

Chapter 2

Black women's health matters

Putting black women on the research agenda

Jenny Douglas

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The aim of this chapter is to review the available literature relating to the experience of health and health services of black women in Britain and to analyse the extent to which it adequately describes and contributes to an understanding of underlying concepts and perceptions of health and illness. Although there is a growing literature on the health experiences of black and minority ethnic women, research studies have been concerned primarily with experiences of maternity services (Hornans 1980; Lumb *et al.* 1981; Homans 1982; McFadyan and McVicar 1982; Clarke and Clayton 1983; Larbie 1985; Curren 1986a). Much of the literature describes family organization and cultural practices to do with childbirth and child rearing; here black family patterns are portrayed as deviating from white families.

The main focus is to examine feminist theory and methodology in an attempt to outline the problems in applying them to the experiences, concepts and perceptions of the health of black women. I aim to discuss the complex interrelations between the dimensions of race, class and gender in the lived experiences of black women. Finally, I will address shortcomings in the field of women's health research and will make recommendations concerning the need for further research in this field.

Race and health

Before examining black women's health research specifically, it is useful to outline the approaches which have been adopted in examining the health of black and minority ethnic communities generally. Early papers and research on the health status and health care needs of black and minority ethnic communities in Britain

tended to be disease-centred and often attributed health problems to individual behaviour or culture.. rather than addressing social and economic factors affecting health and health status (Donovan 1984; Johnson 1984). Most of the epidemiological research was underpinned by a biomedical model and the focus of attention was on illness and diseases affecting black and minority ethnic communities such as the inherited blood disorders, sickle cell disease and thalassaemia (Knox-Macaulay *et al.* 1973; Davis *et al.* 1981); rickets (Goel *et al.* 1976, 1981); tuberculosis (Clarke *et al.* 1979); hypertension, diabetes (Cruickshank *et al.* 1980); mental illness (Littlewood and Lipsedge 1982) and perinatal mortality (Terry *et al.* 1980; Lumb *et al.* 1981). In the case of inherited blood disorders the medical aspects and incidence of them were attended to, in order to manage them satisfactorily, but there was initially little research into the experience of, or support services for, sufferers of sickle cell disease and thalassaemia. In most instances black and minority communities or researchers were not able to contribute to setting the research agenda, and there was little research examining the particular experiences of black and minority ethnic communities.

Furthermore, definitions of ethnicity in much of the early literature are unclear and where comparative epidemiological studies have been conducted populations have been divided into Asian, Afro-Caribbean and African, and white groups. This distinction itself may be artificial as there are many ethnic groups within these rather broad categories. Researchers have attempted to use 'race' as a biological or genetic tool; but although some diseases may have a racial correlation, 'race' is a social construct and has more to do with social structures and relationships based upon power and domination (Phillips and Rathwell 1986).

Early explanations of the prevalence of particular illnesses and diseases were based largely on cultural explanations which did not accurately reflect complex issues determining health status, health experience and health behaviour of black and minority ethnic communities. Anthropological approaches have often divorced culture from social organization or social structure and cultural groups have been perceived as socially homogeneous groups. A meaningful exploration of the health experiences of black and minority ethnic communities in Britain must incorporate an understanding of the relationship of these communities to the social organization of British society, where racial discrimination is central. A black minority culture - is often compared to white majority culture in a

detrimental way such that its beliefs and values are undervalued; its norms and values are perceived as being deviant or pathological. A particular example here is the diets of black and minority ethnic communities, which were seen initially to be less nutritious than western diets, although current research demonstrates that they are much closer to accepted nutritional guide-lines than many western diets.

For example, the condition of rickets in the Asian population was attributed to poor diets and lack of knowledge of foods rich in Vitamin D, or restrictive cultural practices which prevented women and children from exposing their skin to sunlight. Rickets was prevalent in the white population in Britain during the Second World War and was reduced by fortification of particular foods, for example margarine, with Vitamin D. In Asian populations rickets was perceived to be a problem associated with specific cultural practices whereas in the white population it was seen to be a problem of poverty rather than cultural or nutritional practice or preferences. Sheiham and Quick conclude, in a review of the available literature about why British Asians get rickets, that there is no single factor and that neither diet, exposure to sunlight, nor skin pigmentation can alone provide an explanation. They highlight further issues relating to poverty:

In looking for further reasons, it is perhaps worth remembering that in the past in Britain, conditions such as rickets have largely been diseases of economic and social deprivation (as they still are in many parts of the world).

(Sheiham and Quick 1982: 20)

There has been a great deal of discussion about the fortification on either a compulsory or voluntary basis of chappati flour. However objections were raised by the DHSS Committee on Medical Aspects of Food Policy (COMA) in a report *Rickets and Osteomalacia* (Department of Health and Social Security 1980). This report suggested that if there were compulsory fortification of chappati flour, some people may receive increased doses of dietary Vitamin D when they were not in need of it. Many groups argued that if a mechanism had been found for fortifying margarine, then this process could have been extended to chappati flour if the government had the will to do so, and accused the DHSS of racism for not intervening more actively.

Many theoretical difficulties arise with the use of cultural explanations in that often they can impose homogeneity on to a group

of people and ignore wide variations in religion, ethnicity, class and gender. Pearson underlines this approach, arguing that racist notions of ethnicity and culture are used to uphold the view that problems exist as a 'result of mis-matches between minority and majority cultures which according to the pluralist view, meet on equal terms'. (Pearson 1986: 42). She argues that black people and ethnic minorities have always had a second-class image in the health services, firstly as migrant workers and secondly as patients whose different diets, life-styles and religion were causing problems for the established service. Hence culture is perceived to be the problem, rather than the inflexible, ethnocentric service. Black people are seen as having different cultures and it is their culture that denies them equal access to services and opportunities,

A more adequate framework for understanding the health experiences and health status of black and minority ethnic communities is to incorporate into any analysis the dimension of class and socio-economic position. Several studies have concluded that black people occupy a disadvantaged position in British society (for example Brown 1984). Research on social class inequalities (Townsend and Davidson 1982; Whitehead 1987) focuses primarily on social class differentials in illness from data on mortality rates. There is little information linking the economic status of black communities with poor health. Moreover racism and discrimination remain determinants of the social class position of black people and this in turn affects health. However, the effects of culture upon health experience and health behaviour cannot be discounted. It is clear that culture will play a part in determining life-style, dietary practices, health beliefs and health behaviour and will therefore influence the way in which health and illness are perceived as well as responses to ill health. Thus research on the health experiences and health behaviour of black and minority ethnic communities must include an examination of social and economic factors as well as cultural factors.

Black women's health experiences

Research indicates that working-class women and black women are likely to receive less favourable treatment than other groups (Cartwright and O'Brien 1976; Larbie 1985). Black women experience discrimination and racism whether they are Asian or Afro-Caribbean. However the literature examining their health experiences has tended to focus on Asian women (Curren 1986a,

1986b; Homans 1980) and to look particularly at the influence of Asian culture and religion on both concepts of health and experiences of health care. Here, women's experiences of maternity services have been of particular concern and although Curren and Homans were able to use their research to highlight areas where discrimination is structured into the practices of the maternity services, the main emphasis in both studies is an examination of concepts of health in relation to culture.

A great deal of the literature describing the health experiences of black women has tended to focus on family organization and cultural practices in childbirth and child rearing in different communities in an attempt to explain 'bizarre' or unusual practices. Black family patterns are often portrayed as being deviant, compared with white families (see Lawrence 1982; Parmar 1982). Afro-Caribbean families are often portrayed in negative terms as single parent, matriarchal and lacking discipline (Rainwater and Yancy 1967), while Asian families are seen to be patriarchal and rigid (Kahn 1977; Allen 1982; Ballard 1982).

Research studies on the health of Asian women and families have been concerned primarily with perinatal mortality, infant mortality and low birth-weight babies, with a tendency to attribute high perinatal and infant mortality to cultural practices, lack of uptake of antenatal services and diet, rather than to material and economic deprivation (Runnymede Trust and Radical Statistics Group 1980; Lumb *et al.* 1981).

There has been little published research examining the health experiences and perceptions of Afro-Caribbean women specifically. This may be because early research has tended to focus on issues such as the lack of interpreters, female doctors, appropriate diets and translated materials, and these particular lacks have up until recently been seen as having little or no relevance to Afro-Caribbean communities.

Research studies examining the health experiences and health needs of Afro-Caribbean families have focused on child-rearing practices, nutritional disorders, and inherited blood disorders (Martin 1965; Gans 1966; Stroud 1971; Ward *et al.* 1982). Thus Afro-Caribbean women and their experiences and perceptions of health were largely ignored except for some anthropological work by Sheila Kitzinger (Kitzinger 1981).

More recently Donovan (1986) and Thorogood (1988) have examined the health experiences of black women in Britain. Both are

white women and may not document accurately or fully understand the experiences of black women. This is not to say that white women cannot do anti-racist research, but that there may be many experiences that black women have which white women cannot understand or empathize with. Jenny Donovan, in *We Don't Buy Sickness, it Just Comes* (1986), very lucidly outlines methodological and theoretical problems encountered by white researchers when attempting to examine the health experiences of black people. However, in her own research she fails to overcome some of the difficulties she describes. In an ethnographic study of the health experiences of black people in London, Donovan outlines the experience of a sample of Afro-Caribbean people and Asian people in relation to health services, and their perceptions of health. Although the research seeks to examine the effect of racism in determining the health of black people, there has been no attempt to examine the part that gender may play, and little attention has been paid to women as unpaid health workers in the family. Donovan concludes that the informants' lives are more patterned by social, economic and political systems and racism than by culture, but does not explore differing perspectives of class and gender within the black population.

The relevance of feminist methodology and research to black women

Many feminists have argued that traditional social science methodologies have excluded women or have portrayed them in sexist ways (Roberts 1981; Graham 1983). This section of the chapter explores the relevance of feminist perspectives and methodologies, as developed by white women, to the experiences of black women. Stanley and Wise (1983) argue that,

The central and common belief shared by all feminists is that women are oppressed.

- 2 The personal is the political, so that by examining power relationships in personal and family life an understanding of social structures and economic systems can be gained.
- 3 The actuality of a 'feminist consciousness' means that women are more able to understand contradictions present within life and have a double vision of reality.

They further argue that in doing feminist research, the presence of the researcher should be acknowledged and utilized; it affects the

research outcome. Oakley (1981) supports this approach and argues that the paradigms of traditional interviewing where the interview is seen as a one-way process; where the interviewer elicits and receives information but does not give 'it'; where interviewees are seen purely as data; and where interviews are seen as having no personal meaning, are contradictory to feminist theory and practice.

It would appear on the face of it that the theoretical perspectives and methodology offered by a feminist approach have equal relevance for black women. I now wish to examine in more detail some of the underlying concepts and assumptions of this approach.

A feminist perspective seeks to examine shared features in the experience of women and starts off from the basic premise that all women are oppressed. Amos and Parmar (1982: 146), in trying to define the oppression of black women, state,

Racism is not the only oppression a black woman faces. She is also oppressed in class terms, as part of the working class and in gender terms because she is a woman.

They argue further that because of their own racism, white women are unable to understand the experiences of black women who face racism everyday. Furthermore white women fail to understand a number- of cultural traditions which exist in black communities and label practices they do not understand as oppressive. Asian women are often perceived as dominated and submissive (Amos and Parmar 1982), while less attention is paid to the experiences of white working-class women and the oppressive practices of white men.

White feminist researchers, however, while recognizing the inadequacies of quantitative research methodologies and social survey techniques developed primarily by white men, fail to address the issue of white women interviewing black women. There is an assumption that the shared experiences uniting women outweigh differences in relation to race and class. None of the white feminist writers exploring women's experience of health have examined the dimension of race in relationship to the interview process between a white researcher and black participant and the power relations which may affect it.

Donovan (1986) and Thorogood (1988) both point to difficulties that could arise in relation to access to black communities but do not go on to explore whether differences in experiences between the white researcher and the black participant has any effect upon the interview process. Furthermore neither researcher considers the effect of the limitations of her own ethnocentrism on an understanding of

and adequate representation of black women's experiences. An assumption of much feminist research is that women as interviewers may share common experiences with the women they interview. This is not always the case in relation to black and white women.

Feminist research examining gender inequalities has focused particularly on the private world of the family and has examined the social role of women in the family. Again, much of this research has tended to be Eurocentric and has ascribed particular roles to women within the family. I have described in an earlier section¹¹ of this chapter the way in which the health of black families has been portrayed in the early literature. It is this portrayal of Afro-Caribbean and Asian family organization that is central to a critique of white feminist perspectives. The underlying assumption of white feminists is that black women's experience of patriarchy and their relationship to the family and work is similar to that of white women.

Hazel Carby (1982) argues that within white feminist theory the family is seen as the central site of women's oppression in contemporary society and that 'the family', 'patriarchy' and 'reproduction (which are central to feminist theory) are problematic in their application to the lives of black women. She argues that the black family during slavery, colonialism and the present authoritarian state is a site of political and cultural resistance to racism. A further concept inherent in feminist theory is that of 'dependence' and the material organization of the household. Again Carby argues that black women may be more likely to be heads of households, added to which the economic system produces high black male unemployment; hence black women may not be financially dependent upon men. Finally, within the state and increasingly within white feminist theory (Carby 1982; Parmar 1982), the black family has often been constructed as pathological and more oppressive than the western nuclear family structure.

This issue has been examined in relation to health by Curren (1986b) in a study of Pathan women and mental health. She demonstrated that assumptions about the authority of the husbands of Pathan women and *purdah* were incorrect.

To summarize: white feminist analyses of black families have often been ethnocentric, with little recognition that the internal worlds of black women are very different from those of white women in terms of the relationship of women to work, to the family and to concepts of the family. Furthermore, although there is a complex interrelationship between race, class and gender, for black women

racism is paramount (Carby 1982; Parmar 1982; Amos and Parmar 1982).

Feminist theory and methodology fail to incorporate the external factors impinging upon black women as well as internal factors in that the experiences of black women are circumscribed by racism within society. In so far as feminist theory and methodology are products of white society, it can be argued that they too reflect ethnocentrism, individualism and racism and do not allow for the everyday life experiences of black women to be addressed and incorporated.

Developing a research methodology to document and describe black women's experience of health services

There is a dearth of literature which adequately documents and explores the experiences of black women in relation to health and health services. Many policy documents examining the health needs of black communities (Training in Health and Race 1984; Pearson 1985) point to the need to develop health services that are more sensitive to black communities in general and black women in particular, but there is very little documented research identifying specific issues or areas for concern. One of the few published pieces of research by a black woman documenting the health experiences of other black women is a survey of young Afro-Caribbean women's experiences and perceptions of pregnancy and childbirth (Larbie 1985). Another is *The Heart of the Race: Black Women's Lives in Britain* (Bryan *et al.* 1985), in which three black women document the experiences of some black women in relation to health. In a review of research about women who become pregnant early in life, Ann Phoenix argues that narrow cultural definitions are used to explain why young Afro-Caribbean women become pregnant and that this approach masks similarities between black mothers and white mothers (Phoenix 1988). There is a growing body of research and documentation on racial discrimination within the health service in relation to the employment of black health workers (Doyal *et al.* 1980; Baxter 1988). The research on this discrimination focuses primarily on racism and only a few studies have tried to examine the interplay between racism and sexism (Torkington 1984).

The major difficulty in exploring black women's experiences and concepts of health is to find a way to express the complex interrelationships of class, race and gender without being constrained

by anyone of them. Existing approaches may be too restrictive in that examining social and economic inequalities may reduce and subsume issues of race and gender to class, while white feminist approaches may subsume race and class and approaches examining racial inequalities may largely ignore class and gender and seek to unite people because of their common experience of racism. Hence in many areas of research black women become invisible.

Research into women's health, and the experience of women as paid or unpaid workers as examined by many white feminist researchers (Graham 1983, 1984; Oakley 1979; Roberts 1981), has paid little attention to the particular experiences of black women and has assumed that the experience of all women is predominantly circumscribed by gender. Graham (1991) reviews the way in which the concept of caring has been theorized within British feminist research and argues that research on caring has remained largely untouched by black feminist and anti-racist scholarship. Hence contemporary white feminist analyses do not provide the means either for understanding or challenging the position of black women. Although gender is the main concern in the research on caring, the lack of reference to the experiences of black women as paid or unpaid carers in this area is to suggest that white feminist analysis has been racist in terms of the invisibility of black women.

There are indeed many areas of women's health where the concerns of black women have not been addressed to any great extent. These include the health experiences of older women of the menopause and the mental health experiences of black women. Mental health is a further area where the research that has been conducted has been based upon stereotyped cultural assumptions. Again this approach attempts to impose cultural homogeneity on to a particular group and has made little attempt to examine structural factors. Cultural labels are used as a means of identifying an individual's culture as significant rather than social or material circumstances experienced by black and minority ethnic communities in Britain. Inappropriate terms to describe mental illness have been developed, for example 'West Indian Psychosis' (Rack 1982) and 'Begum Syndrome' (Littlewood and Lipsedge 1982).

Thus to conclude this section, methodologies and theories need to be further developed to take account of the complexities of race, gender, class as well as culture and the relationship of black women to their families and communities and to paid and unpaid work. I have attempted to review the existing research in relation to health and its

relevance to black women. Only limited aspects of the lives of black women have been documented and more work is needed to describe wider aspects of their lives in relation to the public and the private domains as well as paid and unpaid labour.

Black women's health: the future

This chapter has sought to identify some of the gaps which exist both in current research about the health needs of black women and the methodological and theoretical frameworks which have been adopted to date. Further research is needed on areas already identified, but also black women must be involved in setting the research agenda and conducting future research. Many academic organizations are structured in such a way that black women are excluded from the research process. Academic institutions presently involved in women's health research need to give consideration to how structures will be developed to allow positive development of work in this field.

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