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Health issues of immigrant women: A qualitative study of domestic services in Turkey

Abstract

There has been a transformation in the nature of international immigration since the 1990s, which can be summarised within the concept of the feminisation of migration. The aim of this article is to highlight the issue of health among women immigrants and to describe their health-related problems and degree of utilisation of health services. Data is drawn from empirical research, conducted through the method of in-depth interviews with fifteen immigrant women and an administrator from an employment agency. The most remarkable finding from this study is the negative consequences of migration for women's mental health status. It is determined that the illegal status of women, as well as the migration process, working conditions and an intense pining for their families and their home countries, has the most striking role in this situation. Immigrants lack adequate access to healthcare services for several reasons, mainly economic ones, a gap which women try to fill with informal ways and traditional medicine.

Keywords: *international migration, illegal immigrants, domestic service, women's healthcare status, mental health, access to health services, working conditions, gender roles, abuse and domestic violence, occupational health*

Introduction

In recent years, millions of women have been moving from less-developed countries to developed ones as a result of the demand for domestic services, regarded as a female occupation according to traditional gender divisions of labour. The direction of this movement has been from Latin American countries to the United States; from eastern Europe to western Europe; from Africa to southern Europe. Most migrant women in Turkey and some middle eastern countries are from the former Soviet Union (Erder, 2007; Ünlütürk and Kalfa, 2009). So-called servants of globalisation, these women perform their traditional gender roles transnationally.

It is known that the utilisation of migrant labour reduces labour costs in labour-intensive sectors and optimises the conditions that keep migrant labour within informal structures, to the point at which some immigrants are driven to illegal status, hide or disguise themselves and endure unfavourable living conditions. Living and working as a fugitive forces immigrants to accept and internalise the negative conditions imposed on them while aiming to integrate in a new country.

When we consider the health issues related to migration, it may readily be seen that immigrant workers are healthier than the community to which they have emigrated. This is explained by the 'healthy immigrant hypothesis', which is independent of the

demographic characteristics of immigrants (Palloni and Morenoff, 2001). Even the decision to migrate is closely associated with the individual health of the person.

The advantage of immigrants being healthier than the original inhabitants is eliminated quickly. Starting shortly after migration, these healthier people become unhealthy over time. This phenomenon, defined as an epidemiological paradox, is explained in terms of the negative conditions encountered by immigrants which are to the detriment of their health (Lu, 2008). Within ten years, the mental health of immigrants is worse than that of the society in which they live (World Health Organization, 1991: 9). However, blood pressure, one of the measures of physical health, is similar to the level in the new society for migrant women within six to nine years (McDonald and Kennedy, 2004).

The 'healthy immigrant hypothesis' is considered to be dependent on several social and health factors. Gushulak (2007) gathered them under three headings:

1. countries from which migrants come are less developed than the countries to which people immigrate. Lifestyle-related risk factors of chronic disease, such as adiposity, physical inactivity and diet, are less frequent in emigrant countries
2. countries usually demand younger people with higher education, which means that younger and better-educated people who can cope with the physical, psychological and sociological problems of migration are the ones who are selected
3. health conditions and chronic disease screening during the migration process eliminate applications from those who have any kind of disease (within the selection process).

Additionally, working life spontaneously selects the healthier people in any community. Morbidity among workers is lower than the community in general because workers are younger, mainly men and subjected to a selection process by means of employment examinations (Checkoway *et al*, 1989). The so-called 'healthy worker effect' emphasises that unhealthiness is an obstacle to finding a job and employment. In parallel, as in the case of Latin American immigrants, the migrant worker returns to their own country when they become sick or permanently disabled (Holmes, 2006).

Another factor that makes immigrants appear healthier is the failure to identify health problems due to the minimum use of healthcare by immigrants or the possibility of under-reporting (McDonald and Kennedy, 2004). Illegal workers' failure to seek healthcare for fear of being caught is a particular reason for under-reporting (Holmes, 2006).

Another dimension of the relationship between migration and health is the effect of migration processes on people's mental health. Stress should be taken into consideration to explain the pattern of mental disorders among immigrants. Stress is the response of the body to sudden events or changes in life requiring huge behavioural adaptation. The body's psychological responses to acute stress are aimed at making people stronger in the face of the sudden event that has occurred. The stress experienced by immigrants is continuous, i.e. chronic stress. In contrast to acute stress, chronic stress causes people to weaken. Constant exposure to a stressful environment disrupts health and disadvantaged people are more susceptible to the health-disrupting results of chronic stress. Even under similar conditions of chronic stress, such people become

unhealthier due to the limited material, personal and social resources which would otherwise allow them to cope with these problems (McDonough *et al*, 2002).

Immigration is also an assimilation process in a new and foreign country; immigrants try throughout this process to preserve their identity from their previous life (World Health Organization, 1991: 8).

In brief, the stress caused by immigration and adaptation problems adversely affects mental health.

The aim of this article is to highlight the issue of health among immigrants and to describe their health-related problems and utilisation of health services. Within its scope, the article deals with immigrants in domestic service, almost all of whom are women.

Material and method

This qualitative study was conducted to determine the health problems facing foreign migrant women working in domestic service in Turkey and to classify the main health needs of these women. The study also aimed to detect the possible physical and mental consequences of any traumas suffered as a result of working outside their own country.

Foreign women working in domestic service in Turkey (patient care, childcare, care of the elderly, cleaners, servants, etc.) constitute the study population. Considering that all these women were working and living in Turkey illegally, a snowball sampling technique was used to reach them.

Fifteen migrant women workers, as well as the manager of an intermediary company, took part in the study. Nine women work in Istanbul, five in Kocaeli and one in Sakarya. Among the migrant women, eight are Turkmen, five Georgian and two Uzbek; the female manager is a Turk. Five of the women contacted did not participate in the study, one being Georgian while the remaining four were Uzbek.

Interviews were held between 24 April and 10 June 2010 in the provinces of the participants. Demographic characteristics and the health status of the participants were determined using a questionnaire created by the researchers. Semi-structured in-depth interviews were also used to obtain information about the ways of dealing with health problems, treatment practices and whether or not they had suffered abuse in their workplace. A voice recorder was used in all interviews except for six interviews in which the participants did not allow the use of a voice recorder.

A non-structured in-depth interview was held with the female participant from the intermediary company. In this interview, information was obtained about the experiences of women whose employment her company mediated, as well as the health-related perceptions of migrant women and the methods they used for healing.

Results

General characteristics of the participants

The participant women are mostly highly-educated (teachers, nurses and economists). One of them was retired and others had left the civil service to emigrate.

They reported very low salaries as the reason for leaving jobs which came with a state guarantee. One of the two nurses now works as a caregiver (hospital or at home) while the other works as the carer of a child with a disability, which implies that they, at least in part, work in the profession they had acquired in their home country. The occupation of both skilled women and housewives often changes after migration; those who have a profession are usually able to perform their own profession in the country of immigration.

Most of the participants had migrated without their husbands. Some of the spouses back in their own countries are unemployed, while those who are employed receive very low salaries. One woman said that, in every phone call with her husband, he told her:

We are grateful for your health.

Another of the women stated that she was separated from her husband who had moved back home to look after the children a short while after his wife's immigration, and that she also pays for his expenses as he is unemployed. A Georgian woman said:

My children and grandchildren would starve if I did not work here.

Working in Turkey is crucial for the survival of the remaining family members, including a divorced spouse.

Other than two of the participants, all had at least one child. One woman said that she had only just weaned her baby before coming to Turkey. Children are often looked after by the husbands left behind or by parents, or, less often, by other siblings.

Working conditions

Migrant women live in Turkey with expired visas (i.e. as fugitives) or by means of shuttle migration on the basis of tourist visas. Most of the women had been in Turkey for two to three years (between eight months and seven years) and had started to work shortly after they arrived. Some of the women are continuing to live in the country illegally, with visas that had expired eighteen months to four years previously.

Employment agencies, one of the ways in which migrant women find jobs, charge the women one month's salary ($500-$550) as commission and some stated that a commission equal to one month's salary was also taken from the employer. This commission is charged by these companies with each change of job and may be observed to be a restriction against migrant women changing jobs. Commission can also be taken where jobs are found through friends, but this is lower than the amount paid to the company ($50-$100).

Only one of the women interviewed (a Turkmen nurse) was unemployed at the time of the interview. Another woman was working in more than one job (patient care and cleaning). All the other women, however, worked in a single live-in job. Considering the number of houses in which they worked and the duration of their stay in Turkey, the participants in the survey change house every year on average.

Most of the women take time off at the weekend, varying from 3-4 hours to 24 hours. Their work involves childcare or care of the elderly, as well as cleaning, cooking and other household chores. Patient care in a hospital is rarely available as a temporary job. Not many of the immigrants had been involved in non-domestic jobs, although one had worked as a Russian-Turkish translator, another as a store salesperson and another at a printing press.

Domestic violence

The problem of maltreatment in domestic service is very common, but not very often mentioned. Maltreatment can vary from verbal violence to physical violence, threats and sexual abuse due to working illegally within the confines of the home.

The participating women said they were often rebuked and verbally insulted. One of the women said:

> *She was constantly shouting at me, did not treat me like a human being; we could not get along. When I said, 'Why are you shouting, I'm doing my job?' she answered, 'Who should I yell at? My child?'*

One of the women said she would prefer a good family to work with rather than to earn extra money and expressed her problems as follows:

> *They shout and yell. I am already troubled with my mind on my children all the time, I get confused and get into a lather when they yell at me.*

A Turkmen woman, complaining about the treatment suffered due to being foreign, emphasised ethnic differences with this striking sentence:

> *They treat us differently than their own Turkish ones.*

None of the women interviewed had suffered physical violence, but all of them mentioned at least one violent event that they had heard about from their friends. The intermediary company owner stated that the most severe issue of violence occurred with elderly women living alone who hit women with their walking sticks; consequently, many women had to change houses. The company manager interpreted this situation as elderly people not being able to accept being taken care of by someone other than their children.

One of the women stated that, in her previous house, her passport had been seized, her salary was always delayed, the host woman gave the children's old clothes to her and made deductions from her salary as a result, and threatened to report her to the police when she wanted to quit.

Health status of migrant women

The participating migrant women were mostly healthy, according to their self-reports. When asked whether they had any chronic diseases, two women said they had hypertension and two said they had anaemia. These women said they were affected by these diseases from time to time, but that they did not affect their daily lives. For in-

stance, the women with hypertension complained of occasional palpitations. These health problems were not seen as an obstacle to their migration decision or their work in Turkey, because both diseases were asymptomatic. Lu (2008: 1338) found that young migrants free of chronic disease and disability are selected, but this was not the case for asymptomatic chronic diseases and acute diseases. One of the participants said they did not inform their employers, which provides one of the reasons for the under-reporting of health problems: the fear of losing the job due to frequent health problems.

It must be taken into consideration that wage-worker women are generally reported healthier; however, the health-promoting effects of work depend on the type of job. For example, lack of control over a job can be problematic for a person's health (e.g. in psychologically-demanding roles and those sufffering from time pressures and rapid production).

With regard to the effects of work on health, women have a higher probability than men of being exposed to conditions of high job strain (McDonough *et al*, 2002: 768). The women in our research had escaped the effects of poverty that caused them to migrate, but they were still in a disadvantaged position due both to a lack of control over their work and to the exhaustive nature of patient care or care of the elderly.

Mental health problems

From a psychological perspective, immigration is defined as 'big breaks and a failure to reconnect', which is an approach that draws attention to the prevalence of mental health problems in immigrants (Teber, 1993: 12). The effects of illegal immigration on mental health are expected to be severe. Illegal immigrants show signs of chronic stress and depression because they are separated from their families, while various physical complaints occur as a result of their stress levels (Magalhães *et al*, 2010: 145).

There are many factors in interaction with each other that threaten the mental health of women. In addition to the constant fear of being deported, women cannot even walk freely in the streets, which makes them unable to relax psychologically. One of the women stated that she covered her head and wore a coat like Islamic women in order to be able to walk freely in the streets and avoid the police asking for her identification details.

It may be observed that women involved in shuttle migration have a better mental health status than those who live in the country illegally; living in a constant state of fear creates very high levels of anxiety. One of the women stated that a police officer demanded money during a security check and threatened to start proceedings if she did not hand money over. Subsequently, she returned home using an indirect route to hide the location of the house and was then afraid to leave the house.

Incidents such as this, as well as being a source of anxiety, appear to be another reason for confinement within the home. Therefore, some women are afraid to leave the house even when they have time-off, whereas women with tourist visas reported that they would meet friends, chat in the cafe or walk about downtown on their days off. Under such negative conditions of indefinite working hours and the house as workplace with no private space, these women do not have any opportunity for personal refreshment and relaxation when they spend their days off at home.

Studies comparing the mental health status of immigrants and refugees show that immigrants have a better mental health status than refugees (Lindert *et al*, 2009: 254). A study conducted in the United States reported that the prevalence of depression and anxiety is similar to that in the general population, while workers who migrate legally to countries with higher incomes have a better mental status. This situation is explained by migrants facing economic difficulties in their own countries deciding to emigrate to search for better economic opportunities. A finding that supports this phenomenon in our study is that two of the women who had health problems before migrating to Turkey reported that some of their problems had disappeared after they arrived. One of the women said she had been very troubled in her country on account of poverty and hopelessness, but that her headaches had reduced after she started working in Turkey. The other woman said that she had chest pains in her country, but had recovered since arriving in Turkey.

Illegal and seasonal immigrants suffer more severely from anxiety, emotional disorders and drug abuse than the local community. It is reported that depression shows itself in the form of psychosomatic disorders and drug abuse in immigrants (Holmes, 2006: 1785). In a study of immigrants who moved to Israel from the former Soviet Union countries, it was reported that the problems of women were associated with their families, while men's problems were mostly associated with work; women had the more severe psychological problems compared to men (Mirsky, 2009: 180). In our study, the manager of the intermediary company working with Georgian women expressed that a drug known as the 'neurosis drug' was widely used among migrant women as a means of survival.

Psychosomatic disorders are commonly observed among migrant women. All of the participants, except one, have at least one psychosomatic disorder. Almost all the women expressed a yearning for relatives left behind, especially for their children. One of the women said that her mother had died recently, but that she could not even go to the funeral because of her illegal status.

In summary, the factors affecting women's mental health mostly seem to be their fugitive and immigrant status; the level of exposure to offensive behaviour; and yearning, especially for their children.

Occupational health problems

Immigrants generally work under precarious conditions, which frequently cause musculoskeletal disorders. This situation, combined with the mental status of immigrants, leads to a number of physical problems, called 'foreign worker syndrome' in the medical literature (Teber, 1993: 73).

There are some studies on the occupational health problems of migrant workers, but almost all have been conducted with men. The occupational health problems of migrant workers are expected to be more severe compared to native workers, on account of them doing the heaviest work in the communities of immigration, their work under the most adverse conditions, their illegal status, etc. Depending on the nature of the work, illegal immigrants who are at the bottom of the hierarchy are also classified among themselves according to their ethnic characteristics (Holmes, 2006: 1781).

Domestic services undertaken by migrant women are grouped under two main categories: care services; and maid services. It was mentioned earlier that elderly, children or patient care is the most common reason for employing migrant women, who also perform such tasks as cleaning, cooking, etc. Some of the migrant women who care for the elderly suffered low back pain and general back pain after taking on this work. Low back pain is known to be common in caregivers and nurses who work in patient care, so musculoskeletal disorders such as low back pain and general back pain are defined as job-related diseases for this occupational group (Ngan *et al*, 2010).

Migrant women are often employed on a live-in basis, which makes their working hours indefinite. Such back disorders thus occur in immigrants more severely compared to other healthcare workers who work in a health facility for eight hours a day at most. However, as mentioned earlier, there are no studies to reveal any kind of frequency in this regard.

Some of the participants stated that they would wake several times a night because of the needs of their patients, so suffered from sleep deprivation. This situation implies that people working in domestic service have limited opportunities to use their right to rest.

Utilisation of health services

The biggest obstacle to immigrants seeking healthcare is the absence of health insurance due to their illegal status. Therefore, they need to pay out of their own pocket when applying to private or public healthcare institutions. However, a significant proportion of women with illegal immigrant status said they could not apply to public hospitals because of the fear of being caught. With one exception, all their applications were made to private health institutions. One woman suffering from various health problems expressed her helplessness, saying:

> *I have never been to a doctor since I came here, and how would I go, it is prohibited. We are fugitives.*

Magalhães *et al*. (2010: 146) argue that illegal immigrants feel a lack of confidence in all elements of the state and, thus, they cannot trust health organisations which they perceive to be representatives of the state. This assertion has a certain degree of accuracy but, in both public and private healthcare organisations, no inquiry is made concerning the person's legal status if the examination fee is paid. Indeed, one illegal migrant woman said she had paid for a hysterectomy in a public hospital.

The situation that prevents immigrants from applying to healthcare facilities can be called a 'psychological barrier'. Out of six women who recently had health problems, one with a residence permit was able to go to the public hospital, while another with a tourist visa went to a private clinic. Three of the remaining four could not apply to any health institution because their visas had expired.

Dias *et al*. (2007: 4) noted that those who did not pay insurance premiums had to pay for the cost of the service in Portugal. Similarly, the African and Brazilian migrant women who were interviewed were mostly concerned about health expenditure when deciding to seek health care.

When health problems arise for migrant women, their employer families do provide them with aid. Aid from the employer was also identified as a finding in a similar study (Kaşka, 2006: 67). In our research, it was expressed that healthcare spending was made by employers but, in some cases, examination or medication costs were deducted from salaries. The women also stated that the employer's health card was used to apply to healthcare facilities, or that only necessary drugs were prescribed, such as the employer's own drugs.

Women who resort to shuttle migration stated that they would have medical examinations when they go to their own countries in cases of non-emergency healthcare needs. This is not only because they are unable to access health services in Turkey, but also because they do not trust Turkish healthcare. Kaşka (2006: 68) found that Georgian and Moldovan women had a perception that health services are not good in Turkey. One Georgian woman was sent to a private health facility for the medical examination of breast cysts, but she was not satisfied with this examination and immediately went back to her country for examination.

The manager of the intermediary company stated that one woman with a tourist visa was involved in a traffic accident with the family for whom she was working, with everyone killed except for the migrant woman whose hip was broken; the woman's medical expenses were covered by traffic accident insurance.

Alternative solutions to health problems

Almost all the migrant women said that they brought drugs with them when they came to Turkey for the first time. The drugs they brought are related to common problems, such as headaches, indigestion, coughing and hypertension. The reasons for bringing drugs were language problems, not being able to read the contents of drugs, etc. A participant who said she brought back drugs every time she goes to her country, and even asks others to bring drugs if she cannot go herself, said:

> *We do not know the drugs here, we are afraid that maybe they could upset us. And even if the same drugs are available, they are expensive here, cheap back there.*

The company manager similarly said:

> *Even though the same drugs are available here – pharmaceutical companies are often international – they do not buy drugs here unless they have to because they do not understand the language,*

and also noted that they were reluctant to have medical examinations in Turkey in case of any disease, but preferred to go to a doctor when they returned to Georgia. Some of the participants said they brought drugs at first, but that it was no longer necessary.

Another reason for women to bring drugs from their countries is that they presume that the drugs in Turkey are ineffective. One nurse participant noted that she used analgesics for headache when she first arrived in Turkey but the pain did not stop, and said:

> *I've had drugs brought from back home. Then I got better. The drugs sold here are not effective.*

It was also observed that they use a number of drugs that they believe to be beneficial and are not available in Turkey. For example, one of the immigrants uses something called Carvovolum 25 mg for irritability and depression. Utilisation of herbal medicines seems to be quite common in these communities of women. Another example is the use of an ointment containing snake venom for arthralgia.

The manager of the intermediary company stated that these drugs were sometimes defined as a problem by employers who asked the company about their contents, raising concerns especially in terms of drug addiction.

Traditional healing practices

The main flow of migration from under-developed countries towards developed countries implies that immigrants are likely to bring traditional healing practices with them as well as various cultural characteristics. For instance, Pieroni *et al*. (2008: 84) found that traditional medicine is still widely used at home by Pakistani immigrants in Britain but, the longer they stay in Britain, the less commonly they use such methods.

Survival of traditional healing practices from the past as cultural characteristics of societies is largely associated with a lack of access to modern healthcare services. Today, traditional treatment methods are used in the absence of access to the healthcare system for various reasons. For example, during the economic crisis in south-east Asia in 1997/1998, applications to healthcare facilities decreased while the use of traditional treatment methods increased by 75 % (AusAID, 2000).

Immigrants who cannot benefit from healthcare turn, not unexpectedly, to traditional practices. Migrant women come from different societies and cultures, and the prevalence of traditional healing practices in their communities of origin should be taken into consideration. Consequently, how women use healthcare in their own countries is an important point of reference for their utilisation of healthcare in Turkey.

Discussion

There has been a transformation in the nature of international immigration since the 1990s, which can be summarised under the concept of the feminisation of migration. This concept refers to increased numbers of women as independent migrants rather than as secondary migrants (İlkkaracan and İlkkaracan, 1998: 306).

A further dimension of this issue is that one feature of the jobs of the participants in our study is that they are in parallel with their traditional gender roles. In this context, it is not important whether they have a profession or not; they mostly work in domestic service or care-based work in the countries of immigration. These occupations are expected to be compatible with female roles, so migrant women are mostly employed as domestic maids in urban areas.

There are both positive and negative consequences of a change in gender roles from those applying in their own country to those in another country. Whatever the consequences, migrant women are in a triply disadvantaged position because they are foreigners from another country, and as a result of social gender roles and ethnic differences (Piper, 2005: 2).

Emigration to a foreign country affects the remaining population in two ways. According to the phenomenon conceptualised as 'global care chains', the children left behind by female immigrants are cared for by their husbands or parents, in which case migrant women's care and love for their children is almost exported to a foreign country.

In Turkey, as a result of the transition to nuclear families away from extended families, childcare and care of the elderly can no longer be satisfied within the family. Furthermore, as in many countries, with the increasing number of working women, public social services are being sacrificed to neo-liberal policies (Sainsbury, 2006). All these factors have created a demand for domestic services. This demand, combined with the supply of migrant women, has resulted in the employment of many migrant women in domestic services in contemporary Turkey.

Due to their illegal status, the women in question do not have any rights. Confinement of their workplace to the 'home' keeps these fugitive women away from the eyes of the public and has all the negative aspects of informal employment. It has been shown in this study that illegal status is manifested as the source of all kinds of threats, abuse and violence.

One of the two major factors that influence the health status of migrant women is their working conditions, e.g. long working hours, no distinction between work and home, insufficient time-off, exposure to abuse and the physical burdens of their work. These adverse conditions lead to exhaustion in migrant women, both mentally and physically. In our study, we found that migrant women are physically healthy, but their mental health has been affected to various degrees.

The occupational health problems of migrant women is a neglected issue. Care giving is the core business of these women working in domestic service, and most of them also do the cleaning. Thus, they encounter the adverse effects of this type of work on the musculoskeletal system as occupational health problems, just as in the case of others doing this type of work (nurses, caregivers, etc.).

Migrant women cannot possibly use the health system to resolve their health problems. The social health insurance system in Turkey aims to include everyone living in the country, but immigrants are still placed at the outermost periphery of this system. Immigrants have quite limited relationships with public institutions, which results from their fear of being caught and deported as well as from the economic barriers.

Discussion of illegal immigrants' need for healthcare is ignored because of their illegal status. Indeed, a number of barriers to their seeking healthcare have been defined by immigrants, even when they are legal. Studies conducted in the agricultural sector found that healthcare-seeking among migrant workers is limited due to various problems (Wilk, 1998: 690): economic barriers, such as poverty, lack of health insurance and wage cuts when they go for physical examinations; physical access issues, such as distance to health centres, a lack of service during workers' off-duty times (i.e. at the weekend and in the evenings, etc.); and cultural issues, such as unfamiliarity with the healthcare system in the country of immigration, language problems, etc.

Organised health services for immigrants may be used to select healthy immigrants and deport unhealthy ones. Many countries check immigrants who apply for work visas through medical examinations, mostly for infectious diseases (tuberculosis, HIV, etc.).

In the case of Taiwan, a healthy labour force is guaranteed by the existence of periodic healthcare checks. The Taiwanese government performs checks every six months on the grounds of controlling illegal immigration and these are applied to both women and men. Pregnancy testing is applied to women during periodic checks and pregnant women are deported (Cheng, 2004).

The reality of foreign immigrants, who are increasing in number in Turkey, and the picture revealed by their health problems and the lack of social security, makes it essential urgently to implement the necessary regulations on this issue. There should not be any economic rationale to subject workers to discrimination based on their ethnic and national identity.

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