'm very sensitive (Angela).

I have lots of Brazilians, I don't call them friends. They are not really close friends. I think there is something wrong in this Brazilian community because they should support each other a lot more and they don't really get together. The more I got involved in the Brazilian community the worse I felt, because they would start talking about each other behind your back. So it looked all right from the outside but on the inside it wasn't so great. I felt I was better off outside the Brazilian community (Tess).

Countless situations of isolation and lack of support during difficult times were mentioned. Though such situations have been detected in the present, they seem to have been worse in the early times of the migration process, when the language difficulty and the lack of knowledge about the new country were stronger. The lack of social support was also related to the lack of support at home, when they fell ill or went through difficult times with their children's health and could not count on the support of their spouses.

I was scared, I didn't have a family in Australia, I only had my husband and my parents-in-law, but they were from another culture. They didn't think the way I was thinking. I couldn't talk to my parents-in-law because they couldn't speak English. So I was insecure about going home

with a little baby. I needed someone to help me with that, to teach me how to look after that baby, to comfort me when I was stressed or when I just needed to talk. It was very difficult without the social and emotional support, it even crossed my mind to give the baby away. I didn't have experience and not having support from my husband made matters worse (Vera).

The women's lifestyle with work overload and shortage of time was considered as a factor that made them unavailable to provide support to one another. Being aware of this lack of time make some of the participants value the support they receive enormously. Those who had experienced serious health problems consider these times useful to revise their lives and to redirect them as new priorities come into play. In such a revision, solidarity emerges as a moral issue.

Our community here is small and not at all united. In my opinion, everyone suffers from lack of time and solidarity is nearly inexistent. People hardly have time for each other and it's a real shame (Raquel).

They don't have that time. You imagine if someone works, then they come home and can still come over, park and visit me when I'm sick. That visit, their time for me is very precious because I know they don't have it. I know they come home tired and still have to make dinner and everything else and instead they drop everything and come to see me. That means a lot (Lili).

The lack of social support to overcome times of uncertainty and change was highlighted in the statements of the participants in this study. It emerged as a strengthening aspect of the vulnerability experienced in face of their lives' peculiar condition. Lack of social support appears in the participants' discourses as being intimately connected to the lack of solidarity, which is seen as a personal phenomenon, as well as a social one, constructed in the course of life.

Barriers to access health care services

During the time of this study, all of the participants had accessed the Australian health care system, either public or private, to treat health problems or to have preventive medical examinations. All of the participants were unanimous in saying that women do face barriers in accessing the Australian health care services. Such barriers have been classified as being sociopolitical, sociocultural and socioeconomic barriers. The sociopolitical barrier comprised social isolation, the language difficulty, the lack of information about the health care system and about one's entitlement to health care. The sociocultural barrier included the

participants' expectations regarding the health care system. The socioeconomic barrier referred to the lack of economic conditions to afford private health insurance.

Sociopolitical barrier

The language barrier was mentioned by all of the participants as a great obstacle to the equitable access to health care services. This barrier was referred to as being greater in the first years of immigration, when social isolation and lack of information about the context were equally greater. The difficulty to negotiate health care needs was described as an experience which contributed to aggravate their emotional and health status. This experience led some of the participants to avoid resorting to health care services, which made their health problems more severe. Some stated that they had not even made the periodical preventive examinations, as they did in Brazil, because of the difficulty with the language, plus the lack of time, given that they were always busy with household chores and childcare. The language barrier made them dependent on their spouses, who were not always able to meet their needs.

The language barrier is very frustrating. It's very hard when you want to express yourself and you don't know how. [...] It's very difficult because you aren't speaking the language; you are not only facing health problems but you are facing other problems as well (Vera).

The language barrier generated a communication gap which led to a lack of understanding regarding medical diagnosis and medical prescriptions. Countless such cases appeared in the participants' statements. There were cases related to surgical procedures without the patient's being fully aware at the time.

I hadn't understood that I had broken the bone. Because if I had understood him, I would have been more careful. I continued working the same way and only later when I went to a specialist on osteoporosis, he saw my x-ray and said 'you have a fracture'. I said 'no', he said 'it's here'. I almost died and it had already been there for weeks. That's when I actually found out. Ah! I went running to argue with my doctor because he didn't explain it to me properly. He said that he had explained it. I said that he spoke inwards, that with me he had to speak outwards and explained that I had broken a bone (Lola).

At the time of this study, all of the participants were aware that the Australian health care system has an interpreter service which is paid by the Australian government. However, few women stated that they

had been through this experience. Except for one, all of them considered the health services unsatisfactory given the difficulty to find a translator for Portuguese, and the long wait to be able to schedule an appointment assisted by an interpreter. When the appointment finally happened, its short duration - 15 minutes - was not enough to describe their health problems, which contributed to render this experience unsatisfactory. In this regard, the short duration of a medical appointment was strongly highlighted as an aggravating factor in the situation.

Also, it's nearly impossible to get a translator to go to the doctor with you; it takes days. You have to schedule it for when they have a translator available (Leticia).

Several participants agreed that the language barrier leads to the ignorance of their rights regarding health care and effective disease prevention, due to the lack of access to important information about available resources. Even though there is available information on health care services and disease prevention, the language difficulty can make them inaccessible. According to the participants, such difficulty has decreased in the last few years, for there is greater access to other Portuguese-speaking community members and to a health care policy which is making such information available to immigrants of different language backgrounds.

If you don't know your health care rights this can be a major difference (Carla).

The sociopolitical barrier proved to be important regarding access to health care services, especially in the early times of the migration process, for it made prevention difficult, as well as the access to treatment and the recovery from illness.

Sociocultural barrier

In approaching health care services, general practitioners were those most often represented as being inflexible and insensitive to the participants' needs. Barriers arose mainly from cultural differences between medical practices in Brazil and Australia. They were related to the doctor-patient relationship, lack of trust in their general practitioner, the doctor's lack of interest in them as human beings, and lack of respect with regards to popular beliefs and alternative health care methods. The fact that in Brazil there was no equivalent of a 'general practitioner' at the time of migration led many of the participants to refer to doctors as unworthy of trust. The short period of the consultation was another frequent complaint, which led participants

to feel that doctors had rushed them through the consultation. They also complained about delays in accessing specialists, as well as the impossibility of buying certain drugs that they used to purchase in Brazil without prescription.

You know, doctors' appointments here are very fast, like five minutes to see a patient, which is one thing I don't agree with. Once I even called Medicare and complained. Usually I don't complain about things, but I think this sort of thing should go right. You cannot go to the doctor and have him ask 'what's your problem' and in five minutes you're out. In five minutes you don't even remember what the question is and why you went there (Iki).

The cultural barrier was present mainly in the doctor-patient relationship, which was mentioned by almost all of the participants. This barrier emerged from their need to be looked after as human beings, to engage in an interpersonal relationship, not in an impersonal one. Falling ill is a condition which participants saw as making them even more vulnerable and ends up increasing social isolation and uncertainty regarding the future.

It was really difficult to find a doctor whom I really liked, a doctor who would sit down with you, talk to you and listen to you; someone who is there because he really wants to help you; someone who cares, who is not there just for the money but with the aim to help (Vera).

There were comparisons made between the Brazilian and the Australian health care systems. In that regard, women evaluated the Brazilian system positively due to the longer consultation time and the better quality of the doctor-patient relationship. To the large majority of women in this study, the doctor-patient relationship in Brazil was warmer and doctors had a greater concern about the patient's psychological / emotional state as compared with the emphasis on biological factors in the Australian medical system. However, all of participants agreed that the access to public health care system in Brazil is much more delayed than in Australia.

The doctors are a lot warmer in Brazil. They have time for you, they talk to you, and they don't just treat you as a patient but as a person. When you go to the doctors here it is a very cold experience (Tess).

I think that people who depend on public health care systems in Brazil are more disadvantaged than here. Here you can get fast access to a General Practitioner, sometimes a 24-hour service, without too much hassle. At least you get the basics done (Márcia).

The sociocultural barrier was shown to be closely

related to the sociopolitical one, both being very much present in the participants' statements. Whereas the sociopolitical barrier was stronger in the early migration process, the sociocultural barrier tended to endure even after several years of residing in the country.

Socioeconomic barrier

Due to economic reasons, many participants mentioned not having private health insurance. This is, in their own opinion, a barrier to immediate access to secondary and tertiary health care and to better health care quality. The most frequent problems related to not having private insurance had to do with the delay in being seen by a specialist or when undergoing an elective surgery, as well as the lower quality of the services provided by the public health care services.

There's a lot of bureaucracy here. If you don't have private health insurance, you have to depend on these people. Now the General Practitioner has referred me to the gynecologist but I have to wait three months for the appointment (Lucy).

Some participants seemed concerned with the changes in the health care policies which took place in the last few years. According to them, these changes made evident the trend towards privatisation of the health care system. Another reason for concern was related to the decrease in the health care quality provided by the health care services in the last few years. If this trend does really happen, they feel they will be excluded from having access to an equalitarian, efficient and fair health care service.

The level of government health care has dropped dramatically over the years. The government is encouraging people to have a private health fund (Marcia).

In this study, the three topics presented, women's health problems, the lack of social support and barriers to access health care services comprised an entangled and complex web of events which make up the daily lives of the participants. Such topics brought evidence to a borderline and conflicting way of living.

DISCUSSION

In this study, 24 women reported having health problems such as: cancer, hay fever, hypertension, asthma, arthritis, and panic attack. They all mentioned being under treatment. These health problems have also been reported as the most frequent to all Australians⁴. Overweight was another issue mentioned by some of the participants.

Loneliness, social isolation and depression were

reported as being the primary concerns in the lives of the great majority of women. Nevertheless, many of them stated that they did not look for health care services to treat emotional problems because of the strong emphasis given by general practitioners on physical aspects and their lack of sensitivity regarding such complaints. Loneliness, social isolation and depression arose in this study as being connected to a complex network of events, such as nostalgia of being away from family members, isolation, the sense of not belonging to the Australian society and the lack of a social support network.

Recent researches have found: "A number of interpersonal phenomena have been linked to depression including lack of sense of belonging, lack of social support, conflict, and loneliness"^{27:215}. Sense of belonging has been defined as "the experience of personal involvement in a system or environment so that persons feel themselves to be an integral part of that system or environment"^{28:215-6}. Subsequent research revealed that sense of belonging was related to both psychological and social functioning, with a higher sense of belonging promoting better functioning²⁹. Lack of sense of belonging has been found to breed a feeling of disconnection and alienation, and is disempowering³⁰.

Other studies with immigrant women have also demonstrated that social isolation, loneliness and distress seem to be connected to depression^{5,8,30}. Culturally isolated immigrants make up a population whose health is at special risk; however, their experiences have received little attention and are poorly understood by health care professionals³¹. Many migrant women tend to stay in their ethnic enclaves, disempowered by the lack of language skills and inability to negotiate complex organisations, including the health care delivery system; this can result in depression and other psychological problems⁶.

The anxiety and depression faced by migrant women are consequences of the trauma of dislocation and loneliness³². Women who depend more on social networks, are particularly vulnerable to mental health problems³². Lack of support, defined both as a structural characteristic of a social network and perceived availability of resources, on the other hand, has been proposed to affect the onset, course and outcome of depression³³.

The impact of immigration on the health of immigrants, especially on women, has been widely acknowledged³⁴⁻⁶. Studies have demonstrated that immigrants and refugees are submitted to a great

amount of stress and frequently show signs of traumatic stress disorders³⁷. This point of view has also been confirmed by other authors³⁸ when they state that the integration into the host society has an effect on the immigrants' health and well-being; and as result of the migration, the feeling of powerlessness, and changes in lifestyle are risk factors. This study points in the same direction with regards to Brazilian women.

In this study, several barriers in accessing health care services emerged from the women's experiences, which were classified as sociopolitical, sociocultural and socioeconomic. It is important to highlight that migrants and ethnic health care, as a social issue in a multicultural society, has not been given priority in policy development and matters of service provision³⁹. "Health services for ethnic communities have not emerged as a logical, coherent and consistent response to a demonstrated need"^{40:7}.

The growing number of publications denouncing the inadequacy of healthcare services to meet the needs of the different ethnic groups supports such criticisms. In that regard, as is supported by the study on Brazilian women, the linguistic and cultural barriers have been worthy of special attention. Immigrants ".with non-English-speaking backgrounds face many linguistic and cultural barriers when trying to use Australia's health services. In this point of view, gender inequalities make matters especially difficult for women with such backgrounds. Their access to English classes is hindered by Australian immigration policies, which regard men as having priority because they are the principal applicants and bread-earners. Furthermore, the burden of working for many hours both at home and outside the home accounts for little time or energy left to attend classes"^{41:157}.

The Australian health care system has been recognised as being still largely mono-cultural, and service providers are often unaware of the subtleties of cross-cultural communication⁴². A study developed in Melbourne, Australia, with immigrant women from a non-English speaking background (Lebanese, Vietnamese, Chinese Vietnamese, Salvadorean Chilean, Russian and Ukrainian), with the aims to promote the equity of access of immigrant women to existing health care services and assist health care providers of women's health services to develop appropriate and culturally sensitive services, found some results which are similar to the results of this study⁴³. "Immigrant women [...] identified language as a major problem in accessing women's health care services. Lack of language skills meant that some women were unaware

of what surgical procedures had been carried out or whether a major disease such as cancer had been diagnosed [...]. Distrust of doctors was evident and may reflect, to some extent, differing medical practices in the country of origin as compared to Australia”^{43: 90-1}.

Other issues which emerged were the length of consultation, and the impossibility to buy drugs without a prescription. In this sense, immigrant women felt they were in disadvantage when attending health care services in Australia⁴³.

Another study with refugee women from Latin America (Chile, El Salvador, Nicaragua and Guatemala, conducted in the Perth metropolitan area, Australia, also found that the difference in language and culture were the major barriers faced by them⁵. Latin American women reported that very often, “The general practitioners did not really “hear” what they told them. They thought this was in part due to the language barrier, in some cases related to their personal discomfort with using interpreters, and in others the reluctance of some doctors to call an interpreter. They also complained that doctors tended to rush them through consultations, and there was no opportunity to develop a relationship in which they could develop trust with the doctor”^{5:74}. Another issue raised was their discomfort with the Australian health system of leaving referral decisions to the general practitioner⁵.

The above studies make evident the strong connection between language and cultural barriers as causes of the miscommunication in the therapeutic relationship, compromising the treatment and recovery of immigrant women. Doctor and patient miscommunication often occurs, not only because of the lack of a common spoken language but because they do not have the same cultural framework and therefore do not share the same illness concepts or language of distress⁴⁴.

Barriers in accessing the health care system have also been pointed out by immigrants in the United States, as shown in two studies⁴⁵⁻⁶.

In this study, many Brazilian women also mentioned not having private health insurance, which was accounted as a barrier to immediate access to secondary and tertiary health care and to a better quality health care service. They also demonstrated some concern regarding the privatisation of the health care system and the decrease in the quality of the health care provided by the health care services in the last few years. Only a study developed with African Americans found the socioeconomic issue as a barrier

to accessing the health care system⁴⁷.

Recent articles published about private health insurance in Australia match the results of this study⁴⁷⁻⁸. Since the introduction of Medicare (1984) until recently, the proportion of the population covered by private health insurance in Australia has declined steadily⁴⁷. Following an Industry Commission inquiry into the private health insurance sector in 1997, a number of policy changes were effected in an attempt to reverse this trend. The main policy changes were of two types: financial incentives that provided subsidies for purchasing, or tax penalties for not purchasing private health insurance; and the lifetime community rating. “The membership uptake that has occurred recently is largely attributable to the introduction of the lifetime community rating which goes some way towards addressing the adverse selection associated with the previous community rating regulations. This policy change had virtually no cost to the government. However, it was introduced after subsidies for private health insurance were already in place. The chronological sequencing of these policies has resulted in substantial increases in government expenditure on private health insurance subsidies, with such increases not being a cause but rather an effect of the increased demand for private health insurance”^{47:33}.

In Australia, choice of health care is of increasing consumer concern⁴⁸. Medicare offers free access choice to general practitioners and public hospitals, whereas access to a specialist is gained by means of reference. Nevertheless, waiting lists for elective surgery and delays in emergency care continue to worry people and make them wonder whether or not they will have access or responsible care when they need it. Private health insurance is the main mechanism people use to ensure this choice. Declining affordability of private health insurance has been a major challenge for some time, as premiums have escalated well above general inflation⁴⁸.

The social-political, social-cultural and social-economic barriers which are found in this study point to the challenges faced by immigrant women - especially Brazilians in this study - when accessing health care services. It is fundamental to highlight that an important determining factor which emerges and also supports these barriers is the asymmetry of power between women and health care professionals, represented in this study by the general practitioners. Medical authority prevails in health services, which is highlighted by the fact that most doctors are men.

Hence, the fact that a large portion of the women have mentioned preferring female to male general practitioners. Such asymmetry makes women patient's disempowerment event more evident, increasing health inequalities and decreasing opportunities to achieve a better health potential. In that regard, greater accessibility to health care services also implies a need for changes in hierarchical gender relations.

Studies found in the literature support the results of this study, showing the need for effective reforms aiming at making health care services more accessible and effective for the different ethnic groups. We argue that accessibility also implies safety, respect, comfort and empowerment; and if all health care services met these criteria, most women would find their interactions with health care professionals positive and productive⁴⁹.

CONCLUSION

The aim of this study was to give an account of the impact of international migration on the health of Brazilian women living in Melbourne, Australia. The main emerging themes were related to: women's health problems, the lack of social support; and sociopolitical, sociocultural and socioeconomic barriers to access the healthcare services. The results of this study made evident that Brazilian women face a diversified range of problems in the migration process to Australia. Such results proved to be consistent with those found in the literature.

Generalisation is not claimed from this small sample to Brazilian immigrant women, not even to the immigrant women in Australia. However, the confirmation of the results with studies reported in the literature suggests that the issues raised serious merit consideration by health care professionals and policy-makers. Furthermore, given the lack of studies on the health of Brazilian immigrant women, we regard this topic as one which deserves priority in the research agendas. In this sense, we suggest that studies in this field be extended to Brazilian men, with the aim to search for gender differences in the manifestation and expression of health problems during the migration process.

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REFERENCES

- 1 Seller MS. Immigrant women. Albany, NY.: State University of New York Press; 1994.
- 2 Mortimer DM, Bryce-Laporte R. Female immigrants to the United States: Caribbean, Latin American and African experiences. USA: Smith Sonian Institution; 1981.
- 3 Choudhry UK. Health promotion among immigrant women from India living in Canada. *J Nurs Scholarship* 1998; 30(3): 269-74.
- 4 Ferguson B. Introduction. In: Ferguson B, Browne E. Health care and immigrants: a guide for the helping professions. Australia: MacLennan, Petty Pty; 1991. p.1-16.
- 5 Allotey P. Travelling with excess baggage: health problems of refugee women in Western Australia. *The Haworth* 1998; 28(1): 63-81.
- 6 Kramer EJ, Tracy LC, Ivey SL. Demographics, definitions, and data limitations. In: Kramer EJ, Ivey SL, Ying YW, editors. Immigrant women's health. San Francisco: Jossey-Bass; 1999. p.3-18.
- 7 Oxman-Martinez J, Abdool SN, Loiselle-Leonard M. Immigration, women and health in Canada. *Can J Public Health* 2000; 91(5): 394-7.
- 8 Anderson JM. Perspectives on the health of immigrant women: a feminist analysis. *Adv Nurs Sci* 1985; 8(1): 61-76.
- 9 Nann BC. Settlement programs for immigrant women and families. In: Nann RC, editor. Uprooting and surviving: adaptation and resettlement of migrant families and children. Holland: D. Reidel; 1982. p.85-93.
- 10 Messias DeAnne KH. Transnational perspectives on women's domestic work: experiences of Brazilian immigrants in the United States. In: Meleis AI, editor. Women's health and quality of life. New York: The Haworth Medical; 2001. p.1-20.
- 11 Goza F. Brazilian immigration to North America. *Int Migr Rev* 2001; 28(1):136-52.
- 12 Goza F. Brazilian immigration to Ontario. *Int Migr* 1999; 37(4): 765-89.
- 13 Martes ACB. Brasileiros nos Estados Unidos: um estudo sobre imigrantes em Massachusetts. São Paulo: Paz e Terra; 1999.
- 14 Sales T. Introdução. In: Reis RR, Sales T, editors. Cenas do Brasil migrante. São Paulo: Bomtempo; 1999. p.7-14.
- 15 Sales T. Brasileiros longe de casa. São Paulo: Cortez; 1999.
- 16 Patarra NL. Migração internacional: questão relevante para a região centro-oeste?. In press.
- 17 Kunst JP. Health care for an immigrant nation: policy and practice in Australia. *Innovation* 1993; 6(1): 39-54.
- 18 Australian Department of Immigration and Multicultural and Indigenous Affairs. The people of Australia: statistics from the 2001. Census; 2003. Australia: The Department;

- 2003.
- 19 Patton M. *Qualitative evaluation and research methods*. Newbury Park, CA: Sage; 1990.
 - 20 Marshall C, Rossman GB. *Designing qualitative research*. Thousand Oaks: Sage; 1995.
 - 21 Spradley J. *Participant observation*. New York: Harcourt Brace Janovich; 1980.
 - 22 Steward DW, Shamdasani PN. *Focus group: theory and practice*. California: Sage; 1990.
 - 23 Wilkinson S. How useful are focus groups in feminist research? In: Barbour RS, Kitzinger J, editors. *Developing focus group research*. London: Sage; 1999. p.64-78.
 - 24 Strauss A, Corbin J. *Basics of qualitative research*. London: International Professional Publisher; 1990.
 - 25 Richards L. *Using Nvivo in qualitative research*. Melbourne, Australia: QSR International Pty; 2000.
 - 26 Weiss RS. *Loneliness: The experience of emotional and social isolation*. Cambridge, Massachusetts: MIT; 1973.
 - 27 Hagerty BM, Williams RA. The effects of sense of belonging, social support, conflict, and loneliness on depression. *Nurs Res* 1999; 48(4): 215-9.
 - 28 Hagerty BMK, Lynch-Sauer J, Patusky KL, Bouwsema M, Collier P. Sense of belonging: a vital mental health concept. *Arch Psychiatr Nurs* 1992; 6(3): 172-7.
 - 29 Hagerty BMK, Williams RA, Coyne JC, Early MR. Sense of belonging and indicators of social and psychological functioning. *Arch Psychiatr Nurs* 1996; 10(4): 235-44.
 - 30 MacCarron G, Tenenbein S, Hindley P. Communication, belonging and health. In: Hayes M, Foster L, Foster H, editors. *The determinants of population health*. Canada: University of Victoria, British Columbia; 1994. p.52-72.
 - 31 Kim O. Predictors of loneliness in elderly Korean immigrant women living in the United States of America. *J Adv Nurs* 1999; 29(5): 1082-8.
 - 32 Kang J. Gender issues in access to English language training. In: *Proceedings of Second National Immigration Outlook Conference*; 1992 Nov 11-13; Sidney, Australia. Sidney: [s.n]; 1992. p.331-9.
 - 33 George LK, Blazer DG, Hughes DC, Fowler N. Social support and the outcome of major depression. *Br J Psychiatr* 1989; 154: 478-85.
 - 34 Hull D. Migration, adaptation, and illness: a review. *Soc Sci Med* 1979; 13a: 25-36.
 - 35 Kasl SV, Berkman LF. Health consequences of migration. *Annu Rev Public Health* 1983; 4: 69-90.
 - 36 MacKinlay J. Some issues associated with migration, health status, and the use of human services. *J Chronic Dis* 1975; 28: 579-92.
 - 37 Report of the Second International Conference on Migration and Health; 1992 Jun; Brussels. Brussels:[s.n]; 1992.
 - 38 Millar WJ, Stephans T. Social status and health risks in Canadian adults: 1985 and 1991. *Health Rep* 1993; 5(2): 143-56.
 - 39 Jayasuriya L. The politics of health care and ethnic minorities. *Migr Monit* 1994; 3: 12-8.
 - 40 Reid JC. Health for multicultural Australia: valuing diversity. *Migr Monit* 1994; 3:7-11.
 - 41 Ganguly I. Promoting the health of women of non-english-speaking backgrounds in Australia. *World Health Forum* 1995; 16: 157-63.
 - 42 Newsletter of the Ethnic Health Policy Unit. Culture, communication and health care. *Connections* 1993; 3.
 - 43 Macintyre M, Dennerstein L. Immigrant women's health project community based research report. Melbourne: The Key Centre for Women's Health. The University of Melbourne; 1995.
 - 44 Ferran E, Tracy LC, Gany FM, Kramer EJ. Culture and multicultural competence. In: Kramer EJ, Ivey SL, Ying YW, editors. *Immigrant women's health*. San Francisco: Jossey-Bass Publishers; 1999. p.19-43.
 - 45 Reese DJ, Ahern RE, Nair S, O'Faire JD, Warren C. Hospice access and use by African Americans: addressing cultural and institutional barriers through participatory action research. *Soc Work* 1999; 44(6): 549-59.
 - 46 Bauer HM, Rodriguez MA, Quiroga SS, Flores-Ortiz Y. Barriers to health care for abused Latina and Asian immigrant women. *J Health Care Poor Underserved* 2000; 11(1): 33-43.
 - 47 Butler JRG. Policy change and private health insurance: Did the cheapest policy do the risk? *Aust Health Rev* 2002; 25(6): 33-41.
 - 48 Stoelwinder JU. The price of choice: private health insurance in Australia. *Aust Health Rev* 2002; 25(6): 42-7.
 - 49 Ballem PJ. The challenge of diversity in the delivery of women's health care. *JAMC* 1998; 159(4): 336-8.