Asian & Pacific Islander Women's Health:
A Review of the Literature

1998

Introduction

"If you educate a man, you educate one person; if you educate a woman, you educate an entire family"

—*United Nations, 1991*

The idea that empowering women will lead to better lives for themselves and their families has been widely advocated. Yet its application has not been integrated into our health care systems or in the delivery of services. The concept of illness and health, though a private matter has a public and social construction (Bair & Cayleff, 1993). Education, understood not merely as literacy but as consciousness of oppression (Freire, 1970), is very much related to health, given that the tools of oppression permeate every aspect of our social fabric. For minority women in the United States (US), well being and health are tied to their consciousness of their history, and to the consciousness of their status in the family and in the community. These women are less able to gain respect and negotiate with the health care system, less likely to have a personal physician and therefore poorly positioned to receive quality health care. There is also a preponderance of studies that have excluded women in clinical trials (Rosser, 1994). In addition, the health and mental status of women of color are 'disproportionately worse' than the mainstream in almost every aspect of measurement (Bayne-Smith, 1996). Given such a scenario, women, in general, have not participated in defining issues relevant to themselves. One result of this has been that there are very few studies on women and health. Not suprisingly, these studies on minority women and health are even more scarce (Bayne-Smith, 1996).

So far, the health care delivery system has not been very amenable to the needs of Asian and Pacific Islander American (A/PIA) women. The consequences of the system not being responsive are serious, especially since by 2010 the percentage growth of the minorities (non-European descent) will result in an equal proportion of European Americans to non-European Americans in the population (Sue, Arredondo, & McDavis, 1992). The A/PIA population from 1980 to 1990 has seen a dramatic increase of 95%, from 3.7 million to 7.2 million (US Bureau of Census, 1992). Women, twenty years and older, constituted 50% of the immigrants from China, Burma, Indonesia, Taiwan, Hong Kong, Malaysia, the Philippines, Korea, Japan, and Thailand, between 1975 and 1980 (Donato, 1992).

Putting together a bibliography on A/PIA women's health can be likened to looking for pearls in the ocean. Research relating specifically to women's health issues is recent. It was not until 1991 that the National Institutes of Health required that studies funded by them include women (Schroeder, 1992). Before then, issues relating to women were extrapolated from research done on men. Even more negligible has been research focusing specifically on health and mental health issues among A/PIA women. Research on A/PIA women is limited largely to studies that include A/PIA among the minority or "other" category, or as serendipitous of other large scale studies that have not specifically targeted A/PIA populations, but find them in their sample when the net to collect data is cast on a large and diverse population.

Thus far the "Asian and Pacific Islander American" category in research and reports has tended to include all the incomparable and diverse groups of people from Asia and the Pacific (Wang, 1995; True & Guillermo, 1996). The Asian and Pacific Islander Center for Census Information and Services (1993) lists at least 48 separate A/PIA ethnic populations in the US. It is frequently ignored that the world's largest continent encompasses countries with very diverse socioeconomic and political histories, languages, cultures, experiences, religions, economic and political structures.

Even their reasons for immigrating to the US are multifarious and includes people who have immigrated recently as well as those whose ancestry in the US can be traced to several generations with very unique and separate histories. The immigration and exclusion acts of the nineteenth century brought Chinese and Japanese women to the United states to work as prostitutes (Hirata, 1982). In the early 1920s Japanese and Korean women, called "picture brides", came to marry men of their own nationalities who were working in the US and Hawaii (Gee, 1982). After World War II, in 1965, with the liberalization of immigration laws, immigrants from Asia included those who were well educated in their home countries. In addition, immigrants arrived from countries that were affected by US colonialism, war, and neocolonialism such as Filipinos, Vietnamese, and other Southeast Asians (Lowe, 1996). In spite of these diverse histories, 'Asian and Pacific Islander Americans' are assessed in research, delivery of services and policy as a single, homogenous unit. This amalgamation into a single homogenous unit can have harmful effects especially when these culturally diverse A/PIA women try to access health and mental health services. In addition to inadequate health care facilities, they encounter various types of institutionalized discrimination based on gender, race, ethnicity, and language, which compound the extant socioeconomic factors such as low levels of income, education, and the lack of social networks (Mayeno & Hiroto, 1994).

To enable access and delivery of appropriate services, it is imperative to identify health care issues specific to A/PIA populations. Researchers should account for the cultural context of the group in which the research is being conducted. Culturally sensitive research augments the ecological validity[1] of the study being conducted (Fonow & Cook, 1991). In the area of domestic violence, for example, studies done in a Western setting, have shown that women who seek help from shelters are encouraged to leave their abusive home and the community with their children to reestablish themselves elsewhere. But among American women of Asian Indian origin who are in domestic violence situations, this method of coping usually does not seem plausible and conflicts with their sociocultural value system. A more innovative and ecologically valid method of dealing with the problem may be necessary for such women. For example, Maria Mies (1991) when working with women's organizations in India, found that the women of a local organization arrived at an ingenious method of resolving the issue of spousal abuse. They felt that in suggesting to the woman to leave her home and community, the burden is placed on the abused woman to reestablish herself and her children elsewhere. Since women's work was in and around the hut[2], they decided that it was the abusive men who should leave the home. In this case, unlike in the Western setting, men are displaced from their homes and communities[3]. These kinds of studies situate research well within the context of the community and social action. By positing research in the community and linking it to social movements and action, the entire process of research results in an outcome which is desirable for all the participants. It is also beneficial to researchers and policymakers since it provides models for further research and enhancement of women's lives.

It is equally exigent to discern for these cultural groups the psychosomatic components of mental illness, and all the issues connected to total well being (and not just physical health), as well as the role of social, economic, cultural and environmental factors (such as safety and security on the job and at home). Since the cultural definitions of many of the illnesses have not yet been understood, the health and mental health statuses of A/PIA women have been incorrectly classified or misdiagnosed. So far the role of traditional, non-allopathic, healing processes have been peripheral to the health care system, despite the use of these practices among many immigrant communities (Frye, 1995). Studies have shown that prescribing dosage of allopathic medication when bodily reactions to such medications have not been well researched or when the interactions with traditional medicines have not been studied can lead to serious repercussions (Lin & Shen, 1991). When discussing the delivery of services, the argument usually centers on "non-compliance" rather than barriers to compliance, showing a bias and lack of emphasis on issues relating to access and utilization of health care.

The lack of culturally competent care for minority women has severe consequences for the women's health as well as for children and families. Many women are the main care givers and mediators of health care for their families (Graham, 1985). The traditional gender roles in A/PIA families are more firmly established making women the main care givers. By restricting women's access to health care, the availability of health care to children and older people in their charge also suffers in the process.

This bibliography answers a demonstrated need for information and presents a review of the available research on health issues relating to A/PIA women. The paucity of research on A/PIA women's health issues is apparent, especially studies that use culturally relevant methods of assessing the issues (Sue and Zane, 1987). Unfortunately in California, the health care system has suffered a set back with the passing of legislation such as Proposition 187 in 1994, which challenges immigrants' rights to citizenship and limits their access to schooling and medical care. In fact, in this law one of the first things denied to the immigrant women is prenatal care.[4]

The agenda to improve the health status of all A/PIA women has to be approached from diverse domains, including but not limited to lobbying, advocacy, activism, policy, community, outreach efforts, research, and education, especially in the current environment of shrinking resources. This volume has special significance for researchers, service providers, community workers, and policymakers who will have the opportunity to direct and shape the course of future research and policy in the field of health care for A/PIA women. The bibliography will also be immensely valuable to students who are interested in venturing into the field of health and mental health for A/PIA women. Lastly, the bibliography is of great interest to women and their families as they try to refocus the attention of researchers and policymakers to issues that have not been studied in depth but are of vital importance to their lives. It is only by taking this multi-pronged approach in assessing and comprehending the needs of women and their families, as well as developing appropriate systems to respond to them, that the overall well being of society will be on the road toward greater improvement.

—Shobha Srinivasan, Ph.D.
National Research Center on Asian American Mental Health
University of California at Davis

References

Asian and Pacific Islander Center for Census Information and Services (1993). *A profile of Asian and Pacific Islander immigrant populations in California.* San Francisco, CA: Asian/Pacific Islander Data Consortium.

Bair, B.,. & C.E. Cayleff (1993). Introduction. In B.B. Bair & S.E. Cayleff (Eds.), *Wings of Gauze: Women of color and the experience of health and illness.* (pp. 19-22) Detroit, MI: Wayne State University Press.

Bayne-Smith, M. (1996). Health and women of color: A contextual overview. In M. Bayne-Smith (Ed.), *Race, gender, and health.* (pp. 1-42). Thousand Oaks, CA: Sage Publications.

Bronfenbrenner, V. (1977). Toward an experimental ecology of human development. *American Psychologist, 32,* 513-531.

Donato, K.M. (1992). Understanding U.S. Immigration: why some countries send women and others send men. In D. Gabaccia (Ed.), *Seeking common ground: Multidisciplinary studies of immigrant women in the United States.* (pp. 159-184). Westport, CT: Greenwood.

Fonow, M.M., & J.A. Cook (1991). Back to the future: A look at the second wave of feminist epistemology and methodology. In M.M. Fonow & J.A. Cook (Eds.), *Beyond methodology: Feminist scholarship as lived research.* (pp. 1-15) Bloomington, IN: Indiana University Press.

Freire, P. (1970). *The pedagogy of the oppressed.* New York: Herder and Herder.

Frye, B. (1993). Health care decision making among Cambodian refuge women. *Wings of Gauze: Women of color and the experience of health and illness.* (pp. 93-108) Detroit, MI: Wayne State University Press.

Gee, E. (1982). Issei women. . In N. Tsuchida (Ed.), Asian and Pacific American experiences: Women's perspectives. (pp. 66-87). Minneapolis, MN: Asian/Pacific American Learning Resource Center.

Graham, H. (1985). Providers, negotiators, and mediators: women as the hidden carers. In E. Lewin & V. Olesen (Eds.), *Women, health, and healing: Toward a new perspective.* (pp. 25-52). New York, NY: Tavistock Publications.

Hirata, L.C. (1982). Chinese immigrant women in the nineteenth century California. In N. Tsuchida (Ed.), *Asian and Pacific American experiences: Women's perspectives.* (pp. 38-65). Minneapolis, MN: Asian/Pacific American Learning Resource Center.

Lin, K.M., & Shen, W.W. (1991). Pharmacotherapy for Southeast Asian psychiatric patients. *Journal of Nervous and Mental Disease,* 179(6), 346-350.

Lowe, L. (1996). *Immigrant Acts.* Durham, NC: Duke University Press.

Mayeno, L., & Horota, S.M. (1994). Access to health care. In N.W.S. Zane, D.T. Takeuchi, & K.N.J. Young (Eds.), *Confronting critical health issues of Asian and Pacific Islander Americans.* Thousand Oaks, CA: Sage Publications.

Mies, M. (1991). Women's research or feminist research? The debate surrounding feminist science and methodology. In M.M. Fonow & J.A. Cook (Eds.), *Beyond methodology: Feminist scholarship as lived research.* (pp. 60-84) Bloomington, IN: Indiana University Press.

Rosser, S.V. (1994). Gender bias in clinical research: the difference it makes. In A.J. Dan (Ed.), *Reframing women's health.* Thousand Oaks, CA: Sage Publications.

Schroeder, P. (1992). *Women's health: A focus for the 1990s. Vol. 12 (1).* Washington, D.C.: Jacobs Institute of Women's Health.

Sue, D.W., Arredondo, P., & McDavis, R.J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development, 70,* 477-486.

Sue, S., & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist, 42,* 565-570.

True, R.H., & Guillermo, T. (1996). Asian/Pacific Islander American women. In M. Bayne-Smith (Ed.), *Race, gender, and health.* (pp. 94-120). Thousand Oaks, CA: Sage Publications.

United Nations (1991). *Women: Challenges to the year 2000.* New York, NY: United Nations.

U.S. Bureau of Census (1992, March). The Asian and Pacific Islander population in the United States: March 1991 and 1990. *Current population reports (Series P20-459).* Washington, D.C.: Government Printing Office.

Wang, G.M. (1995). Health issues for Asian/Pacific Islander women. In D.L. Adams (Ed.), *Health issues for women of color.* Thousand Oaks, CA: Sage Publications.

[1] Ecological validity is defined as the degree to which there is congruence between the environment as experienced by the subject and the properties of the environment the investigator assumes it has (Bronfenbrenner, 1977).

[2] A hut is a one room dwelling made of clay and/or mud with a thatched roof.

[3] Mies attributes this innovative strategy of dealing with domestic violence to the existence of an autonomous women's organization, the reciprocal exchange of the women's experiences with patriarchal authority, their anger, affectedness, concern, commitment, and the frequent exchange of ideas through women's conferences which gave the women the courage and strength to tackle a taboo subject such as violence in the family.

[4] For a more detailed discussion on immigrant acts and their limitations see, *Immigrant Acts* by Lisa Lowe, Durham: Duke University Press, 1996.