ABSTRACT

Taking care of a dependent person means to supply those needs that this person cannot satisfy by himself due to his lack of independence or autonomy (Henderson). Care is transmitted from one generation to another as a social practice and as a cultural heritage. It is taught through culture and social practices, and it is learnt through personal experience. At the same time, care does not happen in an empty context but in the context of systems and health and social structures, among other things, that finish its shape. When caring, the culture and social practices of a carer from one country (country of origin) are different in comparison with those of the country of destination. The concept of transcultural care of Leinnenger echoes the cultural diversity that this difference or opposition involves, and recommends incorporating it in the professional practice, developing care practice which she defines as culturally competent.

Other theoreticians in the field of nursing incorporate additional dimensions such as prejudice, developing approaches in which it is argued that care should be accompanied by an intercultural sensitivity (Campinha-Bacote).

This article presents a study on female migrant carers and their care strategies in key areas in the province of Huelva and the city itself, southwest of Spain, where they provide elderly care in different areas of expertise: specialised care in hospitals and care for the family unit at home. After an initial description of the demographic profile of the carers interviewed in our study area, our objective is to know the strategies they develop when caring for people from different backgrounds and how they are integrated into the social, cultural and institutional context of taking care to dependents of the host society.

Keywords: Transcultural Care; Social Practices; Female Migrant; Dependent Person

RESUMO

Cuidar duma pessoa dependente significa que as necessidades de essa pessoa não podem ser satisfeitas devido à sua falta de independência ou autonomia (Henderson). Este tipo de cuidado passa de geração em geração como uma prática social e como uma herança cultural, sendo ensinados através da cultura, práticas sociais e através da experiência pessoal. Ao mesmo tempo, os cuidados não produzido no vazio senão tendo lugar no contexto de sistemas e de saúde e das estruturas sociais, entre outro, que os final de estabelecer. Quando um cuidador é de outro país são em contraposição as culturas e práticas sociais do origem e de destino no momento de cuidar. O conceito de cuidado transcultural de Leinnenger reflete a diversidade cultural que é esta contraposição e recomenda incorporar na prática profissional o desenvolvimento de cuidados que esta define como culturalmente competentes. Outras teorias da área de enfermagem incorporam dimensões adicionais com o prejuízo de
desenvolvimento de aproximações em que se defende que o cuidado deve ser acompanhado de uma sensibilidade intercultural (Campinha-Bacote).

Neste artigo será apresentado um estudo sobre as cuidadoras imigrantes e o estudo sobre as suas estratégias de cuidados em áreas fundamentais e na província de Huelva, Sudoeste de Espanha, onde os cuidados são prestados a idosos em diferentes áreas de especialização: atenção especializada em hospitais e atenção da unidade familiar em sua casa. Depois de uma descrição inicial do perfil sociodemográfico das cuidadoras entrevistadas nesta área de estudo, nosso objetivo é conhecer as estratégias que desenvolveram no momento de cuidar de pessoas de diferentes origens e como estas são integradas no contexto social, cultural e institucional dos cuidados a dependentes na sociedade de acolhimento.

Palavras-chave: Cuidado Transcultural; Práticas Sociais; Migrante Feminino; Pessoa Dependente

JEL Classification: I 11

1. INTRODUCTION

In recent years, major social changes occurred in Spain that affect the demands from families to health professionals, in particular, and the health system, in general.

The first notable change is the ageing of the population; we can find homes where there is an abundance of the chronically sick, with self-care difficulty and non-external care. Any dislocation or management of the relationship with the health care system must be done with the help of family members or professionals. People at a certain age who have lost the ability of having a relationship with their doctors and the nurses are neither spontaneous nor direct and need the help of their families to accompany them and manage the relationship with the health care system and implement or monitor their treatments (1).

Faced with this situation, the offer of institutional care is very poor (day, homecare, residential centres), and the private offering is unaffordable for the majority of retirees and even their child. Between the year 2000 and the year 2050, the number of people older than 80 years in Europe will triple. Geriatric demands will grow even more than triple because we will have an increase of expectations and demands of this age (1) group; therefore, the only way to deal with the problem is the figure of family or informal caregiver, taking care into the family and, in another way, the extension to the (2) social services network.

Another social change that has occurred recently is the weakening of the source of informal support, mainly due to women that are being incorporated more and more into the professional world, which radically modify its traditional role of caregivers of patients or health care providers. According to surveys by the Ministry of Health, there is a paradox; informal or family carers dedicate less time to take care of themselves, especially when they combine the role of housewives and of active workers. The new social role of women affects the Care System of their relatives. The decrease of women that provide family cares increase the demand of people dedicated to the care of patients outside of the family. These people are also the main caregivers of our patients. The main difference is that the link between them is not family ties, but the consequence of an economic exchange and provision of services, which, in some forums, is called mercenary care.

Another change that has occurred in today’s society is because of prosperity and facilities in the displacement and flow of populations of different countries, which is attracting large
numbers of foreigners not integrated in our society in Spain. The arrival of people from other cultures represents a major social change; but, above all, it implies a cultural impact, mainly for them, because the non-native population is a minority. This inflow of foreigners is experiencing a social change given by the need to acquire jobs that decrease their basic transfer costs, so that immigrant population is subject to some labour niches of job insecurity, low wages and endless hours. They formerly worked in the agricultural and construction sector; this group largely consisted of men, as well as some women also in agricultural, but women were mainly in the domestic sector attending dependent elderly people at home and hospitals. They are emerging as occupational niches that local society rejects, and they are directly absorbed by the immigrant population.

All of these social changes have evolved in the development of a new figure: the new agent of health care, which had not been studied or subjected to analysis until now, and these being the foreign caregivers that belong to different cultures, values and perceptions of the country from which they come, and they developed a type of cross-cultural care in our patients. Throughout this study, we will call them Cross-Cultural Carers. Their work is to assist our elderly, satisfying their basic needs and also engaging in a work of accompaniment, therefore replacing the usual family care or informal care system. This is a new trend, and although there are various studies that describe the informal care provided by members of the family (3), (4), (5), those who describe the support provided by paid carers outside the family nucleus resulting in a migratory processes have not been found.

The living conditions of these new agents of health are very different to family caregivers and the other local, paid caregivers, not only because of the attempt of adaptation to the new society that they are living in but also because of their own experience of the migration process, which involves economic, psychological, physical, social and spiritual difficulties. Culture shock is very strong, and the difficulties to adapt to a new, cultural context and integration in the new model of society become very hard (6). In addition, we cannot forget their pain from whatever is left and lost in their countries.

These factors provide caregivers taking these jobs an opportunity for learning and integration into a house on his new homeland; despite the precarious conditions of the work, it does not affect the quality of the care provided, even with a big cultural shock given by the interaction of two people with different values and perceptions of health and life styles.

Care involves understanding and, therefore, necessarily includes a process of empathy, identification of needs and assumption of knowledge.

Care and health have similarities and differences according to the cultural context in which they are located; the care provided by cross-cultural carers will have features consistent with their own culture, which does not have to be similar to the needs of patients who belong to the culture of the host country. It is necessary to know their knowledge, attitudes, beliefs and values and adapt to a training plan appropriate to each person according to the situation in which they are, particularly concerning knowledge on health/disease, expectations, attitudes, etc. that must be known about the care of dependent persons. We will conduct this study from the point of view of a nurse with the complete care unit consisting of patient and primary caregiver.

In this case, a cross-cultural caregiver exercises the cares with the maximum dedication, and we must ensure that the cares that they provided to our patients are culturally appropriate to the needs of the patient and the standards of quality required. The best way to plan our intervention and address the care unit, and detect their needs, would be using a methodology, which, in this case, is the methodology for cross-cultural care.

With this article we present the results obtained after a completed research project whose objectives were:
• To know the strategies developed by cross-cultural carers to develop their daily work from the vision obtained by their own culture.
• Define the profile of the foreign carers who provide care to patients of the Huelva district.

To address the study on the reality of care to dependent people who provide foreign women, three types of methodological approaches that respond to the different objectives have been used.

Firstly, a methodology focused on the analysis of secondary sources, the exploration of data from other studies and the existing statistics on immigrant carers were used. Among these sources a prominent book is included, *Cuidado a la dependencia e inmigración*, from the Ministry of Labour and Social Affairs and the various statistical reports of the IMSERSO, the collection of social studies No. 6 of the Fundación la Caixa called *Vélez, Dependencia y Cuidados de larga duración*.

Throughout the research, we have taken various approaches to the reality and comparison between the different nationalities of carers.

The different sources appear in the bibliography of this memory section.

Secondly, an analysis of the situation of dependence existing in rural areas was performed, and interviews were conducted in the field, that provided a better understanding of the current panorama, reviewing both demographic issues, including responses raised by this phenomenon, i.e. the way in which protection of the State is organized.

Thirdly, a qualitative methodology centred on obtaining primary data through the in-depth interview to a small sample of 10 cases of carers linked to the private sector, with another 10 applied to carers linked to a company (all of them foreign), where there was a primary focus on aspects linked to their immigration profile, employment, and family. In addition to this main objective, we also attempted to make women’s work visible, as they are the informal carers, who are little known and little valued socially, concerning themselves.

Interviews were in their place of work, performed in the homes where they live and provide care for those in the private sector, and in the hospitals of the city, with the provided carers belonging to a private company.

This change elicited in fieldwork lies in the realization itself, since once immersed in it, we perceive the monopoly of the specialized care in a sole company which provided the “private care” or the informal paid care. It was decided to include this novelty in our research and change the distribution of the sample raised in principle - frequent changes in qualitative methodology given its great flexibility - to make the analysis of the situation lead to more interesting results, with two perspectives differentiated within the foreign, informal care: private self-employed and self-employed. This labour distinction was the only existing one between the two resulting samples, since the rest of the features that complete the profile of the samples remained the same (nationality, age, gender); therefore, we decided to interview 10 carers belonging to the company as urban in the specialty care and another 10 belonging to rural areas (Coast and County) to carers residing in homes.

2. RESULTS

Real Situation. Formal and Informal Care for the Unit
There are several phenomena that show the real situation of dependence on our country and, more specifically, in the province that is the subject of study, Huelva.

The first of these is the transformation of the families of our city, as women join the labour market and the birth rate decreases. A difficulty added to this is the economical availability of households and the increase of costs from the care of another person and
more if the pension does not cover even half of the costs. Regardless, the situation of the need for more dependent care would have much to do with the existence of what has come to be called “proximity services” (service help at home, Tele assistance and day centres). The low stocks of this type of service, enabling formal caregivers to not have to cope with caring for the dependent during all hours of the day, frequently generates the need for someone who allows small spaces of respite to informal caregivers, but that, as we indicated above, necessarily causes a family economic expense. The arrival of immigrants with possibilities of caring for older dependents and the possibility of living at the home of the dependent, may be prompting a new situation which is hiding, in part, the limitation of services of proximity. (IMSERSO)

Real situation. First core study. Aljaraque. Punta Umbria. Characteristics for immigration as a young phenomenon

The basic area of health of Aljaraque, which is only as far as 3 or 4 kilometers from the urban area of the city of Huelva, consists of 4 towns.

In three of them, there is a health centre or doctor’s office. However, there is no retirement home. The population is very mixed, particularly at Corrales, the closest to the city of Huelva. Until about 6 years ago, the majority of them were of a considerable age, as younger people had gone to the Huelva capital or other places for work reasons. But in recent years, there has been a massive construction of new homes in the area, and the population has become younger and more numerous.

Apart from this, the characteristics of the population in this area are consistent with the general trend of the current population, both in demographic changes and the health partner needs. There is a lower birth rate, as well as an increased life expectancy, which together with the addition of women to work, who were formerly the carer par excellence, makes for more people living alone than before, especially women over the age of 80.

In these days, we can find more technology at home; therefore, the assistance of patients who are restrained in bed requires closer and more continuous care due to the techniques to be applied and the devices used.

In any case, the number of carer’s immigrants finally found was fewer than expected, perhaps due to the coincidence in time with the beginning of the benefits of home care derived from the Law of Dependency. It has gone from providing one or two hours of care a day to spending a minimum of three hours per day. In addition, we have the economic benefits that can even exceed 400-500 euros; it has caused some family members to stop working because they could not earn much more than that, becoming informal carers of their families.

Discussing demographics more particularly, we have in the year 2007, 16368 inhabitants, of whom 1411 are older than 65.
- Users who have been considered dependents after the nurse assessment: 169.
- Considered fragile or users at risk of dependence after the nurse assessment: 259.
  Which are followed: 78.
- Immobilized at home in follow-up: 172.
- New users valued and a Care Plan established in their homes: 47.
- New carers valued and a Care Plan established at their homes: 34.
- Visits to patients and carers at home: 2167.
- Localized carers: 108.

On the immigrant population enumerated, we can say that, in 2006, there were 1257 immigrants registered, raising the number of foreigners in 2007 to 436.
In summary, it can be said that City Council Social Services worked quite well; there was a proper active recruitment of home help service for dependent patients if it was suitable and available resources allowed it.

When the family prefers that they have full time care help at home, they will have to hire on their own. Foreign women are preferred, specifically of South American nationality; they are chosen by family members “for language reasons and also because of their temperament”.

**Real Situation. Second Core Study. Almonte area. Distinguished by a consolidated immigration where there are second generations of immigrants**

It is known that the migration process in Andalusia has experienced deep changes in a short period of time. The transformations have been even more significant at the provincial, or even local, level.

Focussing on the local level of the District of Almonte, we must take into account the following factors:

- Seasonality of agricultural crops.
- Source recruitment policies.
- Immigration law.
- Enlargement of the EEC.

These factors were pointed out in the migratory flow in Almonte, where the migration process began following the establishment of intensive cultivation of Strawberry, with an obvious character of temporality and where, after suffering the problems of irregular situations and numerous obstacles that entailed, active policies of recruitment in origin were adopted, at first mainly in countries such as Romania and Poland. Despite this temporality, the stabilization of a population with certain conditions of marginality and with sporadic work in precarious conditions has to be noted. The settlement of this population conditioned at the time the existence of a marginal offer of employment and, for immigrant women, it had specific connotations: lack of training and lower offer of employment in the agricultural sector because of the seasonality of strawberry crops. This perception came from a lack of expectations in their countries of origin and housing needs in their new country.

These connotations, coupled with the increasingly active integration into the labour market of the Andalusian Women and the need for provision of care in the citizen environment, carried immigrant woman to home care, either as what we could call full time help, living at the home of the ill person, thereby alleviating the need for housing while receiving an income which, although low, covered their most essential needs; or rather as external help, with a number of hours agreed to care. In any case, formal recruitment through employment agencies was uncommon.

As recruitment policies have been changed, the enlargement of the EEC and legal measures aimed to regularize these situations has led to progressive change in the nationality of these care helpers, until today they are mainly formed by Latin America women, Eastern European women and Moroccans.

This also indicates an active, local immigrant integration policy that has provided the opening of the Local Council for Immigration, where measures are designed and developed to focus on the normalization and integration of this population.

In this sense, the Care to the Immigrant Municipal Office should be noted, which, among other things, manages all the employment offers, and it is where these carers presented a range of services addressed to prospective employers.

On the other hand, we have been empirically studying the implementation of the so-called Dependency Law; this law has released some carers from working out of their homes, substituting their work outside the home for the economic provision because of the recognition of dependence.
In this regard, indications are that Almonte have made and processed 419 applications for the recognition of dependence, of which 250 were of grade III and II-2, 51 resolutions of grade II-1 and 12 resolutions of grade I.

At the moment, we can speak of an immigrant population that is more stable, including 52 different nationalities, according to a municipal census, with a higher level of integration.

Currently, the Municipal census of Almonte contains a total of 3410 registered foreigners, with 52 different nationalities. The majority are as follows:
Romanian........................................1,890
Morocco........................................ 280
Polish.......................................... 269
Equatorial.................................. 189
Bulgarian...................................... 171

The total number of the foreign population is 15.5% of the foreign population over the total population.

There are a total of 2613 community foreigners, of whom 1416 are women and 1197 are men.

These two, detailed core studies, with women devoted to care, have full time, dedicated work, developing their work in the patient’s home, where they live.

Real situation. Third core. Huelva Capital
The situation of the care in the capital is different, despite the fact that a high percentage of care is carried out in homes full time, with the arrival of the Dependency Law, as referred above; as a result, the situation changes, hiring caregivers in a part-time manner (sleeping out of the domicile) or working for hours.

Another important factor in the development of the field has been that, in Huelva, there are caregivers who work in the hospital and, at the same time, developed work at the home of the patient when he is at the hospital.

This is not a monopoly of foreign women carers who provide cares in hospitals, but there are also women that are health professionals who provide services outside of their administrative situation with the public health service. Within the studied phenomenon in the hospital context, we note another incipient event; under a market structure, companies dedicated to the attention of people exist, whose workers have in common the unregulated experience. Some have a course on home care and Geriatrics; but, even in this case, the labour niches for expatriates make the difference, and a company was created as described above, with the only difference being the nationality of the workers, who are exclusively Latin American. These are trained in care for the employer; he is a professional nurse, one of the first foreigners who settled in our city and also works in the public health service in our province.

With respect to the other companies, the care for elderly people is one of the wide ranges of services offered, as well as home cleaning and other domestic tasks such as picking up children from school, etc...

However, the company managed by this foreign citizen has a unique service of care to older people that varies if the site of the service is at home or, as in most cases, in the hospital. This company differentiates their workers from the rest because all dressed in a uniform, very similar to those used by health professionals at hospitals; the only difference is a logo of the company with advertising and contact details.

In the city of Huelva, we find that in the three existing hospitals, Hospital Juan Ramón Jiménez, Hospital Vázquez Díaz and Hospital Blanca Paloma, the previously named company that monopolizes the market makes it very difficult to find work for women who
are trying to deal with this job niche, since it is more reliable for the families to be served by an employee of a company whose motto is professional care instead of others that do not have endorsing references.

Therefore, non-formal care in hospitals in our province, as well as those at home, are still being carried out under foreign hands, with the big difference that they run within a business framework in specialized care. Regardless, the wages received by these workers, or self-employed, is always less than those who receive local people; there exist differences of up to 15 euros less for service performed.

3. FOREIGN CAREGIVERS. PROFILE

Despite the fact that women have been always present in migratory movements, female migration has been characterized by its invisibility. However, this invisibility begins to disappear from the moment in which it detects the social and economic importance of women immigrants, and not just by their increase in number but by the socio-economic role they play in their countries of origin, as well as countries who emigrate. (Ruiz García, 2002) For immigrants, domestic service acts as a labour niche in which there is no competition between immigrants and locals, especially in the case of the full time domestic service, as this is a type of work absolutely rejected by Spanish women. However, there is a competition among the immigrants, a process of ethno-stratification based on the preferences of employers’ families (Emakunde, 1999), in addition to less expensive wages.

The profile of immigrant women who are dedicated to the care of people in a situation of dependency varies in relation to the described pattern of formal carers, and that is why there are personal circumstances that often surround the work and personal context of this collective (Martinez Bujan, 2004).

The age of Carers

The average age of women immigrants is usually between 20-40 years, with 25-29 being the highest stratum (INE 2007); however, in our data source resulting from the interviews, we see that the average age is significantly higher, with the youngest of the women interviewed being a woman of 31 years. This can be due to preferences from the employers, since older women have more experience, hold more and take more responsibility; young, foreign women tend to be employed in the agricultural sector, living with their compatriots in the field itself or a rural area. The adult women don’t mind staying the weekend at home, in contrast to a 20-25 year old who wants to exit. (IMSERSO 2005)

Origin of the Immigrants

The origin is one of the most interesting issues, since it responds to the way that immigration is developing, i.e. networks. The origin of carers is not at all representative of the origin of immigrants who settle in the territory, and it is not attributable to any other logic that the extension of its own networks can explain, in order to deal with empty niches where the demand can be strong (IMSERSO 2005).

The nationalities of our respondents were as follows:

Romania: 4
Ukraine: 3
Bolivia: 3
Kivavid: 11
Venezuela: 2
Peru: 2
Colombia: 3
Russia: 1
Morocco: 1
It is important to emphasize that, in our areas of study, the logic of social networks reigned within nationalities, so we conducted a more exhaustive search, enriching results and trying to find other nationalities. In some areas, the nationalities were distributed by sectors or neighbourhoods, confirming this theory of recruitment on the basis of the rumour and networking.

**The Family Situation of Carers**

The invisibility of immigrant women, and how this has evolved with the changes in the migratory flows and existing policies, has created a job niche for domestic and care work for the elderly people, where immigrant women do not have any competition with locals, given the precariousness of the work that we mentioned at the beginning of this section. This has enabled women of the families of the country of origin decide to lead migration processes, since arrival in the host country is going to be much easier, because of their illegal status. This is especially the case if they already have another compatriot who is working, as this social network will serve as buffer cost and assistance in seeking their first job. This phenomenon has been observed in 80% of the interviewees; the remaining 20% came regrouped, and they were first dedicated to agricultural work, since they belonged to the rural areas where immigrants were consolidated. One of the women interviewed currently lives at the home of a Lady as a full time worker with her two teenage sons who came re-aggregated.

Once the woman settles and begins to work as a domestic caregiver, it maximizes her revenue, as she does not spent in rent or food, and she saves everything to send to her family in the country of origin. This phenomenon occurs in some of the women interviewed, but others, especially those that are older, prefer to return to their country, and their main goal is to save. That is why one of the interviewed works on her free day for hours as a cleaner, while having her other job as a full time caregiver.

The most important thing in this section is related to the expectations of the interviewees regarding the care. The interviewed know very clearly that it is temporary work, not only because of the possibility that the person being cared for may become deceased, which increases the dynamics of jobs, but also because, in the future, they can regroup with their families or move to their countries. Those who stay in our city changed their full time work or part-time carers, as happened with some of our interviewees.

**4. CARE STRATEGIES**

**Training**

Only two of the 20 informants had received training concerning care: one of them was a clinic assistant in Venezuela and at the Red Cross of Huelva; the other had completed a course. The remaining 80% perform care without any experience. Those surveyed from Ukraine indicated they helped each other, transmitting among themselves their experiences and teaching those who were new; thereby creating a social framework to improve an employment network with their compatriots; 2 of the 3 girls of this nationality were friends, and they had shared the knowledge acquired in each one of their works: “How?” Therefore, the lady who is very good she taught me everything I need. I do not know, I taught my friend. “Before, you took the lady that had Alzheimer’s, and I think I do well because her son and her daughter-in-law were happy”. The Romanian informants were concerned that caring for them was not easy because they did not have previous training, but the need made them learn very quickly. Of the 4 interviewed Rumanians, 3 had a degree at university. Although the 4 quickly learned the work, they were very responsible people and asked us for training during the interviews. Latin American women had a common discourse, such that they do not need training because
care has been done by women all their lives, and this is something innate in women: “women are forced to obey what the husband says, and if you get married it is because you have to comply with their obligations as a woman and be at home while her husband brings the money” and “wash, cook and care for children and the husband”.

These women take care as an innate talent, not learned. European foreigners develop different strategies asking for help from their countrymen and from the family of the employers as well as using their social networks to acquire training; they are very responsible with the assignment and want to do it as well as possible. South American women have more attachment to their macro culture where the fact of being a woman means knowing all of the activities of daily life, including care; they feel well enough formed to develop the work without the need to be trained, although they do not reject training.

Training must be differentiated in our field of work; those interviewed who come from the aforementioned services company, since the owner is a professional of health, were prepared (not full trained). In this company, there are two employees who were nurses in Peru and work here as caregivers; although they feel prepared, they support important cultural differences that may lead to performing a less than satisfactory job. To alleviate this concern, the Manager caretaker of the company has created protocols, thus avoiding subjective care based on the culture of each of its employees: “Carers I have applied their knowledge of nursing but agreement protocol and the work plan which makes it to do, if one wants to exit the scheme tells you because this have not done well.” There are some that try to do so, as they possess ignorance while trying to do certain things that sometimes are not right. “We have seen many times that we worked as companies, and we have coincided in rooms with caregivers who were not companies and us and trying to imitate the care we give to patients”.

Different Perceptions of the Care
Care has a very important dimension related to culture, inherent to the person who makes it; it is very difficult to create recipes for care, according to the origins of the women interviewed, as there are different perceptions within each of the nationalities, according to their own experiences, relationships, education etc... Although there is something common to each of the countries of origin of the women interviewed, the fact is that the women from the same country have common perceptions that are associated to health and political systems. Given this premise, we will try to mix perceptions of the women interviewed with different nationalities and try to create common characteristics that will help us to understand, empathize with them and, thus, contribute to the Spanish health professionals’ competence as caregivers.

Health’s Concept. Expressed by some interviewed:
Latin American:
“Health, as its name indicates, is... okay, the person both internally and externally, right?” either as regards, also environmental issues, everything, or all inclusive, for me, more than everything, too much affection influences. Affection, because a person may be sick and always when love is offered, the disease will be less important. “Clear, because you also feel useful, independent of the disease they have, they are beloved”.

Eastern Europe:
“For me a person with health has no pain a healthy heart, head, and does not take pills”. Also is not sad.”

“Much laughter, great jokes, be happy, eat well, do sport, not to be sedentary, talk a lot, talk is a very good thing.”

The analysis of these definitions of a health concept is very enriching, looking at the similarities in the views of the woman. While they are from dissimilar cultures such as Latin
America and Eastern Europe, the first thing that comes to mind when discussing health is the same association, health with affection; for them, health has to do with being emotionally well and feeling loved. They based their care in love and emotional support, which is very good of course, although it is not enough. This definition in immigrants is normal since the immigration duel is associated with a mental health cost, not only by the longing of their people but by what living in another country entails, in solitude, without the ones you love, with another language, with the lack of integration etc... Therefore, it is normal that their definition of health is aligned with being well emotionally and the absence of mental problems. Their associations of these concepts are basic, probably due to the lack of training, since the definition of health of the person with nursing studies was more complete and elaborate: “because the term of health according to NANDA, according to the UN means and all that you know what..., this, Begoña.” Because there are many factors influencing the weather, place and space more than anything else. The weather, depending of the circumstances of the year, and from health point of view may vary, more than nothing in winter; older people have too many colds, and could be vaccinated for the flu. People that make processes of pneumonia and have to be hospitalized, “The place I say, in terms of the place where you are, places here in Spain can be very controlled, but there is another type of influence that can affect the health of patients”.

If we discern concepts according to culture, we observe that the informants of the Eastern countries (Romania, Ukraine and Russia) added to the affection and emotional state something more: money. As they suggest that, in their countries, the health system is similar to ours in that there are good hospitals, good professionals etc., the big problem is the lack of resources to access them; so, in their definitions, they assume that health has to do with money. Fellow professionals of the health system of the region of study, when they were interviewed, mentioned that, after a Romanian patient nursing consultation, they received 5 euros in their pocket, since it was normal to pay in their country.

Cultural Shocks between Health Systems

Latin America

“Yes to medicine, to things which there are here and not in my country, the comfort of the existing social security, because we do not have it for all, but only for the elderly and the newborn infants under one year.” That is the difference in medicine that I see here. “And another difference I see is the way we live, that all people work and at my country women always stay at home, we are used to be at home and being maintained by men...”

“Communication here is different from my country, very different, because in my country older persons are not treated as if they were equal; for example, if I speak with my friend in a rude way, in front of one older person no bad word would be said, more respect for that is what it is, no ugly faces, because you cannot. Not because it is abuse, but respect it’s something that we learned. In the health system, for example we have injections to prevent flu because you can get many diseases in winter, so they come to the houses and health centres to inject before it reaches the winter. “In that there is not much difference.”

“There what we have as an example of medicine, treatment, or therapies e.g. medicinal plants and all that.” Here, you do not have that. Yes, you do other things? Yes, there is everything there. What happens is that the lack of resources is very bad. Of course we have different cultures right? For example Indians, our Indians, they heal with their powers which they have acquired. People, blacks for example from the coast, they also take care of them, for example. Myself, when I was working in the companies and moving well inside the woods there were people who had to get there, walking 7 hours or more. Lack of resources, I already left almost 7 years ago, and when I go back you can say that everything is the same. Well beyond, for example, cranes do not exist, as far as I know, you can have them, but I
speak, for example, at the working class level; you can have them at an upper classes, but there no, I don’t know. But this is not an excuse to live someone to die…”

“Because the practices are more than anything what is alternative medicine or traditional medicine that are somewhat the use of herbs, ointments of animals, the use of other types of empirical knowledge.” There is a very important work in this aspect that is traditional medicine; and what is it, as it is called, instructive is the medicine studied at the University; traditional medicine has sorcerers, healers, they can heal certain people. [It] occurs too much in Peru, because Social Security there is not as here in Spain, free, but there is very... this... how you can explain? In an expensive way, i.e. costs you, costs you a consultation, costs you a medicine, costs you to ask a question to the doctor, has a cost to go to the emergency room; and if you don’t have money, you stay. Many times I was a witness in the travels that I have had these past years to Peru and recently found the case of a child who had fallen. He had a wound on his forehead and had to be sutured, but the family did not want to take it to the hospital because they could not afford the suture, and said that he will be okay, nothing happens, the scar will heal and should look like this. But [it] needed a suture and simply for not paying the suture and a lack of financial means, the child [who] was wounded badly healed. This is a minimal example of what can happen there. In areas of the forest is where I say that there is a nurse’s work. They develop activities of how traditional medicine must be combined with modern medicine, and sometimes in those villages, more than anything in Amazon, not accepted [are] doctors, nurses or the obstetrician. They are not accepted, [but] rejected, and they prefer to continue his... his..., your sorceress, his sorcerer, his healer, bonesetter, also is named to the person who is responsible for return[ing] to place dislocated bones or treat[ing] any fracture. [This is] because they prefer their medicine by the economic aspect and the confidence they own [in] them. These are the aspects that there is. Because you have already said that they used natural remedies of all kinds, both plant and animal. There is a method called “jobeo”; the jobeo is a Studio that makes the person through an animal, which means good; the animal much used [is] the Guinea pig of India or the cui. The healer has been passed by the people and makes the interpretation of what happened in your body by the animal, and you can see, and matches many times, and there are many anthropologists, sociologists, both of the Peru and from abroad, made the jobeo. The patient is in bed, grabs a Guinea pig, becomes the Guinea pig, and when you’re going through because the animal dies, then they open it and are doing a study if you shock, if you have good lungs, is as a kind of biological x-ray that passes so that you have the animal and is interpreted, and many times you have gases, and this match makes you stay thinking. I’ll tell you from my own experience that I have studied nursing and the difference when I return to my roots tend me to make such practices and match many things, right? What I have, which reflects the animal, and what they say people who are responsible for this. “And this medicine endures today and perhaps as you’ve born in that environment, therefore also trusts your own medicine.”

Eastern Countries

“There are many people who believe in other types of medicine, do not know how here in Spain but in my country, yes.” It is medicine and people think: hospitals, doctors... Well, everything there, but hard to do know? It costs money. Do you understand?” “But there are all the same, but you need money, and that is why we all are abroad and we have to emigrate, you know, be[ing] healthy costs a lot of money...”

“In Ukraine, we have this disease; Chernobyl, did you say?” …In 1976, near our capital, an atom as they say? Broken one... I cannot explain it... For us, [it] is very bad in Ukraine... “Here, thank God, it doesn’t happen...”
“Here everything is it is at hours, all very accurate.” In Ukraine you can do things as well. There are medications when you can, no matter if we must give it every eight hours. “We are more cluttered; we do that when we can.”

“We do not buy diapers or something like that.” There not take care of patients, because they need to work. They cannot devote time to the patient; he is left alone. “The person has to take care of one.”

“Some of those who heal without being doctors.” They say that it is better to be healed by natural remedies. “They are not medical, but they help people.”

“I know a man who is not a doctor, but help[s] cure, with his hands, the hurts or the one that have almost broken something.” He finds where the problem is and solves it. And that man cannot read or write and is very poor. “He lives in the village of my parents.”

“What I find more difficult is to wash a person, especially if he is a man.”

“Here you are very orderly with diseases; in Romania, also, you know what disease you have, and what the organism that gives it, but we cannot buy the drug that removes it from the body; that’s worse.”

“There the nurses have no means to be able to take care, because everything is very expensive; I remember when my daughter was born and the nurse asked me a paracetamol for her headache, because there was not in the hospital for her, only for patients who paid.”

As noted, this section meets one of the objectives set out in the study: learn how care occurs in countries of origin in order to put ourselves in their place, empathize with them and understand some of their practices in health. At the same time, we must be able to train them while avoiding cultural shocks that currently exist both at the macro-sanitary level and the micro-level, in the homes of dependent patients cared for by carers from another culture.

Each culture has its own language, using phrases and expressions of that country that, when performing an assessment, nurses must bear in mind regarding what we are trying to say and the actual understanding and meaning. Then we are going to describe practices performed in the countries of caregivers, to understand their behaviours in our country about health.

Regarding reproductive practices, in the environments of the societies of origin, especially Latin America, women’s roles are fully reproductive. This is even more acute in rural areas. Although some authors find a differential fertility due to drag from the society of origin (three or more children per woman in the African and Latin American societies), it is not clear that these differences remain, or change, when approaching the reproductive behaviour of Spanish women. According to the experience of other European countries of immigration, foreign women who settle permanently, measuring the length of their stay, tend to approach the number of their children with that of the locals (Oliver et al. 2004). A study conducted in the district west of Almeria among women attending an IVE noted that prior use of modern contraceptives was higher among local women than in immigrants: 76.4% versus 55.3% (Soler y Coll., 2004). Likewise, the study on Nursing Diagnoses in immigrant population in the Poniente District detected a Sexual Ineffective Pattern diagnosis in connection with a lack of knowledge of effective contraceptive methods or its inappropriate use (Baraza et al., 2005). Regarding the voluntary interruption of pregnancy, we should bear in mind that in Romania it is not a practice carried out as in our country, since according to our informants, the profession that makes more money is a gynaecologist and the practice of abortion. Of four who were interviewed of this nationality, 100% had practiced an abortion in their country and some had more than two. They told us that, when Romania was a Communist country without access to existing contraceptives and the most commonly used was the IVE, it had generated the culture of abortion. A health observatory of the women of the Ministry of Health (published in 2006, with data from 2004) stresses that the rate of IVE in Spain stood at 8.94% in 2004, being the lowest in the European Union, and that increase was due to the increase in the immigrant population. For example, in Sweden it is at 17% and 50% in Romania. It has influenced the year of des-penalization, the restrictiveness of their
legislative regulation, customs and cultural constraints, and the presence or absence of family planning policies. Forty-nine countries around the world (41 of the world’s population) have no restrictions for the gestational age for the practice of the IVE.

Other practices that are carried out are those related to food and health; these are the views that our women have on this topic:

“Of course, because when you are ill this is the importance that disease has, do you understand?” “If you have a very bad disease, can’t eat as another person who is good.”

“Of course, because of health, I need to eat well; eat well, I think it is very good.” Yes, I need to eat well and healthy, like, good food. I do not know; it seems to me that [it is] the same as Ukraine here... We eat more pork meat; I prepare all food with fat, and that is not good for health, and here I so like lots of fruit. They eat much vegetables; we do not eat vegetables...

“The power is very important for the elderly; for example, if they are in the hospital, the food is not bad, but they don’t eat it; then when they leave the hospital, they need food with much iron, food that takes lots of energy, to give them energy, and that is very important because it will change the environment.” “The food is very important for older persons.”

“In my country it is more important, because here one, for example, arrives...when the person is old; they tell not, for example, do not give little, he eat little, by my experience, then I get and give more e.g. vegetables, fruit and all that; I will increase the dose and the person improves.”

“Well, yes, a good diet produces a good absorption of vitamin complex, proteins and everything you need [in] the body and thereby a normal growth and a strengthening of the defences which give you a well-being, except when [it] breaks by accident or for any other reason.”

There are beliefs that different cultures have a common link with respect to food, in countries with food shortages, either by economic problems or the political regime; when these people go to countries such as ours, where a variety of food is attainable for the working class, they do not understand the restrictions and do not consider food as assumed by the culture of the Mediterranean diet. As they reflect, when one is old or sick, they have to eat in abundance. Nursing has to take into account this cultural aspect to understand many of these carers’ practices and understand how these can be of little benefit for chronic diseases of our elders.

Another practice of our women who left their mark in interviews is the differences in health care systems, as explained above; this, when qualitatively analyzed, has a reading that is very important for the treatment of our elders in what nurses call the ineffective management of therapeutic regimen, with speeches such as: “here everything is going for hours, all very accurate;” in Ukraine you can do things as well. There are medications when you can, no matter if we must give it every eight hours. “We are more cluttered; we do that when we can.” “Some of those who heal without be doctors.” They say that it is better to be healed by natural remedies. “They are not doctors but they help people.” “In Romania, I had TB without taking pills and nothing happened, and here for anything they give pills, to weight loss etc.” These inadequate practices in their countries, due to insecurity and scarcity of their resources, makes the person assume that it is normal; they do not give importance to medicine, or the pharmaceutical industry, given the lack of treatments of this type that occurs in their countries of origin, and they look to their traditional remedies. They do not follow our treatment guidelines, since they are in the same situation as us in their countries, and they do not take it so nothing happens. The lack of adherence to the treatment, as well as the lack of need for these caregivers, is increasing.

Regarding these practices, it is clear that a company’s carers do not allow that because they have protocols.
5. CONCLUSIONS. APPLICABILITY OF THE RESULTS

Ageing is a social issue, but in recent times it has become a political and economic issue of the first magnitude. The physical overhead of people caring for a family member with a high level of dependence does have limitations in bio psychosocial health. This topic has acquired great significance with respect to health policy; it is even spoken of in the Congress to amend the law and expand benefits to improve the overhead carer’s law of dependence. But the current response of our society to this major problem is overcome with unpaid and badly paid carers working many hours with our patients and incorporating them in your home as a full time worker. This type of work, mostly occupied by foreign women, in less than two years, has become the biggest collective caretakers paid by patients in our country. Although this phenomenon has not been the object of numerous studies, the reality is that the population of the fragile elderly, multi pathology, cognitive and affective disorders, difficulty in ambulation, urinary incontinence, hospital attendant and social isolation are being cared for by people without specific training, as well as a cultural heritage that is different from theirs.

This entails a culture shock that can lead to maintenance of health problems and even to an increase in the feeling of isolation from the patient. So the relevance of this study that makes it a social priority is that each of us suffers in our homes.

With the knowledge generated after the research, we can improve the quality carers providing to our elders, since we are able to understand and know the system of their way of life and values possessed by the women interviewed regarding the action of caring for others, and we can involve ourselves in the strategies they have developed to improve the quality of their work.

An applicability of the research set out above would be the elaboration of a guide to clinical practice in which communication strategies are developed with some prevalent foreigners’ nationalities in our community, without falling in automations and recipes that are impossible, since we are dealing with individuals.

It could also be possible to design communication courses with the immigrant population to promote culturally competent care.

Another utility to consider would carry out an offering of informal carers, with payment possibly resulting from this research, who have demonstrated their skills and knowledge to be able to be used in future care; in this way, we would avoid having prepared unemployed people and duplicating the effort of the health centres to train new carers.

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