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Fulfillment of basic needs of the moroccan female immigrant population in Arteixo

SATISFAÇÃO DAS NECESSIDADES BÁSICAS NA POPULAÇÃO IMIGRANTE FEMININA MARROQUINA EM ARTEIXO

SATISFACCIÓN DE LAS NECESIDADES BÁSICAS EN LA POBLACIÓN INMIGRANTE FEMININA MARROQUÍ EN ARTEIXO

Amalia Conceiro Rúa¹, Rosa Pita-Vizoso², Inmaculada Gómez-Besteiro³

ABSTRACT

Although some years ago the Moroccan immigrant population was mostly male, the number of women is increasing every day. This research is focused on this group, and has the following objectives: to know how emigration affects the fulfillment of Virginia Henderson's basic needs; what transformations and adaptations must be adopted in order to fulfill them; and what reinterpretations and strategies are implemented in order to minimize the impact of culture shock. A qualitative study was performed from 2004-2005 by means of semi-structured interviews to 20 Muslim immigrant women in a municipality of Galicia (Spain), and showed that for Muslim people, everything is regulated by religion, so the necessities affected are strongly related with the *need of acting according to one's values and beliefs*. Therefore, valuing the referred need provides fundamental data in order to direct the activities towards keeping and recovering health.

KEY WORDS

Health services needs and demand.
Emigration and immigration.
Women's health.
Qualitative research.

RESUMO

Embora a população imigrante marroquina seja eminentemente masculina, atualmente é cada dia maior o número de mulheres. É neste coletivo que se concentra este estudo, cujos objetivos são: saber como a emigração afeta a satisfação das Necessidades Básicas de Virginia Henderson, que transformações e adaptações tem que se realizar para satisfazê-las, e que reinterpretações e estratégias são postas em prática para minimizar o impacto do choque cultural. Para isso se fez uma investigação qualitativa mediante entrevistas semiestruturadas realizadas durante o período de 2004 - 2005, que nos mostra que, na pessoa muçulmana, toda a sua vida está dirigida pela religião, pelo que as necessidades afetadas estão estritamente relacionadas com a *necessidade de atuar segundo os valores e crenças*. Por isso, a valorização de tal necessidade aponta dados fundamentais para orientar as atividades dirigidas a manter e recuperar a saúde.

DESCRIPTORES

Necessidades e demandas de serviços de saúde.
Migração internacional.
Saúde da mulher.
Pesquisa qualitativa.

RESUMEN

Aunque hace unos años la población inmigrante marroquí era en su mayor parte masculina, cada día aumenta el número de mujeres, colectivo del que se ocupa este trabajo. Conocer cómo afecta la emigración en la satisfacción de las necesidades básicas de Virginia Henderson, qué transformaciones y adaptaciones se tienen que realizar para satisfacerlas y qué reinterpretaciones y estrategias se ponen en marcha para minimizar el impacto del choque cultural. Durante un año 2004-2005 hemos realizado una investigación cualitativa mediante entrevistas semiestructuradas a 20 mujeres musulmanas inmigrantes en un municipio de Galicia (España). En la persona musulmana, toda su vida está regulada por la religión, por lo que las necesidades afectadas están estrechamente relacionadas con la *necesidad de actuar según valores y creencias*. Por ello, la valoración de dicha necesidad aporta datos fundamentales para orientar las actividades dirigidas a mantener y recuperar la salud.

DESCRIPTORES

Necesidades y demandas de servicios de salud.
Migración internacional.
Salud de la mujer.
Investigación cualitativa

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INTRODUCTION

Arteixo is a city with about 28,000 inhabitants, bordering on A Coruña, Spain. According to census data, the Moroccan immigration in this city started in 1990. Nowadays, 329 Moroccan immigrants are registered in Arteixo, 201 of whom are men and 128 women. Their ages range from newborns to an elderly man aged 85 years. Their origins are mostly rural, although some come from urban contexts. In both groups, a majority closely sticks to traditional forms of religion, as a custom, as a form of confirming their own identity or as a defense mechanism towards its possible loss. A small group of people's Islamism is reduced to the declaration of shahada faith:

There is no god but Allah, and Mohammed is his messenger⁽¹⁾.

Initially, this immigrant group comprised men between 25 and 40 years old, including some young women responsible for housework. As they got integrated and achieved some economic stability, families regrouped.

Nowadays, genders are no longer that disproportional and the number of women who come alone is increasing. This situation is similar to other countries, according to the 2006 report by the United Nations Population Fund (UNFPA), according to which 49.6% of all immigrants were women⁽²⁾; a similar proportion is found in Spain (46.99%)⁽³⁾.

In most peoples, women and men live in different worlds as a result of differences in access to education, social relations, resources, the labor world, health. Women have traditionally been marginalized, which continues to occur in their country of origin as well as in the country that welcomes them.

In Spain, Moroccan immigrant women tend to remain invisible and identify themselves in relation to their husband or father; this social invisibility, in combination with the differences in access to education in their countries of origin, lack of knowledge about the new country's language and cultural distance are factors that turn them into a group living in an inferior, more dependent and vulnerable situation.

According to Maria Teresa Losada Campos, immigration produces a great revolution in people's surroundings; everything is change:

they have to reinvent daily life, learn the language, get accustomed to new customs, adapt to a new distribution of time⁽⁴⁾

producing a situation of grieving, considered as a *process of personality reorganization after a loss*⁽⁵⁾.

Due to the above, we believe that women experience greater difficulties to solve the grief emigration implies, which justifies our focus on women in this research. As health professionals, another reason that made us focus

on women was that we share the approach of other authors who affirm that these women's health is an important issue, not only because of its implications for these women in their daily life, but also due to the projection towards their family members in the new country, in the country of origin and even for public health⁽⁶⁾.

Also, we believe that the adaptation process to the hegemonic health culture in the new country is no different from any other adaptation processes.

The knowledge and values of a group reflect its own culture, which contains both updated traditional values and historical elements marked by the place they occupy in society⁽⁷⁾.

And, if we also consider culture as the set of patent and latent behaviors a community develops and which are implied in the needs satisfaction process, it seems important to identify variations in the way needs are satisfied, as a first step for care delivery to the members of a given community⁽⁸⁾.

We selected Virginia Henderson's model because it guides most public health care nurses' work in A Coruña. This model proposes an analysis in which a person is unique and complex, with 14 basic needs: breathe, eat and drink, eliminate body wastes, move and maintain desirable postures, sleep and rest, select suitable clothes, maintain body temperature within normal range, keep the body clean and well groomed and protect the integument, avoid dangers, communicate with others, worship according to one's faith, work in such a way that there is a sense of accomplishment, play or participate in various forms of recreation and learn.

These needs are determined by biological, psychological, socio-cultural and spiritual aspects. The way they are satisfied depends on: age, gender, development phase, life and health situation, culture, environment and different experiences lived.

Nurses' singular function is to help in the satisfaction of these needs when these women do not have the strength, will or knowledge needed to do it by themselves, so as to help them recover independence as quickly as possible.

OBJECTIVE

With a view to improving nursing care in this group of women, the goal of this study was to understand, from these Moroccan women's own perspectives, the emigration process and its relation with the satisfaction of basic needs:

How does emigration affect the satisfaction of basic needs according to Virginia Henderson's model.

What transformations and adaptations do they need to perform in order to satisfy these needs?

What reinterpretations and strategies do they use to minimize the impact of the cultural shock?

METHOD

Qualitative method. The study was carried out in Arteixo, a city in A Coruña. Spain; participants were 20 women between 16 and 60 years old, all of whom were Moroccan immigrants who had stayed in Spain for at least two months and whose education level ranged from illiteracy to higher education.

Participants were selected through an intentional snowball sample. Access was made possible through the nursing professionals at the health center. One of the nurses contacted possible participants and made an appointment.

Data were collected between July 2004 and December 2005. Individual semistructured interviews were used because, like other qualitative techniques, this technique supposes a form of empirical approximation with the social reality, especially adequate for a significant understanding and motivational interpretation of the social actors' conduct in their internal orientation, that is, either conscious or unconscious beliefs, values, images and motivations.

The interviews followed a previously elaborated script to collect socio-demographic data and ask the women openly about the satisfaction of their fourteen needs and what they did to satisfy them (Attachment I).

All interviews were conducted by a single researcher and took between 45 and 60 minutes.

Most interviews were held at the Health Center because the women went there without problems, and the

others were held at their homes. On some occasions, a cultural mediator was needed, a young Moroccan woman who had lived in Spain longer and had good mastery of the language.

The women participated voluntarily and were informed, anonymity and confidential data use were guaranteed, as well as the destruction of all data at the end of the research.

Authorization from the study was obtained from the health research commission under code: XAPLO-2005/03.

Content analysis was used to analyze the data. The expressed opinions were identified and categories were classified according to their relation with the 14 basic needs.

RESULTS AND DISCUSSION

The results and discussion presented next makes no claim on generalizing neither moving beyond the distinct context of the place they were produced in; through this study, we attempt to find culturally relevant information that helps us to value, plan and put in practice nursing interventions or activities that satisfy the needs of these women at our health center.

The analysis results are presented in narrative form and classified according to Virginia Henderson's basic needs, which serve as the reference framework. Fragments of the interviews are used to allow the reader to observe the relation between the category and the data. In the excerpts, sources are identified with fictitious names. In the text, only those basic needs are mentioned in which empirical categories emerged:

Chart 1 - Emerging categories classified according to basic needs

BASIC NEEDS	CATEGORIES
Values and beliefs	High valuation of health. Close relation between good health and migration process. Obligation to follow the self-care standards described in the Koran.
Avoid danger	Difficulties to use health services. Feelings of social isolation and solitude. Spiritual suffering.
Eat and drink	Mediterranean and elaborated diet. Changes in meal times. Food problems during hospitalizations.
Sleep and rest	Sleeping difficulties.
Dress and undress	As a distinctive instrument in social relations.
Communication	Oral expression difficulties in Spanish. Social control. Contradictions in sexuality and reproduction.
Work and accomplishment	Satisfaction with role. Loss of status in women with higher education.
Participation in leisure activities	In one's own socio-cultural group. Cultural restrictions in adolescents.

Throughout the interviews, references were made to contents from the Koran, which served as an important support element for discourse analysis and interpretation and, when they mention concrete aspects related to Islam recommendations, the Koran excerpts they refer to are used.

Our religion is not like it is for you, ours is for life too (Bouchra).

That is why we started to analyze and expose the need to live according to values and beliefs, as these conceptions influence the satisfaction of other needs.

Need to live according to values and beliefs

Satisfying this need in the spiritual sense becomes easier by the day for these women and their families, given the degree of settlement: they are more numerous, have a mosque, cemetery, butchery and halal shop, social networks.... On the counterpart, they are more visible, more annoyed.

Now, when I go to the supermarket, the women talk in the queue: she's Moroccan, they should leave, look how many kids she has... (Bouchra).

The health model is part of a people's system of beliefs.

The illness experience is determined by what that disease means for the person. The health and disease concept depends on each culture and, what is more, inside each culture, it depends on the age, gender and even the group that person belongs to. Moreover, disease is identified with the status and role in society. The disease should not only be sanctioned by a physician for the person to acquire the role of being ill, but also by the community or social structure the person belongs to⁽¹⁾.

En this case ruled upon by the Islam.

In the name of Allah, the Merciful, the Compassionate [...] but not the Lord of the worlds (....) and when I am sick, then he restores me to health (26; 79)⁽²⁾

When you are sick you have to get better, you have to take care of yourself, the Koran says so. (Boushra).

That will make room for a series of contradictions between the distinct representations of health and illness (in the country of origin and the new country), which will translate into manifestations of discomfort with not very precise symptoms⁽³⁾.

I'm never healthy, you know. Before I used to be healthy, nothing hurt. Now my back hurts, my head, everything (Fatima).

In general they attach great value to health, as their migration process depends on it. When they are asked what health is in their opinion, their answers do not differ much from ours:

You're healthy when you're not ill, when nothing hurts and you can work well. If I'm ill I lose my work (Nur).

In a natural trend, they conceive health as something purging, which cleans. They have guidelines for promotion and cure by fasting: Ramadan, prohibition of alcohol consumption, pork and some foods, hygiene and reading of the Koran aloud, which explain the importance of self-care in this group.

According to Goytisolo:

The Islam affirms the autonomous nature of each believer and his right to an inviolable and sacred family environment in which the sight of some unknown female slippers at the door of the quarters reserved for women stops visitors and relatives⁽⁴⁾.

However, given the time they have lived here, the problem of overcrowding described in other sources does not occur: *hot beds, canned people*. It is also true that their housing differs a lot, at least on the outside, from houses in Morocco, which are grouped on top of each other, constituting compact groups, but all looking out on an interior patio. They provide for this intimacy, which they cannot maintain in Spain, maintaining the traditions of daily life through the decoration of their houses, their clothes and foods⁽⁵⁾. That is how they maintain their culture of origin and provide some stability to their family in the society that receives them.

Need to avoid danger

The most frequent health problems detected among these women with regard to the use of health services were: not going to appointments made with health professionals, delaying visits to health services in case of important health problems and lack of knowledge about some services offered in the Spanish health system. Their discourse reveals the following as possible causes of these problems:

The use of natural resources is very frequent and they have all kinds of medicinal plants and oils for health care: Kahal to prevent conjunctivitis, henna to avoid callus on the hands of agricultural workers...; And that is probably the cause of their waiting to visit professionals.

Lack of knowledge about the health system and rights to service delivery in the new country. Some of the services offered by the Spanish health system and particularly prevention programs were not included in the health system in their countries of origin.

The cultural differences in care and in the way health and disease are perceived is yet another cause. In a study about the use of health services among immigrant women in the community of Madrid, it was revealed that due to *cultural reasons, about 20% of Moroccan women did not go to health services during the last perceived morbidity episode*⁽⁶⁾.

Cultural differences related to behavioral standards according to gender and male physicians.

I think I am four months pregnant and I haven't been to the doctor, I have a male doctor and I can't go there. What can I do? (Bouchsra).

Language barriers are another important cause:

She cannot come alone, she does not understand; I have to go the fair, without fair there's no money, no food (Azis).

Distance from work places (in the different peoples' markets):

We didn't come because there was a market in Betanzos, we didn't come for the appointment. We also have a store in Portugal. We cannot always come to the appointment (Latifa).

Similarly to Spanish citizens, they increasingly go to health services in search of fast-acting medication and abandon some treatments early, when the symptoms decrease and they start to feel better. They also tend to abandon treatment during the Ramadan, despite being exempt during disease processes.

They often present feelings of solitude and social isolation. This happened most frequently in the first phase of the emigration, mainly among girls / adolescents who came to help with housework, and later among older girls, due to the difficulty to combine their customs with those of their schoolmates.

They also display manifestations of spiritual suffering, such as verbal expressions of conflicts about their beliefs. What used to be correct and adequate is no longer so.

This frequently translates into somatizations that disappear to the extent that they adapt or reorganize their beliefs to the new life context.

Need to eat and drink adequately

Their diet is Mediterranean. For this purpose, they find almost everything they need in Spain or bring it when they travel to Morocco. Most women do not go out to work and continue their traditional cooking, which is very elaborate and therefore demands a lot of time to prepare.

We eat the same as in Morocco. No, we buy everything here (Meriama).

We buy the veal and lamb meat in one of our butcheries; there's a man who kills like to Moroccans in Pontevedra. There is none here (Laila).

During the lamb party we go down. The Moroccans who cannot go down eat lamb, which we kill in the slaughterhouse here. At home we only kill chicken and rabbit" (Amina).

The Ramadan – ayd al saghir – we do the same as in Morocco. Some men and some women are tired because they act like on fairs. If we don't work we don't eat, if we don't we don't eat ... (Sumia).

On Fridays we eat cous-cous (Soucayna).

A different situation occurs when they are hospitalized, as they say that they have to eat the same as other patients⁽⁷⁾.

When we are in hospital we hardly eat. It's not our food, the meat is not halal (Nur).

Another change they have experienced is that dinner, due to their work hours, has become the main meal of the day.

Need to sleep and rest

They frequently expressed sleeping difficulties.

I haven't sleep since I've come to Spain. I'm always tired. You know, I don't want to get up (Fatima).

Need to select suitable clothes, dress and undress

According to Frantz Fanon:

The characteristics of the clothes, the clothing and grooming traditions constitute the most evident forms of originality, that is, the most immediately perceptible in society⁽⁸⁾.

In the Maghreb, the veil (hiyab) is part of traditional female clothing. In this respect, different attitudes should be highlighted:

On the one hand, some women wear the hiyab as a form of consolidating their culture, as a socio-cultural demand of the Islam outside its cultural context. These are normally college graduates.

"These clothes are part of my culture, my tradition. Why should I change clothes? It's not because I live in Spain that I have to cease being Moroccan, you know, leave my culture behind, my customs (Latifa).

Other women wear the hiyab as a means of making themselves invisible for other men. This is the case of young married women from the Middle Atlas Mountains, who are usually illiterate.

If you are married you can no longer dress as you want to, you dress how your husband wants you to (Laila).

Moroccan men do not like that their women leave their skin uncovered or straighten their hair. Moroccans are very jealous (Fatima).

On the other hand, there are women who wear Western clothes to make themselves invisible:

I prefer Moroccan clothes because they are more comfortable. But if I wear those clothes here people stare at me. I don't want them to stare, I don't like it when they stare. When I go down I always wear Moroccan clothes, no, I don't wear the hiyab (Fatima).

Some Moroccan women dress differently here. Over here they dress like you and in Morocco like Moroccan women (Souaz).

You know, people here tell us: you have to dress like us because that's why you live here (Soucayna).

My parents like it when I dress up, wear make-up, straighten my hair, wear nice clothes: but I don't like it here. In Rabat, if I dress up, nobody knows me. I don't like it here, I don't want them to stare at me, over here all Moroccans know me and stare at me. I don't want them to stare at me (Fatima).

Need to communicate with other people

Communication is one of the most unattended needs. Most women live in the shadow of men: father, brother, husband... They can neither speak nor understand Spanish, which makes them totally dependent for most daily events, they depend on them for transport, to go to the health center, do shopping...

Women have problems to communicate in the language. They do not have time to go to Spanish classes. It concerns them a lot (Rania).

It's very difficult for us to talk, to learn, because we haven't studied (Meriama).

Yes, there's a place for us to learn Spanish but we don't have time (Nur).

Although they know few people, they feel great social control on themselves, by the welcoming as well as by the Moroccan community.

I don't like it here, I don't want them to stare at me. Over here all Moroccans know me and stare at me. I don't want them to stare at me (Latifa).

Difficulties appeared with regard to sexuality. Many girls came without their mothers, when they were practically girls, they went to school in Spain and develop in a two-faced world: on the one hand Islam and, on the other, the new and more tolerant country, so that they sometimes adopt double behavior too.

I don't have anything to say about the sex, I don't want to talk with Moroccan women. I have sex with my fiancé, who is going to be my husband soon, there are some things which I don't know if they are good, my fiancé says that it's like that or that it isn't but I don't know, I cannot talk to Moroccan women, I don't have anyone to talk to (Fatima).

The problem is sharpened and broadens when unwanted pregnancies occur.

I am pregnant. The day I got engaged my fiancé earned a salary, I didn't want to but I also earned a salary, we were already married, in the summer there's going to be the wedding in Morocco, we liked each other. I can't ask anyone, I don't want to ask Moroccan women. I only know you, I was ashamed to ask. My parents kill me. I cannot go to my husband's house pregnant. What is my father-in-law going to say? I don't know what to do. I cannot be pregnant (Nabila).

The boy I went out with is Spanish. When I got pregnant I said that it wasn't his. My family is in Morocco. I have a sister here. My family is very angry, they aren't talking to me, they don't want to know anything about me. I have problems, to take care of a child money is missing, I work at a bar and so does my sister; I cannot take care of a child. I have to go down to Morocco with the child; but my family is very angry (Karima).

After having their second child, most women request a family planning appointment and use contraceptive methods. At that moment, some of the women who have been in Spain since they were girls and who go out to work, normally in clothing factories, think about the pregnancy out of work of getting fired or not being hired in case of the first job.

Need to work in such a way that there is a sense of accomplishment

Most women living in this community feel satisfied with their role performance, as the role expected from them and which they accept is that of being a housewife and preserving the family stability and customs that link them with their country of origin. But there are two other groups of women: university graduates and single women who tend to experience problems due to their loss of status and difficulty to find a job in accordance with their education.

Look, in Morocco I used to teach at university. I have a teaching diploma. Do you know how I can work? Where I have to take the diploma? (Rania).

I wanted to work in a factory, I like to work, I don't want to spend all day at home or go to markets with my husband. I want to go out to work; but a Spanish friend told me that if I got pregnant they would fire me. Do you know about that, what I have to do not to get pregnant? (Latifa).

The women's statements also frequently reveal the dissatisfaction provoked by unreal expectations about the emigration; this is not the paradise they expected.

Need to participate in leisure activities

With regard to this need, two different situations were found, produced by the passage of time. The first women who came to Spain faced great difficulty to satisfy this need. Nowadays, on the other hand, that is not the case because a well-formed and established community exists, with solid social networks.

I am sad and alone here. In Morocco, on feasts we used to go from one house to the other and visit the family. We used to get together, have tea and sing. There are no people here, family, and I'm at home (Nur).

Now we do like in Morocco, we visit, talk, go out. Women here and men in the room next door (Bouchsra).

In this need to participate in recreational activities and leisure, special attention should be given to adolescent girls

who came to Spain when they were little or were even born in Spain and are influenced by both cosmovisions.

I had a non-Moroccan friend, Spanish, since primary school. Last year we were invited to a party and they wanted me to drink and smoke, I didn't want to and they insisted. We were not friends anymore. Now I only go out with Moroccan girls (Samira).

CONCLUSION

On the one hand, the qualitative method gave us access to information that was hidden until now and, on the other, allowed us to get to know some cultural variables and their effects on health-disease conducts, which are necessary for a detailed valuation of these women with a view to culturally competent care delivery.

These results reveal that this group of women have characteristic and unprejudiced health-disease perceptions and conducts that need to be respected and incorporated into care plans.

Other perceptions and conducts related to some standards in the Koran (Ramadan) need previous adaptation

with a view to avoiding harm in people with metabolic diseases or pregnant women....

Focused assessment is needed with a view to detecting, in each particular case, difficulties to get access to the health system and taking corrective measures.

Moreover, systematic assessment is fundamental with a view to discarding whether spiritual suffering and social isolation are a normal consequence of their migration grief or, on the opposite, manifestations of a nursing problem.

We hope that, through this research, we have managed to remove and discuss ideas-prejudices of health professionals at our center with regard to the immigrant population, and we achieved changes in: adaptations of times and appointment and also, in special cases, care delivery by a woman.

It is surprising, though, that violence against women has not appeared at any time, a fact that other authors frequently mention⁽⁹⁾.

We have undoubtedly achieved greater knowledge and got closer to this group but, on the other hand, we are more aware of how much there is left to share.

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Attachment I - Esquema de Entrevista semiestructurada

Datos sociodemográficos

Nombre y apellidos

Edad

Lugar de residencia antes de venir a España

Tiempo que lleva en España

Tiempo que lleva en Arteixo

Estudios: analfabeta, primarios, bachillerato, universidad

¿Con quién vive?

1 ¿Cuáles y como son sus comidas habituales? Hubo cambios en su dieta, tiene dificultad en conseguir algunos alimentos...

2 ¿Qué tal duerme?

3 ¿Cómo te vistes habitualmente? ¿Has cambiado tu forma de vestir, como te gusta?

4 ¿Cómo vive el cambio de clima?

5 ¿Como consideras tu salud? ¿Haces algo para cuidarte?

6 ¿Fuiste alguna vez en Arteixo al centro de salud o al hospital? ¿Por que? ¿Tuviste algún problema en la atención? ¿Qué te pareció? ¿Cómo te sentiste?

7 ¿Consumes habitualmente algún medicamento?

8 ¿Puede comunicarse con los demás?

9 ¿Qué haces en tu tiempo de ocio? ¿Quiénes son tus amigos-as?

10 ¿Puede practicar su religión o vivir según sus creencias?

11 ¿Cómo consideras que son tus relaciones afectivas y sociales?

12 ¿Trabajas en la actualidad?