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# Connecting Gender, Race, Class, and Immigration Status to Disease Management

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## ABSTRACT

**Objective:** Chronic diseases are the leading causes of death in the United States. Chronic disease management occurs within all aspects of an individual's life, including the workplace. Though the social constructs of gender, race, class, and immigration status within the workplace have been considered, their connection to disease management among workers has been less explicitly explored. Using a sample of immigrant hotel housekeepers, we explored the connections between these four social constructs and hypertension management.

**Methods:** This qualitative research study was guided by critical ethnography methodology. Twenty-seven hotel room cleaners and four housemen were recruited ( $N = 31$ ) and invited to discuss their experiences with hypertension and hypertension management within the context of their work environments.

**Results:** Being a woman worker within the hotel industry was perceived to negatively influence participants' experience with hypertension and hypertension management. In contrast, being a woman played a protective role outside the workplace. Being an immigrant played both a positive and a negative role in hypertension and its management. Being black and from a low socioeconomic class had only adverse influences on participants' experience with hypertension and its management.

**Conclusion:** Being a woman, black, lower class, and an immigrant simultaneously contribute to immigrant hotel housekeepers' health and their ability to effectively manage their hypertension. The connection between these four constructs (gender, race, class, and immigration status) and disease management must be considered during care provision. Hotel employers and policy stakeholders need to consider those constructs and how they impact workers' well-being. More studies are needed to identify what mitigates the associations between the intersectionality of these constructs and immigrant workers' health and disease management within their work environment.

**Keywords:** Gender, Race, Class, Immigration, Disease Management, Hospitality

## INTRODUCTION

Chronic diseases account for 70% of all deaths in the United States (U.S.), with heart disease, diabetes, and cancer as some of the leading causes of death (Centers for Disease Control, 2013). Workplace context is important in chronic disease management because most individuals who experience chronic diseases are of working age. Wilper et al. (2008) found that about 7.8 million working age adults have cardiovascular diseases, 32.2 million have hypertension, and 8.5 million have diabetes.

Studies have reported a strong association between race and hypertension. After controlling for important confounders, Blacks report higher rates of hypertension than their White counterparts (Brondolo, Rieppi, Kelly, & Gerin, 2003; Williams & Mohammed, 2009). Blacks (34%) are 1.4 times more likely to have hypertension than their White counterparts (24%) (The Office of Minority Health, 2013). In their review, Williams, Neighbors, and Jackson (2003) concluded that perceived racism, discrimination, and the increased risk for hypertension development were strongly related. It is perceived racism and discrimination that results in increased psychosocial stressors and leads to sustained, elevated blood pressure. Williams and Neighbors (2001) also noted that societal racism may result in a lack of access to services, resulting in poor blood pressure maintenance and control. Thus, race is a germane construct to consider when exploring hypertension among at-risk groups.

In addition to race, disparities relating to chronic disease prevalence and management have been documented to be influenced by the constructs of gender, class, and immigration status (Cutler, Sorlie, Wolz, Thom, Fields, & Roccella, 2008; Williams & Mohammed, 2009; Williams, Mohammed, Leavell & Collins, 2010). Hypertension offers ample evidence to show the impact of these social constructs on chronic diseases and their management. Women and immigrants are less likely to have their hypertension under control as compared to men and U.S.-born counterparts, respectively (Barnes & Lu, 2012; Gu, Burt, Paulose-Ram, & Dillon, 2008). Thus, gender, class, and immigration status are also central factors for unjust conditions, social inequities, and health disparities (Krieger, 2010; Williams et al., 2010).

Researchers have also explored the social constructs of race, gender, class, and immigration status within the workplace (Adib & Guerrier, 2003), but the connection of these constructs to disease management among workers has been less explicitly explored in the context of their work environment. Investigation of the roles of race, gender, class, and immigration status in shaping immigrant workers' disease management provides insight into the various approaches that can be undertaken to reduce health disparities among workers. To this end, this article stems from a critical, ethnographical qualitative study that explored hypertension management among a group of Haitian immigrant hotel housekeepers—a valuable but understudied U.S. workforce. During interviews with the hotel housekeepers, participants were prompted to discuss how their life as an immigrant and their work influenced the ability to manage their hypertension. The issues of being a woman, Black, immigrant, and from a lower socioeconomic class were raised repeatedly. In this article, we discuss study participants' accounts of how these multiple identities contributed to their disease management and overall health within their work context.

### Gender and Work

The concept of gender remains at the forefront of literature regarding workplace context and disparities (Zahradníková, 2009). Studies have reported on perpetuating gender inequality as evidenced by differences in wage (Childs, 2012; Gauchat, Kelly, & Wallace, 2012; McCall, 2001), role attributions, and authority (Kraus & Yonay, 2000). Women are reported to be

stereotyped by their hiring organizations (Gorman, 2005), experience institutional discrimination, and occupy more service-related positions and fewer managerial roles that offer less autonomy than their male counterparts (Kraus & Yonay, 2000).

Women tend to be overrepresented in service industry (Sauter, Brightwell, Colligan, Hurrell, Katz, LeGrande, et al., 2002) especially in less favorable, high demanding jobs with minimal benefits, such as hotel housekeeping. Their disproportionate representation in these positions remains a concern for workforce direction and gender-based health outcomes (Sauter et al., 2002). Women are at greater risk for work-related health problems because they often need to address the dual demands of work and home (Storm-Pallesen, 2007).

### Race and Work

Race is another factor leading to varying experiences within the workplace setting. The term racism has been used to describe the inequality and social oppression an individual experiences as a result of one's race (Chae, Nuru-Jeter, Lincoln, & Francis, 2011). Three levels of racism have been delineated: institutional, personally mediated, and internalized (Jones, 2000). Institutional racism captures race-based discrimination at the higher systems level, including organizational practices in the workplace. Personally mediated racism describes one individual's racially discriminatory behavior towards another individual. Lastly, internalized racism refers to individual identity and self-categorization experienced by an oppressed group. Each of these levels of racism impact the work-related experience of a marginalized individual.

The historical racial disparity in employment is well-documented and believed to be increasing as Blacks have been and are still more likely to occupy blue-collar jobs than their White counterparts (Deng & Zhang, 2008). This disparity is even more prominent within the hotel housekeeping industry where the workforce is predominantly made up of racial minorities (Wial & Rickert, 2002). Hotel housekeepers often experience racially-motivated, discriminatory attitudes and behaviors from management, which can translate into inconsistent work hours and frequent reprimands (Liladrie, 2010).

### Class and Work

Class is another prominent factor that relates to group domination (Euro-American culture domination over ethnic minorities) and unfair treatment. As a relational concept, Karl Marx's take on class was based on a capitalistic system that thrives on the production and division of labor (Marx & Engels, 2012). Marx identified three classes: the capitalists (those who hold the power over production and purchase of labor); the bourgeoisie (those in control of production); and the working class (those who produce labor but have no right or autonomy over their own labor or production).

Unlike Marx, who rooted class relationship in the means of production, Max Weber posited that class domination emanated from individual social factors and relationships and was exhibited through the attitudes and behaviors of one individual towards another (Lowith, 2002). Weber's rationale continues to drive current social research with the premise that one's social, political, and economic positions influence one's well-being and health (Lynch, Smith, Kaplan, & House, 2000).

Zweig (2012) built on Marx's and Weber's discussions to argue that class translates into economic, cultural, political, and social power. Class relates to individual relationships in the workplace, which leads to inequality and domination. In our modern, capitalist U.S. society, there continues to be distinct differences among stratified groups based on factors such as income, race, status, and lifestyle. Even more so this difference is shown in the power and authority one is able to exercise at the workplace in relation to the production of goods and

services (Zweig 2012). Hotel housekeepers are one such example of the lower working class; they have no power over production and experience group domination and other marginalized differences (such as earning a low income) that impact their welfare.

#### Immigration Status and Work

According to the U.S. Census Bureau, immigrants are categorized as any foreign-born persons, which could also include temporary migrants (e.g., students), humanitarian migrants (e.g., refugees) and unauthorized migrants (people illegally residing in the U.S.) from all over the world (United States Census Bureau, 2010). In 2012, immigrants made up 12.5% (38.2 million) of the U.S. population (The Henry J. Kaiser Family Foundation, 2012). Immigrants are projected to account for between one-third and one-half of the growth of the U.S. labor force by 2030 (Lowell, Gelatt, & Batalova, 2006). The Hispanic contribution to the labor force is projected to grow to 30% in 2050, compared to their 15% composition in 2010 (Toossi, 2012).

Despite their increasing numbers and contributions to the U.S. economy, immigrants continue to be marginalized within occupational settings (deCastro, Gee, & Takeuchi, 2008; Landsbergis, Grzywacz, & LaMontagne, 2014; Panikkar, Woodin, Brugge, Hyatt, & Gute, 2014; Tsai & Thompson, 2013). Immigrants' negative experiences with work have been well documented, including poor workplace organization, rights violation, and work-related injuries and illnesses with little to no employer action (deCastro, Fujishiro, Sweitzer, & Oliva, 2006).

Hotel housekeepers, which include room cleaners and housemen, are more likely to be immigrant and non-White (Wial & Rickert 2002). Room cleaners are hired to clean the hotel rooms and replenish the carts. Housemen are usually responsible for deep cleaning carpets in the rooms, turning the mattresses, cleaning the bathrooms, and bringing fresh supplies into the rooms (Bureau of Labor Statistics, 2013). Hotel employers often favor immigrant employees for these positions because they are perceived as hardworking, more likely to accept low-skill and low-wage jobs, and less likely to complain (Dyer, McDowell, & Batnizky, 2007; Shih, 2002; Waldinger, 1997) compared to their U.S.-born counterparts. Thus, hotel housekeepers are particularly vulnerable for poor health outcomes because of their employment experiences and opportunities.

In summary, the constructs of gender, race, class, and immigration status play a major role in workers' experiences. Given that hotel housekeepers are predominantly immigrants or women of racial minorities, they have singular experiences that put them at risk for poor health outcomes. This warrants further investigation of how these constructs may shape workers' experiences with diseases such as hypertension.

#### Intersecting Gender, Race, Class, and Immigration Status within Organizational Context

Intersectionality is a term used to describe the connection and intersecting effects of race, class, gender, and any other additional social constructs that further marginalize individuals, thus resulting in inequalities, hierarchies, and negative health outcomes (Crenshaw, 1991; Seng, Lopez, Sperlich, Hamama, & Reed Meldrum, 2012). In the context of this study, we explored immigration status as an additional marginalizing characteristic. Intersectionality calls for the consideration of contextual factors and non-individual attributes, accounting for the complexity of one's social interactions and lived experiences (Simien, 2007).

Scholars have had ongoing debates about the intersectionality of race, gender, class, and immigration status on workers' experiences for decades (Browne & Misra, 2003; Crenshaw, 1991). Some have argued that the intersection of these constructs are ubiquitous and therefore operate within a societal system where they are simultaneously always at play (Adams, 1998; Weber, 2006). Others maintain that one construct may override the other within a given context

or condition (Brewer, 1999; McCall, 2001). Despite these varying discussions, what is agreed upon is that there are perpetuating unequal power and domination of one group over another at any given time and space as a result of one's gender, race, class, and immigration status.

Within the workplace context, intersectionality of race, gender, class, and immigration status calls for the consideration of work as one of the primary forces driving migration, as well as the role that immigration status and gender play in further marginalizing women and immigrants because each group is more likely to occupy low-skilled jobs (Dyer, McDowell, & Batnitzky, 2010; Kerfoot & Korczynski, 2005). Occupational polarization—whereby the labor force is concentrated into low-skill and high-skill jobs with this two tailed divergence leading to inequality (David, Katz, & Kearney, 2006)—is driven by one's race, gender, class, and immigration status (Browne & Misra, 2003) and thus can potentially influence worker's health and well-being (Krieger, 2010; McGibbon & McPherson, 2011; Weber & Castellow, 2011). With this context, we worked with a group hypertensive Haitian immigrant hotel housekeepers to explore how Black, lower working class, immigrant workers' hypertension management strategies were influenced by their multiple identities within the sociocultural contexts constructed by their gender, race, class, and immigration status.

## METHODS

This paper focuses on an analysis of the accounts of 27 hotel room cleaners and four housemen in a critical ethnography study ( $N = 31$ ) that explored hypertension management in multiple sociocultural contexts. Critical ethnography is a methodology used to explore specific phenomena, with consideration for social, economic, political and cultural forces, resulting in social consciousness and change (Thomas, 1992). The data collection was conducted between July and September of 2010 in Miami-Dade County, Florida, where the majority of the Haitian immigrant population resides in the U.S. The study protocol was approved by an Institutional Review Board before any human subject contact was initiated. All individuals who had access to the study information completed human subject protection training.

### Sampling

Using purposive sampling and snowball referral techniques, 31 Haitian immigrant hotel housekeepers were recruited from local churches ( $n = 4$ ), a barber shop ( $n = 1$ ), restaurants ( $n = 3$ ), boutiques ( $n = 2$ ), and a local resettlement organization serving the Haitian immigrant community ( $n = 1$ ). Individuals who participated in the study had to have migrated to the U.S. from Haiti within the past 10 years, be at least 18 years of age, be clinically diagnosed with hypertension, and be working as hotel housekeepers at the time of participation.

### Data Collection

A semi-structured interview was used as the primary data collection method to inquire about participants' experiences with hypertension, their work as hotel housekeepers, and their hypertension management. Development of the questions in the interview guide was guided by previous literature and the research questions. Interview questions aimed to understand how Haitian immigrant hotel housekeepers defined and managed hypertension and how work influenced their management of the disease. Prior to collecting the data, the primary investigator (first author) travelled to Florida and received feedback from community stakeholders on how to approach potential participants and the wording of the research questions. Example questions were: "Tell me about your hypertension," and "Tell me about a typical day at work," and "Tell me about how your work influences the way you manage your hypertension?" The interview guides were originally developed in English so that the entire research team and Human Subjects

review committee could understand them. The primary investigator, who is bicultural and bilingual in English and Haitian Creole, translated the interview guides to Haitian Creole before actual data collection. A second Haitian Creole speaking individual blindly back-translated the Haitian Creole version into English. Questions were adjusted accordingly to ensure equivalence of the languages (Hilton & Skrutkowski, 2002; Tsai, Choe, Lim, Acorda, Chan, Taylor, et al., 2008). Each participant was given the choice of completing the interviews in English or Haitian Creole; all opted for Haitian Creole.

In addition to the individual interviews, a 30-item demographic questionnaire and a follow-up, photovoice interview were used. The demographic questionnaire (which was also translated to Haitian Creole) had close-ended questions to inquire about the participants' demographics, such as gender, education, income, and length of time since their migration to the U.S. It also included open-ended questions as a technique to further understand the context for the participants' experiences. Examples of these open-ended questions are: "How do you think being a (man or woman) influences the way you manage your hypertension?" and "How do you think your income influences the way you manage your hypertension?"

At the end of the first semi-structured interview, participants were invited to take photos of objects or persons, both within and outside their workplace that had influenced their hypertension management. Photovoice is a well-established research method used to explore experiences of vulnerable populations with specific phenomenon and the forces influencing their experiences (Wang & Redwood-Jones, 2001). The photovoice process and the importance of getting consent before taking any identifiable pictures were explained to the 12 participants who agreed to the follow-up, photovoice interview. The participants returned the camera to the primary investigator of the study within one week. Participants were asked to discuss their pictures using questions such as: "Why did you take this picture?" and "What do you see here?" and "How does this picture relate to how you take care of your hypertension?"

Every participant provided written consent prior to the first interview. Each data collection was audio recorded and lasted between 20 to 90 minutes. Each participant was given a total of \$40 upon full study completion (\$20/interview) as appreciation for their time.

#### Data Analysis

All recorded interviews were transcribed verbatim by the first author in Haitian Creole. ATLAS.ti version 6 software (Friese, 2011) was used to aid in data coding and retrieval. LeCompte (2000)'s approach guided the data analysis through the following steps: 1) all transcripts were read and reread through an iterative process; 2) key words, phrases, sentences, and concepts that best expressed participants' accounts were identified and highlighted; 3) free quotations were assigned to these identified phrases, concepts, and statements; 4) codes that were identified through "in vivo", (directly from the text/paragraph) or open coding (reflecting the paragraph/statement/phrases), were attached to the free quotations; and 5) themes emerged as the codes were organized and sorted.

A series of approaches that are crucial aspects of qualitative research (Thomas & Magilvy, 2011) were undertaken to ensure rigor and validity. They included: 1) a record-keeping process which rendered all aspects of the study process transparent; 2) comparison and member checking, where the investigator consulted with participants to ask follow-up questions about any information that was unclear or was contradicted in their report or that of other participants; 3) consultations, throughout the process, with a team of experienced researchers who had relevant content and methodological expertise; and 4) regular reflections by the primary investigator on issues of power and her position (as a Haitian immigrant nurse researcher from a

university) and how that authority may have impacted her interaction and co-construction of knowledge.

## RESULTS

### Study Participants

Twenty-seven women and four men were interviewed. The average length of stay in the U.S. was 7.5 years ( $SD = 2.75$ ). There was an equal number of married ( $n = 12$ ) and single participants ( $n = 12$ ), followed by separated ( $n = 4$ ), partnered ( $n = 2$ ), and divorced ( $n = 1$ ). The majority (58%) completed between first and fifth grade according to the U.S. education system; only four participants reported having completed high school. More than half ( $n = 20$ ) of the participants reported an annual income of \$20,000 or less, with 32% ( $n = 10$ ) making between \$11,000 and \$15,000 a year, which put them below the 10th percentile of the national annual wage for housekeepers whose annual mean wage is typically \$21,820 (Bureau of Labor Statistics 2013).

### Connecting Gender, Race, Class, and Immigration Status to Hypertension Management

As participants were giving accounts about their experience with hypertension and hypertension management, their gender, race, class, and immigration status became eminent. Participants gave specific examples of how these constructs resulted in unique experiences with hypertension management.

#### Being a Woman versus Being a Man

Eighty-seven percent of the 31 participants were women. All 31 participants believed that managing their hypertension involved staying calm and taking their blood pressure medication regularly. All participants reported that being a woman would have a negative influence on hypertension management in the workplace because of the different work characteristics between housemen (largely male) and room cleaners (largely female), which translated to a difference in the workload. In contrast to the housemen, the room cleaners' heavy workload and the fast pace needed to complete this work led cleaners to be in a constantly agitated state that prevented them from staying calm. One male participant (P 21) stated: "Well [my work] does nothing to my [hypertension]. I work, I am not working fast, [and] I take little breaks." This participant's statement showed that men's housekeeping workload differed from that of the women. Men had more opportunities than women to stay calm and keep their blood pressure under control.

In addition, the women had to constantly work under pressure to clean within a specified time. Consequently, they avoided taking the diuretic blood pressure medications that increased their urinary frequency. Not taking these medications allowed them to complete their task without having to pause to go to the restroom. Participant 24, a female, described this dilemma:

*Some days you have to go pee [and] you need to go downstairs to go to the bathroom. You stand in front of the elevator, and you already pee on yourself, the elevator never opens. Going downstairs to go to the bathroom takes time. When you do go, you waste time while you need to complete the room.*

This participant admitted to not taking her blood pressure medication so that she could decrease her urinary frequency during work hours.

Outside of the work context, being a woman was credited with positively influencing hypertension management. For example, Participant 21, a male, stated:

*Well it is my wife that controls it for me. She does not give me a lot of salt. She does not give me food with a lot of fat. It is my wife. Well I cannot say that I control my tansyon*

*(hypertension). When my tansyon (blood pressure) goes up, my wife boil metsyen leaf<sup>1</sup> and garlic, the tansyon goes down.*

This participant's statement showed that he was not actively taking any measures to manage his hypertension but his wife was managing his condition by introducing western and non-Western biomedical medicines to his diet.

All but two female participants believed that being a woman enabled them to manage their hypertension with more ease. All participants believed women had greater motivation to manage their disease, had more knowledge about cultural remedies, were able to maintain their doctor appointments, and were more likely to take their medications than their male counterparts. As Participant 14 stated, "Women can take care of their hypertension better than men." Participant 29 elaborated on this belief:

*The man will say "I am not sick; I do not need to go to the hospital." But for me, I have to, I always keep my appointments. I think that women take better care of their [hypertension] than men because men never want to go the hospital. They never go check their [blood pressure] to find out if [it] is high.*

As demonstrated, these participants believed that hotel housekeeping was an oppressive factor hindering hypertension management among women employed in this role. The female housekeepers' workload and work pace hindered their ability to adhere to a blood pressure medication regime and prevented them from keeping their blood pressure at a lower level. Outside of the workplace, being a woman was perceived to be conducive to a better experience with hypertension management because females were seen as more apt to control their blood pressure (e.g., keep doctor appointments and medication schedules) than males.

#### Being of a Black "Race"

Institutional and personally mediated racism were described as prominent throughout hotel housekeeping work. Institutional racism was detailed in examples involving hotel housekeeping managers' preference in hiring particular racial and ethnic groups. Some participants ( $n = 7$ ) compared themselves to White Americans and other immigrants (such as those from Cuba who also had strong presence in the city where the study occurred) and said they felt isolated. Conversations that occurred in hotel break rooms between shifts were primarily in Spanish, which prevented non-Spanish speakers from participating. Participants also perceived inequality in the work hours assigned and reprisals handed down, saying that supervisors gave preferential treatment to their non-Haitian, immigrant counterparts. Participant 26's statement is illustrative of this belief:

*The manager is a woman who cannot stand Black people at all. She will give you one day off work and give the Whites five days. You see them all with the same skin color. Those who do not have the same skin color are no longer around.*

Personally mediated racism was evidenced through the reported discriminatory behaviors of the supervisors towards study participants. Two participants explicitly reported that they were mistreated at work because of their black skin color. "They look at this color," said Participant 24, pointing to the skin on her arm. Unlike their accounts of gender, no participants generated statements suggesting that being of a black "race" was a protective factor for them or their hypertension management.

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<sup>1</sup> Metsyen leaf is a home grown herbal medicine (see Figure 1 taken by participant).



Figure 1. Metsyen leaf.

#### Being from a Lower Working Class

Some participants ( $n = 5$ ) reported being openly aware of their low, socioeconomic position as a low-paid, blue-collar worker and the effects of class on their hypertension and hypertension management. This issue was underlined in their discussions about the inability to both purchase medications and pay bills. Participant 30 stated: "I do not like my job. But I have my bills. You understand? I plan on going to school to learn something better so that I can leave this [houseman] job." Participants acknowledged that their position in the organizational hierarchy of a typical hotel was at the lowest level of the industry. They noted their lack of financial stability to have insurance and purchase medications and other necessities. Participant 5 stated: "You understand, I cannot find any other work. There is nothing out there. So I have to do my best. I only get paid \$7.50." Participant 15 noted: "The boss does not give you work. There is no work. Right now, if they give you four days, three days of work, it is not enough to pay the bills." Study participants reported being unhappy with their work even as they faced limited choices to move out of their lower working class status.

Awareness of the factors contributing to their class stratification and power differentials was also eminent. This understanding of the relationship between education, social position, autonomy, and power in the workplace is reflected in the following quote from Participant 16:

*If someone has a higher position at the job, she does whatever she wants to you. You, you are obliged to stay in the job because others will take your place. She places people in a mental condition that is hard to deal with. Me, myself, I experience it [being mistreated and having a mental condition]. You see what I am saying? Everyone, they have an eight dollar job. Of course I am talking about people of high level [higher class]. Someone who comes from a university, she gets a job. That person too can lose a job, but when she*

*gets a job she is much more stable. You will not find a nurse in the morning to just get fired. They don't do that. Nor a doctor, nor an accountant, nor an engineer. But you [speaking of self], they can send you away whenever they want, anyhow they want. Do you understand?*

Participant 6 recognized that her opportunities and chances in the job and economic marketplace were constrained by her limited education. She mentioned:

*For example, you, you go to school. You go to learn what you need. With that you will find a good job to work. You will see life is good for you. But when you come to this country and you have no English. You do not go to school. You only learn a few words by listening to people talk. I don't have to tell you. It is not the same job. The life is hard for you. It is not the same*

Working as a hotel housekeeper placed the participants in a working-class position, one with unusually low levels of autonomy and high levels of stress. These participants were clear about their position in the hotel industry and the level of power and autonomy they were allowed to exert at work. Their lack of formal education and their low income also perpetuated a fear that they lacked job stability and economic mobility, which, in turn, prevented them from properly caring for their hypertension.

#### Being an Immigrant

Most participants ( $n = 28$ ) thought of hypertension as an illness associated with living in a country other than their own, especially in the context of their immigration status. For example, Participant 19 stated:

*Sometimes they say it is stress that causes it... you are living in a country that is not yours. In this country, there are so many problems you feel overwhelmed. When you leave children behind, you are thinking about them. You cannot find jobs also.*

Being an immigrant meant experiencing multiple stressors that their native-born counterparts did not encounter when it came to managing hypertension.

All study participants connected living in the U.S. as an immigrant to having a negative experience with hypertension. Participant 4 stated: "When I was in Haiti, my [hypertension] was not [bad] like that." Participant 16 reported: "As for the pressure in this country, if we are not careful, the [hypertension] will kill you, the way this country functions. You are always on the run. Everything you do, you are always under pressure." Participant 20 also stated:

*In this country [referring to the U.S.], there is no time to relax. But home [in Haiti] you have time to relax. If you buy a home, it is never yours. If you do not pay your mortgage, then they take it from you. Everything is about money. That's why in this country, there are many people with mental problems. They have mostly diabetes and [hypertension], all because of stress. That's why when you go to Walgreens, you see a long line because there are many people getting medication refills. Everyone is taking something.*

The 28 participants who thought that hypertension was an illness believed circumstances associated with being an immigrant (i.e., lack of job opportunities, stress about bills, and the constant feeling of being on the run and under pressure) negatively impacted their hypertension and hypertension management. The remaining participants believed that hypertension was a normal body occurrence and not an illness.

As immigrants from a non-English speaking country, study participants reported difficulties communicating with their supervisors. These challenges resulted in constant stress and an inability to stay calm, which led to constantly elevated blood pressure. For example, Participant 9 had immigrated to the U.S. not long before being interviewed for this study. During

her stay, she had not been able to go to school to learn English. She stated, “I have problems with the language at work. That makes me feel my blood pressure go up.”

In addition to psychological effects posed by the stress of living in another country and a lack of English proficiency, hiring practices also played a role in shaping these participants’ hypertension management. Among 31 participants, four were hired through an agency and not by hotels at which they worked. Agency hiring is a common practice in the hospitality industry where workers are hired temporarily through agencies and are not considered in-house hotel workers (Soltani & Wilkinson, 2010). In this study, the agency-hired workers were new immigrants who had been in the U.S. three years or less and were experiencing language barriers. As agency-hired workers, they were paid less than hotel-hired workers and were not provided with health benefits. These issues only accentuated the disparity among the agency-hired, Haitian immigrant hotel housekeepers.

Although participants were experiencing stress as immigrants within the workplace, being an immigrant also played a protective role in their hypertension management. Eleven participants reported receiving support from their coworkers in the workplace setting. Coworkers gave them advice on remedies that would help lower their blood pressure. For example, Participant 14 stated: “Some [coworkers] tell me to take *metsyen* leaf to lower my [blood pressure]. They [the coworkers] teach me a lot of remedies.” During their breaks or the start of their shifts, they shared information about where and how to access services and doctors. They also shared home-based remedies that were either grown in their backyards or imported from Haiti. Thus, despite the hardships study participants experienced in managing hypertension as Black, immigrant, woman hotel housekeepers, they were also proactive in using resources and seeking support among coworkers in order to lower their blood pressure.

## DISCUSSION

The purpose of this article is to discuss the connection between the constructs of gender, race, class, and immigration status and hypertension management among low-wage, immigrant hotel housekeepers. Compared to their male counterparts whose duties included cleaning the hallways, heavy carpet shampooing, and flipping mattresses as housemen (Bureau of Labor Statistics 2013), all the women participants reported that their tasks as room cleaners were usually time sensitive and negatively influenced their hypertension because they were unable to stay calm in their given work context. Study participants experienced both institutional and personally mediated racism. They were at high risk for adverse health outcomes because of their constant placement in working-class positions and other factors, such as language barriers. The amalgamation of their immigrant status and being low-paid, blue-collar workers influenced study participants’ hypertension management. This study’s findings show that hotel housekeepers continue to have unique experiences with low wage, discrimination, and an overrepresentation of immigrants, women, and Blacks within the industry.

### Intersectionality of Gender, Race, Class, and Immigration Status

Current literature notes a relationship between health and being a woman (Cutler, Sorlie, Wolz, Thom, Fields, & Roccella, 2008); being Black (Brown, Williams, Jackson, Neighbors, Torres, Sellers et al., 2000; Krieger, Kosheleva, Waterman, Chen, & Koenen, 2011; Krieger Waterman, Kosheleva, Chen, Smith, Carney, et al., 2013), from the lower class (Bloch, Betancourt, & Green, 2008) and being an immigrant (Tsai & Bruck 2009; Tsai, 2011). All these factors can be either health-damaging or health-protective, depending on one’s position within the social conditions created by these constructs. For example, Cutler et al.’s (2008) analysis of

the National Health and Nutrition Examination Survey (1988-1994 and 1999-2004) showed that awareness, treatment, and control of hypertension were dependent upon gender and race/ethnicity. They reported trend improvements in blood pressure among men and Whites more than women and Blacks. Coming from a higher socioeconomic class position can play a protective factor for one's health (Williams et al., 2010). So too can being a new immigrant since health promoting behaviors and health status deteriorate with length of stay in the U.S. (Lee, O'Neill, Ihara, & Chae, 2013). In the study by Lee and colleagues (2013), they found that immigrants who lived in the U.S. for 1-5 years, 6-10 years, and 11-15 years had 2.69, 5.24 and 6.20 times the odds of reporting worsening health conditions compared to those who had been in the country for less than one year (Lee et al., 2013). In this study, there were no clear links between the participants' length of stay and their accounts about their health and behaviors towards hypertension management.

Consistent with the literature, this study found that being in a lower class and being categorized in the Black racial group were health-damaging factors that influenced participants' perceived ability to manage their hypertension. However, unlike what is often described in the literature, this study found that gender and immigration status played both a protective role (at the cultural level) and a damaging role (at the occupational level) for hypertension management. Some studies have emphasized that women and immigrants are less able to control their blood pressure than their male and/or U.S.-born counterparts (Gu et al., 2008; Ong, Tso, Lam, & Cheung, 2008). Findings from our study indicate the need to revisit and consider the contexts within which these constructs can be a hindrance or a positive influence to an individual's health.

When exploring intersectionality, several points are to be considered. First, along with family sponsorship and reunification, work is one of the primary forces driving international migration (Hatton & Williamson, 2011). The labor-migration experience dichotomy must be explored to understand the forces at play when immigrants travel to earn more but upon their arrival face unemployment and negative working conditions. For example, Haitian immigrants travel to the U.S. to get a better life and improve their financial status (Zephir, 1996). However, in working in the U.S., they experience challenges with access to employment. They often fall under the lower working class category and their work experiences become influenced by their immigration status (Canales, 2007). Second, immigration status and gender intensify work-related subordination and marginalization. Both immigrants and women tend to be employed in precarious and low-skilled jobs, such as service work (Browne & Misra 2003), which keeps them in working-class status. Particularly, Black immigrants in the workforce must constantly negotiate within their multiple, marginalized identities (Holvino, 2008). This study's findings show the pervasive and concurrent influences of gender, race, class, and immigration status on workplace contexts. As an exemplar of the Black, immigrant population, Haitian immigrant hotel housekeepers had to balance their multiple identities at work on a daily basis.

#### Effects of Intersectionality on Immigrant Workers' Health

As Krieger (2010) stated, "Social realities of unjust and inequitable societal conditions, singly and combined, become literally embodied, thereby producing not only occupational inequities in health but also social inequities in health within specified occupations" (p. 112). This study's findings warrant the need for the consideration of the intersectionality of the social constructs of gender, race, class, and immigration status with respect to health and illness management for ethnic minority immigrant workers within the workplace setting. The findings support the pervasiveness and simultaneity of these constructs within any particular social context (Weber, 2006). Hotel immigrant workers need to constantly deal with the interface of

their multiple identities of being a woman, being Black, being an immigrant, and hailing from the working class when managing their hypertension. More importantly, the effects of this constant interface with multiple identities go beyond the success of managing a physical health condition. As found in this study, the effects of this constant interface can also adversely affect the mental health status and overall well-being of ethnic minority immigrants working in hotels. Psychological distress and mental health problems have cost employers and society billions of dollars annually (Birnbaum, Kessler, Kelley, Ben-Hamadi, Joish, & Greenberg, 2010; Stewart, Ricci, Chee, Hahn & Morganstein, 2003). Previous studies have reported that mental health problems among Haitian immigrants are associated with perceived racism, discrimination, and cultural stigma (Allen et al., 2013; Keys, Kaiser, Foster, Burgos Minaya, & Kohrt, 2014). The findings of this study provide additional support to calls from other scholars for the concurrent consideration of multiple contextual factors (McCall 2005; Simien 2007; Tsai & Thompson, 2013) as a critical approach to address disparities. These findings also highlight the importance of including mental health as one of the health outcomes, along with hypertension management.

### Practice Implications

Hypertension is becoming an increasing concern among women and immigrants. It is predicted that hypertension prevalence will increase by 13% among women by 2025, compared to a 9% increase among men (Kearney, Whelton, Reynolds, Muntner, Whelton, & He, 2005). Immigrants experience poorer management of hypertension than their counterparts (Gu et al., 2008; Barnes & Lu 2012). This study's findings suggest health professionals need to consider the connection between these social constructs within the workplace setting and the effect on hypertension management and health outcomes in ethnic minority immigrants.

Health professionals are advised to regularly consider these social constructs in their clinical practices so that they can better identify the underlying factors for poor hypertension management among ethnic minority immigrants, especially those employed in low-wage, labor-intensive jobs. This approach could also prevent clinicians from assigning the blame completely to the individual (Butterfield, 1990; Krieger, 2010). As found in this study, a participant's choice to not take blood pressure medications was often a response to sociocultural contexts. Health promotion and treatment approaches that do not take an individual patient's or the target population's sociocultural contexts into account are likely less effective in increasing adherence to the prescribed regimen.

The study findings also have implications for the organization and system level practices. The study findings show that social constructs of gender, race, class, and immigration status further marginalize Haitian immigrant hotel housekeepers and lead to poor hypertension management. This indicates a need for employers and hotel managers to consider how these broader social constructs may impact the health of immigrant (and also non-immigrant) employees and to engage in supportive management practices that can enhance the physical and mental health of hotel housekeepers. The findings also call for policy stakeholders to further explore the practices of the hotel industry, notably the hiring practices, and address the health risks and needs of at-risk workers accordingly. The study participants hired through agencies were paid less and were less likely to have health insurance coverage. Agency-hired workers are in need of assistance to obtain health coverage and appropriate wages. Unions representing hotel workers, policy makers, public health professionals, and pro-equality organizations should be involved to ensure fair wages and provide services for this worker group.

### Research Implications

The findings illustrate the importance of considering gender, race, class, and immigration status throughout all research processes, from conceptualization, interview guide development, data collection, analysis, and synthesis to interpretation. McCall (2005) and Simien (2007) discussed the complexity housed within intersectionality that results in methodological and practical challenges. They contended that race and gender cannot just be dichotomized and examined with statistical analysis since it is critical to account for the complexity of one's social interactions and experiences (Simien, 2007). Such consideration enables researchers to use a holistic approach to understanding individuals' experiences with chronic diseases and disease management.

Haitian immigrants are an understudied population that experiences various types of disparities. Studies exploring the similarities and differences between the experiences of Haitian immigrant hotel housekeepers and other ethnic minority groups employed in the hotel industry will provide a deeper understanding of the relationship between the intersectionality of gender, race, class, immigration status, hypertension, and hypertension management in hotel workers to determine if these experiences are unique to Haitian immigrants. Moreover, research that further explores factors mitigating the effects of the intersectionality of these constructs on the health and health management of Haitian immigrant hotel workers will provide insight into intervention designs. Research that identifies interventions which can modify work organizations to promote rather than harm the health of immigrant hotel workers is also needed

### **Limitations**

Only 31 individuals participated in this study. Given the qualitative nature of this study, the goal was to reach saturation of the information and not to focus on the number of participants. Participants' accounts became repetitive by the 15<sup>th</sup> participant, indicating data collection reached saturation. The investigator kept recruitment and data collection going to 31 to ensure there was saturation and to provide a complete and in-depth understanding of participants' experiences. In addition, the study focused on Haitian immigrant hotel housekeepers. Because of the specificity in participant characteristics, study findings as they pertain to hypertension management may not be generalizable to other ethnic groups. Moreover, the participants were primarily women (87%) and only four were men. Despite the primary investigator's attempt to have an equally representative number, men did not show interest in the study. Given that the hotel housekeeping industry is overrepresented by women, this lack of male representation is not surprising. More studies to explore men's experiences with hypertension management within the workplace context, specifically that of hotel housekeeping, will help validate and extend this study's findings.

Photovoice was included as a research method to enrich the data. However, the participants were unable to take photos that would capture how their gender, race, class, and immigrations status influenced their health. The few photos that were taken were only of beds and carts. This limitation was due to participants' fear of reprisal from their supervisors, a general lack of time, and participants' fear of being accused of stealing the cameras.

The last limitation of this study is researcher bias. The primary investigator, who was involved in data collection, is a Haitian immigrant. To reduce the influence of researcher bias, the investigator kept a journal to reflect on the entire research process. She also consulted with other experienced researchers; some researchers were familiar with the research methodology

used for this study and some with Haitian culture and language while others were trained in multidisciplinary disciplines.

Strengths

Despite the aforementioned limitations, it is worthwhile to note the various strengths of this study. Notably, Haitian immigrant hotel workers are a vulnerable and hard-to-reach population. The primary investigator, a bicultural and bilingual Haitian immigrant, had the opportunity to reach this population and used her common cultural background to connect with the study participants. This strength allowed the study to reveal the connections between four salient social constructs and hypertension management among this understudied, immigrant worker population within the context of their work environment. Moreover, the study used multiple sources of data that added richness and depth to the study findings. Finally, a transparent and detailed protocol was followed during study proposal development, data collection, and analysis. This strength supports the rigor and trustworthiness of the data collected.

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**REFERENCES**

Adams, T. L. (1998). Combining gender, class, and race structuring relations in the Ontario dental profession. *Gender & Society*, 12(5), 578-597.

Adib, A., & Guerrier, Y. (2003). The interlocking of gender with nationality, race, ethnicity and class: the narratives of women in hotel work. *Gender, Work & Organization*, 10(4), 413-432.

Allen, J. D., Mars, D. R., Tom, L., Apollon, G., Hilaire, D., Iralien, G., . . . Zamor, R. (2013). Health beliefs, attitudes and service utilization among Haitians. *Journal of Health Care for the Poor and Underserved*, 24(1), 106-119.

Barnes, D. M., & Lu, J. H. (2012). Mexican immigrants' and Mexican Americans' perceptions of hypertension. *Qualitative Health Research*, 22(12), 1685-1693.

Birnbaum, H. G., Kessler, R. C., Kelley, D., Ben-Hamadi, R., Joish, V. N., & Greenberg, P. E. (2010). Employer burden of mild, moderate, and severe major depressive disorder: mental health services utilization and costs, and work performance. *Depression and Anxiety*, 27(1), 78-89.

Bloch, M. J., Betancourt, J., & Green, A. (2008). Overcoming racial and ethnic disparities in blood pressure control: a patient-centered approach to cross-cultural communication. *The Journal of Clinical Hypertension*, 10(8), 589-591.

Brewer, R. M. (1999). Theorizing race, class and gender: the new scholarship of black feminist intellectuals and black women's labor. *Race, Gender & Class*, 6(2), 29-47.

Brondolo, E., Rieppi, R., Kelly, K. P., & Gerin, W. (2003). Perceived racism and blood pressure: a review of the literature and conceptual and methodological critique. *Annals of Behavioral Medicine*, 25(1), 55-65.

Browne, I., & Misra, J. (2003). The intersection of gender and race in the labor market. *Annual Review of Sociology*, 29, 487-513.

Bureau of Labor Statistics. (2013). Occupational outlook handbook, maids and housekeeping cleaners: Pay. 2012-13 edition. Retrieved March 5<sup>th</sup> 2013 from <http://www.bls.gov/ooh/building-and-grounds-cleaning/maids-and-housekeeping-cleaners.htm#tab-5>

Butterfield, P. G. (1990). Thinking upstream: nurturing a conceptual understanding of the societal context of health behavior. *Advances in Nursing Science*, 12(2), 1-8.

Canales, A. I. (2007). Inclusion and segregation: the incorporation of Latin American immigrants into the U.S. labor market. *Latin American Perspectives*, 34(1), 73-82.

Centers for Disease Control. (2013). Chronic disease prevention and health promotion. Retrieved March 28th 2013, from <http://www.cdc.gov/chronicdisease/index.htm>

Chae, D. H., Nuru-Jeter, A. M., Lincoln, K. D., & Francis, D. D. (2011). Conceptualizing racial disparities in health. *Du Bois Review: Social Science Research on Race*, 8(1), 63-77.

Childs, S. (2012). *Gender discrimination in the workplace*. (Unpublished Doctoral Dissertation). State University of New York, Empire State College, Saratoga Springs, NY.

Crenshaw, K. (1991). Mapping the margins: intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, 43(6), 1241-1299.

Cutler, J. A., Sorlie, P. D., Wolz, M., Thom, T., Fields, L. E., & Roccella, E. J. (2008). Trends in hypertension prevalence, awareness, treatment, and control rates in United States adults between 1988–1994 and 1999–2004. *Hypertension*, 52(5), 818-827.

David, H., Katz, L. F., & Kearney, M. S. (2006). The polarization of the U.S. labor market. *American Economic Review Papers & Proceedings*, 96, 189-194.

de Castro, A. B., Fujishiro, K., Sweitzer, E., & Oliva, J. (2006). How immigrant workers experience workplace problems: a qualitative study. *Archives of Environmental & Occupational Health*, 61(6), 249-258.

de Castro, A. B., Gee, G. C., & Takeuchi, D. T. (2008). Workplace discrimination and health among Filipinos in the United States. *American Journal of Public Health*, 98(3), 520-526.

Deng, X., & Zhang, L. (2008). The historical patterns of occupational attainment of racial minorities in Massachusetts: an analysis of the 1974–2002 Current Population Survey Data. *The Social Science Journal*, 45(3), 476-496. doi: 10.1016/j.soscij.2008.07.008

Dyer, S., McDowell, L., & Batnitzky, A. (2010). The impact of migration on the gendering of service work: the case of west London hotel. *Gender, Work & Organization*, 17(6), 635-657. doi: 10.1111/j.1468-0432.2009.00480.x

Friese, S. (2011). ATLAS.ti 6: Concepts and Functions. Berlin, Germany: ATLAS.ti Scientific Software Development GmbH.

Gauchat, G., Kelly, M., & Wallace, M. (2012). Occupational gender segregation, globalization, and gender earnings inequality in U.S. metropolitan areas. *Gender & Society*, 26(5), 718-747.

Gorman, E. H. (2005). Gender stereotypes, same-gender preferences, and organizational variation in the hiring of women: evidence from law firms. *American Sociological Review*, 70(4), 702-728.

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Gu, Q., Burt, V. L., Paulose-Ram, R., & Dillon, C. F. (2008). Gender differences in hypertension treatment, drug utilization patterns, and blood pressure control among U.S. adults with hypertension: data from the National Health and Nutrition Examination Survey 1999–2004. *American Journal of Hypertension*, 21(7), 789-798.

Hatton, T. J., & Williamson, J. G. (2011). Are third world emigration forces abating? *World Development*, 39(1), 20-32.

Hilton, A., & Skrutkowski, M. (2002). Translating instruments into other languages: development and testing processes. *Cancer Nursing*, 25(1), 1-7.

Holvino, E. (2008). Intersections: The simultaneity of race, gender and class in organization studies. *Gender, Work & Organization*, 17(3), 248-277.

Jones, C. P. (2000). Levels of racism: a theoretic framework and a gardener's tale. *American Journal of Public Health*, 90(8), 1212-1215.

Kearney, P. M., Whelton, M., Reynolds, K., Muntner, P., Whelton, P. K., & He, J. (2005). Global burden of hypertension: analysis of worldwide data. *Lancet*, 365(9455), 217-223.

Kerfoot, D., & Korczynski, M. (2005). Gender and service: new directions for the study of 'front-line' service work. *Gender, Work & Organization*, 12(5), 387-399.

Keys, H. M., Kaiser, B. N., Foster, J. W., Burgos Minaya, R. Y., & Kohrt, B. A. (2014). Perceived discrimination, humiliation, and mental health: a mixed-methods study among Haitian migrants in the Dominican Republic. *Ethnicity & Health* (ahead-of-print), 1-22.

Kraus, V., & Yonay, Y. P. (2000). The effect of occupational sex composition on the gender gap in workplace authority. *Social Science Research*, 29(4), 583-605.

Krieger, N. (2010). Workers are people too: societal aspects of occupational health disparities—an ecosocial perspective. *American Journal of Industrial Medicine*, 53(2), 104-115.

Landsbergis, P. A., Grzywacz, J. G., & LaMontagne, A. D. (2014). Work organization, job insecurity, and occupational health disparities. *American Journal of Industrial Medicine*, 57(5), 495-515. doi: 10.1002/ajim.22126

LeCompte, M. D. (2000). Analyzing qualitative data. *Theory into Practice*, 39(3), 146-154.

Lee, S., O'Neill, A. H., Ihara, E. S., & Chae, D. H. (2013). Change in self-reported health status among immigrants in the United States: associations with measures of acculturation. *PLoS one*, 8(10), 1-9.

Liladrie, S. (2010). Do not disturb/please clean room': hotel housekeepers in greater Toronto. *Race & Class*, 52(1):57-69. doi: 10.1177/0306396809354177

Lowell, L. B., Gelatt, J., & Batalova, J. (2006). Immigrants and labor force trends: the future, past, and present. *Task Force Insight*, 17, 1-31.

Lowith, K. (2002). *Max Weber and Karl Marx*. New York, NY: Routledge.

Lynch, J. W., Smith, G. D., Kaplan, G. A., & House, J. S. (2000). Income inequality and mortality: importance to health of individual income, psychosocial environment, or material conditions. *BMJ*, 320(7243), 1200-1204.

Marx, K., & Engels, F. (2012). *The communist manifesto*. New Haven, CT: Yale University Press.

McCall, L. (2001). Sources of racial wage inequality in metropolitan labor markets: racial, ethnic, and gender differences. *American Sociological Review*, 66(4), 520-541.

McCall, L. (2005). The complexity of intersectionality. *Signs*, 30(3), 1771-1800.

McDowell, L., Batnitzky, A., & Dyer, S. (2007). Division, segmentation, and interpellation: the embodied labors of migrant workers in a greater London hotel. *Economic Geography*, 83(1), 1-25.

McGibbon, E., & McPherson, C. (2011). Applying intersectionality & complexity theory to address the social determinants of women's health. *Women's Health & Urban Life*, 10(1), 59-86.

Ong, K. L., Tso, A. W., Lam, K. S., & Cheung, B. M. (2008). Gender difference in blood pressure control and cardiovascular risk factors in Americans with diagnosed hypertension. *Hypertension*, 51(4), 1142-1148.

Panikkar, B., Woodin, M. A., Brugge, D., Hyatt, R., & Gute, D. M. (2014). Characterizing the low wage immigrant workforce: a comparative analysis of the health disparities among selected occupations in Somerville, Massachusetts. *American Journal of Industrial Medicine*, 57(5), 516-526. doi: 10.1002/ajim.22181

Sauter, S. L., Brightwell, W. S., Colligan, M. J., Hurrell, J. J., Katz, T. M., LeGrande, D. E., . . . Murphy, L. R. (2002). The changing organization of work and the safety and health of working people. *DHHS (NIOSH) Publication* (2002-116).

Seng, J. S., Lopez, W. D., Sperlich, M., Hamama, L., & Reed Meldrum, C. D. (2012). Marginalized identities, discrimination burden, and mental health: empirical exploration of an interpersonal-level approach to modeling intersectionality. *Social Science & Medicine*, 75(12), 2437-2445.

Shih, J. (2002). '...Yeah, I could hire this one, but I know it's gonna be a problem': how race, nativity and gender affect employers' perceptions of the manageability of job seekers. *Ethnic and Racial Studies*, 25(1), 99-119. doi: 10.1080/01419870120112076

Simien, E. M. (2007). Doing intersectionality research: from conceptual issues to practical examples. *Politics & Gender*, 3(2), 264-271.

Soltani, E., & Wilkinson, A. (2010). What is happening to flexible workers in the supply chain partnerships between hotel housekeeping departments and their partner employment agencies? *International Journal of Hospitality Management*, 29(1), 108-119.

Stewart, W. F., Ricci, J. A., Chee, E., Hahn, S. R., & Morganstein, D. (2003). Cost of lost productive work time among US workers with depression. *JAMA*, 289(23), 3135-3144.

Storm-Pallesen, E. (2007). *Work-related stress and health among hotel employees in Malmö*. (Unpublished Master's Thesis), Kristianstad University. Retrieved from <http://www.diva-portal.org/smash/record.jsf?pid=diva2%3A230647&dswid=-6748>

The Henry J. Kaiser Family Foundation. (2012). Key facts on health coverage for low-income immigrants today and under health reform. Retrieved March 5<sup>th</sup>, 2013, from <http://kff.org/search/?s=Key+facts+on+health+coverage+for+low-income+immigrants+today+and+under+health+reform>

The Office of Minority Health. (2013). Heart disease data/statistics. Retrieved March 5th 2013, from <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=3&lvlid=6>

Thomas, E., & Magilvy, J. K. (2011). Qualitative rigor or research validity in qualitative research. *Journal for Specialists in Pediatric Nursing*, 16(2), 151-155.

Thomas, J. (1992). *Doing critical ethnography* (Vol. 26). Thousand Oaks, CA: Sage.

Toossi, M. (2012). Projections of the labor force to 2050: a visual essay. *Monthly Labor Review*, 135, 3-16.

Tsai, J. H.-C., Choe, J. H., Lim, M. C. J., Acorda, E., Chan, N. L., Taylor, V., & Tu, S.-P. (2008). Developing culturally competent health knowledge: issues of data analysis of cross-cultural, cross-language qualitative research. *International Journal of Qualitative Methods*, 3(4), 16-27.

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Tsai, J. H.-C. (2011). Immigrant vulnerability: Does capitalism in the United States matter? In M. de Chesnay & B. A. Anderson (Eds.), *Caring for the vulnerable: Perspectives in nursing theory, practice, and research* (3<sup>rd</sup> ed., pp. 313-322). Sudbury, MA: Jones & Barlett.

Tsai, J. H.-C., & Bruck, A. (2009). Sociocultural contexts and worker safety and health: findings of a study with Chinese immigrant restaurant workers. *AAOHN Journal*, 57(2), 51-58.

Tsai, J. H.-C., & Thompson, E. A. (2013). Impact of social discrimination, job concerns, and social support on Filipino immigrant worker mental health and substance use. *American Journal of Industrial Medicine*, 56, 1082-1094. doi: 10.1002/ajim.22223.

United States Census Bureau. (2010). Foreign born persons. Retrieved March 5th 2013, from [http://quickfacts.census.gov/qfd/meta/long\\_POP645200.htm](http://quickfacts.census.gov/qfd/meta/long_POP645200.htm)

Waldinger, R. (1997). Black/immigrant competition re-assessed: new evidence from Los Angeles. *Sociological Perspectives*, 40(3), 365-386.

Wang, C., & Redwood-Jones, Y. A. (2001). Photovoice ethics: perspectives from Flint photovoice. *Health Education & Behavior*, 28(5), 560-572.

Weber, L. (2006). A conceptual framework for understanding race, class, gender, and sexuality. *Psychology of Women Quarterly*, 22(1), 13-32.

Weber, L., & Castellow, J. (2011). Feminist research and activism to promote health equity. In S. N. Hesse-Biber (Ed.), *Handbook of feminist eeresearch: Theory and praxis* (2<sup>nd</sup> ed., pp. 434-454). Thousand Oaks, CA: Sage.

Wial, H., & Rickert, J. (2002). *U.S. Hotels and Their Workers: Room for Improvement*. Working for America Institute. Retreived February 10<sup>th</sup>, 2013, from [http://www.hotel-online.com/News/PR2002\\_3rd/Aug02\\_HotelJobs.html](http://www.hotel-online.com/News/PR2002_3rd/Aug02_HotelJobs.html)

Williams, D. R., & Neighbors, H. W. (2001). Racism, discrimination and hypertension: evidence and needed research. *Ethnicity & Disease*, 11(4), 800-816.

Williams, D. R., Neighbors, H. W., & Jackson, J. S. (2003). Racial/ethnic discrimination and health: findings from community studies. *American Journal of Public Health*, 93(2), 200-208.

Williams, D. R., & Mohammed, S. A. (2009). Discrimination and racial disparities in health: evidence and needed research. *Journal of Behavioral Medicine*, 32(1), 20-47.

Williams, D. R., Mohammed, S. A., Leavell, J., & Collins, C. (2010). Race, socioeconomic status, and health: complexities, ongoing challenges, and research opportunities. *Annals of the New York Academy of Sciences*, 1186(1), 69-101.

Wilper, A. P., Woolhandler, S., Lasser, K. E., McCormick, D., Bor, D. H., & Himmelstein, D. U. (2008). A national study of chronic disease prevalence and access to care in uninsured U.S. adults. *Annals of Internal Medicine*, 149(3), 170-176.

Zahradníková, J. (2009). *Gender and the Workplace*. (Unpublished Bachelor Thesis). Tomas Bata University in Zlin. Retrieved from [http://dspace.k.utb.cz/bitstream/handle/10563/8176/zahradn%C3%ADkov%C3%A1\\_2009\\_bp.pdf?sequence=1](http://dspace.k.utb.cz/bitstream/handle/10563/8176/zahradn%C3%ADkov%C3%A1_2009_bp.pdf?sequence=1)

Zephir, F. (1996). *Haitian immigrants in Black America: A sociological and sociolinguistic portrait*. West Westport, CT: Greenwood Publishing Group.

Zweig, M. (2012). *The working class majority: America's best kept secret*. Ithaca, NY: Cornell University Press.