# RESILIENCE AND HEALTH

# SALVADORAN REFUGEE WOMEN IN MANITOBA

## BY

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**A Thesis
Submitted to the Faculty of Graduate Studies
in Partial Fulfilment of the Requirements
for the Degree of**

## MASTER OF SCIENCE

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# ABSTRACT

This qualitative study describes, from the perspective of women themselves, the health of Salvadoran refugee women living in Manitoba, their understanding of causes of health and illness, and the strategies they use to maintain health and cope with health problems. Participants fled war - related violence in El Salvador and arrived in Canada during the period 1982-1992. The study was designed in collaboration with Salvadoran women. Methods included qualitative interviews with 12 women, two focus groups (for a total of 18 participants) and participant observation. The research process included a feedback stage, which enabled participants both to review excerpts from their own stories and to comment on the interpretation of themes and conclusions.

Differences in social class were associated with systematic variation in women's life experiences and their expectations of, and satisfaction with, services and life in Canada. However, the study identified characteristics and coping strategies which transcended social class, and focused on resilience and pragmatism. Study participants described an understanding of the determinants of health and illness that was multi-causal and multidimensional, and which emphasized the social roots of health and illness. Their perspective suggests major limitations to the Determinants of Health model emphasized in North America. While many participants reported war-related trauma, on-going distress related to adaptation to life in Canada, and continuing community polarization and mistrust were described as having a greater effect on current health. The findings challenge the emphasis on individual diagnoses of psychological disorder, suggesting that efforts should be addressed to the social and behavioral effects of violence, betrayal and uprooting.

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## EXECUTIVE SUMMARY

This research study describes, from the perspective of women themselves, the health of Salvadoran refugee women, their understanding of the causes of health and illness, and the strategies they use to maintain health and cope with health problems.

Winnipeg received approximately 2,000 refugees from El Salvador over the ten year period from 1982-92. These new arrivals fled extreme violence and many had been exposed to war- related trauma. Participants had been in Canada from 7-17 years at the time of the study. As the Peace Accord brought an end to the civil conflict in 1992, community members do have the option of returning to their country of origin. This set of circumstances provided a unique opportunity to investigate medium to longer term effects of trauma and migration on a population.

This qualitative study was designed in collaboration with women from the Salvadoran community in Winnipeg. In - depth interviews, community focus groups and participant observation techniques were used. Twelve women participated in the interviews. In addition, there were a total of 18 other participants in two focus groups. Interviews were generally scheduled over two or more visits, providing the opportunity for clarification and elaboration of issues raised. A feedback phase followed the completion of the report. Individual participants were provided with the opportunity to review narrative excerpts from their stories, and to respond to the themes and conclusions emerging from the study.

# KEY THEMES

Several key themes emerged through this research, and are interwoven throughout the report. These themes are summarized in the following sections.

## Identification of Self in Terms of Family

Women from all social classes identified themselves as members of families and saw themselves as having a central role in the life and health of their families. Because the role of the mother was of central importance, women who experienced neglect or rejection from their mothers demonstrated great distress. Family difficulties appeared to be of greater importance to the women's sense of well-being than the factors related to external violence and deprivation.

## Importance of Social Class

Social class emerged as a key factor in explaining different experiences during the pre-war period, during the war, and in adapting to Canada. Experiences and expectations of life in Canada, and of health and health care are linked to class. In Canada, for the first time, those of different social classes are using the same health, social and educational services, and often forced to participate in the work force at the same level. This mixing of socioeconomic classes in Canada is perceived as contributing to community tension, and while earlier in the adaptation process political divisions were of greatest concern, at this point, class differences are identified as the most divisive.

## Violence

The participants described a culture of pervasive violence, which existed before the "war" erupted. The types and level of violence to which individual women were exposed, however, was moderated by social class. Structural violence, originating with colonialization, denied rights and basic resources to a large segment of the population. Violence within the family, and within the community was also common. War - related violence and exposure to violence during migration had the greatest impact on the poor, particularly those living in rural areas. However, in Canada, women reported taking an active role in addressing violence within the family, by adopting different techniques of child discipline, and using societal resources to protect themselves and others from abuse and violence.

## Faith and the Church

Another theme which crossed the lines of social class was that of religious faith. In general women saw God, and ones faith in Him, as central to their lives and the source of health and protection. Informants also described prayer as a key coping technique. God was understood to transcend ordinary cause - effect relationships and so is key to explaining survival and health.

## The Assault on Community

The theme of assault on community begins in El Salvador, and the effects continue through to the present day. Study participants described a community that

continues to be marked by intense and sometimes dehabilitating distrust. This mistrust, like the violence, appeared rooted in the national history of state terrorism, and linked to the characteristics of the Salvadoran conflict: a deliberate strategy of warfare which led to fear, anxiety and the destruction of normal social relations. For a society which is based on extended family an social networks, this had a devastating effect. A number of women reported events of betrayal or suspected betrayal, by those close to them, including family members. This mistrust and betrayal continues in the community today, and was a dominant theme in the interviews.

## Resilience

Another theme which was expressed by informants was that of resilience, at both the community and individual level. Closely linked to this was the characteristic of pragmatism: women showed little commitment to past practice or tradition, unless it was perceived as useful. Utilization of services, participation in the work force, health care practices, or child rearing approaches, can be best explained by the women's concrete experience of what is effective for them, rather than adherence to any particular belief system. Women describe themselves, and are described by others as strong, adaptable, assertive and practical.

# CONCLUSIONS

## Perceptions of Health Status

Generally, women described themselves as healthy . Most differentiated between physical and emotional health, and tended to rate their emotional health somewhat lower than their physical health.   They describe clear links between psychological health and somatic symptoms.

Many  women described their lives as having been full of challenge, loss and suffering.  However, they did not see themselves as victims, and resented pity.  In most cases they have found ways to survive and to adapt, while protecting and supporting those close to them.

## Explanations for Health and Illness

Study participants described an understanding of the determinants of health and illness that was multi-causal and multidimensional, and which emphasized the social roots of health and illness.  Their perspective suggests major limitations to the Determinants of Health model emphasized in North America.

Psychological concerns and family problems were understood as a major cause of illness.  Both stress and depression were major factors in women's lives, and many women believed that these factors were key to understanding health complaints.  A number of women reported some symptoms consistent with post traumatic stress,

however the women usually normalized these reactions. There was a tendency to focus on the migration and adaptation experience as the major focus of psychological causes for distress. This appears consistent with the emphasis on "present" orientation, the tendency to attribute current health problems to current events. The focus on adaptation difficulties captured one major trauma experienced by all arrivals, and unlike trauma experienced in the home country could even be shared safely with others in the community. Continuing community polarization and mistrust were described as having a greater effect on current health than past trauma.

Most women were open to a number of different possible explanations for illness and health, but generally did not look to family history or genetic susceptibility as an important causes of illness. Although illness due to infective agents was also recognized, this was not seen as a major factor at present. Social factors, consistent with the determinants of health, were recognized as of major impact. God, and ones faith Him, was the key factor in explaining health, or survival, and could override other health determinants.

## Coping techniques

Women used a range of coping techniques to maintain health and treat illness (physiological, or psychological).

There was no organized alternate system of health belief or system of medical practice, although there were various family or community based traditional treatments that some women continued to use. The use of these home remedies was eclectic in nature and variation in patterns of use appeared to be only loosely connected to social class. Effectiveness of treatment in the past predicted current usage. Use of home/herbal remedies and modern medicine were not seen as mutually exclusive and many families used both.

Focusing on the needs of the family, praying, talking, crying and working were reported as useful coping techniques. These were viewed by the participants as gender specific strategies, and there was some suggestion that male coping strategies may be very different.

## Family and Community Health

A number of issues were perceived as influencing family health. Most women express concern about their children, and there was a general concern about the youth in the community, particularly around issues of intergenerational communication, substance use, adolescent pregnancy and involvement in the justice system. Domestic violence continued to be of concern, and there was also concern expressed by some women regarding sexual abuse. Unlike domestic violence, child sexual abuse does not appear to be recognized, or discussed within the community.

A high level of concern was expressed by most informants regarding tension and distrust within the Salvadoran community. This remains the source of much anxiety to individuals.

**Experiences with and Expectations of Health and Social Services**

Experiences with health care provision in country of origin, and satisfaction with Canadian health services were strongly linked to social class. In general, the poorer women were highly appreciative of health care services in Canada, while those from more privileged backgrounds were less impressed. However, there appeared to be no significant differences in use of the Canadian health care system related to class.

Participants used the health service system confidently for physiological complaints, however, they shared little of their past lives and were frustrated in finding solutions for problems they felt were emotionally based. Generally there was no sharing with health professionals of past history, even when this may have been relevant to treatment.

Settlement services, as well as English as a Second Language services, were perceived less positively, and a number of women described negative experiences with them. More positively described were the culture or language specific services offered through community organizations. Participants also reported confident use of the police for issues related to domestic violence. There remains limited awareness of the range of

services available through other not for profit community organizations, including

counselling services. In general, women stated they would prefer to use "Canadian"

rather than "Spanish" professionals for psychological or sensitive family concerns, and

distrust regarding breakdown of confidentiality remained.

### Long Term Adaptation and Integration

Even though all of the women have been living in Canada for a number of years,

with the exception of workforce participation, there was limited participation in the larger

society. Many of the women, for example, reported no "Canadian friends". Many

women expressed feelings of on-going depression and grieving related to loss of family

and of country. A number of women were still limited in their social participation by

limited fluency in English. Many still struggled with lack of access to services and

limited opportunities for employment.

### Summary/Recommendations

The key challenges facing the community were described by informants as rooted

in social causes: the violence and resulting destruction of community during the civil

conflict. The results of this continue to be seen in Winnipeg, in ongoing suspicion and

distrust of other community members. The solutions then must also be rooted in the

community.

While there is some indication that resources to help individuals cope could be better utilized, the focus for addressing the community problems must be based in the community, and realities of the past. There is evidence that dramatic changes to old patterns (e.g. in child discipline and domestic violence) can be made in a new environment, wherever women can find opportunities. The issue of negative gossip, mistrust and betrayal, are issues private to the community and the solutions must come from within. Until this occurs, there is a risk that unresolved community dynamics may delay or complicate the process of long term adaptation and integration. At present, community problems, along with limited integration into the larger Canadian society, continue to create stress and are expressed in terms of individual health concerns.

Study findings challenge the emphasis on individual diagnoses of psychological disorder, suggesting that efforts should be addressed to the social and behavioral effects of mistrust and violence.

# PREFACE

## Organization of thesis

The thesis is organized into four main sections. The first section, the **Introduction,** consists of two parts. *Chapter 1* is divided into two sections. The first sketches a brief historical overview of El Salvador in order to provide the reader with the context of the migratory experience of refugees from that country. The second provides a review of relevant research related to immigrant and refugee health. *Chapter 2* elaborates the design of the study, and discusses some of the methodological issues that arose during the planning and implementation of the project.

The second section, **Themes,** explores six key themes that emerged through the study: family, social class, violence, faith and the church, community, and resilience. These themes emerged in almost all the interviews, and provide the context for the women's experiences with health and illness. The topics are not presented in a particular order but are best understood as themes which are woven through many of the narratives.

The third section focuses specifically on **'Health'** as experienced by study informants. *Chapter 9* explores the women's perceptions of their health; how health is defined and understood, the relationship between psychological conditions and somatic complaints, and the health problems they describe through various life and migration stages. *Chapter 10* focuses on views of determinants of health and causes of illness, with a discussion of the limitations of the model emphasized in North America. This chapter includes a

discussion of other factors and dimensions which more appropriately express the women's perspectives. *Chapter 11* explores the personal coping strategies used by study participants in caring for themselves and for their families. The last two chapters deal with issues of services access, utilization and satisfaction. *Chapter 12* explores access to health care, health education and preventive services in El Salvador. *Chapter 13* discusses the utilization of, and satisfaction with, Canadian services.

In the final section, **Conclusions,** study findings are reviewed in the light of previous research. Characteristics of this population that appear to contribute to resilience and adaptation are discussed. This chapter also explores the implications of the research findings for health and social service practitioners, as well as for community members themselves. Directions for further research highlighted.

## Format

The body of the thesis is set in regular font. Direct quotes from the transcripts of interviews and focus groups are set in indented italics. Summaries of events from the transcripts, and excerpts from the researcher's field notes are also single spaced and indented, but are not italicized.

## Terminology

For the sake of convenience, both the author and many of the research participants refer to Salvadorans living in Manitoba as the Salvadoran "community". It should be noted

however, that this terminology masks the complexity of relationships found among the population of Salvadoran Canadians. Issues related to community are explored in Chapter 8.

## A special note

The reader should be aware that this thesis includes narrative excerpts that contain some explicit description of experiences of pain and violence.

# CHAPTER 1: BACKGROUND

This chapter is divided into two sections. The first provides a brief overview of

El Salvador, the country of origin for the participants in this study. This overview

focuses on the political context which led to the migration of Salvadorans to other

countries. The second section provides an overview of the research related to specific

health issues affecting refugees, particularly refugees fleeing political violence.

**El Salvador: An Overview**

History and Political Context

Although traditionally viewed as the most progressive and enterprising of the

Central American nations, El Salvador has suffered some of the greatest poverty and

social upheaval in the region in this century.

The conflict in El Salvador, which erupted into civil war in the late 1970's, has its

roots in the conquest of the Central American region by Spain in the sixteenth century.

Since colonial times, many of the poor lived and worked on communal lands. In 1881,

this communal system was abolished by the national government, and most of the land

acquired by coffee growers. This had the effect of forcing thousands of people from their

land, while at the same time creating the workforce necessary to support the coffee

plantations. To enforce this legislation, new rural police forces were created. Labourers

lived in a state of virtual slavery; vagrancy, failing to arrive for work, or "running away"

were identified as crimes which could be punished by beatings, fines and imprisonment. When the bottom fell out of the coffee market in the depression, economic desperation resulted in a popular uprising in 1932. This revolt was crushed in two days, and was followed by what is called *La Mantanza* (the slaughter, or massacre) of an estimated 30,000 Indian peasants by the Salvadoran military (Americas Watch, 1991; Beirne, 1996; Brown , 1985). This remains one of the most significant events of Salvadoran history, and of great meaning to the lives of individual Salvadorans. Almost overnight, the indigenous peasants abandoned native dress, language, names and customs, and attempted to merge into the mestizo (mixed race) population (Alegria, 1983; Thomson, 1986).

Following *La Matanza*, the status quo was maintained for almost 50 years, and El Salvador was ruled by the military until 1992. The majority of the population continued to live in desperate poverty, while a small minority controlled the land, the wealth, and the military. Beginning in the 1950's, and throughout the sixties there was a growth in the industrial sector which surpassed that of any other Central American country. This growth, mainly in textiles, resulted in the development of labour unions, and establishment of a minimum wage and some social benefits for the industrial sector. However, there were no such changes in the rural areas. After 1950 there was increasing expansion of commercial crops, with cotton and sugar joining coffee as export commodities. The number of landless peasants increased from 11% in 1961 to 40% in 1975 (Americas Watch, 1991).

In the 1960's ORDEN (*Organizacion Democratica Nacionalista*), an 80,000

member paramilitary network was established by the government, with the purpose of

maintaining surveillance in every hamlet in the country through a system of internal

espionage. During the 1970's, there was growth in such right-wing paramilitary groups

(death squads) which established a pattern of repression that was characteristic of

Salvadoran life (Americas Watch, 1991; Beirne, 1996; Brown, 1985; Dunkerly, 1982).

Death squads, generally plainclothes units of the armed forces, engaged in a style of

abduction and murder that sought to "preserve deniability for the perpetrators" and avoid

government accountability (Americas Watch, 1991, p. 21). The increasing repression in

rural areas contributed to an exodus of the landless peasants to the cities, which in turn

contributed to the growth of urban slums and shanty towns (Americas Watch, 1991). The

Catholic church, a central institution in the society, was at the forefront of the move for

change. This resulted in church workers becoming a direct target of repression (Americas

Watch, 1991; Lernoux, 1980; Sobrino, 1991).

The 1970's were marked by fraudulent elections and escalation in repression and

political killing. An election in 1972 was marked by blatant fraud and increasing political

violence. Rebel military officers led an unsuccessful uprising, the political and military

leaders of the uprising were detained and tortured. As peaceful avenues of change were

closed off, several armed opposition groups formed. Both unions and political groups

began to coalesce, and mass popular organizations began to form outside of the

traditional party structure. The 1977 elections were also marked by intimidation, violence

and fraud. Following the election, "all talk of reform was replaced by an escalating campaign of political killing" (Americas Watch, 1991, p. 6). The rural poor bore the brunt of the repression.

In 1979 the victory of the neighbouring Nicaraguan revolutionaries against a dictatorship in that country, created concern that similar events could occur in El Salvador (the "domino" theory). The result was a military coup which established a five member junta. However, it was not successful and in spite of stated declarations of changes, strikes and demonstrations were ruthlessly crushed. There was increasing death squad activity and military control, resulting in the resignation of two of the three civilian junta members (Americas Watch, 1991).

In 1980, the Farabundo Marti Liberation Front (FMLN) was formed, combining smaller guerrilla groups, and the civilian political opposition united to form the Democratic Revolutionary Front (FDR). In March 1980 a national state of emergency was called which suspended the constitutional protection of basic liberties. Archbishop Romero, a leading voice in the cause of the poor, was assassinated by government forces in March 1980; this accelerated the decline into open warfare. In January 1981, the FMLN called for a general insurrection. While it failed to spark a general revolt, it did precipitate a rampage by military and security forces which took the lives of thousands of civilians and suspected guerilla supporters (Americas Watch, 1991; Beirne, 1996; Brown, 1985; Dunkerly, 1982).

The 1982 elections have been described as a genuine contest between the right and the extreme right (Americas Watch, 1991). The left did not participate, at least in part due to fear. 1984 elections were similar to those in 1982; there were also accusations that the American Central Intelligence Association (CIA) financed the winning candidate (Duarte) to prevent the extreme right candidate from winning. Left wing candidates were murdered and "disappeared". ("Disappearances" were a strategy of extrajudicial executions. Individuals were not officially arrested, held in detention, or executed. They "disappeared". Even if there were witnesses to the "arrest", there would be no record of it having occurred, and in most cases the relatives never could confirm what happened. Individuals did not disappear, they "were disappeared").

By 1984, the FMLN controlled over a third of the country, mostly in the northern provinces. The Gross National Product had fallen a quarter since 1978, while over the same period of time the costs of living had doubled. Wages in the urban sector fell 40% in four years (Americas Watch, 1991). The government forces undertook aerial bombing, including with napalm and white phosphorus (Metzi, 1988; Lopez Vigil, 1991; Lundgren, & Lang, 1989) and ground sweeps known as "hammer and anvil" operations. The ferocity of the attacks depopulated large rural areas and caused the guerillas to adapt their strategy. By 1986 they began to work in smaller units closer to larger towns and cities. It was not until 1989 that the guerillas were able to launch an offensive in the capital. For many urban dwellers, this was the first exposure to the conflict (Americas Watch, 1991).

## The Role of the United States

Although El Salvador was of little interest to the United States until the 1980's, the revolution in Nicaragua in 1979 encouraged then President Carter to support socio-economic reform, and the United States embassy pressured for human rights improvements (Landau, 1993). At the same time the program of security assistance was expanded: at first this was limited to "non-lethal" aid, such as trucks, jeeps and tear gas. However, after the 1981 guerilla offensive, the Reagan administration provided weapons to the Salvadoran army, and in 1982 began training Salvadoran soldiers in the United States. El Salvador's popular revolt was framed by the Reagan administration as an attempt by "the Soviet Union, Cuba and Nicaragua to install communism by force throughout the hemisphere" (Brown, 1985, p. 115) , and to bring chaos and anarchy to the American border. This enabled the justification of increased American military aid, which increased from $5.9 million in 1980 to $196 million in 1984. Aid (military and economic) over a ten year period totalled almost $4 billion US, 85% of which was estimated to go directly to the war effort (Levy, 1997). The U.S. also provided military advisors and was implicated in many of the counterinsurgency operations and subsequent coverup.


## Impact of the Conflict

For over a decade, Salvadoran government forces deliberately terrorized the civilian society in an attempt to maintain power over it. The violence had two sources: open military confrontation, and undercover paramilitary repression directed against all

sectors of the population which supported, or was suspected to sympathize with, the insurgents (Americas Watch, 1991; Martin- Baro, 1989; Lundgren & Lang, 1989). During, (and before) the war, arbitrary arrest, imprisonment and torture of detainees was common. In addition, massacres of civilian populations, aerial bombings, rape of civilians, forced relocation , and dumping of mutilated bodies in public areas, along with the destruction of civil war, served to create a climate of state-induced terror which affected the whole population (Allman, 1984; Americas Watch 1991; Danner, 1994; Desjarlais, Eisenberg, Good & Kleinman 1995; Lopez Vigil, 1991). From the time of the mid 1980's the government also relied on the approach of "low intensity warfare", geared towards the control of populations, rather than of territory, through terror and destruction (Danner, 1994; Desjarlais et al., 1995; Lopez Vigil, 1991).

A characteristic of the war was denial of the atrocities by both the Salvadoran government and the United States. Major massacres of civilian populations, mostly women, children and the elderly, were often reported as "clashes with guerillas", or denied altogether. The story of one such massacre, at El Mozote in 1981, has been documented in detail, along with the subsequent cover-up, and the results of forensic exhumations following the war. An estimated 1,000 civilians, mostly children, were killed in this event (Danner, 1994). Even torture and assassination of North American citizens faced the same denial. Four American nuns and church workers raped and murdered in 1980, were accused of running a road block, and being associated with guerillas (Allman, 1984).

From 1980-1992 an estimated 75,000 (1.5% of the population) people were killed; almost all were civilians killed by armed government forces and deaths squads. Another million Salvadorans (20% of the population) fled the country, and an estimated 500,000 (10% ) were displaced within the country (Levy, 1997). Labour and peasant organizations, church workers, students and teachers, the press, political opponents, and health workers were specifically targeted (Americas Watch , 1991; Brentlinger, 1996; Levy, 1997; Lundgren & Lang, 1989). However, the poor, particularly in rural areas, suffered the greatest number of casualties (Americas Watch, 1991).

The 1992 Peace Accord

In January 1992, a Peace Accord was signed between the government and the FMLN. The peace agreement included a comprehensive plan for disbanding "death squads" and security units, and replacing them with a new civilian police force and intelligence agency under civilian control. Civil defense units were also disbanded and private security services regulated. The Peace Accord also mandated the creation of a *Comision de la Verdad* ("Truth Commission"), to investigate the abuses of the last decade. This has confirmed that violence against unarmed civilians was a systematic policy of the Salvadoran government, and that high - ranking army officers had ordered and participated in such high profile killings as the assassination of Archbishop Romero, the El Mozote massacre and the killing in 1989 of six Jesuits and their housekeeper (Amnesty International, 1994). The role of the United States in this conflict has also been confirmed (Americas Watch, 1991; Amnesty International, 1994). U.S. documents

confirm that many of the atrocities were planned with the full knowledge of the Reagan and Bush administrations (Levy, 1997).

Since 1992 the Peace Accord has held, and Salvadorans generally report being hopeful about the future. Several elections have been held, monitored by foreign observers, and in which the FMLN (the leftist opposition) has participated. Salvadorans have been rebuilding their country. Infrastructure destroyed during the war (roads, bridges, power plants), is being replaced, a process of acknowledgement of abuses of the war is underway, and foreign capital is reinvesting in the country. Many of the refugees from the last decade have returned home; many more have been able to return to visit family. However, there remain many challenges: continuing extreme economic disparity, a high level of unemployment, and a growth in violent crime.

## Demography

The smallest country in Central America, at just over 21,000 square kilometres, El Salvador is also the most densely populated, at 250 persons per square kilometre. The population stood at 5.4 million in 1992; 50% of the population is under the age of 15. Although poor in minerals, fertile volcanic soil enabled it to become an exporter of coffee and other crops. However, population and economic growth have had a negative impact on the environment. El Salvador is considered to suffer from the worst environmental destruction in Latin America, with 95% of its forests destroyed and significant soil erosion and water and soil pollution (Pan American Health Organization, 1990).

El Salvador is also one of the poorest countries in Latin America. The concentration of wealth and income in the hands of a few rich families, which is common in Central America, is exacerbated by the country's small size, a major earthquake in 1986, and a decade of civil war (Beirne 1996). A primarily agricultural country, 70% of the rural population live in absolute poverty. In the rural areas, 85% of all houses lack electricity, running water, or sanitation (Americas Watch, 1991). Only 39% of the population have access to safe drinking water. Half of all Salvadoran children under five are malnourished, (this rises to 75% among those who are displaced from their homes). According to a 1988 survey, 50% of all families have an energy deficit. Of displaced children under the age of 5, only 28.8% had normal body weight, 43.1% suffered first degree malnutrition, and 28.1% suffered second or third degree malnutrition (Pan American Health Organization, 1990). Illiteracy is high, 42% in rural areas. In 1988, the average number of years of schooling completed was 4.5 (urban) and 3.1 (rural) (Beirne, 1996). Half of adults are unemployed (Pan American Health Organization, 1990). At the root of these conditions is the extreme maldistribution of land and wealth.

Because of the economic disparity in El Salvador, the country is often described as having two cultures: the rich (who have similar education, standard of living, health care, and expectations as North Americans) and the poor, often uneducated *campesinos*, or peasants (Stevens, 1993 a).

**Background to Research on Immigrant and Refugee Health Issues**

This section reviews the approaches to multicultural health in general, and

provides some background on research related to specific issues facing refugees,

particularly women immigrants and refugees, and those fleeing extreme violence.

<u>Development of Multicultural Programs and Research Interest</u>

The 1980's saw increased awareness in Canada of issues of multicultural health,

and funding was made available for program delivery and research on health issues

among immigrants and minorities. The Canadian Council of Multicultural Health was

formed, along with several provincial chapters. The Manitoba Minister of Health

established an Advisory Committee on Multicultural health. In Manitoba, specific

programs focusing on health needs of immigrants refugees were funded. The Immigrant

Refugee Health Project at Planned Parenthood Manitoba (now the Sexuality Education

Resource Centre) focused on reproductive health issues, by providing health education,

professional consultation and trained health interpretation (O'Neil, 1989; Stevens, 1993a).

The Cross-cultural Counselling Unit, initially set up to focus on needs of trauma victims,

was established at Mount Carmel Clinic. Organizations such as the Canadian Mental

Health Association developed recommendations to address barriers to access (Nyman

1991).

<u>Approaches to "Multicultural Health"</u>

Several approaches to "multicultural health" can be identified. *Culture specific*

*approaches* focus on learning to understand the cultural values, beliefs and customs,

communication styles, family structure, history, and so forth, of a certain group. The

limitations of these approaches are that they tend to focus on *ethnic or cultural*

*differences* and to overlook the diversity *within* cultures. In this way they can contribute

to stereotyping by promoting a "recipe book" approach to understanding individuals in

terms of a prescribed cultural template. Another limitation is that while knowledge and

skill in dealing with a specific culture may be increased, the learner is only confident in

working with cultures s/ he knows about - the learning is not necessarily transferable.

Nor does a culture - specific approach necessarily address the issues of power and

privilege which affect relationships between groups, and research is generally done from

the perspective of the majority culture (Kaufert, 1990; Stevens 1993a).

Other approaches focus on barriers to understanding between patient and provider

because of language and culture, and focus on strategies for communication (e.g. by

provision of interpreter services).

Several limitations to both these approaches have been identified (Haffner, 1992;

Hamilton, 1996; Kaufert, 1990; Shackman; Stevens, 1993a, 1993b). In particular the

focus tends to focus on deficits or difficulties (e.g. "communication problems") without

questioning the cultural assumptions of the dominant group.

A third approach focuses on mental health issues faced by refugees. This is

discussed in the next section.

## Specific Issues Affecting the Health of Refugees

According to the United Nations High Commission for Refugees (UNHCR), in 1993 there were 20 million refugees in the world, with at least 20 million more displaced within their own countries. Manitoba received over 12,000 refugees in the ten years ending in 1997 (Canada Immigration, 1997). It is generally recognized that there are important differences between the health needs of immigrants (who voluntarily choose to come to a new country), and of refugees (Al Issa, 1997; Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988). Refugees are those "who have had to leave the country in which they lived because of violence and repression by the authorities or by violent groups operating under the protection of the authorities or other militant groups" (van der veer 1998, p. xi). Within this group are included those who have been politically active, those who are persecuted because they belong to a certain group, or relatives accompanying them.

It is recognized that refugees, unlike immigrants, face specific medical problems; infectious diseases because of poor living conditions, traumatic injuries, malnutrition, and psychiatric disorders (Clinton - Davis & Fassil, 1992; Palinkas, 1995), although the first three are seen as important only upon immediate arrival. In addition, refugees are also acknowledged to experience more stress in adapting to a new society (Allodi & Rojas, 1983; Canadian Task Force on Mental Health Issues, 1989; Chester & Holtan, 1992; Stevens, 1993 a, Sundquist, 1995); and stress is linked to higher rates of illness and chronic disease (Palinkas, 1995; Provincial Federal Territorial Committee on Population

Health, 1994).

## Mental Health Issues Facing Refugees

One result of the increased awareness of refugee health issues has been a focus on mental health issues facing refugees (Allodi and Rojas, 1983; Barudy, 1989; Desjarlais et al., 1995; Martin-Baro, 1989; Levy, 1997; Muecke, 1992). Migration does not necessarily lead to poor mental health, however, those who seek refuge from starvation, violence and political turmoil are among those most at risk (Desjarlais et al., 1995).

The refugee experience can be divided into two major life experiences, traumatization (extreme painful experiences that are so difficult to cope with that they are likely to cause psychological dysfunction in the short and long term), and uprooting (the experience of being forced to leave familiar surroundings and settle in a new and unfamiliar environment). Most refugees suffer both, but to varying degrees (Lavik, Hauff, Skrondal & Solberg, 1996; van der veer, 1998).

## Traumatization

Van der veer (1998) has described traumatization in three phases: a) the first phase of increased repression and persecution in country of origin, b) the second phase where the refugee personally becomes a victim, and c) the third phase of a life in exile.

Trauma due to violence can be divided into two categories from a psychological perspective: *terror* (the systematic use of terror against communities or groups, where

victims are clear they are victims and not perpetrators; and *combat experiences,* where individuals may have used violence themselves (van der veer 1998). Different experiences and long term issues may be involved.


Post Traumatic Stress Disorder

In response to the recognition of the severe trauma experienced by many refugees, significant research has been done on Post Traumatic Stress Disorder related to refugees (Allodi, Randall, Lutz, Quiroga, Zunsunegui, Kolff, Deutsch, & Doan, 1985; 1980; Allodi and Rojas, 1983; Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees in Canada, 1988; Cowgill & Doupe, 1985; Goldfeld, Mollica, Pesavento, & Faraone, 1988). Post Traumatic Stress Disorder (PTSD) is defined as the development of characteristic symptoms following a "psychologically distressing event that is outside the range of usual human experience " (American Psychiatric Association, 1987, p. 247). The stressor producing this syndrome would be markedly distressing to almost anyone and is usually expressed by intense fear, terror and helplessness. Examples include a serious threat to one's life or physical integrity, serious threat or harm to those close to you, sudden destruction of one's home or community, or seeing another person who has recently been, or is being seriously injured or killed (American Psychiatric Association, 1987). Much of the trauma experienced by refugees differs from the trauma of natural disasters because the victim has to come to terms with the fact that human beings caused their suffering, and that this was often supported by the authorities (van der veer, 1998). To be diagnosed with Post Traumatic Stress Syndrome, individuals

must not only have been experienced a traumatic event, but must also show the following

characteristics: continued re-experiencing of the event, (e.g. intrusive and recurrent

memories, dreams, or "flashbacks"), persistent avoidance or numbing, and features of

increased arousal (e.g. sleep disturbance, irritability, difficulty concentrating,

hypervigilance). PTSD is often associated with anxiety and depression (American

Psychiatric Association, 1987).


## Controversy Regarding Diagnoses of PTSD

The development of the construct of PTSD has had the advantage of not only

acknowledging the mental health needs of refugees, but also recognizing that these

conditions can be long - lasting and do not necessarily improve with time (Muecke,

1992). However, both clinical and political objections have been raised regarding the

applicability of a diagnosis of PTSD (a psychiatric diagnosis) to victims of political

violence and torture (Desjarlais et al., 1995). It has been suggested that it cannot be

assumed that long term repression and torture result in the same effects as natural

disasters. Rather than one traumatic event, it has been suggested that the trauma can best

be described as continuous trauma and stress. The second objection is that applying a

medical diagnoses risks pathologizing the individual, rather than the political or social

context of trauma, and it has been suggested that being submitted to such a diagnosis can

re-victimize the individual (Millet, 1994; Desjarlais et al., 1995). Medicalization of

trauma also allows us to avoid its social, political and moral dimensions (Desjarlais &

Kleinman, 1997; Fischbach & Herbert, 1997). The victim is seen as in some ways

impaired, rather than aggressed upon or wronged (Millet, 1994). It also allows providers

to avoid addressing systemic issues in the health system which may contribute to

decreased health status, as well as continuing neglect of suffering related to being "out of

place" (Muecke, 1992).

There is a large body of literature on the mental health consequences of repressive

regimes in Latin America. This has led to a situation where "we now know more about

the effects of violence on individuals than on communities and societies, more about the

psychiatric sequelae of violence than its behavioral and social aspects" (Desjarlais et. al,

1995, p. 132). Martin Baro (1989) also makes the case that psychotherapy is inadequate.

He suggests that instead there must be a significant change in social relations, including

an urgent need to work toward a process of greater social sincerity. Because the injury

that affects people has been produced socially, its roots are not in the individual , but in

society.

### Research Related to "Low Intensity" Warfare

Many of the "wars" being waged in the world today are not between independent

nation states, but rather are the result of a government's repression of its own people, or of

minorities within it's borders. This has led to new forms of warfare, often referred to as

"low intensity warfare". The objective of "low intensity warfare", such as that waged in

El Salvador, is control over a population, not a territory, through terror and destruction

(Desjarlais et al., 1995).

A distinctive feature of low intensity conflicts is the persistent assault on the lives of villagers and farmers. In such conflicts, civilians are often targeted rather than simply being incidental victims of fighting between combatants; they often do not belong to any formal organization or political party, and they die from either direct war actions, or war-induced starvation. Those who do survive are commonly victims of "dislocation, hunger, social upheaval, civil violence and unattenuated grief" (Desjarlais et al., 1995, p. 117).

A principal characteristic of such "low intensity" conflicts is that everyday life is subject to continued and fearful tension, and pervasive fear and anxiety are often experienced at a bodily level (Desjarlais et al, 1995; Martin-Baro, 1989). One Salvadoran study found that the mere presence of the army in the vicinity was sufficient to cause 87% of those present to experience fear, 75% an accelerated heart rate, and 64% to be overcome by generalized body trembling (Martin - Baro, 1989).

"When the control of populations, rather than land, is being contested, as is so often the case with political violence, then the mind becomes one of the key battlegrounds" (Desjarlais et al., 1995 p. 118). Fear is used as an instrument of social control. Mass terrorization of a population through violence ("disappearances", assassinations, arrests, torture, rape, encounters with corpses, bombing, massacres), population displacement, censorship, disruption of health services, destruction of homes, and economic and social deprivation, become everyday. Individuals are not just killed, but mutilated and killed in gruesome ways, with the intent of demoralizing the

population.

"Low intensity warfare" creates an atmosphere of stress, fear, bereavement and uncertainty, and is intended to destroy social relationships, networks and solidarity among the civilian population (Melville & Lykes, 1992). The result is to create disorganization in the total society (Martin - Baro, 1989), and to disrupt the routines of everyday life. One effect of this "social trauma" is psychosocial destruction and the impact ranges from psychosomatic symptoms to the unhinging of social relations (Martin - Baro, 1989). Studies of the mental health of civilians affected by the "classical" wars of Europe have found that while frequency of mental health distress increases during conflict, the effect is usually temporary (with the exception of torture victims, prisoners of war, or Death Camp survivors). However, survivors of low intensity conflicts are observed to show different, and often more severe and long - lasting patterns of distress (Desjarlais et al. 1995). Symptoms of post - traumatic stress, depression and somatoform disorders are reported to be common in survivors of organized state violence (Ramsey, Gorst-Unsworth, & Turner, 1993). In addition, those who flee to other countries are also exposed to uprooting, the second component of the refugee experience.

## Uprooting (Migration) of Refugees

The refugee migratory experience can be described as having four stages; the premigration stage, where the individual, still in her home country is exposed to disruption, anxiety, fear, and often persecution and violence; the migratory stage, where

the individual is in flight, seeking safety, often in a neighbouring country; the asylum

stage where the refugee finds temporary safety; and the resettlement phase where she is

permanently relocated. There are risks to health during all of these phases (Desjarlais et

al., 1995). Not all Salvadoran refugees experienced all four stages of migration, as some

were able to travel directly from their home country to Canada.

Most Salvadoran refugees arriving in Canada were "landed immigrants", which is

to say that they are here legally as immigrants, with a right to settle, and remain in

Canada. This is a very different situation than refugees may find in other countries. For

example most of the Salvadoran refugees who settled in the United States, did so as

"illegal" immigrants. Those who immigrate illegally, or arrive as "refugee claimants"

(requesting refugee status) experience additional stress and uncertainty (van der veer,

1998).

New arrivals to Canada can be expected to experience "culture shock" which can

include the loss of love and respect of friends and family, loss of social status, and loss of

a familiar environment which gives life meaning (van der veer, 1998).

Risk and Facilitating Factors for Adaptation

A review of the literature of resettlement suggests a number of factors that affect the

adjustment of migrants. These factors, facilitating or impeding positive adaptation, are

influenced by both the characteristics of migrants and characteristics of the receiving

society. While all refugees are considered at risk of mental disorder, three groups:

women, children and the elderly are considered particularly vulnerable (Canadian Task

Force on Mental Health Issues Affecting Immigrants and Refugees in Canada, 1988).

Detrimental conditions include: previous psychosocial maladjustment, a large

socio-cultural gap between the society of origin and the society of resettlement, change in

socio-economic status, a troubled economy in the host country, unrealistic expectations,

and discrepancy between aspirations and achievement in country of resettlement

(Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees in

Canada, 1988). Social isolation is seen as a major risk factor, and refugees separated

from families or with no access to their own community appear to be at highest risk for

depression (Al Issa, 1997; Desjarlais et al., 1995; Hauff & Vaglum, 1995). Risk factors

for psychiatric illness include: a drop in socio-economic status, inability to speak the

language of the host country, separation from family, lack of friendly reception from the

host country, lack of an ethnocultural community to provide support, traumatic

experience prior to migration, and migrating during adolescence or after age 65 (Allodi &

Rojas, 1983; Canadian Task Force on Mental Health Issues Affecting Immigrants and

Refugees in Canada, 1988).

Facilitating factors include information and preparation prior to immigration,

mastery of the language of the host country and the existence of a large community of

support. (Baker, 1993; Canadian Task force on Mental Health Issues Affecting

Immigrants and Refugees in Canada, 1988). These factors very often do not apply to

refugee groups. Involvement in some kind of meaningful activity is linked to ability to

cope with the stress of exile (Lavik et al., 1996). There is evidence that those who have

been politically involved due to commitment to certain cause or ideology do better in

recovering from torture (Allodi & Cowgill, 1982).

A key aspect of successful migration is the response of economic, health, social

and cultural institutions (Guarnaccia, 1997). The effects of war and persecution are

compounded by adversity factors in exile. Negative life events in country of resettlement,

lack of close confidants and chronic family separations have been identified as predictors

of stress (Huaff & Vaglum, 1995). It has also been suggested that experience during the

first years of resettlement may have a greater effect on mental health than experiences

before migration (Westermayer, Vang, & Neider, 1983).

## Issues Affecting Women Immigrants and Refugees

It has been suggested that many of the variables which increase stress affect

women refugees more than men (Canadian Task Force on Mental Health Issues Affecting

Immigrants and Refugees in Canada, 1988). Women are more likely to be dependent on

their spouse, less likely to speak English on arrival in Canada, more affected by

separation from family, and face conflicting expectations around employment. Women

are at greater risk of abuse, including sexual trauma. Women refugees fleeing political

violence are more likely to be sexually assaulted both in their own country and while

crossing borders (Desjarlais et al., 1995; Goldfeld et al., 1988; Levy, 1997; van der veer, 1998).

Women are likely to be responsible for the health of other family members (United Nations, 1989; Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees in Canada, 1988). Once in Canada, they are more likely to be of low income and social status, and have less in the way of social support networks, lower education, poorer working conditions and higher unemployment. Immigrant women are recognized as lacking many of the positive supports outlined in the determinants of health: income and social status, support networks, education, employment and working conditions, physical environments, and healthy child development (Federal, Provincial, and Territorial Advisory Committee on Population Health, 1994). Women may have poorer access to resources and be more likely to remain isolated and dependent after resettlement (Desjarlais et al., 1995). It is unclear to what extent personal health practices and coping skills, and the available health services act as positive or negative determinants of health.

Many young women arrived in Canada as children or adolescents. While little research has been done on the particular needs of refugee children, it is acknowledged that the experience of trauma and adaptation can affect child development, and problems of family violence, school difficulties, and acting out behaviour have been reported (Allodi, 1980; Friere, 1993; McCloskey & Southwick, 1996; Rousseau, Drapeau &

Corin, 1997; van der veer, 1998).

## Health Care Utilization Patterns of Refugees

With the exception of increased utilization of mental health services within specific communities exposed to catastrophic stress, there is no evidence of increased utilization of health services by refugees. However, some studies report that Latin American refugees utilize mental health resources at a higher rate than individuals born in Canada or from some other refugee groups (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees in Canada, 1988).

There is however, much evidence of miscommunication, misdiagnosis, avoidance of care, and dissatisfaction with treatment, and evidence that barriers to access discourage preventive care for both immigrants and refugees (Doyle & Visano, 1987; Shackman; Stevens 1993a, 1993b). Refugees may seek care for stress and trauma by presenting somatic symptoms; they often find it difficult to trust, and may be reluctant to discuss experiences due to fear, shame, or avoidance of painful memories. Providers are also observed to avoid disclosure of trauma; this can result in the patient spending many years in the health system without finding relief (Goldfeld et al., 1988; Cowgill & Doupe, 1985; Chester & Holtan, 1992). The long term implications of such utilization patterns are unclear.

<u>Limitations in Current Knowledge of Refugee Women's Health</u>

While the predictive factors for emotional distress and adaptation of refugees have been identified, there has been less research as to how these factors are understood by refugee women themselves, and which factors they feel are important. Existing models of refugee health are problem - focused and do not recognize or incorporate the impact of resilience demonstrated by refugee populations (Muecke, 1992). Muecke also observes that refugees are often considered to be ungendered or male, and that any recognition that women refugees have distinctive health characteristics is largely limited to an obstetrical definition of women's health. However, she proposes that gender is an "organizing principle of life in asylum" (p. 518).

Rather than focusing simply on the women as victims of specific events, the scope of this study will recognize the women as survivors, and focus on their role as active problem solvers. What in the experience of women themselves are the important events which have affected their health? How have they understood the relationship between these events, their health and their ways of coping? What has helped, what has created more problems? What are interactions with the health care system like? In a time of resource constraints, it is necessary to know what services are viewed as needed and effective, and to further our understanding of factors affecting the health of an identified "at risk" group.

With the exception of research related to PTSD, much research focuses on

immediate adjustment, particularly of newcomers who require interpretation to access

services; little is known about medium to long term issues. In addition, most of the

work on war-related PTSD is done on men, although sexual abuse and violence is seen as

a greater risk to women (Goldfeld et al., 1988; Mollica & Son, 1989), and

epidemiological and anthropological data suggest different patterns of psychological

distress for women and for men (Desjarlais et al., 1995). This research will focus on

longer term adjustment of women, and will address the interaction of premigration

factors, the effect of the war, exile and resettlement, and their impact on long term

adaptation.

### Predictors of Adaptation in the Salvadoran Population

This next section reviews some of the characteristics of the Salvadoran refugee

population as they relate to factors predictive of adaptation. The Salvadoran refugee

population has been identified as facing many of the risk factors for adjustment and

psychiatric problems, and unlikely to have protective factors. Researchers have found a

high rate of PTSD in Central American refugees (Palinkas, 1995).

### Factors Arising From Pre-migration experiences

Refugees arriving from El Salvador were recognized as being from a highly

traumatized population. Most of the refugees were civilians exposed to systematic

terror, although some (particularly men) have also been involved in combat experiences.

Exposed to continuous stress over a number of years, many had lost family or friends to

violence. However, not all refugees from the same country experience similar trauma; this is often linked to area of residence and social class. Walton, Nuttal and Nuttal (1997) found that children from displaced, rural families in El Salvador had experienced more deaths within the family and witnessed more violence.

The country was, at the time of flight, politically polarized, and demonstrated extreme economic disparity, with most of the refugees being poor, and with little education. Most refugees had been raised in rural areas, and had relied on subsistence agriculture. In rural areas there was little employment, other than as labourers or farm workers. Rural women were generally not employed outside the home.

There was a range in the degree of political involvement of refugees. Some were highly politically involved, and had roles as political leaders, or were active in political education, or actively collaborated with guerrilla groups. Others had family members who were so involved, or were peripherally involved. Others were not directly involved, but were at risk simply because they were poor, had family members who were politically active, or were in an at - risk profession. The last group also included those who were politically neutral.

### The Experience of Migration

For some women the process of leaving their country, and the experience of being uprooted began many years before they arrived in Canada. Regular invasions and

bombing by the army in rural areas, and the deliberate targeting of individuals resulted in tens of thousands of people "on the run", or "in hiding". They sought protection in churches or refugee camps, or attempted to resettle in other towns and villages. For many families this process of internal displacement took place over a period of many years before they left the country.

Although Salvadoran culture is based on the extended family, most refugees fled alone or with some members of their immediate family. Most refugees from El Salvador were forced first to flee to countries of first asylum, usually to other countries in Central America (Honduras, Guatemala, Costa Rica), Mexico, or the United States. Many lived as "illegals" in countries of first asylum and had difficulty finding employment or ensuring the necessities of life. Most of those who left El Salvador fled to the United States, however over 2000 Salvadoran refugees landed in Manitoba from the early 1980's until 1991 (Canada Immigration, 1997).

## Reception in Country of Settlement

The women interviewed for this study had arrived in Canada in the period from 1982-1992. Most arrived as "government sponsored" refugees. These individuals received financial and other support from the government and assistance from community settlement organizations. "Church sponsored refugees" had the same status but the financial support, as well as additional settlement assistance, was provided by a church or other charitable group.

On arrival in Canada, most received government support for up to one year, including ESL (English as a Second Language) training, and job preparation. Few could speak English on arrival. In 1988, 86% of all refugees to Manitoba spoke neither French nor English.

It has been observed that refugees who settle in an area where their ethnic group has already established a significant community experience lower levels of distress (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees in Canada, 1988). Until the 1980's there was no receiving community of Salvadorans in Winnipeg, although other Latin American communities (particularly the Chilean community) did play a role in support and resettlement. In the 1980's the Canadian economy was in recession, and unemployment was high. As almost all Salvadorans (as mixed race, or Mestizos) would be classified as visible minorities, their reception was somewhat different than European immigrants arriving at the same time, and they are generally recognized to face discriminatory hiring practices (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees in Canada, 1988).

Another key predictor of emotional distress is the discrepancy in social status between the country of origin and country of resettlement. Due to language difficulties and the lack of recognition of foreign training and experiences, most professionals were not able to obtain equivalent occupation in Canada. They also faced a significant drop in standard of living. The research literature which finds such immigrants are more at risk

for negative outcomes in adaptation is consistent with satisfaction theory which seeks to explain satisfaction based on prior expectations.

Many Salvadorans who landed in Manitoba migrated to other provinces, and since the signing of the 1992 Peace Accord, many Salvadorans have returned to El Salvador, either to live or to visit. Upon arrival most refugees were young adults. The current population includes many children born in Canada. Almost all live within the city of Winnipeg. The actual numbers of Salvadorans living in Manitoba at the present time is unclear, as statistics are kept only of landings. There is no way of tracking births, deaths, interprovincial migration, or emigration by ethnic group.

## CHAPTER 2: RESEARCH DESIGN AND IMPLEMENTATION

### Project Design and Objectives

The study utilized a qualitative design framework, emphasizing an ethnographic

approach. This approach provides a framework for studying meanings, patterns and

experiences of a cultural group in a holistic fashion. Ethnography provides access to

health beliefs and health practices of a group of people who have something in common,

facilitates understanding of behaviours affecting health and illness, and elicits data from

the perspective of cultural insiders. People's behaviours are understood in context.

Ethnography does more than describe behaviour, it should explain why behaviour takes

place and under what circumstances (Boyle, 1994; Morse & Fields, 1995). It is an

interactive approach that recognizes informants as co-participants in the study. This

project can best be described as "focused" on a particular group of individuals; women

who were forced, due to civil conflict, to leave El Salvador and resettle in Canada.

The purpose of the study was to describe the experience of Salvadoran women

living in Manitoba; their perceptions of their health, and causes of health and illness; as

well as the coping strategies used to maintain health and care for illness. In-depth

interviews, focus groups, and participant observation techniques were the data collection

methods used. A feedback phase was also included.

## Research Objectives

The following research questions were addressed in this study:

*How do Salvadoran refugee women describe their health, and what experiences do they consider important for explaining health and illness conditions?*

- How do they describe their health, while in El Salvador, on arrival in Canada, and at present?

- What importance do they attribute to the refugee experience as a determinant of health status through the phases of migration?

*What strategies have they used to maintain their health, and cope with health problems?*

- In what way have they used the formal health care system, the resources within the Latin American community, and self help/self care strategies?

- What expectations do individuals have of services?

- What key life experiences do women share with providers and under what conditions is such information shared?


## Role of Community Advisors

The study design incorporated, and relied on, the participation of two women from the Salvadoran community who acted as advisors. The role and contribution of these Community Advisors in the design and implementation of the study is discussed throughout this section.

## Limitations of Research Design

The retrospective nature of the study (addressing health issues over a time period going many years back into the past) raises some challenges in design and analysis. Selection of study participants is affected by the changes in the population to be studied. A refugee population arriving in Manitoba is not necessarily representative of the entire refugee population, nor is the "surviving" population of those still in Manitoba at the time of the study necessarily representative of all those who initially settled here. (This is discussed in greater detail in the next section: Target Population and Sample Selection). As importantly, the process of narrative reconstruction is a creative one, which attempts to make sense of life events, and in doing so describes the events and their impact from the perspective of how they are understood *at this point in time*, which may in fact have been different from both the events as they actually occurred, and the relative importance ascribed to them at previous points in time (Williams, 1984). The stories are told from the women's point of view, and there is no way of determining "what actually happened".

The study also faces the limitations of any qualitative study. Qualitative methods are described as inductive, holistic, emic (i.e. "discovered" within the cultural context rather than analyzed from the researcher's perspective or from a prior framework), subjective and process oriented, and used to understand, interpret, describe, and develop theory (Morse & Fields, 1995). They can not be used to answer questions proving causality or to predict the actual prevalence of beliefs, experiences or conditions throughout the target population.

## Target Population and Sample Selection

### Target Population

The target population consisted of Salvadoran women, identifying themselves as refugees, or who immigrated with family members who were political refugees. Refugees accepted to Canada are a subclass of all immigrants, and were required to meet certain standards (i.e. security and health screening). Those accepted as refugees were eligible for certain forms of government assistance in their first year in Canada. Some refugees were sponsored by churches and other groups, these refugees were the financial responsibility of the sponsoring group for the first year, and also received additional settlement assistance from the sponsors.

As indicated in the previous chapter, El Salvador has always been a country of great economic disparity. Two percent of the population (who own 60 % of the nation's productive land, and account for 1/3 of the national income) are described as the "upper sector" or the wealthy. Another eight percent of the population consists of the middle and professional class. The remaining 90% make up what is known as the lower "sector", made up of labourers, small landholders and the unemployed (Haggerty, 1990). The Salvadoran community in Winnipeg is also diverse; there is a broad range of socio-economic and educational backgrounds; campesino ( peasant) to professional, no formal education to post - graduate education. There is also a range of political backgrounds; from those supporting the "liberation" forces, to members of the army and National Guard.

Salvadorans in Winnipeg state that "if you really have money, you don't live in Winnipeg", and so this study does not assume to include representatives of the most wealthy. A number of participants, however, can be described as from the middle sector (which includes business and professional persons), and the lower sector is well represented. The study also found a significant range within what is known as "the lower sector", from rural families who owned some land, to desperately poor single parent families with no land and no income.

This study used a purposive sampling design. There is no listing available of Salvadoran women in Winnipeg. While cultural associations and church groups may have membership lists, many Salvadorans in Winnipeg do not belong to any of these groups. Those who do not appear on any membership lists may differ in important ways from those who do. There are also risks to going through political or religious groups for what is needed to be perceived as objective health research (Stevens, 1993a), and great sensitivity must be shown to political divisions (Hamilton, 1996). In addition to logistical problems in negotiating samples from different membership lists, prior work with this community suggests that individual contact, using trusted gatekeepers may generate less suspicion and more cooperation (Stevens, 1993a). Because the research may touch on sensitive political and personal issues, the use of gatekeepers to "credential" the work is advised (De Santis, 1990), and is a way of negotiating access that is accepted by the community.

The sampling technique was based on critical factors identified through the research literature and by community advisors. As this is a qualitative sample, participants were selected for certain characteristics felt to contribute to the questions addressed by the study. The sampling design took into account the diversity of backgrounds to be found in the community in order to ensure that the study was not limited to one subgroup of the population. Therefore, there was an effort to represent the range of demographic factors found within the community, including age, socio-economic background, and education. Care was taken to sample a range of backgrounds from the lower sector. Those from both urban and rural areas were included, and an attempt was made to identify informants along the spectrum of political orientation.

The two community advisors assisted with recruiting informants. Both were well known in the community and had extensive networks of contacts. They were selected for their standing and reputation in the community; they were perceived by many as informal resource persons and have demonstrated an ability to identify, and gain support of, a diversity of individuals (political, religious, socio-economic class) around various health, cultural and community development projects. One was working in a professional capacity, the other has been active in community organizing and had many contacts among those who were raised in rural areas.

## Issues in sample selection

As indicated earlier, the sample selection was based on observations of significant

differences among Salvadorans of various backgrounds; these criteria were also confirmed as important by the community advisors. In several ways however, the population of Salvadoran women in Manitoba, from which the sample is drawn, is not representative of all Salvadoran women, or even of all Salvadoran refugee women. In a study such as this, which is looking at longer term health issues, there are several issues to be considered.

## Representation of Refugee Population Arriving in Manitoba

The first issue is that families who emigrated to Canada were not necessarily representative of the population of El Salvador, or even of the Salvadoran refugee population in general. Three factors deserve special mention: political orientation, the healthy immigrant effect, and settlement in Winnipeg.

### Political orientation

While there was an attempt to identify women from the whole range of the political continuum, left to right, none of the women included in the sample identified themselves as on the "right" of the political conflict. There are likely two reasons for this. The first is simply that the majority of refugees were those fleeing from the "right", and so refugees arriving in Winnipeg would most likely be sympathetic to the left or neutral. In addition, even those who might have been sympathetic to the right would, for reasons of personal safety, be unlikely to identify themselves as such. Those who described themselves as neutral, could have leanings to the right. Only a few of the women

described themselves as being personally politically active; however, several others

supported their families' involvement, including taking actions that were personally

dangerous.

Some of the women described efforts to remain "neutral", or stated clearly that

they were "not involved in anything". The nature of "low intensity warfare" (discussed in

the previous chapter) is such that many of those who are "not involved in anything" are

nonetheless victims of repression and brutality. However, it is also possible that some of

those who present themselves as neutral did have a position, but were not prepared to

share it. The was reinforced by the observation that more information about political

activity tended to be given at subsequent rather than first interviews.

### The "healthy immigrant" effect

The healthy immigrant effect describes the result of various factors which may

contribute to immigrants to a country being healthier than the general population in

country of origin. As discussed in more depth in Chapter 9, most of the women

described themselves as healthy, and often as strong. One woman linked this to the

decision to come to Canada saying

> *One of the reasons maybe, was we feel like more confident to do it, to take the immigration, was because we are healthy. We are not going to carry any problem that then we are going to have here.*

As not only acceptance for immigration (including medical screening), but even survival

under conditions of deprivation depended on good health, it is likely that those who

arrived in Canada might be physically healthier than the general population.

### Initial Settlement in Manitoba

In general, Manitoba was not seen as a ideal location by most. Some felt that those with any real status in El Salvador would have chosen to live in another part of the world, and would have had the means to do so. It is well known that many refugees who originally settled in Manitoba have since moved to other cities.

### Continuing Residence in Manitoba

Nor are those remaining in Manitoba at the time the study was conducted necessarily representative of the entire group of initial immigrants. In 1992, the Peace Accord was signed in El Salvador, and over the past five years many Salvadorans have returned to that country. We can expect that those who remain may not be representative of the total group who initially arrived. While there is no way of determining the characteristics of those who remain versus those who return, discussions with the community suggest several reasons why the remaining community may not be representative of all refugees.

One factor is likely to be the ability to adapt to life in Canada. Reference was often made to those who had decided to return to El Salvador following the signing of the Peace Accord. The most common reason given was not being able to adapt or being unhappy here. Professional people who had experienced a higher standard of living, and

greater recognition in their country of origin were often highlighted as a group that was likely to return. In addition is was reported that some people returned because of political commitment.

Socio - economic factors are also likely to play a role. Many of those from poorer backgrounds identified many aspects of Canadian life which made it preferable to their previous life in El Salvador (having food, jobs, health care). This suggests that those whose socio-economic status had improved would be the most likely to remain in Canada, even when there was an opportunity to return.

The most common reason given for remaining in Canada given by informants related to the opportunities and safety provided to their children. Several stated that if it was only for their own sake, they would return to El Salvador, but they had decided to stay in Canada because of their children. Age of children is then likely to be a factor in this decision.

It was noted that some of those who plan to remain in Canada also described traumatic events during their life in El Salvador. Some stated quite clearly that they (or other family members) would not "feel comfortable" going back to live in the same place "because of what happened".

It is likely then that those remaining in Canada at this time are more likely to have dependent children, had fewer opportunities in El Salvador, have been able to adapt to life in Canada or value Canadian life or culture, or have had more traumatic events in their country of origin.

## Denominational Affiliation

There is one other important aspect in which this sample is not representative of the entire population of refugee women. While El Salvador is traditionally a Roman Catholic country, there is now, in both El Salvador and in Canada, a significant minority of individuals who identify themselves as "evangelicals". However, all of those interviewed identified themselves as Catholic, although not all attend church, or see themselves as particularly religious.

## Self Selection

There is also the possibility present in interview research that those who chose to participate did so because they *wanted* someone to talk to (Hutchinson & Wilson, 1994). The responses of participants following the interviews suggests that this may have been a factor in their agreement.

## Methods

For this study, in-depth interviews, focus groups, and participant observation methods were used. The design also incorporated a community feedback phase.

<u>Individual Interviews</u>

<u>Sample Selection: Individual Interviews</u>

Semi - structured, open ended interviews with twelve Salvadoran refugee women

living in Winnipeg, using both life history and illness narratives, were the main source of

data collection.

The community advisors assisted in identifying women who they knew, or knew

of, through their networks who might be interested in participating in the project. There

was an attempt to represent the experience of those who a) arrived as young adults, b)

arrived as children or adolescents, and c) arrived as middle - aged or older. Within each

group, women of both low, and medium-high socio-economic status in country of origin

were selected. This selection was done based on socio-economic class indicators as

described by the community advisors. Some of the terms, for example *"Campesina"*

*"servant"*, *"very poor, they had nothing"*, *"professional"*, gave a clear indication of the

background of the individual. (These differences are discussed in greater detail in

Chapter 4: Social Class.) The sample also included informants from both urban areas,

and a number of different rural areas (*"departamentos"*, or provinces), as the war was

experienced very differently by urban and rural inhabitants.

The researcher requested that only a few individuals be approached at any one

time, in order to facilitate a purposeful sampling technique. For example, after the first

few interviews she requested suggestions of younger women. This method of sampling

also allowed the researcher to reach informants who may be the most useful, and willing to share information.

The community advisors used two different methods of selection for the interviews. The first community advisor approached women she knew directly, explained the project, and if permission was granted, passed their name and phone number on to the researcher, who then arranged to meet with them. All of these women were known to the community advisor, and many were connected with the Roman Catholic Church.

The second community advisor used a different method. Rather than go to individuals she personally knew (or knew well), she attempted to identify a list of individuals who she considered the most useful to interview, or who were in a position to identify an informant. Some of these women she knew personally, some she only knew of by name. In other cases, the first contact (who the researcher then approached generally about the project) identified another woman, not known to the community advisor. This process resulted in identification of two individuals who were referred, not by the community advisor, but by those contacts she had recommended. A mapping of the strategy used to identify informants is included in Appendix A.

The researcher also contacted the Canadian Salvadoran Cultural Association, and was originally told that she would meet with the board and ask for their input. After several phone calls, the researcher learned that the Association had folded. No names

were suggested through this route.

Because of the small size of the community, the study was designed to limit the risk that individuals could be identified. Therefore, this report does not provide a matrix of selection criteria and characteristics of the participants, as this would pose a risk of identification. However, the sample selection can be summarized as follows:

The women interviewed ranged in age from 18 to early sixties. Two were currently under the age of 30, six were between the ages of 30 and 45, and four were over age 45. They came from various regions of El Salvador, some had only lived in "the countryside", some had always lived in the capital, others had lived in smaller cities or towns, or had moved from the countryside to the capital. Formal education ranged from no schooling to post - graduate degrees. Two reported no formal education, two reported less than six years of education, three reported some high school, and four had completed high school, or some education following high school. One was a student. At the time of the interview only one of the women had never been married; eight were currently married, one was widowed, one divorced and one separated. Of those currently married or separated, two had been previously widowed, and one previously divorced. All of the ever - married women were mothers, seven had given birth only in El Salvador (or countries of first asylum), two had given birth only in Canada, and two had given birth in both Canada and El Salvador. Only two women had never been employed outside the home. Some women only began working outside the home on arrival in Canada. More

than half of the interview participants had been internally displaced (i.e. had lived as "internal refugees" within El Salvador before being able to leave the country). Several had fled to neighbouring countries of Central America and Mexico as countries of first asylum, and had lived there for a period ranging from months to several years. A few of the later arrivals had been accepted directly to Canada after applying from El Salvador. Time of arrival in Canada ranged from 1982-1992.

Negotiating Access

Written material describing the project, the purpose of the study and confidentiality safeguards was developed and provided to the community advisors, and to potential interviewees, in both English and Spanish (see Appendix B).

None of the informants selected for interviews by the community advisors were known personally to the researcher prior to the interviews. After receiving the names of suggested informants, the researcher then established a plan for contacting them. Various methods of contact for the initial interview were used. When the woman had already given permission to be contacted, the researcher phoned directly to make the initial appointment. In three cases where the contact indicated that the woman did not speak English fluently, the researcher asked the contact person to make the initial appointment. In other cases the researcher either contacted the person directly explaining that the woman had been recommended as a useful resource by first contact, or identified another woman (who happened to know the person identified), who facilitated the introduction.

## Structure of Interviews

Generally, three meetings were planned for the interview stage of the study: an introductory meeting, a formal interview, and a final interview to follow up points raised in the previous interview and to achieve closure.

The first visit was a "getting to know you" encounter, where the purpose of the study, reasons for the interview, and the interest, experience, and objectives of the researcher were discussed. This provided the opportunity for a more relaxed conversation. Any concerns of the participants were addressed, including safeguards for confidentiality and the request for audiotaping. All except one of the informants gave permission to be audiotaped, and in this case notes were taken during the interview. Consent was discussed with each informant, and the consent form reviewed (See Appendix C). The researcher then offered to schedule a follow- up visit for a more formal interview. This was intended to give the participants the opportunity to discuss the project and think about their involvement without feeling pressured to participate. Some of the women stated that they wished to start with the interview during the first visit.

All but three women were interviewed on more than one occasion. In these cases, the women wished to start the interview during the initial meeting, and the interview was completed at this time. Most participants had two or three visits, some had more than three. Total times for the initial interviews (following the first meeting) ranged from one and a half to over ten hours. Only one of the 13 women who was initially approached

and visited declined to proceed with the interview.

Informants were asked whether they would like to hold the interview in English or Spanish. They were also told that if they wished to have access to an interpreter, it could be someone of their choice and with whom they felt comfortable.

Based on the language ability of community members, it was anticipated that most of the interviews would be conducted in English. This did in fact prove to be the case. Interpreters were used for only three of the participants. In two cases, the community advisor who made contact with the woman acted as interpreter. She was well known to both informants. The researcher explained the importance of having confidence in the interpreter, and asked whether the woman felt comfortable using this woman as interpreter; both participants found the question quite amusing but understood why it was necessary to ask the question. An advantage of this arrangement was that the interpreter was a research project participant and so had indepth knowledge of the project and its objectives. In another case, an interpreter was used only for the initial meeting; this person was an acquaintance of the informant.

Planning for more than one meeting provided the opportunity to debrief on issues of concern and for the researcher be available for further contact if painful or difficult topics emerged during the first interview. It also allowed for a more natural conversation; if some topics were not covered in the initial interview, there was an

opportunity to follow up at a later date.

Following the initial interviews, the researcher confirmed that each participant had an information sheet on the project, and invited her to contact the researcher if she wished to provide any additional or clarifying information, or had any questions or concerns. At this time, the commitment to confidentiality was reviewed.

## Implementation of interviews

Informants were asked their perceptions of health status and illness conditions from before leaving their home country to the current time. Where health problems were identified, the meaning of these conditions, and the perceptions and explanations of them given by informants were explored. The interviews also explored the strategies the women used for caring for themselves, either to maintain health or treat illness, and their satisfaction with these strategies and services.

Individual interviews allowed individuals to explain experiences in their own words, and bring up issues of importance to them which may not have been known to the researcher. It was felt to be the best method to explore an individual's perceptions of her own health and illness. Interviews were held in a private setting (in most cases in the informant's own home) which facilitated sharing of incidents and history that would not be shared with the larger community.

As issues and themes emerged from individual interviews, the focus of the interviews was sharpened. For example, when a number of individuals raised issues of abuse within families, this issue was raised directly in subsequent interviews. Some women confirmed such issues when asked, but had not raised these spontaneously.

General themes emerging from the interviews were also incorporated into the research project in two ways. Key issues were raised with the focus groups for feedback. After further analysis, the themes were presented back to interview participants for feedback (see the section Feedback Phase on page 54).

The quality of the interviews differed based on the recruitment technique selected. Those contacted by Community Advisor One were, in general, more open, and gave more indepth information. This may be attributed to the fact that the researcher had been vouched for by the community advisor, and so there was a greater sense of safety in sharing information that otherwise may have been kept hidden. The method used by Community Advisor Two provided access to a greater variety of informants and informants who were chosen objectively based on the criteria outlined for the project. Valuable data was also collected from this group. However, many were more cautious in the interviews, perhaps because the personal contact (from a Salvadoran they trusted) was missing.

## Focus groups

Focus groups, designed to explore community perceptions of issues related to health status of women and families in the community, were held after the interviews had been completed. Focus groups were seen as an appropriate format for discussing service issues, and built on initiatives (such as community forums) already undertaken by the Salvadoran community.

## Sample Selection:  Focus Groups

It was decided that groups that were fairly homogenous would be more effective for three reasons. The first was the clear tension around issues of social class, and the suggestions that there would not be open sharing in a socially mixed group, but instead domination of the group by the more educated members. The second was the degree of community suspicion emerging through the interviews that suggested that the use of already existing clusters for discussion may be more effective. The third was the issue of language. While many community members are fluent in English, a number are not. This suggested that the conversation could be dominated by those who are more confident in their English language ability. Therefore it was felt to be important that one group be conducted in Spanish.

Two different focus groups were selected.  One of the community advisors organized a group of women through one of the Roman Catholic congregations. She and the researcher met with the parish council prior to organizing the meeting to request

permission. The plan received full approval: the only concern expressed was that the

group not exclude other Spanish - speaking women. A general invitation was made by

the organizer, and some women specifically encouraged to come. These were women

who had expressed an interest in some kind of group earlier. Reminder calls were made

to those who expressed an interest. This group did include women from a range of

backgrounds, however, they were already known to each other through the church, which

provided a point of commonality. The group met on two occasions with the researcher.

Most of the women attended both sessions, but some attended only one. Some of the

women continued to meet after these two sessions. A total of 10 women participated in

this group.


The second group was made up of community representatives, spokespersons, and

professionals (both male and female). The list was developed by the researcher based on

recommendations from the community advisors. Approximately 2/3 of those invited

were able to attend the meeting. Participants included those working in the health and

counselling field, community activists and organizational representatives. While the

recruitment of participants was undertaken by community advisors, some of the

participants were previously known (though previous work involvement) to the

researcher. There was little evidence that this had much effect on the discussion,

although it may have contributed to the rapport in the group. Most of the participants

knew each other through their work in the community, however it was not a pre-existing

group. Eight people participated in this group.

## Objectives of Focus Groups

The focus groups were used to generate data that may not have come out in individual interviews, and allowed for input of community spokespersons from a variety of perspectives. In this way they provided the opportunity to validate whether the information provided by individual informants was typical of community experience, assess to what extent these perceptions were known and shared by community spokespersons, and test interview data for alternative interpretations. They also allowed the researcher to observe the process of discussion and the level of consensus on key topics (Carey, 1994; Kitzinger, 1995). Focus group participants were not asked to share personal health histories, although some, particularly in the women's focus group, did give examples of their own experiences. Transcripts from these discussions have been included.

## Implementation of Focus Groups

Consent (including permission to audiotape) was obtained in writing from each individual before the focus group began (See Appendix C). No concerns were expressed about this process. The original intent was to have the researcher take notes as recorder/observer of the session, with a bilingual (English / Spanish) facilitator conducting the session. This, however, did not occur. In the professional group, the organizer suggested that it was a better strategy to have the researcher lead the group; in the women's group, the organizer did not in fact take the lead role in the discussion. It appears that this was not a realistic goal at the time; and that having an outsider ask the

questions was seen as more acceptable.

The focus group of professionals and community leaders took place in English. This group was organized by the second community advisor and took place in the offices of a community organization. A total of eight participants attended this focus group, which lasted approximately two hours.

The two sessions with the women's focus group took place in Spanish, with the researcher posing questions in English with interpretation help from one of the women who organized the group. Interpretation was not provided for the discussion, except where the researcher requested clarification. The group met on two occasions on Sunday afternoons, at the church. Most of the participants were the same at both meetings, but some attended only one meeting. Each session lasted about 1 1/2 hours. The total number of participants was 10. One woman who was not from El Salvador attended. (As the focus of the study is specifically on Salvadoran women, specific quotes from this woman are not included in the report).

Participant Observation

In addition to her role as participant observer in focus groups and interviews, the researcher had the opportunity to participate in social events in a number of different settings; in individual homes, at community social events and rites of passage (such as a *fiesta rosa* - a girl's fifteenth "coming of age" party -, or a funeral). In these less formal

situations, she participated either as friend, or as a spouse of a member of the community. Field notes were kept documenting key events throughout the period of the study.

## Feedback Phase

The research design also included a feedback phase. Following analysis and writing of the draft report, individuals interviewed were contacted with two objectives: a) To confirm that participants felt comfortable in having portions of their story included in the report, and to remove, or further mask, sections which may be identifiable, and b) To discuss key findings from the report and get reaction on emerging themes. The feedback stage generally took from one to two hours. In addition, the two community advisors also provided feedback on emerging themes throughout the analysis stage.

Following analysis and development of a draft report, both the community advisors and the individual participants in the interviews were recontacted for feedback. This feedback step proved to be very important, as some participants did ask that some information be changed or deleted to further mask their origin. During this phase some quotes were removed, and others were edited or masked to remove information that informants feared might be identifiable. While a few of the informants requested that some minor changes be made to ensure that the narrative excerpt could not be linked to them, most requested no changes, and only one narrative excerpt was completely removed.

Although the purpose of the feedback stage was to obtain consent and feedback from individual women regarding inclusion of excerpts of their stories, it also provided opportunity to obtain feedback on the themes emerging from the interviews as to whether they were shared more broadly by other women.

## Analysis

Audiotapes of interviews and focus groups were transcribed; and field notes recorded. Transcriptions of interviews which took place in English were undertaken by the researcher. Transcriptions of interviews conducted in Spanish were undertaken by the researcher in conjunction with the interpreter used for the interview. This was done in order to maintain confidentiality. Transcriptions of focus group discussions were done by a bilingual Salvadoran women from the community, who also translated the Spanish transcript into English. Analysis took place simultaneously with data collection, allowing constant comparison of data. Focus groups were used to verify data, and suggest alternative interpretations of themes raised in interviews.

Following transcription, data from all sources were compared and contrasted to generate a categorization scheme; first by development of codes and collection of data by these various topic areas (e.g. gossip). Following this stage, the codes were reviewed and organized to identify patterns, themes and relationships between health determinants, health conditions, and perceived causes and care - seeking behaviours. Codes were often combined to make a larger category (e.g. mistrust) by organizing these codes to identify

patterns, themes and relationships between health determinants, health conditions and care-seeking behaviours.

In addition, these categories were refined in the writing of the first draft of the report. This activity forced a higher level analysis which resulted in merging of these categories into higher order themes, which transcended the time and place of events. For example, the code of *"'underground"* was combined with that of *"hiding"* and was linked to the codes of *"knowing and not knowing"* and *"the official story"*, and all three were combined with others into the larger theme of *"mistrust and betrayal"*.

## Ethics

Several ethical issues have been addressed in the design of this research. Formal ethics approval was obtained from the Human Ethics Committee, Faculty of Medicine, University of Manitoba. In addition, the project received funding from the Prairie Women's Research Centre of Excellence. Eligibility for funding required that the project demonstrate community participation and direction.

In addition to these requirements, additional precautions were taken to ensure both individual confidentiality and accurate representation of community concerns and priorities. The Salvadoran population in Manitoba, like that of many other newcomer groups, is small and arrived politically divided. Therefore great care was taken to ensure that it was understood that the study was not aligned with any particular political or social

group. Both the community advisors and the participants emphasized the need for specific strategies to be used to protect confidentiality.

## Issues Related to Trauma

This type of research has the potential to touch on sensitive issues; both of loss and trauma, and of continuing divisions within the community (Lipson, 1994). Due both to the number of individuals within the community who have suffered severe trauma, and the intensity of political divisions and distrust, maintenance of confidentiality and privacy were given high priority. Although interviews were structured in such a way as to encourage sharing of information on all health - related experiences, no questions were asked directly about trauma experiences in order to avoid triggering memories of events which informants did not wish to disclose. Where in the process of telling life stories, women indicated or demonstrated on-going distress, the researcher explored supports and services already in place for the woman, and in some cases made specific referral suggestions.

## Negotiating Consent

Consent was negotiated with each individual informant, and consent forms in Spanish and English, outlining the purpose of the research, use of material, and how confidentiality would be maintained, were utilized. By scheduling an initial visit to explain the project, care was taken to avoid "pressuring" potential informants, by giving them time to consider their decision. Participants were informed that they could

withdraw their consent at any time, or decline to answer any question. Consent forms were also obtained from all those participating in the focus groups; participants were assured that individual comments from the group would not be attributed to specific individuals.

In addition to the issue of individual consent, the issue of "community consent" (obtaining authorization for the research and the process used from leaders or those who represented the interests of the community) was also considered. There is no one organized community, so official "community consent" was not feasible. However, the community advisors were selected based on their credibility and access to networks, and this informal process indicated that there was good support for the project. The advisors also provided guidance as to how the research should be done in a way that was respectful both of individuals and of the "community". The Canadian Salvadoran Association was approached regarding the project and expressed support during the design stage of the proposal. However, this organization was reported to have folded shortly after the interviews began.

## File Security

Informant files were given codes (e.g. I01, I02) and a separate list of names kept in the researcher's office. All tapes, transcripts and other information were kept in secure location - the researcher's private home office. The researcher's computer is not networked into any system. Tapes were erased following the completion of the project.

## Interpretation

In many parts of the country there is no systematically available, trained, health interpreter service. Fear of breakdown of confidentiality, or of inaccurate interpretation are potential risks in health care and research (Stevens 1993a). Consent for participation in the study therefore included consent for participation of a particular interpreter. By avoiding use of interpreters, and having the participant select an interpreter she trusted, the risk to confidentiality was minimized. Although the researcher's Spanish language ability was too limited to allow her to work in Spanish, it was adequate to allow for some monitoring of accuracy, completeness and tone of the interpretation. Other issues related to interpretation are discussed in the section Dynamics of Interviewing and Group Discussion, later in this chapter.

## Editing and Masking of Information

Several measures were taken to protect confidentiality in the final report, while at the same time allowing the women to present their own stories. All names were changed, and in some cases other identifying information related to the woman and her family was removed, or disguised (Lipson, 1994). For example, no regional locations or town names were included.

While the working drafts identified informants by number, these have been omitted from the final draft. This is to minimize the risk that a reader could piece together identifiable information with more private information - a real possibility in a

very small community. The quotes in the final report were taken from both the individual

interviews (total of twelve individuals), and from the focus groups (total of 18

individuals).

In many cases stories have been deliberately broken up into various sections of the

report. This does have the disadvantage that it does not allow an indepth understanding

of a particular woman's experience, and the sense she makes of the events in her life.

However, in this community it was felt that this potential advantage is far overshadowed

by the advantages of allowing women to speak with the greatest degree of anonymity

possible. Some of the issues involved in sharing information in the Salvadoran

community are covered in Chapter 7: Community.

## Feedback Stage

As it was possible that individuals in a small community might still be

identifiable from details provided, informants were contacted to review individual quotes

and descriptions which were to be included in the report. This was to ensure that there

was no identifiable information remaining in these sections that would cause concern to

the participants, or through researcher misunderstanding would inaccurately represent the

concerns of individuals or the community.

## Profile of Researcher: Biography

### Background of Researcher

As this is a qualitative study, where the researcher is utilized as the research instrument, it is important to outline the author's background and prior connection with the community. This section is therefore written in the first person.

My previous involvements with the community gave me partial insider status, and provided me with contacts who agreed to act as advisors in the study design and who were members of networks which provided contacts for selection of participants for the interviews and focus group activities.

I have been involved with the Salvadoran community since the early 1980's, when refugees from El Salvador first began to arrive in Winnipeg. My initial involvement was through volunteer work in assisting refugees to settle in Canada. I was the contact person, and chair of a refugee committee that sponsored some young men from Central America. For some time we also had new arrivals, including torture survivors, living in our home, and I was active in doing community education, emergency interpretation, and solidarity work around the events in El Salvador.

Many of the first arrivals had been politically active. Most were young men, or young families. As with most refugee groups there was a great need for general settlement assistance, accommodation, employment, language interpretation, and

psychological counselling and support. The absence of appropriate mental health services was acute at that time.

By the late 1980's the community was better established and I was less directly involved, although my work in community health involved training and supervising staff and volunteers who worked directly with Salvadoran families.

My professional role has included designing programs to improve access to health services for immigrants and refugees, and providing consultation and professional education programs on multicultural health issues to professionals. Through this work I have found that providers of health care services are often not aware of, or are unresponsive to, both the perceptions of consumers of health care needs, and the priorities and preferences they may have for service. From many years of work with refugees, both within health programs ( Manitoba Association for Childbirth and Family Education and Planned Parenthood Manitoba), as well as from personal experience in assisting with refugee settlement, I have been made aware of a number of difficulties faced by refugees both in accessing health services and communicating with providers in the health care setting.

I have found most health care providers to be unaware of refugees' life experience and the barriers to appropriate health care. In particular, I have found that war - related trauma is an invisible problem to many health providers. I expected to find that refugees

who have experienced some kind of trauma would have had difficulty raising issues, or

being heard by health providers. I am also aware of incidents where providers have been

profoundly disturbed by the information shared by refugees (Stevens, 1993a) and suspect

that providers may be unsure of how to incorporate this information into diagnosis and

treatment.

As I have since married into the community, I remain connected to it, although I

have not recently been involved in either a volunteer or professional role. In 1993, the

year after the Peace Accord was signed in El Salvador, I made my first visit to the

country, and have visited yearly since. During these visits I live with family, both in the

capital and in one of the rural departments (provinces). I have had the opportunity to

travel to most of the departments, as well as visit various projects and health services.

## Impact of Researcher

In many ways I came to this study as a partial insider. Although not a member of

the community, through prior involvement and ongoing connection to the community I

have access to information and networks not available to most. I have extensive

experience in working in the area of multicultural health, particularly newly arrived

refugee populations. I have specific information on the culture of El Salvador, including

the social/ historical/political context, the value system of the community, and much of

the history of the Salvadoran community in Winnipeg. In addition I have been able to

travel and live in El Salvador for short periods of time. While not fluent in Spanish, I am

able to understand much of Central American Spanish speech. As importantly, I am

familiar with the language structure, the verbal and non verbal communication patterns,

and much local vocabulary.

However in other ways I remain an outsider. I am not from the country, and do

not participate in more than an occasional way in community affairs. This places me in a

"limnal" position on the boundaries of the Salvadoran community, neither a member of

the community, nor excluded from it.

While I believe that such a background is on the whole largely beneficial, it does

pose some challenges. In some cases informants expected me to understand what they

were talking about, and would often ask whether I had observed certain things, or would

make comments such as "*you probably know that..*" Some informants seemed more

comfortable talking to someone who already knew the background. In addition, the

awareness I had of the "*la situacion*" (literally 'the situation', a general term used to

describe the environment of repression, war and political violence) made it possible for

me to pick up on important details that may otherwise have escaped notice. Two

examples come to mind here, both of which occurred in during interviews with study

participants.

> In one case an informant talked about taking things, like food or medicine to a
> nephew in a certain town, and being harassed and suspected by the army.
> Knowing that this town was indeed in an area under guerrilla control provided a
> perspective to a story that otherwise would have been unclear.

In another instance, a woman told me of having to identify the body of her husband, who had supposedly been killed in crossfire. While she did not articulate any doubts about this story, she did tell me that the body looked fine - except for the thumbs. Knowing that securing prisoners by tying their thumbs behind their back was the signature of the death squads gave a different interpretation to the story.

Knowledge of the language was also useful as it enabled me to conduct interviews even with informants who were unsure of their English language skills, and monitor the interpretation where an interpreter was used. There were also occasions where an informant, though fluent in English, would not know a word in English (sometimes there was no equivalent English word), and I found I was able to supply it. In other cases however, there would be an expectation that I would know a word and its importance and I found I did not. One example of this was the word 'tatu' - dugout air shelters or hiding places for people (particularly the old or ill who could not run away) or food and supplies. As I was unaware of this practice, I was at first thinking that this word referred to a cave, and so only later realized the desperate living conditions to which the woman referred.

On the other hand, my relationship with a Salvadoran also may have created more guarded responses in some cases, or caused some informants to avoid an interview. While this was never directly suggested, the divisions within the community may have created more caution on political or personal topics than in speaking to a genuine outsider. However, in some cases this relationship, (even though my husband was unknown to them) did provide an explanation for my interest in research in this area

which appeared to allay suspicion.

> In one focus group I was asked why I was choosing to do research on the Salvadoran community. In the course of my explanation, it was the information that my husband was Salvadoran that appeared to provide the legitimate reason, and after the group, the questioner came up to speak to me and make sure I had not taken offense. (field notes)

There are also risks arising from the fact that , as a partial insider, I am already familiar with the community in a non - research setting. One risk is that previous exposure may "dull" sensitivity, the other is that there may be social or political problems associated with the role change (Morse, 1994). One clear difficulty I faced was that after over 15 years of involvement with the community, I felt I may have lost touch with what was unusual or remarkable.

I also sometimes found some role conflict, particularly where for some reason we had social contact with a Salvadoran family where I had interviewed the wife. In some cases I was privileged to information that others in the group, perhaps even other family members, did not have. In some cases, simply observing felt somehow conflicted. I also found during the feedback phase of the project, some pressure to avoid bringing up some issues that may reflect badly on the reputation of the community (e.g. sexual abuse).

My experience with my own family, and involvement in solidarity activities with those from particular political positions also posed risks to my ability to be objective to the information shared with me. For example, I found that I was surprised at the degree of family violence and sexual exploitation that I found among the study participants.

Although my previous relationships and contact with the community may have

some disadvantages, on the whole I feel that there were many more advantages. These

involved both knowledge and experience of the historical background to the conflict and

the community in Manitoba, and perceived credibility as someone who could be expected

to understand the issues shared by informants.

## Dynamics of Interviewing and Group Discussion

This section discusses some of the issues related to interviewing and

communication specific to research with individuals whose first language is not that of

the interviewer. Interpretation (for interviews and focus groups), and translation (of

written narratives), as well as observations of dynamics of communication are outlined in

this section.

### Interpretation

Interpretation for the interviews was done in quite an informal fashion. It was

agreed with the interpreter that the researcher would not ask for a translation unless she

felt that she did not understand. However, all the interview questions were translated

into Spanish. In some cases, after the researcher posed the question in English, the

interview participant began to answer before the question had been translated, indicating

that she had in fact understood the question, even if she could not comfortably express

her response in English.

In these interviews the interpreter acted in many ways as a participant in the interview, rather than strictly as an interpreter. This was due in part to the context of the interview (she was a confidante of both of the women), and to her lack of formal training in interpreting. She would expand on or clarify the question if she felt necessary, and sometimes would probe with specific questions based on her knowledge of the informant and her history. In some cases she would occasionally add information in English that had not been given to the researcher by the informant but that she felt was important.

> On one occasion, there was a conversation between the woman, her husband and the interpreter when the researcher arrived. The husband then left. Afterwards, the interpreter pointed out that the husband had not wanted the wife to sign the consent. The two women had simply ignored him. (fieldnotes)

On occasion the interpreter would alert the researcher to a sensitive area. In others, she would provide additional contextual information. Some of the most useful information obtained was the commentary on, and contextualizing of, the narrative by the interpreter. It was extremely beneficial to the process, but could have caused problems if the researcher had not been able to monitor the conversation in Spanish, as the interpretation provided did not necessarily differentiate between the actual statements of the participant, and the commentary of the interpreter.

> In one interview, the interpreter, after clarifying for the researcher the extent of a family members injuries, then went on to explain the frustrations when the family arrived in Canada and an older man realized he would be unlikely to find a job. The interpreter explained in detail the high value given by this family to being employed, and also the role she played in helping the family coming to terms with the situation. However this information had not been provided by the informant. (fieldnotes)

It was a good illustration of the risks involved in interpretation if, for any reason, the

interpreter were not representing the interests and intent of the speaker.

In one case, the researcher was introduced to an research participant by a contact (identified by one of the community advisors) who acted as interpreter. This younger woman, who had arrived in Canada as a child, assisted making contact with one informant. She was a careful and thorough interpreter, though anxious about her language ability. In fact, although she spoke both languages well, her lack of experience in her own country meant that she did not have certain Spanish vocabulary. The purpose of the first meeting was to explain the project, and determine whether the informant wished to be involved. Another issue arose in this interview. Although the interpreter had agreed only to introduce the researcher to the informant and act as an interpreter in describing the project and process of consent, the informant began talking about some traumatic experiences. The interpreter was visibly shaken, and afterwards, as we were debriefing, said to the researcher "I didn't know any of this".

Two women interviewed had limited ability in English, but requested to attempt the interview in English, without an interpreter. In both cases confidentiality appeared to be a concern. In these cases, some of the interview also took place in Spanish, and often the researcher would speak English, and the informant would speak Spanish. Assistance in translating the Spanish portions of the transcript was then obtained.

There were some difficulties with language and understanding in the focus group.

There was an awkwardness in directing the conversation, as while the researcher had a general sense of what was going on, she would often miss the underlying intent or subtleties of the discussion. It became apparent after the tape was transcribed and translated that at some points she had misunderstood some of what was said. This can be assumed to be frustrating to both parties as the women did want, not only to talk, but to explore some of these issues. In spite of this the focus group provided very useful information.

Experience of the researcher with using interpreters highlights several important cautions in using interpreters for research projects. It may be assumed that interpreters are not needed for groups who have been settled in the country for some time, especially if many community members demonstrate good English skills. However, while in this sample (of whom the most recently arrived had immigrated in 1991/92) a number of the women were quite fluent in English, two of the women interviewed required an interpreter, and an additional two required that the interview be conducted in a mixture of Spanish and English. It was also necessary to conduct the womens' focus group in Spanish .

One challenge is in even obtaining informed consent for an interpreter when an interpreter is needed to make contact. How comfortable would the informant feel in declining the use of the interpreter the researcher first brought with her? In this case providing written information in Spanish for the Community Advisors (or their contacts)

to share before the informant agreed to meet with the researcher was one way of protecting this.

The researcher's (limited) understanding of Spanish provided some other safeguards that would not have been in place had she had been interviewing individuals who spoke other languages. For example she was able to monitor the interpretation, identify areas where the interpreter had taken initiative in expanding the question, and identify what were the participant's, and what were the interpreter's, contributions to the conversation. She was able to clarify the intent of the question if she was not confident that the interpretation had accurately conveyed what was intended. On occasion she was able to "catch" a word that had been mistranslated into Spanish (for example in one instance the interpreter had translated '*sarampion*' to mean chicken pox, when in fact it refers to red measles). It was also possible to monitor any side conversation with the interpreter.

In one case, while describing medical care in pregnancy, the woman interrupted her story to ask the interpreter ' *se le puede contar a ella todo eso?*' (*can I tell her all this?")*. The response of the interpreter was that this was "no problem" and the woman continued with the story. However this did alert the researcher the fact that the information (indicating her involvement or contact with the guerrilla movement) would not be shared with everyone, and likely would not have been shared with the researcher if the interpreter had not been able to reassure her that she was a "safe" person to talk to.

The researcher was also able to notice some subtleties in vocabulary which alerted her to important information. For example in one instance it was observed that while talking about the treatment her sister received from the family, one woman used the term *"ellos"* (they, the others in the family) rather than *"nosotros"* (we) which would have been expected. When the informant was asked about this she explained that it is because she didn't like to admit that was how she was treated as well.

The use of *"usted"* versus *"tu"* (the formal form of "you" versus the familiar form), an important distinction in such a class conscious society, was another detail that the researcher was able to pick up. This often provided a great deal of insight into the social relationships of those involved in the story. As one would only the use the term *"tu"* (or the appropriate verb form) when addressing a child, a friend or social inferior, use of the term among strangers explained a great deal about the relationship. Consider the following example, where a woman reports what was said to her by a soldier: *"No queres decir donde esta tu marido. Pues vos las vas a pagar."* ("You don't want to tell where your husband is. Then you are going to pay", emphasis mine). Here the verb form for the informal *tu* is used, which is an indication of disrespect of the armed forces for the person addressed.

The researcher's ability to understand the general content of the conversation also assisted in establishing direct rapport with the informants. Because she could rely on translation of the audiotapes to clarify any missed points she was able to engage directly

with the informant, who talked *to her*, rather than the interpreter, and enabled the discussion to flow normally, with few interruptions. This was particularly important in the telling of a difficult story.

It has been observed that while talking about personal or stressful topics, even individuals who are fluent in English may revert to speaking, in whole or part, in their mother tongue. Informants who agreed to be interviewed in English were informed that shifting into Spanish if at any point this would help express certain ideas was acceptable. This switching between languages was noted, particularly in the stories of those who were unsure of their English.

## Translation

Translation of tapes was done in two ways. The two interviews conducted in Spanish were transcribed by the researcher with assistance from the woman who acted as interpreter. This was time - consuming but necessary as the informants did not feel comfortable in letting anyone else hear the tapes. The process of transcribing also provided the opportunity for the interpreter to provide more explanation of what was said, and in many cases this process often triggered the telling of other experiences that occurred, or filling in the context to the particular events described.

As this process of transcription provided the researcher with a good understanding of the content of the interview, only the excerpts which were to be included in the final

report were translated. These small sections were translated by another woman.

The tape of the focus group was transcribed and translated by a Salvadoran woman with a professional background. She stated that she found the transcription fairly straightforward but the experience of transcribing quite upsetting. She found the translation of the tape difficult and time - consuming, and she was able to provide several examples of the limitations of literal translation.

In addition to these interviews, informants who were being interviewed in English often inserted Spanish words in the conversation, or asked for a translation if they were searching for a word. In these cases the researcher would suggest a word in English. The transcriptions include both the Spanish, and the suggested translation. In a few cases the equivalent word in Spanish could not be determined in the interview. In these cases the researcher would refer to a dictionary or ask for assistance for the word or phrase from other Salvadorans after the interview. This was required on several occasions as many local idioms were used that are not found in a regular Spanish dictionary. Some expressions appeared to be local and the researcher's Salvadoran contacts were sometimes unsure of the translation. For example, in one interview the woman described being eaten by *"guerras"*, a type of insect. The researcher could not find a translation for this from other Salvadorans, and from the description concluded that the word was probably a local (or even family) expression for ants. Some of the names given to plants could not be translated, nor were the names recognized by professionals in the

community, again suggesting that local names were used.

In other cases there were words used particular to the context of the war. The words *guinda* (describing the flight of civilians to escape the army), or *animales* (a term commonly used throughout the country by those sympathetic to the left to describe the army) are two examples.

The English translation has been used in the body of the text with the exception of those instances where a Spanish word or expression was used, or did not have an exact translation. Both the original Spanish and the English translations were kept in the text for the feedback stage in order to ensure that participants knew which narrative excerpts were being included and to allow for review of the translations by the community advisors and interpreters. However, only the English translations are included in the final copy. These are loose rather than literal translations, as an attempt has been made to provide clarity provided from the context of the interview. For example in one excerpt, *abuelito* (literally a diminutive for grandfather), was translated as *old man* as the individual was not a relative but was being referred to in an affectionate manner. Where, during an interview conducted in English, a Spanish word or expression is used, this is included in the text with an English translation following in parentheses. In addition, because many of these words have a particular meaning which may not be easily translated, additional information and context may be provided in the text.

## Patterns of communication

### Laughter and Crying

Noticeable in the transcripts of the interviews, as well as in informal conversation, was the use of laughter in telling of stories. Laughter often occurred in unlikely context. In some cases laughter would signal an intense emotion, and appeared to be used to diffuse the recounting of a painful event.

*And I was on the list. I was on the list to be killed. (laughs)*

*But I said if I didn't come, I would be dead, so it was one or another. So they said, "Well it was your choice, but the problem was it effect us".(laughs)*

Less frequently, a humorous aspect would be inserted into the telling of a painful story. The insertion of humour into the telling of even desperate situations is consistent with what one will observe in social interactions. There is much joking and teasing, and humour is valued. However, it sometimes occurs in settings where Canadians may find it disconcerting.

> Several years ago, I attended a workshop on treatment of torture survivors. As part of this workshop a Salvadoran drama group presented a play, placed in a Salvadoran jail which included scenes of torture. Canadian spectators were so upset one person stood up and asked to have the play stopped. After the performance one of the performers asked me "Didn't you get the humour in it?".

Crying too, appeared to often mean different things. While in most cases crying accompanied the telling of painful stories and could be seen as a symptom of distress, it was also identified by the women as a technique for coping, and was so transformed into a positive activity. Most women cried, without embarrassment, through at least part of the interview.

## Levels of Disclosure

A review of the narratives revealed that the women often told their stories in layers. A common pattern was that on the first visit, personal history in El Salvador would be downplayed, particularly that there had been any political /community involvement *(Nothing much happened)*. Often on the second interview there was more information provided *(This happened)* including in many cases details of some of the specific events women had experienced *(This happened and this is what is was like)*. It was at this level that women began to show some of the emotional reaction to events. The final layer was that of sharing *suspicion if what might have gone on* including the darkest fears, or evidence, of betrayal by those close to you.

Clearly not all layers were exposed with all informants, though most did share in a very open and emotional way some of the difficulties they had been through. These deeper levels of disclosure was found more commonly in situations where the researcher had been "recommended" by a community advisor, and suggests that being introduced by, and vouched for, by a trusted contact is key to the quality of data collected. This layering of information also emphasized the need for several contacts over the time of the project, in order to establish a level of trust and rapport. Some of the most open sharing occurred in the final phases of the project, during the feedback stage, where many more personal stories were shared. This layering of information was also one of the indicators of caution and distrust and the need for individuals to protect themselves from potential risk.

**Effect of Research on Participants, Interpreters and Transcribers**

It has only recently been recognized that exposure to painful narrative can have an impact on researchers (Dunn, 1991) and on transcribers (Gregory, Russell, & Phillips, 1997). This section reviews the observed effects of participation in the project by study participants, translators, interpreters, and transcribers.

<u>Effect of Research on Participants</u>

The actual interviews themselves clearly had some effects on the participants. Most cried through parts of the interviews, some also demonstrated other emotional effects such as trembling, or flushing. One participant reported that increased dreaming had occurred after the interview, and many stated that it had caused them to think of the past. However, although this was experienced as painful, there were no stated regrets about discussing the topics. One woman commented that talking and remembering did not cause *dano* (damage). Some appeared to find the discussions helpful. Certainly the value attributed to talking as a coping technique (Chapter 11) would support this interpretation.

The feedback phase, where the actual words of the informants were presented back to them appeared to have an equal though different impact. Many of the informants appeared emotionally moved, or even shaken, by hearing their own words, some more so than during the actual interviews. Many made comments such as *"That's true"*, or *"Yes, that's what happened"* as the narrative excerpts were read. Some of the women

stated that having this information presented back to them felt different or "strange". Some reported (or showed signs of) anxiety and increased alertness during some parts of this process. One woman commented, laughing, (as we moved from narratives excerpts related to the war years to topics related to life in Canada) *"Whew! I can relax; I am in Canada now!".*

One result of the women's focus group was that some of the women continued to meet, in spite of the stated concerns about community distrust. However, this may have occurred in any case as the women who attended included those who had indicated an interest in meeting about such topics.

### Effect of research on interpreters, translators and transcribers

This research project confirms that exposure to such narratives, or even to excerpts from these narratives, may have profound effects on translators, interpreters and transcribers (Gregory et al, 1997). One woman who interpreted was already aware of some of the life history of the women, and while the interpretation did cause her often to reflect on her own experience, the researcher did not get the sense that this was particularly disturbing. In another case however, a younger interpreter was quite unprepared for what was disclosed and appeared shaken. The researcher spent some debriefing with her after the event.

Two different women assisted with transcription of Spanish tapes. One woman

assisted the researcher in transcribing the individual interviews for which she had provided the interpretation. During the time of transcription (as we were in a private setting) many more of her own life experiences were shared - emerging in response to the events being transcribed. The process of transcription appeared more disturbing than actually interpreting for the same interviews.

The other woman assisted with transcription of the focus group, and was not present for the focus groups themselves. She reported finding the transcription emotionally upsetting and requested the opportunity to discuss her experience in transcribing/translating the tapes, discussing the impact the experience had on her. She also stated that it had caused her to reconsider her assumptions of what was occurring in the community.

These results suggest that the same material may have a different impact on the same individual depending on whether the individual is interacting with the information as an interpreter, translator, or transcriber.

# CHAPTER 3: THE SALVADORAN FAMILY

The pictures painted by the women of their life in El Salvador prior to coming to Canada were vastly different in many ways. However, one area where there was observable similarity among informants was in the informants' definition of family and the importance given to family relationships. Whether women were rich or poor, well educated or illiterate, from urban centres or rural areas, all the women described themselves as part of a family, and defined their identify in terms of their families.

## The Family in El Salvador

### Definition of family

Informant life narratives demonstrated a much higher level of family connectedness and interdependence than one would expect to find in women born in Canada. Family was described as including extended family, and implied close emotional relationships.

> *I never will feel like living in my country. For me family not only my husband and my children, family is also other people. In our countries families are large and very close, so your uncles, your grandparents, all those people are very important.*

Some women described their grandmother as being the one who raised them, and said they were closer to their grandmother than their mother.

> *Well, I grew up with my grandmother because my sister (was sick) and my mother couldn't take care of me. ...I stayed with her until I was 11 years old?*

> *The house wasn't my house, my parents house, was my grandma's house.*

Some of the women commented on the differences they found between Canadian and Salvadoran views of family. A typical statement emphasizes the attachment to ones family:

> *I know that Salvadoran families, we tend to just stick together a lot. To get, the families we get, El Salvador is really small so everybody lives close by and they always get together for holidays and Christmas and things like that. And Canadians, like they do that, for Thanksgiving, they have a dinner but its not like Salvadoran people because Salvadoran people are more I don't know, they try to stay together. And when you're 18 here, you think O.K. I'm going to move out of the house now, that's just the typical idea, yah now I'm 18, I can leave now. And that just doesn't come to mind, when I think I'm going to turn 18, I don't think O.K. I can leave the house now! It just doesn't come to my mind because I don't even, I don't intend to move for a while. So just being close to my family and things like that.*

## Family Role as Practical Support System

Thompson (1986) states that "family relations continue to be very important both economically and socially in El Salvador. For the poor, the family network represents a crucial welfare system, and for the rich, access to political power is determined by family ties and influence" ( p. 30). This was reinforced by the women's stories.

Women also showed a high level of awareness that the family social position played a large role in determining health status, and of the family's role as a practical support system. Many began the interview with a response to a general question regarding their health as children with responses focusing on their family and its resources. As will be described in following chapters, family is seen as a key factor both in maintaining health and safety, and in treating illness.

The definition of oneself as a member of a large extended family, created the basis for one's community. Especially in rural areas and small towns, large extended families formed economic and social bonds based on family relationships. One's life revolved around the family.

## Of Marriage and Husbands

Salvadorans use the same terms, married (*"casada"*) and husband (*"esposo"*) to refer to three very different marital states; common law relationships, civil marriage, and marriage within the church. Common law unions are common even among the devoutly Catholic, especially among poorer families. Many of these unions are stable and long-lasting. Others are more casual.

In El Salvador, church weddings are not "'legal" marriages, so a couple who wished to be married both in the eyes of the church and in law would need to go through two ceremonies. As the church wedding is more complicated to arrange, couples may become legally married at one point, and married in the church at a later date.

During the interview, women sometimes identified the form of their marriage by saying something like, "my husband, well not really my husband", or "he is my husband *now"*, This report does not distinguish between the form of marriage of the informant unless it is in some way important to the woman herself.

## Family as Mechanism of Social Control

The Salvadoran family emerges not only as a source of social security, but of social control. The family unit is essential to survival, and so there were clear risks to going against the wishes of the family. One woman describes the treatment her sister received when she married a man of whom her parents did not approve.

> *She was sort of left alone, and "you are married and now you are leaving the home", and they didn't give her anything when she left and she didn't get any support. I remember hiding food from my mum so I could bring it to her; I knew he was poor. They didn't like him, and they got married without my parents permission, and that's maybe the problem why she was all on her own, like no friends, no family, nobody. She has raised her children like that. Alone.*

The form of marriage is also a potential source of stress in families. Parental disapproval of the intended husband may lead to a common law marriage. If a religious marriage is important to the parents, women who live common law, or who are married only in a civil ceremony and not by the church, may be condemned. The couple may even be ostracized from their families.

> *One time when I was pregnant I came home, and my mum said, "Aren't you ashamed of what you did?" - because I was pregnant, and I said "No, I love him mom." I was married, but not by the church and that is not acceptable by my dad.*

> *But well, I get married, and my mum and dad was too angry! ......Sometimes, even my dad told me, they feel ashamed that only I get married, only in the civil, not in the church. They feeling ashamed. I don't know how in English, the peor fracasa* (worse thing you could do, the greatest failure) *in the family that I just get married in the civil. Not in the church. ....My mum told me, "if you don't marry in the church (name of husband) don't put one foot in our house."*

This family showed a great deal of displeasure that the daughter did not marry the man they had approved.

> *Even when my husband talked to them for permission, they telled me, they can*

*give me the money to go back to marry the other one.*

She says that had she still been living in El Salvador, she would have married the man her family supported even though she didn't love him.

Rejection by one's family is experienced as a severe penalty. Some women described their experiences of family rejection or betrayal as teens or young adults. One of these women was in the midst of such an event now in Canada.

> *But I think just only my big, big problem, that's my family. ...I tell my husband, not twice, maybe three, four, times, let's move (from) this province. Maybe we can live in other province, just alone. Not close (to) my family. I love my family, but sometimes I'm not feeling comfortable.*

What is striking about the women's stories of rejection by their family is the degree of distress shown. Rejection or abuse from one's family of origin, particularly the mother, was the topic which elicited the greatest distress - even in the stories of women who had suffered direct trauma (e.g. rape, imprisonment, death of family members) as the result of political oppression. Negative feelings towards one's family also appeared to cause a great deal of guilt or distress.

> *I know that family is very important to us. I know that when I get mad I, my parents, I don't, and I feel, they've done so much, how could I get mad at them for something that's not even worth it? (crying)*

### Role and Status of Women in Salvadoran Families

Salvadoran society is often described as patriarchal, in that men have the economic power, and the culture of machismo allows for male domination and a society *"where the man is going out and the woman is going to stay home"* (focus group). The

terms *machismo* (noun) or *macho* (adjective), are often used by both Latin and North Americans to describe male domination in often quite critical terms. The original meaning of this term however included a positive aspect, that of responsibility. (*A real man takes responsibility.*) According to this definition, abusive or irresponsible behaviour is not 'macho', and men have responsibility for ensuring the protection of their family or group.

> Shortly after the 'Montreal massacre' in 1989, I overheard a group of Salvadoran men discussing the event. Like many other Canadians they were shocked and outraged at the event. This outrage however was not focused on the perpetrator, but on the young men who had been in the classroom when the gunman took control. "What kind of man", one of them asked, "when told to leave by a man with a gun, would just leave the women there? What did they think was going to happen?". Another added "If the men had all jumped him, maybe 2 or 3 of them would have been shot, but not 14 women!".

As these women were classmates, it was felt that the male students had some responsibility to protect them. It was also apparent that from the perspective of the speakers the fact that hostages would be taken and threatened by an armed man was unremarkable, this kind of violence was 'ordinary'. The focus instead was on the response to it.

There was discussion in one focus group as to whether Salvadoran society was patriarchal, or matriarchal. Some argued that it was matriarchal in that women (in particular the mother) were seen as central to the family, and holding the emotional and moral power. This was confirmed by the interviews; women saw themselves as central to the family and responsible for their families physical and emotional health and

wellbeing. Women are also seen as stronger and more resilient than men. This theme is expanded in Chapter 8: Resilience.

## Importance of Relationship with Mother

The importance of acceptance by one's family was reinforced by the professional focus group, and there was an emphasis placed on the particular importance of the role of the mother. A disruption in this primary relationship was seen as the cause of a great deal of difficulty. During a focus group discussion one informant stated:

> *Maybe this is also a particular idea, but talking about the isolation, in this case, what I have observed is that our background, the relationship between the woman and her mother is fundamental. They can have husband, they can have...nothing would be....there is no comparison between the relationship between the mother and the daughter. (expressions of agreement) .*

The intensity of this is well demonstrated by one woman, separated from her mother as a child, who while talking about a suicide attempt she made as a young woman says:

> *Crazy. You know, sometime do crazy stuff. I don't know, the life. Always I want to live with my mum but she don't know.*

The sense from the life narratives was that alienation from ones family was understood to result in guilt or depression, but did not result in rejection or abandonment of the mother in return. Instead forgiveness and understanding were emphasized. One woman explained that her mother had abandoned her (to abuse) but that she had been "very poor". The women interviewed continued to show support and loyalty to their mothers, even in cases where they had been abused or neglected.

## The Impact of War on Family Relationships

The increasing violence and social disruption of the civil conflict also had a number of effects on the lives of families. Family separation was common, as was the permanent separation of families through death or "disappearance". In addition, the conflict created additional reliance on family for survival, and in some cases resulted in the women taking on a wider variety of roles.

### Family Separation

The separation of families by the civil war had a major impact on a society where family closeness is valued. This separation took many forms, and began even before flight from the country. At times separation was only temporary, losing track of family members during flight or attack

> ....*There was a battle, and I lost two of my children. Two of them were lost, they were not with me for the whole day, they spent the day without eating or drinking.*

In other cases, the men of the family would live in the fields or mountains, and come home occasionally only to get food. In other cases those considered most at risk would stay or work at home during the day, but sleep outside at night.

However, families could be separated for long periods of time. In the rural regions this was often because husbands or brothers left to fight with the guerrillas, or left the home because their presence would jeopardize the safety of the women and children. One woman described losing two sons, who went to fight with the guerrillas when the

youngest was only eleven. Another describes being separated from her infant daughter

> *In January 1981, it was the offensiva, so we had to split up, like go places, we couldn't stay where we were living at that time because then I would put my family in danger. .... So I had to leave my daughter, and find someone to look after, to babysit.*

Men and women who were politically involved often lived "in hiding" for periods of

months or years. Sometimes if one family member was threatened, he/she would leave

the country temporarily. It was not unusual for women to be left alone during their

husbands' flights from the country.

> *Was my husband was the one who had a high risk to stay in our country, that's why he, I told you, that I told you that he spent one year in the United States with his mum.*

> *Illegal. And they, he, the police choose him, stay in the detention? Detention centre, for I don't know how many months......He stay in the prison for about, I'm not sure how many months, and the lawyer told him, do you want to go back your country, or he help to fill out the paper to come here. Sponsor by the government.. They give the paper for immigration in Canada, and he tell all the truth about why he come to the United States, and why he doesn't want to come back to our country. Because in this time is dangerous for his age, he was 20, 21, but its too dangerous, he came back, he say its difficult situation for he.*

As these narrative excerpts illustrate, the United States was a common destination for

those who left the country; many of those entered illegally.

Internal displacement was another reason for family separation in rural areas.

(Urban families experienced less displacement; while some did relocate to another house,

they generally remained in the same centre). Because of army attacks on rural

settlements, there were mass evacuations, or strategic retreats (called guindas) from areas

under assault. A great deal of anxiety was experienced by informants related to their

attempts to locate family members at this time. Many of the women described being separated from other family members for safety reasons, long before they had to leave the country.

## Increased Reliance on Family for Protection

As the political situation worsened, individuals were forced to depend more than ever on one's family for protection, and having a family member in the right place could save your life. One woman who became involved with the revolutionary movement described how a family member warned her of danger:

> *And one day, my other cousin, who was in (city) by that time, phoned me, and said, I need to talk to you. And I want to come,", He was the second in charge at (military base), then he came and said, " I was at a meeting today at the (place)" where all the commandants from all the places came together to analyze the political situation and see 'who is on the list'? And I was on the list. I was on the list to be killed. ......and my cousin said, "I need you to (leave the country) right now. Take the kids and leave. And don't come. You are on the list." (laughs)*

However, particularly in poorer families, one's family, once the key source of security also had the potential to pose an additional risk. It was reported that at the beginning of the war only men were targeted, but as the repression escalated, women and children too could be tortured, raped or killed for being associated with any family member suspected of involvement with, or even sympathy for, the revolutionary forces. Suspicion of political involvement of one individual often resulted in a situation where even members of the extended family were placed at risk

> *Because my mum was the one that was actually involved in the war and they*

*weren't, and just because of my mum kind of thing, they were sort of dragged in too? Because they were family?*

*And then we began to have problems with the family, because the army started searching for me, and asked me to hand over my sisters. And they asked me "Where are the arms?" That supposedly, they said, we had weapons in the house. And the day came when they came to interrogate me, and to ask for the arms. And to give my sisters to them.*

*At that time they respected women, and if they didn't find men at home, we were O.K. But a year after or so, it was very unsafe, even for us, because they were threatening if we don't tell where they are, they will kill us.*

Women were also put in danger attempting to protect other family members. At that time a male could be forcibly conscripted into the government armed forces simply by being "picked up" by passing army. Sometimes buses were stopped and any male of the right age would also be apprehended on the spot. Protecting younger brothers, or sons, was therefore a priority for a number of families.

*One lady close to my house, and she told my mum, your son is chosen for the army! The army. And I tell my mum, "Stay here, and I am going to see what happened". And my sister and me went to the place, that the people, the young men chosen, and I tell the soldiers ," I coming for my brother". And he told me "Why are you coming for your brother?" And I said "Well because my brother is working, and he is not people from the street, why are you not choosing people from the street, why are choosing people who is working?" The soldier was angry, told me "Why are you coming to tell me stupid ideas?!" And I said "Well, the first time, I am Salvadoran, I am a woman, and he is my brother". And he, and he lying to me, "But this is not the reason for coming to me for your brother". And I said, "Be careful, because you are a soldier, and I am a civil, a civil? Civilian people". And I said, "I can't talk to your superior?" and that man told me, "Do you want your brother? Shut up!". And my brother, and my sister, just only - how do you call, like this? Yeah, pulled me. She said, "OK, don't do that nothing".*

## Changes in the Role of Women

The "disappearance" of men - through death, or because they were in hiding, also forced some of the women into more active roles. This change was more clearly seen in rural families where it was unusual for women to work outside of the home. Some women became combatants with the liberation forces, a greater number were politically involved in community organizing and political education. This changed the traditional relationships between men and women in some families. *"I was the leader like, I was the head of the house after my brother left"* one woman remarked.

It should also be noted that playing the "female", particularly the "mother" role in this context of violence was in no way a passive role. To protect and care for family members would often involve not only being assertive but in taking great personal risks. Hiding family members who were being sought by the army, lying to protect loved ones, confronting authorities (as in the case above) to protect family, even the acts of obtaining food and medical care were all fraught with risk. Even the actions taken on behalf of the larger community were seen as consistent with this role. One woman described going to visit her husband, who was commanding a group of guerrilla combatants.

> *And they were all very tired, and needed to sleep. So I said I would (keep watch) during the night. They didn't feel comfortable with this because I was the wife of the leader, like. But I was in better condition, they needed to rest. So I did. But because I was so pregnant, the ammunition belt would not fit around me! (laughs). Yes, we used to talk, and dream of a normal life.*

Involvement with the liberation forces also involved for many a "re-education" of

the roles of men and women. Women were not only combatants, but held high political and military positions among the guerrillas. 30% of combatant roles, and 40% of leadership roles were reported to be filled by women in the zones controlled by guerrillas (Haggerty, 1990). The revolutionary forces stressed equality for women, who were seen as comrades in the struggle. They discouraged domestic violence, and promoted sharing of household chores. These role changes however did not affect all of the rural poor, only those who were actively politically involved with the opposition forces.

## Loss of Family Members

The greatest impact on family as the result of the war was the death or disappearance of family members, an experience reported by most of the participants.

*We were planning to marry when he disappeared. He was being, uh, like my brothers, the, uh, soldiers were after him and one day he just disappeared. He left me in San Salvador, with him, so I don't know, like that day as I remember as that day as being, I don't know. . I just remember being with him, and my youngest sister was with me, and then he left and he said "I'll be right back", and he never did. So I can't, so I don't know what happen. I wait, wait and wait until about 10 at night and then, and I, he never came.*

He (her husband) say "Goodbye, you take care of my children" (still crying). And I say "O.K.". "I'm maybe not come back anymore", he say. I say "O.K. The God take care of you". (Pause, crying.) He say that "Take care of you(self) - the fighting", he said goodbye, and hug me and hold me. I say "O.K. Goodbye". I not see him any more. .... Somebody told me, "Your husband is die in the fighting, the dog, the something fly, eating him, animales lo comieron". Animal. Yeah. The black animal , with the long neck "sope" (vulture). In Spanish sope. Dog too. Perro? eating him . (Cries)

*The first times that they invaded us, when they killed our relatives, the brothers of my husband. They killed one brother, one niece, the one who was the most dear to me. We were almost the same age. But we loved each other like sisters. At that time I was about 4 months pregnant. And I say, of course all of those things were*

*going to affect me, all those painful emotions that I had then.*

The result of these losses was the experience of intense grief and depression, and the disintegration of the family unit. Women raised their children without fathers, and without the support of grandparents, or aunts and uncles.

> *Was really tough. That was what I found, not alone uh, because all my family was really helpful with me and my kids, but I felt really bad because I wasn't... my man with me.! see! In the middle of the war. Because we never knew when the war was going to end. And meanwhile I had my kids and they were in the same situation as anyone in my country, exposed to everything.*

## The Impact on Family of Immigration and Settlement

### Further Family Separation

As indicated above, many of the families were separated even while still living in El Salvador. Many became displaced from their own communities to other regions of the country. However, the attempts by many rural families to relocate to other areas of El Salvador were not successful and eventually they made the decision to leave the country. For most families, flight from El Salvador was to a neighbouring country in Central America - Honduras, Guatemala, Costa Rica, or Mexico. It was from there that application for refugee status in Canada was initiated.

However, urban dwellers who left later in the war were often able to apply for sponsorship from El Salvador, and on approval travel directly to Canada. This experience of migration did not include the phase of asylum, with its resulting insecurity. For these families the stress was the waiting, and the continued anxiety of living in a dangerous

environment.

> *Fortunately they never did anything to him but this friend says, if you can get out of the country, go. And if you can take your family, take it.*

A key issue for all however, was the separation from other family members. Many women were separated from their husbands during the process of flight or immigration. Even the task of getting children across borders was difficult for women alone, and posed additional difficulties. For example, at that time the husband's signature was required to take the children legally out of the country. This posed major difficulties if the husband was in hiding, or missing.

> *I had just come to Mexico with nothing, we came illegal, I couldn't get papers. (My husband) came legal, with papers, with visa. but I couldn't , I had to cross the river, because (my husband) had to sign for my children to come and for me too because we were married to get the passport. So I couldn't get any papers, I had to come illegal.*

Another woman described how she bribed another family to smuggle her children across the border into Guatemala as she had to leave suddenly without obtaining her husband's authorization. However, even when the nuclear family remained together there was for most the stress of separation from the extended family.

> *But when we come, when just only the Canadian embassy? The Canadian embassy approve our paper, we wait for 1 year, for the visas, the papers. But sometimes we are thinking that they forgot our papers, or maybe we are not going, or that's not true. But November, my mum, my dad come to work, and my mum take care of my grandma who was sick, but my dad maybe he left the house about 6 o'clock in the morning, but he came back about 8 o'clock in the morning, the same morning. And we ask our dad why he come back. And he say "OK, we are keeping everything because this telegram? telegram, we are going to Winnipeg, November 28." For us it was a big surprise. Because my grandma was sick, she had a cancer, a cancer in the stomach. My mum take care of my*

*grandma, at my uncle's house, and now we are going to Canada, what happens? But my grandma tells my mum, "If, if you're, if is ready to go, then you can go. Is for your children, not for me. I am old, I am ready to go to the heavens, I not live longer, but your children, is the better way. Go, go, go, go. Don't miss me. I'm going to the heavens, not so far". Even she made the song for us. She sing many times when we are, when we come here. But we come here 29, November 29, and my grandma dead?.....died on December 9. That's, my mum was affected so much, because just only one week more.*

This separation, given the nature of the Salvadoran family was extremely difficult. Also indicated in this narrative excerpt is another theme, the "weeding out" of the old and unwell through the immigration process.

Some women fled alone or with their children and recreated families in other countries. In other cases women were separated from their children, particularly adolescent or adult male children who were involved in the armed struggle.

It should also be noted that the key reason for many families to migrate was to protect the younger male family members. Some of the women told stories of attempts to protect brothers or sons from recruitment, from either the army or the guerrilla forces.

Once in Canada, concern over family members left behind continued. Many of the women described emotional difficulties of stress and depression during this time and identified the separation from family members as a major stress. Others were involved with coping with the depression or adaptation difficulties of husbands or children.

*I felt very depressed. And I guess it was because I left my grandmother. I think so. I think that's what it was.*

Others suffered a great deal of anxiety about family left behind in El Salvador or who were known to be living in other countries. For some, assistance to those left behind began as soon as they arrived in the country. One woman described how the family managed to provide economic support monthly beginning on arrival, even though the family was on social assistance, by cutting back on food and expenses. "*(They) only ate rice and beans, but you know, we are used to that,*" she said.

Depression and grieving over loss of family members was not limited to initial arrival. Many women described a state of ongoing depression that often appears to be related to ongoing grief regarding separation from family.

> *They die, we won't ever see them anymore. I, for example, am planning to go El Salvador, because the people I have there are very important to me. And last week my uncle passed away. He was one of the main reasons why I wanted to go, and what happened? Because I was here, I never saw him again, and then that is a wound that cannot be healed, and that starts affecting me. Our (children) will never have the relationship with our cousins, and our friends.*

> *I think I feeling depressed. Because for my friends, all my friends stay in my country, and I stay here, alone. Sometimes even now, I feel lonely. Because sometimes I can't explain, or I don't have anyone I can tell what happened to me, or how am I feeling. I don't have anyone. I don't have friends, I don't have nobody.*

For this community, such separation appears as a state of extended grieving. There also continues to be anxiety about those left behind. It is to be expected that refugees experience a great deal of distress regarding those they have left behind when the country is in a state of chaos and war. A less well documented experience is that many individuals continue to feel stress, even at this time, seven years following the signing of

the Peace Accord. Much of this appears to be due to economic worries. Many continue

to provide economic support to families still in El Salvador. One woman felt stressed by

a phone call from her sister asking for money (this was a year of drought and food was

very expensive). In the focus group another commented:

> *I mean financially, here no one is really in need. On the other hand, in our country, people are dying of starvation. Literally.*

## On going Family Support

Those who were able to immigrate with, or sponsor other relatives to Canada,

continue to find practical support from the family system. Assistance with child care,

transportation, or in finding employment were commonly mentioned. Families continue

to provide financial support to relatives here in Canada, and in El Salvador. In addition,

those with extended family in Canada often find family an important social support

network; a small community with shared experiences (where it is safe to talk about the

present and the past).

## Changing Roles and Status

Although some women, particularly those who arrived as sole heads of families,

continued to play a strong role in the family, some women describe a situation of

increased dependence on male family members, particularly husbands, immediately on

arrival. Commonly, the woman would rely on the man to negotiate new situations or to

take the lead role in speaking English. This appears unrelated the actual language skills

of both parties.

> *Maybe that's two years ago and I start to speak more English, but before, I always stay away. Just only my husband, if we are going alone, I always ask my husband, "What he did, what he said, what happened ?". Always. But now my husband sometimes he says, "Sometimes you understand more than me."*

However, this appears to be an initial pattern and both the women themselves, and the

professional focus group, state that it is women who are more quick to adapt, learn the

language and be "assertive about rights". It appears that it took little time for them to

recover their traditional role as family caretaker.


One woman who had been politically active noted that a major source of stress in

the first year of arrival was the pressure her husband was feeling from males in the

community to play a more traditionally dominant role, even though this was a change

from the equality they had practiced in their relationship during the war. This presented

as one of the key issues in adjustment and the cause of family conflict until it was

resolved, largely it seems, by the woman finding employment.

> *And he didn't help, he expected the house to be clean, completely clean, and food made, and I was supposed to serve him because I was at home, that made me feel so bad! And at times I cooked something special, oh, he like this, so I didn't give my kids more, because he liked that, so I gave them something else, like that food, but a little bit, and then something else. And then he comes, and "This is not good. I don't like it the way my mum didn't make it this way." But I never told anybody about these problems, never. But that was about, between a year or so, between a year and a half........It wasn't like that (in El Salvador) . He had changed for that time SO much that I couldn't believe. And because he had changed already, and because he had been so good to me, he felt pressured that he should do that, because he had an obligation to do that. And that's why he changed. .... And after I found a job too and that helped. Yeah, so that helped. And now he helps, he does. Like he changed, little by little he was changing again. And now we talk about it, "Remember when you did that?" And he says "I know, because I*

*felt the pressure from everybody, and I felt that I had to do it, not because I love you, because it was, like men do that, change, not because they love their wives, but because they have too, and I felt myself that I was worth nothing then."*

Significant changes within the family are reported with adaptation. Particularly for poorer women life in Canada provided the first opportunity to work outside the home, and so have access to money, and to independence. However the areas of greatest change are found in the tolerance for domestic violence and the changing of patterns of child discipline. These topics are discussed in Chapter 5 : Violence.

## Parenting in a New Society

Another impact of immigration on the family is the stress of parenting children in a new society and the attempt of parents to hold on to their children. The adaptation of children to Canadian society can appear to threaten family cohesion and identity, and parents struggle with knowing how to respond.

> *Parents have double the work; on the one hand they must educate them, and on the other keep all the traditions and customs, preventing the system from changing them. ...We are having two fights at once. We fight to keep our customs identity, idiocrasies, our temper, our responsibilities as parents, and we are also fighting against the outside system. ...We ask ourselves, should I give permission or not to go to the party? Should I allow them to go with their friends and sleep over? Should we? If we don't allow them to, people from outside will judge us negatively. As we will judge them as well. There is judgement in two ways: what will the Latino friends of theirs say, and what will the Canadian friends say?*

The differing rates of adaptation between children and parents is also a stressor, and parents worry that they will "lose" their children, that their children will reject them and values that are important to them.

> *Children no longer respond in a loving manner as they did in El Salvador. Instead, they say "We are here in Canada, not in El Salvador!" It is like a big blow in the stomach to all parents and there are many homes in where that is the problem. Parents lose their children and they ask themselves "Why did I come here? I came for my children, and I don't have them anymore. " They have lost their children. Now they belong here in Canada, not there in El Salvador. Parents want to go back to El Salvador but they can't go back because they don't have a reason to. They lost everything they had over there, and here they have lost their children. ..As a result parents feel sick. (women's focus group).*

Because so much importance is attributed to family and to the need to sacrifice on behalf of one's family, such reactions can result in parents questioning their decision to immigrate, and literally result in illness.

However, in spite of the preoccupation about their role and responsibilities as parents in Canada, some of the women showed a great deal of insight regarding what the challenges were, and what was needed to facilitate adaptation. For example:

> *We have moved to Canada and we can't bring El Salvador here. We can't still have all the customs we once had. What we should do is keep a good relationship with our children and that doesn't mean it has to be in a Salvadoran fashion. We are not about to blame Canada if everything goes wrong; otherwise we are saying every single teenager in this country is bad, which is not necessarily true. There are many people that have good relationships with their children, even being Canadian and even if their children leave home at the age of 18. They are still considered good children because that is the custom here. It doesn't mean that when they leave the house they are going to take the wrong path. What we have to do is constantly talk with our children but not in the same manner as would do back home. ......The truth is that they are living here. ...For me the main problem is not accepting the new culture in Canada, not being willing to accept that we had to leave our countries and that we have moved here.*

There appears however some important differences related to parenting and to problems of adaptation of children. These are discussed in the Chapter 4: Social Class and Chapter 11: Coping Strategies.

<u>Fear of Separation and Loss</u>

The experiences of separation and loss, along with the fear of danger, led to a number of precautions to protect family members in El Salvador. One woman describes the precautions taken to protect her as a teenager:

> *So he said that he , uh, at the time he was the only one being followed so he was afraid that anyone like us, especially my sister and I could have been followed. Because..we had to take a bus to school and we had to go alone. The school is in the city centre, so I guess he was afraid of anyone of us getting followed. Because I remember after school, we used to get to the City Hall, we used to get there, we have something to eat and then go home. But I guess it was from, because I remember there was always a friend of his, when we used to get to city hall, there was always a friend of his waiting, kind of waiting, for us. To see that maybe no one was following us or something. Or even, I didn't put anything of it, to think at the time. But now, he used, even we used to say, "We're going", he used to, not follow us, so that we could notice, but he used to follow us until we got onto the bus. But I didn't know anything. I knew in that, but I didn't know...how dangerous it was.*

Other women reported that there was difficulty, particularly expressed by their husbands, in giving freedom to their children, in not being overprotective in Canada. One woman described a high level of anxiety experienced by her husband regarding any form of family separation (such as trips). Informal discussions with other families indicate that acute anxiety may be a fairly common response to what would be considered here as "normal" separation. Even in a "safe" country, separation from family members can continue to trigger a great deal of anxiety.

## Summary

Family was described as central to the lives of Salvadoran women, who often

defined themselves in terms of their families and saw themselves as central to it. In general, the women continued to hold the same image of the family, and to value family relationships as they had in El Salvador. While there have been significant changes in the rights and opportunities poorer women find in Canada (e.g. workforce participation), their fundamental role in the family has not changed significantly, and appears to provide some continuity between life in El Salvador and Canada.

It was also clear from the interviews that the women had clear perceptions of the health of not only individuals within the family, but more globally of the health of the family. The family itself, as a unit, could be seen as healthy or unhealthy.

While this chapter focuses on common characteristics of the Salvadoran family, there were also some important differences found between families. Domestic violence was seen as a serious, and relatively common issue in family health. Substance abuse, particularly of alcohol, was another. Problems of youth behaviour (such as substance abuse, adolescent pregnancy, involvement in crime and violence) and adaptation were also seen as key issues in family health by both individual informants and focus group members. Some of these topics are covered in subsequent chapters on Violence, Community, and Coping. Significant differences were also found in all stages of the migratory process between families of different social classes. This topic is discussed in the next chapter.

## CHAPTER 4: SOCIAL CLASS

### Class Divisions in El Salvador

Another theme which can be carried through all stages of the women's life is that of the impact of social class.

If family was described as key in the life of the women, opportunities were clearly defined by social class. One informant said "In El Salvador, we have two cultures, the rich and the poor". The well - off had a life experience with a similar standard of living to the well - off in North America. The poor, on the other hand, lived in abject poverty in what appeared to be another era (shanty housing, no sanitation, electricity or safe water, no access to health care, and sometimes education). While this characterization is somewhat of an oversimplification, and certainly there is now a middle class, the realities of most of the women interviewed could be defined in these terms.

Even before the "war" erupted, the women's narratives of their life experiences were significantly different based on their socio-economic class, and rural / urban location. Poorer women struggled with issues of access to adequate and safe food and water, and of basic health care and education. They did not have a right to such services and so family was essential for survival and protection.

There was also a great difference between urban and rural life, with most of those living in rural areas being very poor. Many of those working in the cities, however, also

lived in poverty. In the 1960's and 70's, many of the rural poor migrated to the cities, resulting in growth of urban slums. There was some employment for women in the cities, either as servants, factory workers, or as street vendors (Haggerty, 1990).

The contrast in standard of living is extreme - from professional families with access to private schools and hospitals, large houses with servants, to those who lived in shacks with not enough food. This disparity was recognized and acknowledged by all the women.

> *I believe I have been privileged to be born in El Salvador, in the family I was born. Where all the time we had food shelter, love, family. Not many people had that possibility......I grew up in a full family, my father was (a professional). I was educated in private school. We usually had holidays travelling in Central America, or when we were older, to the States.*
>
> *I belong to a nice family, a healthy family, my dad was a public, a government employee. And my mother was a businesswoman, so we have you know, a middle class lifestyle. ...And the other thing was we always have a maid at home, so she also was taking care of us .*

In contrast the life narratives of poorer women included descriptions such as these:

> *The problem is, that my mother don't have food, very poor, is going somewhere to find the food. ...I not eat very good...I am working after I am 11 years old. I am planting coffee, pick coffee too. No money to go to school, no money*
>
> One woman described getting a job as a servant when she first went to the city. The first day she saw a big pot with meat cooking on the stove, and was heartened thinking that the servants would at least eat well. In fact the food was being prepared for the employers dogs, and the servants ate tortillas, or leftovers.

In one of the focus groups the point was made that Canadians cannot understand how "classist" a society El Salvador is. This confirmed the impression created by the

women's stories, as they described a society where the poor do not have rights, and where the different classes did not have contact other than "with their own kind", except in a master/servant relationship. It was expected that not only the rich, but middle class families would have servants.

> *We were the children of Mr.__ you know? And this kind of oppression, that, it was, the oppression was there. And we were treated with respect, even we were children. We were treated like Nina, or Don, instead of by our names. And we used to have servants...all of us were very condescendant with them. My father didn't allow, never allowed abuse from us to the servant. But....usually happened. They are treated like nobody.*

This narrative excerpt shows the importance of language in indicating social level. *Don* (male), or *Nina* (female) are respectful forms of address which precede a person's given name (For example *Nina Maria*). These forms are usually used with older persons or those of a higher status.

The civil conflict is understood to be rooted in centuries of disparity and the denial of basic rights and resources to the majority of the population; the ruthlessness of the repression is attributed in part to the dehumanization of those "different" from oneself. Martin Baro reports on an attempt he undertook in El Salvador in 1987 to replicate research undertaken in the United States on the formation of the concept of social class. One of the questions asked was "What would have to happen in order for there to be no poor people?" He reports that several children from higher economic levels gave the response of "kill them all". He noted that the studies carried out in the United States have never reported this kind of answer. (Martin-Baro, 1989)

## The Impact of Social Class on War Experience

As in the general conditions of life, the escalation of hostilities had different effects on rural families, and those living in urban areas. Specifically, bombing and invasion, and the resulting mass flight, was confined to the rural areas. The greatest number of civilian deaths also occurred in the countryside (Americas Watch, 1991). Some of the effects of war were experienced by both urban and rural dwellers. Even here however, the effects were not felt equally. Killings and disappearances also occurred in the city. However, the effects of the conflict were not felt by most urban dwellers until the late 1980's.

In general, the rural women do not describe a sudden change from prewar to wartime conditions. However, they do describe a state of increasing repression, including disappearances, killings, rape, bombing, invasion by the army, family separation and forced flight. The experience of those in the cities varies.

We are warned not to ignore the different ways in which such an event can affect groups and individuals (Martin - Baro, 1989). Even in the cities, the effects of the war were not experienced equally. The urban poor were at greater risk than those who were well off. For many privileged families life continued unaffected, and (at least in the early stages of the conflict) the war was an event experienced only through the media (Martin - Baro, 1989). One urban woman interviewed commented that for many in the city who supported the liberation forces, the war was a "romantic idea".

In general, those at risk from professional classes were those who made individual choices to become involved (though there were certainly exceptions to this), or who belonged to certain targeted professions. The poor were suspect simply because they were poor, and need take no action to be placed at risk. Even the ability of family to protect individuals varied by social class. Several informants stated that those who were better off would be safe as long as they were "not involved in anything", even if other family members were discovered working for the opposition. Even if they chose to be politically involved, those from more privileged backgrounds had much more protection from the army. One participant explained:

> *And who is the army? Oppressed people. You just scream that you are so and so, and that's it! That was enough at that time.*

Among poorer families however, even suspected political activity by family members could result in the deaths of others in the family. The exposure to both the type of violence, and the amount of violence was moderated in large part by social class. The particular patterns of violence experienced by women of different social classes is outlined in the next chapter.

## Effect of Social Class on the Migration Experience

The family experience during the migration stage was also in large part determined by class. As discussed in the previous chapter, poorer families from rural areas generally faced a long period of internal displacement before leaving the country. During this time (which often spanned a number of years) they continued to be threatened

by hunger, bombings, rape, disappearances and death.

Urban dwellers on the other hand, were largely unaffected by the war until 1989, the first time that battles erupted in any major way in urban areas.

> *Most of the time were in the countryside but we weren't affected in the capital city. But 89, was the final offensive, they say, and that was the worst, in the capital city. Yeah. And at that time my kids were, you know, grow up enough to understand or follow some direction or indication, and they were not exposed to, they, how do you say, because our house had a wall around our house, so we were kind of secure. But they were fighting around our house.*

The poor often had to escape to countries of first asylum illegally, and often continued to be threatened there. They often continued to be in hiding and vulnerable while awaiting word on their refugee status. Food was often short, and there was often limited, or no, access to health care. In addition, adapting to new a new country was experienced as very stressful.

However, many of those who left El Salvador towards the end of the war made application from within El Salvador and travelled directly to Canada. Of those later arrivals interviewed, all were living in the city at the time they applied for acceptance to Canada. Their experience at this stage was quite different. For many the decision was a carefully thought out one.

> *But at the same time, we have the opportunity to see, what's coming next, and we prefer to see, we can go out of the country for safety reasons, especially for our childrens you know.*

It seems then that urban residents who arrived in Canada towards the end of the war may

have had a very different migration experience. While some may have been forced to change their place of residence, they were able to continue living in their own city until they knew they had been accepted into Canada, and often flew directly here, rather than escaping by foot, and facing danger crossing borders.

## Social Class in Canada

If the poorer families described more difficulties before and during the war in El Salvador, it is the professional families who describe more difficulties in adapting to life in Canada. In some ways experiences described throughout the process of settlement are similar. Adaptation to climate and language, as well as the confusion related to adapting to a new culture, were similarly described by those from all backgrounds. However, there are other areas where the situation was experienced quite differently. In particular there are some aspects of culture shock, particularly the loss of social position, which appear to have had a greater impact on those from more privileged families.

### Economic stress

Economic stress was a concern reported by the women who had been in professional situations in El Salvador.

> *However, my major stress has been financially, and then the inability to get more money makes me crazy. And because (my youngest child) is the more, has been the more deprived child in my house, I want him to know other life. Is not healthy for him to struggle with financial situations and so that bothers me, because I am tied, I cannot move, so I cannot get more money home. And besides I am old now and is more difficult. And so that is the major problem.*

These women also reported frustration in relationship to their employment, and the inability to find work at an equivalent level of responsibility.

For poorer women there was the opportunity to participate in the workforce and achieve a standard or living and security for ones family, they could only have dreamed of. Many of these women focus on the benefits of life in Canada for their children, even while they continue to grieve what they have lost and left behind. Women from more privileged families also faced change, but with the exception of safety, there are fewer benefits for them to life in Canada.

The economic conditions in Canada were also creating stress in a number of families. Some of the women were concerned about layoff or potential layoff of their husbands during the time of the interviews. However, the less educated women did not seem to see anything unusual about this. In all families interviewed however, there was shame expressed in "going on welfare", and this was described as a source of stress for those with self respect.

The professional focus group, on the other hand, felt that some of the adaptation difficulties experienced by the Salvadoran community in general was due to the time of their arrival; that the main wave of immigrants to Canada had occurred at a time when unemployment was high.

Those from more privileged backgrounds found themselves in drastically reduced financial circumstances in Canada, and this had other effects. For example, professional women often did know how to cook ; they had never had to prepare meals as there were servants to do this. Having to learn these skills while living on a very limited budget caused a great deal of stress, and it is likely that (due to lack of experience in meal preparation) that they may have also had greater difficulty in managing the food budget.

## Adjustment of Children

Those from professional families also reported a higher level of stress within the family due to discontent from children who were forced to cope with often drastically reduced living standards and the loss of social position. Often they had little understanding of the reasons why this had occurred. Sometimes the children showed a great deal of resentment and blamed the parents for the choices they had made.

> *They don't understand. Sometimes I get blamed because we are here, and we are living poor. But I said, "If I didn't come, I would be dead, so it was one or the other." So they said "Well, it was your choice, but the problem was, it effect us!". (laughs) ...I try to educate them and make them understand that this system of injustice has to change. Why so many people don't have even food? And why some have so much, even they don't need?...So, um, but they are in the stage where they missed a lot, what they had in the past. But they don't want to go back! Is a dichotomy!*

In some cases children of more privileged families are also reported to face significant challenges to their assumptions about their home country. One woman reported that her son had come home from school upset that some of the other students (from poorer backgrounds) were "claiming to be from El Salvador". Because their life experience had

been so different from his, he did not believe them.

## Loss of Social Position

Perhaps as important as the drop in economic circumstances and the inability to obtain an equivalent professional position, is the loss of social position. All families described receiving the same services and being treated in similar ways by settlement services. While generally those from all classes were uncomfortable with being dependent (financially or in other ways) on first arrival, being in such a position was even more difficult for those who in their previous life had been in positions of power and were financially well - off. They often felt that they were treated here in Canada in a disrespectful and condescending way, and were quite offended by a number of interactions. The fact that they were treated the same as any other "refugee", that they were seen to be the same as those from lower socio-economic brackets, and that their education and expertise were neither valued or recognized, continued to be experienced as particularly difficult.

For the first time, children of the rich (and middle class) were attending the same schools, receiving the same services, being admitted to the same hospitals, and working in the same jobs as those who had been very poor. Even those who actively supported the revolutionary struggle were not prepared for the challenges these changes would present.

## Race in El Salvador

*"Un Indio menos, una tortilla mas" (one less Indian, one more tortilla)*

This Salvadoran *"dicho"* (saying) suggests that the issue of race also requires

some discussion. El Salvador, unlike other Central American countries, did not maintain

an ethnically distinct population and by the 1980's was considered virtually homogeneous

in ethnicity and basic cultural identity (Haggerty, 1990). In the late 1980's the population

was estimated at 89% mestizo, 10% Indian, and 1% white, however there were no

ethnically or linguistically distinct indigenous cultures or communities.

Officially, there are no different "races" in El Salvador. Only a few villages can

be identified as indigenous; and there are only a few native language speakers left.

Almost the entire population is mixed race, with the continuum ranging from completely

"European looking", to "Indian". It is stated, often emphatically, that there is no

discrimination by race or colour; certainly light skinned, European - looking people can

be found among the most poor, and "Indian - looking" persons hold positions of influence

and authority. Nor was the political conflict divided along racial lines.

However, on closer examination, the situation appears more complex. Many

more urban dwellers are "European", and campesinos, "Indian". A light - skinned visitor

to the country will be struck by the fascination with skin, hair and eye colouring, and this

will be commented on openly. It is not unusual for people to be referred to, or nicknamed

by their skin colour. (*"Chele"*, (pale) *"negra"* (black), for example). And there is clear

evidence that value judgements are made on skin colour.

> On a recent visit to El Salvador, my 23 year old daughter made friends with a student at the University. My daughter was shocked at the attitudes expressed about colour, that brown was *"feo"*,(ugly) and by questioning of why I (a light skinned Canadian) would marry an *"Indio"*.

> One of the women interviewed expressed distress that her daughter was being avoided by another Salvadoran family in Winnipeg because she was "Indian looking".

> One of the women interviewed described herself as the *"darkest one in the family; the others have lighter hair, they are not as Indian as me"*.

> In other settings too, the words "Indio" refer to what is wild. e.g." *Pollo Indio"* (Indian chicken) is the reference to free range farm chickens. Other sayings (such as the one above) indicate the low value given to indigenous persons.

Attitudes to Aboriginals in Canada vary, but Salvadorans appear very conscious of Aboriginals and their status in Canada. The researcher has also observed social situations where some Salvadorans have been assumed to be Canadian Aboriginals. Some of the politically active Salvadorans have built solidarity bridges with the Aboriginal community, and romantic liaisons are common. However, some informants mentioned being warned on their arrival in Canada, by other Salvadorans, to "stay away from the Aboriginals". Some informants made negative comments about Aboriginals, and some were concerned about their children socializing with them.

> *The white people, very friendly, say hi, very nice. The Indians very bad, ask me something bad. The job, many, the people native. Yeah. " Bitch" say today some lady. "Get out of my way", she say. I'm sorry, I don't understand.*

Other women show concern about this.

> *I could say though, acceptance and I don't want to do this, but I can see that an*

*immigrant women that I am, have opened more doors than an Aboriginal woman..... Yeah is very sad. Is good for us though, but is very sad.*

Attitudes to being "Indian" are linked to "*La Matanza*" of 1932, where during the massacres individuals were targeted because they were Indian. Almost overnight, survivors abandoned Indian dress, names and customs. One focus group member said:

> *We are a complete mix you know, we don't want to be identified with our native roots....The thing is that these people, have their Indian last name, they change it, in order to avoid to be killed. In our culture if you want to offend someone we say "Indio bayunco" (literally "silly Indian"). But then this create a very weak cultural group. What happen is that we are totally open to accept foreign ideas.*

Another commented:

> *You know, we didn't ever have a culture in the sense of the Guatemala. We were affected or penetrated by different cultures, the British (English speaking), Spaniards, never have been what is called a pure Salvadoran culture.*

In addition to the obliteration of distinctive indigenous culture or medicine, it appears that "La Matanza" also has resulted in the official denial of other aspects of difference. There was some evidence of this in through the interviews. One of the women who had stated emphatically during the initial interviews that she did not believe that there was racism in Canada was struggling with this issue when a followup visit was made during the feedback stage. She was being treated very rudely by a certain person at work, and was having difficulty coming to terms with why it was upsetting her so much. She had started to question whether the behaviour was the result of racism, and discussed how denying this as a possible cause could create a great deal of psychological distress.

## Summary

The economic disparity in El Salvador is so extreme that it is useful to think of the rich and poor from this country as coming from different cultures. There were also significant differences between rural and urban dwellers.  In El Salvador there was little mixing of the social classes, and different health, educational and social services were available for the poor and those who were middle or upper class.  The social inequities are of long standing and lay at the root of the recent armed conflict.


Women's experience of life within their own country, of the war, and of immigration and settlement in Canada are in large part determined by social class.  While the poor faced many more difficulties before arriving in Canada, in some ways those from the professional families now face greater challenges.

## CHAPTER 5: VIOLENCE

### Violence in Salvadoran Society

Violence is a theme that pervades the narratives of most informants. Mortality statistics from El Salvador provide some perspective on this. From 1978 until the 1990's, violent acts (homicide and intentional injuries) have been among the five leading causes of death in El Salvador. In 1987 the country had the highest age-adjusted mortality rate from accidents and violence of all countries in the Americas : 127.1 per 100,000. Among males aged 15-24 the 1984 mortality rate from these causes was 432 per 100, 000. The rate of homicides alone is 16 times that of Canada (Pan American Health Organization, 1990).

While data collection focuses on mortality and morbidity statistics, violence has a broader impact than this;'"the effects of violence are trauma, disintegration of families and communities, the destruction of economic infrastructures and the imposition of a general culture of fear " (Desjarlais et al., 1995, p. 26).

This chapter looks at the women's experience of violence within the family, within Salvadoran society, and as the result of the war, displacement and migration. It also focuses on how the women have responded to violence and the threat of violence to themselves and their families.

## Structural Violence

The theme of violence does not begin with the outbreak of hostilities during the war; it is a fundamental characteristic of Salvadoran society. The conflict itself is rooted in social injustice and is "characterized by the social and economic privation of the most dispossessed classes " (Pan American Health Organization, 1990, p. 138). Violence consists of more than the individual acts which result in physical assault, but includes the conditions which lead up to it: the structural violence of poverty and repression. The disparity in living conditions outlined in Chapter 4: Social Class provides some examples of this.

The police and the army served the interests of those in power; violation of basic human rights was unremarkable, even before the "civil war" erupted. One woman describing why she was not worried when friends of her father were arrested and abused in jail stated:

> *Because my father was in a union and unions over there are illegal. And he had all his friends, all his friends were captured by the soldiers, all of them were beaten up. They said, I don't know, they said all of them were in bad shape when they got out of jail. I didn't put anything of it, to think at the time, ....I didn't know how dangerous it was. And I knew some of his friends went out of the country. And I knew they had been in jail and bad treated, but, back then, and back home, everyone gets treated really bad.*

## Violence Within Families

The actual experiences of women growing up in their families differed significantly. One of the greatest areas of difference was in the presence or absence of

abuse and neglect within the family.

## Domestic Violence

A number of the women interviewed described spousal violence to themselves or in their immediate family. In some of these cases the children were also abused. As women were not asked directly about such abuse, the frequency may even be higher.

> *I had this problem that when he was drunk he would treat me badly, yes, even when I was pregnant he would beat me as well.*

> *Yes, we had problems with this because my husband would be very aggressive with the children and beat them excessively . He beat (my son) so much and he kept it in his mind that one day he was going to hit him back. When they are treated this way when they are little they don't forget.*

This last quote demonstrates the awareness of the cycle of violence. Although, due to the intervention of adult children, this woman was no longer abused by her husband, violence within the family continued.

Domestic violence was most often described within the context of male drinking. Of the women interviewed, several included in their stories some history of drinking by male partners (or fathers) which had created some problem for the family. In all these cases family violence was linked with male drinking. This is consistent with research on alcohol use in poorer societies. There was in El Salvador, as in many countries of Latin America, an increase in per capita alcohol consumption in the 1980's (Pan American Health Organization, 1994). It has been estimated that 15-20% of adults in Latin America are alcoholics or excessive drinkers. Wife - battering by alcoholics is common.

It has also been observed that " drug and alcohol use are exacerbated by rapid social change, repressive social institutions and lack of employment opportunities" and " is a way of alleviating boredom, frustration and intolerable living conditions" (Desjarlais et al., 1995, p. 114). This would certainly describe the situations of many men in El Salvador.

> *My father was an alcoholic. He didn't go home when he was drunk. He would stay somewhere else, but he didn't go home. Only, I think once.......they left him on the patio and my mother tried to pull him inside...and she says, he, grabbed her by the hair. So she got away from him, she went to my grandmothers.*

The professional focus group also identified spousal violence as a "terrible" problem in El Salvador, but felt that it had improved here in Canada. This is consistent with the stories told by the women interviewed.

## Child Discipline and Abuse

In addition to sexual and physical abuse, the women from all social classes described corporal punishment as common within society and within the home as they were growing up.

> *And if we did something my father wasn't pleased with that, we received physical punishment. And with the girls, by father was a bit soft, I could say, and with the boys he was very rude. He was very rude, he was very harsh.*

While none of them described this as abuse, some of the corporal punishment described would be considered abuse in Canada

> *We were raised in very hard discipline...It was bad. The last, when I had my last, I think I was about 10. It was REALLY bad. ...So she took me home, she made me clean myself, take a shower, and then she beat the hell out of me that day. And I was so mad at her, because at some parts, I think I had some bruises. With a belt.*

*I do things, they spank me. My dad never did but my mum did. If she couldn't do it because I ran away, she would find somebody to do it for her. My uncles will hit me because, 'your mum told me', a belt and anything they did......They did it so much to me, that sometimes I was bleeding from my legs, because they used the belt, the other, the metal part.*

Corporal punishment often was administered by the mother (as in the two cases above).

Nor did physical punishment necessarily stop when the child reached adulthood. After

confirming that her mother was still physically disciplining her at 16 years of age, one

woman says:

*Oh, my brother was married and my mum would still hit him if he got drunk. My sister - in - law would come home and say (he) just came and he's so drunk, and she would go and hit him. Sometimes the next day, sometimes right then, depends on how mad she was.*

A few of the women described childhoods of great deprivation as children of

single mothers, where they were abused and neglected within the family.

*One woman, was told when she was older "You small, your mother did not take care of you". At two months old, neighbours found her being eaten by "guerras" (ants), and rescued her.* Her mother also put boiling water on her face. While she says maybe it was an accident, she also states that her stepfather (who was a "very good stepfather") was very angry with her mother saying "Why are you doing this?"

She later describes being chased by one of her mother's boyfriends who was threatening

her with a machete. Another women said:

*My mum, she was poor...My mum told me that (her father) were killed when I was three months old. There was drink, fight. You know, revenge. My mum she always go away to cut coffee, and (cotton)....far, I don't know where. She always leave us with my uncle, my auntie, but it's hard you know (lowers voice) ..... They're always treat us very bad.....They treat like here in the U.S., they are treating people a long time ago, the black people. ...They hate us, they abuse.*

*Nobody protect us. And my mum, she always go away. The problem with my mum, she like to get, it's not liquor, but this stuff, she make it for sale, to make money. And she has to go to jail.*

She then was "adopted" by another lady.

*I have to wake up every day at 5 o'clock in the morning, cleaning the house and dusting everything, and sometime she go and touch it where I'm dusting, and she grab my hand and squeeze me and, you know, like you know, you're dusting and she grab your hand ..Put your duster in the face. This is what my auntie do. My uncle wife, sometime she send me to wash the clothes here, don't do it, she squeeze, she has to drink the water......How do they call, because you have to, you know, don't have too much to wash it very good She squeeze some more and make you drink the water. Sometime I say how is it people is so bad*

The women in these families also received no education, and were working at a very young age. They report siblings with a number of different fathers, chronic hunger, violence and abuse.

## Class Differences in Reporting of Family Violence

Neglect, physical and sexual abuse, and spousal violence were reported more frequently by poorer women. However, it must be stressed that the women were in most cases not asked directly about experiences of abuse, so the information was volunteered. It may be that professional women, if they were, or had been abused may be less likely to volunteer such personal information. However, the two informants who reported the most significant experiences of childhood abuse and neglect come from the poorest of families. Both were from families headed by single mothers.

## Level of Random, or Street Violence

Women interviewed also described a society where general violence was common. The family was the social safety net, and provided protection from external violence. Even today, families take responsibility for protection of it's members, and women without the protection of fathers or brothers are seen as particularly vulnerable. In addition, many stories included the recounting of deaths of family members by random violence: a brother who was killed while sleeping on the street, a father- in - law killed at a social event, the death of a father in a fight, being shot in the course of a crime. One woman commented that it was a society where violence was the means of addressing problems. This however was not the experience of all women, and as discussed in the previous chapter, many of the women from better - off families were often protected from this reality.

## War Related Violence

Given this backdrop of pervasive violence it may come as no surprise that many of the poorer women do not describe a sudden change from prewar to wartime conditions. However, they do, particularly in the rural areas, describe a state of increasing repression, including disappearances, killings, rape, bombing, invasion by the army, and forced flight. As the political situation deteriorated, so did the lives of the women and their families.

Some themes were found only , or mostly in the stories of campesina (rural)

women. These are displacement and forced flight, bombings and massacres,

environmental destruction, and war - related hunger.

## Themes Common to Rural Women

### Displacement, Forced Flight

One of the first themes to emerge is that of dislocation, the loss of place,

possessions and security. In order to escape killing by the army, often the whole village

would leave on foot, on what were called *guindas*. They would often travel days at a

time, sleeping during the day, and travelling at night in order to avoid detection.

> *And there were times that I was walking in the dark, from one town to another.*
> *We were suffering hunger because in those walks, there was one time we were*
> *eight days walking, with our children, I had a second baby only one month old,*
> *and another of two years. And walking for a great distance, walking alone in the*
> *night, without sleeping, and in the daytime we would go and hide in the bush so*
> *that the airplanes wouldn't see us. As soon as night arrived all those people*
> *walked to prevent being detected by the airplanes. And all this without eating or*
> *sleeping and the fear of being chased.*

In other cases individuals were separated and fled alone

> *I going at night, 12 o'clock, walking, I don't see my hand...Very dark, I don't see.*
> *No house, nobody living. I go in the (mountains), at 12 o'clock, walking, very*
> *crazy my head, this a little baby, my baby. ....I put him here (points to chest) for*
> *no crying. I sleeping maybe, I walking, my knees hurt, my legs hurt, I sleeping in*
> *the (mountains), I put the leaves over my body, I no have blankets. No.*
> *....Because the soldier is, um, I run away, the soldier is following me, running!, I*
> *am running, running with my baby, running. I, um, the soldier follow me with the*
> *gun, is tirazon, tirando balas por mis pies. (shooting bullets at my feet) Yo*
> *corriendo con mi nina. (I was running with my daughter) Corriendo, y*
> *escondiendome in one hole, yo escondiendome en un hoyo, hole? (running,*
> *hiding in a hole) Ellos passaron buscarme asi.(they passed by looking for me*
> *there).*

Note how the theme of pursuit, of being chased is key to the memory of the events.

## Bombing and Massacres

Another theme that is only found in the stories of women from the rural areas is of indiscriminate killing, of bombing and massacres.

> *My father got shot in the head too at that time. He was sitting, praying, and it was at night and they started shooting, just anybody, they came to kill just anybody.*

> *After two years, is, listen one bomb. I see what happens, its a war now. Some people tell me "Its a war now". Why? "Its the people poor, rich people, poor". Oooh. After very, very danger(ous) the street, killing, the soldiers coming, 20 cars full of soldiers, kill everybody working in the farm, for nothing! Everybody die, for nothing, the soldiers kill, the coffee plantation, the people working there.*

> *The saddest was when the airplanes passed overhead, bombing. Deliberately aiming at the houses. Running, looking for ditches. But yes, there was panic. I felt that as soon as I heard the rumble of the helicopter or of a plane. There was a panic that we had because we knew that the plane was not flying just for the heck of it. They didn't fly for nothing, every time they passed the village they were shooting rounds at us. Always, always shooting. One time I was eating like this, leaning on the wall with my little girl, the two of us sitting eating cooked beans. Alone by myself with my little girl, when the rumble of the helicopter came in front of us. "Oh my God", I said, "they are going to shoot. Best I leave here," I said to myself, and I went inside the kitchen, and both of us huddled down and took cover, when the helicopter passed over. They were shooting exactly where I was sitting. It hit there and sprayed dirt in the beans that I was eating. If I had not moved I think the bullet would have hit my head. It is for this reason that I say that these things are only because of God, maybe because I believe so much in him. (laughs). It's only because of him that I am still alive.*

## Environmental destruction

Another aspect of the war which only affected the rural communities was environmental destruction. Destruction of food and crops, and contamination of water supplies, exacerbated an already desperate situation of hunger and poverty.

> *Because the army came on our terreno (a small property, piece of land) They set fires to the land but the house where we were living didn't burn because some*

*neighbours were throwing water on it to prevent it catching fire. Because they set the whole property on fire when they came.*

*Like the water, bodies were found in the water, and all that and the water was contaminated, in the fish even, if people went fishing if they caught a big one, sometimes there was little pieces of fingers in there because they ate the bodies.*

## War Related Hunger

The combination of environmental destruction, and forced flight, which caused

families to leave their crops, contributed greatly to hunger and starvation.

*For five days not eating, nothing, nothing! I have food in my house, tortillas, chicken...the soldiers put my food outside in the garbage, everything. I no eating nothing, everything is put outside, dirty. ....I believed I would die because I had nothing to eat.*

*Yeah at the time we were trapped in some caves in the bush. And they had given us some pieces of beef. We had no place to cook it, and we did not know how to cook it, but at least we had something. And an old man said that he had a piece of tin roof and on top of that, he put some little pieces of beef to dry in the sun. And I was overcome by a great sense of despair, that I didn't have anything to give them. And I was crying to think that I had to give my little girl raw meat (laughs).*

Even those who had not had food shortages in the past, now found that as they were

forced to flee, food became harder to obtain.

*I used to be like chubby, like I used to be, and then I lost, like after that I went down so much. And sometimes even if we had the food, I didn't feel hungry, yeah, and sometimes because we didn't have food. ...After we left home, we had no money, like we left everything behind.*

*We live in the, like a refugee, because everything, nothing cheaper, everything more expensive. In our village we eat three times (a day), in the morning - breakfast, lunch dinner. But is different than in the city because in the village, in the morning we eat tortilla, beans, cheese or something. But in the city, no. Just only bread, or no more than...Sometimes, not enough food. ...The food is not enough.*

The herbs which grew wild, and which were relied on by poor families for medicine, were also harder to obtain.

> *Because of the war we moved to the city, which didn't make it any easier because it was hard to find the herbal tea because it was the city. In my village we had it handy, like it was everywhere, we plant things, or they just grow.*

## Themes Common to Both Rural and Urban Women

The themes described in this section, (assaults, witnessing atrocities, psychological stress, and indirect exposure to trauma) are not limited to those in rural areas. However, the themes of assault and witnessing atrocities are found mainly in the stories of rural (and therefore poor) women. This may be due in part to the protection that is provided those from other classes from such events.

### Direct Personal Assault

Some of the women were directly assaulted, (including sexually) imprisoned, or threatened with execution. Sometimes the assaults include witnessing the abuse of others.

> *And they locked my kids in a room, and beat up my husband. It took a year for him to recover. For that reason we did not stay in the house, because they beat him up, and also me. They put a machete right up to my throat and told me they would kill me. For this reason we were afraid to go home, and we started to sleep hiding outside. After a while we did sleep at (a relatives) house, but we did not come back to sleep at our house because the army was looking for us.*

> *Some men, in my same town, put the gun to my head, I had in my house a big rock, I fall down on that rock. He put the gun, is explosion, very noisy, smell of smoke in my face.*

Women could also be imprisoned. Imprisonment often involved beatings, physical and

psychological torture.

> *And they hit me, and they threw me to those big, big trucks. From the floor. Like one grabbed me from here and one from the feet, like was tied like, with my bra they tied my arms. ..Yeah with my bra. They ripped it off and tied my arms. And then they tied my feet and one grabbed from here, and one grabbed me from the feet and threw me to big truck. And they step on me. I don't know how many of them, but they step on me, like some of their uniforms on me so people wouldn't see? And then they threw me down when they got me off the truck. But after that they didn't beat me. Mentally they treat me like, things, "your brother got killed here, he die of hunger only because he didn't eat. Well they gave me food once a day. But that food looked like food that had been chewed already, or something like that. So, I didn't eat. I thought maybe they had poison in it so I didn't eat.*

In another conversation this women described being kept naked in a cell, where the walls were smeared in blood, and the names of those who had died there were written in blood on the walls.

## Witnessing Atrocities

Witnessing of atrocities, or viewing of dead and mutilated bodies, was commonly reported. It has been reported that while the guerillas wanted to kill as many enemy soldiers as quickly as possible, the focus of the government was different - the intent was to demoralize the population, and instil terror into all as a means of social control (Desjarlais et al., 1995). Therefore, leaving bodies in public places, and torturing, raping or killing individuals in front of others was commonly practiced.

> One woman described how her youngest brother (aged 15) was tortured over a three day period in front of the villagers. She says he was "unjustly killed", accused of being a guerilla. She describes him being beaten about the head, and forced running and marching for 3 days without food, and then ("he was already dead, his memory was gone") shot in the side of the head. (field notes)

> *The soldiers killed babies, some old people, young. .... Very hard.*

Another describes having to walk on a daily basis through a field around a safe village of the army. Bodies of people from all different regions were dumped there. She remembers having to carry her child because it was so hard to avoid stepping on the bodies.

## Psychological Stress

While the emphasis in the stories told by rural women was on the trauma experienced or witnessed, the concerns of many of the urban middle and professional classes were around what *might* happen.

The insecurity of never knowing what would happen, or when was of course a characteristic of rural life as well. This is clearly indicated in the excerpts from the narratives which described the bombing raids. In fact, a principal feature of "low intensity warfare" is that everyday life is subject to continued and fearful tension (Desjarlais et al., 1995). However, for rural women the emphasis is on the actual trauma, and the anxiety *(aflicion)* is linked more to the theme of being always pursued and under threat. For urban women in contrast, the most commonly reported stressors were psychological; of not ever being able to feel completely safe, and feeling that one always had to take precautions. One woman contrasted this environment with her current life in Canada:

> *Now I can think in different ways, maybe with more, like freedom? Because I*
> *don't need to think about those things. Only the bus, what time is the bus coming,*
> *is normal, you know. ..I don't need to protect for anybody, just to go.........I don't*
> *feel like I need to think, how to go on the street and protect myself. Because in my*
> *country, OK, in the last 3 years, I was thinking first, OK, I have my plan, I know*
> *how to do it, but when I'm going to the street, or one place to another place, first I*
> *have to think, how to go to protect myself. .. And I think in my country, even if you*

*live in the capital, you never have a safety place, a safe place to live, because the fighting was everywhere.*

Another said:

*When we were in El Salvador we were always expecting something to happen suddenly. We didn't have any time to say "We're going to have a bomb", you know. You see, all the time, we're even, not just the fact of the blasting? (is when the bomb) explosion. Or some people attacking someone or like you know (lowers voice) for example these guerillas were doing some kind of kidnapping...and the radio always giving many bad new, and say for example "Someone disappeared and they are asking for some amount of money". ....But not just that, I remember I already apply in 1989 and then I went to the bank and some people were following me when I left the bank, and they robbed my money.....I was really scared and I said "I don't want to go out now, today, because I don't know if they are still looking, watching me or trying to do something".*

## Indirect Exposure to Trauma

While the narrative excerpts provided so far describe events women themselves

have experienced, it is also important to recognize that they have also been affected by

the violence experienced by other family members. In some cases this included different

forms of trauma. For example a number of the women had husbands, sons or brothers

who were combatants with the guerilla forces, and so were exposed to combat trauma.

Initial discussions suggest that few of these men have sought help for coming to terms

with these events. However, in many cases the women appear to be taking responsibility

for their care.

*One woman described how a young man who had been disabled due to war injuries when reunited with his family was physically abusive with them until police intervention was sought.*

Another, who was coping with a spouse's alcoholism and violence reported that her

husband's sister had been one of those killed in a massacre:

> *Oh!, One sister, killed, the soldiers killed, in (name of massacre)? Killed children too! Everybody. This is more bad, (name of massacre) many people died, my husband is looking at many people died. The smell! ...Yeah, he told me, he told me, "I going to after the massacre", he going there for looking (for) the family there is dead. The children of the sister die too. Very good sister, rich sister die. He is crying. Yeah. (she cries). Very hard. When asked what her husband does now, she replies: Nothing. Not working, only looking out the window, sit down the sofa, thinking, thinking.*

Women report feeling the pain of other family members

> *And so many times seeing dead people! ..My husband...maybe his experiences have been worse because they killed a brother of his. They chased them, shooting at them, but they didn't hit them because it was meant to be. But after, they killed another brother and cut him into pieces. Another brother of my husband. And they had to gather the little pieces of his body, that they found of his brother. For this I say, I wonder how he felt.*

Another described the ongoing grief and guilt experienced by her husband; his teenage brother was killed with machetes in front of his mother, because the army was looking for him and couldn't find him. She reported that he did not believe in counselling, and only talked to her.

## Themes Common to Urban Women

There were two themes that were found only in the stories of urban women. One was that of being caught as bystanders in street battles, the other was of the targeting (for death) of certain professionals.

## Being Caught in Street Battles

Some of the women reported being caught in, or separated from family by street battles

> *They stay there I think for two nights and three days. I was just, Oh! sick and desperate!....That was a really scary problem. ...And after that I applied to come to Canada. Ah! (laughs) Yes. In the second day, that, they were still there when I*

*went to apply. Trapped you know. Were in my house and I went with one of my brothers to apply. Yeah, I said "That's it!" Oh, yeah.*

*Oh, God. Let's tell you more, because this is the first time. And (19)89, when was the war in the city? Is the same. Does the same, but we are all there. Its a different experience but always the same. We run again... then.....eight days under the bed, no food. Yeah!...all the city was fighting. ..And just the last two days, no water, no food, nothing.*

*I remember we were about two blocks from the house, we were in front of my aunt's mother, in front of the house, when everything started. They started fighting the guerrillas and the military. They just started fighting. And we were in the middle of the street. Many people was. ...But it was bad, so we had to seek shelter in the homes that were, in the homes that didn't close the doors ! (both laugh).....We were there for about four hours, when all the fighting was going on, the fighting was going on for about four hours. And then we had to stay for another two hours waiting that nothing else was going to happen, waiting to go back to the streets, so we could get to my grandmothers. Because we knew that she was going to be worried about us, and that's the only thing that I remember.*

## Targeting of Professionals

It has been documented that those in certain professions; teaching, health care, the church, unions were often deliberately targeted (Americas Watch, 1991). This was confirmed by the women's life narratives.

*(My husband) start to receive (threatening) phone calls, and everytime that we went to drop the childrens to the school, we change the street, you know, just to avoid, that he never stay with us together. We knew from where they were coming and everything.*

*Sometimes I couldn't have my class because my room was taken. For military instruction....with or without the consent of professor. One day, I had at the basement I had my class, I had my room. And I had an exam or something. And then I went, and someone with, cover, with her face, said, you cannot go in today. And I said, Why not? .."There is another class going on." It was how to arm and disarm a weapon, G, a kind of big thing. All kind of armament. So there were classes how to make Molotov, how to make mines, how to make the popular armament it was called (laughs), how to sabotage, how to you know, how to make many things in order to stop the military.....So, by that time also, the situation was*

*getting worse, more people were missing, more people were taken from homes
and , but if you were at the university, you were a target ...And my friends were
disappearing, and some of them were appearing later on, dead*

## Migration and Settlement

### The Migratory Experience

As indicated earlier, for some of the poorer women, exposure to violence

continued even after they left El Salvador. Crossing borders was particularly dangerous

for women, and even on arrival in another country, women - particularly without the

protection of family members- continued to face many of the same kinds of risks as they

did in El Salvador. Refugee camps (inside the country and in countries of first asylum)

were often very dangerous places, and individuals could be attacked or killed in a camp.

> One woman made two attempts to get into Honduras, as the first time they were
> turned back by soldiers who opened fire on them. When she did get to refugee
> camp in Honduras, there was no food. Soldiers abused them, came into the camp
> and killed people. *"Mucha gente mataron".* (Many people were killed) she said.

For some women, this migratory period lasted a number of years.

### Life in Canada

Freedom from war - related violence was as one of the main reasons for coming

to, and remaining in, Canada. Being in Canada also appears to have had an effect of the

level of family violence.

### Addressing Domestic Violence

As mentioned earlier, the professional focus group observed that domestic

violence was a serious problem in many families, but that the situation had improved in Canada. The women's stories also provide evidence that in this setting, they have taken assertive steps to protect themselves and their families from other types of violence, particularly domestic violence.

> *Yeah is hit me before..., I called the police, before. Very bad. "Not my problem, Your problem. You're drinking. I'll put you jail you drinking", I said. "You're drinking, Yeah ", I say, "no more drinking" I say. (sighs) Very problem..Drinking only make him violent.*

> *Like I just came from work, and went to bed and didn't say a word to him, and that made him so mad that he wanted to take the car keys, so, when I was fighting for them, he pushed me. So I said "I am going to phone the police if you are going to start doing that because you are drunk and you are not going out".*

> *Yeah, he has been very demanding* (physically aggressive), *because of what he learned when he was with the guerillas. He continues to behave in this way, even here. One day he turned aggressive, it was very ugly. Yes, I have had many problems with him. One day he came just to make a scandal. He said that he wanted to kill his brothers, that we were not his family. He was very aggressive with us, but we denounced him in order to get his respect. We called him to the court and told them what he had said to us. He admitted that it was the truth, and to what he had done to his brothers, and to us.*

As indicated by these narrative excerpts, there appears little hesitation in calling the police and using the justice system in order to protect themselves and their families. Domestic violence appears to be recognized as a common problem, however, in no cases did the researcher get the impression that this was acceptable or excusable, either by the women themselves, or by others in the community. It was recognized as clearly wrong, if unfortunately common. At the same time there is also an emphasis on understanding and forgiveness. Although they reported having the man removed from the house, the women

continued to support and care for family members who had abused them once they

returned.


## Changes in Approaches to Child Discipline

Another significant area of change appears to be that of child discipline. A

number of participants identified changes in parenting as one of the positive areas of

change they had made in Canada. Some women reported that they continue to spank their

children. However, others were looking for other disciplinary techniques. This change

appeared to cross the lines of class and education.

*Well, I'm not as hard as my mother and my grandmother were with me, with the
kids. I tell them, I will beat them up, but I never do! (laughs). I say, when they
are doing something wrong, I tell them, if you don't stop, I'm going to hit you.
And they just stop and look at me and say "NO!" (laughs) So I never do, no. I
guess I won't have the heart to hit them.*

*Discipline for me is not so tough. Is not.*

*I am more better than my mother...my mother not thinking very good....I say (to)
my children, my mother different, I different. I take care, I love my children, I
take care my children. My mother no take care of her children.*


However, changes in child rearing practices were also reported to increase friction

within families. As in issues of domestic violence, the narratives suggest that it is often

the women who push for change.

*Something I can't give up is, I don't want (my husband) to spank the kids, its not
that he'll hit them, but like back home you believe in spanking them eh? Its, just
the way of raising kids there, and I never believe in it. Even, like I am, I consider
myself a stubborn one, like at home, I even as a child, I didn't believe. If my mum
spank me, I do it more. Because I don't want them to suffer the way I did. .....We*

*don't agree. We don't agree. But we came to terms that he can do his.... But we had arguments like that maybe all of our marriage about this because he spanked them. He still does. But I don't believe in it, I say "Talk to them". And he says, "I talk to them but they don't listen! "(laughs) And I say "They talk to me more". "Yah, but they don't obey you!" I don't, I can't. Because I felt they were doing it to me, they would hit me and I would not listen anyway?*

The women reported that their husbands often had more difficulty in adapting to other differences in parenting as well.

## Sexual Victimization

One type of violence that was also a part of the lives of many of the participants was that of sexual violence. Sexual victimization in the Salvadoran community must be understood within the historical context of structural violence: where the poor had no rights, where women without status had no protection in law or in the administration of justice, and where the few rich acted with impunity. Four kinds of sexual victimization emerged from the narratives. Because of the concerns regarding confidentiality, few transcripts are included in this section. Some disclosures related to sexual abuse and victimization also occurred following the formal interview, and during the feedback phase.

### Systemic Victimization

The women described a society where men in positions of power could abuse women under their control with impunity. Both women who had worked as servants, and those whose families had employed servants, reported that sexual abuse of domestic

servants was common. One woman, for example reported her distress over a male relative's abuse of their servants. As servants, women were at risk of abuse not only from the employer, but adolescent or adult sons of the house, or from visiting male relatives. The same abuse was perpetrated by bosses on the *haciendas*, or in factories (Thomson, 1986). This form of abuse was based on economic and social power, and only poorer women were abused in this way. One woman interviewed wondered whether the level of sexual abuse of poorer women wasn't one of the reasons for the level of "class hatred" in the community.

## Family Sexual Abuse

The professional focus group did not identify sexual abuse of children as a common problem in the community. Informal conversations with other community members also reinforced the perception that sexual abuse is considered rare. Sexual abuse of children was not only described as repugnant and deviant, (by both males and females) but specific examples were given of individuals being killed because of such activity (whether by the state, or the victim's family and friends).

However, some interview participants volunteered information regarding personal experiences of sexual abuse or assault by family members in the past. Instances described included childhood sexual abuse by older cousins, sexual abuse by a distant relative, a sexual assault by a brother, and sexual fondling by an uncle. Some of the women, at the time or subsequently, reported the abuse to their mothers; none of them

had found support. In addition to the direct experiences of the women interviewed, two women talked of sexual abuse within their extended family.

It is possible that the community perception of sexual abuse as an extremely rare problem is accurate, and the sample was unrepresentative. Certainly the type of sample utilized in the study does not allow any conclusions as to the prevalence of certain behaviours or events in the community as a whole. However, there is a striking difference in the reaction to domestic violence and sexual abuse: domestic violence is a recognized problem that the community can talk about. Women can therefore reach out for help. However, this does not appear to be the case with sexual abuse, and some of those interviewed requested advice on where to find counselling in this area. It may be that the stigma of sexual abuse prevents the same kind of reaching out for help that domestic violence (an openly recognized problem) allows.

Some informants believed there was a difference in prevalence of sexual abuse related to social class: that such abuse was found more commonly in the lower classes. As men of higher social class would have access to many other females (children and adults) outside of their own family, this may in fact be accurate.

### Street or Acquaintance Assault

Women outside of the protection of their family were at great risk of assault. One woman who left her home to seek work in the capital reported three assaults within a few

days. Again, it was poorer women who were at risk.

## War Related Assault

Rape, sexual torture, and other forms of sexual assault and harassment were used as weapons of war (van der veer, 1998, Goldfeld et al., 1988). While some of the war - related narrative excerpts suggested that women may have had more protection than men, they were more vulnerable to sexual assault. As in other forms of sexual victimization, war - related assault was reported more often by poorer women.

> One woman was attacked and beaten by soldiers with a big stick on her back, her buttocks and legs. She was locked in a house with other women who were being "punished", and raped by a number of soldiers. One woman with her had her leg blown away by a bomb, she had to drag herself. She described (sobbing) how terrible the rapes were for the young girls, and how one girl, aged 15, was killed after she was raped. (fieldnotes)

Sometimes the women were raped, sometimes other forms of sexual assault took place within the context of threats or assaults.

> *They threatened me. "Don't make any move, or we are going to die as well". They asked me if I was a man or a woman. "And you dress as woman," that is what they told me. (laughs) And with a pistol held to my head, saying that maybe I had a high fever and that I was a man but I had my head covered because I could not stand the headache. This was the day that they killed the brother of my husband. And they threatened me saying "You too will die. You don't want to say where your husband is and so you have to pay". (laughs) They pointed the rifle at us. "And who knows if you are men dressed as women? Can you see, even if the head is wrapped?" (laughs) Show me your breast!" they told me, " show me your breast to see if you are truly a woman."*

> On a recent visit to El Salvador a fisherman explained that he had fled with his family illegally to the United States for several years during the war, because the army would come through the area, "raping the women and girls".

## Impact of Sexual Assault and Abuse

Of all of these forms of abuse, sexual abuse and assault within the family was most commonly reported in this study. This form of abuse also appears to continue to cause the most distress currently. Childhood sexual abuse appeared to be linked with on-going depressive symptoms, and reports of past suicide attempts in adolescence. In a society where talking is seen as therapeutic, this is one topic that cannot be talked about, even within the family. The high level of repugnance expressed by community members about child sexual abuse may prevent victims from making abuse known. One woman stated that if she had told her mother what had happened it would "kill her".

## Summary

Many of the women's life narratives described lives filled with violence. Often they were exposed to the structural violence of poverty, and violence from within the family and the general community even before the escalation of the political conflict. However, the types of violence to which women were exposed, and the potential for protection from societal violence was moderated by social class.

Here in Canada, with access to a police and legal system which offers them protection, many women have taken an assertive stand on domestic violence. There is also an indication that patterns of child discipline within families is changing significantly, and that it is the women who are taking the lead on this. However, sexual abuse remains a taboo subject.

## CHAPTER 6: FAITH AND THE CHURCH

### Faith

At the time of the war, El Salvador was characterized as an overwhelmingly "Catholic country" (Haggerty 1990), and most families were profoundly religious. The theme of *faith* must be explored at two levels. The first is that of individual religious faith. The life narratives reveal a profound spirituality which pervades all aspects of life. God, and one's faith in Him, are described as key factors in survival, strength and health. Prayer is also identified in as a key coping technique. (These themes are further developed in Chapter 10: Determinants of Health and Chapter 11: Coping Strategies).

It has been observed that religious influence on daily life was strong both pre-conquest and in colonial times, and it has been suggested that the animistic nature of Indian beliefs allowed for the ready assimilation of Roman Catholic teachings (Haggerty, 1990). Certainly, the narratives indicate an often eclectic religious belief system, particularly amongst the less educated. While devoutly Catholic, women would also commonly believe in the power of other supernatural or spiritual forces at the same time. There also appears to be a greater openness to other profound religious experiences such as visions.

Many of the women demonstrate what, for many in Canada, would be extraordinarily strong faith. One woman described a time of being alone in great danger. During this time she relied on prayer and experienced a vision of "Nino de Atoche" (a

saint this informant referred to as "the baby Jesus").

> *I pray and pray and pray, and then a voice told me "You are leaving tomorrow, don't worry. And (your son) is O.K."........I thought, "How could I be hearing this? I don't know if it was in my dream, I can't say that I was sleeping and I can't say that I was awake, I just know that I saw that light, a little light coming and saying "You are going to leave tomorrow" So the next day I left...*

During a conversation on a later date, she provides more information.

> *Yeah,, it was the fifth day that I saw that light and I remember that, the baby Jesus with that basket, yeah,, I remember that. Jesus with the basket, and the red apple. A big apple! Apples in El Salvador are very expensive. I always wanted to eat one but I didn't have the money. It was 5 colones* (now worth about $1 Canadian) *one apple, how could I afford that! So I never bought one. And I remember I didn't remember eating it, I just remember that apple and the baby Jesus. And that's why we kept the picture of him, the baby Jesus, she has it in her room. Did you notice it?...... My dad used to tell me that this baby Jesus is the one that watches over people when they have problems, and if you ask baby Jesus to help, he'll help you. And people in jail, he'll help you, baby Jesus will help you to get out? Or will give you comfort, sick people or people in jail.*

## The Role of the Church

### The Popular Church in El Salvador

The second level at which this theme must be explored is at that of the organized

church in El Salvador. The theme of "the church" is also found in the stories of many of

the women, for whom the church played a key role in value - formation and in providing

leadership for social action. The Medellin and Puebla conferences of Latin American

Bishops in 1968 and 1979 demanded that the primary relationship between the church

and society be based on an option for the historically oppressed. Many church leaders in

El Salvador believed there was an obligation to support and guide the struggle for justice

and to accept the same fate as the oppressed (Lernoux, 1980; Sobrino, 1991). However,

the church too became divided, between the conservatives (who wanted to remain neutral to the conflict, or who supported the government) and those who supported the struggle of the poor.

This movement is also referred to as liberation theology. Community members formed Christian Base Communities *(Comunidades Eclesiasticas de Base)* and met in small groups to reflect on scripture and its meaning in their lives. Unlike the traditional Catholic church, these groups did not believe that it was the lot of the poor to suffer in this life while awaiting reward in the next. Rather, they promoted action for social justice in the present. For this reason the church came under attack, and clergy and lay workers were specifically targeted during the years of increasing repression. The popular church was identified as an enemy of the government, in fact a slogan at the time was "Be a patriot, kill a priest" (Lernoux, 1980). In addition to several high profile killings (of Archbishop Romero, four American nuns and church workers, and six Jesuit priests of the faculty of the Central American University in 1989), thousands of Salvadoran lay church workers were tortured and killed. Some of those interviewed were active in the church and they (or their families) persecuted because of this.

Many of those who chose to become politically involved spoke of the influence of the church in their decision.

*In my life I have been taught to be with the weak, not with the one who has power. But then, all this exposure, and the education that I was getting, make me realize*

*that something was wrong, in El Salvador. And I had the fortunate to meet, a priest. In my neighbourhood, and this priest was Father. L. They were crucial in the movement, the revolution movement. At the school, when I was at school, there was a priest in there, and this priest teach us social justice, and was the first things you know. And because the church took the side of the oppressed, right, and so the message was around there, disguised through the Bible, but it was there. P, P___ was the name of the other Father. In all my exposure, some kids, they didn't care. But for me, was a turning point, when I went to the university and confirmed what was happening. And I had to do many jobs, homeworks from the university in where I had to visit, like, misery you know. Like it was really, I never had a chance to see in reality. I knew that someone came home and pick up newspapers. I knew that someone got the bottles from my home, But I never knew how people survived. And by that time professionals, friends, and all the environment was getting, you know, hot, and some friends of mine were involved very soon in the movement. One of my best friends, he is a doctor, he got involved in a clinic, and was discovered, and he was killed. And another friend was a psychologist, her name was___, she was in a cell, she was working in a cell, and they were discovered. And so I wasn't involved yet, but my friends were dying!*

In choosing the option for the poor, the popular church drew most of its support from poorer families. However, many from more privileged backgrounds also responded, and church involvement was often the first step in political involvement. The lines between church and political work became blurred.

*We didn't know what was going on because we were only involved in community work as far as I knew. And I, uh, we were, leaders in the community, my family, we were leading here, and doing this, and getting people organized just to bring up the community. And the church too, like we were very involved in church and all that. And so, but, and then we found out, they told us they had found armaments and they wanted us to give them the armaments we had that my cousin had brought it. We didn't know and they searched everywhere in our home but they didn't find anything so they left.*

Not only did the church provide the leadership for many who became politically active, but, was often the first refuge of those under attack. The first response when forced to flee army attacks, to hide, or to recover from assaults or torture, was often the church.

*At the beginning we left for the ah, now do you call it the (archbishop)? Because we didn't have anywhere to go. We knew people, but we couldn't just run to them because we had about 25 people with us from the village, so we had to go there and we had to ask the Archbishop for help ....Everything changed, because it was, its wasn't peaceful anymore, and a different lifestyle I guess, and not knowing where with so many people, so many people, it was so stressful. So we stay in San Salvador, it was, Monsenor Romero* (the Archbishop) *helped us and put us in a house where, it used to be how do you say a seminar for priests? it used to be that so they had lots of rooms and all that, so we stayed for about a month, and more people were coming, everywhere from the country they were coming, so this building was full, and we had to leave, a month after we got there.*

The Church was also instrumental in advocating for the release of prisoners and in documenting the violations of human rights through its own Human Rights office.

*The next day early in the morning, the guards came, they were looking like at the door, and they said I was going to leave, that the Archbishop had called, had called for me that we should get out and all that and they were in the process of the peace or whatever, the democratic,...At that time, so that's why they let us out.*

Archbishop Oscar Arnulfo Romero was appointed Archbishop in 1977, and considered at that time a somewhat conservative candidate. However, by the time of his assassination in 1980, he had promoted the cause of the poor and used his influence to push for a political solution to the conflict. On March 23, 1980, he called on soldiers to disobey orders to fire on their fellow citizens.

*I would like to make a special appeal to the men of the army, and specifically to the ranks of the National Guard, the police and the military. Brothers, you came from our own people. You are killing your brother peasants when any human order to kill must be subordinate to the will of God, which says, "Thou shalt not kill." No soldier is obliged to obey an order contrary to the law of God. No one has to obey an immoral law. It is high time you recovered your consciences and obeyed your consciences rather than a sinful order. ....In the name of God, in the name of this suffering people, whose cries rise to heaven more loudly each day, I*

> *implore you, I beg you, I order you in the name of God: stop the repression.*
> *(Archbishop Oscar Arnulfo Romero, March 23, 1980).*

The assassination of Archbishop Romero, while celebrating mass the next day,

accelerated the descent into open warfare.

The "popular" church which focused on living out ones faith through commitment

to the community, also reinforced the focus on community even when families were

displaced.

> *.. and I met another community, Catholic community, and I worked always in that*
> *community. And I help, lets say, in that community for many, many case, to visit*
> *sick people, teaching the children for the first communion, helping the young*
> *people, teenager, teenager people.*

## The Church in Canada

In Canada, the church continues to play an important role in the lives of many

families. For a number of the women interviewed the church continues as the centre of

their life. However, some noted that the church here was not the same. Many avoided

church involvement although they continued to see themselves as devout Christians.

Some gave the reason for this decreased involvement as community suspicion and

tension. This is described in greater detail in the next Chapter 7: Community. A variety

of other comparisons were also made; specific concerns appeared to be related to the

degree of political involvement (or avoidance) experienced in the women's own

congregation in El Salvador. For example, one woman initially avoided the church

because there was too much "mixing" of religious and political issues. Others felt that the

church is not as much a part of the community as it should be.

One way that the teachings of the church continue to have influence here in Canada is on the emphasis on forgiveness and understanding. There was a high value attributed by women to values fostering forgiveness and understanding particularly to those in ones family.

> *I go to church and I pray, and I pray. I said to myself I have to forgive her completely.*

## Polarization and the Church

The Roman Catholic church was not united in its embrace of "liberation theology", and it is believed that the level of social activism of the Catholic church has decreased in El Salvador (Sobrino, 1991). Since the 1970's there has been a significant growth in Protestant conversion, particularly evangelical Protestantism, imported from the United States (Haggerty, 1990). This has created additional polarization (in addition to class and political divisions) within the community. In Canada there has also been a growth in participation in evangelical churches, which focus more on individual salvation. There is now, in both countries, significant tension between the two groups, with many leftists viewing (with some good evidence) the promotion of evangelical religion as right - wing American political strategy. (You will find in both El Salvador and Canada signs on the doors of some Catholic homes warning away evangelical missionaries.)

It is important to note that those participating in the interviews were all Roman Catholic, practicing or not. It is beyond the scope of this study to explore the impact of the growth in evangelical congregations on the lives of individuals or of the community.

## Summary

The majority of women described religious faith as extremely important to their lives; many also exhibited a greater level of integration between spiritual and everyday life than is commonly seen in Canada.

The "popular" church in El Salvador played a significant role in the recent conflict. It became actively involved in a struggle for justice and served as a practical resource for families suffering persecution and loss. As a result, those working with the church were often targeted for death. The church was also an integral part of the women's community life. The popular church reinforced the obligation of individuals not only to an individual moral code, but to support and work for the *community*. In this way it played a role in expanding the sense of community to a wider group than ones own family. The theme of assault on community which is discussed in the next chapter, is interwoven with the theme of the assault on the church.

Since arrival in Canada the relationship of many women to the church has changed, although most continue to see themselves as devout.

# CHAPTER 7: COMMUNITY

## Community in El Salvador

A major focus of both individual life narratives and focus group discussion, was

on the idea of community. While both Salvadorans and Canadians refer to ethnocultural

groups as "communities", the concept of community requires closer examination.

In El Salvador, individual loyalties pre-conquest were to the family and to the

village. The Spanish did little or nothing to build any substantial sense of national

identity (Haggerty, 1990). The result of the abolition of traditional communal lands by

the Spanish was to destroy some of the "community" focus, which was replaced by a

focus on family survival and self sufficiency. Throughout this century as well , there was

little sense of the larger community of Salvadoran society. There was little in the way of

public services, meaning that only those who could pay for services would receive them.

There were rights and laws (which were ignored in the treatment of any but the wealthy).

Because the law was not honoured, there was little respect for it by ordinary people, nor

was there confidence in any public services that may be offered. Community was also

defined by social class, as those from different social classes not only did not socialize,

but had different health, educational and other services.

However there were many grassroots initiatives taken to build community.

Throughout the twentieth century," Salvadorans have joined forces in independent social

groups - unions and peasant leagues, community organizations, churches, schools and political parties - to seek a better existence within a political system dominated by a tiny oligarchy and its powerful military elite" (Americas Watch, 1991, p. 17).

By the 1970's two groups were active in building another understanding of community. One was the popular wing of the Catholic church, in the formation of Christian Base Communities, and the promotion of commitment to the poor (and to those outside of the family/village circle). The other group which was demonstrating a different vision of community was the political left, through the popular organizations. These mass organizations grew up outside of the traditional party structure when it was realized that action for change could not take place through "official" channels. In zones of guerrilla control, there were other efforts to build community, including promotion of literacy, training of basic health workers, and promotion of popular education. The success of the guerrilla movement was based on its ability to join together individuals from various regions, and differing social classes in developing a sense of solidarity. Perhaps not surprisingly, there was a great similarity in vision of community between the church and the political left, and many of those most active in the political movement were also active in the popular church.

Rural women described their community as integral to their lives. *"My whole life, since I was little, is being working with the community"* one woman says and gave as her reason for becoming politically involved, *"because we loved our community"*.

## The Assault on Community

With the rise of ORDEN (*Organizacion Democratica Nacionalista*), a

paramilitary and rural intelligence network, in the 1960's and the later development of

"civil defense" strategies, the previous sense of rural community - of extended family and

village - was eroded. ORDEN (Spanish for order) provided for a system of informants

that infiltrated each village, and could report on any "subversive" activity. The strategy of

civil defense leagues was designed to prevent popular support for the left by ensuring

army contact in every region. Particularly in the liberated zones (which through much of

the 1980's covered a third of the countryside), the guerillas *were* the community - as this

was in large part a peasant uprising. One of the objectives of "low intensity warfare" is to

destroy community, and the confidence people have in each other, in the battle for "the

hearts and minds" of the population. In El Salvador this was captured by the expression,

"*Quitarle el agua al pez*" ( "To catch fish, you must drain the sea"). What resulted was a

deliberate policy of driving out peasants (the sea) from areas of guerrilla control, in the

understanding that the guerillas could not survive without a community of support

(Danner, 1994).

Many of those who were specifically targeted for death were those who were

"community leaders".

> *In the very beginning when we left the village because there were soldiers coming*
> *to kill anybody that they could find that were on their list, and we were the first*
> *ones, so we had to leave, .... my family, and some people who were following us*
> *too, because we were doing this kind of work, community work. I mean I wasn't*
> *doing anything else, just the work building the schools and things like that, and*

*organizing people, socials and things like that.....But we had to go, we had no choice, because, they told us, many people were coming to tell us to leave, because they were already in the nearest town, they are already there, there are big trucks full of soldiers, so better leave or otherwise you will get killed because they said **they will kill anybody who has been involved in leaders in anything, they will kill them all.** So they killed 40 people who didn't run that day.....That they didn't, they thought they were safe. Young children, 14, 16, they killed many people. Yeah, people that we knew.* (emphasis mine)

### Mistrust and Betrayal

The major subtheme of community which is prevalent in the stories of both urban and rural women is that of mistrust and betrayal. Many of the stories described increasing suspicion and distrust of those around you, as well as coping with the evidence of betrayal of family, friends, and community. Both sides could be infiltrated. No one could be sure who the enemy was. The conflict was not divided among racial or religious lines, and while it was termed by some as a war of the rich against the poor, there were many well - off individuals who sympathized with, or actively collaborated with the revolution, and poorer individuals who supported the army.

*In every family we have relatives who are with the military. (laughs) So, (laughs) is, is oh, oh, you know in El Salvador things happened that you can't imagine! (still laughing) Salvadorans fighting with Salvadorans for external influences* (the United States) *and Salvadorans helping opposite sides for different interests. It was a crazy war.*

As discussed earlier, some of the mistrust that was experienced was part of a deliberate government strategy. The formation of civil defence leagues, and right - wing paramilitary groups provided the structure for neighbours to spy and inform on each other. The destruction of social relationships, networks and solidarity among the civilian

population is used as a strategy of war (Melville & Lykes, 1992). This had the effect of disrupting the routines of everyday, and creates disorganization in the total society (Melville & Lykes, 1992; Martin - Baro, 1989).

One effect of this "social trauma" is psycho - social destruction. The impact ranges from psycho - somatic symptoms to the unhinging of social relations. Martin Baro describes the Salvadoran civil war as characterized by a) violence b) social polarization and c) the institutional lie. (The theme of violence has been covered in the previous chapter on *Violence*, and the chapter on *Social Class* provides some indication of the levels of social polarization.) The *institutional lie* is described by Martin-Baro (1989) as a "systematic screening of reality", in order to create an official version of the facts. He believed that when there is a prevailing climate of falsehood, and particularly when people are forced to lead a double life (as did so many of those "working underground"), there is insecurity and increasing scepticism, and a general atmosphere of tension and mistrust is the rule (Martin Baro 1989). Sobrino (1991) takes this idea further when he states that "truth has not existed in Salvadoran public life. It has been ignored, distorted, falsified". Education is not based on truth "nor do the people expect to be told the truth. It is not a fundamental value of Salvadoran society" ( p. 169). He quotes Archbishop Romero as saying there is "a world of lies where no one believes in anything, a world of repression, violence, murder and torture involving so many people...this is the empire of hell" ( p. 169).

Mistrust and betrayal were not limited to tensions between the political right and left, but the popular organizations themselves were often distrustful of each other (Americas Watch, 1991) and individuals may have been betrayed even by their own organization (community). One politically active woman in describing why she left the organization said:

> *Actually we didn't leave them. They left us (laughs). ....They left me because um, I didn't support what some of the leaders were doing and I was supposed to. They say at the last meeting that if I didn't support them then I shouldn't be working with them. But I never thought that they were going to let me, just like that. I left another contact with them for a next meeting and they never came and picked me up, so that was the last time that I saw them.*

> *I didn't support them, because I thought what they were doing wasn't right, like I wasn't raised that way, and my thoughts weren't like that. (Sexual behaviour) ....and money too. Money problems and then I told them that they should take responsibility, plus, one of the leaders that had made that mistake was the husband of one of my friends, she was a friend and a co-worker, like we were working in the same place. So I knew her, how faithful she was and how much she loved him. So I felt so bad, I would betray her if I didn't say anything. But I never said anything to her. .. But I mentioned it to them, to the leaders, and I said, "That's betraying her. She's my friend, not only my companera (comrade)", so that put me in that position. I told them, and I never was quiet. If I don't like something I tell you, "I don't like this because of this." So they just dropped me..... It didn't change the danger for us. That was even worse because we felt like the organization was kind of protecting us in some ways you know. Hiding our identity and all that. And we felt unprotected and all that. That's why we decided to leave El Salvador. Like if we are not with the organization then we have no protection.*

> *What we found out, they were giving money, like monthly money, there was money assigned every month, like a budget for us, and they never gave it to us? Like for over, I don't know how many years. Because I found out. We got a letter, that was the end of it, like we were struggling, like we were asking them like "I don't have bus fare for tomorrow and all this week, so what am I supposed to do? Coming to the meetings when I had no money?" So I asked them and they gave me a little bit here, a little bit there, very little! Like not for food or anything like that, so when that letter, that's when they assigned a new one to come from the top, somebody came, and brought a letter, and said the budget is cut to so and so*

*much? Because we are having economic problems throughout the organization.
So the people who will have - stipendo they call it - the money, the people who
will have it is only those that are leaders and working directly with the
organization, so for you, each one of you will be assigned only this much" And I
said "What are you talking about?" I never had any money". And he said, "We
have to look into that. But for now be quiet, don't say anything to anyone else."
That's what they told us right there. And so I asked the others, "Did you get any
money?" "No". Some did though, some did. Those that were close friends to the
guy in charge......And they can buy new dresses. You know there were leaders in
the organization that they were up to the style , like every style that came on,
shoes and everything they would wear. And we were starving, hungry, like my
children, like one time they told me for my baby there was no milk..You know, so
I felt bad, and I said "and there is that budget that is coming every month, and
where is that money?" I argue, and I said "I never had money, and I been with
you for all these years." Like being a national leader I was for about 3 years. If
we never found out we wouldn't mind about it. But we did, and that's the big
problem. (laughs)*

Several subthemes can also be found within the theme of mistrust and betrayal.

The next section outlines four of these: *"The personal and the political"*, *"Knowing and*

*not knowing"*, *"The official story"*, and *"Underground"*.

## The Personal and the Political

While the polarization and resulting mistrust appear to be precipitated by political

differences, a disturbing overlap between the personal and political could be found in

many of the stories (such as the one above) and perhaps provides some insight into the

current state of the Salvadoran community in Winnipeg. While on the whole the conflict

was described as in societal terms, involving large forces, *la justicia, la pobreza, la*

*querra,* (justice, poverty, the war), some of the most disturbing stories were those where

personal goals or resentments were played out within this political arena of extreme

violence. Betrayal did not simply occur because of political differences, but often, it

appears, to serve personal ends.

It was often unclear to the informants why things had happened - whether events

were random, or targeted to them in a particular way.

> *Sometimes I, well at that time I though it was something personal because I was*
> *sort of those threatened people because we were working for the National*
> *University. But I don't think I was. The other situation that I had, was, that car*
> *with the tinted windows, they were the whole day in front of my house. And that*
> *was the police department used to do that.*

In other cases the individual was clear as to what had occurred:

> *And I was on the list. I was on the list to be killed. (laughs) Because, I told you*
> *that he had a brother (with the armed forces) and because (the accuser didn't get*
> *the job he wanted). ...Personal things become political things! Became political*
> *things! .*

However, in many cases there was no way of proving what was really being done or said,

forcing people to interpret events with no provable facts. One woman described going to

a magistrate to ask for an investigation into her husbands death.

> *Yeah! you know, and we end up just leaving things the way they were because we*
> *couldn't find exactly a good help, to find out exactly who was the right person.*

> *(The magistrate) said it, you know what, I think, like, how things are being now,*
> *he said, I think its, it will be better if you take a long holiday. But I thought it was*
> *because we were in a way related. But he said it will be* **healthy** *for me to take*
> *some holidays, and I also talked to my doctor and he said, I think so. But he was*
> *(speaking) in the way of my general health. The other was probably more, you*
> *know.... personal safety.*

Note in this example too how favours were being provided because of family connection,

and also that the justice system was unable to address her concerns.

## Sexual Jealousy

Sometimes the betrayal appeared to based on sexual intrigue or jealousy.

> One woman, whose husband was killed accidently, shared her (unprovable) suspicions that a military commander (who had previously been romantically interested in her) was behind his killing. She states that he was not politically involved, but while supposedly killed "in crossfire", his body, except for his thumbs looked OK. Later, the commander showed great interest and concern for her, and seemed to know details of the killing.

A calling card of the death squads was to tie prisoners by their thumbs behind their back, often with wire. The damage to the thumbs suggested that this was not a simple accidental killing. However, even after all these years, his widow was still unsure of what happened.

Another woman described the intensity of her feelings towards the wife of a man believed to have fingered her brother, his friend, for death.

> *And then another person told us that my brothers best friend had point him to the army that he was coming home and things like that, so I used to hate him, I used to hate him . And I said "If I had a gun.". One time his, see, I met his wife in the bus, we were going on the same bus, and she asked for him. This woman asked me "How, Did you ever find out about K?" And I said "You killed him, you (h)ate him and you still ask for him?" Yeah (laughs)....... Like she once she used to love him. She was going, she wanted to be his girlfriend, but my brother, knew that his best friend, was, liked her, and so he respected that. And maybe she never got over it, or I don't know.*

## Suspected Family Betrayal

The most devastating of all was seen as suspected family betrayal. Sometimes it was those closest to the women who were suspected of betrayal.

> *But other neighbour in this town, said my mum and dad was to help to guerilla....*

*And then, in April, in April 78,.......Outside the house, that the group on the community, of the village, just only with machetes - you know machetes?...OK, the big machetes using, and they going around our house, all the time, staying in front our house all the time. And one lady went to our house to tell my mum "Nina M___, that's, Nina M___, be careful because that people says, first is the children to kill, because they cry or they make too much noisy. Then the older. Be careful at night because they want to kill you......And then they just April 8, April 8, guess, in the morning, four o'clock in the morning, my mum said, "Keep some clothes, in a box, carton, box, keep some clothes, and we run this morning" And about five o'clock, and we run in the middle of the, the small mountain, we run,......This day run to my, uh, grandparents house, and in the, about six o'clock, we went to the city, by car? We went to the city and we went to my cousins church because he was a priest. We went and my mum tell everything, what happened in my house. But everything else, even hens, even roosters, chickens, live in our house, everything, everything, nothing. Even our dog?...My dad returned to our house in about a month later, but no hens, no dog, some stuff for our kitchen gone, something missing because they open the doors.*

Note how in this narrative excerpt even young children are threatened with death. And who were those outside the house who were threatening the family?

*Because even when we stay in the city, we lived safe, but all the time when my mum, when my dad visit our village all the time said "Ah! that's my auntie, that's my other thing". But that's the same people who want to kill us!*

Some of the women confided doubts which indicate that the suspicion of possible betrayal infiltrates even the closest of families. For example one woman, who maintains close relationships with her parents, still wonders (over 20 years later) if the reason her husband "disappeared" was because they did not approve of the marriage.

One of the most disturbing stories was told by a woman about a neighbour in the village where she lived, whose husband was beating her when he was drunk. The informant said:

*The war was already going on. Nobody went to the police for anything, because you knew they were just looking for an excuse to kill people. But she went to complain that he was beating her. He was a good man except when he was drunk. They said to her, "How do you want us to do it? Do you want us to strangle him, or do it with machetes?" She said, neither, I just want you stop him beating me. She went back home and told her family what had happened and stayed in another house that night. The next morning when the women went down to the river to do laundry, they saw a hand and hair sticking out of the soft sand. It was her husband.* ("How did they kill him?" she was asked.) *Oh they just shot him. His body was in one piece.*

The woman who told this story continued to struggle with understanding what her neighbour had intended. She can not know for certain that the woman knew, or suspected, what the outcome of her complaint would be. However, she feels that the woman "should have known".


## Knowing and Not Knowing/The Official Story/Underground

The effect of the "'institutional lie" is found in the subthemes: *Knowing/not knowing, the Official story, and Underground.* The expression, "I don't know", or "I think, I don't know," was used so often in the narratives that it emerges as a subtheme of mistrust. The "disappearance" of individuals, never knowing what happened to them, and never finding the body, is the most extreme example of this. This strategy of politically motivated abductions by government or paramilitary groups allowed the authorities to deny knowledge of what has occurred.

*We hear that two of them, people saw them, but nothing official that we could say, oh yeah, is true. Like people make things up there eh? So we never knew.*

The theme of "knowing and not knowing" occurred and reoccurred through many of the interviews. Not knowing who one could trust, not knowing what had happened or was

happening to family members, being suspicious that things were happening (but not having clear evidence) were often reported.

On one hand acknowledging "not knowing" can be viewed as demonstrating high tolerance for ambiguity and a willingness to be aware of the actual situation. However "not knowing" is also linked to ongoing suspicion; a feeling that nothing is ever as it seems, that there is always another agenda, that one always needs to be on guard, and nothing can be trusted. Some informants acknowledged that these responses were often seen as "paranoia", by others although they did not support this interpretation.

A related theme is that of *The official story*. There is always an official version of events, and the *real* story. *(We don't know where your brother is)*. The official version can't be trusted, it may be *"the institutionalized lie"*. This leads to distrust and suspicion of any official or government initiative. Family planning and AIDS education activities, for example, were often seen to have a hidden agenda (Stevens, 1993a). Suspicion of family planning programs for example, was based on the experience of government sponsored population control programs in El Salvador which which were not based on the best interests of the population. The suspicion as to what the "real story" is pervaded many stories and interactions.

The subtheme of *"underground"* can also be found in many of the narratives. Sometimes the term itself was used to describe being in hiding ( e.g. *"we were living*

*underground"*). At other times this theme was implied, as when an informant discussed

hiding her true beliefs and activities from others. Not only activities, but services such as

self help and health services, may also need to go "underground".

The theme of suspicion, mistrust and betrayal, (with the sub themes of " not

knowing", "the official story" and "underground") was not limited to the experience in

home country. As the following section shows, similar personal dynamics continued to

be played out here in Canada.

The forced displacement of an estimated 30% of the population from their homes

was another way that community was destroyed. The scattering of many of these

refugees to North America (and many other areas of the world) ruptured the community

of origin and forced the re-creation of "community" in a new country.

### The Salvadoran Community in Canada

What is this reconstituted "Salvadoran Community" like? First of all, it would be

an error to assume that any immigrant "community" is necessarily a community either in

the sense of being complete and self sufficient, or in the sense of being cohesive and

supportive. There was no receiving community when the first Salvadoran refugees

arrived in the early 1980's. The first arrivals were often traumatized, and there were

significant political and social divisions. Many were supporters of the political

opposition, however others were sympathetic to, or members of families which

supported, the government. The community then, consisted of not only victims of government repression, but families of the army, or of informants. In addition, all socio-economic classes were represented. One of the frustrations mentioned by some of the participants was that Canadians did not understand that simply originating from the same country did not make a community. The assumption that individuals from the same country would necessarily have something in common or want to make social contact was expressed as both disturbing and offensive.

Many of the informants spent significant time discussing the Salvadoran community in Manitoba. Some raised the issue of the community as a key factor in their own emotional and psychological health. Others discussed the state of health of the community itself. Whatever the perspective, the conclusion reached by the study participants was the same: the Salvadoran "community" was not seen as healthy. A concern heading the list of most interviewed was the lack of trust within the community. This concern crossed lines of age, employment, education, or politics, and provided the most consistent similarity between those interviewed.

## Involvement in the Salvadoran Community

Most of the informants stated that they were not, or did not like to be, involved in the Salvadoran community. Many described themselves as having withdrawn from the community because of distrust, gossip, jealously, and people trying to make trouble. Some of those describing themselves this way still continued to attend church, and were

known in the community, however, they perceived themselves as being removed.

> *Since then we don't have close friends. It is different than in El Salvador, we liked to see people like us. We are scared to be close to people.*

> *No, I don't have friends that are Salvadoran. I have more friends another country. Because....the people in my country only talking about the person, ....in a bad way. I don't like it! I don't like.......Yeah, no safe.*

> *Not any more. I was. Well, I go to church. But ah, the community's not too.......related. They are not very close together as you might know. Not very close, we do our things by our own, everyone goes their way.*

## Perceived Problems Within the Salvadoran Community

### Jealousy

Several informants describe jealousy as a major problem. Some reported losing friends

because they were successful in obtaining employment or buying a house.

> *Everyone is friendly to a certain point. They give you reassurance but once they see you in competition with them, they don't help anymore. They don't feel secure, they see you as different. ...When we bought our house friends said we weren't talking to them now because we are having a house.* (And about her job) *What kind of job? How much money they pay you? They were very jealous. We don't see them now.*

> *So, um, people say, you have to start from the bottom, and if you are in a position, is nothing, you know. I like what I do, and I respect what I do, is not what I would like to do for ever. However, people see you in a position, and "Oh, you have that position because you are lucky". Or "I don't know why you have that position". "Why did you get that position?" You know, a kind of angry?*

> *I know that sometimes, I think they're jealous? of my mum, because my mum is so, I don't know, my mum has achieved everything she's wanted. She has a house for us, she has a job, we go to school, and it seems like, they, maybe not jealousy, but they feel like, yeah, she has a lot, and we don't really.*

<u>Gossip</u>

Perhaps the most serious problem is felt to be that of gossip.

> *Many people have had bad experiences when they have confided in someone, and as soon as they turn around the other person starts to blab. So, one keeps to oneself. This is the same everywhere, it can happen here or there. This is a cultural problem maybe.*

> *... this lady calls me and she says are you P.? And I say "Yes I am P. What's the problem? I don't know you". And she says " You know there are so many things going around about you", and I said "What?". I mean I didn't even know, the, the community is , you know that's why, (begins to get upset) I kind of, I felt so hurt, I mean how can this woman being doing that? I mean I know is not true.*

> *You know, mentally that makes me, drains me. If its not one problem its another, and that's why I said to (my husband), I don't even want to go to Spanish church. ....Everybody against each other, everybody talk behind your back, like they will start telling me, "You know about so and so?", and I say "I don't know. I just come to church, I don't. " Because they put against each other you know.*

> *We have a defect as a community. We are very gossiping, and we, and we say things that later on are very damaging to the image of an individual, or even a community. We are not supportive. We are, if someone does a mistake, Salvadorans are the worst, condemning the mistake......Is why I don't mix with Salvadorans. Because of a sudden you get involved in a gossip, and you didn't know what you say! And if you speak your mind, as I do, usually I say, "I don't like this because ta, ta, ta" and then! change the meaning and change my words! So I avoid that. I don't like that. And so you are working with a cloud of ignorance sometimes! The majority of times!*

Gossip about sexual behaviour was seen to be one area that was common, and damaging:

> One woman confided in a friend about her husband's warning not to talk to a certain Salvadoran man, an "entrador" ( this term refers to someone who coming on to , or trying to seduce a woman) This friend then went and made a big story with her family regarding her husbands jealousy, adding untrue information. The result was to create additional strain between her husband and her family. (transcript summary)

Of course, gossip is not only a concern within the Salvadoran community. The important

finding was the level concern expressed by study participants about gossip, and their

recognition of the its damaging effects not only on their own lives but on attempts to build " community".

## Malicious Rumouring

Some of the behaviour goes beyond gossiping, but is described as planned and malicious. One woman described a particularly disturbing experience where someone, (and she believes she knows who it was) appears to have undertaken an elaborate plan to convince the informants' family that she has been having an affair with her first husband. This appears particularly cruel, as the husband disappeared, and has been presumed dead for almost 20 years.

> *Like, she did so many things. She went to Los Angeles, send a letter in ( name of disappeared, husband) , because I went on a trip to Los Angeles too. And at that time, soon after that, she went. I don't know she went, if she went, just to put that letter, just to put her relatives or what, but a letter came, not in my name but in my mother in laws name, the one that was here? In her name, from my first husband, it was supposed to be from him, saying in that letter "I remember the good times we had at the hotel when you were here in January, and all, like all things." And.....An, and it was in my mother in laws name, so that she could see it and show it to (my husband) without me knowing. She has tried so desperate to separate me and (my husband). Yeah. And my mother in law phones me right away and says "I got a letter here from this person, and its in my name, so I open it, because I didn't know who it is but it comes from the United States it has stamps from there." And so I say "Oh, O.K., open it." So she open it, and she, I was on the phone, not at her house, so she says "Oh, I'll read it". "O.K.", I said, "read it". And she read it on the phone, then she says "What do you think about it? Who could have sent that letter, for you inside, but for me on the envelope?" (Laughs)......Oh she knew right away. And I said "Yeah, I know", she says "I know who it is." And I said "Just bring it over and I'll show it to (my husband)". So I showed it to him right away. I said "Here is the letter", she put it there maybe, and now he says "You know what, maybe she, maybe she wrote the letter and left it to my sister". He. has a sister that gets along with her so good. And she sends her money so she has, like bought her?*

The informant believed that the hate/jealousy towards her was so strong that it could even result in the woman making a special trip to the United States. According to this story, the plan is carefully thought out by making sure her husband's mother actually receives and opens the letter. One result of this was to cause the woman to wonder whether it was possible that her sister in law would participate in this by mailing the letter, and so did affect confidence in other family members. It also opened the old wound of wondering whether it could be possible that her first husband was still alive - an agony faced by families of the disappeared who have no proof of death.

The informant described three stages of coming to terms with this event: sharing information with her husband and some other family members, going for counselling for help in coping with the distress the incident resurfaced, and finally, struggling to forgive the person she is convinced did this. As difficult as it appears, she believes that the only way to put this incident behind her is to forgive.

## Family and Social Problems

Several of the individuals interviewed, as well as the two focus groups also identified specific social problems which are showing themselves in the Salvadoran community.

> *So, because, it has been hard, and how many people from the same community, in similar conditions, are twisted right now. Are in drugs, are with pregnant, and with many things.*

> *Also, here there are many kids who were well brought up and have lost*

*themselves along the way. To the point that some of them have had to face going to jail. Some of them are street kids and into drugs.*

Abuse of alcohol and drugs, particularly among men and the young was identified as key concern. Domestic violence was also highlighted.

Examples were also given of mistreatment within families. One woman shared a story of neighbours who had sponsored the mother to come to Canada, but had then denied her food, and forbidden contact with others.

## Distrust

Gossiping (in both its more innocent and malicious forms) is both a means of control (several women confided to me that they avoided taking any "leadership" role in the community because it invited gossip), and a means by which mistrust and divisions within the community are perpetuated. A similar message was given by women both in individual interviews and in the women's focus group. Statements such as these (from the focus group) are common.

*That's the problem that we have. We don't trust people*

*No, I don't trust anybody.*

*No, here and in my country, I don't trust anyone. That's my problem, I don't trust anyone.*

Distrust leads to insecurity, and *not knowing* what is true or who you can trust. The knowing and not knowing then, contributes to community suspicion and inability to trust and work together.

## Linking Current Problems with the Past.

In general, the women did not make a direct link between the experiences they were having with the Salvadoran community in Manitoba and the previous betrayal and trauma they experienced during the war. Some of the women felt that the situation with the community here was different than what they experienced in El Salvador.

> *In my country I have friends, they are good friends, they no looking at you, talking about you, no!......The people Spanish in Winnipeg (when they are out of their country), is different. In my country is different.*

To this writer however, some of the same patterns of jealousy , sexual jealousy were described by informants as also happening in El Salvador, often with more traumatic consequences.

## What are Seen as the Causes?

### Political Divisions

The refugee community that arrived in Canada was polarized because of the war. Even those on the same side (e.g. the left) were often divided from each other, and initially organizations were created along political lines. For many, these political divisions have faded over the years. Certainly, there are no longer the number of separate political organizations. However, there appears to be long lasting distrust based on these political divisions.

> *Oh yes I am nervous. That's why we don't talk about this to friends, because we don't want them to find out what we really are. Like in a sort of way, we still feel sort of scared about the things that happened back there? .... because in a way we feel like we have to hide the past. We can't talk openly because we know that there is many people here that hasn't been involved or don't think the way the we*

*do, like about political things, we are more on the population side you know? Not on the government side. And because of that we find we have to hide. Yeah. Getting close to friends that are close to the government side, we never do. Or if we don't know that person? We didn't know him (reference to common acquaintance.), and once we know, we try to get away from him. We don't feel safe somehow. So we have problems that way, we don't want to get close to people like that. So that's something we have to improve, or just leave that like that.*

Note in this example the theme of "underground", or hiding. She then goes on to say:

*I don't know, but I, fear that might be? That they are not comfortable with the war, with the system, and everything so that makes them fight each other?...Like the stress brought back, it comes out like this because its all kind of minds. Like some are against the government, some in favour, like you mix, but nobody talks about it, like I won't tell to the whole community my life? ..So if I tell somebody, that will be somebody that I trust. But not from the Spanish community. ...Is not healthy, not a mentally healthy community because of all of the stress that we brought from there.*

Followup in the feedback phase elicited strong confirmation that women felt it was unsafe to discuss the past, and that war-related experiences could not be discussed in the community. As there are no longer *official* (organizational) differences, this issue does appear to have to some degree gone *underground.*

## Class divisions

Class divisions emerged as a major explanation for community tension. Being forced to interact with those from different classes can create stress and (as in this case) lack of confidence.

*No, it was not the same, you know why? Because we have village, campesino people there, that's all you deal with. Here you have city, you have poor, you have rich, you have professionals, you have everything. It's so hard. And I feel*

*that because back there, people who have money don't get too involved with poor people, you know? That's, uh, that's the way it is. Middle class and higher, they don't have anything to do with poor. You know, so I feel here, because of that, I feel less? than some people?*

In El Salvador the different classes lived in different worlds and did not socialize, attend the same schools, or work in the same kind of jobs. Here in Canada they do. Canadians do not usually recognize class or educational differences, treating all new arrivals the same. Those who come from lower socio-economic backgrounds in El Salvador now take offense to those who continue to show class superiority. Several of the women identified difficulties in now having to socialize with those from different socio-economic classes but from the same country.

*Some people want to show you that they have more power, want to show you that you are just one more, but they were something in El Salvador.* (She then went on to describe an incident at a cultural gathering where someone called her husband (who is over 40) not by his name, but by the term *'muchacho'* - boy, or young man.) *But I don't think they are of a high position, because if you are, you don't need to show. Need to understand that here in Winnipeg, are people of different levels. They want to keep looking at different levels. In this society we are a small community. The common point is immigration, every family has their own reasons, and need to respect them. Immigration puts us all in the same situation. Some people fight to be superior. .....Behaviour here in our community is the effect of situation in our own country...... if they have friends in a higher position, they use these friends to get ahead, and put others down. It is easy to see differences between classes.*

Those who come from more privileged backgrounds find that they are often in the same economic situation as those who were desperately poor. Their children attend school with the children of illiterate parents. These women struggle with their own upbringing, and resentment that their skills and education are not recognized.

*...in El Salvador, many people who live here, I wouldn't mix up with people that lives here, with so many people that lives here. I never should have a chance to meet them! Never, ever! Never! So, um, the dynamic is different. ..Another thing that bothers me sometimes is that, um, Salvadoran people, don't ask me why, I believe that I am very open minded, and very progressive, but I hate when people like__ (I am referring to her because you know her) treat me as an equal. I don't like that. And then I avoid those people. (laughs) That is (pause) bizarre. (laughs) I think it is a problem because I am preaching different things, and I am acting following the old structures. I hate that, but is something that bothers me. Or people like (name) came and said to my kids "Mira". I am sorry, she should treat my kids as "Mire" instead of tu, tu, tu or you to you...I don't know, I cannot explain why I feel like that. And I fight against that and ey..!*

*Mira* (Look!) is the form one would use to a child, an intimate, or someone of lower status. *Mire* is the verb form for the formal term *usted* (you), which conveys respect.

This woman went on to describe a social event in the community she had attended shortly after she arrived which highlighted the class differences.

*.And someone approach us, and start to, try to make friends with my kids, and my kids saw them, and they expressed disgust to be approached for these people. I felt embarrassed in that moment. ....And someone said "The problem is that you are from the rich" or something......I saw my kids and they feel, or they express, a feeling of to be afraid to be there, because people was not the kind of people that they wanted to meet. And they said "We don't want to go there any more, is awful, the people is awful! They are ugly!".*

The class tensions were obvious in the individual interviews. Even those professionals who were involved with the left against the government, (and for that reason find themselves in Winnipeg ) find difficulty in being considered the "same" as the less educated. Those from poorer families continue to show suspicion of those from more privileged backgrounds, and share examples of instances where they feel they were slighted or where people were trying to take advantage of them. In one example a woman

described how she had been invited to a social event with a group of women, and found that she was invited because the women (from better off families who would not have learned to do this cooking themselves) wanted her to make *papusas* (a traditional Salvadoran food made of fired tortilla stuffed with cheese, beans, or pork).

Class divisions, at this point appear far more pronounced than political divisions. The Peace Accord has been signed. The opposing sides of the conflict were not readily identifiable, but in one sense the conflict was a rising up against injustice of the most poor. Many of the arrivals were not politically involved, but simply wanted to get out of a dangerous situation. Now in Canada, as political divisions fade, it appears that the divisions are reverting to the old ones of class. There is even somewhat of a sense of retribution in some of the descriptions:

> *So, I really don't like to work with them. Is this fact that the oppressed want to be no oppressed, and to confront those that represent the oppressor. (Some people are) capable to differentiate, and to separate, you know. (Name) has no problem with that, even she didn't expect or think that I am a person who could be her enemy, her class enemy.*

The on-going sensitivity to skin colour and to "looking Indian" also suggests that these class divisions are unresolved for the community.

Other problems

Other women suggested that some of those who came to Canada had problems that they brought with them.

> *Some people don't need to move here, but come because they have problems.*

*Money, or alcohol. They have unrealistic expectations, like employment. Some people blame problems on immigration but were there before....Some people don't like to accept reality.*

Not all difficulties then, were perceived as the result of uprooting and migration.

## Finding a solution

Community gossip, intrigue and suspicion were experienced as immensely painful by most informants. These women described this distrust not simply as a characteristic of the community but as a great sense of personal loss. As indicated earlier in this chapter, community involvement was key to the lives of many in El Salvador. The sense of loss was particularly noticeable for those who had been (or whose family had been) politically active in the community in El Salvador.

### Avoidance

Many have coped by distancing themselves.

*At the beginning it was very hard, and still sometimes if I think too much about it? It was very hard, yeah, very hard. Because with the Spanish community I was forced to withdraw because of that.*

*.. my husband says sometimes, if you stay away for the same language, you stay away for the problems. Because even here, some people like to make too much problems. But I don't like to stay in the middle of the problems.*

*The more the help, the more into problems you get, and that is why (my husband) has made me, practically to not be so close to people? Because I am a person that once I get so close to somebody, I, uh, learn to trust them so much, and then with the time they (voice breaking) I feel I can't trust them anymore. Because they say something that wasn't supposed to be said or something?*

A deep sense of irony can be found in this situation. The attempts of the government

and of the army in El Salvador to destroy the "community" through violence and repression have in some ways been successful. Many years after the survivors had fled the country - often after risking their lives for their community - one of the key things for which they had fought was now taken from them.

## Group Activity

While most identified community "ill health" as major concern, there is a sense that there is not a clear picture on how this can be addressed. The history of the country, and the stories of the women themselves show a great resourcefulness in addressing community problems, and providing peer support. Some of the initiatives of the political left educated the community on self help and community - based responses to social problems. However, in Winnipeg, gossip and divisions within the community have destroyed many attempts to organize to address common concerns:

> *In associations, it doesn't work. Well, every single intention has been unsuccessful. We organized a group of women who were abused, and um, I am not an abused woman, but I saw the problem. And we start to talk to them, and we said, organize, lets organize, and get a grant, and ta ta ta, and we did. And then, males in the community start to blame the group and tell them that they were prostitutes and they were complaining because the guys disappeared. The folk group is made up of, or is gather a lot of small children, or young individuals and is the only one who have been able to survive, and is maybe dying.*

There is also a sense that the women (who describe themselves, and are described as the emotional and moral centre of families and the community), are overwhelmed:

> *Another thing we have in common is depression. But, oh God, if I tell her about my depression, that will depress her as well and make everything worse. It's a common fact that depression comes with the adaptation process. I want her to be able to support me, and I will tell her I am sad, but again so is she, and then we*

*both end up feeling depressed together*

*The problem is, one listens to others, but we don't know how to console them because we are in the same situation.*

Nor does one get the sense that the community as a whole is discussing and coming to terms with the damage that has been done to it; this would explain why attempts to join together to address the problems have been of limited effectiveness. One woman makes the following observation:

> *I think if you are an individual and you have a problem, you need to recognize the problem and try to get help for yourself. Its same with communities. I know that the community knows something is wrong. As a whole, I know that they know. And we are having the effects, we are seeing the effects. Pregnancy, drugs, ta ta ta, guns, ta ta ta. So, some leaders, formal and informal leaders in the community are trying to get together in order to combat, to cope or to help, you know, but this will require more involvement from more people. Which is very difficult to get more commitment. People like professionals, medical doctors, they are worried about being doctors, but they are not, or about their families, but they are not worried about the community, in the sense of the community is lost because of the war. So, how to recover and make it a community is through activities that can be produced through the same community.*

While participants talked of avoiding the "Salvadoran community" and described themselves as not feeling safe within it, the transcripts of focus groups reveal that in fact there is a level of social interaction, and in some cases genuine sharing on important, and even painful issues. This suggests that women are continuing to reach out for social contact.

## Integration with "Canadian" Community

### Level of Integration

If, as these interviews indicate, many women are feeling alienated and distrustful

of their own community, are they then becoming more involved with the "mainstream" of

Canadian culture? Are they making friends with Canadians, and finding a social life

there? The experience of one woman who began volunteering with a Canadian

organization suggests that this might be possible.

> *I felt so good, because there is engineers, so many kinds of people, like different you know, backgrounds, Mennonite and all that. So they welcome me, like you know, I feel so good. I felt like, "Oh I am somebody." They treat me as a human being, not as a woman from El Salvador, and being so poor, coming from the war and all that. And the Spanish community on the other hand, was you know, I didn't feel good? ....And I felt at that time, people that was on the board at that time, I felt that they really feel it, they didn't fake it?*

However even this woman described being alienated from Canadian society, and

many others had not even these kinds of experiences to share. The majority of those

interviewed described limited interactions with those born in Canada, although a few

stated that they had "friends" among other "new" Canadians.

> *I do, yeah, I do, I have Canadian friends.....Well, now I think, its more Salvadoran yeah. Yeah, because after I stopped going to school, I stopped seeing all my friends, they have gone their ways.*

> *Well some people uh, helped us, I think, I don't have Canadian friends, and this time, I don't remember anyone who, Canadian, just only Spanish people but no more. And we are coming for the Interfaith, but they never give us 'padrinos' (patrons, host family)?...No. Anyone. Even my, even my family, I think they never had a friend, Canadian friends, even me.*

A younger woman who came to Canada as a small child described a different experience

however.

> *...well I know outside of school I do a lot more things with uh Spanish people, with Salvadoran people, but in school there's only like another Spanish girl in my class and I pretty much have just Canadian friends and things like that. And I do things with them outside of school and things like that, but um, I don't go out with them a lot. ... I think its the same, I do things with Spanish people, and with Canadian people. But its always different things. Because I know with Canadian people its you say, "I'm coming over", and then you just do whatever. You don't really plan anything? Cause we do whatever, drive around, we don't usually have anything planned, I don't usually with Spanish people we usually plan something, like lets go to the movies, and that's exactly what we do.*

The response to questions about Canadian friends often elicited a comment about

Host families. Host families are Canadians who volunteer to be friends with newcomers

to Canada, and assist with settlement issues and adaptation. While programs may have

different names in different cities, they are generally operated by settlement agencies.

One woman reported that the only Canadians she had met were the host family of her

sister. Another woman reported that her family had made a real friend through this

program who also assisted, through personal contacts in finding employment, and access

to other resources. However these relationships were more often described as less than

successful, with examples given of incidents that caused embarrassment or offense.

Some women took offense at being given (and expected to be grateful for) cast - offs

(such as clothes or furniture in poor condition).

In the women's focus group some stated that they had Canadian friends, others did

not. However the tone of the discussion indicates that this is not real friendship, as they

go on to make comments such as the following:

*No, it really isn't a real friendship*

*No way that they are going to visit me, and have me go their homes, no, no!*

*Many times you don't know what to talk about. They have lived in Canada all their lives, and we have lived in El Salvador.*

The result of social isolation is, for many women, intense loneliness.

*I think I feeling depressed. Because for my friends, all my friends stay in my country, and I stay here, alone. Sometimes even now, I feel lonely. Because sometimes I can't explain, or I don't have anyone I can tell what happened to me, or how am I feeling. I don't have anyone. I don't have friends, I don't have nobody. ...But sometimes I want some people who help me, just only talking, or just only for saying, that's my friend.*

## Barriers to integration

There appear to be a number of factors which contribute to social isolation of women in this community. One of the factors is the difficulty in trusting, as discussed in the previous section. Other factors include English language skills, racism and discrimination, and strategies for establishing new networks.

### English language skills

There appear to be a number of women who still struggle with language learning; limited English language skills appear to have a profound impact on adjustment and contributes to the social isolation

*Because my English is no good. I always go away from people who speaking English.*

*I have been in gatherings where only English is spoken and one feels inadequate.*

*On the one hand you don't feel good because you have to speak in English and "What?, What? What?".. and then one feels bad, and feels down. Instead of improving your pronunciation you don't want to repeat it again. Then, oh well, you choose not to speak anymore and stand there like an idiot.*

## Lack of acceptance, racism and discrimination

Others feel more generally that they are not accepted, or that discrimination or

racism is a factor. Note how in a number of these examples, ability to express oneself

clearly is seen a part of the problem:

*And I said, OK, the thing is not exactly the system....Sometimes is the people. Is the people. Because for me, at that time I understand that they want to tell you, "you are here, you are not part of this society".*

*Sometimes, someone doesn't understand, right? Sometimes I feel, like one says, humiliated. There have been times when I have felt like that, times with the neighbours, like I said before. Even over a little thing, they were threatening the kids they would call the police. Because we play music and you can hear it on the other side. And all that. And you can't defend yourself, because we don't know how to express our rights, we don't have the ability in English to defend ourselves. And they do, they can say whatever they want. In that way I have felt emotionally (humiliated)...*

*Well, in the last time, in these two months maybe, in my workplace, the supervisor offer to me training for instructor, but I tell her I wait, I go for interview or something, but she told me they call me when you are going. I wait, I wait, I wait, I waiting three weeks, and when I asked her again, what happened to the training, she said, "Oh, (name) start last week" And I tell her, well, "What happened, why you didn't tell me when the training start?" I didn't want to thinking about the name, my name is a Spanish name, or they want people who is English, the school or what. I don't want to think they are rac(ist) - ...... But why they give this training another lady? She speak nice English, she is white, not me. I don't thinking about discrimination, but why?*

Sometimes the feeling of not belonging is not linked to discrimination, but rather

to an attitude of condescension and of ignorance of Canadian acquaintances.

*They are good people right? What I find is that they look at us like (to me -
Sorry), like an alien, who come from countries that....They have everything, they
listen to us. It's true. However, I never felt that I was talking with someone that
really could connect with my problems. Only once did I openly talk, but that time
I felt like they didn't appreciate me confiding in them. She was a good person
with me and everything and they gave us a lot of social invitations, like Christmas
for example, but....I felt like we were separated under the same roof.*

*I'm still thinking we are equals, but because I didn't feel like that I decided to give
up. I don't speak English. However, we are still equals. We are from different
cultures but we are equals. That is why we are afraid to express ourselves,
because when we talk to them it seems like they do not perceive what we are
saying to them with the same intensity. We don't want compassion or pity; what
we want is to be understood. ..It is one thing for them to know our problems, but
another to really understand them.*

However, discrimination and racism did not emerge as a major theme in the
narratives. In some cases it appeared that the participant wished to minimize the
importance of discriminatory behaviour.

*Sometimes there are people that make rude comments and stuff, especially when I
couldn't pronounce things properly, but you just kind of ignore it. ...Sometimes,
some people are, there is always the people that make fun of you and things like
that but its not anything that I really felt that strongly because most of the people
uh, they were, I don't think they cared where I was from, or what race I
was.....and there are people who make racist comments sometimes but I just
ignore them and I don't really pay attention to them.*

It is unclear how many of the women felt that discrimination and racism is an important
problem for them in Canada. One consideration here is that many of the participants
(particularly those from poorer families) faced direct persecution in their country of
origin, and regular violation of rights. The fact that some people in Canada may "make
rude comments", then may be viewed as relatively unimportant.

Of more importance appeared to be the resistance expressed by many women to the feeling of being pitied, looked down on, or condescended to. One of the participants in the professional focus group commented, (in the context of a discussion on national character), that Salvadorans are *"terrified to be made to look ridiculous"*. This sense of pride often appears to emerge in an aggressive way.

> *For example when I came to Canada I pretended that I was mad, when I was at the bus stop. I saw people who were only trying to get close to me; I thought these people are going to talk to me, and I do not understand, I do not know how to answer.*

## Need for new strategies for developing social networks

It appeared that most of the women wanted, often desperately to make friends; the isolation was not of their choosing. However, barriers to greater integration were not seen to be simply of language and ethnic culture, but of vastly different life experiences.

> *Many times you don't know what to talk about. They have lived in Canada all their lives and we have lived in El Salvador. Besides, we just met, and what are we supposed to talk about? Now I could talk to Sarah about our past.*

It became apparent through the discussions that new ways of making friends may be needed. Especially in rural communities, relationships have been based on extended family and intergenerational connections. It sometimes appeared that the women did not know how to develop other strategies for making friends. This, combined with a generalized sense of alienation and often distrust, and the workload of family and employment demands, contributes to problems in integration. In one focus group the women discussed the differences they are finding in making friends in this culture:

*The daughters of my mother's friends, as well as mine, knew each other since...Well, we were born together, we grew up together. I mean, we had trust in each other, right? Here we can't trust anyone, right? Sometimes I think, what will a stranger care about my problems?*

*The reason is that we don't have friends right? In our country of origin we had friends since kindergarten, but here, no.*

Adaptation and participation in society, not only the openness of Canadians to accept one were seen by some as of key importance.

*What do we think is to be integrated? I am actively participating in the society...... I don't need to be accepted. (Pause) I have my presence, and whether I am accepted or not, I am there. I don't expect you to accept me, I expect you to be my friend. So is different. I don't expect the women from (name of organization) to accept me. I am there, and I have a job to do, and I do it. And that participation is my acceptance, is my key. So, I don't think, um, I don't know, we are eight years since I came here, and I think that I handle the society, I handle the situations. I feel that I am able to operate in this society. However, I don't think that I will be able to adapt to this society. If you want more explanation about that?.....I work, I have friends, many friends from different countries, and I am a person who needs friends. But these kind of friendships, without interest, and also, if I need, I am able to move and to go to the right place. I am able to move and do things you know. But the adaptation, and the thing, this has been one of my struggles.*

## Summary

Community of origin has been "lost" because of the war, and those Salvadorans who now live together in Winnipeg continue to struggle to recreate community in a new setting. The strategies of "low intensity warfare" had the effects not only of direct brutality and repression, but also the undermining of social relations and trust. The Salvadoran community demonstrates that it has the means to address the problems of violence, particularly the patterns of violence within families. However, the mistrust and

suspicion resulting from the "social trauma" continue to create distress for many in this community.

The narratives also suggested that to date there has been limited integration with other women and families from other sectors of Canadian society. The result is a great feeling of loneliness and isolation.

Less educated and rural women appeared to have the greatest difficulty in participating in the larger Canadian society, with the exception of the workplace where job participation and satisfaction was generally high. (Employment as a coping technique is discussed in Chapter 11: Coping Strategies).

# CHAPTER 8: RESILIENCE

The sixth dominant theme emerging from the narratives is that of resilience, both at the individual and the societal level. Resilience can be defined as competence or functional ability in spite of losses or stressors (Muecke, 1992). This theme also has several subthemes: " *strength", "pragmatism"* and *"suffering does not make one a victim".* These themes appear to transcend class boundaries, and so help to describe the "national character".

The smallest country in Central America, El Salvador has nonetheless earned itself the reputation of being a country of entrepreneurial, hard - working individuals. During the 1950's and 1960's El Salvador, underwent greater industrialization than any other Central American country. Salvadorans are often referred to as the "Germans", or "Jews" of Central America due to these characteristics of diligence and entrepreneurship. These values are also expressed in the lives of individuals.

## Strength

The theme of strength appears many times in the women's life narratives. Many of the women interviewed took pride and satisfaction in being strong and self-sufficient, and there is admiration for other women who are strong. This strength, even in the face of suffering and deprivation is part of their self image. Stubbornness and assertiveness are also valued.

Women who described themselves as physically strong, also tended to describe themselves as strong characters as well.

> *When I was pregnant with (child's name) I was VERY strong. And I could lift like a big, um, a big jar, cantaros they call? It was 20 litres and I could just lift it on my head, and I was almost nine months pregnant. ...and then sometimes I even have to run, because we were hiding and that, and if we knew someone that knew us, if we met somebody that knew us, we run and had to hide, and I did that through my whole pregnancy.. And ...I went six days without food...and (child) is healthy!*

She then goes on to say:

> *I been, in my family the strongest, I have two older sisters, but after my brothers left I was the strongest one in the family, and the one that had to think what we do next, what to do, .....I learned to be strong, and deal with anything that had come, and to have faith in it? I loved my parents, I loved my mum, I loved them so much, but I didn't feel I should do just to please them. Because I had also my rights, I had my own feelings..... I been like that. I stole food from home to give it to people who didn't have nothing...and I am not sorry that I did.*

*"I had a strong character"* another says. Interestingly, these descriptions came more frequently from women who had chosen to be politically involved. Women who viewed themselves as strong were more likely to become involved in political groups or community organizations, to make their own choices about reproductive health and marriage (even if these were not approved) and reject traditional health guidelines that did not suit them.

> *And the same restriction was when you had a baby? I heard that. When I had mine I did my own thing. Like I had been so independent that I didn't do what they told me to do (laughs).*

For many this strength is linked to religious faith, or to commitment to higher cause. Some of the women were also clear about the risks they were taking but felt

prepared to take such risks:

> *Yeah, I (was) scared! But I think, sometimes in my family, I think, I was strong sometimes.*

> *That work, that work was very dangerous, but at the same time, was very exciting! And my friends were disappearing, and some of them were appearing later on, dead. But I, I was sure I was supporting a good cause. The cause that would reach those who did not have the opportunities. You know, so it was an informed decision because I decide that that is what I want to do. I want to make changes in my country, and I want people to have the same opportunities.*

However for most, it is commitment to family, particularly to ones children, that provide

the strength needed.

> *But I think my children is a big part of my life...I tried to feeling strong for them. Because I want to see my children big, or I want to feeling proud for my children.*

## Pragmatism

> *The people might be ignorant about some things, but they have a wisdom learned from their own reality and experience, and they know how, when and why they have been deceived throughout history. Guillermo Manuel Ungo (past leader of the political opposition in El Salvador).*

Lock and Kaufert (1998) state that "by force of the circumstances of their lives,

women have always had to learn how they may best use what is available to them" (p. 2).

The women in this study have found that it necessary to be pragmatic to survive. More

than any other factor, the characteristic of pragmatism appears to predict service use,

service satisfaction, and behavioral patterns.

This research indicates that Salvadoran women are relatively unattached to past

practice, custom, or belief system, unless it has demonstrated benefit, and continues to be

demonstrated as superior to new methods. Instead they focus on "*What works*" and "*What is necessary to survive*". Surviving (and protecting family) during the war, establishing in Canada, maintaining health and treating disease, all of these can be partially explained under the heading of pragmatism. *"Whatever works best, that is what we will do".*

One of the members of a focus group , in discussing the nature of Salvadoran character quoted Roque Dalton (one of the best known Salvadoran poets, executed during the war) who described Salvadorans as *"los hacelotodo, los vendelotodo, los comelotodo"* (those who will do anything, eat anything, sell anything). This poem is included in Appendix D. These lines capture the pragmatic approach articulated by the women throughout the interviews and discussions.

### Pragmatism and Survival in El Salvador

Women survived in situations of poverty by being adaptable, creative and hardworking, and using whatever was available to survive. Herbs and other home treatments were used when there was no other source of medical care. During the war, many families had to be ready to uproot and relocate on a moments notice. Those that were not prepared to do so, often did not survive.

> *So they killed 40 people who didn't run that day.....That they didn't, they thought they were safe.*

They had to find food and care for their families in whatever way they could. One woman describing the birth of her child, explained that the person who helped her had

received no training in childbirth,

> *Hasta nacio tambien mi nino este, con otra senora que tambien no era preparada. Pero si, hacia sus cachitas (laughs)*

The regional expression *hacia sus cachitas* translates loosely as saying, *"She does it the best she knows how, she doesn't really know how, but will try it if she has to".*

Pragmatism is expressed by both parties in this example; by the childbirth attendant who will try her best even with no training, and the birthing family who will use the services of whoever they can find simply because that is all that is available to them.

## Pragmatism in Immigration and Adaptation

The decision to immigrate is also based in large part on pragmatism. There was for these women, no sense that life in Canada was a dream they were hoping to come true, but the only alternative to survive, or provide their families with a reasonable life. So they were prepared to uproot, if not for their own sake, for the sake of their husband and children. In Canada, pragmatism is again demonstrated in the assertive manner in which the women take on the tasks of language learning, establishing a home, and obtaining employment.

> *So, I have to find out for myself, and find the solution for my family, and so I said, "O.K.", I have to learn the language", and I don't like to ..to be you know like...I would like to stay in my field. So I went and find the ways to succeed. I am not a modest person in this case because I consider myself a successful person, because I find the ways and I'm on the way and I will succeed, probably, with my whole family.*

## Suffering and Survival

The life narratives portray a world view that values survivorship, and takes pride in beating the odds. The women talked openly about the scope and intensity of suffering they had endured in their own country and in being in "exile" here. However, it was clear that they did not, generally, see themselves as victims, but rather as survivors. They described themselves as strong individuals, who were placed in difficult (and often horrendous) situations, but who coped, and while coping took care of others. This was confirmed by comments made in a focus group discussion.

> *What some women have here are strengths that probably are completely unknown for Canadian women. ...The way the women deal with pain. Salvadoran women deal with pain...they can take so many pain! Their tolerance to pain is unbelievable.*

Part of the alienation felt in Canadian society seems to be that as the women are viewed as "refugees" this strength, and pride in surviving is not recognized by others. One of the focus group participants stated, *" We don't want compassion or pity; what we want is to be understood."* A clear message was that the women do not like being condescended to or pitied, and resent being helped in a "one down" situation. Nothing is worse than to be made to look foolish.

There is a practical acceptance of the existence of suffering and of evil. These things exist, and to be exposed to them does not make one a victim. There is also an openness in suffering, and a lack of embarrassment in acknowledging suffering.

## Differences in Resilience Between Men and Women

In both of focus groups (including the professional focus group which included

male participants), it was stated that women are viewed as stronger, able to adapt more

quickly to new situations, and are more assertive in using the rights and resources

available to them.   They were also described as tending to take an active role, rather than

a passive one in dealing with difficulties.

> *I believe women are stronger than men. Men give up very quickly and we women, in spite of everything, we have to endure lots.*

> *Salvadoran women tend to be more aggressive during the adaptation process, and that is something very consistent....For example they learn the language first, which is an indicator of adaptation, they get jobs first, they are more willing to accept the new rules, the new situation. They start by using the rights better than men, absolutely.  ....I can say in general seems to be that the women suffer less the adaptation process mentally speaking than men. Seems to me that men are weaker when they go through the process.*

> *Speaking in general terms, my impression is that the women take, the take charge of the situation most of the time here, more than men. Usually men are waiting to see what happen. Women take care of the situation immediately when they come here....because they have always been in charge of their home in general. When they come here it seems just natural for them to keep doing that. I think in that sense it is easier for women to adapt.*

These views are confirmed by the women's own descriptions of themselves and

their handling of events that emerged in the individual interviews.  Another example of

the practical and adaptable approach to new situations can be found in the use of police

services for situations of domestic violence.  In spite of the fact that previous experiences

with police forces in the country of origin would be expected to create a situation of

avoidance of police in Canada, the women in fact indicate that they utilize the police

readily. When questioned about this one of the informants responded:

*Yes, in our country, we were afraid to call the police. But here in Canada, we have learned that we can count on them to help us.*

This demonstrates a readiness to learn new strategies in a new environment even when such strategies are radically different from those used before. Note too that the change in behaviour is not linked to what they are told to do, or what they are "supposed to do", but what they have *learned* is effective. The official story is not convincing, one's own experience is.

## Effects of Characteristics Related to Resilience

While these characteristics facilitate survival and adaptation, they may also have other effects which may be less evident. Many of those working with Salvadorans when they first arrived in Canada, found them suspicious and "paranoid" (Stevens, 1993a). Some of the study participants also described themselves or others in this way. However, rather than see this as a sign of psychological disorder, it can be better understood as an adaptive technique. Experience has taught that it is never safe to take situations at face value, or to trust what you are told. It is wise to be sceptical about the "official story". This is being pragmatic.

Another characteristic observed by some working in refugee settlement was the tendency to hide or distort the facts. This again is linked to experience. There are many versions of the truth; be careful what you share because you do not know how it will be

used. Tell people what it is useful for you to have them believe.

It may also be that characteristics related to resilience may actually lead to a
tendency by both Salvadorans and Canadians to understate some of the cultural
differences between Salvadoran and Canadian culture, as well as the impact of certain
events. As there is often little attachment to past practices, there may be a rapid
accommodation to new demands and situations. (Whatever the new requirements or
expectations are, they will be met). This surface adaptation may mask issues which lay
beneath the surface, and the degree of stress experienced in making such adaptations.

## Summary

The characteristics of resilience, strength and pragmatism have important implications for
the participants' understanding of health conditions and their response to illness,
including use of health care services. As described in the next section, the themes of
resilience and pragmatism are demonstrated throughout the women's health narratives.

# CHAPTER 9: PERCEPTIONS OF HEALTH STATUS

## Definitions of Health

At the beginning of each interview the woman was asked generally about her "health" with no definitions given. Towards the end of the interview the researcher would probe perceptions of a variety of health issues, by referring to emotional/ psychological health, family health or "the health of the community", if these themes had not been raised by the informant.

Most women began talking about their physical health, and often about the health of the family. Many spontaneously raised issues of stress, or other psychological concerns. They also discussed health not only within the context of the individual but also the family and the community. For example, they would often refer to a "healthy family" or an "unhealthy community".

One interesting finding from the interviews was that some of the women distinguished between health (as a positive state) and survival.

> *Oh yeah! I think that a lot of people don't actually understand poverty and um, just when your poor you don't think, I am healthy, I am not healthy, you just think, "I'm alive!"*

> *Hiding, about running from the, you know, to save their lives, nobody thought about health or anything like that. If they were sick they just had the herbal teas and that, and that, um, and didn't care much about health at that time. And that is how it is, life was sort of stressful, but like we didn't, health for us wasn't important at that time.*

## Perceptions of Individual Health Status

The perceptions of health status found among participants of this study are

consistent with what is found in many health related studies; most of the women

interviewed describe themselves as healthy, regardless of their socio-economic

background. This was also their view of themselves as children and younger adults.

> *Well, when I was young, I think my health was good, because I don't remember*
> *too much illness.*

> *(referring to prenatal and early infancy deprivation because of the war) It didn't*
> *affect me that much because I'm pretty healthy, I don't have a lot of problems.*

> *No, a little bit, not very sick, a little bit, a little bit sick. I am grow up, not too*
> *much sick. No, I am strong. I not eat very good, (but) I am very strong.*

> *I consider myself a healthy woman. ...I didn't have any specific system illness, I*
> *don't have. ..And my kids also are healthy.*

> *And during that time, I never had, as far as I'm concerned I was never sick at all,*
> *except..I have a shot wound.*

At one level it might appear surprising, given the intense poverty and lack of

access to preventive and treatment services experienced by poor women, that they do

describe themselves as healthy. However, this can probably be attributed in part to the

"healthy immigrant effect". All of the poorer women interviewed described having to

flee their home, and live in hiding, or in refugee camps for periods of months or even

years. Not everyone survived, and those that did needed to have both the motivation to

take on a new life, and the ability to pass medical screening tests to get into Canada.

For example the birthing stories of the campesina women in this project all described uncomplicated (and medically unattended births). One woman describes her births as follows:

> *I only remember was just push, like they told me push, like I was so fast, I didn't suffer that much? Was so fast, was only about two hours labour, like with so much contractions, it was for about an hour and the baby was out. I didn't have problems with my labours, but I been like that for all of them.*

Not only did campesina women give birth without medical care, (and were often poorly nourished throughout their pregnancies), but during the war they were often "on the run", or under attack. Those that had complications were unlikely to survive, and so would not be an a position to emigrate to Canada.

Another factor that contributes to this view of self as healthy is the pride taken in being strong, and in surviving. As outlined in Chapter 8: Resilience, most women see themselves as physically and psychologically strong.

One aspect of the interviews was a discussion of women's current, and past illnesses, or other health problems. This discussion elicited accounts of health experiences extending from early childhood to the current time. These experiences covered all phases of their life, from growing up in El Salvador, through the months or years of transition and immigration, to their current life in Manitoba. Both somatic conditions, and psychological conditions were discussed.

## Reported Health Problems: Somatic Complaints

### Health in El Salvador

Reported physiological health problems in El Salvador appeared to be linked to social class. The most common early health memories reported by campesina women are of gastrointestinal illnesses. Diarrhea, dysentery, and "amoebas", were all commonly mentioned. These diseases were clearly explained by the women as being related to polluted water, poor hygiene and lack of health education.

> *I remember that when I was little, a lot of diarrhea, or parasites, worms, we called it there. Stomach ache, caused by these same parasites, I suppose this was because of the absence of running water, the absence of hygiene, right? That could make you sick, because we didn't have running water, but only from pozos (wells, or puddles), and from places where the water was very dirty.*

> *From the river at that time, we just went and get water (from) the river....And I think that was the main reason, was we didn't boil the water or anything, it was just like that....And that time there is mangoes like on the side of the street, and they fell down, and like messy road and all that, and like that and we just pick one up and eat it, like as a child I remember doing that.*

Death of the ill and the young was a fact of life among the poor. Two women described the deaths of their children due to malnutrition and gastrointestinal illness. Others mentioned siblings who had died in infancy or childhood.

> *Like my two youngest, one brother and one sister, they died when they were very small, of diarrhea and vomit(ing), from that they died.*

> *I was at work and my mum, she was supposed to take care he, but when I took to the doctor they say is infection of the stomach. It was Sunday, because I have to work, and like I have to work, cleaning the house, like employ here, I need somebody stay with me, cleaning, take care, cook, everything. And I can get a permis(sion) every weekend, in the weekend to go home, see my mum. And I went to the doctor Sunday, he died there. It was too late, he say. He was very big, because I buy the box for one years old.. and he can't, like, you know almost*

*scared it was too small.. He was white..... They say maybe the milk or something.*

Pan American Health Organization (1990) statistics from the 1980's indicate that over 60% of infant mortality was related to infectious diseases, and one study reported that up to 40% of children under the age of five suffered diarrhea in the previous month. Diarrhea in this age group accounted for 31% of deaths. The five leading causes of death in children under the age of five were intestinal infections, respiratory infections, measles, nutritional deficiencies and accidents. The five leading causes of death in those 5 to 9 year old were accidents, intestinal infections, measles, violence, and influenza and pneumonia.

*"Paludismo"* (malaria) or other febrile diseases were also commonly mentioned. Some described respiratory problems. Other commonly reported health concerns were dental problems, and headaches. Menstrual problems were commonly reported by young adulthood, as was *"gastritis"*.

Women from middle class backgrounds or above described a very different situation both in terms of their memories of their health as children, and of access to health care.

> *Yeah, I had flu, colds, nothing serious. And it was treated, this is maybe something unusual, but my father, as soon as we were born, he got us a doctor. And in Canada you take for granted you have a family doctor, you have a paediatrician, and blah, blah, blah. In El Salvador if you don't have money to pay, you don't have it, that service, so for my father was very important for us to have a doctor. We did the regular checkups, we had all the vaccinations.*

Gastrointestinal illness was not an important health memory of those from professional families. Often the prevalence of gastrointestinal diseases was mentioned, usually accompanied by a discussion of why this was not a common concern in woman's family.

> *Most of the time when we get sick, lets say uh, because in my country as you know, most people have gastrointestinal problems, infections. We didn't exactly.*

Given the differing access to safe water and sanitation, and the crowded living situations of the poor, this may in fact represent an actual epidemiological difference. While 39% of the population had ready access to drinking water, most of these were urban dwellers. Only 11% of rural population had sewage services, while 23% of the urban population did (Pan American Health Organization, 1990).

However, reproductive health concerns, as well as gastritis were also raised by middle class and professional women.

## Health During Flight and Migration

The differences in types of health problems reported continued to be linked to social class through the period of flight and immigration. This was due in part to the lack of protection and resources provided to the poor. Unlike more privileged families, who could often arrange transport out of the country and financial support while living in exile, poorer women often had to flee on foot and were often destitute. The uprooting, first in home country then in countries of asylum, had a number of health effects: shortage

of food and water, long journeys on foot, no access to medical care, no home, crowded

conditions in refugee camps, and many psychological effects related to flight, including

being undocumented in country of first asylum. Many were forced to live in even less

healthy conditions than they had experienced in El Salvador. Malnutrition was a major

concern.

> *No, this is, my daughter in Honduras, yeah, very stomach, big stomach ... at refugee camp there. Big stomach, very white, very sick.....Is going for nutrition, is giving eggs, milk.*

Refugees also continued to suffer violence. One woman showed me a large scar on her

head which resulted from an attack in a refugee camp.

Other health effects were less dramatic. Many rural families had to adjust to life

in the cities which was found to be both more polluted, and more stressful.

> *Because in the city there is more population than in the villages, and so everything is more contaminated, like it's a different, even you suffer more from all that, we had to live in a very small apartment. I shouldn't even call it an apartment it was just a room. A very small room that only two beds would fit there. And that made a big change for us. And it was very crowded there, and I felt more, because we were hiding and all that from, for us it was more mentally, uh, for me is stressful because of the small room, and the city and the stress.*

> *But when we came to Mexico, we start to realize that we were more into problems like headaches, stomach problems, and smoke in the city. Like you wake up in the morning and your nose was smoke like. For seven months, we were like right downtown, and it wasn't, well I just didn't like it, but we couldn't go anywhere else.*

Access to health services was also extremely limited for most. However, those who were

better off, especially if they left El Salvador towards the end of the war, were often able to

travel directly from El Salvador to Canada. The main impact on health reported by these

families was the psychological stress of waiting for immigration approval.

## Perceptions of Current Health Status

In the interviews, women discussed a wide range of health conditions. Many of the poorer women reported difficulties with their teeth due to poor dental care in their country of origin. Problems with gall bladder were perceived by the women's focus group to be common, not in El Salvador, but in Canada. (This led the group to look for possible explanations - stress and food were seen as the most likely causes). Some women had been told that diabetes was common, but lacking direct experience indicated that they were not sure if this was true.

However, only three categories of physical health problems were mentioned with any frequency. These three areas were headaches, reproductive health concerns, and "gastritis".

### Headaches

Headaches were commonly reported both in El Salvador and in Canada, beginning with adolescence. Many different reasons were given for this; some of these reasons were linked to physical causes (e.g. heat from the sun), and others to emotional causes. In Canada, headaches were often believed to be associated with stress and worry. Difficult situations were often described as a "headache", as they are by many of those born in Canada.

Reproductive Health Concerns

Most of the women interviewed reported that they suffered from one or more reproductive health problems. This is not an unusual finding in women's health research, however the number of concerns among a generally young and healthy population was notable. These difficulties were not discussed in the women's focus group, perhaps because they were seen as more private. In the interviews reproductive health and childbirth experiences were described in detail.

Menstrual irregularities, menstrual pain, and heavy bleeding were reported by several, and seen as common. Unplanned pregnancies, both in Canada and El Salvador were also commonly reported. Gynaecological conditions requiring surgery were reported by four women, and complications of pregnancy and childbirth (including caesarean births) by five. Caesarean births were commonly reported by those who had given birth in hospitals in El Salvador. Other reproductive health conditions included sexual abuse, rape, and pelvic and vaginal infection.

The frequency with which such problems are reported, in a group of women who generally consider themselves healthy, may require further investigation. Sometimes there were explanations given for the difficulties; these included a range of possible causes. One woman suggested that menstrual difficulties were seen as normal, and that women expected to have pain. Lack of access to medical resources in childbirth, and the aging process were also mentioned. It was also suggested that childbearing difficulties

could be linked to stress, particularly the stress of "*la situacion*".

> *But most people, for example they delivered earlier than the date due. Because of too many problems or too much pressure on them, they delivered earlier. I remember some people that they said, "I don't know what happened but I was just, uh, devastated for some specific problem because of the war."*

Some women linked reproductive health complaints to sexual victimization,

particularly experiences of child sexual abuse. For example, during the feedback phase,

when asked why she thought there were so many reported reproductive health complaints

among women in the community, one woman replied, "*I don't know about other people,*

*but I think for me it was because I was raped as a child.*" This had not been disclosed in

the initial interviews. It is not possible to speculate to what degree sexual victimization

may play a role in the high level of reported difficulty. However, sexual assault, common

in war environments, (Allodi, et al., 1985; Domovitch, Berger, Wawer, Etlin &

Marshall, 1984; Goldfeld et al., 1988) and sexual abuse (Lechner, Vogel, Garcia-Shelton,

Leichter, & Steibel, 1993) are both linked to subsequent reproductive system complaints .

## Gastritis

One of the mostly common physical complaints reported by women in the

interviews was "*gastritis*" which appears, from the descriptions of the women, to describe

a symptom complex that involves digestive system pain and discomfort. Some of the

women report diagnoses of gastritis from physicians in El Salvador, although the

symptoms they report vary. However the pain appears to be centred on the stomach.

*I think I have some form of gastritis because I usually have kind of acidity in my stomach, and the liver I think is not working properly.*

*But uh, otherwise, other problems I got gastritis they call it, I had lots of pain there, but some, it went on and on, on and off, but I just took herbal teas and stuff like that, I don't take any treatment. I haven't done it yet, not even here....If I sometimes, once in while I feel it, I just eat something, a candy or fruit or something and it goes away.*

The descriptions given of gastritis are in some ways similar to the condition described by one young woman (who saw a Canadian doctor) as an ulcer.

*But I, when I did come here, I have an ulcer problem? Because um, well uh, I don't know maybe its because I didn't eat, but for a while when I was younger I didn't have breakfast, I just had my lunch at school which was just a sandwich, and juice or anything I could find in the house because it wasn't, I just didn't make it, I didn't bother to make a lunch to bring to school and then there was no time for breakfast. And in the evening I had supper, and that was it, and I had a lot, I was in pain a lot, and so I went to the doctor many times, and he said that's what it was, and that I needed to have regular meals ...and now I don't have that problem any more unless there's some days that I, maybe I don't have time, or I don't eat like until 2:00 and then I feel that it starts to hurt.*

As indicated above, gastritis is believed to be caused mostly by poor eating habits, particularly "not eating when you are supposed to", as well as aggravated by certain foods. Both shortage of food, and poor lifestyle choices could lead to this condition.

*Uh, I, I, well, over there, and I still think that its sometimes we just didn't eat, we just didn't eat properly, or eat on time, because sometimes we had food, but we didn't have time to eat. We weren't at home, or we had to leave, or so, and since I was very young, like that happened most of my life.*

*The thing is that we probably have not an organized schedule to take our meals, and the hydrochloric acid in our stomach raise probably too much so that produces some kind of disorder. (Acidic condition) that's what it means, yes, yes, yeah, yeah. Or if they're drinking a lot of, lets say, coffee, that is, or if they are drinking a lot of carbonated drinks. ... But you know what, the other thing could be the thing is some people can't eat properly, because lets say for example,*

*(lowers voice) lets say in the poor neighbourhood, people can't eat regularly, and they also produce some kind of acidity in their stomach because they don't have.*

While eating habits were generally the first reason given for gastritis, probing revealed that stress is also recognized as a major contributor to "gastritis". Gastritis is often discussed in the context of *"aflicion"'* (anxiety) particularly the acute anxiety and fear linked to such events as being on the run, bombing, or worry about disappeared relatives. While, through the narratives, *aflicion* was often mentioned in the context of events in El Salvador, it was not used to explain current anxiety in Canada.

> One woman with long standing and serious health concerns talked about the pain in her stomach that was "caused by the war" . This was first described as "aflicion" when she heard the bombing, or battles, *"I feel something here, a little pain, but I didn't put cuidado"* (I didn't take care) The doctor at that time said it was gastritis.

Another woman reports an incident of extreme fear, where the pain was similar to gastritis.

> *The pain. Yes, the same kind.....Was more extreme. Like I just couldn't get up, I fall on the floor, I just couldn't get up, I just went around and around on the floor, twisting myself. The pain was so terrible that I felt tight too? I couldn't breathe? It was so tight and so sore, but I was worried, about my daughter too, because we had left (her), she was 3 months old? ....And I started already feeling that sore a little bit? But when the bombing and that made it worse, I thought maybe (my husband) got killed there. You know, knowing that he was there. ...... (The worry) and the pain too. But before that I had suffered from that pain too. A little bit, not as much. Like now. Like I will feel that sore here, but only if I don't eat properly, or I miss a meal, sometimes I am in a rush doing things? I miss a meal, and then I can feel it. Otherwise I don't. Or if I can't sleep at night. I get that funny feeling in my stomach. But otherwise, I don't have any other problems.*

Other women describe more general forms of stomach distress. One woman , who complained of "*ardor*" (heat) rather than pain, also complained that her breath smelled and she was bringing up "water". It was noted during the interview (also audible on tape) that she was having difficulty with stomach gas. Some women had sought medical care for gastritis - type conditions, but some had not. Herbal remedies were reported as one form of treatment for this condition.

> *I never seen, I never told the doctor about it. What I do is if I feel that, because I know that I have that since back home, it hasn't got any worse, and that's why I haven't even cared about it.*

It is clear from the descriptions of gastritis, that this is a recognized symptom complex which can be explained by either a physiological model (not enough food, or not the right kinds of food, at the right amounts, at the right times) or a stress/anxiety model. Most of the poor would have been at risk from both causes (irregular eating and anxiety).

## Psychological Conditions

Many of the women described themselves as being under great stress, and suffering from worry, fatigue, anxiety and depression. Some reported significant improvement in stress since coming to Canada, and the experience of *aflicion* is no longer found in the narratives. However, both stress and depression continued to be described as ongoing problems many years after arrival.

## Evidence of Post Traumatic Stress

A number of the women described extremely traumatic events, and reported, or

were observed to have one or more symptoms consistent with Post Traumatic Stress.

## Re-experiencing of events

Re-experiencing of the events was commonly reported, either through dreaming,

or intrusive imagery.

> *Yeah, sometimes I have bad dreams.. is coming fire and everyone is running, the earth is fire, corriendo fuego en la tierra, como agua corriendo el* fuego.(Fire was running across the earth like water) *...I wake up, think is real. In the morning I scared, a little shaking, say Is real? .. Very bad dreams sometimes.*

> *Nightmares I had, just after my husband pass away.*

However, in most cases nightmares were described as fading after arrival in Canada,

although dreaming of El Salvador is commonly reported. One woman reported that

dreams had started reoccurring since starting to talk to the researcher.

Intrusive thoughts and feelings were also described by a few women. One women

described her "*sentimientos*" (feelings) as:

> *trying to come up, I pushing them down. ...I am crying, I not support, is coming my crying, my sentimiento, I have many. My crying, is , I push my, not coming up, is coming. I push my feelings down, no, its coming! Yeah. I don't know what happened! What can I do?*

The same woman demonstrated these intrusive flashbacks in the interview, suddenly

breaking down weeping, while describing a jumble of traumatic memories. This is one

section taken from the interview.

*"You no show me your husband, I kill you". I say, "O.k. you kill me for nothing", I say. "You kill me with my children" I say. Finish. I say, "You kill me, kill my children too." I say it. "You kill me for nothing" I say. God, I pray, for God help me. I going at night, 12 o'clock, walking, I don't see my hand...Very dark, I don't see. No house, nobody living. I go in the (mountains), at 12 o'clock, walking, very crazy my head, this a little baby, my baby. ....Because the soldier is, um, I run away, the soldier is following me, running!, I am running, running with my baby, running. I, um, the soldier follow me with the gun, is tirazon, tirando balas por mis pies. Mi corriendo con mi nina. Corriendo, y escondi, in one hole, me escondi en un hoyo, hole? Ellos passaron buscarme asi. I lost 2 children, I lost, I running, my children is lost, stay at another house. I lost my children, I am scared. Only take the one more small, the others got lost.....Very hard. I am running, walking, dark at 12 o'clock, some animal is jumping my body, jumping, jumping, jumping my body ! (with hands moves hands from one side to the other).*

Note how disjointed the description is and how, under stress the woman switches back and forth between Spanish and English.

There was also evidence in some cases of intense distress when exposed to events which were reminders of the traumatic events.

*That I am afraid of the dark is because of that, I know. Because before that I was never afraid of the dark, before I was in jail. But.. for 6 days. Dark, dark, no light at all, very dark. ..And since then I am scared, even in the washroom here, I leave the door open if I am alone. ....And the windows, is the first thing that I do in the morning is open all the curtains, even in my bedroom, my blinds are wide open. All the time. I like light in my room. So I am afraid, and I feel like it is from before. I am scared, I don't know, I haven't got over it. I haven't got any counselling or anything but I feel like it is because of that. I get panic, I don't know why, I get panic.*

## Increased Arousal

Features of increased arousal were also commonly observed, or reported.

Difficulty in concentrating and focusing was reported by a few women; this was

particularly linked to the experience of aerial bombing. Difficulties in learning English were also linked to the bombing. Hypervigilance can be commonly observed in the Canadian Salvadoran population, as well as exaggerated startle responses. Often the woman's descriptions of traumatic events were accompanied by physiological reactions such as flushing, trembling, or tics. One woman reported on-going problems with dizziness, and disorientation saying

*I am going to work and say, "Where am I ? , What street is this?" I don't know.*

## Avoidance and Numbing

There was however, no evidence of numbing of responsiveness in this sample. Emotional reactions were strong and appropriate to the situations being described. Many women cried through much of the interview.

There was some indication of avoidance of certain situations. In one instance the researcher was made aware of an event where a family was being approached socially by an individual who appeared to be "on the other side" during the war. This was enough to trigger severe anxiety, and resulted in active efforts to avoid further contact.

## Usefulness of "Post Traumatic Stress Disorder" Diagnoses

While the women reported these symptoms as distressing and often displayed (and verbalized) a great deal of grief in recalling past events, they also portrayed understanding of these symptoms as normal in the context in which they occurred. They did not see

them as pathological, had not reported them to the health care providers, or feel that treatment is needed. Bessel, van der Kolk and McFarlane (1996) observe that "as long as they can make meaning out of the trauma, victims often experience the symptoms of PTSD as natural reactions that do not require professional help" (p. 16). The attitude of participants that such symptoms were normal to events experienced, and the women's stated ability to cope with them, indicate that using a framework such as PTSD, or recommending psychiatric treatment may not be that useful for most. The women felt that such symptoms were decreasing with time, and with the exception of one (or perhaps two) individuals, there was no evidence that such symptoms were affecting their ability to function. Of concern however, is the fact that one woman was continuing to suffer a great deal from symptoms and did not appear to be obtaining relief through the medical system. She had suffered severe trauma, reported all of the above symptoms, and expressed concern that some of her symptoms might cause her to be unable to work.

## Current Reporting of Stress and Depression

Stress over current events (family problems, difficulties in adaptation, social isolation and community tension) were reported as being the source of more psychological distress than past trauma.

A number of women described themselves as being depressed in Canada. Seven to seventeen years after arrival, the women continued to speak of great struggles with depression. Some of this is related to the ongoing stress of adaptation. One woman

described the greatest contributor to stress for her was:

> ... *having to leave the country where you are born. For me it is like one has died, but then is born in another country, but older, where one has no history, friends, culture. To accept that situation is very difficult. It is like being in denial about accepting the need to adapt. Then to be in constant denial leads to depression.*

This depression can be acute:

> *I suffered from depression for two years to the extent of wanting to kill myself. No one knew that I was sick for two years. ..Depression is pain. A pain that is aggravated by every single thing. It is caused by many things. I started to work six months after my arrival and I have been working at the same place for 12 years now. At that time I used to say there are enough jobs, I don't have problems in my home, I am happy with my family, you see? But it is not only that. There are many things that affect us.... ..It is a suffocation that one feels that leaves you on the edge. It feels like your head is going to explode. Every little thing makes you get angry, frustrated, despairing. If someone says something, then it bothers you. But I insist that this is the situation we are in here. Everything effects you.*

Some of this depression appears to be related to ongoing grief regarding separation from

family and friends.

> *They die, we won't ever see them anymore. I for example, am planning to go El Salvador, because the people I have there are very important to me. And last week my uncle passed away. He was one of the main reasons why I wanted to go, and what happened? Because I was here, I never saw him again, and then that is a wound that cannot be healed, and that starts affecting me. Our (children) will never have the relationship with our cousins, and our friends.*

> *I think I feeling depressed. Because for my friends, all my friends stay in my country, and I stay here, alone. Sometimes even now, I feel lonely. Because sometimes I can't explain, or I don't have anyone I can tell what happened to me, or how am I feeling. I don't have anyone. I don't have friends, I don't have nobody.*

For this community, such separation appears as a state of extended grieving.

There also continues to be anxiety about those left behind. It is to be expected that

refugees experience a great deal of stress about those they have left behind when the country is in a state of chaos and war. What may come as a surprise however, is the fact that many individuals continue to feel stress, even at this time, seven years following the signing of the Peace Accord. Much of this appears to be due to economic worries. Many continue to provide economic support to families still in El Salvador. One woman described the stress caused by a phone call from her sister asking for money (this was a year of drought and food was very expensive). In the focus group another commented:

> *I mean financially, here no one is really in need. On the other hand, in our country, people are dying of starvation. Literally.*

### Relationship Between Physical and Emotional Health

It is interesting to note that although generally women describe themselves as healthy, a number of women clearly differentiated between their perceptions of physical and psychological health. In the women's focus group, the first woman to respond to the question regarding the health of Salvadoran women in Winnipeg states:

> *How healthy? Well, in my particular case I believe that physically I consider myself as a healthy woman. However, the fact is, all the changes, the adaptation, and coming to a strange country, makes me feel sick.*

Others also rated their psychological and physical health differently.

> *I think it's (my health) good. Emotional, psychological, I think it's sensitive. Yeah, it is. Because sometimes for any reason, I start crying.*

That psychological health can be rated separately from physical health suggests that one can be sick, without having any underlying organic cause. Another woman says

she knows she is healthy because she has had all the tests (an objective measure).

At the same time as the women differentiate between emotional and physical health

status, they see emotional/psychological health and bodily states as closely interrelated.

In particular they describe stress, loss and depression as impacting physical health.

<u>Evidence of Somatization</u>

Somatization has been defined as "the selective perception and focus on the

somatic manifestations of depression, with denial or minimization of the affective and

cognitive changes" (Katon, Kleinman & Rosen, 1982, p. 127). The term is used in

different ways: to describe medically unexplained somatic symptoms, to describe

hypochondriacal worry or preoccupation, or to describe somatic clinical presentations of

affective, anxiety or other psychiatric diseases (Kirmayer & Young, 1998). Somatic

symptoms are considered the most common clinical expression of emotion distress, and

are found in all cultures.

This study found that women described a clear link between psychological

distress and bodily complaints. The condition of gastritis, for example, recognizes stress

and anxiety as a cause of the condition. Descriptions of psychological distress often

referred to somatic effects or utilized somatic imagery, such as the ones that follow:

> *The fact is, all the changes, the adaptation, and coming to a strange country
> makes me sick. However...as the years pass by, I think I am adapting. All my
> maladies are gone.*

> *We don't have more friends other than the few people that were here already, and*

*they are only friends by telephone. This creates a barrier and one starts to suffer from headaches, aches and pains. ...So we suffer a great deal here, and our emotions influence us, and one catches pains that may not even exist.*

*Seems to me that in the moments of enjoyment or happiness, nobody has pains or aches. That reaffirms once more that we are healthy, but not emotionally.*

*Most of the pains and problems are imaginary in relation to our emotional state. Not all of the pains, but most of them are imaginary.*

*Children no longer respond in a loving manner as they did in El Salvador...This is like a big blow in the stomach to all parents...*

The clear link that the women described between their emotional state and bodily symptoms confirms the observation that many of those who present with somatic symptoms are capable of acknowledging psychosocial causes for their symptoms (Kirmayer & Young, 1998). The study participants showed a great deal of insight into the link between emotional states and resulting somatic symptoms, which they described as natural. Notably absent from the narratives was any indication of dualism. Rather, the women expected that when one was anxious or depressed, one would also have somatic symptoms. The mind, the emotions, and the body are all one. The somatic experiencing of pain, for these informants, is clearly not accompanied by either denial, or minimization of the affective or cognitive aspects of their depression and stress.

Kirmayer and Young (1998) critique somatization as" a concept that reflects the dualism inherent in a Western cultural ideology of the person", and inappropriately differentiates between objective evidence of disease and the patients subjective reports of distress (p. 427). This study suggests that somatization is not a particularly useful

concept for explaining the women's experience of the relationship between psychological states and somatic symptoms.

<u>Knowing and Not Knowing</u>

The theme of *knowing and not knowing* occurred and reoccurred in many of the interviews, and many of the transcripts included so far indicate expressions such as *"I don't know"* used in discussions of health.

*Knowing and not knowing* is an important theme in coming to understand, and accept, health problems, and is linked to suspicion about whether advice can be trusted (distrust of *the official story*). In spite of generally high satisfaction with services in Canada, when participants described interactions with the health system, a common story line emerged, which went something like this:

*I was sick/I had this symptom/I knew (or suspected) something was wrong.*

*I went to the doctor and he didn't think it was serious/he said nothing was wrong*

*I continued to have symptoms/I knew there was something wrong (even though I was told differently)*

*I persisted/I went back/I saw another doctor*

*Finally someone (the same provider/another provider) recognized that there was something wrong*

*I was vindicated. (I suspected, now I know).*

This story line is very similar to some of the stories told of life in El Salvador, and suggests that this non-trusting world view (which proved to be very functional in that

situation) is now being applied to a variety of other life experiences.

The relationship between emotional/psychological health and physiological health is also linked to the theme of *Knowing and Not knowing*. People may look healthy, but may not be as they seem. One woman illustrates this in her comment:

> *You can see all these people here, we look at each other and we might look healthy, we are all happy, right? But we don't know anything.*

## Family and Community Health

The family, and the community, are entities that can also be healthy or unhealthy. The narratives suggest that family is the centre of one's life and that if there is dysfunction in the family, one cannot be well. As indicated earlier in Chapter 3, the mother is seen as central to the health of the family, with responsibilities both for the health (physical and psychological) of individual family members, and for the overall health of the family unit. Women often focus more on the health of their children or other family members than on their own health. These expectations were recognized by some as a source of stress.

> *Because what happens is, women are so busy doing so many things. That they don't really know what is going on with their bodies or their mental health, sometimes we don't have the time to do this. They don't have the time to do that. So, having your health diminished a great deal is something that we don't really see, and there is a point where women just can't manage it anymore. So, I guess in that way it affects the life and health of women, physically and mentally. (focus group)*

There was agreement expressed with this statement. Another stated:

> *It may be because of the roles they have because women have to take care of their house, their families and I think is one of the things that happen because we don't have time to think about what is happen around us, we just have to accommodate*

*everything for everyone else instead of taking time to be thinking on what's happening.*

As "family" means extended family, women may find themselves responsible for a large number of people. Some are providing care for family members here (parents, siblings, or nephews/nieces), and also worrying about (and seeking resources for) family in El Salvador. This is a particular stress on poorer women, as those from professional families may have other family members who can share the responsibility.

There was evidence that some women are continuing to cope with extremely difficult issues within the family. Family rejection, domestic violence, alcohol abuse, and the ongoing psychological difficulties experienced by men and children in their families continued to be key concerns for many of the women interviewed. If the women appeared to be coping fairly well with issues of "post - traumatic stress" it is not clear that the men in their families were doing so. Perhaps of even greater concern are problems or fears related to one's children, and to the youth of the community.

Disruption in other social relationships was also linked to ill health. This view that social contact was crucial to health, and that isolation contributed to health difficulties was consistent with the importance placed on community in the lives of the women. The life narratives showed a clear understanding that "health problems have social consequences and often social roots; social problems have health consequences and sometimes health origins" (Kleinman & Becker, 1998). As discussed in the chapter on

community, women continued to experience distress because of negative dynamics within the Salvadoran community, and alienation from the "mainstream" of Canadian life.

## Summary

The women interviewed utilized a broad definition of health which included the health of the individual, the family unit and the larger community. Somatic symptoms and psychological concerns are seen to be clearly interrelated and a great deal of insight is shown in recognizing the effects of anxiety and depression on perceptions of physical well being. At the same time women are able to differentiate between psychological and physiological health and rate themselves differently on the two measures.

Headaches, reproductive health concerns and gastritis are among the most commonly reported health problems. Both anxiety and depression are commonly reported psychological concerns; both conditions are seen to be "reality - based" in that they are normal reactions to significant life events. Some of the women report, or demonstrate symptoms consistent with, Post Traumatic Stress Disorder, however in general they attribute less importance to past trauma than to current adaptation or family issues. Separation from family and the stress of adaptation continue to have an important impact on health.

Health is also understood to be linked to the social environment. Disharmony (within the family or social network) are linked to distress, and to somatic symptoms.

# CHAPTER 10: DETERMINANTS OF HEALTH AND CAUSES OF ILLNESS

This chapter provides an overview of the factors that women who participated in the study found to be important in maintaining health, and avoiding health problems.

In many ways, the women show understanding of what we would describe as the determinants of health. However, they also include other causal and protective factors which are not found in the commonly accepted Determinants of Health framework. In addition, some of the determinants of health are considered of less importance, or it is believed that they can be "overridden" by other factors.

This section first outlines the study findings under the standard headings of the Determinants of Health framework (Federal, Provincial and Territorial Advisory Committee on Population Health, 1994). This is used as a convenient framework for organizing the study findings, but the intent is not to propose this model as representative of the women's views.

## Determinants of Health

### Income and Social Status

Income and social status are clearly understood by women from all socio-economic levels to among the most important determinants of health. The life experience of the women has taught them that not only health, but access to the most

basic necessities of life often depend on socio-economic status. *"La Pobreza "* (poverty) is understood as a key health determinant. *"La represion"* (repression) is another factor which is related to income and social status. Money and social position could also provide protection of individual rights, and safety from violence. The effects of repression were experienced by, and therefore explained more clearly by, poorer, or more politically active women.

This study also indicated that a drop in social position in itself can also be linked to decreased health status. Those from professional backgrounds in El Salvador who found themselves in reduced circumstances here, experienced a great deal of stress, which was often described as having a negative impact on health.

## Social Support Networks

Social support was perceived to be a critical factor in health, if not the most critical factor. Individual health was most often described within the context of, and determined by, the family and the social network. Family was described as the key source of such support, and having a supportive family probably the most important factor in health from the perspective of women themselves. Rejection or abandonment by the family was described as an important cause of psychological ill health.

Families are also the support to health education and positive lifestyle choices. Where individuals were able to remain healthy in an unhealthy environment is was

generally the family which enabled this to happen.

The absence of perceived support and safety within the Salvadoran community in Winnipeg, and isolation from the larger Canadian community is also understood to negatively affect health.

> *We don't have more friends other than the few people that were here already, and they are only friends by telephone. This creates a barrier and one starts to suffer from headaches, aches and pains, etc.*

> *Yes, I think that one thing is very important, I think that what helps, is when we gather and also have a joyful spirit, that we coexist.... I mean live together the celebrations, something to distract from our afflictions.. With the same people that we coexist, distracting our minds from our problems, right? Even our physical pains in the legs, in the arms, our back, stop, and one is happy.*

Social support however is more than a determinant of health. As indicated in the previous chapter, health and illness are understood in the context of social relations, and one's social support groups (family and community) may also be healthy or unhealthy.

The importance of social interaction is also expressed in the value placed on "talking" and socializing (this concept is explored as a coping technique in Chapter 13). Those issues that can be talked about cause less distress than those that cannot. For example, there is evidence from this study that domestic violence can be talked about within the social network, but sexual abuse cannot. Similarly, individuals from the Salvadoran community can come together and talk about the stress of adaptation, however, there is less safety in talking about wartime losses and trauma.

## Education

Education is valued in large part because it is understood to be linked to employment and income. However, it is understood to be more than this. Families are also seen as the key source of education. A badly behaved person is often referred to as *"maleducado"*, or badly brought up. Lack of education *(La ignorancia)* is also understood to be the cause of a number of social problems. In explaining why her husband beat her, one woman gave this explanation

> *Pero como uno no entiende, verdad, ni mi esposo, el bien ignorante tambien. (Because one didn't understand right? Neither my husband, he was very ignorant too.)*

Education is not limited to that provided through the formal educational system. Wisdom accumulated through life experience is valued, as is education that occurs outside of the formal system (as in popular education, or political education). In some cases "official" education campaigns, particularly those promoted by government, may be treated with distrust.

## Employment and Working Conditions

Employment was understood as beneficial to health, not only because it provided income, but because it had psychological benefits, particularly by providing contacts for socializing, and enabling one to "keep busy" and distracted from problems. The frustration experienced by many professionals in not being able to obtain employment at the level of their training and experience was understood to have a detrimental effect on health, as were barriers to advancement due to language difficulties and discrimination.

## Physical Environments

The most serious risk to health in the experience of the study participants was
seen as that of repression and violence. El Salvador was seen as unhealthy both because
of the war and the level of societal violence. The Manitoba community came into
existence because of armed conflict, and most all of the study participants had lost family
members and friends due to war. Society provides the setting in which violence is
discouraged, or allowed to occur.

> *My dad was wounded by a man that he said he was defending the government.*
> *He was drunk and he was trying to kill my father. He was in the church in front of*
> *50 children. .... with a machete, he hit him, he still has the scar on his arm, yes.*
> *ah, but the parents (of the children) came and helped him, and took him out and*
> *they sent him to the hospital. He almost died.*

As discussed in the previous chapter on Perceptions of Health, the trauma of war
was seen to have a severe impact not only on physical, but also on psychological health.
The particular form of violence experienced in El Salvador is understood to impact other
determinants of health: it exacerbates poverty, and destroys social networks (and the trust
needed to participate in them). It also has an effect on education both at the societal
level (by destroying schools and killing teachers) but also at the individual level. For
example two women identify the bombing to which they were exposed as a source of
difficulty in language learning.

Both poorer and more privileged women pointed to environmental factors in
health. Those from poor families described environmental conditions that led to disease.

As indicated earlier, some of the women identified the link between diarrhea and

intestinal parasites, and lack of access to clean water. Another describes increasing

illness after she moved to the city:

> *Because in the city there is more population than in the villages, and so*
> *everything is more contaminated.*

As well, more privileged women listed such factors as access to clean water, proper diet,

and properly prepared food as factors influencing their health. Environmental factors are

also understood to contribute to psychological distress.

> *And it was very crowded there, and I felt more, because we were hiding and all*
> *that, for, for us it was mentally, for me is more stressful because of the small room*
> *and the stress.*

Physical heat or cold could affect health.

> *Sometimes one can catch some illness here that in our home country we never*
> *had. For example, not long ago, in February, I developed bronchitis. In my*
> *country I never had this kind of illness. It is only logical because the climate is*
> *completely different.*

However, even during the course of the discussion this woman expands the list of other

possible environmental causes.

> *What I'm talking about is that in my country I experienced some kinds of flu. I*
> *treated it, got cured, and I was fine again. I did not suffer any more until one or*
> *two years later. On the other hand, here I am definitely aware that every winter*
> *I'll get the flu. Now that I got bronchitis, I was scared because of the job I have.*
> *It requires me to be in contact with so much dust, to be close to paint, chemicals*
> *etc.*

Both narrative excepts (which indicate an early emphasis on washing of hands,

and of food), and observations of homes in both El Salvador and Winnipeg indicate that

cleanliness is highly valued, and linked to increased health status. A dirty house, or unkempt children are considered a sign not of material poverty, but of parenting failure.

## Biology and Genetic Endowment

Genetics were not described as an important factor in disease. As mentioned earlier, most of the women interviewed described themselves as healthy, and strong. They did not describe health problems as due to inherited causes, pointing instead to environmental, psychosocial or supernatural causes. Strikingly absent from description of causes of ill health were statements that indicated that certain problems ran in families, or that other relatives had a certain disease or resistance. However, one woman who did not see herself as healthy described the cause of her problems simply as *"algo funcionando mal"* (something isn't working right). This was the only such mention.

Some health problems are seen as a natural part of aging. This arose most clearly in the women's focus group. *"Of course if we pass the 'enta' we have to face health problems"* one woman said. (Beginning with age 30, the numbers in Spanish end with the suffix 'enta', ie. treinta (30), cuarenta (40), cincuenta (50). This view was reinforced by others in the focus group. Age in itself was felt to be some of the explanation for increased health problems in Canada, and the women returned to this theme, with comments such as these: *"I am also aware that it is not the same to be twenty years of age as forty. It is completely different."* or *"It is not the same, like when one is young. With age, everything gets worse."*

Gender is also seen a factor in health. However, in general, being female was seen as a benefit in that women were viewed as emotionally stronger and more adaptable than men, and so able to cope better.

### Personal Health Practices and Coping Skills

Lifestyle choices were also seen as of crucial importance in maintaining health. Poorer women in particular identified proper diet as key to health. In discussing why she felt healthier in Canada, one woman stated:

> *Because I drink a lot of milk, I drink whatever is good for me. I keep milk, fruit the good one. Whatever I don't have in my country, I keeping that for my daughter, has eat it. ..I say, I going to die one day, I not going to die because I am hungry. No.*
>
> *I um, I used to exercise more, I don't do it now, I don't feel like it. But I walk, and I drink lots of water, lots of water. We eat, most of the food is from my country, like we don't eat much bread, we eat tortillas, which we think is healthier because it doesn't have oil? We just use water and the corn? We mix that and we make the tortillas. We make them at home, we don't buy them ready made. Every day we make tortillas, and fresh fruit we eat. We don't eat canned food, very rare we do, but not as a regular, and I find that that way even the kids are healthy. My children don't have very many problems, like health problems, stomach problems or any other big problems. Yeah.*

Even those who suggested they were not eating as healthily as they should, were well aware of the importance of nutrition.

> *I don't eat a lot of healthy food. I eat a lot of fruits because my mum makes sure there is fruit around the house and uh, but I eat a lot of junk food, chips, chocolate bars, and pop and things like that at school, for lunch like. I always bring a pear or apple, or an orange or something like that, and then just a sandwich, and at school I buy a chocolate bar, or chips or something like that, for a snack. And I know I should be eating healthier, sometimes I feel that yah I should, not totally stop eating junk food because I know that would be impossible, but just start to eat healthier foods, and just eat my foods on time. Because*

*sometimes when I'm not hungry I don't eat, and then I even if its time to eat, like sometimes I just don't have supper because I just don't feel hungry, and then I think, no, I should have because its not right, I should be eating my meals, and things like that.*

As indicated in the section on "Gastritis" in the previous chapter, improper eating habits, along with inadequate food were understood to cause digestive problems.

*A stomach ache, it was common, like after eat, its because you didn't eat too much, or because you didn't eat, or because you ate too much (laughs).*

While being adequately nourished is the main concern, and the women who raised this issue all expressed a clear understanding of which foods were healthy, and which not, there were some *potential* risks seen to nutrition in Canada.

*It is important to keep eating the same kind of foods we are used to. For example, there are always beans at my table. I don't feel complete if I don't eat beans; I feel it is like a need. The body needs it. It asks for a certain type of food, food that we miss.*

*I know at least four women who were operated on the same year because of gall bladder. Like it was a fashion around here. ..it may be the type of food that we eat? Or what could it be? Because it was happening very often. I said, "this is an epidemic. We have to ask what they eat, because I don't know."*

However, it is not clear whether the concern about eating different foods is related to the actual food itself, or to the belief that change can have a negative effect on health.

Only two women mentioned any concern about their weight. One identified stress as the cause of excessive weight gain. Another was a woman who had been raised since early childhood in Canada; she was able to identify this as a cultural difference.

*And I know I worry a lot about my weight, and sometimes I feel like I'm really fat,*

*and then my mum's like "No you're actually skinny", but I know that like, especially at this age, I think, I worry a lot about my weight, but there's really nothing I do about it, which really bugs, actually it bugs myself, because I'm always complaining, "Oh, I'm fat, this doesn't fit me, but I don't do anything about it. And I don't really know why, its just ..... I don't, its just here the standards of who's pretty, or who the models and the media, just everything is so different from there, because I know this summer when we went (to El Salvador), like I don't remember from when I was young, but in the summer when we went, it wasn't like, people don't really notice that kind of thing there? They don't notice, they notice that you're fat or that your skinny, you're , its , maybe its just the people I was with because they were my family, but it just doesn't seem that big of a deal. And I'm sure it is to some people but it just didn't seem like it. And here its so..if you're not skinny, you're not pretty, sort of thing.*

The women also expressed strong opinions on other lifestyle choices. Drinking, smoking, or taking too much medicine were not viewed as healthy.

*I don't drink, I don't smoke. I don't like to drink medicine, because I said that, I don't know what reaction I can have.*

Exercise was not usually mentioned as a health maintenance factor, although work was.

## Healthy Child Development

There was some ambivalence expressed regarding the importance attributed to healthy child development as a factor in current health. The emotional effects of being raised by caring or neglectful parents are generally accepted. Although the participants understood the theoretical importance of prenatal and child nutrition, they did not feel that these factors necessarily had damaging effects. Some of the women, after discussing the experiences they had been exposed to while pregnant or while parenting young children, would then point to their children and claim they were fine. One woman who

was both malnourished in pregnancy, and did not have enough food to feed her children

when they were young comments:

> *One of my thoughts that makes me happy is when I observe my children and I can not find any abnormalities. Right? They are studying, I see that they are doing well in school, that their minds are functioning well.*

One young woman who talked about what she had learned in school stated:

> *(My mother) went through hard, a lot of hardships while she was pregnant, sometimes she didn't eat as much as she should have eaten because, um, there were a lot of nutrition factors that, ah, that would make a baby healthy and I know that a lot of, a lot of the food that should have been eaten, and the kind of medical care that she should have gotten while she was pregnant was not, was uh, not there, she didn't have it and uh as I was, when I was young she only breastfed me for like, I don't know, about 3 months, something like that. For a little while, it wasn't a very long time. And when I was young also , I don't think I got the nutrition, the food and stuff, that I should have gotten, but I think that I'm not, I'm not (pause, some amusement) sick. It didn't affect me that much because I'm pretty healthy.*

There also appeared to be some ambivalence about the impact of violence and

disruption on the psychological health of children. Better educated parents talked openly

about the negative effects of a decreased standard of living, and the stress of immigration

on their children. On the other hand those whose children were exposed to more direct

trauma in El Salvador sometimes appeared to minimize the effect this would have on

their children.

> *In a way they were more like normal. Maybe became normal once you are in a refugee camp and see that many children like that. In the beginning it was hard but then they feel that's normal, like every kid is there and even if they come shooting they just go hide under the beds, and it becomes normal.*

These findings are consistent with the findings of Rousseau et al (1997), who found that

parents were generally likely to minimize the impact of trauma on the lives of their children. This tendency was confirmed by the discrepancy found in this study between the women's recognition of impact of the war on the life of the community (including youth) in general, and the impact on their own children.

## Health Services

Poorer women were acutely aware that absence of health care services was a potential cause of cause of later problems. This was most apparent in the case of dental problems, which were commonly mentioned. Another example was offered by this woman, who suffered a prolapse of the uterus and hysterectomy here in Canada:

> *I believe that this is because when my children were born, I pushed too hard, and before it was the right time. Because when I had my children I didn't have anyone, I could not go to the hospital. Then, one uses too much force for that. I suppose that is why that was falling out and I did not recover until I had the operation.*

Lack of medical care in their experience is linked not only with decreased health status, but with disability and death. In contrast, some of the women indicated that modern medicine itself could contribute to health problems.

> *The kidney stones are caused by too much medicine I think, at least that is the reason my friend needed to be operated on here. It seems that some medicine was producing the stones as she had an take of 40 pills a day.*

## Classification of Factors Identified by Informants

Table 1 classifies the factors identified by informants according to the categories outlined in the Determinants of Health model (Federal, Provincial and Territorial

Advisory Committee, 1994). Most of the factors have been discussed in this chapter.

The variety of personal coping techniques reported by informants is discussed in Chapter

11: Coping Strategies.

Table 1

Classification of reported factors according to Determinants of Health

| Determinant | Factors reported in interviews and focus groups |
|---|---|
| Income and Social Status | *La Pobreza* (Poverty), *La Repression*, (repression), social class, drop in social status in Canada |
| Social Support networks | +Family, friends<br>-Loss of family friends, community<br>- polarization and mistrust |
| Education | *La ignorancia*, access to education, family education, political education |
| Employment and Working Conditions | +Income, social contact, distraction,<br>-status inconsistency, discrimination |
| Physical environments | Emphasis on violence - effect on health, education, social supports, environment.<br>Social class, rural/urban differences |
| Biology and Genetic Endowment | Women are stronger<br>Aging<br>Little emphasis on genetic factors |
| Personal health practices and coping skills | Prayer, talking and socializing, working, crying, family (gender linked)<br>Knowledge of health choices<br>Pragmatism |
| Healthy child development | Theoretical but minimized<br>Effects can be overridden by God |
| Health Services | Absence leads to lower health, class linked in El Salvador |

## An Alternative Approach to Exploring Health Determinants

As indicated in the introduction to this chapter, while the Determinants of Health framework described above was used to organize the discussion of the factors study participants felt were important to health, this framework did not best fit their world view. The framework suffers from five limitations in this regard.

Firstly, it fails to include major categories (e.g. spiritual forces, or change/stability) considered by the women to be of prime importance. Secondly, it does not incorporate the dimension of time or immediacy, which emerged as a key factor in explaining current health status. Thirdly, even when the framework allows for inclusion of factors considered important to the study participants, it classifies them in a way that limits understanding of the women's perception of the relationship between factors. For example as the following section explains, "Family" is seen as a key factor which subsumes many other "determinants".

Another limitation is that the standard framework does not allow for expression of perceived *hierarchy* of factors. In the view of participants, certain factors were seen as more important, and could "override" the influence of others. And finally, even where the model does provide a framework for categorizing the women's experiences, it fails to capture an aspect that is often implied throughout the narratives, that of the degree of personal control. For example, repression, or poverty are perceived as powerful social forces, over which an individual has little control. And while women were well aware of

the importance of "lifestyle choices", many of these were not under their control. Understanding the components of a healthy diet for example, did not mean that one had the means to provide it for one's family.

This section provides an alternate model for presenting the views of the study participants regarding important factors in health determination. The main determinants were seen as family, God, immediacy, change and psycho-social factors (particularly stress, trauma and loss).

## Family as a Mediator of Health Status

The theme of "family" as a determinant or moderator of health emerged as a separate, overarching category which included income and social position, social supports, and many of the other determinants such as physical environment. In El Salvador the family social position determined access to resources and was usually included in a description of health status. Family was often a reason given for being healthy, particularly by women from more privileged backgrounds.

> *(Family) gave us all the principle things....helped us with education and with medicine, education, moral education I think I grew up in very healthy environment. Maybe different than, with opportunities, I can tell you like that, with opportunities.*

For poorer women as well, families can control access to the basics of food and health care. One woman described stealing food from home to give to her sister, who

was allowed to go hungry when her husband could not provide for her, because her parents disapproved of the marriage. Family connections to health care providers, as well as family status within the community could also effect the quality of health care received.

Women also discussed their health, particularly psychological health, within the context of the family. Dysfunction within the family was viewed as causing individual illness. For example, in one of the focus group discussions, the stress of feeling that one was losing ones children was described, followed by the comment, *"as a result, parents feel sick"*. Healthy families were described as being complete (including two parents and the extended family), attentive to the physical health needs of its members, and providing of love and support. Of note was the importance attributed to maintaining open communication within the family. The ability of families to talk and confide in each other was described as a key characteristic of family health. As indicated in previous chapters, abuse, neglect or rejection by the family was recognized as a major factor, particulary in psychological health.

For poorer women the family also provided health education and health care. In all families, including middle class and professional families, it was teaching from within the family which helped avoid illness and maintain health. Many of the women gave specific examples.

*We never touch anything without cleaning our hands.*

*We never carry any stuff, any candy, anything because my grandma was always taking care about our teeth. ....We learn that its a bad habit to eat things ...out(side) of the meals*

*Another thing that she always said is we need to drink a lot of water.*

*..we never buy anything on the street .*

Families were the key source of protection from physical danger. This was most apparent during the war, but it should be remembered that neither the police force, or the law provided protection to the individual. Visiting El Salvador even today, one is struck by the absence of social services, and the reliance on family members for personal safety. Without a healthy family which provided support, and could offer protection from poverty and violence, an individual had no safety. Extended families were also the only protection from domestic violence and sexual assault. If your family was unable to protect you, there was little other recourse.

Women identified themselves as members of families. Lack of support or abandonment by one's family was therefore one of the worst things that could happen. In general, lack of support (or betrayal) from those close to you was described as more damaging than trauma from external forces.

### Spiritual Forces and Their Effect on Health Determination

One of the inadequacies of the Determinants of Health framework is that is does not include a spiritual dimension. Health, for the participants, was understood to have

not only a physical and psychological dimension, but also a spiritual one. While a

number of different factors were recognized as important in influencing health, they were

not seen as *determining* or constraining, and could be overridden by faith, or by God's

intervention. Being healthy or escaping danger are most often attributed to God.

> *I'm actually kind of lucky because there could have been so many things that could have gone wrong with me, I could have been, there's just so many things that could have happened, and um, I'm fine, as far as I know, I'm not sick or anything ... I know that my mum, well she was in jail like I said, she has lots of faith, and I think that helped her get through all the problems and her faith was passed on to me.*

> *And ah, I don't know, I went six days without food when I was in jail, I was without food for six days and she is healthy! It could be my faith, I put it into my faith that I believe in God that much that I believe he's been there for me, even if I had no food, even if I had nothing, I had to run and hide and all that, I believe that my faith make me to keep healthy and to, you know, my prayers helped me. I knew a day before that I was leaving the jail, because I pray and pray and pray, and then a voice told me "You are leaving tomorrow, don't worry.*

> *There, my whole pregnancy I endured alone, without medicine, vitamins, and nothing more than a few scraps of food, because in that time we were in the middle of the war. It was not only a matter of not having ways of obtaining food; I had no strength. Because we didn't have enough food to nourish us. But my pregnancy went pretty well. To the point that my son was born, with another woman who was not trained . But she was willing to try it, and to help. (laughs) I had no problems giving birth. It was quick, in spite of the fact that I had no medical attention. Only in the hands of God, who for me is the best doctor. (laughs)*

There were a number of ways that God intervened to ensure safety. In some cases the

narrative excerpts describe situations where He intervened directly.

> *I say "God help me". (Breaks down crying for a couple of minutes). God helped me. I pray. I'm alone, I'm praying "God help me!" (Breaks down again).....Yeah. God listen to me! Yeah. I not making nothing for anybody! Why kill me? (still crying audibly). God listened to me! I...I passed the fire! I passed the fire! God helped me. Finish. I say no, I say help God!*

In others He caused the intervention of other people, or spiritual beings.

> One woman describes an incident where she was planning to commit suicide by jumping. As she was getting ready to jump, a man appeared and placed his arms around her, holding the railing, so she could not jump, and started asking her what was wrong. She reported that he stayed with her for several hours after that, and followed her to the church. It is unclear whether she believes him to be a human or angelic messenger. However, she says it was strange that he would not give his name, and seemed to know what she was planning to do. As a result she abandoned plans to kill herself.(fieldnotes)

## Integration of Spiritual Beliefs With Health Beliefs

Often modern medical care, traditional treatments, or awareness of psychological factors were intertwined with this faith in God's intervention. This eclectic and pragmatic view of health allowed and encouraged use of a wide variety of health treatments, including an openness to high - tech modern medicine. But in the end, the result depended on God. One woman describing a long attempt to get relief from surgical complications stated:

> *Slowly I was getting closer to God and I said, "I'll stop taking so much medicine". I did it! I asked God for strength to continue and to make it, to succeed in this country. ....Thanks to God, now I am feeling very well. My physical problem no longer exists, and nothing right now, nothing, can stop me from making my way through and moving ahead.*

Note in this example that in addition to viewing faith in God as the key factor in recovery, the woman also linked the difficulties of adaptation to somatic health problems arising from surgery.

While good health was most often attributed to God, never was illness or misfortune attributed to Him. There was no suggestion that God's will could ever result

in illness or misfortune. God and faith in Him can only contribute to health and safety. Not believing in God, however, could contribute to problems. One woman stated of a family member's violent behaviour:

> *Si porque ya ni en Dios creia. El salio asi bien mal portado desde que estubo alli, en la guerrilla. (It's because he didn't believe in God. He had been behaving badly since he was with the guerillas).*

## Malevolent Forces

This is not to say that other supernatural or spiritual causes were not sometimes held responsible for negative events. One uneducated campesina women described the death of one of her children at only a few months of age:

> *I don't know. They say maybe the milk or something --I don't know.. I cannot accuse my mum. Um, sometimes, there believe in stuff, like if you take somebody at the house, maybe they want to hold, they doesn't hold, they get sick. I don't know, I don't believe that, like uh, come se dice,* (how do you say it) *oh, like somebody is strong, I like it, they're so cute! but they never touch it, right? They say they die from that, but I don't know, there's lots of different stuff. Tradition?* .....*Because your eye is forever, is more strong, make you sick, the baby or somebody. It's like for example, the men, who work, coming from outside, sweating, hot. If he, the baby's there, they have to hold. ...because, you see, his eyes, you know, is very strong. Make sick......This id a tradition for outside* (outside the capital, i.e. in the rural regions). . *The doctor doesn't believe that. But some of the people, yes. I don't know. My mum told me this is what happens but I don't know.*

Often scientific explanations were combined with spiritual, or metaphysical beliefs about causation. One woman (an educated urban woman) described an infection following a Caesarian birth. At first she explored the explanation of a breakdown in infection control:

*They said it was a contamination with the things, you know? They use, I don't know what kind of thing was happened. But, um, people said, I don't know, if I, is hard to say because sometimes doctors they don't believe (laughs) what people says! Because in that time, was more than one woman had the same problem that I had. We were like around ten, you know. And my relative, that is a doctor, ask a friend, and he told to my mum, was so many people and the same day, for (caesareans), for the same problem, they don't know what happened with the babies, but was a very common things in these situations, and sometimes the cleaning people, when they change things, they don't, they didn't have ....was, because, one was first, then following the second, and seconds was the difference between one and like the other one. And they said this could be contamination for anything you know.*

But she did not discount other explanations:

*Yeah, and a woman that was close to me, she said in this year, I think two months before I think, I don't know, the same year, we have the comet in my country, we see the big comet. And she said that she believe in the things from the air, and when the comet passed the baby came, the rotation came, change. That's funny, that's why I said, is funny! Doctors don't believe in that! But she said, we follow the moon with the month, why they don't we believe that this can happen? Because they give us the calendar from the moon, 40 weeks, and she said to me why don't they believe that this can happen!?*

In conclusion, when asked what she thought about this, she replied:

*I believe that. Yeah. Sounds logical you know. And I said, yeah, I was doing very well, and then, for nothing, my son changed the position, and things happened so fast, and is not just me, is other people, you know. I said, "OK, I'm going to believe".*

Importantly, God, or one's faith Him can "override" other causal factors. Miracles happen. This is usually the reason provided for why things that should have caused problems (e.g. malnutrition in pregnancy) are not seen to have an effect. Associated with this can often be found a "fatalistic" attitude. While an individual can take precautions, and follow health advice, the results are out of our hands. "If I'm going to die, I'm going

to die", was a  sentiment commonly expressed.

## Immediacy as a Key Determinant

A number of factors related to change and current events clustered together to

provide a general explanatory category of "present orientation" to explain health and

illness. In general, current rather than past events were seen as having the greatest

influence on health.   Several women reported highly traumatic life experiences and recall

of these events often led to symptoms of emotional distress, including crying, nightmares

and trembling.   However, in general, the women saw these reactions as normal given the

circumstances and gave less importance to the influence of wartime trauma on current

health than expected.   The women described the stress of current adaptation, and any

family problems as overshadowing the effects of previous trauma.

Because the informants were asked about the impact of events that happened

many years in the past, their "reconstruction" of events can be expected to affect the

relative importance given to events in the past.   The present stimulus is perceived to be

the most immediate determinant. The "present" focus,  however, appears to be the result

of more than narrative reconstruction, it is rather a cultural characteristic. One informant

stated *"We don't pay too much attention to what happened before, or what will happen"*.

Current events are seen to produce current problems,  in the same way that events in the

past produced problems in the past ( i.e. trauma was very important then, and had serious

health effects at the time.  However, these events were not generally seen as continuing to

produce health effects). New health problems were more likely to be attributed to events in the present.

The "present orientation" may provide a partial explanation for why few of the informants made explicit links between past experiences and current community problems. It may also partially explain the low importance attributed to childhood malnutrition or neglect to current health problems, while current abuse or rejection was seen as sufficient cause for health problems.

## The Effect of Change on Health Status

Change of any kind may be perceived as a cause of either improved or decreased health status. For example, while visiting El Salvador, gastrointestinal problems experienced by the researcher were generally attributed to "*el cambio*" (the change from one country to another). In some cases the direction of the change is not as important as the fact of the change. The same change can have a negative impact on some conditions, and a positive impact on others. Two women reported a change in an arthritis condition on coming to Canada - one in a positive, and one in a negative direction. The one who improved explained arthritis as caused by the heat. The one who developed the condition in Canada blames the cold. Other women give similar examples.

> *I want to say one thing; in my country I had colitis. I was under treatment when we had to come here. However, when we came, a change occurred. Here I did not feel any pain, I never have had to visit the doctor because of that, it doesn't bother me any more. I was surprised as we have been here for nine years. I don't know if it is the change in climate, everything, I don't know.*

*It seems to me that those who brought problems got cured and those who didn't developed problems here.*

Immigration and resulting adaptation was noted as the biggest change and was described as a leading factor in determining health status. Often the women gave other reasons related to the change, but not always.

Change is linked to "present orientation". Adaptation to Canada is the most recent major change in the lives of most. Many women tended to explain current health problems in the light of this most recent change without exploring the contribution of past events, whether these be malnutrition, environmental exposure or trauma.

Linked to the concept of change was that of association in time. A change in health status may be attributed to any life event which occurs at the same time. There was a sense in many of the interviews that women were open to a number of explanations of causes to events - that there was no framework for prediction or cause. Events that occurred closely in time may then be seen as causal without a "logical" link. The example of the comet given above is one. In another example, a woman who started haemorrhaging after delivery reported the following:

> *I said "I don't want you to touch me any more, it hurts" and (the doctor) said, "Well, we have to make the blood come out, make it clamp down, make the blood come out, otherwise you'll get an infection." And so I said "Can I go to the washroom", about three hours later, and he said "Yes, but be careful". So I went to pee, after I pee the haemorrhage stop. (laughs) So it was weird in that matter, it was weird. **Because** (emphasis mine) I pee, it never started again.*

Many of the less educated women, in explaining the cause or improvement of a problem,

would link it to an event occurring around the time the problem, or its amelioration, was first noticed. It was not unusual for pregnancy and childbirth to be linked with the start or cessation of problems. One woman describing her headaches said:

> *Yeah, porque si senti que ese dolor que manejaba se me quito cuando tuve la primera nina. Senti que se me fue quitando.* (Yeah, I felt that the pain that I had disappeared when my daughter was born.)

## Psychosocial Factors: Stress, Trauma and Loss

Psychological factors were understood to affect physical health. Stress, anxiety and depression can cause somatic illness. However, the illness does not replace or substitute for the distress. "Psychological problems" cause somatic illness, as well as problems within the family and community. Loss of family members was the greatest trauma described by women, and this situation was naturally seen to result in depression.

## War - related Trauma and Loss

> *When (my husband) disappeared, that's when I went into some kind of depression.*

> *....because it was a very deep, it wasn't too severe a depression but kind of. That was my worst problem that I had after my husband passed away. That was what I considered the toughest time that I had because trying to survive from a tragedy, and that was affecting me too much. And I started to, you know, look for some help. ...Was really tough.*

Loss, or exposure to traumatic event can also have somatic effects. One woman explained that her mother - in - law had died of heart problems a few days after her teenage son was brutally murdered. Her death was described as *caused by* this killing. Following her husbands death, another woman described the following symptoms:

*Yeah, my intestine. Always I have a those, the syndrome?...... my gross* (large) *intestine was inflamed all the time? And I wasn't, and all the time my back also was sore, and my intestine, and headaches, so. But my blood pressure always was good. I haven't had any problem with that. But my intestine was just a disaster.*

"Being on the run" or chased, and being exposed to bombing were two of the situations most often identified as the cause or contributor to many health problems at the time.

*And life was very stressful since then, running from one place to another*

*With the affliction of always being chased. All of that for sure affected us. Even though I didn't see it, not at first, but when I stop to think about it, I think that all of that had an effect.*

Two women also identified exposure to aerial bombing as the source of difficulties in learning English, one attributed ongoing headaches and dizziness to the results of bombing.

Participants generally described trauma as having an effect at the time, but the effects of trauma (such as nightmares) fading after arrival in Canada. Some women, even those who suffered extreme situations in the war, reported that this trauma has not had lasting major effects. One woman who lived for three years under a situation of constant bombing, invasion, and deprivation explained the situation as follows:

*We didn't have enough food, and I was living with the constant affliction because of the situation we were in because of the war. I saw horrible things. My anguish was not only because of the lack of food, but also the fear of being killed. Or that they would kill my children or my husband. It is not certain how we managed, and I believed that all of that is going to affect my children. I started thinking of this. And I said, for sure, this is going to affect them. Because they feel the same thing.*

However, when asked how these experiences affect her today, she stated:

*Well, really I think that they don't . I think that all of that has not affected me, not in my mind, no, none of that, because I feel healthy. In spite of everything that has happened I feel healthy. Here there is peace, I have been feeling well, I don't feel I have any problems caused by that.*

Another noted of her experience in jail:

*Ah, I can't say that it affected me that much because I learned to be strong, and deal with anything that had come and to have faith in it?*

However, other women expressed the opinion that traumatic experiences can and do have a lasting effect. One woman, after stating that she did not feel that the events of the war have left her with any psychological problems, went on to say:

*Yes, I believe that all of that cannot be forgotten. No, because there have been too many problems in El Salvador. Yes, yes, sometimes I start to cry, and I feel that if I cry I release all that I suffered before. Yes, and my children as well, and all that my husband has suffered. All that. Of course, if I start to remember, I feel affected.*

As indicated in Chapter 7: Community, some women identified long term effects of the war "situation" for many of the problems in community health.

## Current Stress

The loss of family, friends and country through exile though continues to be experienced as a stress, and was seen as a source of both physiological and psychological problems.

*I believe that the physical health is being affected by our emotional health. I have a friend who is in a state of deep horrible depression. She has been very delicate. The sickness she is experiencing now is not emotional but physical. The doctor said that they are related with depression. She was diagnosed with kidney and gall bladder cancer and she had to face surgery. .... So, we suffer a great deal*

*here, and our emotions influence us and one catches pains that may not even exist.*

*It seems to me that in the moment of enjoyment and happiness, nobody has pain or aches. That, reaffirms once more that physically we are healthy but not emotionally.*

In the discussion about causes of gall bladder disease in the women's focus group, one

women suggested:

*Maybe they had it already, and because of the stress, they developed it here but they had it from before.*

*Health in Canada has been very hard, because the stress produce me a lot of anxiety, and maybe I wasn't prepared to cope with the anxiety. All of a sudden I find myself, alone, and with my kids, and with my kids suffering because of the shock. And the, and uh, all the unknown situations. I cut them from home where they had a pretty good life, and all a sudden they didn't have a car, they didn't have many material things that they used to.*

The stress of adaptation was the stress most frequently mentioned. Women more

frequently mentioned depression here in Canada, than they did related to their time in El

Salvador.

*Don't have family, nobody take care of my children, make me depressed.*

*I think I got homesick! Year. I was really depressed. I was really depressed. I think I was very depressed for about 6 months.*

Summary of Determinants Not Explained by Determinants of Health Model

Table 2 presents a summary of the factors identified by informants which are not

included, or adequately explained by the Determinants of Health model outlined on page

231.

Table 2

Other determinants not included in Determinants of Health framework

| GOD, and other spiritual forces<br>(can "override" other factors) | |
|---|---|
| **FAMILY** | Income and social status, social support, education, physical environments, health services, health practices and coping skills *(social)* |
| **IMMEDIACY** | "Present orientation" |
| **PSYCHOSOCIAL FACTORS: STRESS, TRAUMA, LOSS** | Past trauma, "cultural bereavement", adaptation stress, current family problems *(social)* |
| **CONTROL** | Poverty, War, Repression, Ignorance, Large *social forces* |
| **CHANGE** | Uprooting, adaptation *(social)* |

This table indicates that most of the determinants are understood by informants to

be linked to *social* factors, and social determinants of health emerge as the most

important grouping to explain health and illness.

## Multidimensional Determinants

It was often noted that women would give several possible explanations for the

same problem. Often a number of alternatives were suggested at the same time. This

was not necessarily expressed as an *interaction* between factors, but rather as an openness

to number of different explanations. Participants did not feel constrained to one

explanation for a problem, nor did they rely on one approach for responding to different

problems. There was therefore a great deal of openness to incorporating a range of

different responses and coping mechanisms.

One woman who continues to suffer from headaches and dizziness first linked these complaints to her exposure to bombing when she said:

> *Sometimes make dizzy. I remember don't know what happened in my head. Something, dizzy, headaches, I don't know what happened. I don't understand what's coming in my head.*

But later, she said *la causa de algunas enfermadades* (the cause of some illnesses, including these headaches) was the birth of her children. Even later, she suggested another cause: she was attacked and hit on the head by another woman while in the refugee camp. This resulted in a large cut needing stitches. This caused her to reflect on the fact that her mother too, hit her with *piece of wood in my head.* She then went on to say:

> *Yes, is something scary, is up in my head, is miedo (fear)? Fear is up, is something dizzy. Aflicion is miedo, some people die of miedo.*

This illustrates an openness to exploring a number of possible explanations. The implication is that as a multidimensional explanatory model is used, a multidimensional approach to intervention and treatment is also needed. This woman reported several physician visits complaining of headaches and dizziness. She remained frustrated that the doctor *"only give me Tylenol. I take a Tylenol, its gone, and is come back another, again"*.

Another woman described her son as very ill when he was an infant. Several reasons were offered for this:

> *When he was born he was very sick and what I think (laughs)..or what I thought at that time it was because we hold him, because we didn't want to put him on the floor, because he was our first born, and we didn't want to put him on the floor, and like grandmas, and they all help and they all wanted the best for this child, so we held him so much. It took him so long to walk, and to talk, he wouldn't talk, because as soon as he wanted , pointed something and we just gave it to him.* (overprotection)

But she went on to say:

> *But before that because we were sleeping like in fields, and all that, and that can affect him somehow.* (physical environment)

> *He had bronchitis, when he was two and he suffered from that from about the time he was about two months old. ..and he turned blue, like, and if I, I had to be very careful with him, and that made us to overprotect him too.* (infection)

> *And because of what happened when he was six months old, his dad disappeared, so then that make my nephews to protect him too. He disappeared in the war, ...We never saw him again. I wasn't then, that maybe then, made us to, and then for a while I didn't even care about him, like I forgot about him.(her son) ..I went into like some kind of depression.* (family trauma, loss).

In addition to discussing a range of possible explanations for health problems, this discussion also illustrated a progression from fairly neutral explanations (such as parental overprotection) to acknowledgement of a severe trauma to which the family was exposed, and the possible influence of this trauma and the mother's resulting depression on the child's health and development.

## Summary

This study indicated that most of the women, even those with little education, had a clear understanding of the influence of the determinants of health. In particular, the women clearly identified social conditions (poverty, ignorance, repression) and social supports as key determinants. However, the Determinants of Health framework commonly used in North America did not adequately outline the complexity of contributory factors emerging from the women's narratives.

Many of the factors (social support, income and social status, education, and lifestyle) were understood to fall under the broader heading of family. Varied health problems were attributed to psycho-social factors, which provided the largest explanatory category. The narratives indicated that women viewed health in a social context. If one's family or social group was not functioning well, one was not healthy. Illness (somatic or emotional) could express problems with the family or the community. God was central to the health belief system, and could intervene in ordinary cause - effect relationships. While participants recognized a number of possible causal factors for disease, etiological theories focus on causes within the social and supernatural world.

Change of any kind was understood to have the potential to cause disease, or improve health. The study also found that current events were felt to be more important in explaining present health status than past trauma. The stress of adaptation to life in Canada was understood to have a major impact on health. Not only does it result in

separation from the extended family and social network, it is a major and recent life change which has disrupted the whole community.

# CHAPTER 11: COPING AND HEALTH MAINTENANCE STRATEGIES

In the previous chapter, the women's perceptions of determinants of health and causes of illness were explored. In this chapter strategies used by the study participants to maintain health and cope with illness are discussed.

## Self Care and Care Within the Family

For most women, the first response to health concerns, or in seeking advice on health maintenance, was to look within the family. This applied to psychological as well as to physical health complaints. Some of this appeared to be related to the trust they had in their own family.

> *My brother, yeah. He's, I always consider my brother really smart, and whatever he tells me I believe it. I just, I don't know, it's the same thing with my parents. There's a lot of things that they say and things like that and I believe them because they're my parents and because don't think they would lie to me and things like that.*

Even when an individual had a number of resources available to her, family was identified as key. For example one woman who used a number of resources to cope with a crisis (church, psychiatrist, and stress management program) stated that of all of these she found her family the most useful.

## Traditional / Home Remedies

All of those interviewed referred to use of home or traditional medicines for treatment of illnesses and conditions. These treatments were relatively undifferentiated,

and included use of local herbs, traditional practices as well as elements of biomedicine, and reflected family based, lay health treatment. For these reasons, and because they are not part of an organized alternate health belief system, they will be referred to as home treatments. The two main areas of traditional treatment emerging from the interviews were herbal treatments, and food or activity avoidance (particularly during menstruation, and postpartum). While these two areas are discussed separately, there is some overlap of these categories, particularly in the area of food used as specific treatments.

Poorer women, particularly those from rural areas, appeared to have the highest levels of familiarity with, and usage of, traditional treatments. For poorer families, prior to coming to Canada, this was often the only health care available. However, home treatments were not limited to this group.

## Herbal Treatments

Herbal treatments were mentioned most often in three areas: a) treatment of common illnesses (e.g. colds, coughs, headache, fever, flu); b) treatment of gastrointestinal illness; and c) treatment of menstrual complaints. A variety of herbal treatments were mentioned; there were many differences in usage reported by individual informants. Herbs were usually prepared in the form of teas, sometimes they were first made into a paste. Many of the women were unsure of the names of herbs in these teas, even in Spanish. Because of the great variation in treatments reported for the same conditions, and the lack of confidence most of the women had in remembering the exact

herbs used by their families, the specific treatments are not outlined here. Treatments

most commonly reported were camomile, salvia, garlic, ginger, peppermint, lemon,

epazote, altamisa, ruda, pepper, and ajenjo (absinthe). Some teas were used specifically

for certain menstrual problems.

> *Well everybody says this is helping to make the period good. Because sometimes the blood is not red, red, is like clear, but this tea the water is red, red.... even is helping for the colour of the face.*

Chocolate was reported as a treatment both for menstrual problems (in some cases mixed

with Chapparo, a home made liquor), or to improve milk production postpartum. Some

treatments were used specifically during childbirth, for example plants which when

mixed with hot water made a slippery liquid, were use to "*help the baby come out*".


Unusual treatments were also reported. One woman outlined the use of water

made from washing the *peidra de moler* (stone used for making tortillas) as a treatment

for childhood diarrhea:

> *One lady told her. They wash all this stone and they move, move, move, move the two stones and this water, they give the children for disenteria or diarrhea. This water.*

The same woman reported that the white substance found on river rocks was also used:

> *...Even this, in the river, some stone have the white, this is for the dirty water, some stone make like a material, something white, like a powder,... This taken from the stone and making paste and give the children.*

One woman reported that when her toddler was slow to talk it was recommended that she

make a soup out of the "*huacalchio*" bird, "*a bird that is so noisy, back home*". This

story was told to me as an old wives tale, with laughter, and the informant stated that she

did not in fact try this treatment, consulting a paediatrician instead. Foods were also used

as treatment by some, for example honey and carrot juice may be used for eye problems.

*I put a little bit (of honey) on his eyes when he was born, when he was first born because his eyes were yellow. When he was born. And they told me to put that, a little bit of honey. ...And now I just use the honey to eat, and rub his eyes with honey.*

Commonly described was a pattern of escalating interventions, beginning with

self, or family treatment. If this failed, other women may have been consulted, or patent

medicines (such as aspirin or agua de florida) may have been purchased at the local store.

*Mothers will do it for the children, uhuh, yes, mothers will do the treatment for the child, and then uh, we run to the store, its like a grocery store but they sell pills for diarrhea and that, and so..if nothing work from like herbal teas or whatever, she will just go to the store and buy a pill for diarrhea.*

It was only if these treatments failed that poorer women considered going to a doctor.

However, for those with more resources, a doctor may have been tried first, and herbal

treatments tried when "modern medicine failed".

*So my parents took me to the hospital, they gave me some medicine, some pills, my dad bought them. But the pills didn't do anything, because the pain, I had cramps the same time, they were really bad. The pills worked for the cramps, not for the bleeding. But the pills didn't do anything. So my mum talked to a friend, her friend talked to another friend, and they gave me some herbal teas...The taste was horrible, the smell was horrible, and I said, "No, I'm not drinking that". I drank one and it was so bad! The first one didn't work. So then another friend who said to make a mixture of several herbs to make a tea. That worked! (altimisa, epazote, chipilin), those were the three herbs she had to mix, boil them and then make it into a tea. Drink it the hottest that I could take it.*

This pattern of use continued to occur in Canada.

*Well I know there's, for my stomach yeah, because I know one time I had a really bad stomach flu, and I was taking antibiotics and they didn't seem to help at all.*

*And um, she, I forget what its called, we always have it and it tastes really bad, I don't really like it, but she makes it as a tea, and then she made me have that, and I don't know, I guess because I believed her, she's my mom, and I believe what she's giving me is going to make me better, I got better.*

## Drinking Water

One of the greatest areas of agreement among the informants was on the issue of drinking water, not only for the purpose of maintaining health but to treat headaches. The following description is typical of many of the women who mentioned headaches.

*And if I have a headache I just have a Tylenol and lots of water. Back home, throughout the war, like when I was in the war they told me, if you have a headache, drink lots of water. That will help. So I did. It did help, without a pill, just water. Lots of water. That's why I believe in drinking lots of water for headaches.*

As El Salvador is a country with an extremely hot and humid climate, and a shortage of potable water, this treatment appears very sensible. (In El Salvador it can also be observed that due to the lack of public services, those who have to travel any distance will often restrict the intake of fluids). However, none of the informants gave any reason why the treatment was recommended or why it should work. The fact that it did work was enough.

## Food and Activity Avoidance

All classes of women also reported being taught some forms of food or activity avoidance during menstruation and the postpartum period. Some also mentioned food restrictions during pregnancy or identified certain foods as having curative or health - giving properties for certain conditions. While some of the treatments appeared to

overlap with the herbal remedies discussed above, the emphasis was more on avoiding

the potentially negative effects of specific foods for certain conditions. ·

Foods commonly avoided during menstruation were lemon, fish, avocado, and

particularly eggs. Egg avoidance was mentioned by most women for the reason that

eating eggs would cause a bad odour during menstruation.

> *They used to believe that the eggs, because of the smell, it would give a bad smell, as well as the fish, the bad smell in the blood, when the blood is coming out.*

Other foods avoided by some women included sugar, bananas, oranges, cold drinks,

onions, spicy foods, pepper. However, these were less commonly reported.

Similar restrictions were reported during the postpartum period, which was

generally described as lasting for forty days. Foods to be avoided during this period

included beef, eggs, lemon, oranges, oily foods, and avocado. In some cases there were

also recommended foods to be eaten in the postpartum period. The most commonly

mentioned were "Indian" (free range) chicken (grilled) and chocolate. One woman also

reported being instructed to avoid beans, beef and eggs during pregnancy.

It was noted however, that Salvadoran hospitals did not follow these food rules,

even those practices which some felt were beneficial.

> *..but in the hospital is different, they give you ..whatever, they said you have to eat everything. And they prepared, for example for dessert, jelly, and they also give you eggs, any kind of eggs. And I like to drink orange juice and they prepared exactly from the fruit, they prepared, well that was at home. But at the hospital, I*

*can't remember , I think it was processed food, milk, you know juice. But at home we have always the best.*

Food restrictions were remembered as a form of hardship by poorer women.

*Well, she told me to avoid eating everything, because everything was harmful for me to eat, like fried things. Yes, I worried a lot because I ate so many things she told me to avoid. I felt so worried because I wanted to eat everything (laughs).*

*She gave me like SO many things that I can't eat, like because I had that (menstruation) ...Not eat these, like not eat any kind of fruit, is bad for you, only bananas you can eat, but they have to be cooked.*

*So it was a pretty hard diet when we had our periods back there.*

A number of activity restrictions during menstruation, and particularly the postpartum period were also mentioned. Many of these practices appear to be based on cold avoidance (both from food and from activity).

*Like for a, my mother still does it, she did it with me, for a normal labour you couldn't go out of the house for 40 days, and you couldn't even go to the door because they said the air is not good for your lungs. And if you have a c-section, you have to stay at home for three months.*

*Something else, I couldn't drink anything cold either. Because it was cold, gets an icy feeling in your uterus because its too cold?*

*(Bathing is bad) because your body is warm at that time, and she said if you bath yourself, then, like there is not heat, maybe that's why, I don't know, but she only said, Your body is warm, is like a fever, and if you bath, that's bad for you, for your body....And you have a baby, the same thing, you are only supposed to have your first bath after nine days. On the ninth day when the baby's born, you are supposed to have a shower with cooked water, they put some kind of um, herbs to cook with it, and then with that water you bath yourself. ...Is warm, it will keep you healthy, you won't get sick with that.*

Some of the restrictions were accompanied by warnings of what would happen if the rules were not obeyed:

*Also I couldn't eat bananas because of the vein? The vein creates some kind of like, how can I said it, makes a blood clot in the uterus. ...And my grandmother used to tell me that there was a lady, was a young girl, was about 13 I think, and she got her period, and she never had any diet, specially with the bananas, she said. And then this lady, used to, after a while, they noticed that her stomach was growing, like she was pregnant. And her mother used to treat her like dirt, because at that time, getting pregnant like a single mother was really bad. So she didn't want the girl in her house. And after about 9 months, or more than that, she said that something came out of her uterus, but it wasn't a baby, it was more like an animal, I don't know. I don't know!*

In other cases the restrictions were seen as a way of maintaining health:

*"See me", she said, "I am O.K., I have no problems, and I never had any problems in my life." When she had her menopause, she didn't even feel it, like she just, the menstruation didn't come and that was it! That was it. She says "Its because I look after myself." She never had a bath, or a shower, or nothing. You can't bend down too much, you can't exercise because that's bad for your body, and like all those things, eh?.*

## Importance of Traditional Remedies

There was little consistency reported by informants in the actual treatments used,

or the degree to which the recommendations were followed, which suggested the lack of a

dominant explanatory model of causation or treatment. That stated, several points

emerged from the discussion of traditional treatments.

## Variation Between Social Classes

The transcripts suggested that while adherence to food restrictions and use of

herbal medicine may be found more frequently among the poor, it was not limited to this

group. Educated and financially well - off women may also have followed these

practices, although food avoidance appeared generally less pronounced among the better

educated. Customs related to avoidance of "cold" also appeared to be more prevalent among rural families, as were some of the more unusual treatments.

## Abscence of "Alternate" Health System

As mentioned earlier, while both use of herbal treatments and exposure to teachings about food avoidance was reported by all informants, these practices were clearly not based on an alternate, organized, consistent system of treatment. While there were some common themes throughout the interviews, the treatments were described as those learned through extended family and neighbours. They were not presented as part of an organized health belief system and, in fact, the actual treatments used varied significantly among informants, or were even contradictory. (Note in the examples above that for some women bananas were one of the few foods allowed while another was specifically forbidden to eat bananas). This was in contrast to what might be seen in other immigrant groups where there is a consistent alternate health belief and practice system (such as Chinese or Ayurvedic medicine). Similarly, there were no official practitioners of herbal or alternate medicine. For example there was no description of "*curanderas*" as may be found in other Latin American countries (Young & Garro, 1981).

The women did not provide clear explanations as to why certain treatments were used, or why they were effective. Little concern was actually shown about the theory of treatment. When prompted for the reason why certain practices were followed the response was usually quite vague.

*I don't know! I don't know. The people in my country is, I don't know, is cultural, I don't know.*

*I don't really know why, but if a woman back home has a kid and has someone, like a grandmother or someone, they have to cover their ears, and they have to cover themselves well. I think it has to do something with the immune system, is not in its normal system yet. So you wouldn't get any ear infections, you had to cover your ears pretty good, and, uh, if you have to go out you have to wear a sweater even if its 40 degrees outside....Which is every day! Yeah, you have to be pretty well covered, say like winter time here. I don't know why though. I don't know.*

Other women were given explanations for certain practices, however there appeared to be a lack of a well - defined explanatory framework. The clearest explanation given was the need to avoid certain foods to prevent menstrual odour. Some women gave general explanations regarding avoiding cold, however, these were vague prohibitions and did not appear based on a specific belief system of body functioning. However, some foods were believed to have specific effects.

*She never mentioned, she only said, well avocados, is because they are too cold, and if you eat them, even when you are not sick you, like you, because they are cold, that's what my mum said to me. And lemons are too sour, will stop your period. Like things like that.*

*....because you get gas in your stomach, that's what you're told. And when you have the baby is the same thing, and the baby will be sick? Because if you are breastfeeding, and most of the women in the countryside, in the villages they breastfeed them. There is no money for milk, to buy milk. So that's what they said, the baby will get sick, get colic. Will, and will cry at night, and if you don't want that, or you will get sick, stomachache and diarrhea, stuff like that? If you eat that, then you will be sick. So they rather not eat that.*

## Generational Differences

Treatments were used among all classes, but there were marked generational

differences in the use of, and belief in traditional treatments. Sometimes this led to conflict.

> *My great grandma, she decide to put home medicine, I don't remember what she put there, but I remember was very hot, and she started with, not massage, but through that side. ....But on the second day I had a very high fever after school and they phoned the doctor. And when he found out that she had put all this kind of stuff, he was so upset with my grandma because he said it was a big mistake. ....and they send me for tests....and they decide to do a surgery, because when my great grandma do this movement, from the front to the back, she broke the gland.*

In this family there was generational conflict regarding home treatments with the grandmother relying on "modern medicine" and the great grandmother resorting to traditional treatments.

More often, however, it appears that these treatments were tolerated and obeyed if so directed by older women in the family, but then ignored, if not effective, when the women were living independently. Note in one example above, the informant prefaces her description by saying " *if a woman back home has a kid and has someone, like a grandmother, or someone, they have to..."*

> *There were times when I didn't do what my grandma told me. She told me not to eat fruit or tomatoes, she told me no, but I didn't do it. So I ended up eating everything behind her back.*

> *But I did though! I didn't, (laughs), sometimes I hide to eat it. I didn't eat in front of my family, but I ate the stuff.*

One woman laughed while describing her reaction to these rules.

> *My mother said don't eat eggs. I ate. Anyway. I didn't restrict myself. My mother said eggs produce bad odour. And I didn't like it. So I told my father I didn't like the smell during my period and he bought me, a kind of deodorant for that period. In my life I didn't have many restrictions, so I was able to make many decisions.*

## Current Usage of Traditional Remedies

Most of the women interviewed continued some form of herbal treatments, or food avoidance here in Canada. The degree to which women continued to rely on such treatments varied considerably. The response does not appear to be clearly related to education or socio-economic status, but rather to whether in the experience of the particular woman the treatment was experienced as effective.

### *Herbal treatment*

A significant number of women felt that such treatments were effective, and superior to western medicine. When asked which of the treatments she found most useful one woman replied that she used Advil here. but *"in a way, I like the teas. Because they relax your muscles, make you feel better. "* Some expressed frustration that they were not able to obtain the herbs in Canada, and two described arranging to have these herbal treatments brought back to Canada by visitors. Some women (of all educational classes), while confident in western medicine, avoid taking medicine and saw "pills" as a last resort. It should be noted, however, that those avoiding medical interventions were also more likely to speak of using techniques such as rest, relaxation, and particularly prayer, for minor discomfort and illness.

Some of the women described these treatments simply as an alternative, and showed no anxiety in replacing these treatments with something else. Others viewed western medicine as superior.

*I know my mum believes in a lot of that kind of stuff, a lot of herbs and stuff like that, and I - just pills!...They're like, "pills aren't always exactly the answer" and I just take a Tylenol!*

## Food and activity avoidance

In this area as well, there was great variation in whether such restrictions continued to be followed in Canada. Many reported continuing to avoid eggs during menstruation, but other than for this practice there was no consistency.

*Up to now, I try to keep it. (the food practices) So, when I get my period I try to stay on the same diet....So I guess its a habit now.* (young mother)

In contrast, other women suggested that these practices were based on ignorance:

*Because after you give birth in El Salvador, there are so many things you can't have, they say you can't have this, you can't have that, you can't eat anything pretty much, just cheese and something. But it just seems so mythical! ...And it just seems like it, to me it seems absurd and to me it seems like it doesn't make any sense. (young woman)*

*No, not now (laughs). Now many things are more clear to me ; people back there who said thing to you were ignorant, not knowing what they were saying, it was because they were not educated people. (older woman)*

## Integration of Traditional Practices with Western Medicine

In none of interviews was there a sense that home/traditional remedies were incompatible with western medicine (pharmaceutical, surgical) or that the traditional practices could not be used together with western medicine.

The pattern of use that emerged from the interviews appeared to be based on pragmatism. The women used what was available, and tried more than one remedy if

relief was not found, or there was some indication that another treatment would be more effective or more readily available. Continued use of home remedies depended more on personal experience than any belief system. There appeared to be little reluctance to replace herbal treatments with "modern medicine" if it were available and seen to be effective, although some women reported avoiding drugs, which were perceived to risk causing other problems.

## Personal Coping Techniques

The women identified a number of personal coping techniques that they found effective in coping with psychological and somatic concerns. These include focusing on the needs of the family, prayer, talking and socializing, working, crying, and community action.

### Focusing on Needs of Family

One of the coping techniques mentioned regularly by informants was that of focusing on the needs of the family. The role of women as family caretakers has remained consistent throughout the migration process, and provided women with a sense of purpose. Many women stated that their families' needs, and their perceived responsibility to meet these needs were a key factor in being able to "keep going".

> *I think the commitment to families is something. To me as a woman, I think as a single mum, sometimes I was really sick, then I thought, wow, yeah but my children! I can't afford to get sick, so that kept me going. I think lots of Salvadoran women have that commitment, I guess, to the family. You can't fail. It's no way you can do it, its impossible.*

*I haven't had a depression. That's to start with. That's one of the biggest issues in many families, and I never had a depression. Because I knew that I am not allowed to have a depression, because my kids needed me.*

One younger woman said of her parents:

*They're both very determined to get what they want, and I think that basically their whole life was us, helping us achieve what they couldn't get, a better education, to have a better life and things like that. Yeah (whispers)*

This commitment to family was such that a number of the women, while not happy in Canada, would not consider moving back to El Salvador, either because their children do not want to leave, or (in the case of women from less privileged backgrounds) because they recognized that their children would not have the same opportunities as they do now.

## Prayer and the Church

### Personal Prayer

One of the most common coping mechanisms used by women was reported to be that of prayer. Not only was God seen as responsible for health and for saving the women and their families from difficult situations, but prayer was the main resource used by many women in coping. For most this was a personal and private event.

*The first things that I'm doing for me, is to pray. Believe you know, that God is with me. This is the big medicine that I have......When I feel tired or something that is not good for me, the first thing I do is pray. I read my Bible, you know, the connection with God. ... I always read the Bible, I always pray, and I feel positive that I'm going to do the next day.*

*I know that, um, just the fact that we believe in God and that we know that he is here for us (crying) and that, um, that there's someone there that cares, and that's helping us in everything, I just, I don't know, it helped us get through all the pain.*

For some, the help asked from God is to forget: *"I say Oh, God, help me forget*

*everything. Yeah.*", one woman said.

Prayer was also used as an attempt to forgive others for what has happened. Some

of the women discussed their personal struggles to forgive others for wrongs either here

in Canada, or in El Salvador.

> *It's hard to understand! Like I don't hate her, I don't hate her, but I feel bad. I go to church and I pray, and I pray, I said to myself I have to forgive her completely. But is it forgiveness that I don't feel like talking to her? (laughs) I, I don't hate her but I don't feel like....if I meet her on the street, I just don't feel like talking to her, like I even saying "Hi"? So I, I pray, and I ss, I don't know because is that forgiveness, or is it that I haven't forgive her?*

Church Attendance

For some, faith involved attending church. One woman in discussing the stress

she experienced during the war explained:

> *From very young, the faith, I learned from my parents, this helped. I went to meetings four times a week and felt happy. My faith grew a lot. I felt that my problems were given to God. I felt stronger.*

Another noted that she attended church more frequently here in Canada, and identified

this as a coping strategy. She also noted (and this was supported by others) that church

attendance also provided the opportunity to socialize.

> *One of the ways I found how women cope is, and may be this is a phenomena that happen just in Canada, but is attending the church. I wasn't very religious in El Salvador, and here I become very religious. Yeah, I am attend(ing) more frequently, like seven Sundays in a row, or seven Sundays in a year, but I am attending. In El Salvador I never went and I was Catholic. There are a lot of small churches and people congregate around those churches, maybe as a way to cope, as a way to socialize, or as a way to...I don't know if this is a coping technique.*

However, a number of the women interviewed, while identifying themselves as very devout, did not attend church. Most of these stated that it was not necessary to attend church to be a good Christian. Sometimes this avoidance of church appeared to be avoidance of dealing with the community, although some women reported attending for other reasons.

> *I don't even want to go to Spanish church, but because of my dad. The only thing that makes me go to the Spanish community church is because of my dad. I love him. I love him so much and I know that makes him happy.*

For others, church attendance was a way of showing gratitude:

> *And um, we um, well we try to go church every Sunday, and when we go to we try to do it because we want to go....I don't know, sometimes I feel like maybe I don't have to go church, but when I think about everything we've gone through (voice breaking) and how just God, was the one that helped us, I think no, its, just my responsibility to go, and to say thanks, and to pray to him.*

## Talking/Socializing as a Coping Strategy

Talking was another coping technique commonly described by the women. Talking was seen as important, as therapeutic, and not being able to talk (because of the nature of the event to be talked about, or because of family/social isolation) was a key source of distress.

> *However, I have some private matters that I keep to myself. Nobody knows of them, only me. Sometimes that is a problem in itself, because if you don't externalize to others, you stress over your worries and that causes many headaches.*

> *It's hard because, uh, I not feeling comfortable to tell someone, this happened to me, I can't tell nothing, I can't tell nobody.*

This was reinforced by experiences in the interviews. There was usually a sense not simply of agreement to the interviews, but of appreciation of the opportunity to talk. *"Thank you for coming to talk to me"* was the response at the close of more than one interview. One women commented that one of the difficulties in having real friendships with Canadians was that Canadians "don't want to talk" about experiences in El Salvador. At the end of one interview, another woman stated that after talking about her experiences, she felt, *"depressed, better, both"*, and even when it was stressed that she did not need to talk about things that were too hard for her, said she wanted to go ahead.

## The Importance of Talking Within Families

Families that could talk together were considered to be more healthy. In describing why she felt her family was healthy, when so many were not, one woman stated:

> *Because we talk about it. We are open with our children about our problems, and we want to (leave) the past, even when we talk about it, but we don't, maybe what helps is that we don't, problems in the past we don't take them so hard on us. Or because we talk about them the problems are not as bad as they were, like we don't, even if they were so bad, sometimes I even cry talking about them but we talk about them more in the family maybe? Not with friends, it depends about which friends you know.*

Another described how talking was essential to helping families cope with the stress of adaptation.

> *And also, when you see for example, in my case, I talk to my kids about everything, on the contrary than my mother. ...Kids need, my children, during this stage they need to talk a lot with me. They need to face the frustration and recognize that they are frustrated because they are not getting what they used to have. They have to acknowledge, **through communication**, that this is a different*

*society. (emphasis mine).*

Another explained:

> *Oh, with, well, we, I know that we, sometimes feel stress and stuff and we feel that we 're all just bickering at each other, and getting mad at each other, my mum, you know, we just sit down as a family and um we talk about what's going on, why we're so stressed, why we're so mad at each other all the time and I know that that really helps a lot. .... Well I know I talk a lot to my mum. Especially my mum, about how I'm feeling stress. And she tries to help me. I really depend on my grades, and my mum always tells me, if you just do your best and you just can't, then you just can't. And that helps me. To just talk, and to just tell her how I am feeling, or how it makes me angry or how I'm just frustrated.*

Some women specifically mentioned talking about the past. Talking about the

past (particularly the trauma experienced in El Salvador) if discussed, in most cases was

only discussed within the family. This was described as painful. One woman, when

asked if they talked about the death of a family member responded:

> *Yes. **We know how to talk.** But we don't like to do it much because we end up crying. Aih!!! (laughs). (emphasis mine)*

Talking was understood to be more than something that "just happens". As the

above narrative excerpt suggests, one must know how to talk, and have the ability to

talk. A clear sign of distress in the family was not talking:

> *Uhuh. No nothing about it. Nothing about it. No, we didn't talk about anything like that. Not till now we don't talk about it. Just want to keep it quiet. Over with.*

> *Because sometimes my mum doesn't talk to him. Even now. I feeling like my mum and my brothers don't like talk too much with him... And my husband went to my house and my mum never tell him, you want to eat, or you want water, or you want something. Nothing. Even my husband says, "Good morning!" or "Good evening!", something, my mum, nothing. Why? And always my husband says, if, sometimes I don't want to go to your parents house. And I tell him all the time*

> *"Why?". But he said, "Because I feeling not comfortable". Because just only my dad talking to him. Not my mum, not my brothers.*

Disapproval is also shown by not talking, or sharing information. Not talking, not sharing information was recognized as a form of rejection. One woman who was not given information, confronted her mother saying

> *Now I want to know why you didn't tell me. Why you, I feeling you put me out of my family?* (Emphasis mine)

All talking did not have to be "serious". *Platicando* (social talk, relaxed chatting), was often mentioned as therapeutic, and was the type of talking often referred to by women in their discussion of work, and distraction in the following sections.

It should also be noted that in spite of the stated distrust and perceived risks of sharing within the community, women did appear to find the opportunity to talk, at least in the sense of *platicando* (chatting). It was observed in the women's focus group for example, that although distrust and not being able to talk was stressed, the women did actually participate in some very open, and emotionally intense discussion.

## What is Not or Can Not be Talked About

As talking is considered important to so many in the community, exploring what is not, or can not be, talked about is important. As indicated earlier, two topics appeared to be more difficult to talk about openly. One was sexual abuse, which did not appear to be recognized as a problem of concern to the Salvadoran community, but was of great

concern to individual women. Unlike domestic violence which was discussed openly as a community problem, child sexual abuse was not acknowledged.

There was also evidence that there is avoidance of discussing war - related issues, particularly the atrocities committed, except with close confidants. This makes sense given the level of trauma and the divisions within the community. It may also partly explain the emphasis participants place on adaptation as the cause of much anxiety and depression. Adaptation can be discussed in a public setting, and much common ground can be found even among those who have had vastly different war time experiences. The stress of adaptation then provides a "language" which the whole community, in spite of divisions, can speak.

The lack of discussion of past experiences with health care providers (discussed in Chapter 12), even when they may be relevant to health concerns, is another example of what is not talked about. It may be that even in this setting it may be too threatening, or upsetting to discuss.

## Working as a Coping Strategy

Employment was recognized as determinant of health. It was also described by study participants as a coping strategy, which was helpful not simply because of financial benefit, but because it was therapeutic. Working (defined both as "keeping busy" with productive activities, and as formal employment) was identified by the majority of

informants as key to coping and to maintaining mental health.


## Keeping Busy

Talking, working, socializing are all seen as ways of distracting oneself from ones

problems. Even listening to music or watching T.V. can be seen as helpful.

> *I try to go out, or listen to music, or sing along, mostly get busy doing something*
> *so my mind doesn't... Going to work helps me. Yeah, helps me a lot.*

> *(prior to this had highlighted calling on god to forget). Oh, what I do? Oh, I*
> *turn the T.V. I watch, news, I watch the shows, it's gone. I listen a little music,*
> *it's gone.*

Keeping busy then is a way of preventing oneself from ruminating on painful memories.


## Employment

Many of the women mentioned the particular importance of employment in

helping cope.

> *What affects women the most is not having a job.*

> *And after that I got a job too, and that helped.*

In some cases the women described this as a particularly effective form of distraction:

> *But yes, it helps ...it helps to have something to put your mind to, other activities*
> *that distract us from our preoccupation. I feel that getting a job helped me lots.*
> *It makes me take many things more easily. I don't think too much about my*
> *country. I think about my family of course but it is not with the same continual*
> *and painful thought. I have stopped making comparisons between here and there.*
> *Right? It has helped me a lot, and, well its logical that I get tired because the*
> *work is hard. I come back dead tired but the same tiredness stops me from*
> *thinking about anything else than what I am going to cook for tomorrow.*

> *Sometimes I feel like I am going to be crazy, because I am thinking too much.*
> *But, uh, I feeling that's my job, help me, because .. because I can't talk with my*

*partner, I can't talk, sometimes if I feeling lonely, I can laugh with them, they are joking, joking ....Yeah, in my workplace. I can talk to them about everything. Not my problem, because I don't like to talk about my problem. I don't like to talk about how I'm feeling. ..But before when I just stayed only at home maybe I feeling, but now, um, I think my job is, is uh, part maybe of my psychologic life. Because I, if I feeling, even when I feeling sad, or when I know something and I saw something wrong at home with my husband, just only talking, talking, sometimes even garbage!, I feeling better.*

This last excerpt also demonstrated the perceived importance of employment in providing an opportunity for talking and for social contact. One woman explained that she preferred to work in a long term care facility (even though she could only get casual work at nights), rather than provide home care, as there was more opportunity for social contact.

For many women of course, employment provided more benefits than social contact. Poorer women often found in Canada the first opportunity for employment outside the home. This contributed to both a level of economic independence and accomplishment in meeting the needs of the family, and to a sense of self esteem.

*Yeah, because you can get a job, I can work. I have never been on welfare, wish I never go. Sometimes I feel sick, tired, weak, but I never miss a day. I don't know, because I grow, when I was small, work, work, work, there, I never rest......See you working hard here, you make money. There you can work 24 hours, you don't get nothing.*

However, in the area of employment there remained a significant difference in satisfaction with employment related to social class. Professional women, or those from wealthier backgrounds, did not generally feel as positive about work opportunities here, and employment was described as another source of frustration. The lack of recognition

of foreign credentials and experience was identified as a key factor in psychological stress, as well as economic hardship. This lack of opportunities for those with professional training to obtain employment at the previous level was recognized by women of all social classes.

> *Some of the people coming to Canada, have education, diploma, but they don't have the job!....They say they need people has diplomas, but no, is not true. Everybody has to come just cleaning or sewing or........you don't need the diploma just for sewing.*

> *You will find many people here who was servants. Many people! For them, to do some kind of job, it doesn't bother them? Because they are making more money than they ever thought they could. For me is on the contrary.*

Of the women interviewed, almost all were currently employed, even if only part-time. Of those who were not working, one was a student, one had young children at home, one described herself as too ill to work, and one arrived in Canada as an older woman. Only one woman lived in a family where there was not at least one adult employed full time. However, some of those interviewed were experiencing anxiety regarding job stability for a family member at the time of the interview. There was a great deal of pride shown in the ability to overcome barriers to obtain employment, and avoid social assistance.

## Crying as a Coping Strategy

Another coping mechanism identified by several of the women was that of crying. Most of the women cried, without embarrassment, through parts of their interview, and in the focus group too, some women were close to tears. Several women gave the

response of "crying" in response to the question of what helped them to cope. In some

cases this was presented as "the only option".

> *Crying. That's it, crying. No more. How can I, umm, how can I call someone to*
> *tell look, I feeling depressed, or I feeling lonely, how? Nobody. Even I can't, I*
> *can't phone my brother, or my sister because they never know when I feeling*
> *lonely or when I feeling depressed. Never! (shaky and teary).*

However, in other cases it was seen as a positive activity that actually helped them feel

better.

> *I cry. I cry a lot. It helps. Makes me feel better. But, uh, I really don't know.*
> *...(My husband) gets mad at me. (laughs) He says: "Why are you crying!"....And I*
> *say, "I don't know, I just feel like crying, so leave me alone".*

> *Yes, at times I cry, and I feel that if I cry, I get rid of the feeling of the suffering I*
> *went through before. My sons as well, my husband suffered very much. All of*
> *that. If I begin to remember all that, yes, I begin to feel emotionally affected.*

In these cases then, crying was not seen as symptom of distress, but rather as a positive

release and way to cope.

## Involvement in Community or Social Action

A small number of women also mentioned involvement in social action or

community work. This was described as providing an opportunity not only for social

contact, but also to fulfil a sense of duty. "*I feel guilty sometimes,*" one woman said, "*I*

*am in a good situation here, and other people are suffering*". These were women who

had, prior to coming to Canada, been politically involved in community work. In some

cases these women had decided, due to negative community dynamics, to withdraw from

activity within the Salvadoran community. This was perceived as an important loss. It is

unclear whether the current dynamics explain involvement in community activities as

being mentioned by only a small number of informants, or whether, even in El Salvador it was a strategy employed by only a minority.

## Summary

Prayer, work, focusing on family needs, crying, and talking were key coping techniques described by a number of women. The first response for addressing either somatic or emotional concerns was to first look within the family. Coping techniques used by women were described as different from coping techniques used by men. Men were reported to have greater difficulty in adapting, and coping techniques such as drinking or acting out with violence (fighting and domestic violence) were seen to be common.

While many of the women reported home remedies (including herbal remedies) and patterns of food and activity avoidance, there was no organized, systematic, or consistent alternative health belief system. While home treatments were found more among poorer families they were not limited to them, and within each socio-economic class there was great variation in the actual treatments used. There is evidence that for this community, traditional practices can best be viewed as family practices, and governed by the same rules of compliance as any other family customs in this country. The key predictor of continued use of such home medicine here in Canada was whether the user had found it beneficial, and no significant relationships were found with education or social class. There was also no indication that such practices were seen as

incompatible with western medicine. As the differences are not important to the women themselves, this area does not appear a significant area for further study.

While the first response is to look within the family for support, women also report using health and community services that they find useful. This topic is discussed in Chapter 13: Utilization of Canadian Health and Social Services.

# CHAPTER 12: HEALTH CARE ACCESS IN EL SALVADOR

The women interviewed described a range of experiences with, and attitudes to, the health care services available to them in their country of origin. Striking differences are found between the poor (particularly those living in the countryside) and those from more privileged families.

## Access to Physician and Hospital Care

For poorer women, health care, if available at all, was available through public health services and public hospitals. While in some cases the service was free, other issues affected access. The first barrier was distance - for many any form of health care was a long walk away, and so only used in serious cases. *"Then the next step was to go to the doctor which was very expensive, and far"*, one woman said.. In other cases it was necessary to pay for the consultation.

> *There were times when I went, and one time I had a urinary tract infection. I couldn't go to a doctor because I didn't have the money to pay for it.*

Even in serious cases the hospital would not necessarily be utilized however, as while even if the diagnosis was free, any medication needed to treat the problem was not. Many people could not afford the treatment and knowing this chose not to make the trip to the doctor.

> *There is a hospital where you can pay less, so you could see the doctor, but you had no money to pay for the medicine and it was, and so sometimes they just waited, it wasn't worth it to go. If I don't have the money to buy the medication, then why will we go to see the doctor?*

> *Like (my husband) cut his finger, half like this, it was open this way and that way, and only what we did was tie it, wash it and tie it, and he went back to work. It*

*was so swollen! And turning purple....Yeah, to go to the doctor, he could hardly afford to feed us. I remember he went to the farm, the coffee plantation, where he worked, and he brought the tortillas, they gave him 2 big tortillas, and that's all we ate.*

Even for those who could potentially afford to pay for medical care, there was an issue of

priorization.

*Like we were considered ah, in that village, we were like a family with money, but still a doctor is expensive and for them it is, was, food is more important than anything else. .They just cured us with herbal tea and things like that. It did work ..Like we only went to the doctor when we were really very, very sick.*

Another issue that emerged during more indepth discussion were psychological

barriers to accessing health care. Several of the poorer women reported being badly

treated by medical staff. This was often described as being "treated like nothing".

*Because in my country is different. The last time I talking to my doctor and I tell, in my country maybe the racist is too bad. Even in my country because the nurse uh, if you are a nurse, you have a high education and the poor people, nothing. But if you have a high education you can make the poor people less than you, maybe.......put them down. And you know many things, and the other nothing. You tell everything the other people, and the other people can tell you nothing.*

*....The rich woman use another hospital. .....Oh, yeah, is different. Because in my country is many hospitals, public, private, but in the public just only the poor people, and maybe the nurse, working in a private hospital and in the public hospital. But the nurse know that in the public hospital just only poor people. And they can treat the people like nothing. But in the private hospital, no. Because they have money. And they know, in a private hospital, maybe that lady can tell to the doctor, put away this nurse, and she lost the job. But in the public, no.*

Another women described trying to get help for a serious throat infection.

*There (in El Salvador) I went one time to the hospital, I had a serious throat infection. But I had to wait two days at the hospital to see the doctor. And another day to get the medicine.*

Even if one was admitted to hospital, the quality of care in a public hospital was nothing like the experience of hospital care in Canada.

> One my first visit to a Salvadoran hospital in 1993, one was greeted by a handwritten sign on the building wall. An arrow pointing to the left was labelled *"Colera y diarreas"*. Another arrow pointing to the right was labelled *"Otros"* (others). The hospital was filthy, and reeked of urine. Electricity and water supplies were erratic. Chickens and dogs could be seen running through the halls. Filthy, ripped mattresses were hanging to dry over a railing, while a man sprayed insecticide around patients in the hallway.

However not all reported being badly treated in the public hospital. One woman who was hospitalized in the city after being wounded as a child recalls:

> *We were looked pretty well, we didn't have any bad experiences, like sometimes I notice that many people complain about the nurse, they're not too kind, but no, I didn't experience that, and I didn't even saw that the other kids were treated bad. For that matter, I was treated good in that matter.*

Some hospital services were provided by the state. One campesina woman told us that her husband had spent four months in a hospital for tuberculosis.

The situation faced by middle class and professional women was very different. For hospital care there were two options. Salaried employees were covered with health insurance under *Seguro Social* (the Salvadoran Social Security Institute), a system of care insured by the work place. Seven percent of the population had access to this system (Pan American Health Organization, 1990) which operated a large modern hospital in the capital. Some of the women reported using these services. Services were described as of quality and modern, not that different from services available in Canada.

> *I, the first time, actually the first two times I went to a, like a we have soc, its called institute of Social Security, something, but this is for working people. This is a very modern, this is the most modern hospital in my country. Lets say, not*

*exactly the most modern hospital, but kind of, because they have all the
equipment, medical equipment, so that's why we consider one of the best. And
then with my third one, our financial situation was better, so we went to a private
hospital.*

When asked how the private hospital differed from the Seguro Social, she replies,

laughing:

*Well, you know, if you paying they treat you better! And is kind of, this is for
people who has that kind of like insurance, but in the other hospital we also have
an insurance but my husband was paying everything. Yeah So that was a little bit
better.*


Those who were better off, and could afford to pay for health care privately, were

highly satisfied with the health care they received in El Salvador. (*"if you had money

could get anything'"* one woman remarked). Money also gave you access to services

which were illegal, (such as abortion), and to mental health resources such as psychiatric

care and stress management courses.

*I decide to go for the pill. But what happened, I start to create a lot of shadows
on my face, and I forgot about that, and I got pregnant. Immediately after. I got
an abortion. ...I had a cousin who is a nurse. (laughs) And is forbidden in El
Salvador, is not legal. I got, I talked to her, and I said, I have a problem. And
she was a very good cousin. She was older than us, but she cared. And I said, I
am pregnant. And then she said, "What do you want?" "I want an abortion"
.....and I was able to do the abortion because I was not very religious. ...It was
done in the clinic where my cousin work.*


## Childbirth

Most of the rural women interviewed gave birth at home. Some women gave

birth in hospital, but did not receive any prenatal care. One woman did get medical care

during one pregnancy (this was provided by a Canadian doctor who was part of a medical

unit assisting the guerrillas) but gave birth while on the run from the army. One women

had only her last child born in hospital. This was because:

> *I thought about going to get sterilized, because I couldn't stand to have more*
> *children, this is the reason I went to the hospital.*

While many were assisted by women in the community, these women were not

usually identified as midwives, but simply more experienced women.

> *A lady from there,... well she had done in the beginning she did with her own*
> *children, and then she helped, as soon as she knew, she didn't have training or*
> *anything like that, but when people knew she had done it on her own, they would*
> *just come and ask her. Then for (second child) it was somebody else.*

> *During the pregnancies we sought help from a woman who was prepared to*
> *provide assistance..We looked for her to take care of me when I was having the*
> *pains (contractions).* However, this person did not provide care during the
> pregnancy.

Urban women were more likely to give birth in a hospital, but here too the

standards of care differed by whether one could afford a private hospital. More privileged

women reported the same type of prenatal care and childbirth services as expected in

Canada.

> *You go directly to the gynaecologist, you don't go like here, you go first to the*
> *family doctor and then, no, we went directly to the person who is the specialist in*
> *the area. He start to tell me what I need to do. The first thing that they do is do*
> *an exam, take blood tests, all the blood tests that you need to prove the*
> *pregnancy, urine, all this, and he asked me about whether I was taking pills to*
> *avoid children and I said I never take those things you know. ....But no, I received*
> *a good education for my pregnancy. ...Just for the doctor. Just for the doctor.*
> *This hospital is very good They give you vitamins, they make sure how big is the*
> *baby, in case I feel something that is a difference because it is my first time.*

## Dental Care

For poorer women dental care appears to have been even less available than medical care. Distance from dental care was also a factor for the poor. The dental care that was available was basic, consisting of extractions. Many women now have a number of spaces from extractions, or have a plate.

> *In my country if you have a sore teeth, they just pull it out. ...My dad took me to the hospital. (I) was very small still, I was about 10 or 12. Those were my adult teeth I think because they never grew again. So I had three missing teeth, three in the front , and one here and one here....They were so sore they just pulled them out. At that time they never fixed teeth. Plus, we didn't have the money. ...Most of the people like my age, like from out of, even in the city they have false teeth, people like my age. Now younger people they learn to take care of their teeth.*

The lack of knowledge of preventive dental care was identified as an issue by poorer women - along with the lack of toothbrushes.

> *I didn't remember brushing my teeth when I was small.*

> *Yeah, my country, no brush, toothbrush, I don't have any, I brush with salt every day.*

However, for professional women dental care was taken for granted, and even the some of the lower middle class employed in towns were able to access some dental care. One woman had access to a dentist both through the school and through her father's work.

## Health Education and Prevention Services

The narratives indicated that access to health education and preventive information also differed significantly based on social class.

## Infectious Diseases

Some of the poorer women discussed the absence of knowledge of basic

sanitation and spread of infectious diseases they had while growing up. They attribute

this to ignorance (lack of education) and to poverty. The access and attitude to health

education reported by women from middle class and professional families was very

different. Women from professional families often recalled clear health messages (don't

eat food on the street, wash your hands and food carefully) that protected one from

infectious diseases. No mention was made of malaria. In addition, some of these women

mentioned the presence of servants who were available to ensure food safety and

supervision of children.

It was interesting to find that although diarrhoeal diseases were commonly

mentioned, (as were respiratory diseases) there was not one mention of Chagas disease,

even though the seropositivity rate is estimated to be approximately 20% in El Salvador

(Pan American Health Organization, 1990). Chagas is caused by a protozoa transmitted

to humans as a result of infected triatomid bugs feeding on human blood. It causes

lifelong infection, and in the chronic phase may be associated with cardiopathy (Prata,

1994). Those most at risk are the rural poor who live in substandard housing (WHO,

1991). In conversations where community members were discussing younger individuals

who were having "heart problems", the researcher would ask if they had been checked

for this disease; it appears that many community members have never heard of it.

## Reproductive Health Education

Reproductive health education in poorer families was provided through the

family. These women reported an absence of any kind of preparation for menstruation, or

education about conception, birth and contraception. Menstruation was reported by these

women as arriving as a surprise, and they were often very frightened.

> *No my mother don't tell me, only I have a cunada* (sister in law) (who told her)
> *"You put on underwear "- don't put in my country, don't put kotex - "only
> underwear, 4 or maybe 5 underwear." I made a little cloth to put there. I go to
> work and .....my menstruation is down (my legs). I put something long here, a
> towel, very long. Yeah, I don't understand before, my first time I am crying. I say
> "What is happening to me? I don't have nothing" I say, "I don't have nothing, why
> is coming this?".....Ella me dijo, "Todas las mujeres en el mundo tienen esa" me
> dijo.* (She said to me, all the women in the world have this) *"Yeah, that
> happened to me too," she said. O.K. I am scared...I don't too, nobody told me
> where born the baby. Nobody! Only the boyfriend. ....I scared of boyfriend too
> my first time, I don't know, scared, I never....Nobody tell me, no (tears).*

Note in this example that although the woman reports that "Don't put (use) Kotex", this

was not the experience of the country in general. Others had access to commercial

sanitary supplies, which were not available or were too expensive for the poor. Many

poorer women used home made reusable pads. Another women explains her first

menstruation as follows:

> *Nothing. I cried when I, um remember I was peeling corn to make tortillas and I
> was sitting down and then I got up and one of brothers said to me "Go inside and
> get yourself clean" And I didn't know what he meant? I didn't know anything
> about it!....But my mum never talked to me about it. She never said anything,
> nothing about that. ...And after, well, I cried and cried and cried. I didn't know
> what happened. I thought maybe I am sick, am pregnant, or, I didn't know how
> you could get pregnant. (laughs). At home we never heard about sex or that.... I
> think I was about 12 or 14 when the kids were being born, like babies, my
> nephews and nieces, but that was something we never talk about. "But how do
> you get them?", but my mum never say anything. "You shouldn't be asking that"
> she said, "That is adults things, you are too young". So I never knew until I was*

*about 15.*

*(My mother) didn't tell me anything about this. I didn't know. I was ignorant of this subject. I wasn't prepared. No. The one who told me a bit was my grandma, but she only told me when I got my first period. Then, she told me that I needed to avoid eating everything. (Laughs.)*

Preparation for menstruation was also a different experience for those from more educated families. Contrast these descriptions of first menstruation with those of the campesina women:

*Even when it was my first time was very nice, I receive a good training. She said I need to prepare myself, because I'm gong to have changes, and she start to explain the first change. ...And she said, "Don't be scared", and she said we had to learn, to see ourselves in the mirror, because through the mirror we can see how our physiological changes are coming. ...she explained to me that this is going to change you, someday you are going to have a mark on your panties. And don't be scared, just tell your mum, or tell me, or tell your nanny.*

*...we had a family doctor, this doctor, when I was, 10 years old, I start to grow up my breasts, so my father, my father took me, to the doctor, and said, please explain her what she is going through. And the doctor told me, but my father, not my mother......Nothing. And so my father took me to the doctor.*

However, the women from more privileged families were also given a clear message on the importance of sexual purity:

*I learned that the most precious thing that we have, as a child, was to be innocent, to keep the innocence until you need to talk about things.*

*The main thing was to avoid sexual activity. The problem was to get pregnant and destroy your future. That was the lesson.*

The contrast in access to health information continues into adulthood. Many campesina women didn't even know where they could get information. One woman

described her attempts to get contraceptive information.

> *Yes, I only had four (children), I told the Nina M about that. I wanted to take something, but I didn't know what to do to avoid pregnancies, so I consulted this lady. She told me that she had some pills she could give me, and if I had told her sooner, she would have given me some. "You can take these", she told me. I took the pills the lady gave me and that is why my last pregnancy, that with my daughter, was bigger than the last one. There was the biggest age difference, there were three years between her and the last one. The last daughter.*

Contrast this story with the story given by a professional women regarding her access to

birth control information:

> *Yes, I used birth control before I was married, because I was having sex....So I talked to a friend and I said, "I need to know about gynaecologists. Who is your gynaecologist?" And I chose__, it was a very pricey person, but then I don't want to meet anyone at the clinic, so the price that the doctor charged allowed me to remain anonymous, right?*

Excerpts from the women's life narratives personalize the data on availability of

health services in El Salvador. According to statistics provided by the Pan American

Health Organization, only 37% of Salvadorans have access to formal medical care. In

1992, the Ministry of Public Health and Social Welfare had 5 physicians per 10,000

population, 3 dentists per 100,000, and 6 nurses or nursing auxiliaries per 10,000. Health

care resources remain highly concentrated in the urban areas, particularly the capital of

San Salvador (Pan American Health Organization, 1990).

## Response to Health Concerns

Most of the poorer families described reliance on health advice from within the

family and on home remedies. For some women, these remedies were seen as an

effective (and sometimes superior) alternative; for others they were clearly the only

resort - it was this or nothing. If these were ineffective, the next step for some was to

buy patent medicines available at pharmacies, or more often *"tiendas"* (small corner

stores). Self diagnosis and self medication were therefore common. As a last resort a

doctor may have been consulted. Wealthier families may have also used herbal or home

remedies for minor ailments, however, any serious concern resulted in a physician visit.

## Importance of Personal Connections to Health Care Access

The relationships, or connections women had through their family were also a

crucial component in health care access. You may recall that the woman who arranged an

abortion did so through her cousin. Other examples were also given

> *..my doctor at that time, my doctor was a member of my family, my grandma's side?, and when I was sick, I needed the penicillin at that time, he always go to our house,.....so I didn't need to go out. But I think, that's what I said, was a privilege that my family had that, the possibilities to do that.*

> *You know, I had really good luck, always, God always bless me because when I went for my first baby, my, my in laws had a nurse, so she was the head of the nursing department, so she put me in a nice room........And she always was checking me, you know. "Do you need something special, do you " you know. And then with my second one, they set up a small room, just for two, so I was like pampered again. (laughs) And some of my, one of my brothers classmates was one of the physicians who was taking care of my kids, so was nice. And my third one, one of my friends was my doctor, and I was in a private room.*

It should be noted that even those who were less well off depended on "connections" to

get necessary care. One woman describing being injured as a young girl and needing to

take an ambulance to the hospital said:

> *They said, because the ambulance was too small, they said they could only take*

*one of us. But the other guy said "I'll pay you anything, so you can take me too".*
*They didn't want to take him, they only wanted to take me, because my father had,*
*he used to work with the Red Cross before.*

## Impact of the War on Access to Health Services

Rarely did the women directly compare health care access and quality before and

after the escalation of the conflict. This is in large part because issues of service were

related to position in the society, and this did not change. One professional woman,

widowed due to the war, said:

> *And I started to, you know, look for some help. I went to see the psychiatrist.*
> *And also I asked for some help in my church, and also I took this mind control,*
> *(the Silva)method. That was really good help. ( Later she says of the course she*
> *took) This club is kind of, well this course is really expensive, so unfortunately is*
> *just for people who can pay.*

### Violation of Patient Rights

However for many of the poor health care access appeared to get worse. As the

war intensified, the discrepancy between'"what was supposed to happen" in terms of

health care delivery and standards and the actual situation was exacerbated and the lack of

respect for poorer patients, and their safety was further compromised. One woman

reported the treatment her father received after being taken to hospital (for what was later

described as a mild stroke):

> *After my mother left, because she had to take care of the children, they loaded him*
> *into an ambulance and took him to the waste grounds at S__, by the river. Then*
> *they just dumped him there.*

When asked why they would do this, she said it was because the family was *"under*

*suspicion".* She felt that it was by a miracle, by God's intervention, that he was able to make his way to the nearest village, where he collapsed in the street. By chance one of the people passing by recognized him, as he had relatives in that town. They took him home and cared for him.

Violations against both health workers and patients, usually by the Salvadoran military, have been clearly documented. Violations include discriminatory practices directed against sick and wounded, including denial of care to sick and wounded; arrest and detention of sick and wounded; assault, rape, torture and murder of medical personnel for engaging in activities consistent with medical ethics; deliberate disruption of training programs for medical personnel; inhumane treatment of both medical personnel and the sick and wounded; and military attacks on medical personnel and transport units. A high death rate among guerilla medical personnel was reported, including medical professionals from six other nations (Brentlinger, 1996; Lundgren & Lang, 1989).

### "Underground" Health Services

As the conflict intensified, more and more services were delivered "underground". The fact that some families were in hiding made it dangerous to seek medical help. After her husband was attacked and left for dead, one woman described caring for him alone.

> *They hit and left him for dead. Like he still has problems with the ribs, like I think*
> *he had five broken ribs, at that time.....Because he was so sick, he didn't get any*
> *care, like nothing. He couldn't go see a doctor, he couldn't just leave, he was just*

*hiding, like he opened a big hole, and then he hide there.* (summary of interpreter).

It took him a year to recover, his wife was only able to treat him with herbal medicine and with prayer. Another woman described helping "kidnap" a doctor in order to provide an operation for an injured guerrilla.

Those living in areas controlled by the guerillas had the least access to medical personnel (Pan American Health Organization, 1990) and medical units were often the target of the army. Some care was available from doctors working with the guerillas who also trained local people to provide basic care. However, medicine and supplies were extremely scarce (Metzi, 1988; Lopez Vigil, 1991) . Women gave birth "on the run", with no experienced assistance.

*My boyfriend helped me, my mother in law helped me too .*

*People who were more or less prepared to help with this, we didn't have them. For this reason, I had no one who attended me for the birth, no doctor, or personnel who were prepared who had experience. My first daughter was born only with us, my father, my mother, and my husband. And one friend who was there. But she only knew how to keep me company. Only knew how to cut the cord? But she didn't have any training, study or anything. The two first ones were born only through the will of God (laughs). But no, we didn't have anyone.*

For those injured in battle the situation was even more precarious. One woman describes how during one battle, her son was missing and presumed dead. However he was located and taken to hospital where he was admitted under a false name. While he survived his injuries, relatives in Mexico were unable to apply for him to come to Canada

with them, as he could not be located under his real name.

## Disruption of Health Services

As indicated above, the war created severe difficulties for rural persons in accessing health care. In addition, the conflict also had impact on the working and middle classes in the towns. One young woman described being injured as a bystander:

> *They wanted to kill the owner of the store, and I was there at the time so I got shot. They had to take me to the hospital and I had to spend a month in the hospital. We had to go by ambulance. And at that time it was the worst time in the war. The war was still going on, they didn't want to take me because it was in the middle of the night, it was about one o'clock in the morning. So they didn't want to take us.*

> *When they treated me for the wound in the hospital, it was really bad. Because the hospital was full, they didn't have any anesthesiologist available, so they cured me without anesthetic. It was really bad. (crying). Without any painkillers.*

It has been documented that the health budget was decreased during the war, with funds diverted to the military budget. From 1980-1991, health services dropped from 10.8% of the total budget to 8.1% of the total, while defense spending rose from 14.4 to 22.8% in the same time period (Beirne, 1996).

## Health Access During Migration

It must also be remembered that families (particularly from rural area) often spent many years as displaced persons within their own country and in countries of first asylum. In this context too, the experiences were very much determined by social class. Many of the poor faced the same issues of access to health care as they did in their home country.

In some cases it was worse, as they were undocumented and separated from family and

friends.

> *And then (my son) was born in a clinic in Mexico because we didn't know*
> *anybody that could do that for us, and uh, I was more scared because it wasn't*
> *people that I knew. Plus it was only a month before he was born, that we moved*
> *to that small town. ....I was scared to stay home, we went to a clinic. We had to*
> *pay a lot of money, it cost us 40,000 there at that time, at that time it was about*
> *$40 I think, but it was a lot of money! (My husband) was making only 2000 a*
> *week and to pay 40,000, that was a lot of money, he had to borrow money.*

> *But the hospital in Honduras a very poor hospital. Some lady, dying the five days*
> *born baby, is very blood on the clothes, is fall down , die, the doctor is in line,*
> *going many women, in line, the same waiting, I am in line too. The lady die on*
> *the floor. Many blood on the clothes. I scared, I see the lady die, I scared I am*
> *(bleeding) too, Oooh, maybe I am die too I am thinking! (laughs).*

## Summary

Salvadoran women who were better off financially reported access to medical

services very similar to that in Canada. The key difference was that services were based

on ability to pay. For the middle class there were also some reports of quality of care

being linked to personal connection. However, the poor had a much different

experience, and many had little or no access to health care as we know it. Access to

medical care continued to be an issue for the poor in countries of first asylum.

The impact of the war had little effect on the health services received by those

who paid privately. However, for the poor, escalation of hostilities resulted in reduction

in services, and some cases, blatant violations of patient rights. In addition, it has been

documented that medical neutrality was violated in a number of ways during the war.

# CHAPTER 13

# UTILIZATION OF AND SATISFACTION WITH CANADIAN SERVICES

## Access to Health Services: Arrival in Canada

Immediately on arrival, newcomers were given the name of a doctor to attend. Some women indicated some dissatisfaction with this as they did not feel that they were oriented to the choices they had. Often they were simply told to go to a particular physician. One woman stated that she was sent to an English speaking doctor, and not informed of Spanish speaking ones.

> *We visit Canadian. Because is the doctor they had for people, they didn't have Spanish. Or if they did they didn't show us. (laughs)... I remember, Doctor ____They show us, yeah. They give us the name. For our checkup, yeah. Was English, yeah.*

Initial reaction to health services was linked to social class. There were no complaints from those from poorer backgrounds, however those who were used to getting the services they required sometimes felt that they had to accept lower standards and services

> *But maybe it was a little bit different because we depend on the government at that time. And certain things, you not allowed to have it. ....Like for example, my daughter use the braces. She have the braces when she came here. They took it out because the government cannot pay that thing. Was a very bad thing for us because she just had one year, she must to continue because she need it for the treatment. But, uh, was impossible, even that we said maybe we can pay one part. But they said no. And that's very bad, because we stop her, you know.*

> *With the glasses was another thing. ...The quality was very like, uh, older, not really the quality, older, is better to give it to you to throw in the garbage. For me was a very bad experience , because I said, my eyes are so important for*

*me.....And maybe I think maybe they considered was a luxury?* (She then offered to pay the difference in price herself, but this was refused.) *My husband was so upset....And is not possible that we have it in my country, and because we come here as an immigrant we are not going to have the same thing. She is going to have more problems. Why? Just because you don't want to accept the difference in the money?* (This latter situation was resolved by appealing to the manpower counsellor, who authorized them to pay the difference.)

## Current Use and Satisfaction

Women appeared to use basic health services confidently and appropriately.

There was no evidence from this study that there were any differences in utilization of

health services based on social class background. However, it was not surprising, given

the diversity of experiences that women faced in their own country, to find that the level

of satisfaction to health care services in Canada also varied considerably.

For poor women, health care in Canada was generally felt to be excellent, and

was, for many, one of the reasons they would choose to stay in Canada:

> *Well, I, I think its great, because I know when you go to the doctor, that's why its so, so, hard for people in El Salvador to go to the doctor, because every appointment is money, and a lot of people don't have money to just go for a check up and things like that. But I know like here, if I ever, if anything ever happens to me, I know the doctor is just there, and I can just go and its just, I feel a lot, not safer, maybe yeah, safer, just that you can depend on them to take care of you and things like that.*

> *Many times, in the situation I found myself in, I had no money to pay the doctor, so I couldn't see one. Yeah. And here no, because here, if I have a pain, I go to the medical centre, or the hospital. And I am very well looked after. And there (El Salvador) no.*

> *Here though. Is more clean, and we have everything. And even the medicine. We buy the medicine ourselves here, we can afford to buy it.*

This appreciation is not simply because the service was free. The standard of care was

perceived as being higher, people were treated with greater respect, technical standards

were higher, and simple hygiene was maintained.

> *Well I never stayed in a hospital in my country but this, is completely different in my country because in my country everybody say about the bad treatment for the nurse, even the doctors, especially when they deliver the babies. Because, in my country, the nurse, is, I don't know, maybe joking, I don't know, for the woman in the deliver time. But here, the nurse, that's good, because they try to help the woman. Even they try to help the husband. But in my country, no.*

The Immigrant Refugee Health Program (at what was then Planned Parenthood

Manitoba) also documented instances where some pregnant women from El Salvador

were afraid to give birth in the hospital because of fears of mistreatment (Stevens, 1993a).

> *Definitely, I felt good to have my two children here. They looked after me very well, I felt perhaps better here. Because of the help! ..And I felt happy to have feel that someone was with me. Cleaning me in the first place. Yes, I felt more comfortable (laughs), Yeah. In that way I felt more comfortable here because of the hygiene. Over there, out in the country, there was no way for you to keep clean. I have seen the difference in hygiene, the assistance here is better. It's better.*

> *Even for the Caesarean, in the, in the Caesarean my country make here. (demonstrates vertical cut)... Some people, some people in the tummy, big stitches, big mark for the stitches. But my husband says, nobody can say that you have a caesarean, because no stitches, nothing, nothing. That's good.*

(Note that this example also is an example of the different standards of care received by

women of different social classes. In another discussion, one woman explained that those

who could pay would get a "bikini" cut, but in poorer women, "no one cared". ) In

general, women report learning how to access the system, and what was expected of

them as patients, with little difficulty. Sometimes the information they were given was

not correct. One woman was told that she had to have her baby delivered in a hospital,

or the police would come, that birth at home was *prohibido* (not allowed). While access to doctors and hospitals were the health care services mentioned most often, access to dental care was also highlighted along with other community health care services. One woman described her experience with the public health nurse following the birth of her baby as follows:

> *Give me more pamphlets to reading about the babies, about the kids, when they going to school. Yeah, because for my caesarean she checked me, checked me what happened, or I not bleeding too much, she asked me what happened, or she give me the phone number, even her phone, house, at home, if I feeling uh, something at night, I can phone her! Yeah. But I don't need it. In my country never receive!*

Women from more privileged backgrounds were less impressed with the health care delivery system. Some found the health care quality similar, and some even less than that to which they had become accustomed to in El Salvador.

> *Yes is very good. I didn't feel the difference because we have similar. I not talking about general things that everybody in my country has, but my own experience, with my family we have.*

> *The system helped me in the sense that there is a doctor that I don't have to pay like I used to? But for me, doesn't make a difference because I am accustomed to pay?*

While none made comments about the relative quality of care, the lack of personal treatment was of concern for some. In addition, the inability, now that they were in Canada with reduced incomes, to obtain the same standard of care to which they had become accustomed, was a significant stress for some. While for some women this drop in health care access was temporary and passed once they were employed, for others, it

continued to be a concern. One single mother stated:

> *I had my first cavity at 18. (laughs) And this is something that bothers me now. Because I cannot go to the dentist as regular as I used to go? And my dental, um, situation is not as good as used to be. Is deteriorating because my lack of money to go, even though I receive 80% from (insurance at work). But who are the priority? The kids. So, so it bothers me. Because before I could do that and now I cannot. I could do many things before that I cannot now.*

This is not to say that the women interviewed were completely satisfied with all of their providers. Many of the same gender - related issues that caused complaints from Canadian women were commonly mentioned. In particular there were complaints that physicians did not listen or explain, that they did not present treatment alternatives, and that responses to psychological complaints were inadequate. There appeared to be no difference in these types of complaints whether the woman was receiving care from a Spanish - speaking or English - speaking provider. One woman used a Spanish - speaking pediatrician for her children, but described two instances where he was not taking the action she felt necessary and so took them back to her Salvadoran family doctor, to ask for the tests or treatment she perceived to be required.

Another woman delayed surgery because of her lack of confidence in the specialist, and feeling that he was trying to pressure her into surgery.

> *I mean, he didn't explain anything! Like things should be explained to somebody, like you do this and this and that, and this can do that and this can get complications. But explain to me first and then say there is options. You can cure for this and there is surgery too, like that's what I felt...I never even go and see him again. I said no, this doctor is no good for me.*

One woman had difficulty understanding what the doctor was telling her was wrong - even though both were speaking Spanish. She attempted to clarify some health concerns with me, saying , *I don't understand this sick. I don't know. I don't know what kind of sick.* Another changed her parents' provider of primary health care (even though they could not speak English) because she could not get appointments quickly when they were needed. The Spanish speaking physician was "very busy", and would not necessarily be available when needed.

Another issue, raised by some of the rural women specifically related to reproductive health, was the embarrassment of a pelvic exam.

> *I was so scared, I never had. Like women, only in El Salvador I never would, you know, let any doctor see me there? ...I still, I am not comfortable with a doctor.*

> *Yeah, I am shy, never see me the doctors. Yeah. I am, when born my son, I am shy...no good for me, many doctors looking at me.*

This, however, was an issue of class and access, not of societal culture as pelvic exams were a procedure with which city women were well acquainted.

Only one of the women interviewed expressed a high level of dissatisfaction with health care in Canada. This woman had been suffering from a number of health problems for many years; some of which appeared to be the result of medical mismanagement. This was the only woman interviewed who did not describe herself as generally healthy. Interestingly, she at first settled in a smaller Canadian city where there were few Spanish - speaking persons, and she could not gain access to a Spanish - speaking provider. Lack

of access to service in her language was described as the key reason she moved to Winnipeg. Her description of her experience with the health care system suggested that language barriers, and racial/cultural stereotypes may have contributed to the problems and misunderstandings. This woman remained highly critical of health professionals, suggested that the providers may be racist, and felt she has had worse experiences with medical care here than in El Salvador. It has been suggested to her that her problems may be psychological, but she vehemently denied this.

## Issues Related to Health Care Access in Canada

Two problems related to access are reported, only one of which remains a current concern for most women. The first is that of interpretation for medical appointments; the other is of finding appropriate treatment for conditions they believe to be rooted in psychological causes.

### Health Interpretation

Most of the women interviewed did not spontaneously raise the issue of language interpretation as an issue for health care access. There appear to be three reasons for this.

a)  At the current time there are Salvadoran physicians (as well as other Spanish speaking physicians) practicing in Winnipeg. There are also Spanish speaking pediatricians, and gynaecologists. Most women interviewed reported using Spanish speaking physicians.

b)      The majority of women interviewed are at present quite fluent in English, and

while they may choose to consult Spanish - speaking professionals, can obtain

health care in English without assistance.


c)      The women selected for interviews had arrived in Canada at various times, from

the mid 1980's to the early 1990's. Those arriving since the late 1980's were able

to find other women to interpret for them. Some specifically mentioned using

trained staff or volunteers from the Immigrant Refugee Health Program at Planned

Parenthood, or Manitoba Association for Childbirth and Family Education.


Generally, the difficulties in communicating with health care providers were

minimized, although some women recalled times when not being able to communicate

with the provider created concerns.

> *We were able to handle because my husband has a little bit English. Is different because we were always, the first year, we went together everywhere. We never need a translator.*

> *Just only my first pregnancy, when I went to the doctor, I just only said "Hi!" And she said, I remember she asked me, "How are you?" And I know that, I remember, and I said "Oh, good!". But I went to the nother doctor and I told him what happened to me, because I bleeding some time, bleeding. But I couldn't tell my, my gynaecologist, I couldn't tell her because I didn't know how.*

This woman also ended up with an emergency caesarean without her husband, or an

interpreter present. When asked how much she understood what was happening she

responded:

> *Well, not too much. But my sister speak more than me. ......And the last time, the*

*nurse, she speak Spanish......And she helped me.*

The fact that most women did not identify interpretation as a major issue however is perhaps misleading. One of the characteristics and limitations of narrative reconstruction is that past events are "reconstructed" from the perspective of the present time. That problems in communicating with health professionals on arrival are not from the current vantage point considered of prime importance, does not mean they were not a concern at the time they occurred.

The reality faced by many new arrivals perhaps can be demonstrated by the problems faced by one informant, a woman who first arrived in a smaller Canadian city with few Spanish-speaking immigrants. She described tremendous difficulties in obtaining interpretation for serious health problems, The doctor who performed her first gynaecological surgery did not speak Spanish. The woman had two interpreters, a nun who had spent time working in Central America and spoke good Spanish, (at the hospital) and a volunteer from a settlement agency. The result of her continued pain and complaints resulted in her being sent to a psychiatrist. She said:

> *"Why I need? I don't need."* A family doctor, described as very nice, also a
> minority, told her it was not true that she needed a psychiatrist. *She said that I*
> *was very sick but said "I can't pressure them, I might lose my license". She said*
> *they had done muy mal trababjo (very bad work). She said I should go to another*
> *province. The nun also thought I should leave. A resident told her "She has a*
> *very big problem with her stomach, but my boss won't do anything." They don't*
> *care about patients. I felt that they were maybe racist, if were Canadian would*
> *treat me different. Another reason is I couldn't speak English and explain my*
> *pain.*

In Winnipeg the woman continued to have health problems that prevented her from working. She was fearful that she might have cancer, and found it hard to accept reassurances from doctors. It is difficult to determine whether any of her difficulties could have been avoided or minimized if trained health interpretation had been available when she arrived. Its absence has clearly contributed to the distress she experienced.

Although she has been able to find a health interpreter in Winnipeg who she trusts to maintain confidentiality, sometimes this person was not available. She has also used another interpreter she trusts from another organization but this person was not supposed to be interpreting for health appointments. She has been told *"please don't tell anyone I came to help you, it is not my job"*. She described one incident in the hospital where in the process of doing an invasive procedure:

> ... they *called in a cleaner, a man. I said "Please go", but the doctor said "No, he has to stay here".* She described the situation as *"mucha verguenza"* (extremely embarrassing, causing shame) for both herself and the man. She then asked if she could not have her son (a high school student) interpret *but they will not let me, they say is not good. But they will use that man, a cleaner.*

### Response to Psychosomatic and Psychological Concerns

The other issue that arose both in the individual interviews, and in the woman's focus group was the problem of getting help for health problems believed to be caused by stress, and for psychological concerns. Several reasons were given for this

## Confidentiality

An important barrier to service use is the fear around confidentiality. Sometimes

fear of confidentiality breakdown focuses on use of interpreters, and other Spanish

speaking helpers.

> ..I didn't want a translator, a Spanish one. I have that fear because of all the
> problems, so I don't want anyone from the Spanish community; I don't want, like
> even if I don't understand.

Some women recognized that counselling may be useful, were aware that

services were available, but were afraid that accessing such resources may result in their

concerns becoming known in the community. This was most pronounced where

counselling services were needed in Spanish.

> One time I want to tell Dr. __, if he can help me for a psychologist? But
> sometimes I say, maybe not, because, one, does the psych in Spanish, I don't know
> who is. One lady told my brother, if you want tell something to psychologist,
> maybe another people know, what do you tell her.

The fear of gossip, and the distrust directed towards others in the community appeared to

contribute to this. One woman gave a specific example of a breakdown in confidentiality

regarding psychological services obtained for a family member. Negative experiences

with one individual risk creating distrust with other providers even if they were

meticulous about confidentiality.

## Awareness of Resources

In some cases, women did not know where to go for help, other than to their

family doctor. On two occasions the researcher was asked for referral for counselling

services. Over the course of this project she became aware of increased use of such

resources for one family; however it is not known whether discussions regarding use and

availability of such services affected the use.

## Embarrassment Regarding Stress Related Complaints

Some women recognized and described a pattern of somatizing physical

complaints. This was expressed most clearly in a focus group discussion where one

woman stated:

> *Sometimes I imagine things. Once my doctor jokingly told me "Mrs..., you already have had cancer, diabetes, tuberculosis, heart disease, everything!" Everything was only in my mind.*

Another said:

> *If someone dies from something, would I die from the same disease? Another person died....Oh my God! I am starting to feel similar pains here and there! The doctor keeps telling us "You don't have a thing wrong with you" and we go back so many times to see the doctor to the extent where we feel ashamed, right? "Doctor, I have this pain here, I have this pain there!" People may say about me "Oh, here she comes the woman that has all the aches and pains!". I feel ashamed.*

> *I think the doctors may get fed up. They may think (in a joking tone) "I am going to give these aspirins to this woman, I'll say they are for her heart. So, so she will stop bothering me".*

The group laughed and agreed. However, while the group was able to joke about it, there

was real frustration expressed in some of the individual interviews. However, as

discussed in Chapter 9, developing somatic complaints in response to psychological

distress is seen as normal. Physical symptoms expressed emotional distress, they did not

appear *instead of* emotional pain.

There appeared to be a range of attitudes to using psychiatric or psychological services. Some have used psychiatric and other mental health services for specific problems, either here or in El Salvador; others have not. Use of such services in El Salvador, as in the use of other health services, appeared to be class related. Some women stated that one does not see a counsellor or psychologist unless there was something wrong with you.

> *Yeah for me counselling, like back home counselling is just for people who are crazy. (laughs) People that don't, you know. And psychiatric places are just for people that are really, really,.....sick! Not for a family like us. So, so its just that you don't believe in it.*

At one level this view is shared by many other Canadian families. In this context however, of a family which has survived severe trauma, there was another statement being made. Counselling is for situations where there is something wrong with the individual or family. In this situation the woman believed that the family was healthy; it was the "situation", they have experienced which was "sick".

There appeared, however, an openness and interest in accessing psychological or counselling services. It appears that the lack of information on services, and fears related to confidentiality are the real barriers.

In the cases where the women interviewed discussed going to a counsellor, it was for assistance with family or relationship problems. A number of concerns were reported; stress related to an adolescent children who were getting into trouble, help with coming

to terms with sexual abuse, and problems in a current relationship.

> *So, so I went to a psychologist. For counselling. Because I felt like I have to talk about it, I have to say something about it. ... And so, finally, without counselling or anything I just got over it. But then when these problems start again, and then I was confused again. I knew what to do, but I needed somebody to talk to, somebody that I could trust. And that's why I went to counselling.*

Others spoke of participation in school or workplace counselling programs. One woman reported visiting a school counsellor while coming to terms with an accidental death of a friend. Another spoke of the usefulness of such critical incident debriefing in the work environment. These contacts were reported as helpful.

## Sharing Information With Professionals

One of the findings of this study was that very little of past personal history (particularly the events of their life in El Salvador) was shared with health providers, even those who were Spanish - speaking. In spite of the fact that many of the women who participated in this study recognized that psychological factors played an important role in their experience of health, little information regarding trauma, or family stress was shared with professionals. Research related to disclosure of sexual abuse supports these findings, with as few as 5% of women who have experienced abuse reporting this to their health care providers (Lechner et al., 1993).

This information was probed for with two questions in the interview "Have you ever told your doctor, or any other health care professional about these experiences?", and "Did he/she ever ask you about your past experiences?". Both of these questions

received a negative response in almost all cases. This issue was also explored further during the feedback stage. In general women reiterated the belief that it was not a good idea to share information regarding war related events in El Salvador, "unless you are really sure you can trust the person". This was not necessarily a distrust of the particular provider, but a general coping strategy. There was also evidence that even when there had been some attempt to share information, the response may be less than ideal.

> *When I was a newcomer, I had very repeated and strong headaches, very strong. I visited the doctor frequently, and he said, "Do not think of your son, do not think of anyone you have left there." But of course I had to think.*

Another woman who survived a number of atrocities and reported a number of symptoms consistent with Post Traumatic Stress Disorder, says she has never been asked about her past experiences by health care providers, and has told them *"not too much, a little bit"*. She says that when she complains about severe headaches, the doctor *"only give me Tylenol"* About the dizziness he says, *"You have nervios"*. *Yeah. Tengo nervios de la guerra, talvez creo yo, estoy nerviosa"*. (The doctor says the headaches are due to her nerves. Yes. Sometimes I believe I have "nerves" from the war, I am nervous). When asked whether she has talked to anybody else about the war, she says *"No, only to my children talk about this"*. At another point she complains about gynaecological difficulties. She has *"infection, itchy, pain. The doctor give medicine to put inside"*. When asked whether she has ever told the doctor that she had been raped during the war she says *"No, I am shy. Only you. "* She stated that she has never had "counselling" about these issues.

Sharing with health care providers or counsellors may also be selective. For example, in a marital crisis one woman did talk to a counsellor,

> .......*but not that (specific trauma) or anything. No, no. None of them knows about it. Not even Dr......, I go to him, but he doesn't know about it. I don't talk to him about that.*

There was also some indication that even when women are asked about their lives they may be reluctant to share information. In the course of the project the researcher encountered an acquaintance who immigrated from El Salvador in the early 1980's. The woman had experienced significant trauma in El Salvador serious family·problems here. She spoke of worries about her health, including investigation of cardiac symptoms. She said that the doctor had asked her whether she had any stress or depression in her life *"No!. No, no, no., nothing like that"* she reportedly told them.

## Use of Other Community Resources

While the study focused on utilization of health services, use of other resources within the Winnipeg community was also explored. Utilization of community resources can be further subdivided into use of settlement services and ESL Programs, use of resources within the Latin American Community and use of generic community services.

### Settlement Services and ESL Programs

An important resource for new arrivals are settlement services. The federal and provincial governments provide some services, with "settlement agencies" and ESL

(English as a Second Language) programs funded to provide additional services.

One finding of these women's recollections and interpretation of their initial

settlement experience was the significant level of dissatisfaction found with the services

provided by the settlement agencies and by ESL programs. While not all women reported

negative experiences, and some stated that services had been helpful, the positive

evaluations were at best lukewarm.

## Settlement Services

Experiences with non profit settlement services were often described in negative

terms. Two of the women described the helpfulness of *specific individuals* that they had

met through the settlement programs, in both cases "Canadian" helpers. However, in

general the women spoke critically of the support they received (although the response to

the government services was generally not as negative). Some of the women focused

specifically on negative experiences with the Spanish speaking case worker assigned to

orient and assist new arrivals:

> *She was so rude, she just said, for what reason are you here?........And then she said, "OK, you think you're going to find a better life than in El Salvador, if you think you are going to get a better job than in El Salvador, then you are wrong."*
> *.....But she never show us, like friendly. She always complain about her job, I don't know why she had this kind of job. Because when you working with people, especially in that situation, you must to be polite you know.   ....And then with the lady who is supposed to help us with the apartment, she wants to give us apartment in the area she likes....One lady, she told my husband that the reason that they always like to put people in the same place is because they are receiving commission, from the landlord or for the manager, I don't know. My husband was so upset at this time.*

Services that are assumed to be available by service providers were not found to be so by the women reporting their experiences. For example provision of interpreters during the settlement period was reported to be less than satisfactory.

> *Well I did once, to go to the dentist. Well, the interpreter came with us, but left us there (laughs). And he didn't stay. He was supposed to be our interpreter. We didn't use that much. He came once to the dentist, and he came, went, we went to register the children for school....*

> *We don't even know how (we managed). I remember going to pay our deposit for our apartment at the beginning. Like when we first, they gave us the money, gave us the address, and said this is the deposit for your home, for your apartment. So go and pay it, this is the address. We didn't know how to get there. And they told us the bus 12 goes by the apartments, and so we got bus 12, but we didn't know how to get off or anything. We didn't know how to ask, it was very hard, we were lost for about 2 hours. But finally we took the bus on Elgin, or on William I think, we asked people how to take bus 12, and so we went tot the apartment, and I was so afraid because I didn't speak any English, I didn't understand, I didn't go in the building, only (my husband) went in and he came out with the receipt. How he did it , I don't know. I asked him "How did you pay?" "Oh I just went and told them that (name) sent me and this is the deposit, in Spanish." So he paid, and they gave him the apartment number where we were going to move in. And then to get back we didn't know what to do. It was very hard, but he says "If we took that bus there, that bus should go there somewhere, close or.." Or before, when we were living at Balmoral Hotel, we went this way, we went everyway, like getting the street names and everything. Everyday, to know more how to get around. ... That was the hardest time that we had. And then we started going to school, we came Thursday, and we started going on Monday. We didn't want to wait. Like, but we were very scared! And we didn't use that many interpreters.*

As outlined in Chapter 7: Community, host family programs were also not well evaluated by many.

It should be noted that these services were used by informants on initial arrival only (and for many participants this was many years in the past). This is appropriate as the mandate of such services is initial settlement. It is unclear whether the participants

would have described service satisfaction so negatively had they been interviewed at the time. As date of arrival spanned a period of ten years ending in 1992, it is expected that there have been not only staffing but programmatic changes since then.

## English as a Second Language Programs

Most, of the women participated in ESL (English as a Second Language) programs upon arrival. Again, there was a some criticism about this service. Some of the criticism was related to the program quality itself, some to the length of time ESL was provided. This was the experience of one woman who was one of the latest arrivals:

> *The first, and the second I went to the school, February 14, everyone speaking Spanish! From this course. Everyone talking, talking, talking Spanish. How can I learn English, if everybody speak Spanish? That's a big mistake I think (name of program) make. Even the teacher try to speak Spanish.*

> *When I finish this three months, the social worker tried to helping to me to find a job, but I was a sewing machine in my country. When I came here I went one factor(y), and they tried if I could use the machine. But maybe my nerves, my English, my confuse, I couldn't use the machine. I, and the lady said no, maybe another time, she need practice. But that, maybe that's for that reason. And then Manpower sent me to receive the, how do you, ummm, the school between, the ,, no, ummm, how do you say, oh my God, I forgot! El courso de verano? (Summer school).Summer school, OK. They sent to the Elgin for the summer school, and that lady, went to our classroom, and said, these people are coming to the summer school, but this is not allowed because they stay with Manpower. Just only the people who not stay with Manpower can to receive the training. Because Manpower can pay for another training ...... No just only me. Four or five going out, because we are stay with Manpower and we can't taking this course. How can I learn English in this time! Nothing. I didn't have opportunity to, I can't go to the school, because I don't have English. But how can I learn!?*

The professional focus group was also highly critical of the ESL system and provided a more systemic critique. These are excerpts from the discussion on ESL programs:

*But there were a lot of racist teachers there..*

*Also it is an economical interest there. If you lose your students you, you teach them how to fight you know, how to increase their self esteem, they'll go as soon as possible.*

*That happens in service agencies as well, you have to keep the population there, and so you have a job. ...You keep the population, you don't empower people because you need to guarantee that you have a job, so you keep people there, you don't empower people. So that happens at ESL too.*

*Well the ESL is pathetic....*

*but especially because there is a lot of racism.*

*There is still a group of people that have been here for 17, 15 years in ESL classes at (location) and somehow they are stuck. People are afraid to go to that school because if you go there you're stuck and you don't leave and you don't advance.*

It appears that for some of the women, the reception they received immediately on arrival set the tone for further interaction with both the Spanish - speaking, and general community. There was evidence that in some cases those assigned to help exacerbated the suspicion and distrust of the community, as well as feelings of social isolation. *"After (this experience), we were afraid to trust people'"* one woman stated in the conclusion of her description of experiences with the settlement agencies. In addition, a number of women continued to struggle with English, even after several years in the country. While there were very likely several reasons for this (illiteracy, responsibility for young children, avoidance, and learning difficulties attributed to past disruption), it does appear that access and satisfaction issues also play an important role.

<u>Use of Resources within the Latin American Community</u>

An important characteristic of the Salvadoran community in Manitoba was the absence of an established ethnocultural community prior to the first arrivals in the 1980's. This meant that, unlike immigrants from some other countries, the community was not in any way "institutionally complete", and that Salvadorans could not expect to receive professional or other services from those from their own country. However there was a Spanish - speaking community in Manitoba. The Chilean community, (which grew significantly during the 1970's) played an important role in initial settlement, as in addition to language, there were some similarities in the political context of immigration.

## The Church

The "Spanish - speaking church" was viewed as a key resource within the community. Most of those interviewed attended a large Roman Catholic parish with a Spanish - speaking priest. Church attendance was described both as a support to faith, and as an opportunity to socialize and find community. While none of the participants were active in other churches, there are number of Salvadorans active in Spanish speaking "evangelical" congregations, and a smaller number who attend other congregations. Those sponsored by a church sometimes attend church with that denomination.

However, there was some ambivalence about church attendance even from those who attend, and some of those interviewed, while describing themselves as believers who

rely on God to cope, do not, or do not regularly, attend church. Gossip, and distrust of

the Central American Community was given as one reason. One woman gave examples

of gossip going on at the church, and of being forced out of church responsibilities by

community rivalries. Others simply stated that it is not necessary to go to church to be

close to God.

> *I no stealing, I no making nothing bad. Some people is good, some people not, in the church. Yeah! ...Some men say, you pray in the home, God listen you for yourself. He say, you no making nothing bad.*

## Salvadoran Associations

None of the women mentioned any of the Salvadoran associations as resources for

coping. However, a few mentioned participation in associations, particularly in

preparation for Folklorama, or in cultural activities for their children. A few of the

participants discussed the difficulties in establishing and maintaining Associations (this

was discussed in greater detail in Chapter 7: Community).

## Latin/Central American Staff

Many of the women reported that they had used language/culture specific

programs within "mainstream" organizations. The Planned Parenthood Immigrant

Refugee Health Program, the Manitoba Association of Childbirth and Family Education

(MACFE), Mount Carmel Clinic (including the Cross Cultural Counselling Program)

were mentioned by one or more participants. The Immigrant Women's Association of

Manitoba was also mentioned. Usually these services were used for a specific purpose at

a specific time. Both Planned Parenthood and MACFE were mentioned by informants as resources for prenatal care and childbirth. The Immigrant Women's Association was mentioned once as a resource for interpretation. The Cross Cultural Counselling program was discussed as a resource for family issues, although it also specializes in issues of adaptation and trauma.

## Use of Other Community Resources

### Police

The resource mentioned most commonly by the women for assistance with problems of family violence was the police. A number of women had called on the police to assist them or others when faced by family violence. The women spoke confidently of use of this resource, and the only negative mention came from a woman who had concerns about a family member's drug involvement: she was critical that they were not able to intervene to prevent the problem.

This finding is not consistent with other observations made by those working in the area of domestic abuse in immigrant communities, and appears surprising given the negative experience with police authorities in the women's country of origin. While there are surely some women in the Salvadoran community, as there are in other communities, who do not reach out for assistance there appears to be a significant number who do.

Government Services

The first contact of new arrivals was with what was referred to as "Manpower" (Employment and Immigration). These contacts were generally described in positive terms. In response to the difficulties with settlement staff, one couple above talked to their counsellor at "Manpower".

> He was *always polite, never rude. And this counsellor explained to us that these people in the (name of settlement agency) is working for them. To give to us the necessary things to live or have the settlement here. And they don't have the right to treat as nothing. They must treat us with respect because we are clients.*

Another woman talked about her experiences with Social Assistance:

> *And I had to go on welfare, which I was so scared, I didn't want to. I refused to go on Welfare. So we had saved the money, because we came in September so in February we got about $3000 from income tax so I used all that money for food so that I didn't have to go on welfare, plus the kids, the children's money, the family allowance? I used that money for food, and I said " I am not going to welfare!" Because what I hear from everyone is that people go on welfare just because they don't want to work. And I don't want to feel like that, and so I don't want to go, and I refused. But he said, what if we have no choice? What are we going to do? So, finally for a week we went, we didn't have food for that week, and I said to him, I don't know what to do, I really don't know. I can't see my kids without food and um, maybe I'll phone welfare, so I phoned them. That was, I think it was Friday when I phoned them, so I booked an appointment for me, for Monday, right away. They said they needed (my husband) to be there, so he phoned his job, he was working on a farm at that time, so he stayed and we were the first ones that go in, so they give us I think it was $350 for that week? And then I was supposed to go back the next week, but by then I was looking for a job. I said to (my husband), I don't want to go on welfare, I refuse, and I will never go. So, the same week that we got that money, I expected $50 or so, like for me, 350, oh boy!, how can they give me so much money for one week only! Like he was going to get paid at the end of the week. So, and then, the next week I never phoned welfare. I was supposed to phone them because they were going to give me money. They were, I must say they were very kind, very good people the lady that interview us. But I didn't phone them. I didn't phone them, and then they phone me. "What is going" - I told them that I have used all my income tax money, I have used all that, they were even surprised, "How did you manage all these months? Like you never came, and your husband is only making this money*

*and for this long. "*

However, not all reports were this positive. One woman felt she was treated in an embarrassing way by welfare, in part because she could not express herself well in English. She also questioned the fairness of welfare workers.

## Educational Services

Education appeared to be highly valued. Many of the less well educated families, as well as those coming from professional families had made a decision to send their children to private schools, and it was commonly expected that children attend university. Use of such services did not, perhaps surprisingly, appear to be much influenced by social class or educational level of the parents.

## Other Social Services

Awareness of available health and social services, other than physician and hospital services, appeared to be low, even among women who speak English well. On two occasions the researcher was asked for referrals for counselling resources. Some women (including one with severe post trauma symptoms) stated that they were not aware of the Cross Cultural Counselling Program at Mount Carmel.

While there was little reported use of other social services, this did not appear to be the result of any resistance to use, or negative experiences, but rather to lack of

awareness, or hesitation about appropriate routes of access. In most cases, women

identified their family doctor as the access point for other services, but if they were not

comfortable sharing the issue with their physician did not know where else to go.

Concern about confidentiality issues appeared to be affecting access to such services.

Because there was limited contact outside the Salvadoran community, locating

confidential advice on generic services still posed concern. It should also be remembered

that there remain many in the community who continue to lack the English language

skills to negotiate access to unknown services. In general the preference appeared to be

to utilize non-Spanish resources wherever possible for reasons of confidentiality and

perceived safety.

## Summary

Satisfaction with Canadian health services (but not access or utilization of such

services) appeared to be strongly influenced by the social class of the informants. While

it appeared that women were using basic health care services confidently, there were

barriers to use of other services due to both lack of awareness of services and fear of

breakdown in confidentiality.

Health interpretation was not seen as an important need at this point in time; however,

this does not mean it was not an important issue at the time of arrival. Reports of early

experiences with the health care system suggest that more could be done to orient

newcomers to the range of services available and their rights to seek out other health

providers.

Little information regarding past trauma appeared to be shared with health care providers, and most study participants reported that information is rarely volunteered or requested. This was found even when the woman felt that past events may be linked to current distress, or when information on past experiences was directly related to the reported complaint (e.g. rape and vaginal symptoms).

Settlement services, and ESL programs in general were not described positively. Many women reported using specific programs with language or outreach capability offered through community organizations. Some other services, such as police and social assistance were evaluated more highly than would have been predicted from the literature. Utilization of services appeared to be pragmatic in nature, and not based on previously held beliefs or past practices. Women demonstrated assertiveness in reaching out for assistance on behalf of themselves and their families, but only if such contacts were experienced as useful.

# CHAPTER 14: CONCLUSIONS

The purpose of this qualitative study was to describe the health of Salvadoran

born women living in Manitoba, from their perspective. This chapter reviews the

findings of the study under five main topic headings. The first section *(Project*

*Findings)* reviews project findings in light of the specific research questions. The

second section *(Discussion of Findings)* discusses areas where study findings support,

challenge, or extend previous research. The third section *(Factors Contributing to*

*Resilience)* explores factors that appear to be contributing to resilience in this population,

along with factors that may create barriers to adaptation. The fourth section focuses on

the *Implications of Research for Providers* and *Implications of Research for the*

*Salvadoran Community.* Finally, recommendations are made for further research.


## Project Findings

This section is organized according to the specific research questions posed in the

research proposal:

1.     **How do Salvadoran refugee women describe their health, and what**

        **experiences are considered important for explaining health and illness**

        **conditions?**

- How do they describe their health, while in El Salvador, on arrival in

    Canada, and at present?

- What importance do they attribute to the refugee experience as a

    determinant of health status through the phases of migration?

## Perceptions of Health

The study participants generally described themselves as healthy and strong. Reported health in El Salvador was reported to be linked to social class, and families' ability to provide the necessities of life and protection from danger. Women differentiated between physical and psychological health, and tended to rate themselves differently on these two measures. Health was understood in a social context, and stress and depression were described as key causes of somatic complaints. Stress related to adaptation to life in Canada, and ongoing grief and loneliness were described as having a great impact on current health.

The Determinants of Health model as outlined by Health Canada (Federal, Provincial and Territorial Advisory Committee on Population Health, 1994), does not adequately capture the scope and complexity of the informants' views of health determination and illness causation. It fails to capture spiritual factors or the dimension of time, as well as the hierarchy of contributory factors and the complex interrelationship between them.

## Importance of Refugee Experience

As outlined in the first chapter, the refugee experience can be described as having two main components: trauma, and uprooting. Interestingly, the second component of the refugee of experience, uprooting, is described as having greater impact on current health status. This appears to be due in part to the "present - orientation" which tends to

attribute current problems to recent events. The stress of adaptation is reported as source of continuing distress, and high levels of grief and alienation are reported.

### Impact of Trauma Inside and Outside the Family Unit

Data also suggest that past traumatic events perpetrated by family members are often reported as causing the greatest degree of current distress. Exposure to childhood sexual abuse, or family rejection or betrayal, appear linked to high reported levels of current emotional distress, particularly depression. Where women reported both abuse within the family, and war-related trauma, the family issues appear, at this point in time to cause greater distress.

2. **What strategies have the women used to maintain their health, and cope with health problems?**

- In what way have they used the formal health care system, the resources within the Latin American community, and self help/self care strategies?

- What expectations do individuals have of services?

- What key life experiences do women share with providers and under what conditions is such information shared?

### Use of the Formal System

Most of the women report using the formal health care system for physiological concerns appropriately and with confidence. Difficulties with access related to

interpretation were reported on arrival, but is not reported as a major concern at the time of the interviews (7 to 17 years after arrival). Caution must be shown in generalizing these results however. There are a number of Spanish speaking providers within the city of Winnipeg, which facilitates access. This situation may not be equivalent for other immigrant communities, or in other Canadian towns and cities. Services provided by Latin American staff hired by health or community organizations were described positively.

There was less awareness of services available for psychological concerns, and many women found little support from the health or social service system in dealing with complaints they believed were linked to stress and depression. Fear of violation of rules of confidentiality appears to be hindering seeking referrals for resources beyond physician care.

Police services were reported to be used confidently related to issues of domestic violence.

## Self Care Strategies

Study participants identified a number of strategies used to maintain their health and treat problems. Coping strategies most commonly described include prayer, talking, working, crying and focusing on the needs of the family. These appeared to be gender specific. Such coping techniques also appeared rooted in the beliefs regarding health

determinants and causes of illnesses.

## Expectations of Services

On arrival in Canada, expectations of Canadian services varied with social class, and to some degree current satisfaction was also linked to class in country of origin. Those who came from poorer families were highly appreciative of health and other services in Canada, and often gave service availability as a reason for remaining in Canada. Those from more privileged backgrounds were less impressed, and were more likely to be critical of services, particularly on arrival.

Patterns of service use can best be explained by pragmatism. Individuals reported using services that they found helpful and effective. No significant barriers to service use related to cultural beliefs or practices were reported.

## Sharing Information With Providers

Data from this study suggest that few women are sharing information on past trauma even when this may be directly relevant to diagnosis and treatment. Women report two reasons for this; lack of trust, and the fact that they are simply not asked. In most cases the women reported that they were not asked about such events, so do not volunteer such information. This observation has been made by other researchers (Goldfeld et al., 1988). Information may not be shared with a particular provider not because of active distrust, but because the provider fails to demonstrate clearly that this

information can be safely shared.

## Discussion of Findings

Some of the research findings confirm earlier research. In other areas, however,

the findings challenge both previous research, and commonly held beliefs about women

refugees.

### Prevalence of Emotional distress and Mental Disorder

From a review of the research related to refugee health (Allodi & Rojas, Canadian

Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988; 1983;

Lavik et al., 1996, Palinkas, 1995) and from both Human Rights reports (Americas

Watch, 1991; Amnesty International, 1994) and the data from this study, (which describe

continuous and often severe traumatization) one would anticipate that the Salvadoran

population may demonstrate a high rate of disorder related to this trauma.

This study did not attempt to identify and diagnose mental health disorders; the

focus was instead on determining, from the point of view of the informants themselves,

women's experience with health related concerns. Many of the informants reported

ongoing high levels of emotional distress; however distress does not necessarily indicate

disorder. Generally this distress was described as depression, or as stress. Depression

was most commonly reported in relation to family separation, loss of country and what is

familiar, and social isolation. Stress was reported related to the ongoing demands of

adaptation, language fluency, employment, parenting and other family relationships. These symptoms appeared to be reality - based, in that they were an accurate assessment of the loss, isolation and difficulty experienced.

In spite of a high level of reported distress, most of the women reported being able to cope with their situation, and to provide support for family members. Emotional reactions were generally described as normal related to the issues precipitating them. Eisenbruch (1991) suggests that the concept of "cultural bereavement" may identify those who can be diagnosed with Post Traumatic Stress Disorder but whose "condition" is a sign of normal or even constructive rehabilitation from traumatic experiences. Data from this study support exploration of such a concept.

## Interaction of Factors Related to Adaptation

Previous research also suggests that a number of factors interact to affect adaptation. These factors include a) individual and family characteristics, b) factors relating to the pre-migratory and migratory experience, and b) factors related to reception in country of resettlement. (Allodi & Rojas, 1983; Al-Issa, 1997; Guarnaccia, 1997; Lavik et al., 1996; Westermayer et al., 1983) Data from this study support the findings that a number of factors appear to interact to predict adaptation ease or difficulty.

### Individual and Family Characteristics

Data from this study suggest that those informants who had made choices to

become politically involved in the issues in their own country tended to be more assertive in efforts to participate in life in Canada, and to express determination to succeed in Canada. These informants tended to describe themselves as strong, or stubborn, and explain their involvement in terms of religious or political commitment. This supports findings that some form ideological commitment is linked to greater likelihood of recovery from traumatic events (Allodi & Cowgill, 1982; Desjarlais et al., 1995 ). Those who reported neglect, rejection or abuse within their families were also more likely to report current emotional distress.

Socio-economic class emerged as a key factor which affected all phases of the migration process. Life experiences in El Salvador were affected at every level by social class: access to health , education and other services, types and intensity of disease and violence to which individuals are exposed, as well as route of migration. In general, those from more privileged backgrounds had experienced less direct exposure to violence, access to health services similar to Canadian services in standards and approach, fewer gastrointestinal diseases, and predictably, were of higher education. Poorer women, particularly those from rural areas, had greater exposure to violence, experienced more types of violence, had a greater exposure to infectious disease, and had often lost family members to disease, violence or both. Walton et. al., in a study of internally displaced Salvadoran refugee children (1997), report similar findings. Different life experiences led to differing expectations of life in Canada, and different challenges in adaptation.

Some of the narratives also suggest that the issues facing the children of refugees may be linked to social class. There was evidence that children of poorer families were more likely to be dealing with issues related to past trauma, and those of more privileged families with issues related to loss of social and economic position here in Canada.

This research supports previous findings that disparity between social position in country or origin and country of resettlement is a major stressor (Al-Issa, 1997; Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988; Federal Provincial and Territorial Advisory Committee on Population Health, 1994). Professional women reported the highest levels of economic stress in Canada, as well as psychological stress related to inability to find employment at an equivalent position. They tended to be less satisfied with Canadian services, including health services. Poorer women generally experienced economic relief on arriving in Canada, and were generally satisfied with employment opportunities.

Several researchers have identified an increased prevalence of psychological difficulties among family members of the "disappeared" (Allodi, 1980; Desjarlais et al., 1995; van der veer, 1998). "Disappearance" can be described as an extreme example of *"not knowing"* (never knowing for certain that the person is dead, resulting in the arrest of the grieving process). This research suggests that psychological distress is linked more generally to " not knowing" (e.g. not knowing who was responsible for the betrayal, why things were done) and is not limited to the extreme example of "disappearances".

## Pre-migration and Migratory Context

The research suggests that the effects of war and persecution are long lasting. (Allodi & Rojas, 1983; Desjarlais et al., 1995; Hauff & Vaglum, 1995) Certainly, the past conflict continues to create tension in the Salvadoran Canadian community. The Salvadoran political context has been described as marked by violence, polarization, and "the institutional lie" (Martin-Baro, 1989). Informants describe the Manitoba Salvadoran community in ways that reflect these dynamics.

The lives of many informants, particularly the poor, have been pervaded by violence. The descent into civil war intensified the level and types of violence to which women were subjected, but this was not their only or first experience. Structural violence which prevented access to the most basic services, and violence within families was also common. There was evidence from this study that in Canada, women are taking active steps to address the dynamics of family violence.

Polarization within the Salvadoran "community" was described as continuing in Canada. There was evidence that political polarization has moderated over the past several years, and that many Salvadorans here (as in El Salvador) want to put the past behind them. As an example of this, organizations within the community are no longer structured around political lines. Class divisions were identified as a main source of current community tension, and created barriers even among those who were politically "on the same side". There was also some indication that not only have political

divisions been replaced by class divisions, but that they may have "gone underground".

Two common reactions point to this. There was a strong negative reaction by informants

to any suggestion that war related experience could be "talked about"', outside the circle

of family and close confidants. It was also observed that some of those who had been

politically involved would avoid social contact with those from the "other side", and

inadvertent contact could create a great deal of anxiety. Mistrust and resentment related

to class divisions continue several years after arrival in Canada and there is little

willingness to mingle socially with those of other classes.

There was also polarization along religious lines. In Manitoba, as in El Salvador,

there has been significant conversion to evangelical churches. Many community

members see the individualized view of salvation promoted by evangelicals as linked to a

right-wing political agenda.

The "institutionalized lie" is expressed by informants as "mistrust" and suspicion,

both towards others in the Salvadoran community, and towards life in general. Trauma

survivors have been observed to show lack of trust and suspicion (Canadian Task Force

on Mental Health Issues Affecting Immigrants and Refugees, 1988; Chester & Holtan,

1992). Unlike the issue of violence, which women have begun to address through

initiatives on spousal violence and child discipline, there appears little confidence in

measures to address distrust. Data from this study suggest that addressing the social

trauma related to mistrust and betrayal may be a more complex task than addressing past

This study, therefore, suggests that the specific political context which caused migration from the country of origin appears to affect the conditions for adaptation, many years after resettlement, and even after a peace accord has been signed. .

## Reception in Country of Resettlement

The third category of factors identified as contributing to successful adaptation is that of reception in the country of resettlement. Unlike Central American refugees in the United States, almost all of those immigrating to Canada did so legally, and so were entitled to the rights and services of Canadian citizens. This is linked in the literature to positive adaptation (Guarnaccia, 1997; van der veer, 1998). However, informants generally reported more positive interactions with Canadian institutions and services than they did with individual Canadians. Given the length of time living in the country, a number of informants had few, if any, meaningful relationships with those born in Canada, even though greater social contact was reported as being desired. Isolation, alienation, and feelings of non-acceptance, or non-understanding were often reported.

It is possible that distrust in one's own community would not be perceived as a significant problem, were it not for the concomitant social isolation. Informants report a low level of integration with the larger Canadian community and so continue to look for social networks within the Latin American community. The importance attributed to employment related to mental health appears to be at least in part due to the opportunities employment creates for informants to participate in the wider community.

In general, informants were positive about Canada and the opportunities it provided for them and their children. Since the signing of the Peace Accord in 1992, Salvadorans have been able to return to their country of birth, however many have chosen to stay in Canada. Interestingly, the decision to remain does not appear to have decreased the stress experienced around adaptation to life in Canada.

This study found a link between stated depression and lower levels of English language learning. Some of those who were less fluent in English attributed learning difficulties to lack of formal education, illness, or stressful events (particularly exposure to bombing). Many felt that improvements could be made to the English as a Second Language system.

### Are Women Refugees More Vulnerable Than Men?

Other research (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988; Desjarlais et al., 1995; Federal, Provincial and Committee on Population Health, 1994) suggested that women face more difficulties and may do less well as immigrants than do men. This was not the perception of the study informants. Data suggest that women (and some men) within the Salvadoran community view women as better prepared for a new life than the men, and better able to access and utilize resources. They were described as stronger, more adaptable and more assertive. The role continuity Salvadoran women experience through all phases of the migration process may contribute to this perception.

Women generally saw themselves as having good coping skills, and as taking responsibility for other family members. Many believed that they have had a hard life, but feel offended by pity, as well as discrimination. They do not see themselves as victims, who need to be saved or helped by others. If services are available they will use them to help themselves. The clearest example of this is the use of police services in response to domestic violence. Although this would have never been viewed as an appropriate response in country of origin, calling the police in Canada is a strategy that women have found effective.

However, the central role of women in maintaining the health - emotional, social and physical - of their families does create additional strain during the process of adaptation as they take responsibility not only for their own health, but that of their families.

## Social Trauma versus Individual Psychiatric Focus

A major emphasis in refugee health research is in the area of Post Traumatic Stress, and in identifying and measuring other depressive and anxiety - related symptoms. The recognition of Post Traumatic Stress Disorder as a formal psychiatric diagnosis, in the 1980's has contributed to a vast literature on diagnosis and treatment of victims of trauma (Van der Kolk et al., 1996).

## Evidence of Post Traumatic Stress

Some of the women also reported symptoms consistent with Post Traumatic Stress Disorder, however these were reported as being the source of less distress than the general experiences of depression and stress. In general, women reported a diminution of symptoms in Canada, and had found ways to cope with them. Where help had been sought for symptoms of emotional distress, it has been sought for symptoms attributed to the on-going stress of adaptation or family difficulties, rather than past trauma.

## Factors Affecting Reporting of Past Trauma

There are two other characteristics observed through this study which may complicate the observation of greater reported distress related to current adaptation than of past trauma. The first is that while talking about problems is generally seen as therapeutic, there was agreement among informants that it was not considered safe to talk about past traumatic experiences except within the safety of the family, or among close friends. The stress of adaptation, however, is a topic which appears to be one which can be safely shared with other community members and so provides a "language" of shared distress, or a metaphor for collective experience (Kleinman & Becker, 1998).

The second characteristic which may be affecting this observation is the "present - orientation" commonly found among community members. Participants describe Salvadorans as " living in the present", and look to current events and problems to explain current distress. It has been observed that, over time, connections between symptoms and

histories can be obscured (Van der Kolk et al., 1996). The "present orientation" may emphasize this tendency.

## Links Between Psychological and Physiological Health

Informants also demonstrated a profound understanding of the relationship between psychological and physiological health. Many of the women reported a number of somatic symptoms they believed were stress related, and in general, psychosocial factors were considered a leading cause of distress and illness. The somatic symptoms experienced were not therefore replacing awareness of emotional distress, but were understood to flow from this recognized distress.

## Usefulness of Individual Psychiatric Focus

Informants were clear in that they saw the cause of distress rooted in social causes, rather than individual pathology or vulnerability. Even when women continued to suffer from past trauma, they understood that there was *nothing wrong with them*, there was, or has been, something wrong in the social environment. This suggests that the research findings related to PTSD are not inaccurate as much as they are irrelevant to many informants. The informants were not looking for psychiatric services, they were struggling with awareness that their own community did not feel safe, and that past events had destroyed trust.

There was a high level of consensus found regarding the level of community

distrust and functioning, which suggests that "social trauma" continues within the

Salvadoran community. However, the focus of settlement services, as in most health

research, is on the adaptation of individuals, rather than the development of healthy

communities.

It has been stated that one of the most pressing problems in the world today is

dealing with the long term effects of violence which are usually pervasive and highly

damaging (Desjarlais & Kleinman, 1997). Social trauma can leave a whole population

affected (Martin - Baro 1989). Desjarlais and Kleinman (1997) state that "alongside the

loss of life, the fragmentation of families, the displacement of populations, and the

disruption of social and economic institutions exists a range of trauma. The problems

include fear, pain, loss, grief, guilt, anxiety, hatred, sadness, and the dissolution of

everyday forms of sociability, language and experience. In turn, the breakdown in

economic, social and political systems, and the weakening of a society's moral fabric

often coexist with domestic, civil or ganglike conflicts" ( p. 1143).

This study supports the conclusions of Desjarlais et al. (1995), Martin - Baro

(1989), and Millet, (1994) who suggest that efforts should be addressed to the social and

behavioral effects of violence and uprooting, rather than individual psychiatric sequelae.

While it appears that some participants could benefit from individualized counselling,

many of the issues are correctly seen as "community problems". Addressing the problems

within the community only through such interventions as individual counselling would

therefore be inadequate, and may even risk giving the woman an illness she "does not

have" (Eisenbruch, 1991, p. 673). Rather than psychiatric treatment, community - based

approaches which focus on understanding the contributions to polarization and mistrust

would be more useful.

The evidence from this study that ongoing mistrust is perceived by many as a

greater problem than past violence also lends support to the concerns that PTSD does not

adequately distinguish between trauma caused by natural disasters or accidents, and

trauma caused and organized caused by other people (van der veer, 1998). While there is

open acknowledgement of the suffering caused by physical violence, the barriers to

resolution appear to be related to mistrust and betrayal (the human factor). Findings

emphasize the importance of supportive social contact to health (Federal, Provincial and

Territorial Advisory Committee on Population Health, 1994).

Physical and Psychological safety.

Immigration to Canada has had several effects on the experience of "Violence".

The provision of physical safety from war - related violence is only one aspect of safety.

A living income, and access to health care address many of the issues related to the

structural violence experienced by so many of the poorer families in El Salvador. As

some of the narrative excerpts indicate, there is also the experience of increased safety

from street, or random violence. Informants report assertive efforts, in this new

environment, to address issues of family violence, by changing disciplinary methods, and

calling on the police for protection from spousal violence. In other words, the

institutions of Canadian society have provided the resources for many in the community

to begin to resolve many of the issues related to violence.

To address mistrust, however, it appears that more than physical safety is needed.

From the informants' perspective, life in Canada has not provided the psychological

safety to address the issues of mistrust. There appear to be two factors related to this; the

first is the unresolved divisions, tension and mistrust within the Salvadoran "community"

itself. The second is the perception of informants of continuing alienation and isolation

from the larger Canadian society, the feeling that one does not "fit in", or is not accepted.

## Limitations of Determinants of Health Model

Study participants articulated a view of health determination and illness causation

that was far more complex and complete than the population health model commonly

accepted in Canada. Key to this was the understanding of other *dimensions* such as the

spiritual dimension (God's intervention, and one's faith in God, which could "override"

other factors, or logical cause and effect relationships), and the dimension of time (the

"present orientation"). In addition there was a greater understanding of multicausal

effects on health, and an openness to exploring a number of different causes and

treatments. The emphasis on "social health" led to a indepth understanding of the impact

of social relationships on health beyond that outlined in the model. The women's experiences also challenge the assumptions made about the degree of control that an individual may have in determining many of the health determinants, such as lifestyle choices.

## Factors Contributing to Resilience in this Population

As indicated in the previous section, while the data indicated that women viewed themselves as having undergone suffering they did not see themselves as victims, but rather as survivors. What are some of the characteristics that contribute to this resilience in the population?

In spite of the significant differences between individual Salvadorans, there do appear to be some characteristics and responses that transcend class and other divisions, and can be seen as descriptive of the "national character". In this section, these characteristics are outlined, with particular emphasis on how they contribute to overall resilience and coping ability in this population.

### Religious Faith and Commitment

In general, the informants describe women in the community as having a deep religious faith, and the belief that God is working in their lives. Within this context, they are confident in a value system which provides direction and standards even when faced by horrific events. "God is good, and only wants good for his people". Violence of any

form (including domestic violence) is against the will of God. For many, religious faith also provides the framework for community and political action. One takes certain actions (even though they may be risky) because it is the right thing to do. This faith provides a moral centre even in times of change and disruption.

Some of the women also discussed the imperative to "forgive" those who had harmed you. The obligation to forgive appeared to be most strongly felt when the offender is a family member. Some of the informants described their struggles to forgive, both in the context of family conflict and the civil conflict in El Salvador.

Women were understood by informants to be more religious than men, and one of the roles of women is to lead men towards a more religious life.

## Views of Suffering and Victimization

The narratives suggested that suffering was seen as part of life. One expects to suffer, because there is evil in the world, but suffering does not necessarily make one a victim. Pride in survival, and refusing to play the role of victim is another characteristic that appears to contribute to resilience.

## Societal Values

The life narratives demonstrated values that appear to be shared at a societal level. Strength, resilience, action, and self-sufficiency were valued, in women as much as in

men. Salvadorans are described as independent, and do not expect others to take responsibility for them. There was an expectation that one will need to be adaptive to survive, and little attachment to the superficial trappings of culture. Pragmatism directed individuals to focus on doing what was necessary to meet the demands of any situation. This orientation created an assertive approach to resettlement and adaptation.

## Expectations of Women

Salvadoran women play a central role in the family; while this role carries great responsibilities, it is a role in which women take pride. In spite of popular conceptions of women oppressed because of "machismo", families tend to be matriarchal with women holding a great deal of emotional and moral power. Strong women are valued and admired. The relationship with one's mother is considered the most fundamental relationship, and healthy families show a great deal of respect for the mother.

Salvadoran women experience role continuity throughout the process of migration. Although there may be some changes in the woman's role in Canada (e.g. the woman may work, and more housework may be shared), their position in the family remains central. The responsibility to take a lead role in the care of the family provides both a focus for action, and role continuity once in Canada. It also appears to buffer some of the distress women may feel in coping with their own difficulties. This appears to contribute to resilience and ability to cope in high stress situations.

## Family Focus

Salvadoran society has always placed a great emphasis on the importance of family relationships, not only for emotional and social support, but also economic survival and social advancement. Most women immigrated with at least some members of their family, even though they were separated from the larger extended family. The tradition of family support appears to be continuing in Winnipeg, and women report receiving practical assistance (child care, transportation, assistance in finding jobs), as well as social support and access to a social network, through their families.

## Externalizing Source of Problems

One characteristic of the Salvadoran community observed through the study, was a tendency to externalize problems ( i.e. to identify the cause of problems as being outside of oneself). If one is poor, it is because of economic injustice (not because one does not work hard enough). If one is assaulted by the army, it is not because one has done anything wrong, it is because the army is trying to terrorize the population. Because there has so often been a clear external enemy, much of what is bad, is attributed to the other, outside of oneself. This appears to contribute to personal resilience.

This characteristic also suggests a reason why the framework of Post Traumatic Stress Syndrome, or other psychiatric diagnoses, may not be the most relevant. If women continue to suffer distress, it is not because there is *anything wrong with them*. This a normal reaction to what they have been exposed to. On the other hand, some women are

not coping as well with family dysfunction. This too can be partially explained by the tendency to externalize problems. As women identify so strongly with their families, if they have been mistreated by family members, it is much harder to "externalize" the source of the problem.

### Indepth Understanding of Psycho-social Factors and Health.

The narratives indicate that women have a clear understanding of the relationship between psycho-social factors and health, including somatic symptoms. Simply put, the narrative excerpts indicate that stress, loss, or trauma can normally be expected to contribute to *both* psychological distress and somatic symptoms. One does not replace another, any more than bleeding from a wound is expected to replace the pain of that wound. The participants showed a high level of ability to identify sources of pain, as well as coping strategies which are appropriate to the cause of the pain. For example prayer may be seen as an appropriate response to emotional distress related to betrayal, and socializing as a coping technique for depression. At the same time it is understood headaches or stomach pain may result from either of these problems.

### Vulnerability as a Result of "National Character"

While these "national characteristics" on the whole facilitate adaptation, there are also some risks associated with them. The tendency to "externalize" problems may contribute to ongoing polarization and mistrust in the community. ("There's nothing wrong in what I have done, its the 'other' "). The emphasis on self sufficiency may work

against community responses to common problems, and contribute to jealousy and competition. It may also be the case that an environment such as Canada (where there are more opportunities) may create internal stress as individuals attempt to explain why some families do better than others. The focus on family may leave women more vulnerable to distress in the face of family difficulties. The resilience and pragmatism shown in adjusting to a new environment may mask both the degree of change undertaken, and the stress experienced as a result of that change. Characteristics and coping techniques most adaptive to past life in El Salvador may contribute to adaptation problems here in Canada. In particular, the high level of distrust and suspicion sometimes appears to be counterproductive in the Canadian environment. Acute sensitivity to condescension or pity may cause individuals to overreact to overtures which are awkward, if well meaning, and contribute to social isolation.

## Implications of Research for Service Providers

What are some of the implications of data generated in this study for those providing health and social services to Salvadoran women and families, and to refugee families in general?

### Length of Adaptation Process

One of the most important issues to emerge from this study is ongoing intensity of distress regarding adaptation to life in Canada. It is recognized that services are required for new arrivals, and that the initial period of settlement for immigrants is stressful. For

this reason services are focused on first arrival, and tend to focus on "hard" needs, such as employment, housing, and English language training.

This study suggests that families may continue to have adaptation difficulties over the long term. Some women continue to lack fluency in English, to suffer depression about lost family and country, and fail to make meaningful connections with women in the larger society. Now, after several years in Canada, they are not eligible for "settlement services" but often do not find support within the larger community either. Many informants appear to have concluded that they will never fully adapt.

Providers need to be aware that immigrants, and particularly refugees who were forced to leave their country of birth, may continue to suffer often severe difficulties in adaptation for many years, even if they have "settled", are employed and raising Canadian children. There is a need community programs which focus on addressing the longer term issues of adaptation.

## Risk of Cultural Stereotyping

The informant narratives describe, with great clarity, the diversity of life experiences and expectations from women arriving from the same country. While knowing a woman is from (for example) El Salvador may provide some indication as to the types of information that may be relevant, this will actually tell a provider very little.

It is common for health and social service providers to transfer information learned from a few individuals to the larger ethnocultural community (Hamilton, 1996; Kaufert, 1990; Stevens, 1993a). In this community there are such significant differences between the life and war related experiences of individual families (including risk factors for disease) that such generalization can pose serious risks. Differences in social class resulted in vastly different life experiences, health impacts and service expectations. Information such as urban or rural residence, and date of immigration can provide important clues as to actual life experiences. Assuming similarity between members of the same ethnic community may also be perceived as offensive.

## An Alternate Approach

Rather than looking to the differences between health care practices between the country of origin and Canada, it may be more helpful to focus on the individual's past experience with services and her expectations of Canadian services. This would provide more useful information to the provider without risking stereotyping an entire community based on the experiences of one or two individuals.

Expectations related to previous experience of service quality in country of origin appear to be a key predictor of satisfaction and adaptation. In general, those who had fewer opportunities in El Salvador, are the most positive about services in Canada, while those who had access to a greater variety and quality of services (because they could afford to pay), were less impressed.

It is not surprising that those who had limited access to health care even for life threatening conditions, and who were treated with disrespect or abuse, are highly satisfied with (and appreciative of) health care in Canada. What may be less evident is that those who were used to receiving special consideration (because they were in a position of importance, related to someone in authority, or able to pay), may be quite dissatisfied with their treatment. Providers then need to be aware of the previous experience of individual newcomers and not assume that care provided in Canada is unusual or better.

## Heterogeneity and Demographic Variation

Results of this study also indicate that in addition to variation by class, education, and rural / urban residence, there was also great individual variability in health beliefs even among families of the same socio-economic class. It would be a mistake to assume that beliefs or treatments used by an individual from a certain country will necessarily be shared by others from the same country, even if they are from the same socio-economic class, or same region.

In addition, while alternate health practices may be intriguing to North Americans, for this population, the use of traditional medicines was in most cases seen as a "non-issue" by informants.

This research suggests that while satisfaction with service is linked to expectations of service, use of services or reliance on alternate medical treatments is

solidly pragmatic, based on past experience. Treatments or services that are helpful, and are experienced by the user as effective, are the ones that will be used. Women demonstrate assertiveness in using services and rights, on their own behalf and on behalf of their families, but only if such contacts are experienced as useful. Non-utilization of services then should not be explained by "cultural differences"; but by barriers to access or lack of usefulness of services.

## Working with Ethnocultural "Communities"

In Canada it is common to hear ethnocultural groups referred to as "communities". This implies a sense of cohesion, and often completeness, that may not exist. Newcomers from the same country do not necessarily share the same culture, (defined as the totality of ideas, beliefs, values and knowledge of a group of individuals who share certain historical experiences). This study found significant divisions related to social class, political orientation and religion. These divisions may also be much more intense than Canadians may recognize; "political differences" are likely to refer not to voting patterns, but to survival. Class differences are similarly deeply rooted, to the point that individuals may even express distaste or hatred for those from another social class.

As such divisions are often the source of a great deal of distrust and anxiety it is essential that those planning to hire individuals from a certain ethnic population (to do programming, outreach or interpretation) are aware of the divisions within it, as well as the characteristics of the individuals with whom they wish to work. In this community

both political and class differences continue to be a concern in the choice of helpers. Asking a less educated women to provide interpretation or educational services for a professional woman for example, is unlikely to be well accepted. Asking a family who had been terrorized by the military, to accept a helper who had been supportive of the Salvadoran government may actually exacerbate existing problems by increasing anxiety and distrust. Some of the women interviewed now have a negative view of certain services because of the Spanish speaking individual hired to help them. In addition, these negative experiences contributed to already existing distrust, and a pattern of avoidance. Similarly, determining who will be an informant on behalf of a community poses the same risks, as it may be that the informant represents, or is knowledgable about, only one sector of the community. This poses an important challenge for community health research.

Nor can it be assumed that because a service is available through a practitioner of a certain language that all service needs are therefore met. It has been reported that many immigrants would prefer in most cases to use "regular Canadian services" rather than see a professional, or use a resource from their own community (Stevens, 1993a). While most of the study participants stated a preference for using a general practitioner from their own community, (and most are using Spanish speaking physicians) this was not true of "non-medical" needs such as counselling. Women report wishing to utilize other services but of being unsure of where to go. A number do not feel comfortable asking their family physician for a referral. In some cases women fear the breakdown of

confidentiality if problems are shared within their own community. In other cases they simply wish a broader choice of providers.

Location of services may also be a key concern. While there has historically been support for funding initiatives through the ethnocultural associations themselves, there is some risk to this for certain health or social services. If a community is fragmented, and if there is a great deal of mistrust within the community, placing a service within an association (which may represent only one part of a community) may have the result of denying access to other users.

## Working with Salvadoran Families

Women described themselves as the health guardians of their family, and took the lead role in all health concerns, physiological and psychological. The needs of family members will often take precedence over a woman's own needs. The mother is seen as central to the family, and a healthy family will show respect for the mother. Older women in the family may be directing the health care of younger members, even in cases where the "patient" does not agree with the care. Therefore including mothers and grandmothers in health education initiatives is important.

Women also define themselves in terms of their families, and there is generally less individualism within the family. This research suggests that women suffer more distress regarding problems occurring within the family, than from forces external to the

family. For example, an incident of childhood sexual abuse appears to be the source of a much greater level of current distress than war - related trauma; being rejected by (or even harshly criticized) ones family is likely to be experienced as a major trauma. Providers therefore need to be aware of the relationships of a woman within her family, and see alienation as a cause of concern. Because of a woman's identification with her family, some of the coping techniques of resilience do not work as well (e.g. she will not be able to "externalize the problem").

Women were described by themselves, and by others, as being strong and resilient. They recognized suffering as a part of life and did not identify themselves as victims, even when they were suffering. There was a great sense of pride, and offense was easily taken if help was given in a patronizing manner. The manner in which services are designed (with the community, and in response to needs identified by them rather than 'for them') is likely to be crucial.

Domestic violence is recognized as a serious problem within the community and is often linked to male drinking. It has been suggested that in El Salvador civil warfare was preceded by domestic violence but that the general culture of violence in the country has augmented it (Desjarlais et al., 1995). In their review of the literature, Rousseau et al. (1997) conclude that "Research conducted with refugee populations has repeatedly stressed the effects of the violent social climate of country of origin on the level of family violence in the host country" (p. 1116). However, although domestic violence is

described as common, it is not viewed as acceptable, and many women will reach out to family, friends, or the police in cases of spousal or other domestic abuse. There is the perception by many in the community that domestic violence is decreasing, in part because women are reaching out for help, and using the protection they have under the law. This is a somewhat different finding from what has been reported by other sources, for example that immigration complicates and contributes to spousal abuse, or that fear of police may prevent the use of the justice system (McCleod & Shin, 1992). Women often report support and sympathy for the batterer, who they may also see as victimized and needing of support. This is confirmed by previous research (McCleod & Shin, 1992).

It appears as though the tradition of valuing strength in women, the increased financial independence of women from poorer backgrounds, the influence on some of the revolutionary movement which promoted the rights and participation of women, and the pragmatic approach to adapting and using what works may explain the current use of police services. Another factor may simply be that families now find themselves in a different context. In Canada there is a lower level of societal violence, and while stress of adaptation may increase for some men, increased safety and opportunities may decrease stress for others. At the same time that societal protection increases the confidence of women it also increases the likelihood of negative consequences for those who abuse.

There is some indication that sexual abuse may more common than is acknowledged by the community, and unlike the issues of societal or domestic violence,

cannot be discussed. There was much greater disparity in reaction to the issue of sexual abuse of children than that of domestic violence. While there is acknowledgement at the community level of other kinds of violence, sexual abuse of children is seen as repugnant and strongly condemned. However, this research indicates that a number of women have suffered sexual victimization, including sexual abuse from within the family. It appears from this initial research that women do not know where to turn for assistance with past abuse issues, but it is clear they do not feel confident seeking help from within their community. Further research to determine the prevalence of such abuse as well as outreach efforts from groups providing services to women appear to be needed.

## Usefulness of Specific Health Frameworks

The study also suggests the usefulness of mapping community specific models of determinants of health. The narratives indicate that most of the women, even those with little education, have a clear understanding of the influence of the determinants of health. Nutrition, lifestyle choices, family and other support, environmental factors and access to education, employment were all seen as important. In particular, the women clearly identified social conditions (poverty, ignorance, repression) as problematic. The importance of the family as a source of emotional support was paramount and viewed as a key factor in health. As indicated earlier, a "present - orientation" suggests that there may be more openness to explanations of illness linked to current events. Because psycho-social events are seen as of major importance to health, illness is more likely attributed to a recent stress or loss than to genetic, or communicable agents.

As well, factors contributing to health or illness were not seen as constraining and can be overridden by faith, or by God's intervention. Being healthy or escaping danger are most often attributed to God. Holistic care for women in this community then should be based on a framework which includes a spiritual dimension. There may also be a larger role for the church to provide support in addressing many of the problems identified in this study, particularly in addressing community mistrust and facilitating both reconciliation and community reconstruction.

Several factors may be viewed as contributing to the cause of disease. Because of this, and the belief in the power of God's intervention, there was an openness to a variety of interpretations of disease causation, and consequently to a variety of treatment responses.

Providers are advised to look at specific dimensions of causal models of health and illness, and not to rely on a generic, "determinants of health" framework. There is little indication that there is any change in the model of health used by the women since their arrival in Canada, in part because both the families themselves, and those providing care to them, may be unaware of the assumptions they are making. This suggests that in order to undertake health education interventions, it is essential to work with community informants to develop responses based on the health framework of the community.

## Information Sharing

Providers need to be aware that failure to raise issues of concern is not necessarily because the women do not want to talk of them. Often they do want to talk, and know how to explain what they are feeling, and what they believe are the causes of their distress. However, they first need to feel safe to do so.

Simply reviewing a number of topics that the provider may feel are relevant to health, and that she/he would be open to discussing with the patient or client, is a first step. Providers are also advised to take additional time explaining their requirement to maintain confidentiality, and in offering to assist with making referrals to other services if required. It is important, however, to avoid intrusive questions, or conveying any sense that the patient or client is being interrogated. This may trigger reactions based on past trauma (Stevens, 1993a), and intensify concerns regarding safety.

It is also useful to know what types of topics women may find the most difficult to discuss. Because talking is seen as therapeutic in this community, what *cannot be talked about* is of concern. Through this study, two topics emerged as ones which "cannot be talked about". One of these is sharing of past trauma. War related events were reported to be shared only within the family, or with close friends. It was viewed as unsafe to talk about such topics within the larger community. In addition, some state that they do not feel safe sharing such information with any one "unless you really know you can trust them". Therefore indicating that such reticence is understood may be helpful.

Sexual abuse is another topic which cannot be discussed. However, unlike war related trauma, this topic cannot be shared within the family either. In a few instances women reported having shared information with their husbands. In these cases, husbands were reported as more supportive than family of origin. There is an indication that women are open and interested in finding resources for discussing this issue, as long as such resources are not part of the "Spanish - speaking" community. Fear of confidentiality breakdown and gossip on such a sensitive topic discourages almost any level of sharing.

This research also suggests that women are, in a safe environment, prepared to talk about the difficulties they are facing, and of their past lives. Providing opportunities to share safely, outside of the Salvadoran "community", appears to be necessary.

### Adequacy of Settlement Services

Most of those interviewed were (at best) lukewarm about the settlement and English language services they received on arrival. Neither was the "Host" program, designed to link Canadians with new arrivals to assist with adaptation, practical orientation and friendship, described as particularly helpful. Community representatives were also quite critical of such services. Key concerns appear to be the actual helpers hired, and objection to an attitude which is perceived, accurately or not, to perpetuate dependency rather than empowering individuals.

For all of those interviewed it has been a number of years since arrival in Canada, so it was not possible to determine whether they felt dissatisfaction at the time, or whether retrospectively they see such services as inadequate. There does however appear to be a role for more comprehensive orientation, particularly around the "softer" concerns identified by women participating in this study, and in particular to assist with strategies for social integration. Strategies for supporting long term adaptation also appear to be required, along with specific initiatives focusing on professional families and the issues related to class assumptions. Settlement services are not necessarily the best resource for this, and other community agencies, and women's groups have an important role.

### Services for Treatment of Psychologically Based Complaints

This study suggests that within a very short period of time Salvadoran families were using the health system for physiological complaints appropriately and with confidence. However, many of those interviewed describe a high level of ongoing psychological distress.

There is a fairly high level of reported discontent regarding medical response to physiological symptoms that the women themselves believe are rooted in stress or depression. Many of the women show a high level of awareness that problems are rooted in psychosocial distress but are not able to cope with them. Some report regular physician visits in an attempt to obtain relief. As they themselves suspect an underlying psychological cause, they also feel embarrassment in continuing to use the health system

in this way.

Given that many of the women are able to identify and discuss their problems with great clarity, initiatives which assist in furthering this understanding and facilitating self - help approaches may be useful.

## Provision of Psychological "Safety"

This research suggests that services to assist in adaptation of refugees must address social, and not only individual needs. This finding presents a challenge not only to health and social service system, but to women's and other community organizations to work with newcomer groups and assist them in developing strategies for providing an environment which may assist in addressing the issues of mistrust.

## Implications of Research for the Salvadoran Community

The greatest area of consensus of the participants in the study was distress over the functioning of the Salvadoran community as a "community". The Salvadoran community in Manitoba, as described by the participants in this study, shows signs of significant social trauma, and is permeated by distrust and suspicion. As one informant commented, *"I know that the community knows something is wrong."* There is also a sense that "what is wrong" is understood to be rooted in historical events. However, knowing *how to recover* is more difficult. The community must be able to recognize and name the problems it faces to begin the work of repairing the damage done at the

community level. Before there can be forgiveness and reconciliation, there must be an honest facing of facts; of what did happen (van der Kolk, McFarlane & Weisaeth, 1996). What is "not known" must be made known. Not looking back may keep victimized individuals and groups from learning from experience, and there is a danger of recreating trauma in new social environments ( McFarlane & van der Kolk, 1996). Herman (1992) also feels that telling the truth about past events are prerequisites for both the restoration of social order, and for the healing of individual victims. She proposes three stages of recovery from trauma: safety, remembrance and mourning, and reconnection.

Addressing community distrust and tension will require identifying and challenging "the official story" of the community and naming the issues which have "gone underground". Recognizing the individual and societal strengths which contributed to survival and resilience, as well as the negative potential of these same characteristics, may be the first step in this process.

It must be the Salvadoran community itself that finds solutions (Barudy, 1994). The community has already demonstrated that it has the determination and ability to make significant changes, and to undertake great challenges. There is evidence that significant changes are being made in addressing some of the patterns of violence within families; the same progress is not yet found in the areas of social trust and cooperation. Women have played a leadership role in these changes and will continue to have a role to play as the emotional and moral centre of families. Some of the participants are already

working on forgiveness at an individual level, and meeting for mutual support.

## Indications for Further Research

### Topics for Further Research

#### Community Based Interventions to Address Social Trauma

In spite of demonstrated strengths of individuals, and insights regarding community problems, responses to addressing community suspicion and distrust have had limited effect. What kinds of interventions would be most effective? If a community is demoralized, how can it be remoralized? How can the recovery process be facilitated? How can we prevent the most damaging long-term effects of violence from being perpetuated (Desjarlais et al., 1995)?

#### Comparison of Refugees in Canada and El Salvador

Only an estimated 20% of the Salvadoran population fled El Salvador during the war. Many of those traumatized remained in the country. While they may have been exposed to war related trauma for a longer period of time, they were not exposed to the trauma of uprooting. As the participants in this study identify the stress of adaptation as having an important impact on health, how does the health of Canadian Salvadorans compare with the health of those who remained in El Salvador? What is the impact of the migration experience? Are there perceived health differences between those who remain in Canada, and those who returned to El Salvador after the signing of the Peace Accord?

## Cross Cultural Comparison

Many of the community characteristics and coping strategies appear to rooted in the history and culture of the particular refugee group studied. Little research has been done comparing health, adaptation and coping across various refugee populations, however there is some evidence that both reported difficulties and coping strategies may differ between immigrant groups (Roussea et al. 1997). Are there significant differences between groups, or can results of this research be generalized?

## Health of Salvadoran Men

A parallel study on Salvadoran men focusing on similar research questions would also be useful as many of the coping techniques appear to gender - specific. Is the general perception that women are adapting better than men indeed correct? It has been suggested that men tend to externalize their suffering through substance abuse and aggressive behaviour, resulting in an under-reporting of psychological distress (Desjarlais et al., 1995). Are these findings borne out in this community?

## Psychological Health of Salvadoran Refugee Children

There were a number of indications from the interviews that there may be particular effects of the type of wartime trauma, and current community dysfunction on the children of Salvadoran families. As well as identified "community problems" (such as drugs, adolescent pregnancy), there is indication that there are also less visible problems within families (violence perpetuated by children, long term effects of trauma,

adaptation difficulties). There is also a suggestion that the issues facing children of refugees may vary by social class.

## Research Methodology

"A community is not just an environment for research, but a critical actor in the research process" (Kaufert & Kaufert, 1998, p. 35). This study has demonstrated an effective partnership between women of one community and a researcher with partial insider status with the community. However, this type of research poses important challenges which should be dealt with at the design stage: the issue of "community consent", appropriate time lines, and funding.

Issues of community consent can be complex and, as this project indicates, formal community consent may not be possible. However, support and encouragement for the project were received from individual women in the Salvadoran community, and two advisors guided the project. Defining and obtaining "community consent" in such communities requires a good understanding of the issues and divisions within communities.

Working in conjunction with community partners requires additional time, particularly at the planning and review stage where feedback was sought from individual participants. Flexible time lines are also required as significant volunteer time war required during the review stage.

Funding also poses ethical questions. Based on experience working with newcomer communities in the past, where there has been legitimate resentment about funds applied for "on behalf of" a community, the researcher did not make grant applications to cover her research costs. However, in recognition of the need for practical assistance, and unwillingness to ask for volunteer services from the community, a funding application was submitted to Prairie Women's Health Centre of Excellence to cover the community costs of the project. This application received the support of the community advisors, and funds were allocated for costs such as transcription, interpretation and translation, for which Salvadoran women were hired. However, a significant volunteer contribution was made by the community advisors in guiding and reviewing the project.

In spite of these challenges, those involved felt that significant advantages were obtained through utilizing such methodology. It is therefore recommended that further research in this area also incorporate community input and direction.

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# APPENDIX A

## SAMPLING METHODOLOGY



**COMMUNITY ADVISOR ONE**

**COMMUNITY ADVISOR TWO**
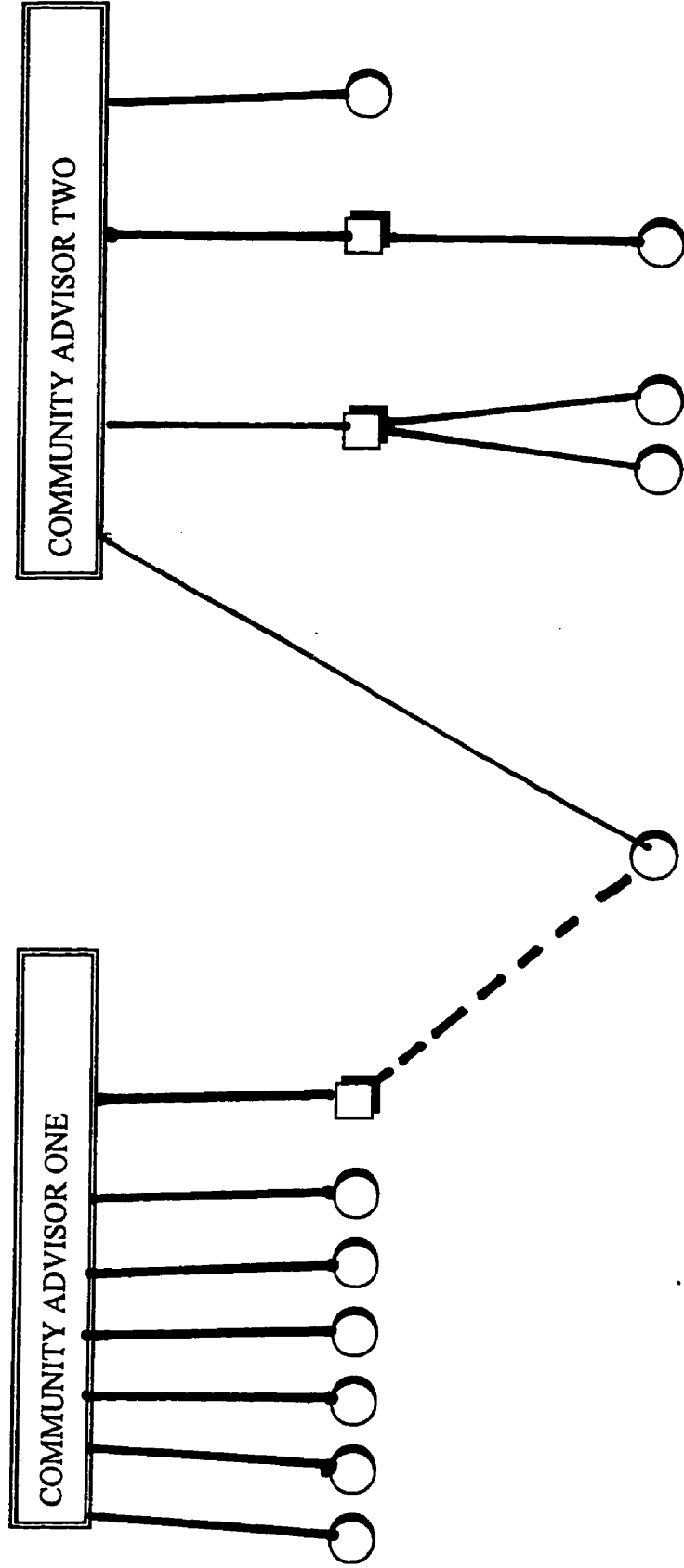
○ Informant (interview)

□ Contact

# APPENDIX B: INFORMATION SHEET (ENGLISH)

## HEALTH OF SALVADORAN WOMEN IN MANITOBA

Sarah Bowen is a graduate student completing her M.Sc. in Community Health Sciences. She is conducting a study into the heath status and health concerns of refugee women in Manitoba. This project is supervised by Dr. Joseph Kaufert of the Department of Community Health Sciences, University of Manitoba.

The purpose of the study is to describe the health of Salvadoran women living in Manitoba, and the strategies they use for maintaining their health and coping with health problems.

Two methods will be used. Individual women will be interviewed in private. Participation in the study is completely voluntary. Names of those contacted for the study will be suggested by other women in the community. These contact persons will obtain consent from each woman before the woman's name is passed on to the researcher. The interview will take from one to two hours, and with the respondents permission, additional interviews may be scheduled. Interviews will take place in the woman's home, or in another place mutually agreeable to both the researcher and the woman interviewed.

All information collected through the interviews will be kept confidential. Information included in any written report will not include any identifying information, and will be shown to the woman providing the information for her approval before the final report is released.

Women may withdraw from the study at any time, and may choose not answer any questions.

Focus groups will also be held. Individuals from the Salvadoran community will be invited to discuss health concerns of the community, and their experiences and recommendations regarding services to meet these needs.

Research results will be available to participants, and to interested community groups.

For more information, contact:    Sarah Bowen
Department of Community Health Sciences
Faculty of Medicine, University of Manitoba
Phone: 783 - 3421

         or          Dr. J. Kaufert, Project Supervisor
Department of Community Health Sciences
Faculty of Medicine, University of Manitoba
Phone: 789 - 3798

# INFORMATION SHEET (SPANISH)

## LA SALUD DE LA MUJER SALVADORENA EN MANITOBA

Sarah Bowen es una estudiante graduada completando el grado de maestria en Ciencias de Salud Comunitaria. Ella esta conduciendo un estudio acerca de la situacion y las preocupaciones de salud de la mujer Salvadorena refugiada en Manitoba. Este proyecto es supervisado por el Dr. Joseph Kaufert del Departamento de Ciencias de Salud Comunitaria de la Universidad de Manitoba.

El proposito del estudio es decribir la salud de la mujer Salvadorena viviendo en Manitoba, y las estrategias que ellas usan para mantener su salud y la manera en que enfrentan los problemas de salud.

Se usaran 2 metodos: Las senoras seran entrevistadas individualmente y en forma privada. Su participacion en el estudio es completamente voluntaria. Los nombres de las personas a contactar seran sugeridos por otras personas en la comunidad. Estos contactos (senoras) obtendran consentimiento de cada senora antes que el nombre de ellas sea pasado a la investigadora. La(s) entrevista(s) tomara de 1 o 2 horas, sera planeada con la persona a ser entrevistada, y puede ser mas de una.

Toda la informacion recabada durante las entrevistas sera mantenida confidencialmente. La informacion incluida en cualquier reporte escrito no incluira informacion que pueda identificar al entrevistado. La informacion sera mostrada a la persona para su aprobacion, antes que el reporte final sea publicado.

La persona se podra retirar del estudio en cualquier momento, y podra decidir no contestar ninguna pregunta.

Tambien se tendran grupos de discusion (focus groups). Personas de la comunidad Salvadorena seran invitadas a discutir problemas de salud en la comunidad, sus experiencias y recomendaciones con respecto a servicios requeridos para satisfacer estas necesidades.

El resultado de la investigacion estara disponible a los participantes y grupos interesados de la comunidad.

Para mas informacion contactar a:

| | |
|---|---|
| Sarah Bowen | o Dr. J. Kaufert, Project Supervisor |
| Department of Community Health Sciences | Department of Community Health Sciences |
| Faculty of Medicine, University of Manitoba | Faculty of Medicine, University of Manitoba |
| Phone: 783 -3421 | Phone: 789 - 3798 |

# APPENDIX C

## HEALTH OF SALVADORAN WOMEN IN MANITOBA

## CONSENT FORM: ENGLISH

I understand that Sarah Bowen, a graduate student with the Department of Community Health Sciences, University of Manitoba, is conducting a study on the health of Salvadoran refugee women in Winnipeg, and the ways that they maintain their health and cope with health problems.

I agree to be interviewed by her, and that information I provide may be used in the research report on Salvadoran women's health. The interview will take from one to two hours. With my persmission, additional interviews may be scheduled. I agree to let the researcher interview me in my home, or any other location that is agreeable to both of us.

All information I share will be kept confidential and anonymous. My name, or any other personal information will not be included in the research report, and I have the right to review my individual information before the report is released. I may withdraw from the study at any time, and withdraw permission for my personal information to be included in the research report.

I agree that the interview(s) may be audiotaped.

❑Yes
❑No

I have the right to ask for taping to be discontinued at any time. Audiotapes will be erased once the transcripts have been completed.

I give permission for _____ to act as interpreter for my interview(s) with Sarah Bowen.

_____          _____
Signature                                              Witness

_____          _____
Date                                                    Date

## Interpreter Consent

I agree to provide interpretation for interviews between Sarah Bowen, and
_____.

I understand that all the information provided in this interview is completely private and confidential. I will not share any of this information with any other person.

| | |
|---|---|
| _____ | _____ |
| Interpreter | Witness |
| _____ | _____ |
| Date | Date |

**If you have any questions or concerns about this project, please contact:**
**Sarah Bowen at 783-3421, or Dr. Joseph Kaufert at 789 - 3798**

## CONSENT FORM: SPANISH

## LA SALUD DE LA MUJER SALVADORENA EN MANITOBA

## FORMA DE CONSENTIMIENTO

Entiendo que Sarah Bowen es una estudiante de maestria con el Departamento de Ciencias de Salud Comunitaria de la Universidad de Manitoba. Ella esta conduciendo un estudio sobre la salud de la mujer Salvadorena refugiada en Winnipeg, y las estrategias que ellas usan para mantener su salud y para enfrentar los problemas de salud.

Estoy de acuerdo en ser entrevistada, y la informacion que yo provea puede ser usada en el reporte de investigacion sobre "La salud de la mujer Salvadorena". La entrevista tomara de 1 a 2 horas y con mi permiso otras entrevistas pueden ser planeadas. Estoy de acuerdo que la investigadora me entreviste en mi casa o en otro lugar que ambas acordemos.

Toda la informacion que comparta sera mantenida en forma confidencial y anonima. Mi nombre y alguna otra informacion personal no sera incluida en el reporte de investigacion. Tengo derecho de revisar mi informacion individual antes que el reporte sea publicado. Puedo retirarme del estudio en cualquier momento y retirar mi permiso de que mi informacion sea incluida en el reporte.

Estoy de acuerdo en que mi entrevista pueda ser grabada.
☐ Si
☐ No

Tengo derecho de parar la grabacion en cualquier momento. Las grabaciones seran borrados cuando las transcripciones hayan sido completadas.

Doy permiso a _____ de ser mi interprete para la(s) entrevista(s) con Sarah Bowen.


_____         _____
Firma                                    Testigo

_____         _____
Fecha                                    Fecha

## Consentimiento del Interprete

Estoy de acuerdo en servir de interprete durante la(s) entrevista(s) entre Sarah Bowen, y __

_____ .

Entiendo que toda la informacion proveida en esta entrevista es completamente privada y confidencial. No compartire ninguna de esta informacion con nadie.


_____          _____

Interprete                                      Testigo

Fecha: _____              Fecha:_____


**Si tiene alguna pregunta o interes acerca de este proyecto, por favor contactar a:**
**Sarah Bowen al tel: 783-3421, o Dr. Joseph Kaufert al tel: 789 - 3798**

# HEALTH OF SALVADORAN WOMEN IN MANITOBA

## CONSENT FORM: FOCUS GROUP

I understand that Sarah Bowen, a graduate student with the Department of Community Health Sciences, is conducting a study on the health of Salvadoran women in Winnipeg, and the ways that they maintain their health and cope with health problems.

I agree to participate in a focus group, held on _____ . This group will discuss health issues of the Salvadoran community, experience with health services and service needs. The focus group will take from one and a half to two hours. I may withdraw my participation at any time.

Information obtained through the focus group discussions may be used in a research report on Health of Salvadoran Women in Manitoba. My name will be listed as a group participant but individual comments made by me will not be identified.

I agree that the group discussion may be audiotaped. Audiotapes will be erased once the study is completed.


_____          _____
Signature                                          Witness



_____          _____
Date                                                Date




**If you have any questions or concerns about this project, please contact:**
**Sarah Bowen at 783-3421, or Dr. Joseph Kaufert at 789 - 3798**

# LA SALUD DE LA MUJER SALVADORENA EN MANITOBA

# FORMA DE CONSENTIMIENTO: GRUPO DE CONSULTA

Entiendo que Sarah Bowen, estudiante graduada del departmento de Ciencias de la Salud Comunitaria de la Universidad de Manitoba, esta llevando a cabo un estudio acerca de la salud de la mujer Salvadorena en Winnipeg, las formas en que ellas mantienen su salud y como manejan sus problemas de salud.

Estoy de acuerdo en participar en un grupo de consulta que se llevara a cabo en_____. Este grupo discutira los problemas de salud de la comunidad Salvadorena en Winnipeg, sus experiencias con los servicios de salud y las necesidades de servicios. El grupo de consulta tendra una duracion de 1.5 a 2 horas. Entiendo que, si asi lo deseo puedo dejar de participar en cualquier momento.

La informacion obtenida atraves de las discusiones del grupo podra ser usada en el reporte de la investigacion "Salud de la Mujer Salvadorena en Manitoba:. Doy mi autorizacion para que mi nombre aparezca listado como participante en el grupo, pero mis comentarios no podran ser identificados.

Estoy de acuerdo en que las discusiones del grupo sean grabadas. Entiendo que todos los materiales grabados seran borrados una vez que el estudio se haya completado.


_____          _____
Firma                              Testigo


_____          _____
Fecha                              Fecha


**Si tiene alguna pregunta o interes acerca de este proyecto, por favor contactar a:**
**Sarah Bowen al tel: 783-3421, o Dr. Joseph Kaufert al tel: 789 - 3798**

## POEMA DE AMOR (LOVE POEM)

Those who widened the Panama Canal
(and were on the 'silver roll not the 'gold roll')
those who repaired the Pacific fleet
in California bases
those who rotted in prisons in Guatamala, Mexico, Honduras, Nicaragua
for stealing, smuggling, swindling,
 for starving,
those always suspected of everything
("Allow me to place him in your custody for
suspicious loitering
aggravated by the fact of being Salvadoran")
those who pack the bars and whorehouses
in every port and capital
("The Blue Grotto", the G-string:, 'Happyland')
the sowers of corn deep in foreign forests
the crime barons of the scandal sheets,
those who nobody ever knows where they're from
the best artisans in the world,
those who were riddled with bullets crossing the border,
those who died from malaria
or scorpion bites or swarming bees
in the hell of banana plantations
those who got drunk and wept for the national anthem
under a Pacific cyclone or up north in the snow
the spongers, beggars, pot-heads,
the stupid sons of whores,
those who were barely able to get back,
those who had a little more luck,
the forever undocumented,
those who do anything, sell anything, eat anything,
the first ones to pull a knife,
the wretched, the most wretched of the earth, my compatriots,
my brothers.

**Rogue Dalton**
**English translation by Richard Schaaf**

## POEMA DE AMOR

Los que ampliaron el Canal de Panama
(y fueron clasifcados como 'silver roll' y no
como 'gold roll'),
los que repararon la flota del Pacifico
en las bases de California,
los que pudrieron en las carceles de Guatamala, Mexico, Honduras, Nicaragua
por ladrones, por contrabandistas, por estafadores,
por hambrientos,
los siempre sospechosos de todo
("me permito remitirle al interfecto
por esquinero sospechoso
y con el agravante de ser salvadoreno")
las que llenaron los bares y los burdeles
de todos puertos y las capitales de la zona
("La gruta azul," "El Calzoncito,"
'Happyland')
los sembradores de maiz en plena extranjera
los reyes de la pagina roja,
los que nunca sabe nadie de donde son,
los mejores artesanos del mundo,
los que fueron cosidos a balazos al cruzar la frontera,
los que murieron de paludismo
o de las picadas del escorpion o la barba amarilla
en el infierno de las bananeras,
los que lloraron borrachos por el himno nacional
bajo el ciclon del pacifico o la nieve del norte
los arrimados, los mendigos, los marihuaneros,
los guanacos hijos de la gran puta,
los que apenitas pudieron regresar,
los que tuvieron un poco mas de suerte
los eternos indocumentados,
los hacelotodo, los vendelotodo, los comelotodo,
los primeros en sacar el cuchillo,
los tristes mas tristes del mundo,
mis compatriotas,
mis hermanos.

**Roque Dalton**