Storytelling, Marginality, and Community in Australia: How Immigrants Position Their Difference in Health Care Settings

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Stories of conflict with hospital services, medical mismanagement, and negative outcomes of procedures and treatment circulate within immigrant communities. While the interpretations of medical events are often based on misperceptions and misunderstandings, the stories have instructional value in that they explain an unfamiliar system to new immigrants and provide starting points for advocacy for improved services. Our analysis of gossip and storytelling among women from the Horn of Africa involves an examination of stories of “pork injections,” rejection of “black babies,” and clinical incompetence. The data are drawn from a study of reproductive health and reproductive rights that was conducted among refugee and immigrant women from Sahel African and Middle Eastern communities in Melbourne, Australia.

Key Words: Australia; women’s health; immigrant; cross-cultural communication; gossip

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INTRODUCTION

Australia’s non-English-speaking migrant population has a lower level of utilization of health services and a lower uptake of screening and preventative services than does the Australian-born population, although migrants are also more likely to report with severe presentations of conditions. This suggests that, among immigrants in Australia, as among immigrants in other settings, there is a delay in health seeking and poor uptake of screening (Reid and Trompf 1990; Naish, Brown and Denton 1994; Hoare 1996). Steps have been taken to address many of the barriers to presentation at all levels of the health system, including through the establishment, in both federal and state departments of health, of specialist multicultural/ethnic health policy units; the provision, in most large public hospitals, of bicultural liaison staff to facilitate access for minority migrant groups; and the development of various multicultural resources (see Allotey, Manderson and Nikles 1998a; Allotey et al. 1998; Allotey, Manderson and Nikles 1998b) to assist mainstream services in providing culturally sensitive and responsive care. Several primary care centers also provide services designed to address the special needs of these groups. Notwithstanding these efforts, many groups are still reluctant to engage with the health system, and health disparities continue (Allotey, Manderson and Grover 2001; Jirojwong and Manderson 1999); consequently, the long-term value and financial viability of such programs is problematic (Kelaher and Manderson 2000).

The limitations of multicultural interventions, with regard to addressing immigrant health, reflect their inability to address structural and economic barriers to health care that are external to medical institutions. Immigrant families typically reside in areas with poor transport services; women have limited mobility because of children and other domestic obligations; if employed, they often find it difficult to take time off work; in some cases, they lack someone to accompany them as chaperones. At the same time, there are some institutional reasons for the disappointing outcomes of multicultural health interventions, including, for women, the lack of female providers, uncertainty regarding choice of gender of the provider, and the unpredictable availability of translators. Women, in turn, have been wary of certain services because of the lack of fit between medical advice and their own health beliefs and concepts of good treatment. In the case of interventions, there is also concern
about effects and outcomes (ALSWH 1994). Some of the institutional issues can be addressed by establishing adequate resources: it is possible, for example, to schedule appointments to fit with the availability of female or male providers, increase the number of interpreters, and provide information through various media. Other issues, such as fear of hospitalization and beliefs about health and health care provision, are less easily addressed (Manderson and Allotey N.d.).

In this paper, we are concerned not with health services or health beliefs per se but, rather, with the stories of contradiction, conflict, and poor outcome that take on emblematic value within the community, thus fueling the suspicions held by recent immigrants regarding the host country’s medical services. This storytelling reflects immigrant women’s interests in health services. Our findings indicate that the short-term negative impact of “bad stories” about medical encounters is balanced by longer-term positive effects, for the ultimate purpose of these stories is to improve services for women.

GOSSIP, STORYTELLING, AND SOCIAL CAPITAL

Stories of misadventure, misunderstanding, and poor quality of care through contact with medical and health services provide narratives of marginality. Yet while reinforcing a distinctive, oppositional community identity, the stories also, contrarily, serve to reinforce connections to the wider society and, hence, a commitment to resettlement (Anderson 1983; Chavez 1994). As we illustrate in this paper, these stories are narratives of misdiagnosis, perceived unnecessary medical treatment, inappropriate tests and interventions, medical mischief, negative outcomes, and poor clinical care. Their telling takes place within a variety of public settings. Women routinely meet various government and non-government services, where they present for settlement assistance (e.g., for housing, advice about immigration status, or financial aid) and take advantage of waiting times to share information and experiences. Women’s organizations, including a number of religious associations, provide more formal occasions for women to report their encounters to a wider group. In addition, special-purpose group meetings with an audience of women from the same or similar communities are held sporadically, and these too enable women to
share their experiences and add to core anecdotes of misadventure. Accounts of poor-quality care also circulate semi-privately, at familial gatherings, in one-to-one encounters, via the telephone, and among community advocates and bicultural workers. The stories reinforce women’s perceptions of disadvantage and distinctions between in-group values and outside interests, but they also provide opportunities for individuals to debrief and solicit personal and practical support.

Since stories of mishap and misunderstanding circulate consistently through these informal mechanisms, we have chosen to categorize them as “gossip.” There are a variety of definitions of gossip, many of which have negative connotations (see, for instance, Goodman and Ben-Ze’ev 1994). Within the context of this paper, however, we use the term “gossip” to refer to informal talk conducted within small groups of familiar participants in order to elicit and share information or knowledge (Ayim 1994). In general, gossip is an important feature of human communication, arguably particularly for women, and it serves an important social function. In closed systems or societies where individuals associate largely with each other, as is the case among many minority groups, gossip provides an important dynamic through which the judgments and values of community life are transmuted and refined (Tebbutt 1995). Tebbutt has demonstrated that closed networks characteristic of the working class in urban villages in the United Kingdom during the Second World War used gossip as an important means of preserving vernacular forms of language and ensuring that group norms of behavior thrived. In Turkey, as Lloyd and Margaret Fallers (1976) illustrate, women’s gossip is a means of disseminating economic, political, and social knowledge, often making them privy to more information and contacts than are available to their husbands (Fallers and Fallers 1976). Similar observations have been made in migrant settings. Elley (1985), for instance, writing of Turkish immigrant women in urban Australia, notes the use of home gatherings for pyramid sales (of home goods, clothing, and so on) as a vehicle for women to exchange information about housing, the availability of jobs, social security, and so on.

These accounts provide the most positive aspects of gossip, although, as is illustrated by accounts of the circulation of stories of fear in the face of perceptions of political and economic hostility, gossip also functions negatively (Chowdhury 1998). Riots and communal fighting are typically precipitated, fueled, or explained by
circulated stories of atrocity and outrage (Dingwall 2001). Terror works through gossip. However, even when the outcome of such stories is violent, gossip provides a mechanism of inclusion: the most malicious stories often apply to those perceived to be on the outside and are representative of interactions, intents, and expected outcomes.

Suls and Goodkin (1994) use the term “medical gossip” to refer specifically to the transmission of information about health and illness, usually by a friend or relative with no medical training, in an attempt to provide assurance or to express alarm. Other sources of medical gossip include the mass media and organized groups offering alternatives to conventional medical treatment. Suls and Goodkin argue that most people discuss symptoms with laypersons before making a decision to seek further services, that at least three-quarters of symptoms taken to physicians have been first discussed by a layperson, and that these lay consultations lead patients to reject medical advice or to overuse physician time. A prospective study of diaries showed one consultation for every 18-symptom episode (Scambler and Craig 1981). These findings are consistent with research undertaken in resource-poor communities in which hierarchies of resort and pluralist modalities operate (Leslie 1980; Welsch 1983; McNee et al. 1995; Simon et al. 1996). Medical gossip is integral to lay decision making, referral systems, and the interpretation of health care advice and treatment in both small-scale and complex societies.

We use the term “gossip” neither to refer to the specifics of information sharing and advice seeking by which people seek to clarify and act upon symptoms of illness, nor to connote idle talk or groundless rumor about individuals (which is often how it is used in everyday speech).¹ Both meanings are relevant to this article, but we use the term to refer specifically to informal (though not necessarily unrestrained) talk about social and medical incidents – incidents in which individual involvement provides an example of, and testimony to, generalizations. We see gossip not as idle but, rather, as providing its participants with parables of the nature of Australian society and its institutions. This is particularly important in new communities where the adult literacy rate is low, where there is no established community able to provide knowledge (cultural capital) that would facilitate settlement, and where access to information is limited.

We examine stories of conflict between hospital/clinical advice and practice, medical mismanagement, and negative outcomes (the
knowledge of which circulates within immigrant communities). Our analysis is developed through our examination of three case studies: (1) Amina, whose fear that she would be given a “pork injection” were she to have a Cesarean section drew attention to community concerns regarding hospital disregard of Islamic requirements; (2) Fatimah, whose experience of amniocentesis and fetal death supported rumors that Australia did not want “black babies”; and (3) Zahra, whose misdiagnosis reinforced for others the value of traveling from Australia to Egypt for quality care. The data for these case studies were collected within the context of a study of reproductive health, which we conducted among women of the Horn of Africa refugee community in Melbourne, Australia.

METHODS

The data upon which this article is based are drawn from a study conducted from 1999 to 2001; they are a component of a larger study of 255 women from the Sahel African and Middle Eastern refugee and migrant communities in Melbourne, Australia, the majority of whom are Muslim. The main aims of the study were to investigate, in these target communities, (1) cultural understandings of reproductive rights and reproductive health factors that hindered or enhanced the use of reproductive health services and (2) indicators of the general well-being of migrant and refugee women. The study used a combination of quantitative instruments and in-depth interviews with 150 women to determine predictors of well-being in the short and long term, and to identify the problems that continued to affect their reproductive health in the course of integration into Australian society. These data were supplemented with focus group discussions with a further 105 women. Data were also collected through participant observation of community gatherings, the observation of clinical encounters at a large women’s tertiary hospital (which many community women used for their primary health needs), and from our involvement in providing personal assistance and advocacy, as required.

The project was established with the aid of two bicultural research assistants and a community advisory committee consisting of service providers, policy advisors, and community groups. This was to ensure that the information collected would be both relevant and available to inform practice. The women were recruited into the
study through social networks, community meetings, and publicity via the vernacular media.

THE COMMUNITY

The study involved refugee and migrant women in Australia, most of whom were recent immigrants. The African participants were from Sudan, Somalia, Eritrea, and Ethiopia; the Middle Eastern participants were from Egypt, Lebanon, Iraq, Jordan, and Syria. As a group, the average duration of the Middle Eastern women in Australia was 13 years, with the exception of Iraqi women (who had been in Australia for approximately two years). Most of the women had come to Australia under a family reunion scheme (61 percent), again with the exception of the Iraqi women (who were humanitarian or refugee settlers). The average duration in Australia for the African women was six years, and they were predominantly humanitarian or refugee settlers (85 percent). This article addresses the data from women from the Horn of African communities.

Like most of Africa, countries in the Horn of Africa were created by colonial governments with little consideration for ethnic, economic, or social realities. Subsequent border disputes have, to a large extent, created or fueled the violence, civil and political unrest, and economic and social instability that characterize the region internationally (Maleken and Ganyu 2000; CSIW 2000). Ethiopians have fled their country for reasons of civil and political strife as well as due to a series of droughts and famines. Eritrea’s war with Ethiopia led to large-scale emigration, and, for almost 20 years, refugee camps in neighboring Kenya and Sudan have been the home of many Eritreans. Civil war and an oppressive military government in Sudan has also led to the emigration of Southern Sudanese to refugee camps in neighboring countries. In Somalia, political and social disruption and a massive displacement of the population has been the result of over a decade of factional fighting (Nsubuga-Kyobe and Dimock 2000). Migration to Australia from these countries, therefore, has been largely from refugee camps and displaced communities in Egypt and Kenya. Significant numbers of women from these communities were brought to Australia through the Women-at-Risk Program (Manderson et al. 1998): these women may have lost husbands, brothers, and fathers and are, within the cultural and refugee context, “without protection.” Other women have come
to Australia under a family reunion scheme or community support scheme but may still lack immediate family or close social networks and have no option of repatriation in the near future. Unwilling immigrants, they are here to stay.

The study participants are from different countries, regions, and ethnic affiliations, often with histories of hostility, and they tend to maintain these distinctions in family and everyday community contexts in Australia. Some factional hostilities continue, particularly within the Somali community. In addition, as with most communities, there is a great deal of variation according to socio-economic status and level of education. Some of the women are highly educated and come from urban backgrounds; others have low levels of literacy and come from rural backgrounds. However, in broad terms, the Horn of African communities can be described as cohesive and closed (Tebbutt 1995) insofar as community members mix with each other and have limited interactions with people from other communities, including those from the Australian-born population. Over 80 percent reported to us that their social support networks come from their own ethnic groups. This is not surprising, given that women migrated to Australia either independently, having been sponsored by family members who already had permanent residency or citizenship, or as refugees, having been linked with fellow community members by sponsoring agencies after their arrival. Most women in these communities have little or no English language skills, and this increases intra-group dependency; few Australians speak Arabic, far fewer speak Tigre, Somali, or Amharic. However, these women are often brought together through their own community organizations, Islamic associations, or service providers, and they gather together for religious festivals. Within these contexts, women identify as Muslim women rather than by country of origin, and they communicate with each other in Arabic. In public meetings, at which service providers or representatives of government are present, English may be used. Women from these communities retain a strong oral tradition/culture, and this has resulted in the publication of a book that reflects the joy of sharing information and culture through stories and humor. This book, Our Journey: Traditional and Refugee Stories by Women from the Horn of Africa, was funded by a local city council and the art council (Maleken and Ganyu 2000). Storytelling is a feature of any social gathering.

Women from the Horn of African communities are marginalized within Australia because so many of them wear the hijab (veil). This fosters the stereotype of an oppressive community and,
consequently, these women (and men) are presumed to be culturally incompetent within Australian society. In addition, they are represented in the popular press and within medical institutions as universally subject to clitorodectomy and infibulation. This has led to very public discussions of a private aspect of women’s lives. African women have been assumed to be without agency within, and to be highly victimized by, their cultures. Paradoxically, they are seen to belong to a culture that abuses children and so their families are placed under surveillance by social welfare workers, and there are numerous stories of school teachers and others reporting families suspected of planning to genitaly mutilate their daughters. There is a morbid fascination with a community that is both sexualized and criminalized by the practice of female genital mutilation (Allotey, Manderson, Grover 2001).

The social life of women of the Horn of African communities consists largely of gatherings for births, funerals, religious ceremonies, and celebrations of good news and life events pertaining to friends and relations (both in Australia and in the countries of origin). In Melbourne, these events are supplemented with occasional public meetings, including those convened by researchers. These meetings, as previously stated, provide an ideal medium for gossip and for sharing information, although stories also circulate rapidly via telephone (include mobiles) and are fed back to such women as bicultural workers, who have reasonable to good language skills and who are able to follow up on and resolve negative stories. The stories that circulate include those of unhappy clinical encounters, questionable diagnoses, unexplained negative outcomes (such as fetal deaths), and culturally inappropriate treatment.

The case studies presented below are compilations of stories told to us in the course of our research and, from them, emerge complete pictures. While the specific content of these cases raise a wide range of health service issues, our purpose in presenting them here is to illustrate the influence of storytelling and gossip on women’s perceptions and, ultimately, on their use of health care and health services.

CAUTIONARY TALES

Case 1: “Halal Injections”

When Amina (pseudonym) was 30 weeks pregnant she was told at the antenatal clinic that, although she would be given a trial of labor,
she had to consider the possibility that she might need an elective Cesarean section (CS). The obstetric team managing her pregnancy did not give her a specific reason for this. In her account to us of her obstetric history, however, she mentioned that she had a previous CS when she gave birth to her older child in a hospital in Khartoum, explaining that this would account for the possible need for surgery if the labor were not progressing satisfactorily. Amina was very distressed about this possibility, even though she stated that her first experience of it was not particularly unpleasant. When we spoke to her, she wanted to know what her options were: whether she really needed to undergo surgery and, if so, whether she could choose an alternative hospital.

As the interview progressed, we learned of a discussion she had in the waiting room of the antenatal clinic during her last visit. Amina had gone to the clinic with another pregnant woman whom she knew from her community. After her consultation, Amina had described to her companion what had transpired, and her companion, in turn, had recounted the stories of two other women. These two women had undergone CS’s at the same hospital, and, after the births, had been given an injection, which they were told was routine. The husband of one of them had asked specifically what the injection was. He was told that it was HeparinTM, that it was given to all women “as a matter of routine,” and that “there was nothing to worry about.” The indications for the use of the injection were not explained. The husband decided he needed more information on the injection and found, among other things, that HeparinTM is prepared from the gut of pigs. As a Muslim, this caused him a great amount of distress, and he was still in consultation with the local Imam to find out if his wife could undergo a process of cleansing. The family of the other woman was also very unhappy about the products in the injection (which they found out about from the first woman’s husband); they would have preferred to have kept the information of the “contamination” to themselves. Now, however, most people in the community knew about the “pork injections” and were warning women who had to have CS’s to go to other hospitals or to refuse the injection.

Because of the edict against pork, Amina was concerned about being given HeparinTM following a CS. She firmly believed the process would leave her body contaminated, unclean, and would affect her religious standing in the community. Amina said that she would rather die a good Muslim woman than have a “pork injection.”
Her concerns were brought to the attention of the health care service, which was expected (1) to consider the religious implications of giving a Muslim patient Heparin™ and (2) to identify an acceptable alternative treatment. Our follow-up of this problem with the service provider determined that no action had been taken and, at time of writing (six months later), the Islamic religious leaders were pursuing the issue with the relevant authorities.

Heparin™ is an anticoagulant made from porcine intestinal mucosa (MediMedia 1999). It is used to prevent and treat thromboembolic disease, a major cause of maternal death in developed countries (Thompson, Walker, and Greer 1998). Thromboembolic disease carries a particularly high risk for women who undergo in-labor CS (Macklon and Greer 1996; Brocklehurst 1998). What women were concerned about, however, was not the potential risk to themselves but the “contamination” of their bodies by the introduction of a non-halal product. Nothing else mattered, as Amina’s response (i.e, that she would rather die than take pork) indicates. It is also worth noting that the term “pork injection” has become commonplace in the community, and pregnant women are told by other women to insist that they not be given this injection when they are in hospital.

Case 2: Amniocentesis and Misunderstandings of Risk

The following account of events was provided at an informal gathering specifically held to commiserate with Fatima over her bad fortune in having a miscarriage. At the gathering, individuals who had been with Fatimah through the course of her pregnancy added to her own account, embellishing and contradicting each other in the process. Our case report derives from this data, background information collected during the course of the study, and other interviews conducted to substantiate and/or clarify the sequence of events.

Fatima is a 22-year-old refugee resident in Melbourne and was pregnant for the first time by her first cousin. She presented to the antenatal clinic of a public women’s hospital at sixteen weeks, where she underwent a full check-up, including blood tests and screening for potential congenital abnormalities. On the basis of the results of the test, she was advised that there was a strong likelihood that the infant would be born with Down’s syndrome. She underwent an amniocentesis, which she understood to be “for the good of the baby.” Two weeks later she was advised to terminate the pregnancy.
Concerned, she sought counsel from other young mothers in her community and discovered that at least four other women had been in a similar situation. Three of the four had refused to believe there was a problem with the fetus and had gone to term, giving birth to apparently normal infants. The fourth had terminated her pregnancy and regretted her decision when she heard about the outcomes for the other three. Fatima was now very confused. Several women in her community told her of a conspiracy by the Australian government to prevent the African migrant and refugee community from “breeding.” Fatima decided to wait. A few days later, she reported back to the antenatal clinic because of mild cramping. She was given two white tablets (which we subsequently identified as Paracetamol) and was sent to have an ultrasound. Fetal death was confirmed and labor was induced to allow expulsion of the fetus. Fatima reported to us and to other members of the community that the baby was alive when she went to the hospital and that the tablets she was given had killed it. Within a couple of weeks, most women in the community had heard the story, further evidence to them that Australia did not want “black babies.”

Fatimah was confused by the initial ante-natal counseling and screening, although it supported a view widely held in her community; namely, that Australian doctors were prejudiced against cross-cousin marriages. She did not understand the risk factors for congenital abnormalities, did not understand what amniocentesis was for, and was not advised of the risk of miscarriage as a result of the procedure. Her interpretation of the amniocentesis being good for the baby was based on her interaction with the bicultural worker and interpreter who accompanied her through the consultations. Crucial though their role may be, during the course of the study there were regular reports of role conflicts; these indicated that bicultural workers were perceived to represent the institutions to which they were attached rather than their patients/clients. These reports had been a source of miscommunication and re-interpretation of information from patient to provider, and vice versa.

Case 3: Superior Standard of Care in the Third World

Zahra had problems with her stomach for as long as she could remember. Her most vivid early memories of severe cramps and vomiting focused upon when she was an 11-year-old in a refugee camp in Sudan. Her family finally managed to travel to Egypt about
a year later; there she saw a physician who prescribed some medication, which seemed to settle the cramps. By the age of 14 years she was resident in Australia and in high school. Although she still had occasional problems with her stomach, she was no longer on medication and was trying to come to grips with her studies in Australia. She had never been a big eater and still had not developed a taste for the food in Australia.

She was first admitted to a hospital in Australia when she was 17 years old. She had fainted while shopping at the supermarket and had been taken to the hospital in an ambulance. She was given a transfusion and several tests were conducted, none of which she understood. Zahra reported that she found the hospital stay very boring. She stayed late in bed in the morning, took a long leisurely shower, and was out in time to catch particular programs on the television before family and friends came to visit. She was in hospital for ten days before being discharged. On the day she was due to go home, she had her family bring in a box of chocolates that she gave to the nurses on duty as a token of her appreciation for the care she had received. She was therefore quite taken aback when one of the nurses told her not to be too happy about going home. “I know your sort,” she said. “You will be back again in no time.” It was after this comment that she found out from the discharge nurse that she had been diagnosed as being anorexic. Part of the evidence for the diagnosis was that she was very meticulous about her appearance and spent “hours” in the shower, deliberately missing the morning tea round. That would also explain her tendency to vomit. The medical team had written a referral letter for her to see a psychiatrist.

Although Zahra was very upset by the diagnosis, given the stigmatization of mental illness within her community, she saw the psychiatrist. Her impression of the consultations was that he tried to convince her that she was obsessed with her weight and appearance and that he would not be convinced otherwise. She continued to have pains in her stomach and continued to vomit for almost four years after that, with a further five admissions to hospital. In that time, she also graduated and started work with a large firm.

On her first annual leave, her family supplemented her savings and she flew back to Egypt to find the doctor who had treated her successfully seven years before. She had an endoscopy and blood test and was diagnosed with *Helicobacter pylori*. She reported that, for a period of about two weeks, she had to take a combination of drugs that involved almost 20 tablets every day. But she returned from
Egypt feeling much better than she had in a long time. Within a few weeks, the news of her recovery had spread through the community. The story carried warnings of a tendency in Australia for people to be locked up in mental institutions rather than to be offered costly investigations and treatment. Zahra’s recovery coincided with the return from Egypt of another member of the community who had been treated for a liver condition, which Melbourne physicians had told him he would have to live with. The result was that the community set up a fund to aid seriously ill individuals, who were to be flown to Egypt for treatment rather than rely upon the health service in Melbourne.

The stories reflect and add to women’s mistrust of individuals (i.e., specific doctors and nurses), institutions (i.e., the hospital), and places (i.e., the city, the country, and other Australians). These are stories told by members of a community who have yet to find a place within the country of resettlement: few have employment, few speak English well enough to interact with others, and few have occasion or opportunity to leave their immediate environment except for visits to hospitals and to welfare providers. Even then much of the communication and learning about the country of settlement is conducted via a bicultural worker or employers at a migrant resource center.

At the same time, these stories do other work. First, they validate the experiences of those who tell them, offering them a mixture of catharsis and social support. Such stories may result in practical solutions since they are often told to bicultural workers and, thus, elicit problem-solving strategies. They also provide other women with accounts of “how things are”; they are the beginnings of the social capital that people need in order to negotiate institutions of power, technology, and authority. Finally, the stories underscore commonalities among women who have often migrated to Australia from conflict zones. They are stories that establish insider from outsider, with the majority, in an inversion of everyday life, being cast as outsider.

SPEAKING OUT

While public and semi-public gatherings provide a venue for negative gossip of the kind told over tea and telephone, the etiquette of the more formal of these events (e.g., community meetings) also
allows for ritual acknowledgment of positive events. At one meeting that we convened, for example, two bicultural research assistants presented a summary of our work to date. After a few specific questions directed to the researchers, individuals in the audience contributed their own experiences, which either contradicted or corroborated our findings. Mariam stood up and recounted to the audience her difficulties in finding appropriate diagnosis, treatment, and care for her seriously ill son. Her story precipitated a series of accounts of the difficulties of negotiating an unfamiliar medical and welfare system whose professionals were unhelpful and uncaring. These accounts were punctuated as Mariam provided additional details of her own case, finally eliciting explicit promises of follow-up and support by others in the room who had prior experience of the services that were eluding her. At this point, the commentary—the stories that are the stuff of gossip in less formal settings—took a turn. Hadi commented that she was very grateful to Australia and that, from her point of view, everything was perfect except for antenatal and maternal health (the explicit subject of the meeting). “Now the good stories start,” one of the bicultural workers commented sotto voce. And indeed they did, even more so after the meeting, as women, one by one, grabbed hold of individual researchers and spoke far more positively of their experiences in Australia and their interactions with health, medical, and maternity services than might have been anticipated given the earlier part of the meeting.

Medical and ancillary hospital staff at the meeting were annoyed, however, seeing mischief in the creation of an opportunity for women to speak out against their services. The most senior member of the hospital staff present, mindful of a range of initiatives for cultural responsiveness, took advantage of the occasion to address the women, reassuring them that the hospital was “doing its best” and acknowledging that it was “not perfect.” This public statement was at variance with statements made on other occasions, although these varied too. One response to our reports from the community was that everything that could be done was being done and, hence, that women’s stories of negative experiences were (always) singular events due to unpredictable breakdowns in the system (e.g., seeing a locum rather than a regular doctor) or to the particular intransigence, complexity, or communication difficulties of the woman concerned (e.g., “an isolated difficult case”). The alternative account of hospital relations with immigrant communities, offered with
equal frequency but always in the absence of a community story that might be interpreted as a criticism, was that the hospital and its staff were poorly placed to respond to community needs, that they were suffering from inadequate funding, and that staff from other sections failed to understand the imperative for cultural responsiveness. This latter response is, of course, part of institutional gossip, and it functions as advocacy for change within the system.

In turn, we interpreted women’s stories at the public meeting as serving a number of immediate purposes. Mariam’s story of her difficulties in negotiating the health and welfare services functioned to elicit help. Women at the meeting also contributed tales to corroborate and/or to supplement the summaries provided by the research assistants and to underline the importance of their cooperation and the need for us to listen to their stories. They also took advantage of the presence of senior hospital staff to draw to their attention the continuing difficulties women faced in dealing with the institution and, consistent with the purpose of story as parable, to inform others of possible negative events, circumstances, and misadventures that they, too, might face. While hospital staff felt that we had acted with bad grace in allowing community women to speak out and so to “spoil” the positive comments presented in the first part of the meeting, we considered it a mark of success that women felt comfortable enough to speak within the hospital and to address its shortcomings in front of hospital staff, including community liaison officers and bicultural workers.

CONCLUDING REMARKS: THE RIGHT TO GOSSIP

Embedded within gossip is the ability to control. Conventionally, gossip controls individual behavior and morality, including sexuality, because the stories of which it consists operate as moral tales for both the tellers and the listeners: either might be the next subject of rumor. Similarly, gossip about communities serves to control by restricting access to or questioning the allocation of resources, widening social gaps, and/or maintaining status quo relationships between communities. Inter-ethnic stories play these roles. However, as Heyman (2000) argues with respect to immigration officers and their stances toward legal and illegal immigrants, moral ideas and sentiments are deployed within wider geographic contexts and, through gossip, are reflected as models for moral thought and action, shaping peoples’ understandings of social information
and motivating their personal and collective responses. This is, in part, what gossip and storytelling among immigrant women from the Horn of Africa is all about.

Part of the function of the sad or bad story is, as we have noted, to elicit practical responses. In the field of health and welfare, women are encouraged to offer to each other their ability to negotiate bureaucracies, to get more information, to identify different providers, and to reassure the individual that her experiences are not unique and that, hence, she is not at fault. The stories are a vehicle for the “imaginative distribution of empathy,” highlighting the presence of morality within the community by delineating the distinctive notions and practices of particular cases (Heyman 2000:637). This is significant in the case related to the use of Heparin™, whereby the host community (which is presumed to be Christian) is shown to be morally void; it is also implicit in the discussions related to amniocentesis and abortion. Other stories also capture how Australian institutions affront the Islamic community; conversely, stories from Anglo-Australians about the Islamic and, especially, the African community highlight their weaker moral positioning (e.g., with respect to female genital surgery [see Allotey, Manderson, and Grover 2001]).

Heyman (2000) also argues that contemporary institutions shape moral conceptualization and treatment in specific ways. The hospital is a perfect site, capturing and fixing ideas of power, authority, gender relations, technology, and so on. Hospital staff (both management and employees) hold to the idea of the hospital as a moral institution responding to the needs of local immigrant communities, which use it both as a tertiary and a primary care center. They see the hospital as the first point of call, in the suburban precinct, for women from a variety of different communities. This is reflected in the provision of special services for people from “culturally and linguistically diverse communities,” including community workers, translation and interpreting services, brochures and signs in various languages, community representation in reference groups, community education programs, and so on. The tension reflected in the community meeting described above occurred precisely because of these efforts. They developed, despite the lack of resources, because of tensions around ideals of quality of care, the conflict between practical action and culturally appropriate behavior, difficulties related to resistance to procedures (e.g., certain prescriptions, surgery) that follow protocol, and the legal responsibilities of medical
staff to patients. Hence the tension when people gossip and complain, for this arouses moral indignation, the specter of unfairness, and the risk of creating resistance.

Some of the stories are deeply critical of the host societies and its services: the case study of Zahra, and its outcomes, is a perfect example. Yet immigrant engagement with services and the public storytelling that is part of this also reflects people’s self-perception as local community members rather than as outsiders. These stories, which depict women as hospital patients demanding better quality care, reflect women’s intention and commitment to stay in Australia as well as their vision of themselves as part of the local community (hence, as patients with rights). Community values and social relationships are articulated in gossip and storytelling, reflecting how immigrant women see themselves as part of the wider society and how they establish themselves as members of it. Chavez (1994:54–55) notes the lack of attention (scholarly and political) to the changes that migrants experience and the links, both perceived and material, that they develop to their new communities. An important step in settlement is feeling as though one is part of the local community. The women from the Horn of Africa with whom we worked had relatively little choice about whether to migrate or where to settle, but they still had to negotiate the differences in services and institutions. Their willingness to participate, to be critical rather than passive, and to accept the right to be so engaged is an important aspect of their establishment.

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NOTES

2. Refugees in camps are those who have fled from their country of nationality or normal residence and who have suffered and/or have a well-founded fear of prosecution.
3. Displaced persons are those who may be inside or outside their country of nationality, have experienced substantial discrimination or violation of their human rights, and for whom resettlement in a third country is an appropriate solution. People in this category are often located within the community.

4. The available equivalent in the United States is Acetaminophen.

5. This cumbersome phrase, now collapsed to CALD, was introduced to replace the earlier acronym NESB (non-English speaking background) and is part of an ongoing attempt to express a commitment to, and to operationalize, multiculturalism.

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