Social and Cultural Factors in Health of Children of Immigrants*

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A knowledge of our patients' environment and of the many ways in which it contributes both to health and disease is essential to diagnosis, treatment, or prevention (Saunders, 1954). There is the relation, too, between us as practitioners and our patients, which is necessary to the practice of our skills. If, because of our manner or our lack of understanding of group-related differences, we cannot establish a relation which gives satisfaction to our patient, and especially in paediatrics, to his family, then however efficient in other techniques, we cannot give good medical care in the fullest sense.

The skill required to establish and maintain these relationships is based on a knowledge of the psychological and social factors underlying the behaviour of people including, of course, the physician himself (Saunders, 1954).

With patients from our own social *milieu* or cultural environment, rapport can be easy and much can often be taken for granted; but with patients who are immigrants or on a social class level different from our own, there must be a conscious effort to learn and to understand; they too have to learn about us, but this will be a much more gradual process because they start at such a disadvantage.

The Study

In this paper, I describe a research project undertaken by a team from St. Mary's Hospital Medical School. The field of our activity was Paddington, the area served by the St. Mary's Hospital Group and having a high proportion of immigrants among its population. The larger groups of these immigrants are from Eire and the West Indies. West Indians were forming an increasingly substantial

part of our patient population. Clinical experience and some small-scale studies made us think that West Indian children were facing difficulties in growing up which differed from those experienced by the indigenous population. The problems included iron deficiency anaemia, rickets (Oppé, 1964), and burns (Stroud, 1964); but other less specific findings disturbed us; the young children who just sat, immobile, uncomplaining, through a long outpatient interview; the often-repeated reply of the mother 'yes please' to our questions which made us feel despairingly, 'are we really making contact?' We felt that we did not know nearly enough of the backgrounds of our patients to understand fully the genesis of many of the clinical problems presenting at our infant welfare clinics and hospitals.

We therefore set out to study some West Indian children and their families, with a particular interest in the use they were making of the medical services: were those services readily available at the times when mothers might need them and, if used, did the patients at the same time obtain benefit? We planned a continuing study, to follow the family fortunes and the child's development, and chose 1-year-old children for the first investigation (Hood *et al.*, 1970), following them up 18 months to 2 years later. We saw 101 mothers and babies, selected only by age and locality, so the generalizations to be drawn from our results are limited. It is a description of some 1-year-olds and the setting in which they are growing up. Yet, since all of the children studied are children of first generation immigrants, some of our findings will apply to other such immigrants, no matter what their race or locality.

Though the main study was confined to West Indians, we obtained parallel information from Health Visitors on non-West Indians and their families who lived in the same area, and reliability

*Based on a paper given at the 41st Annual Meeting of the British Paediatric Association, Scarborough, 22-25 April 1970.

tests allowed us to make certain comparisons (Hood *et al.*, 1970).

The 1-year-old children

The babies at 1 year were on the whole healthy and there was certainly no evidence of physical neglect or deformity, and, developmentally, the majority came within the limits of normal. To this extent the medical services were obviously fulfilling their function. There was some doubt, however, about the quality of the 1-year-olds' diet, and they had suffered more from respiratory disease and other minor illness and had been in hospital more often than their non-West Indian peers. There was also evidence of lack of environmental stimulation, particularly for the walking, exploring toddler. In fact, we felt that this was the area which merited more detailed investigation in our follow-up: the environment of these toddlers, their experience in care both at home and with minders, and its effect on their present and subsequent development.

The Mothers

Comparing them with the non-West Indians we found that in all the aspects studied, the mothers were at a disadvantage: in employment, in housing, and in health. Social class ratings tended to be lower; the mothers had to care for a larger number of children in more overcrowded conditions (64 of them having just one room) and fewer of them had the consistent support of a father figure. More than 50% of them had the additional burden, economic and emotional, of children living overseas. Three times as many had to work outside the home, and despite the fact that West Indian mothers used the available medical services at least as often as the control group, their children had experienced more illness.

Follow-up at 2½ to 3 years

At age 2½ to 3 years (Table I) the numbers were reduced to 87 and we lacked a control group for comparison, largely for practical reasons. The children still suffered from a high incidence of respiratory infections, 20% at the time of my interview showed evidence of this; and the attendance at casualty for some accident or injury, usually minor, had increased.

In so far as developmental attainment was concerned, the picture was more disturbing. Miss Nora Gibbs, the psychologist who worked with us in the follow-up, tested 65 of the children. By choice, she did this 'blind', that is, without any prior

TABLE I
*Evidence of Illness or Abnormality at Follow-up
Aged 2½–3 years*

Disorder	No. of Cases
Respiratory system	17 (20%)
Gastrointestinal system	2 (2.5%)
Skin	9 (10%)
Cardiovascular system	4 (5%)
Emotional disorder	2 (2.5%)
More than one of above	7 (8%)

knowledge of their background or illness or care-taking experience. I quote now from her interim report to the rest of the team: 'One cannot help asking, are these children held back all round by one or more environmental factors?' The tests used (Stanford-Binet scale, the Merrill Palmer scale, and the Vineland Social Maturity scale) had, of course, been standardized on English and American children and they had to be administered under conditions that were less than ideal. On those tests which assess verbal development in particular, performance was poor, yet the children also failed to do well on tests where manual dexterity is an asset. The psychologist generally had the impression of a conforming culture with emphasis on manners, cleanliness, and obedience.

I have described, then, a group of immigrants whose children have increased experience of ill health and who, as they grow older, seem developmentally *not* to be fulfilling their potential.

Environmental and Cultural Factors

The burden of increased ill health can undoubtedly be related to adverse environmental circumstances. Sufficient evidence has already been amassed to show the effects of poverty and its consequences to explain partly at least their health problems (Schorr, 1966). Yet these environmental factors may not entirely explain why the West Indians differed so much from the control group. Both groups share similar demographic characteristics and both have had ample opportunity to learn the workings of the various health services. Both, after all, live as neighbours in a relatively deprived community.

Though the West Indians use the health services at least as often as the non-West Indians (Hood *et al.*, 1970), we cannot be certain that they benefit in the same way as a result of these contacts. It could sometimes be that, however well motivated they are to use advice given them, they simply do not have facilities to implement it to the full. It was a painful and humbling experience for me,

when visiting their homes, to recall some of the advice I have given from the setting of an infant welfare clinic. Again, though advice may be accepted and understood by the mother, it may not be implemented by the minder who cares for the child for most of the day. Finally, since our services depend so much on effective communication, these mothers may be experiencing the disadvantages of being a group who do not share our cultural norms and whose health practices and attitudes have been fostered in quite different circumstances.

West Indians do share with us a common citizenship and adherence to Christian doctrine, but the social and cultural patterns of the lower income majority (and these form the bulk of the present-day migrants) differ in many respects from the pattern of the lower and lower-middle class indigenous population (Patterson, 1963). Our study showed some of these differences. It is not always easy, of course, to separate out cultural from other factors: economic pressure, for instance, or limitations of the physical environment. But it is very likely that environmental factors reinforced by cultural attitudes and patterns played a substantial part in holding back some of the children 'all round'.

Family Patterns

In the West Indies, where patterns relating to sex and kinship were set in slave days, 'the permanent marriage tie has remained an index of high economic as well as social status' (Patterson, 1963). In view of this, it came as a surprise to us that 65 of our mothers were said to be married. 14 were living in stable cohabitation, the more customary pattern in the West Indies. 20 were single. Though the pattern does seem to have altered since coming to Britain, nevertheless 20% of these children, as compared with 5% of the non-West Indians, were living with just one parent (Hood *et al.*, 1970). It is still accepted in British society that the stable nuclear family as represented by the married couple and their child provides the best environment for optimal development. Otherwise the whole burden of providing falls on the mother, and the young child lacks, among other things, the link the father can provide with the world outside the home.

At most social levels West Indian attitudes to sex and procreation remain relatively untouched by puritanical teachings, and sexual intercourse is regarded as a natural activity with procreation as the natural outcome. Barrenness and artificial prevention tend to be thought of as unnatural,

unhealthy, even wrong (Patterson, 1963). This attitude makes itself explicit in the number of children the West Indian mothers bear, and with each new addition the material or emotional demands on the mother increase. In our study, current households averaged 2.5 children to each West Indian mother as compared with 2 to the non-West Indians; but if we add to this those children still living in the West Indies who are making their own financial and emotional demands, then the average rose to 3.5. Further, at the time of our interview, 6 of the 1-year-olds were no longer the babies and 25 mothers were pregnant. And, just 18 months or so later, there were 50 more babies with 8 more expected (Table II).

TABLE II

Number of Babies Born to, or Expected By, Mothers in 18-Month to 2-Year Period Between First and Second Interviews

Babies and/or Pregnancies	No. of Mothers
One baby	30
Two babies	4
One baby + miscarriage	4
One baby, pregnant now	8
Pregnant now	2
No further babies or pregnancies	38
Not known	1
Total	87

Clearly, given the limitations of their present living conditions, the practice of effective contraception would be to their advantage. Some had already recognized this and had been to the family planning clinics. Many hesitated to practise: 'It makes you sick', 'I am Catholic', 'My husband says it will harm you', they said. And yet, they were interested. Whereas 46 in the first study had taken 'no steps at all', this number had fallen to 32 in the follow-up. Nevertheless, we must view this with cautious optimism since 9 of those who earlier had practised had now given up for a variety of reasons, and several were expressing anxiety about continuing. 5 of the study mothers had been sterilized.

Working Mothers and Child Minders

The West Indian islands are poor, and there is no universal compulsory education. Our mothers made it clear that they had been brought up with the idea that women worked wherever employment was available; this was the accepted pattern. Many gave the possibility of employment as their main

reason for coming here. Yet only 4 had had any specialized training. The average weekly income of the fathers was £14.75, so that many mothers, while expecting to work also, for economic reasons, *had* to work. The circumstances of the family are greatly affected by the mother's contributions and this has considerable bearing on her ability to meet the physical needs of the child; but the amount of time she can spend in taking care of her child is greatly reduced and she may well be tired when he is in fact with her. 51 of our mothers were working outside the home, and an additional 14 had worked at some time during that previous year, whereas just 18% of the non-West Indian group were working. By the time the study child was 2½ years old, only 17% of the West Indian mothers had never worked (Table III).

TABLE III
Mothers Working Outside Home

	Mothers (%)
At first interview	51
At follow-up	56

This of course means that their children had to be minded; for some, the experience had begun in the early months, and some, by a year, had had 2 or even 3 minders. Though there are undoubtedly pressures compelling the mother to work, it is also a fact that few children in the West Indies are brought up entirely by their own mothers since there the 'extended' family plays a much more active part (Gregory, 1969). The mother is not so conditioned to our idea of a child's close relationship with one person, and this makes her less reluctant to leave her child with others. These factors may make her less discriminating, too, when choosing substitute care. The social worker in our follow up study found that great importance was attached to cheapness and nearness of the minder, and often the mothers expressed bewilderment and exasperation about the whole concept of having to pay since this was contrary to established practice in the West Indies (Gregory, 1969). The first choice of minder here was probably a relative (Table IV), and 27% of the children at follow-up were cared for in this way. 37% were with unregistered minders. The number of available day-nursery places is small, but three-quarters of the mothers had not even considered them. The majority of the unregistered minders and of the relatives lived in overcrowded conditions similar to those of the mothers.

TABLE IV

Arrangements Made by the Mother for Baby Minding

	At 1st Interview (%)	At Follow-up (%)
Day nursery	14	24
Registered minder	16	4
Relatives	42	27
Unregistered minders	28	37
Left alone for half a day	Not known	8
	100	100

Relationships Outside the Family

Finally, West Indian social organization and culture are still primarily rurally based, which makes it more difficult for the immigrants to adapt to the highly complex sociocultural environment of our cities. Most of our mothers came from the country or minor towns. At home, the principal supports for mother and child had been the 'extended' family, particularly the maternal grandmother, the local community, and the church. Over here they tended to lack, or were unable to use, such supports. Church attendance had declined, and 75% of the grandmothers remained in the West Indies. The majority did in fact have some relatives in London with whom they kept contact, and this was important for them, but there was little evidence of organized social or group activity or community life. Providing the basic necessities for living took up too much of their energies. Beyond contacts at work, it appeared that little else was derived from the larger community which might enrich family life.

Yet the families were making use of the health services (Hood *et al.*, 1970)—often substantial use. Their expectations of us may well be greater because they have less from the community at large.

By omitting to say that there were those children who remained well physically, who did well developmentally, and whose family life seemed rich and secure, I have given a rather one-sided picture. Yet they were in the minority and I think that as doctors we will see fewer of them.

For the others, the more radical solutions may not lie with us. But for those of us who do organize or provide medical services for groups such as the West Indians in Paddington, it is only, I think, by taking the factors I have described into account that we can make a really effective contribution.

Summary

A study of 1-year-old West Indian children and

their families, with a follow-up study when the children were aged 2½-3 years, has shown the following: (1) The children at 1 year suffered more from respiratory disease and other minor illness and were more often hospitalized than non-West Indian 1-year-olds. (2) At 2½ to 3 years these children seemed developmentally not to be fulfilling their potential.

It is suggested that adverse environmental circumstances reinforced by cultural attitudes and patterns, many of which differ from those found in the indigenous population, play a substantial part in explaining these findings.

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