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Chinese Immigrants' use of Human Services During the Transition to Parenthood

by

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ABSTRACT

The purpose of this study was to explore Chinese immigrants' experiences with human services during the transition to parenthood. The data were generated through three rounds of individual interviews with six Chinese immigrant couples. Latent content analysis was used to identify primary patterns in the types and prevalence of services used by participants, their reasons for using human services, and the quality of their experiences with the services. The findings indicate that participants commonly used (a wide range of) health care services, while social services were not commonly used. When participants sought help from human services, it was mostly for their infants' health-related issues. Overall, participants' experiences with human services were positive. Services seemed to meet participants' needs, providers were perceived as pleasant to interact with and most were easy to access. Finally, a language barrier to services was not a common experience for participants.

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CHAPTER 1

INTRODUCTION

Purpose and Rationale of the Study

The purpose of this study was to explore the experiences of Chinese immigrant expectant/new parents with human services[1] during their transition to parenthood in Canada. Research about immigrants is important as Canada has been and continues to be an immigrant receiving country. At the time of the most recent 2006 Census, foreign-born individuals accounted for 20% of Canada's population (Statistics Canada, 2006). Between 1999 and 2008 Canada admitted circa 2,300,000 immigrants (Citizenship and Immigration Canada, 2008a). Apart from contributing to Canada's population growth directly (i.e., by coming to live in Canada), many immigrants become parents in this country, thereby contributing to the country's natural reproduction. In 2004, births to immigrants accounted for 25% of births nationwide. In Alberta, the proportion of immigrant births was circa 20% in that year (Statistics Canada, 2007a).

Research on immigrants' use of human services is important. Infants born to immigrants today will have a significant impact on the health of Canada's population tomorrow, as the foundations of adult health are laid before birth and in early childhood, as a function of fetal and infant health and, more broadly, through early childhood experiences (Barker, 1994 as cited in Catford, 2000; Shonkoff et

[1]I use the term "human services" as an umbrella term to refer to health care and social services. For the purpose of this study, health care services are defined as those available through the public health care system (e.g., a hospital birth) and services provided by private practitioners (including non-traditional medicine). As to social services, I define them as those provided by community-based agencies (e.g., programs for parents with infants available through municipal public libraries).

al., 2009; Wilkinson & Marmot, 2003). One determinant of infant health is access to human services by expectant mothers during pregnancy and by mothers and infants in the post-partum period (United Nations, n.d.; The Federal, Provincial, and Territorial Advisory Committee on Population Health, 1994; US Department of Education, 1999).

Furthermore, aside from the concern about infant health, it is important to pay attention to immigrants' access to human services in its right. Immigrants transitioning to parenthood should have access to services for their own needs, not just for the needs of their infants, as the transition to parenthood can be fraught with difficulties and challenges (Russell, 1974). One such issue is post-partum depression, which affects 10 to 15 % of women post-birth (Ndokera & MacArthur, 2010). Among other common challenges associated with new parenthood which do not discriminate between genders are lack of sleep, fatigue, emotional instability (Russell), and work-family role conflict (Cowan & Cowan, 2003). Transition to parenthood also brings about a decline in marital quality as reflected in a decrease in quality time spent together as a couple (Cowan, Cowan, Heming, Garrett, Coysh, Curtis-Boles, & Boles, 1985; Cowan & Cowan, 2003) and an increase in marital conflict (Cowan & Cowan, 2000).

It appears that becoming a parent in the context of immigration can make the adjustment to parenthood even more difficult because recent immigration is associated with a host of issues that might interfere with coping and securing support. These issues include, but are not limited to lack of proficiency in English (Kinnon, 1999), a sense of alienation and uprootedness (Westwood & Ishiyama,

1991), financial insecurity (Statistics Canada, 2007b), and social isolation (Stewart, 2003; Tastsoglou & Miedema, 2002).

To reiterate, it is very important that immigrants who are expectant/new parents access human services both for the needs of their infants and for their own needs. However, previous research is inconclusive as to whether childbearing immigrants, particularly in Canada, have optimal access to services (see Loiselle et al., 2001; Katz & Gagnon, 2002, for instance). The literature on immigrants indicates that there are issues with immigrants' access to social welfare services, in general. For instance, there is evidence that immigrants are less likely to use employment insurance, social assistance, and subsidized housing than Canadian-born individuals at the same income level (Baker & Benjamin, 1995; Fleury, 2007). Also, with regard to health care, there is an indication that immigrants are less likely to use preventative care in Canada (Chu, 2008). Furthermore, there is research suggesting that immigrants might face barriers to services, associated with language, unfamiliarity with human service systems, ineligibility, and cultural inappropriateness of services (Bowen, 2001; Fowler, 1998; Katz & Hofer, 1994; Ngo-Metzger, Massagli, Clarridge, Manocchia, Davis, Iezzoni, & Phillips, 2003; Stewart, 2003). Yet, it is not clear what the perspective of immigrants themselves is regarding their needs for services, what they do to address their needs, and what their experiences are as they attempt to meet their needs through human services, particularly, in the context of childbearing. The goal of this study was to begin filling this gap by exploring how one particular group of immigrants, Chinese immigrants, use human services during their transition to parenthood.

Although I am interested in the experiences of immigrants as a group, this study focuses on a particular immigrant group, the Chinese. A central reason I am focusing on Chinese immigrants relates to the study from which I accessed data. The study, Mobilizing Intergenerational Social Support During the Transition to Parenthood (*MIS* project) (Kushner, Williamson, Stewart, Letourneau, Spitzer, & Rempel, 2006-2010) is examining how new parents and grandparents seek and experience social support to manage multiple responsibilities in family and paid work during the transition to first-time parenthood. The sample of the MIS study included participants who were born and raised in Canada, as well as immigrants from Mainland China and the Philippines. My study is based on the data generated from the Chinese immigrant couples only.

Aside from practical reasons for focusing on Chinese immigrants, advancing knowledge about Chinese immigrants is important as this ethnic group comprises the largest proportion of Canada's immigrant population. In 2008, Chinese accounted for 15.4 % of all immigrants in Canada. Thus, the needs and experiences of Chinese immigrants (along with issues common to all immigrants) should be acknowledged in the planning and implementation of human services related to childbearing.

Research Questions

Despite the importance of acknowledging the needs of Chinese immigrants in planning and implementing human services related to childbearing, there has not been any scholarly work on the use of human services by new/expectant parents from China, upon which to base recommendations. Furthermore, there has

been no academic research into any aspect of the transition to parenthood experience among Chinese immigrants in Canada. Thus, the purpose of this study was to explore how Chinese immigrants use human services during the transition to parenthood in Canada, to determine the extent to which they turn to human services to meet their needs, and whether they see such services as helping them meet their needs. The study was guided by three research questions:

1. What human services did participants use during their transition to parenthood and how often were these used?
2. For what reasons did participants seek human services?
3. What was the quality of participants' experiences with human services?

Structure of the Thesis

The rest of the thesis consists of four chapters: Chapter 2 (*Literature Review*), Chapter 3 (*Method*), Chapter 4 (*Findings*), and Chapter 5 (*Conclusions*). In Chapter 2, I review the literature about the use of human services by Chinese immigrants, as well as other immigrant groups in the context of the transition to parenthood. In Chapter 3, I describe the methods I used to explore Chinese immigrant expectant/new parents' experiences with human services during the transition to parenthood. Then, in Chapter 4, I report the findings of the study. Finally, in Chapter 5, I discuss my findings in light of previous research, note contributions of the study to research and practice, and comment on study limitations.

CHAPTER 2

LITERATURE REVIEW

The purpose of this literature review is to gauge the scope of research about the use of human services by Chinese immigrant expectant/new parents and to identify gaps in the knowledge about this topic. The search for the literature was conducted systematically and was limited to academic sources as found in four electronic databases: CINAHL, Medline, Academic Search Complete, and Proquest Dissertations and Theses. I blocked my topic of interest into four descriptors, or conceptual pieces, namely, (1) *Chinese,* (2) *migrant*, (3) *human services*, and (4) *transition to parenthood*. Then I generated a list of key words for each of the descriptors: "Chinese" for (1), "migrant" and "immigrant" for (2), "service", "access", "health care", "healthcare", "help-seeking", "health-seeking" for (3), and "childbearing", "pregnancy", "prenatal", "perinatal", "postnatal", "postpartum", "birth", "labour", "delivery", "maternity", "infant", "paediatric"/"pediatric", "parent", and "family"/"families" for (4). I searched for the above terms in the title, abstract, and the subject of a publication.

The first search, which included all four descriptors (represented by their corresponding key words) was not successful in that it did not return any relevant results. In other words, I did not find any literature about (1) Chinese (2) immigrants (3) using services (4) during the transition to parenthood, although most of the searches satisfied three of the four descriptors. I took the failure to locate publications on the topic of interest as indicating that my search terms were too specific, or/and that the topic of interest is not a major focus in published

academic literature and is instead subsumed under a broader topic, such as (1) transition to parenthood among the Chinese, (2) use of human services among the Chinese, or (3) use of human services among immigrants during the transition to parenthood.

Accordingly, I changed my search strategy and performed new searches for each of the aforementioned broader topics. I was able to locate a total of 458 unique references, and I read their abstracts. The majority of these publications approached the topic from a biomedical perspective (e.g., the rates of folic acid intake among Chinese immigrant women) rather than from a social sciences perspective. Such sources were discarded as irrelevant as my study was concerned with human experiences, rather than biomedical data. Another portion of the retrieved publications was excluded from the literature review because the articles did not describe empirical investigations. A considerable number of the sources proved to be irrelevant as they referred to immigrants in China (i.e., former/current nationals of other countries living in China) rather than Chinese immigrants (i.e. current/former nationals of China living elsewhere). Furthermore, a portion of publications was excluded from the literature review for logistical reasons, such as a non-English language and unavailability or inaccessibility of the full text.

As a result, I was left with 27 sources. I then read these publications in-depth to check whether they contain any information (a section, subsection, or even a paragraph) on my topic of interest. This helped me identify two articles *on* the topic of interest, which discuss the experiences of Chinese immigrant women, living in Scotland, with the health care system during pregnancy and birth. The

other 25 articles proved to be *around* the topic of interest, not on it. Six articles addressed various aspects of the childbearing experience among Chinese people (either Chinese people in China or Chinese immigrants), another seven focused on the use of services (typically, health care services) by Chinese immigrants, and the remaining twelve publications were devoted to health care service use among immigrant women from the developing world and living in Western countries. Given such a small number (two) of publications *on* the topic, I decided to include the 25 publications *around* the topic in the literature review.

The remainder of the literature review is organized as follows. In the next subsection, I will review various aspects of the Chinese childbearing experience, including service use, as discussed in the literature. Then, I will present what is known about the use of services by Chinese immigrants beyond the context of childbearing. The following subsection will address patterns and experiences of health care service use among immigrant women around the transition to parenthood. Finally, I will discuss the role of social networks, including family, in the use of services by immigrants during the transition to parenthood.

This literature review is driven entirely by the content of published work on/around the topic, rather than a preconceived schema. Although the study targeted human services, the majority of the sources reviewed here address health care services. Therefore, the reader will find references to health care services rather than human services throughout this literature review.

Childbearing Among Chinese Women

This section addresses various aspects of the Chinese childbearing experience. Key areas that researchers have explored include (1) patterns of and experiences with health care system use among immigrant Chinese women, (2) patterns of and experiences with health care system use among Chinese women in China, (3) personal and social meanings of childbearing, (4) traditional Chinese childbearing practices and their meaning, and (5) postnatal mental health. The subsection *Use of Health Care by Immigrant Chinese Women* relates most closely to the topic of my study. It is based on six studies, all but one of which were qualitative (Brathwaite, & Williams, 2004; Cheung, 1997, 2002a, 2002b; Chu, 2005; Kartchner & Callister, 2003; Pettigrew, 1988) and none of which included men in their samples. Four studies focused on Chinese immigrant women in Canada (Brathwaite, & Williams; Pettigrew) and Australia (Chu; Matthey, Panasetis, & Barnett, 2002), one study focused on new mothers in China (Kartchner & Callister), and one provided a cross-cultural comparative analysis of Chinese immigrant women in Scotland and Scottish women (Cheung). The remaining subsections describe literature around the topic of interest, rather than on it, but serve as an important medium to contextualize the content of the first subsection.

Use of Health Care by Childbearing Immigrant Chinese Women

This subsection draws on Cheung's (2002a, 2002b) qualitative cross-cultural study on women's experiences with health care service use, the meaning

of childbearing, and postnatal health care practices in Scotland. This subsection discusses the findings of the study pertaining to health care service use only.

To date, Cheung's (2002a, 2002b) study is the only piece of academic evidence about the use of human services by Chinese immigrants during the transition to parenthood. Cheung should be credited for the rigour with which she conducted her study. First, the sample included 10 Chinese immigrant and 10 Scottish women who participated in four semi-structured interviews each (twice before childbirth and twice after childbirth). This is a fairly large sample by qualitative research standards which yielded rich data. Furthermore, an additional 45 unstructured interviews were conducted with health care workers, as well as with some of the participants' relatives and friends. Last, but not least, the researcher is a midwife and a Chinese immigrant woman, which gives her study credibility.

It should be noted that Cheung (2002a, 2002b) used a particular conceptual lens in her investigation of the topic. Specifically, she was interested in how choice and control were exercised in women's interactions with the health care system during pregnancy and around the birth. Chinese immigrant women were found to have difficulty exercising choice and control due to their unfamiliarity with the Western health care system. When offered choices regarding their childbirth (e.g., different types of pain relief), they found it difficult to make a decision because they lacked information, and went with the option that was presented to them by health care providers as "standard". Furthermore, the Chinese immigrant women did not mind and even expressed preference for

standard options as "[t]hey felt if it was generally good for Scottish women it was good enough for them and that they could not ask for more of this free medical service" (Cheung, 2000b, p. 208). The Chinese women's preference for a "standard" or "normal" (i.e., medicalized) birth was in stark contrast with the Scottish women's preference for "natural" (i.e., the least invasive) childbirth.

In addition to the exercise of choice and control, Cheung's (2002a, 2002b) study provided some insights about how Chinese immigrant women perceived good quality health care. In particular, they valued the doctors' authority rather than the midwives' experience. However, they could not make sense of the hierarchy of medical professionals during birth: most women could not tell whether their delivery was by a doctor or a midwife, who was who, and whether the doctor was present at all. These women simply assumed that because doctors attend births in China, this was the case in Scotland. The presence of a doctor at birth, underscoring the Chinese women's trust in authority, signified good quality care to these Chinese women. In general, the Chinese immigrant women were less likely than Scottish women to speak negatively of their interactions with the health care system and had more confidence in medical staff.

Despite the methodological strengths of Cheung's (2002a, 2002b) study and the richness of the data, her investigation is limited in that it did not explore Chinese immigrants' experiences beyond pregnancy and the birth in hospital, thus leaving out the postnatal period at home. Furthermore, she focused on women's experiences of the birth and service use, ignoring men's perspective, and did not address human services other than health care.

Use of Health Care by Childbearing Chinese Women in China

Previous research has demonstrated that use of certain types of health care services by migrants in the receiving country is influenced by their exposure to similar services in their country of origin. In particular, in Portes, Kyle, and Eaton's (1992) quantitative study of mental health and help-seeking behavior among Haitian and Cuban refugees, prior exposure to mental health services in the country of origin emerged as the principal factor in seeking such services in the US, after controlling for individual-level variables, such as age, sex, and marital status. In the same vein, Sherraden and Martin (1994) speculated that the choices that immigrants make regarding use of human services in the receiving country are influenced by the make-up of social welfare in their country of origin and their experiences with the system. Given the focus of this study on immigrants from Mainland China, it would be helpful to learn about the types of human services that new parents in China use, and more broadly, about their experiences with and perspectives about such services. However, I was only able to locate one study that touched upon the issue. In particular, Kartchner and Callister's (2003) qualitative study of 10 new mothers in China found that most women attended at least one prenatal class. It is noteworthy, though, that these women indicated that they had received the most valuable information from books and from conversations with relatives and friends who had been through the childbearing experience. Kartchner and Callister also reported that women held positive attitudes toward ultra-sound testing and all used this service at least once. Unfortunately, Kartchner and Callister's study of Chinese new mothers did not address women's experiences

with service use beyond the pregnancy stage. Thus, evidence about service use following the birth and during their transition to parenthood is limited.

Personal and Social Meaning of Childbearing Among Chinese Women

Personal and social meaning of childbearing was addressed by Cheung (2002a) and Kartchner and Callister (2003). Although the study by Cheung focused on Chinese immigrant women and the study by Kartchner and Callister focused on Chinese women in China, the two studies generated some consistent findings. In particular, for Chinese women, the birth of the first child had a special symbolism for the adult union and was intricately tied with the meaning of family. To the Chinese women in Kartchner and Callister's study, the arrival of the first child signified the completeness of the [nuclear] family, which had previously consisted of the wife and the husband.[2] Similarly, the Chinese immigrant women in Cheung's study spoke of the arrival of a child as the "fulfillment of marriage". Cheung argues that the "fulfillment of marriage" referred to by Chinese immigrant women is different from the fulfillment of the adult union, that is, "the normal consummation of a heterosexual love relationship" (p. 281). The fulfillment of the adult union was the meaning ascribed to childbearing by Scottish women. To support this contention, Cheung points to her finding that Scottish women preferred their husbands to attend the birth, which accords well with their conceptualization of childbearing as the couple's project, while Chinese women did not state a preference for the husband. Rather, Chinese immigrant women (would have) preferred their close female relatives (a mother, or a sister) to

[2] On a related note, the women also reported that the relationship with their husbands had improved upon becoming parents.

support them during the labour and birth. In contrast to similar findings by Cheung and Kartchner and Callister, different findings also emerged from the two studies. First, although the Chinese immigrant women in Cheung's study identified the fulfillment of womanhood as a central meaning of childbearing, the Chinese women in Kartchner and Callister's study did not talk about the fulfillment of womanhood.

Importantly, there is some evidence that in Chinese culture, there is a preference for sons over daughters (Chan, Blyth, & Chan, 2006). This issue was addressed by both Cheung (2002a) and Kartchner and Callister (2003). Cheung reported that the Chinese immigrant women spoke of the implications of bearing a son versus a daughter for the woman's status in the extended family on the husband's side. A woman who gave birth to a son rather than a daughter would find herself treated with respect and would receive more help from the in-laws in recognition of her providing an heir to the family. The Chinese women in Kartchner and Callister's study, however, did not bring up the issue of differential treatment on the part of in-laws as a result of bearing a son. Yet, the common finding across the two studies was that the Chinese women in China and in Scotland alike did not state a personal (as different from the societal) preference for a son. The women in Cheung's study "had no problem in accepting their baby daughter" (p. 283). Similarly, the women in Kartchner and Callister's study stated that it was the health of the baby, rather than the gender that mattered to them.

Lastly, Kartchner and Callister (2003) provide some insights into Chinese women's emotional response to the arrival of the first child and family dynamics

associated with the transition to parenthood. In particular, Kartchner and Callister found that new mothers responded to their childbearing experience very positively, expressing excitement, happiness, and joy about learning of their pregnancies, seeing their newborn for the first time, and their new role as a mother. The experience of labour and birth was described as "first bitter, then sweet" (p. 109). Furthermore, giving birth to a child was a consciousness-altering experience for the Chinese women. Having a child emerged as a before and after kind of experience. With the birth of an infant, mothers came to realize the amount of hard work needed to care for and raise a child. They talked about a new appreciation of their own parents' hard work and they developed a sense of a new connection between themselves and their parents on the basis of their appreciation.

Traditional Chinese Childbearing Practices

It appears that traditional Chinese childbearing practices and beliefs represent a relatively well-researched topic. All of the six studies forming the basis of my literature review on childbearing among Chinese women touch upon traditional childbearing practices and beliefs. In three of the six studies, these are the object of inquiry itself (Brathwaite & Williams, 2004; Cheung, 1997, 2002a, 2002b; Pettigrew, 1988). Two other studies were interested in traditional Chinese childbearing practices in relation to postnatal mental health (Chu, 2005; Matthey et al., 2002). In the sixth study, traditional practices emerged from the participants' discourse as an essential part of the Chinese childbearing experience (Kartchner & Callister, 2003).

Collectively, the studies reviewed in this subsection suggest that traditional practices and beliefs permeate the entire childbearing experience, from pregnancy through birth and postpartum. As to pregnancy, some of the behaviors that both Chinese women in China and immigrant Chinese women reported engaging in during this period of time include keeping a special diet, restricting one's mobility, and "educating" the fetus (Cheung, 2002a; Kartchner & Callister, 2003). The practice of fetal education is based on the belief that the fetus is susceptible to both positive and negative influences coming from the mother's environment, which have a potency to affect the child's personality in a positive or negative way (Cheung; Kartchner & Callister). Behaviours believed to positively influence the child's character and temperament include talking to it silently (Cheung), listening to music (Cheung), and trying to stay calm (Cheung; Kartchner & Callister). Fetal education was practiced by all women in Kartchner and Callister's study of new mothers in China and by most women in Cheung's study of immigrant Chinese women in Scotland.

As far as the birth is concerned, Chinese women have a reputation for remaining quiet during this phase of childbearing (Callister, Khalaf, Semenic, Kartchner, & Vehvilainen-Julkunen, 2003). There is some evidence that such stoic behavior is influenced by the belief that loud noises, such as screaming, could harm the baby's spirit (Kartchner & Callister, 2003).

The traditional practice pertaining to postpartum is referred to as "zuo yuezi", or "sitting in for the month" (Cheung, 1997). In compliance with this tradition, a new mother is to stay indoors for a month, adhere to a special diet,

avoid any physical work, avoid exposure to cold and wind, limit her social contact to close family members, and not engage in pleasure-seeking activities. These practices are meant to address the new mother's weakened health condition, which is believed to be caused by yin and yang imbalance. The first month following childbirth is considered to be critical for a woman's health in the future. Failure to adhere to the restrictions of the "month" is believed to result in illness, even if it is to manifest itself many years after the event of the childbirth. "Sitting in" during the first month after the baby's birth seems to be a persistent tradition in Chinese childbearing as it is very common both in contemporary China, and among Chinese immigrants. "Sitting in" was practiced by all women in Kartchner and Callister's (2003) study of new mothers in China, and by all women in Cheung's study of Chinese immigrant women in Scotland.

Given the prescribed restriction in physical activity involved with the "sitting in for the month" ritual, women who engage in the ritual must rely on the support of others, typically mothers or mothers-in-law (Cheung, 1997). The practice of mothers and mothers-in-law moving in with a new mother for the postnatal period is relatively well-documented (Cheung; Kartchner & Callister, 2003; Matthey et al., 2002).

Other studies about Chinese childbearing have pointed out that traditional childbearing practices may not be followed fully (Brathwaite & Williams, 2004; Pettigrew, 1988). In particular, Pettigrew, in her qualitative ethnographic study of traditional Chinese practices, conducted in the Edmonton Chinese community, asked the participants to list the traditional behaviors and whether or not they were

followed. The study showed that the prescribed behaviors were not followed fully, which was evident either in non-adherence to or creative modification of a practice. The analysis showed that patterns of adherence/non-adherence were idiosyncratic. However, a more recent qualitative study with six Chinese Canadian women (Brathwaite, & Williams) connected adherence/non-adherence to traditional practices to women's nativity (i.e., how long she had been in the host country).This connection was established only for traditional practices related to pregnancy, but not to the postpartum period. In particular, more recent immigrants to Canada reported not following any traditional practices during pregnancy, although all groups of participants practiced the "month". Cheung's (1997) qualitative study of 10 Chinese immigrant women in Scotland traced non-adherence to a woman's country of origin: it was the women from the People's Republic of China (PRC, hereafter) who were less likely than the women from Hong Kong or Taiwan to endorse the traditional practices, considering them "superstitious" and "feudal". Nevertheless, even skeptical women from PRC followed the "sitting it for the month" ritual, just like the other two groups of Chinese women.

Postnatal Mental Health of Childbearing Immigrant Chinese Women

In the literature on childbearing among Chinese women, represented in this literature review by six publications, the issue of postnatal depression is the subject matter in two (Chu, 2005; Matthey et al., 2002) and a secondary topic in one (Cheung, 2002a). The fact that almost half of the literature on Chinese childbearing relates to postnatal depression is not surprising given that postnatal

depression is a major concern in childbearing research in general (Matthey et al.). Matthey et al., in their quantitative study, examined the connections between the mood of 124 Chinese immigrant women in Australia at six weeks postpartum and (a) their (non-)adherence to traditional postpartum practices (specifically, to sitting in for a month), and (b) how they felt about (non)adherence to traditional postpartum practices. The findings did not provide evidence of such connections. Women who did not adhere to traditional practices did not score differently on a measure of postnatal depression. Quite unexpectedly, though, on a measure of global distress, the women who practiced the sitting in ritual were more distressed than those who did not. Matthey et al. take this finding to suggest that "the women who adopt cultural practices are those who are more at risk of developing mood disorders" (p. 574). It would be useful to know how prevalent and severe postnatal depression was among the Chinese immigrant women in their sample, but Matthey et al. do not report such findings. Thus, the picture of Chinese immigrant women's mental health after the birth remains unclear as to its incidence and prevalence, cause, onset, and connection to prenatal mental health and global distress.

Another study on postnatal mental health among Chinese immigrant women (Chu, 2005) is a qualitative investigation of the experiences of 30 immigrant women from China, Taiwan, and Hong Kong living in Australia. Chu began the study with the contention that the rest and support afforded by the traditional Chinese ritual of sitting in for the "month" safeguards a woman against postnatal depression. The essence of the "month" is seen by Chu in having a mother or a mother-in-law present in the household doing all the chores for the

new mother. In other words, the ability to practice the "month" necessitates the availability of a mother or mother-in-law to take care of the new mother. Chu asked the women about their migration history, postnatal life circumstances, health concerns, and health beliefs and practices. Chu found that as a group, women from China were more likely to suffer from postnatal depression symptoms (such as tearfulness, sleep disturbances, change of appetite, fatigue, anxiety and the feeling of loss of control) than women from Taiwan and Hong Kong. As well, the findings indicated that the women who experienced postnatal depression lacked "postnatal support", especially Chinese women. Chu was quick to interpret this finding as supporting her contention about the role of the "month" in safeguarding women from postnatal depression. However, Chu did not clarify what she understood by "lack of postnatal support" and did not provide evidence to illustrate what the women themselves meant by "lack of postnatal support". It is unclear whether the women associated the "lack of postnatal support" with the inability to practice the "month", that is to have one's mother or mother-in-law present to help with the chores. Therefore, Chu's claim about the potency/ability of the "month" to safeguard Chinese immigrant women against postnatal depression should be taken with caution

Yet, Chu's (2005) study provides some clues as to factors associated with postnatal depression. The depressed women (who tended to be from PRC) complained about "downward social mobility, unsatisfactory employment, economic insecurity, a lack of a supportive social network, inadequate English language skills, and communication difficulties" (p. 52). Chu interpreted these

findings to indicate that there is an association between the aforementioned factors and postnatal depression. This conclusion fits well with research that has established a connection between depression and both poverty (Bruce, Takeuchi, & Leaf, 1991) and lack of social support (Kessler, McLeod, & Cohen, 1985). However, what is missing from Chu's analysis is any consideration (even speculative) of the processes by which a given factor contributes to postnatal depression. One possibility is that the socio-economic and socio-cultural factors referred to by Chu most likely started playing their part long before the childbirth. In other words, the women who were identified by Chu as suffering from postnatal depression might have been depressed or at risk of depression before the childbirth. It is possible that the nature of the data did not allow Chu to identify the "mechanism" of postnatal depression among Chinese immigrant women. The data were cross-sectional and were collected retrospectively from women who gave birth up to three years before the interview.

A qualitative study by Morrow, Smith, Lai, and Jaswal (2008) contributes a more complex understanding of the issue of postnatal depression among Chinese women. In particular, Morrow et al., from their interviews with 15 Chinese and three Indian women, found that interactions of immigrant women with close relatives had a bearing on their postpartum mental health. The participants tended to speak of their mental state almost exclusively in connection with their relationships with family members. "In general, women indicated that after the birth relatives, husbands, and others focused much of their attention on the baby and on the woman's physical health and not on her emotional well-being" (p. 610).

This left the women feeling neglected and unsupported. Other factors that made women feel sad were a lack of husband's involvement and pressures from in-laws. One Chinese woman spoke of her depression in connection with her husband who did not even notice that she was feeling sad. Another Chinese woman, who had her in-laws move in with her after the birth, spoke of the pressure that the presence of the in-laws, and especially her mother-in-law put on her. This Chinese woman explained that her mother-in-law expected her to be a "good wife" and attend to her son (i.e., the woman's husband) and that she was protective of her son in that she discouraged his participation in house work and infant care.

Chinese Immigrants' Use of Human Services Beyond Childbearing

Among the studies on childbearing experiences of Chinese (immigrant and non-immigrant) women reviewed in the previous section, the use of services by Chinese immigrants during the transition to parenthood, which is the focal point of my study, was addressed in one (Cheung, 2002a, 2002b). However, Cheung focused on the use of health care services, while my interest is in human services, which are not limited to health care, but include social services as well. Under the circumstances, it makes sense to draw on the literature about the use of human services by Chinese immigrants in contexts other than childbearing. I was able to find seven studies that fit this description. Five of these studies investigated the use of health care services by Chinese immigrants in the context of illness (Duval, 1983; Green, Bradby, Chan, & Lee, 2006; Ma, 1999; Wang, 1998; Wang, Rosenberg, & Lo, 2008) and the other two examined the use of social services by Chinese immigrants (the context is not specified) (Liu, 1998; Ma & Chi, 2005). I

decided to include these publications in the literature review as they may provide some clues about the use of health care and social services by Chinese immigrant women during the transition to parenthood. Below is an overview of these two bodies of literature.

Chinese Immigrants' Use of Health Care Services and Heath Care Decision-making

This subsection is based on five studies, three of which used qualitative methods (Duval, 1983; Green et al., 2006; Wang, 1998) and two of which used mixed methods (Ma, 1999; Wang et al., 2008). Two studies were conducted in the U.S. (Duval; Ma), two in Canada (Wang; Wang et al.), and one in Great Britain (Green et al.). The issues addressed in this body of literature include (1) choice between traditional Chinese medicine and Western medicine by Chinese immigrants, (2) utilization of family physicians, and (3) interactions with health care providers.

The most commonly studied aspect of health care use by Chinese immigrants is their choice between traditional Chinese medicine and Western medicine. Four of the five studies reviewed in this subsection addressed this topic. Two studies approached it as their primary object of inquiry (Green et al., 2006; Ma, 1999). In another two, the disposition of traditional Chinese medicine and Western medicine was something that emerged from the data (Duval, 1983; Wang et al., 2008). The studies consistently found that traditional Chinese medicine and Western medicine represent two very different approaches to health and illness and that Chinese immigrants assign different meanings to each. Western medicine

is believed to be the best choice for treating acute illnesses (e.g., heart diseases, cancer) and critical conditions (e.g., fractures) due to its fast action and emphasis on symptoms. Traditional Chinese medicine, in contrast, is deemed by Chinese immigrants to be more effective for minor illnesses and chronic conditions as it targets the root of the disease rather than symptoms (Duval; Ma; Wang et al.).

Another common finding is that Chinese immigrants draw on both traditional Chinese medicine and Western medicine depending on need. In particular, findings from a recent ethnographic study of 42 Chinese immigrant women in England (Green et al., 2006) showed that there was no preference of one system over the other. Rather, Chinese immigrant women pragmatically drew from both systems, often concurrently, guided by the principle 'If one fails, I'll try the other'. Green et al.'s findings coincide with those obtained by Ma (1999) in her mixed-methods study of Chinese immigrant patients and Chinese physicians in Los Angeles and Houston. Ma reported that exclusive utilization of either traditional Chinese medicine or Western medicine was very atypical. Duval (1983) obtained similar findings from her ethnographic study of health care decision-making among Chinese immigrants living in the New York City Chinatown.

Additionally, some researchers have asked questions about pathways in Chinese immigrants' health care behavior. While Green et al. (2006) did not see any consistent trajectories in the use of traditional Chinese medicine and Western health care, Duvall (1983) did identify such a trajectory. In particular, Duvall found that all illnesses were first treated at home with traditional remedies, such as herbs or a special diet. If a traditional treatment proved ineffective, treatment with

a healer practicing traditional Chinese medicine was sought. Western medicine was resorted to if traditional Chinese medicine failed.

Furthermore, other studies have found that Chinese immigrants' pragmatism in health care behavior goes beyond the Western medicine versus traditional Chinese medicine dimension. Common health care strategies used by Chinese immigrants in Western countries include having relatives and friends in China send herbs or medication (Duval, 1983; Green et al., 2006; Ma, 1999; Wang et al., 2008) and/or making trips to China for treatments (Duval; Ma; Green et al.).

Another consistent finding from the studies of health care service use by Chinese immigrants is their preference for ethnically matched family doctors. In particular, Ma (1999) found that "Chinese patients almost always want to call and visit Chinese doctors because of the mutual sympathy, common language, and flexible appointment schedules" (p. 431). A similar finding was obtained by Wang et al. (2008) in their study of Chinese immigrants in Toronto. Among those who had a family physician, almost all (96 %) were ethnically matched. The quantitative part of the study revealed that preference for a doctor of the same ethnic background (especially if he/she could speak the patient's language) was found to be unrelated to socio-economic status, the proximity of physician's location, or demographic factors. The search for an ethnically matched physician occurred in the period of settlement and typically took a long time. The focus groups with these Toronto Chinese immigrants revealed that their preference for Chinese doctors was motivated by difficulties understanding English medical

terminology and the expectation that the Chinese doctor would be familiar with traditional Chinese health beliefs.

Chinese immigrants who did not have a regular physician stated that they wanted to circumvent the lengthy diagnostic process and had chosen instead to self-diagnose and self-treat with medications brought from China. However, even among Chinese immigrants who did have a family physician, self-diagnosis and self-treatment for minor ailments was common (Wang et al., 2008).

The studies that have been reviewed in this section thus far, examined heath care related choices made by Chinese immigrants and patterns of health care service use. Wang (1998), in her qualitative study of Chinese immigrant women conducted in Canada, turned to another subject matter, the nature of immigrants' interactions with service providers in the host country. Her study demonstrated that Chinese immigrant women tended to have problematic interactions with physicians[3], and often family physicians, rather than other types of health professionals. In general, the women's interactions with physicians made them feel frustrated, devalued, and disconnected. Participants shared experiences in which physicians did not take time to listen to the women's concerns or did not show interest in them as human beings. In addition, the women felt that the physicians did not bother to explain their rationale for decisions. These dynamics were accompanied by women's limited English proficiency, which made it difficult for them to express themselves and made them dependant on their partners for assistance with interpreting during appointments. Ironically, experiences of

[3] Wang (1998) provides no information as to physicians' ethnicity.

appointments with husbands as interpreters were not always seen by the women as beneficial and positive. In such situations, the women often felt excluded and non-existent as they watched doctors and the husbands speaking of them in the third person.

Among the studies on health care service use by Chinese immigrants, Duval's (1983) and Wang's (1998) studies are notable in that they located health care behaviors with the family rather than in the individual. Wang's study draws attention to the fact that individuals often come from and/or live in families and to the dynamics associated with the involvement of family members in interactions with the health care system. Duval's ethnography of health care decision-making among Chinese immigrants in New York City Chinatown is unique in that it sees health care behavior as a result of family, rather than individual decision-making. In particular, Duval reports that in Chinese immigrant families, "adult (20 to 60 years) and elderly (60 and above) women are the primary health-care decision makers, ... especially for children" (p. 69). Women decide on the severity of illness and, accordingly, on the course of action.[4]

Collectively, the studies reviewed in this subsection provide credible evidence about the use of health care services and health care decision-making among Chinese immigrants. Among the strengths of this body of literature are the successful incorporation of quantitative and qualitative methodology in one study (Wang et al., 2008), the use of multiple data collection methods such as observation and interviews (Duval, 1983), the triangulation of data from different

[4] Duval (1983) did not provide any information regarding Chinese immigrant decision-making about care for themselves.

types of participants (Ma, 1999), and a sample size that is large in qualitative research standards (Green et al., 2006). It is notable that this body of literature was generated by both Chinese and non-Chinese researchers, which allowed for looking at the subject matter from both emic and etic perspectives, respectively.

However, this body of literature is not without limitations and gaps. While sufficient knowledge exists about the health care strategies used by Chinese immigrants (in particular, regarding the traditional Chinese medicine versus Western medicine dimension), research about interactions between Chinese immigrants and health care providers is scarce and is represented by a single study (Wang, 1998).

I would like to make a special comment about how gender is treated and/or emerges in this body of literature. Two of the five studies include only women in their samples, which is positive as women's voices and experiences are revealed. The rest of the studies use both women and men as informants, but do not pursue an analysis of gender. As a result, it is unclear how Chinese immigrant men and women differ regarding health care behavior and their use and experiences with health care services. The picture that emerges from this body of literature is that women's perspectives are beginning to take shape, while men's perspectives are not visible at all.

Chinese Immigrants' Use of Social Services

My literature search resulted in only two studies on the use of social services by Chinese immigrants. One is a survey study with recent Chinese immigrants in Toronto, Canada (Ma & Chi, 2005), and the other is a qualitative

study of Chinese immigrant seniors in Phoenix, U.S. (Liu, 1998). Some clarification is needed as to the term "social services". While both studies refer to "social services" in their titles and text, the term refers to different types of services in each study. In the Canadian study, social services were understood as services conventionally provided by community-based agencies to new Chinese immigrants in need, while in the U.S. study, social services were conceptualized as national social programs, such as income and housing assistance. Ma and Chi found that one-third of recent Chinese immigrants in Toronto had not used any of the available social services because they were either not aware of them, perceived it was not appropriate to ask for external assistance, or did not perceive they needed such services. Educational attainment was inversely related to social services use. Furthermore, Ma and Chi stated that Chinese immigrants "are often unfamiliar with the differences between social welfare and social services" (p. 156), but, unfortunately do not provide any findings from their analysis to substantiate this claim, which is a serious limitation.

The U.S. study of first-generation immigrant Chinese seniors who came to the U.S. in old age (Liu, 1998) found that patterns of social program use and attitudes about use/non-use among the seniors varied. Some seniors were not aware of the programs for which they were eligible. Others were aware of and were using the services so as to not be a financial burden to their adult children (who were also living in the U.S.). Still others knew of the services, but considered it unethical to apply for them because they had lived most of their lives elsewhere and had not paid taxes in the U.S.

Immigrants' Use of Services During the Transition to Parenthood

In this section, I am turning to the literature on service use by immigrant groups other than Chinese. Evidence on how other immigrant groups use services during the transition to parenthood could provide insights into service use by Chinese immigrants during and after pregnancy. This section is based on 11 studies of service use by immigrants during the transition to parenthood. Of these 11 studies, four were conducted in Canada, another four in Australia, two in the U.S., and one in Sweden. Quantitative methods were used in six studies, and qualitative methods were used in five. All of the studies discussed in this section focused on health care services. The studies differed in terms of the stage of the transition to parenthood that they examined: five focused on pregnancy, three on the postpartum period, two on birth, and one touched upon all three stages. Accordingly, this section is divided into three subsections that correspond to the aforementioned stages, (1) pregnancy, (2) birth and postpartum in hospital, and (3) postpartum at home.

Immigrants' Use of Services During Pregnancy

Use of health care services by immigrants during pregnancy is a subject matter in six of the 27 studies selected for this literature review. These are a U.S. qualitative study of 41 Mexican immigrant women in Chicago (Sherraden & Barrera, 1996), a U.S. mixed methods study of 97 Mexican immigrant women in North Carolina (Bender, Harbour, Thorp, & Morris, 2001), a Canadian qualitative study of five Muslim immigrant women in Newfoundland (Reitmanova & Gustafson, 2008), an Australian qualitative study of 15 Muslim immigrant women

(Tsianakas & Liamputtong, 2002), a Swedish qualitative study of 13 Muslim immigrant women (Ny, Plantin, Karlsson, & Dykes, 2007), and an Australian quantitative cross-cultural study of 1616 women (Brown & Bruinsma, 2006). The aspects of service use covered in one or more of these six studies are patterns of service use, perception of the quality of care, experiences of interactions with health care providers, and health care decision-making. Below I discuss each of the aspects of service use in turn.

Patterns of service use. Patterns of health care service use were addressed systematically only in Sherraden and Barrera's (1996) study. More specifically, Sherraden and Barrera examined attendance of prenatal check-ups by Mexican immigrant women in Chicago. They found that the care of these women was fragmented and discontinuous. Many participants changed clinics more than once and missed appointments. When a woman stayed with one clinic, she was attended to by different professionals each time. Long waiting times and apprehension about communication difficulties with health care providers due to women's lack of English speaking ability were reported by the participants as barriers to prenatal care.

Sherraden and Barrera (1996) were also interested in women's perspectives on prenatal care. Interviews with these Mexican immigrant women revealed that they did not view medical appointments/check-ups as the centerpiece of their prenatal care, although most of them believed that "prenatal care was important to make sure that the baby was healthy or when there were complications" (p. 344).

Sherraden and Barrera do not report what the Mexican immigrant women viewed as the centerpiece of their prenatal care.

Perception of the quality of care. Immigrant women's satisfaction with prenatal care was examined in five studies (Bender et al, 2001; Ny et al., 2007; Reitmanova & Gustafson, 2008; Sherraden & Barrera, 1996). The results of several of these studies are consistent regarding what immigrant women appreciate in a health care service provider. In particular, Bender et al., Ny et al., Reitmanova and Gustafson, and Sherraden and Barrera all found that pregnant women in their studies appreciated the willingness of doctors and nurses to listen to their emotional concerns. Two studies provided additional insights that were not shared between all studies. In particular, a study of Middle Eastern immigrant women living in Sweden (Ny et al.) found that staff's caring attitudes and their willingness to listen were deemed by the women as far more important than awareness of and sensitivity to cultural and religious beliefs and practices. Reitmanova and Gustafson's study of six Muslim immigrant women in Newfoundland, Canada showed that in addition to emotional support, women also wanted informational support from their doctors. By informational support, the Muslim immigrant women meant the provision of information and the promotion of beneficial information (e.g. prenatal class and its benefits) by the doctor without being prompted by women's questions.

Experiences of interactions with health care providers. With regard to immigrant women's actual experiences with prenatal care providers, the aforementioned studies generated inconsistent results. In particular, the Mexican

immigrant women in Sherraden and Barrera's (1996) study described their overall experience with prenatal services in positive terms, despite various adverse circumstances, in particular, not being attended to by the same provider over time and language/communication barriers with their health care providers. Regarding language barriers, the women stated that because of the language barrier, doctors did not explain things to them and did not reassure them. However, this was not seen as doctors' fault and did not seem to matter in view of the women's perception that health providers were motivated to help them and their babies. Sherraden and Barrera attribute the reluctance of these Mexican immigrant women to be critical of the services to their appreciation of the difference between Mexico and the U.S. health care systems. In contrast to Mexican immigrant women in Sherraden and Barrera's study, the Muslim immigrant women in Reitmanova and Gustafson's (2008) study were openly critical of their prenatal care providers. They complained that neither emotional nor informational support was given to them as the doctors seemed very busy.

Brown and Bruinsma's (2006) approach to the issue of immigrant women's satisfaction with prenatal care is different from that used in other studies on the topic in that Brown and Bruinsma used quantitative methods and a cross-cultural perspective to examine immigrant women's experiences with prenatal care in comparison to Australian-born women. Brown and Bruinsma found that women born in non-English speaking countries were more likely to be dissatisfied with prenatal care services, regardless of the model of care (namely, public hospital clinic, birth centre, a combination of private care and public care, practitioners

plus hospital, midwives clinic, and shared care) in comparison to Australian-born women. However, it is premature to interpret these findings to mean that immigrant women were dissatisfied with prenatal care. The researchers only state that immigrant women were more likely to be dissatisfied with prenatal care in comparison with Australian-born women, but they do not say whether/that immigrant women as a group were dissatisfied rather than satisfied with prenatal care. As a result, it is difficult to compare their findings to those obtained in the studies by Sherraden and Barrera (1996) and Reitmanova and Gustafson (2008).

Health care decision-making. Immigrant women's decision-making regarding prenatal care was addressed in Tsianakas and Liamputtong's (2002) qualitative study of Muslim immigrant women's decision-making in the context of prenatal testing. They found that doctors were the primary influence. The participants shared that prenatal testing (aimed at screening for abnormalities) was presented to them by physicians as a must, rather than a choice. Despite their doubts and, in some cases, unwillingness to undergo certain procedures, these women did not oppose the doctors and did not voice their concerns. They had complete trust in the medical authorities and perceived that they were acting in the women's best interest. Furthermore, these women seemed to endorse the "what is must be best" philosophy. In other words, they believed that the standard "menu" of services is the best, and accordingly, strived to comply with what was "normal". The authors speculate that being submissive to doctors was a strategy by which the Middle Eastern women shared responsibility with doctors for potential negative

outcomes (e.g., a birth defect), although the women themselves never articulated this.

Immigrants' Use of Services During Birth and While at Hospital

Use of health care services among immigrants during birth and while in hospital was addressed in three of the 27 studies included in this literature review: an Australian quantitative study of 318 Vietnamese, Turkish, and Filipino women (Small, Yelland, Lumley, Brown, & Liamputtong, 2002), an Australian mixed methods study of 104 Vietnamese, Turkish, and Filipino women (Small, Rice, Yelland, & Lumley, 1999), and a Canadian qualitative study of six Muslim immigrant women (Reitmanova & Gustafson, 2008). These studies focus on women's perspective of the quality of hospital care around birth and their perceptions of interactions with hospital staff.

Women's perspectives on their interactions with hospital staff were among the main foci in Reitmanova and Gustafson's (2008) qualitative study of six Muslim immigrant women living in Newfoundland. The researchers found that the women perceived the care received at hospital as culturally insensitive due to such issues as the presence of males in wards, diet, and the absence of a quiet room for prayer. In general, participants reported that health care providers expressed their frustration or anger when women asked that their religious or cultural needs be acknowledged and respected.

Similar to the negative experiences described by the Muslim immigrant women in Reitmanova and Gustafson's (2008) study, Small et al. (2002) found that immigrant women who gave birth in Australia were less satisfied with

intrapartum care at hospital than the general population, overall, and in such specific aspects as friendliness of staff and having a say in decision-making (despite wanting it). In contrast to the findings obtained by Reitmanova and Gustafson, Small et al. found that when immigrant women were unhappy about their care at birth, it was not so much about cultural insensitivity on the part of staff and the language barrier as it was about staff being perceived as unkind and unfriendly. However, in their earlier study based on the same data set as their 2002 study, Small et al. (1999) found that the language barrier did play a role in immigrant women's experience. The study demonstrated that women who did not speak English very well were less likely to describe their prenatal care as very good, were less likely to be very happy with their care during labor and birth, and were less likely to be very satisfied with their postnatal hospital care.[5] More specifically, Small et al. found that women with better English skills were more likely to characterize the midwives as very helpful during labor and birth in comparison to women with poorer English skills. No such association was established for doctors. Furthermore, women who spoke English less well were also more likely to say that they did not always have an active say in decision-making regarding their care during labor and birth. Also, women unable to observe their cultural/religious practices fully as they wished were less likely to be very satisfied with their postnatal care than women who were able to do so fully. Surprisingly, for women with poor English skills, the availability of somebody to assist with interpreting did not make a difference in their satisfaction with hospital

[5] Finding (3) was not statistically significant.

care. Small et al. interpreted this finding as evidence pointing to the importance of speaking for oneself.

Immigrants' Use of Services During the Postpartum Period at Home

This subsection is based on the review of four Canadian studies, including a study of the medical records of 22 immigrant women in Vancouver (Katz & Gagnon, 2002), a study of six Muslim immigrant women in Newfoundland (Reitmanova & Gustafson, 2008), a cross-cultural study of 108 Canadian-born and immigrant women in Quebec (Loiselle, Semenic, Cote, Lapointe, & Gendron, 2001), and a cross-cultural study of 1,250 Canadian-born and immigrant women in Ontario (Sword, Watt, & Krueger, 2006). These studies addressed immigrant women's needs after the discharge from hospital and whether those needs were met by health care services. Three of these studies are quantitative and one (Reitmanova & Gustafson) is qualitative.

The evidence that these studies provide regarding the adequacy of postpartum care received by immigrant women is inconsistent. Katz and Gagnon's (2002) quantitative study of 22 immigrant women's medical records and Reitmanova and Gustafson's (2008) qualitative study of six Muslim immigrant women suggest that immigrant women might be receiving sub-optimal postnatal care. In contrast, Loiselle et al.'s (2001) study suggests that the postpartum care of immigrant women is not a concern. Sword et al.'s (2006) study provides a more nuanced picture, with findings indicating that some aspects of postnatal care were a concern, while others were not.

Katz and Gagnon (2002) approached the issue from a providers' perspective. They examined nurses' reports of immigrant women's problems, and the extent to which such problems were resolved while in hospital. In addition, they examined the medical records of these women to see if the problems/concerns were addressed in the community. The sample included 22 immigrant women who were identified as having concerns requiring a longer than usual stay in hospital. Katz and Gagnon found that immigrant women were identified by nurses as having breastfeeding difficulties, maternal psychosocial and physiological issues, and infant physiological issues. As a general rule, these concerns were not recorded as resolved either in hospital or in community records. Based on these findings, Katz and Gagnon conclude that immigrant women in Canada might be receiving sub-optimal care while staying in hospital after giving birth and during the postpartum stay at home. Reitmanova and Gustafson (2008) obtained similar findings using the client, rather than the provider perspective. However, their findings refer specifically to nurses, rather than to health care services in general. The Muslim immigrant women in their study were dissatisfied with the support that they received from nurses during the postpartum period at home. These women complained that nurses had not given them information about community resources, and that when nurses called them or visited them at home, they seemed to be concerned about the baby only and not the mother.

The results obtained by Loiselle et al. (2001) led to conclusions that were different from those made by Katz and Gagnon (2002) and by Reitmanova and Gustafson (2008). Loiselle et al. surveyed 108 immigrant and Canadian-born

women living in Montreal regarding their perceptions of breastfeeding support. Their findings indicate that immigrants were more likely to be visited by a nurse at home and be shown how to breastfeed, whereas Canadian-born mothers were more likely to be referred to support groups and specialists. There were no differences between the two groups regarding satisfaction with breastfeeding support from nurses: both immigrant and Canadian-born new mothers were satisfied. Similar results were obtained by Sword et al. (2006) in their study of 1,250 Canadian-born and immigrant women who were surveyed at four weeks following hospital discharge. The researchers found that, overall, immigrant women were as likely to use health care services as their Canadian-born counterparts. Furthermore, immigrant women were more likely to use obstetrician's services and be visited by a public health nurse at home. Also, there were no differences between immigrant and Canadian-born mothers in their perceptions as to whether their physical health problems/needs were met by health care services. However, Sword et al.'s findings regarding mental health concerns resonate with those by Katz and Gagnon and especially those by Reitmanova and Gustafson. In particular, approximately 44 % of immigrant women and 16 % of Canadian-born women stated that they were unable to get care for such concerns. "Unable to get care"/"able to get care" was the exact wording of responses in the survey. By "ability to get care", the researchers understood having one's concern resolved by a health care provider. Although the difference of 18 percentage points was not statistically significant in the study, the fact that almost half of the immigrant women did not have their concerns addressed is notable. It is also important to note that women in both

groups had more difficulty getting help for their emotional/mental health problems compared to physical health problems.

In sum, the findings about the adequacy of post-discharge health care services received by immigrant women are inconsistent. In general, quantitative research findings paint a more positive picture than the qualitative findings and findings regarding providers' perspectives.

The Role of Family/Social Networks in Immigrants' Use of Services During the Transition to Parenthood

This section discusses evidence on how immigrants' family and social networks are involved in immigrants' experience of using health care services during the transition to parenthood. The evidence is from four qualitative studies of Muslim immigrant women in Canada (Reitmanova & Gustafson, 2008), Middle Eastern immigrant women (Ny et al., 2007) and men (Ny, Plantin, Karlsson, & Dykes, 2008) in Sweden, and Mexican immigrant women in the U.S. (Sherraden & Barrera, 1996). These studies shed some light on the involvement of husbands (Ny et al., 2007; Ny et al., 2008; Reitmanova & Gustafson), mothers (Ny et al., 2007; Sherraden & Barrera), and friends/neighbours (Reitmanova & Gustafson) in the use of health care services by immigrants around the transition to parenthood. It should be noted that family and social network involvement was not the primary focus in these studies, but something discussed in passing. As a result, the evidence on the subject matter is a collection of isolated facts, rather than an integrated account.

The studies that addressed the involvement of husbands found that husbands accompanied their wives to prenatal appointments (Ny et al., 2007; Ny et al., 2008) and to the birth (Ny et al., 2007; Ny et al., 2008; Reitmanova & Gustafson, 2008). However, the findings from these studies were inconsistent regarding the nature of husbands' involvement and women's satisfaction with their husbands' involvement. In particular, the responses of the Middle Eastern women (Ny et al., 2007) contradicted the responses of the Middle-Eastern men (Ny et al., 2008). The women stated that men did not communicate with health care providers directly, and that they did not want their husbands to assist them with interpreting as it was very important for them to communicate with the nurses directly. However, the men stated that they accompanied their wives to prenatal appointments and interpreted for them as the wives were not proficient in Swedish, the health care providers' language.

Furthermore, there were inconsistencies in the findings from the studies of women's satisfaction with their husband's involvement. The women in Reitmanova and Gustafson's (2008) study were happy about having their husbands involved as this eased their anxiety. However, the responses of the women in Ny et al.'s (2007) study suggest that they were not satisfied with the support from their husbands in the context of interactions with the health care system. In particular, the women shared that they would have preferred their mothers to accompany them to prenatal appointments and the birth rather than their husbands, but they did not explain why. Furthermore, the dissatisfaction of these Middle Eastern women with their husbands concerned not only the support related to service use,

but also practical support. The women would have liked their husbands to give them more help with household chores and caring for older children during the perinatal period (Ny et al., 2007).

The involvement of expectant parents' mothers in health care service use by immigrants was touched upon in two studies. Both studies addressed the involvement of one's mother in decision-making, but yielded inconsistent results. Mexican immigrant women in Sherraden and Barrera's (1996) study relied on their mothers living in Mexico for guidance and information during their pregnancies. At the same time, they had a high degree of trust in medical authorities and were very motivated to comply with doctors' instructions. Conflicting information coming from women's mothers and their doctors put these women under stress. In contrast to the Mexican women in Sherraden and Barrera's study, the Middle Eastern women in the study by Ny et al. (2007) reported that they followed the doctor's advice rather than that of their mothers.

Evidence about the involvement of immigrants' social network in health care service use is limited as it comes from one study only, which was conducted with six Muslim women in Canada (Reitmanova & Gustafson, 2008). The women reported that during pregnancy, they had not received the needed information related to childbearing from doctors. Consequently, some women sought information from friends and neighbours instead. However, acquiring information was a problem for some women who did not have well-developed social networks.

Summary of the Literature Review

This literature review makes clear that research on the use of human services by Chinese immigrants is scant. It is represented by a sole study of Chinese immigrant women's pregnancy and hospital birth experiences in the UK (Cheung, 2002a, 2002b). Experiences of Chinese immigrants with human services in Canada have not been studied, which justifies the purpose of the present study.

Also, my literature review has demonstrated that research *around* the topic is sizable, as a collective body, but by no means extensive. Furthermore, evidence on the use of human services by Chinese and other immigrant groups in the context of childbearing has multiple gaps. First, the use of human services other than health care, in particular, social services, has not been addressed. Even beyond the context of childbearing, there is a dearth of evidence on the use of social services by Chinese immigrants. Second, for the most part, research on childbearing among Chinese immigrants and other immigrant groups has not addressed experiences beyond the first month after the birth of an infant. Third, the perspectives of women dominate the research on immigrants' (including Chinese immigrants') transition to parenthood. Chinese immigrant men's experiences of the transition to parenthood have not been documented at all. Fourth, evidence about the role of family and social networks in immigrant women's use of human services during the transition to parenthood is a collection of isolated findings. Fifth, no study discussed in this literature review was conducted with couples as opposed to men and women who are not related to each other. This study is intended to start addressing the aforementioned gaps by examining the experiences

with human services of six Chinese immigrant couples during their transition to parenthood.

CHAPTER 3

METHOD

This chapter is organized as follows. First, I position my study as a case of re-analysis of qualitative data. Then, I talk about the nature of the data used in my study, how they were generated, and my role in the generation of the data. In the subsections to follow, I discuss how I analyzed the data, how I ensured rigour in my research, and finally, what measures I have taken to comply with ethics standards.

My Study as a Re-Analysis of Qualitative Data

As I mentioned in the introductory chapter, my study is based on a larger qualitative study, *Mobilizing Intergenerational Support during the Transition to Parenthood* (*MIS* study) (Kushner et al., 2006-2011).[6] The primary focus of the *MIS* study was first-time parents' and grandparents' experiences of intergenerational social support during the transition to parenthood. However, the MIS study participants were also asked to talk about their experiences of support from other sources, including informal supports, such as friends, and formal supports, such as health care and social services, workplace programs and policies, and more broadly, government programs and policies (e.g., Employment Insurance). It is this secondary or satellite focus of the *MIS* study that I explored in my study, using the data from a sub-sample of its participants. The sample of the *MIS* study, which included 21 families, was socioeconomically diverse, with some ethno-cultural variability. Fourteen families were Canadian and the other

[6] For a summary of the *MIS* study, see Appendix A.

seven were immigrant, including one Filipino family and six Chinese families. In all but one case, families included two generations, new parents and their parents (as grandparents). In my study, I analyzed the data generated from the sub-sample of six Chinese immigrant couples.[7]

Data Generation

The Chinese participants' data in the *MIS* study were generated through three[8] face-to-face, and, in some cases, telephone interviews, that were from 6 to 12 months apart. The first, second, and third interviews were conducted during the third trimester of pregnancy, a few months after the baby's birth, and when the baby was between 12 and 18 months old, respectively, at a time and place convenient for participants, typically in their homes.[9] For the sake of brevity, I will refer to participants' experiences during the third trimester of pregnancy, a few months after the baby's birth, and when the baby was around 12 months old, as Time 1, Time 2 and Time 3, respectively. The interviews focused on participants' experiences of social support that they received as expectant/new parents. All interviews were audio recorded, transcribed verbatim, and stored as Microsoft Word documents.

As part of the interview process, a demographic profile, genogram, and ecomap were completed. The demographic profile was a standardized form to document information about participants' age, marital status, household members, occupation, employment status, income, and the pregnancy due date. The

[7] My study did not include grandparents.
[8] Five families completed three rounds of interviews, and one completed the first two.
[9] The participants were offered $20 gift card as a token of appreciation for participation in each interview.

genogram, which is "a graphic portrayal of the composition and structure of one's [extended] family" (Rempel, Neufeld, & Kushner, 2007, p. 403), included annotations about family members' names, ages, relationship statuses, and notable family events (e.g. births, deaths, marriages, divorces, and re-locations). The ecomap, defined as "a graphic portrayal of personal and family social relationships" (Rempel et al., p. 403), was used as an additional tool to collect information about an individual participant's support system. The demographic profile and the ecomap were individuals' documents which were kept confidential from other family members while the genogram was a shared document constructed with contribution from each participating family member. In my study, I analyzed interview transcripts as my primary data. Demographic profiles, genograms, and ecomaps were used as reference material to assist in the interpretation of the interview data.

Data Analysis

This subsection is organized as follows. I start with a comment on how I approached the analysis in general. Then I describe my method of analysis, particularly, how I turned the research questions into analytic categories. I would like to note that what the reader will find in *Method of analysis* subsection is a "sanitized" version of the analyses, that is, the final and most successful analytic strategies. This is followed by the subsection *Personal perspective on the experience of data analysis*, where I provide a more complete, "unsanitized" version of how the analysis evolved, as well as my personal perspective on the experience of conducting a qualitative data analysis.

General Approaches to Analysis

As mentioned earlier, in the *MIS* study, each Chinese immigrant participant was interviewed at three different times, during the first trimester of pregnancy, within six months post-birth, and when the infant was around 12 months old. I analyzed the data from the three data points separately. However, my ultimate goal was to identify patterns in the data that cut across all times. In other words, my approach was to break down the data and then consolidate the individual pieces back into a whole. Another methodological decision that needed to be made was about handling couple data. In the *Findings* chapter (Chapter 4), the reader will notice that I refer to individual participants (e.g., mother or father) sometimes, and to couples at other times. This reflects the nature of the *MIS* data, specifically, how participants talked about their experiences. In short, there were two ways in which a participant talked about his/her experiences: (1) as an individual experience, and (2) as a couple experience. An example of the latter is either member of the couple relating a story about how they took their infant to the Emergency. Also, in this study, I did not systematically analyze couple data in the sense that I did not compare spouses with one another. Rather, I used couple data to reconstruct "the facts". It was not uncommon that I could retrieve "missing data" about an experience described by a participant in the account of the experience described by his/her spouse. Finally, in accordance with the social sciences research convention, I analyzed (and will report) men's and women's data separately.

Method of Analysis

I analyzed the data using the method that Mayan (2009) refers to as latent content analysis, "the process of identifying, coding, and categorizing the primary patterns in the [qualitative] data" (p. 94). To assist me in this process, I used a qualitative data analysis software, NVivo 8 (QSR International Pty Ltd, 2008), designed as a tool to record and manipulate codes. NVivo is classified as a code-and-retrieve type of program (Neuman, 2000), which allows a researcher to attach codes to lines, sentences, paragraphs, or blocks of text" (p. 439). This software package is "a good choice for [analyzing] interviews and other text-based research" (Lewis, 2004, p. 461). NVivo is "a powerful yet easy-to-use entry-level qualitative analysis tool" (Durian, 2002, p. 738). Below, I describe how I proceeded from research questions to categories.

Research question # 1: "What human services did participants use during their transition to parenthood and how often were these used?". I started this analysis with two broad predetermined categories, "health care services" and "social services". I turned these categories into codes, which, in the language of the NVivo software, would be referred to as parent nodes. In the texts of the interviews, I assigned these codes to passages pertaining to health care services and social services, respectively. The broader categories (or parent nodes) of health care and social services were further broken down to specific sub-categories (or children nodes) that captured specific types of services (for instance, "a program for parents with infants"). On the completion of the coding, I had a list of specific health care and social services that participants referred to in their

interviews. I then used NVivo report and statistical tools to locate and count episodes of service use by participants. This involved three steps. I started with identifying and counting the participants who talked about using services. Then I worked within each participant's "report" or case to locate references to service use and count such references. I should note that it was not uncommon that a participant would refer to the same episode of using a certain service multiple times at different points during the interview. This required that I re-analyze a participant's references to service use as episodes of service use.

Research question # 2: "For what reasons did participants seek human services?". This line of analysis began with making two parent nodes, "seeking or receiving help from services", and "type of issue/need". As to the former node, it was important for me to discriminate between instances of participants' seeking help from services, on the one hand, and instances of them receiving help from services, for which purpose I created two corresponding children nodes, "seeking help from services" and "receiving help from services". The code "seeking help from services" was assigned to instances where the reason for service use belonged with participants themselves, that is, contact was initiated by the participant (the recipient of a service), and not by a service provider. The code "receiving help from services" was used to capture instances where help was provided by a service provider to a participant without asking. An example of the former code is a couple making a phone call to a public health telephone service to address their concern about the infant's symptoms, which they saw as abnormal. An example of the latter code is advice received by a mother from a public health

nurse (PHN) about how to rectify the infant's flat head condition, when this advice was not solicited by the mother. Although my interest was limited to instances of seeking help as opposed to instances of receiving help, I coded both scenarios.

In contrast to the category of seeking or receiving help from services, which was a "top-down" category (in the sense that it was determined by me), the category "type of issue/need" was more data-driven. Its specific cases, or the children nodes, were determined by what participants themselves talked about. The result of coding the data with regard to type of issue/need was a list of reasons for which participants sought help from services. Also, as I was coding instances of participants' seeking services for the node "type of issue/need", another salient distinction emerged from the data: it concerned whose issue/need it was. I turned this distinction into the code "owner of issue/need", the sub-codes of which were "infant" and "mother". This code allowed me to obtain a more nuanced picture of reasons for seeking services. The next step in the analysis as per research question # 2 was using NVivo query tools to relate types of issues/needs to types of services, that is, whether certain types of issues were addressed to certain types of services.

Research question # 3: "What was the quality of participants' experiences with human services?". The starting point for this analysis was the fact that participants often assessed the services and/or service providers with whom they had experiences in terms of their helpfulness or supportiveness. In fact, interviewers, in accordance with the *MIS* interview guide, routinely asked

participants questions about help or support from services.[10] An example of such questions is "Did you use any health care services, and if you did, were they supportive?" There were various ways in which questions about help/support were framed by interviewers and understood by participants. Examples of how "helpfulness" was understood include (a) the extent to which a provider resolved the issue that the participant addressed to him/her, and (b) the extent to which the provider was pleasant to interact with. Furthermore, participants often discussed these matters spontaneously, not necessarily in response to the interviewer's questions about help or support, and participants sometimes did not label their experiences with words "help", "support', and the like. Such discussions formed the backbone of my analysis of the quality of participants' experiences with services, and were turned into corresponding categories (or parent nodes). Another two broad categories associated with the quality of experience were the ease of access to services and the ease of communication with service providers. I should note that I did not think of these two categories as belonging with the quality of experience until later stages of the analysis. For instance, the "ease of communication" node was assembled using the "material" of my earlier (free) nodes, "language".

To summarize, the essence of my coding approach beyond the specifics of the particular research questions posed in my thesis, involved several steps: (1) breaking down the data into categories and assigning codes to passages of

[10] See Appendix B for the *MIS* (Time 1) interview guide. The *MIS* interview guides for Time 2 and Time 3 were essentially the same as the Time 1 interview guide, but had slight modifications to the wording of questions to refer to different periods of time.

interview transcripts, (2) assessing the prevalence of a phenomenon captured by a code,[11] (3) exploring relationships between phenomena captured by different codes, and (4) creating higher order categories and re-thinking the data through categories.

Personal Perspective on the Experience of Data Analysis

The above discussion of data analysis is a "sanitized" version of the story. The details omitted are certain conceptual and methodological challenges that I experienced in the course of conducting this study, which I describe in this section.

One of the major challenges was that some of the research questions I posed initially did not lead me anywhere. One such question could not be answered on the basis of the data. It read: "How does the use of human services by Chinese immigrants influence their adjustment to parenthood?" Much as I tried to explore this question, there was not enough data on this: participants did not talk about how services helped them with their adjustment to parenthood. Another research question among those posed initially that did not lead me anywhere was "How does the environment impact the access to and use of human services by Chinese immigrant parents?". This question was inspired by human ecology theory, particularly by its fundamental premise about the mutual influence between people and their environments (Bronfenbrenner, 1979; Bubolz & Sontag, 1993). The problem with this question was that it was very broad as the concept of the "environment" itself is very broad. The "environment" can be thought of as the

[11] The prevalence of a phenomenon captured by a code was assessed in three ways: (1) counting the number of participants who referred to that phenomenon; (2) counting the number of references to the phenomenon made by each participant; and (3) counting episodes of the phenomenon where applicable.

social and societal milieu of the individual (Bronfenbrenner) and/or material/physical contexts of the individual's life (Bubolz & Sontag). My working definition of the concept was the amalgam of the above, and included the people with whom the participant interacts, the material conditions s/he lives in, the culture s/he lives in and was socialized into, etc.

When I set out to develop a coding framework intended to help me answer the research question about the role of the "environment", I was overwhelmed by the amount of information that needed to be captured as almost everything can be thought of as "environment". However, at that time, I thought that it was normal to be overwhelmed by the amount of coding, and I started coding diligently. As to my initial conceptualization of the people with whom the participant interacts (such as service providers, spouses, parents, friends, co-workers, etc.) as an "environment" in which the participant exists, I thought that I needed to capture the nature of these relationships. I presumed that a good way to capture this is by noting the types of energy/matter exchanged between the participant and his/her "environment" as the exchange of energy/matter is one of the key notions in human ecology theory. Examples of the type of energy included "information", "emotions", and "material things". I did not want to miss anything and implemented a very detailed coding framework regarding the types of energy/matter exchanged, and from whom the energy/matter was received or to whom it was given. Coding with the aforementioned framework required a large amount of time. When I was finished coding, I asked myself the following question: "Given the coding that I have implemented, the result of my inquiry will

be the types of energy/matter exchanged between the participants and their 'environment'. Now, how can this be useful for practitioners working with (Chinese) immigrants transitioning to parenthood in Canada?" This question was, in part, prompted by discussions with my supervisor who was wondering at that time if I had identified any broader patterns beyond the details about the types of energy/matter exchanged. Asking the above question was a turning point in my analysis as I realized that this line of inquiry was leading me to something very abstract. This is when I decided to abandon one of my original research questions about the role of the "environment". This decision was also supported by the fact that inquiry into the "environment" as material conditions and culture, was not fruitful. I found that the participants did not talk much about the influence of the material conditions and culture on their experiences in general, and with human services in particular.

One of my other original research questions read as "In what situations do Chinese immigrant parents seek human services?", which was a prototype of research question # 2, as stated in this thesis, about the reasons for seeking services. In my early coding framework with regards to this question, I implemented a distinction between "problems", "information needs", and "concerns" as meta-types of issues experienced by participants. I eventually abandoned this category altogether as the data showed that "problems", "information needs", and "concerns" were artificial distinctions which in reality were intertwined for the participants. When I started exploring the question of situations, or reasons for seeking services, I also became interested in how the

events developed beyond the point/fact of seeking help, in particular, whether an issue was resolved or not, and whether it resolved on its own if help was not received.

For ideas on promising lines of inquiry, I turned to the abstract that I, along with two of my committee members, had submitted for the 2011 Canadian Public Health Association conference. In this abstract, I reported my preliminary findings as the abstract was submitted rather early in my data analysis. One of the findings that I reported in the abstract was about participants' satisfaction with services, which I worded in terms of "appreciation". This led me to pose the following research question: 'What did participants appreciate and what did they complain about with regard to human services?" This research question was neither stated in the study proposal, nor did it "survive" into this thesis. This analysis resulted in more than a dozen "appreciation" codes and "complaint" codes. My next step was another cycle of very minute analysis to explore which of the codes were (more) frequently associated with which services. At that time, I believed that this line of inquiry was very important, but eventually abandoned it. The rationale for this decision was that there was not much variation among different types of services providers (e.g., doctors and nurses) and specific services with regard to the quality of the participants' experiences with them. Furthermore, a closer examination of the patterns on appreciation and complaints by my supervisor revealed that many of these are variations of broader patterns. Also, I realized, with the help of my supervisor, that the term "appreciation" might not be an accurate representation of the data. I used the term loosely to refer to all things good and/or whenever

participants said or acknowledged that services helped them. When I checked my coding, I found that in many cases, I had used this code to refer to situations in which the participants stated that the issue was resolved, but resolution of the issue is not necessarily the same as appreciation, as my supervisor pointed out to me. I later re-conceptualized many of the earlier "appreciation" and "complaint" codes and their contents as belonging with the category of "quality of experience". The category of extent to which an issue was resolved was also re-thought as belonging with "quality of experience". Finally, research question # 1 as stated in this thesis was not raised and systematically explored until the final stages of my work, when I had to prepare the presentation for the 2011 Canadian Public Health Association conference.

Thus, my data analysis was not a straightforward process, despite my initial, extensive efforts to follow the apparently straightforward path dictated by my proposed research questions. I experimented with several analytical approaches and techniques, some of which were instrumental in answering my research questions, while others were not but subsequently were helpful to analyses that answered the research questions, and yet others were dead ends that needed to be abandoned. The research questions were not explored and answered in the order in which they are presented in this thesis. In fact, most of the questions are different from those that were originally proposed when I planned the study. Metaphorically speaking, the data analysis was a journey where I was travelling through a somewhat familiar terrain. I had a general sense of my destination, but did not know exactly how to get there. I took different routes, sometimes getting

lost, becoming distracted by interesting things on my way, and/or returning to the place from where I started. Finally, this journey ended, but not exactly at the place where I was heading initially (keeping with the metaphor, I did not arrive at the address intended, but arrived in the same vicinity or neighbourhood), which I can now appreciate is not uncommon in qualitative research (Rossman & Rallis, 2011).

Rigour

In this section, I discuss issues specific to the re-analysis of qualitative data and the measures I took to ensure rigour in my study. I start with the discussion of methodological challenges associated with re-analysis of qualitative data as, in the process of doing my study, I had to deal with such challenges first.

Issues of Rigour in Qualitative Data Re-analysis

There is an agreement among researchers that re-analysis of qualitative data involves unique challenges. The two major methodological challenges identified in the literature on qualitative data re-analysis relate to (1) the lack of contextual knowledge, and (2) the fit between the original data and the research questions as posed in the re-analysis study (Gladstone et al., 2007; Heaton, 2008; Hinds et al., 1997; Mauthner, Parry & Backett-Milburn, 1998; Szabo & Strang, 1997; Thome, 1998; Van den Berg, 2005). Below, I discuss how I dealt with these challenges in my study.

Lack of contextual knowledge. The literature on re-analysis of qualitative data cites “not having been there” as a major threat to validity in this type of research (Heaton, 2008; Mauthner, Parry & Backett-Milburn, 1998; Thome, 1998;

Van den Berg, 2005). "Not having been there" means that "salient features of the context or research process that are obvious to a primary researcher may not be apparent to a secondary investigator one step removed from the data source" (Cicourel, 1982; Scheff, 1986 as cited in Thome, p. 549). Since context is central to qualitative research (Holstein & Gubrium, 2004), lack of contextual knowledge in qualitative research that involves re-analysis of data may preclude a valid interpretation of the data (Mauthner et al.).

My position with regard to the "not having been there" problem is somewhere in the middle, which I will explain. I came to the *MIS* study as a research assistant at the concluding stage of data generation. Of 12 third-round interviews conducted with Chinese immigrant parents, I conducted seven. As part of my research assistant work, I experienced the first and second rounds of interviews with Chinese parents vicariously, through writing summaries of these interviews, and coding them. My active involvement in data generation as an interviewer gave me the knowledge of the context. However, this knowledge was not complete as it did not extend to the interviews conducted by other interviewers with the participants I included in my study. However, Van den Berg (2005) argues that a researcher engaging in the re-analysis of data can reconstruct the context which, in the case of my study, is the context of the interviews that I did not conduct. Following Van den Berg's guidelines, I accessed this contextual knowledge in the following ways: 1) listening to the recordings of the interviews for non-verbal clues, for instance, evidence of emotion (e.g., laughter) and hesitation (e.g., stumbling or struggling for words, and silences); 2) reading

through field notes to learn about the setting and timing of the interview, and the presence of third parties; and 3) talking to the research team members who conducted these other interviews about the context of the interviews and their impressions of the participants.

Gladstone et al. (2007) and Van den Berg (2005) note that the reconstruction of the context may not be feasible unless a researcher engaging in the re-analysis of data is given full access to the original data (e.g., to both recorded interviews and transcripts, rather than to transcripts alone). In my case, I had full access to the original *MIS* data.

Fit between the original data and the research questions of the re-analysis study. The fit between the original data and the research questions of the re-analysis study is a judgment about the extent to which the original data are capable of providing evidence to answer the research questions of the re-analysis study. This is a matter of the following conditions: (1) the amount of data must be sufficient (Szabo & Strang, 1997), (2) the data must be rich (Szabo & Strang), and (3) the phenomenon of interest to the re-analysis study must be salient in the original data (Hinds et al., 1997). Below I present my argument to support the contention that my study meets these conditions.

Is the amount of data sufficient? Literature on qualitative re-analysis points out that for re-analysis purposes, the original dataset should be large enough to permit further analysis (Szabo & Strang, 1997). The three rounds of interviews

with twelve Chinese immigrant participants yielded 34 interviews.[12] The 34 interviews resulted in 867 pages of transcribed text, which is a fairly large amount of data, from a logistical viewpoint. From an analytical viewpoint, the data from 12 participants seem to be sufficient, in qualitative research standards, based on the guidelines provided by Sandelowski (1995), according to whom "a sample size of 10 may be judged as adequate for certain kinds of homogeneous … sampling" (p. 179). I believe that the sample of participants in my study can be considered rather homogeneous, given that the participants shared many characteristics, in particular, ethnicity, nativity status, length of stay in Canada, country of origin, the timing of the transition to parenthood, age range, and level of education.

Are the data rich? A large amount of data, as measured in pages of transcribed text, for instance, does not by itself guarantee that the dataset is workable for re-analysis. The data should be not only plentiful, but also rich (Szabo & Strang, 1997). Richness is understood as a sufficient amount of detail coupled with the elucidation of meaning (Kvale, 1996; Richards & Morse, 2007). One factor that allows for the *possibility* of obtaining rich qualitative data is the interviewing approach. To obtain rich interview data, an unstructured or semi-structured interview should be used (Szabo & Strang). In unstructured and semi-structured interviews, meaning is produced because the participant is in control of the story. The *MIS* interviewing approach was semi-structured. Another factor that is critical to the richness of data generated in an interview with a participant is the degree to which he/she is able to express himself/herself verbally to provide a

[12] 36 interviews (12 participants by 3 rounds) minus 2 interviews (two participants did not take part in the third round of interviews) equals 34 interviews.

detailed account of an experience (Kvale, 1996). The amount of detail that Chinese immigrant participants in the *MIS* study used to describe their experiences varied across participants and varied within individual interviews. However, overall, and for the most part, their accounts contained a sufficient amount of detail in the sense that it was clear how the events developed, emotions were expressed, and an appraisal of a situation was given.

How salient is the phenomenon of interest in the original data? The phenomenon of human service use was salient in the original data which is evident in the fact that the *MIS* participants were asked about their service use. Questions about human services were part of questions about social support/non-support. The interviewer would ask: "Who or what has been helpful?" Once the participant talked about whatever he/she deemed as helpful and in what ways, probes about human services would typically follow.

General Standards of Rigour in Qualitative Research

In conducting this study, I followed Lincoln and Guba's (1985) framework for ensuring rigour. In this framework, the conventional standards of validity and reliability, which make for rigour in quantitative research, are re-conceptualized as trustworthiness. Trustworthiness is established through credibility, transferability, dependability and confirmability. Although Lincoln and Guba think about these as criteria for evaluating completed research, I used them as guiding principles as I was conducting my research.

Credibility (comparable with internal validity) is a "fit between respondents' views and the researcher's representation of them" (Schwandt, 2001

as cited in Tobin & Begley, 2004, p. 391). In this study, credibility was achieved through peer review, "the process of engaging a colleague (another researcher) in an extended and extensive discussion of one's findings, conclusions, and tentative analyses" (Morse & Field, 1995 as cited in Mayan, 2001, p. 28). My peer reviewers have been other members of the *MIS* study team and my supervisory committee members, who are investigators on the *MIS* study. Transferability (comparable with external validity) refers to the generalizability of inquiry, that is, the applicability of the research findings to other contexts (Lincoln and Guba, 1985). For the users of my research to make a judgment about the transferability of its findings to other contexts, I provide a detailed description of the study context, including information about the participants (see pp. 60-62), and the circumstances under which the data were generated (see pp. 42-43).

Dependability (comparable with reliability) equates to auditability. Researchers can ensure dependability by keeping an audit trail, the purpose of which is to demonstrate that "the process of research is logical, traceable and clearly documented" (Schwandt, 2001 as cited in Tobin & Begley, 2004, p. 391). My audit trail consisted of memos and a journal in NVivo, which I used for planning analyses, recording my decisions about codes, and commenting about the data and about my experiences conducting the study, which I have summarized earlier in this chapter. My audit trail also includes a draft of the findings, reported in this thesis, that identifies the sources of each quote and statement as a strategy to ensure that reported experiences reflected the breadth of participants'

experiences and not only a few highly evocative experiences or the most articulate participants.

Confirmability (comparable with objectivity) is concerned with establishing that the researcher's interpretations are not products of his/her imagination and can be traced to the data (Tobin & Begley, 2004). As was the case with dependability, confirmability was achieved through an audit trail and by talking with other research team members on the *MIS* project and my supervisory committee members.

Ethics

The original *MIS* study received ethical approval and followed appropriate procedures to provide informed consent and protect participant anonymity and confidentiality. The ethical approval for my study was granted under the original study approval, as a focused re-analysis of the original study that is consistent with the purpose of the *MIS* study.[13] Below, I discuss how I ensured that this study complies with the ethics standards of informed consent, anonymity, and confidentiality.

Informed Consent

It has been a common practice for researchers who conduct "primary" analysis to make provisions in the informed consent form for possible re-analysis (Gladstone et al.). In the *MIS* study, these provisions were stated in the *MIS* study proposal and indicated in the consent form that was signed by each participant.

[13] See Appendix C for a copy of the ethical approval.

Anonymity and Confidentiality

I ensured anonymity by not using unique identifiers (such as names of persons, organizations, neighbourhoods, and streets) in the text of this thesis and in the oral presentation. Similarly, I am committed to not using any unique identifiers in a journal article that will be submitted for possible publication. I tried to achieve confidentiality by: 1) safeguarding the data from becoming available to unauthorized persons (i.e., those not involved in the *MIS* study), and 2) not disclosing private or potentially identifiable information in this thesis. I prevented unauthorized access by storing the electronic documents in locations unavailable to anybody except me and my supervisor(s), that is, a secure folder in the office password protected computer. With regards to non-disclosure of private information, I considered all information shared by the participants as confidential. My obligation with respect to confidentiality is ensuring that in a report on the study, identity of participants cannot be inferred. This was achieved by a careful use of sensitive data such as verbatim quotes and descriptions involving demographic characteristics, as well as by using the admittedly generic language of “man”, “woman”, “father”, or “mother” in reporting findings in the final thesis to prevent potential linking among experiences to specific participants.

CHAPTER 4

FINDINGS

In this chapter, I report the findings of the study. The chapter consists of four sections. In the first section, I describe the sample of the study. The subsequent sections correspond to each of the research questions. More specifically, the second section details the findings on the types of human services used by the participants and on the prevalence of use. In the third section, I report my findings about the reasons for which the participants used human services, and the fourth section is on the quality of the participants' experiences with human services. I illustrate the findings by providing quotes from the participants' interviews. The chapter concludes with a summary.

Sample

All of the Chinese immigrant participants in my study originated from mainland China and had been in Canada for 1-6 years (1-4 years for women; 1-6 years for men) at the time of the first interview. The participants' mean age was 32.1 years. All six couples were married. The participants' mean annual family income was in the range of 77.5-88.8 thousand dollars. Almost all Chinese immigrant participants held at least an undergraduate degree.

There was variation in the participants' employment status over time and by gender, with men's being more stable than women's. At Time 1, all men were employed full-time. At Time 2 and through Time 3, all but two men maintained continuous full-time employment. One man was unemployed for a period between Time 1 and 2, whereas the other stopped working at some point between Time 1

and 2 and remained unemployed. In comparison to the men's employment status, the women's was more variable over time. Half of the women were unemployed during the third trimester of their pregnancy (Time 1), whereas half worked either full-time or part-time. At Time 2, four women were unemployed, caring for their infants at home, whereas another two women resumed their full-time employment within six months of their infants' birth. By Time 3, three women were in the labour force either full-time or part-time, whereas the other two[14] remained unemployed.

It should be noted that most of the couples were involved with a particular ethno-cultural organization (church) in one way or another. Three of the six couples were members of this church, and another two couples seemed to attend from time to time. Only one couple was not affiliated with this organization. Yet, all couples attended the prenatal class provided at the church.

All couples had their parents, that is, either maternal or paternal parents, come to Canada from China to live with them for extended periods of time (several months) at some point during their transition to parenthood. For convenience, I will refer to the participants' parents as "grandparents". All couples except one had (a) maternal/paternal grandparent(s) (more often, maternal grandparents) move in with them within three months before the birth of the infant.[15] All couples, except one, had (a) maternal/paternal grandparent(s) living with them when the infant was born. There was variation among couples as to

[14] By Time 3, one woman withdrew from the *MIS* study.
[15] The couple who did not have a grandparent living with them at the time of the infant's birth had made plans for the maternal grandmother to come to Canada, but she was unable to come because of health problems.

when the grandparent(s) returned to China. However, most grandparents who came to Canada prior to the infant's birth stayed until the infant was six months old.

Types of Human Services Used and Prevalence of Use

The two broad types of human services used by participants were health care and social services. I will first discuss patterns pertaining to health care service use and then patterns concerning social service use.

Participants Used a Wide Range of Health Care Services

Health care services available to childbearing Alberta residents can be thought of in terms of two types, (1) "standard", biomedical, and (2) "alternative" childbearing services. This tentative classification is based on my personal knowledge of the Edmonton community, the data obtained from the Canadian-born participants in the *MIS* study, and personal communication with a doula who works in Edmonton (M. Keirstead, personal communication, November 22, 2011). "Standard" health care services available to Alberta residents, whether they are expectant/new parents or not, infants or adults, include Health Link Alberta (a phone line operated by Registered Nurses to answer health-related questions), pharmacies, family doctors, or general practitioners[16], primary care networks, walk-in medical clinics, Urgent Care Centres, and Emergency Departments in hospitals (ER) (Alberta Health Services, 2011). There are services in Alberta specifically for childbearing women, their partners, and infants. In particular, for their prenatal care and delivery, women in Alberta can see a family doctor, a

[16] Some family doctors, or general practitioners, specialize in paediatrics (www.caringforkids.cps.ca, accessed August 26, 2011).

midwife, and/or an obstetrician (Government of Alberta, 2011). In addition, the public health care system offers prenatal classes for women and their partners. The services available to women post-birth and their infants include but are not limited to Healthy Beginnings Postpartum Program (home nursing services including health assessment, counselling, education, and support to all families up to the first two months after birth and hospital discharge), Early Maternity Discharge Program (a home visit by a PHN to mothers and infants shortly after discharge from hospital after delivery), Healthy Beginnings Hotline (a subsidiary service of Health Link Alberta for parents of infants under 2 months of age), and immunizations provided at Community/Public Health Centres. Also, among other services, geared towards newcomers, including childbearing newcomers, are those provided by the Multicultural Health Brokers Co-operative, which provides "liaison, referral and information between newcomers and the health system"[17] (Government of Alberta). As to "alternative" childbearing services, examples of these are prenatal, birth, and/or post-partum support from a doula.

I found that participants in this study used most of the "standard" services listed above. In particular, prenatal classes were attended by all participants, that is, by all couples. Also, all couples, with one exception, at Time 1, had a family doctor. All women seemed to be receiving regular prenatal care from a pregnancy clinic/obstetrician. Also, all women gave birth to their infants in the hospital. At

[17] These include "prenatal education, post-natal support, health and sexuality education, telephone counselling and referrals, home visits when necessary, resource material development, community development and health promotion and consultation concerning cross-cultural issues" (Government of Alberta, 2011).

least two of the fathers attended the birth.[18] All women opted for and received a postpartum visit by a PHN. All families took their infants for immunizations through public health centres. All women used the post-partum support services provided by PHNs for women within two months after hospital discharge. All families called the Health Link phone line for infants under two months at least once. And lastly, by Time 2, all families had a pediatrician. Thus, families used a wide range of health care services available for expectant/new parents and infants. The participants did not explain their decision-making around the uptake of the services they used, with the exception of one mother. Looking ahead to the birth of her infant, this mother explained why she saw the need for both the postpartum visit by a PHN shortly after the infant's birth and having a regular pediatrician for her infant. As to the postpartum visit by a PHN, this mother looked forward to receiving the service as she saw it as an opportunity to receive "professional" information about infant care, as opposed to the lay, traditional Chinese infant care practices she could learn from her parents:

> "I want [a PHN] come here, … test my baby … . it is my first baby and my parents, they only have the Chinese traditional. Is different as Canada … So I want the professional people to come to visit me and tell me how to take care, how to feed my baby. It's very nice for me. …I'm blank in my plan. I don't know anything."
>
> Expectant mother

With respect to this mother's perceived need for a pediatrician, she explained,

> "… I want to get a good kids doctor. …I don't know if my baby is very healthy. I'm very, always worrying … about this. …because I think this

[18] Only two couples made a reference to the husband attending the delivery. The participants were not specifically asked about the fact.

> period [during pregnancy] I'm not too happy so I'm worrying it will impact my baby."
>
> Expectant mother

As to "alternative" childbearing services, I found that the Chinese immigrant women in this study did not talk about any such services. There is no indication from the data why this is the case as participants did not talk about their motivation for not using the aforementioned services. However, according to a recognized representative of the doulas' community in Edmonton, "the large majority of women (at least in the Edmonton area) who use 'alternative' birth and maternity care options are … white, middle- to upper-middle class women" and "there are few low-income, women of color and immigrant women who access these services" (M. Keirstead, personal communication, November 22, 2011).

The pattern of immigrant women gravitating towards "standard" childbearing options within the biomedical model of childbearing, found in my study, has also been documented in scholarly literature. For instance, similar to the participants in my study, who opted for the standard, biomedical model of prenatal, birth, and postpartum care, the Chinese immigrant women in Scotland (Cheung, 2002) and the Middle Eastern immigrant women in Australia (Tsianakas & Liamputtong, 2002) made choices that were presented to them by health care providers as "standard" (e.g., the choice of hospital delivery over alternative birth options, the uptake of certain prenatal tests as recommended by their doctors, etc.). The authors of the above studies suggest that immigrant women, by choosing to stay within the biomedical model of childbearing, surrender their right to exercise

control over their childbearing experience to professionally provided health care services.

This section, on the types of health care services used by the participants, is probably a good place to discuss my "peripheral" findings about the use of traditional Chinese medicine (TCM) by the participants. These findings are peripheral in the way that they were obtained not in answer to the study research questions, but in response to previous research on Chinese immigrants. As I noted in my Literature Review (Chapter 2), the use of TCM by Chinese immigrants emerged as an essential health care practice among them. In particular, Duval (1983) reported that in the treatment of minor illnesses, TCM therapies, such as the use of special herbs, was the first choice. Also, from previous research, it appears that Chinese immigrants commonly use TCM practitioners along with "mainstream" health care services (see Duval; Green et al., 2006; Ma, 1999). In contrast to this literature, I did not find that TCM was commonly used among the participants of my study; more precisely, the use of TCM was rarely reported by participants in my study. In fact, it was reported only by one woman who used Chinese herbs to treat her vaginal bleeding during pregnancy, as well as post-operative bleeding from her cesarean section incision.

Health Care Services Were Commonly Used

Another major pattern regarding the participants' use of health care services during their transition to parenthood was that services were commonly used, where common use means that: (1) all twelve participants reported experiences with health care services, (2) health care services were used at all time

points (Time 1, 2, and 3), and (3) each participant reported experiences with multiple health care services. This pattern

of common use of health care services included two sub-patterns, specifically, variations over time and by gender. Although the use of health care services was common overall, the "amount" of health care service use fluctuated over time. Men used health care services less than women. I discuss these patterns in more detail below.

Health care service use peaked in the first six months after the infant's birth.

At Time 1, Time 2, and Time 3, the "amount" of health care service use can be described as moderate, high, and low, respectively. I assessed the "amount" of service use with three indicators: (1) the number of participants reporting at least one episode of using a service, (2) the number of episodes of service use, and (3) the number of individual services used by each participant. Thus, at Time 1, health care services were used moderately: use was typically limited to regular prenatal care (including attendance at a prenatal class). At Time 2, health care service use increased and diversified dramatically: there seemed to be more contacts with services and there was a wider range of services used. At Time 3, health care service use appeared to be low: only half of the participants reported use, each participant typically reporting only one episode of use.

Men used health care services less than women. There were differences between men and women as to the range of health care services for which they were the end recipients of care. In particular, the women in this study used a

variety of health care services for themselves (as opposed to services used for the infants' needs), such as health brokers, prenatal classes, obstetricians, pregnancy clinics, family doctors, specialist doctors/clinics, and PHNs in their postpartum support mandate. In contrast to women, the only service that men used for themselves was prenatal classes.

The pattern in which women used health care services more than men did is probably not surprising as pregnancy and childbirth are the woman's bodily events, not the man's. When I examined the issues for which women used health care services for themselves, I found that these issues were, indeed, limited to childbearing/rearing needs, such as prenatal care or assistance to address a breastfeeding concern.

Furthermore, men and women differed as to how often they appeared to interact with health care services. Overall, men reported fewer episodes of contacting and/or interacting with health care service providers. In particular, most men in this study did not report interactions with PHNs after the infant was born, for instance, calling a PHN with a question or concern about their infants. One man specifically commented that it is his wife who communicates with PHNs, not him. One possible explanation for this finding is that most men had fewer opportunities to interact with health care service providers as most of them were employed full-time through all time points, in contrast to women, most of whom stayed at home for a prolonged period during their transition to parenthood. It is also possible that men's limited interactions with health care providers might be a reflection of a gendered ideology concerning family responsibilities in which men

are expected to provide financially and women are expected to care for the health of the family, including for self during pregnancy. However, there is a tentative indication from the data that not all men in this study might endorse such ideology. There was variation among the participants as to men's involvement in their wives' prenatal care. There were two contrasting cases. One man seemed to be keen on accompanying his wife to her ultrasound appointments:

> Interviewer: "Have you been to Mom Care?' Father: "…Just once, because I need to work. …I want to see my child."
>
> Expectant father

In contrast, another man, according to his wife, did not seem to show interest in accompanying her to ultrasound appointments:

> "I went to see the doctor every month … and he never ask me which doctor you go to or he never offered to go with me. So I just feel like … maybe …I just keep it, because I don't need him to be there, it's just regular checkup …but then one day I was reading on the internet and they say it's a very good experience for the dad because they can hear the baby's heart beating ... so …next time I ask him 'Do you have time to go?...' … and he did come."
>
> Expectant mother

Participants Used a Limited Range of Social Services

In contrast to the participants' use of health care services, which was represented by various types of services, their use of social services was limited in that the only type of social services used was programs for parents with infants. The complete list of such programs for parents with infants identified by the participants included story reading programs for toddlers, singing and dancing programs for young children, facilitator-led educational sessions, and meet-up tea programs. Some of these were offered by/at a public library and/or a municipal

recreational facility, while others were offered by a local church organization with which many of the study participants were affiliated.

It is not clear from the data why participants did not use or did not express interest in receiving social services other than those focusing on infant development and/or parenting. One explanation posited in the literature is that immigrants use services in the way they use services in their home countries (Portes, Kyle, & Eaton, 1992; Sherraden & Martin, 1994). An extension of this idea is that if a certain service does not exist in an immigrant's home country, he/she would not have the notion of that service and would not even expect to find it in the host country. According to one participant in this study, in China, there is a lack of services attending to individuals' needs other than their physical health problems:

> "[in China] you just go to hospital. … you talk to doctor and … it's just … all medical, …all physical things. … here [in Canada] you know like you probably get depressed after you have the baby. And not all the things you know and you're going to have a place …to get help and each other. We [in China] don't have all those things. So it's total different. They just care about [you]… physically…"
>
> Expectant mother

This mother also indicated how she heard of services available in the community:

> "…when I go to the doctor [in Canada] I see a lot of … [brochures and pamphlets]. … And there are … a lot of things … I can go to. I know that …if I need I can get some help…"
>
> Expectant mother

The above quotes may be interpreted to suggest that this expectant mother would probably have not learned about some human services for new mothers, if she had not seen information materials about them displayed at her doctor's office because

she would not have known that such services existed as they do not exist in China, as she noted. As to a broader range of social services, it is possible that doctors' offices distribute information materials about only a limited range of health care and social services, which takes away an opportunity for expectant/new immigrant parents, such as the mother quoted above, to receive information about the full range of available services.

Despite the fact that the participants in this study did not articulate a need for services other than those geared towards infant development and/or parenting skills, the data indicate that services in other domains might have been needed. For instance, many participants in this study experienced family conflict, particularly marital and/or intergenerational conflict. Although some form of marital tension was reported by most couples, intense and/or long-lasting marital conflict was experienced by members of two couples only. The nature of marital conflict in these couples was similar in that conflict was associated with the perception on the part of one spouse that his/her emotional needs were being neglected due to the other spouse's preoccupation with the infant. However, in one of these couples, this was complicated by conflict over parenting. One couple did not report seeking any external support, formal or informal, for their marital problems. In contrast, the other couple sought and received support from friends in their church community. The wife provided an example of informal marital counseling:

> "Last time, ...my husband too strict with my son. ...I feel so bad that I could cry. I say 'You can't do that to my son'. Then we quarrelling. ...Then we don't speak to each other. Then we call my friends. ...Then they come from their house to our house. ...And they just know what happened. We ask their experience. And then they say ...they also have the same thing happen to them. And they teach us how to ...handle all these things. Don't

> fighting again. ...They later ask to do some prayer to calm. And then they ask [husband] to say sorry to each other. ...they are very, my close friends, ...every time that something happen, ...we call and they come to our house."
>
> Mother

This mother also considered taking a course provided by their church for married couples.

As to intergenerational conflict, all participants reported experiencing and/or observing some kind of tension among themselves, their spouses, and/or their parents(-in-law), at the time when parents(-in-law) were living with them. What underpinned this type of conflict were disagreements over infant care and chores, and grandparents' interference into the functioning of the marital dyad. Despite the salience of intergenerational conflict in the participants' lives, none of them mentioned the possibility of seeking help from formal services.

These findings suggest that Chinese immigrants are not likely to seek formal services for issues associated with family relationships, although they might be open to seek informal help from trusted members of their community. One explanation that comes to mind is that the participants in this study might not have been comfortable to discuss private matters with strangers. However, this does not align well with the fact that they did disclose such issues to the *MIS* team members who conducted the interviews. Thus, it is likely that the participants did not even consider the option of talking to a human service worker about their family relationship issues because they were not aware of such services.

Social Services Were Not Commonly Used

In contrast to health care services, which were used by both men and women, and used frequently, social services were used only by women, and not extensively. I will first discuss the pattern about men not using social services, and then the pattern pertaining to the extensiveness of social service use (by women). I should note that in the discussion below, social services are used synonymously with programs for parents with infants, as this was the only type of social services used by the participants.

Men did not use social services. The use of social services by men was non-existent. One man mentioned providing transportation for his wife and infant to use the programs, but did not make it clear if he participated in the program himself, as the quote below illustrates:

> Father: "That playschool, our Mom group is …Friday". Interviewer: "…And both you and [wife] go?..." Father: "…just [wife] … I go a little bit … I go with her to the library. I always do that because I need to drive [wife]."
>
> Father

It is probably not surprising that it was women, not men, who had experiences with programs for parents with infants. First, women would have had more opportunities to use such programs as, at least during the first year of the infant's life, most women were staying at home with their infants. In contrast, most men would not have had that opportunity as they were in the labour force/in school at Time 2 and Time 3. Some previous, practitioner-led, research has also shown that work and scheduling conflicts can be a barrier for the involvement of fathers in programs for young children (Office of Head Start, 2011).

In my study, two of the men were staying at home at Time 2 and thus, had an opportunity, theoretically, to attend programs for parents with infants. However, neither of these men reported experiences with programs for parents with infants, although their wives did. It could be that there was something about the programs that deterred these men from using them. None of the participants talked about such factors directly. However, there is evidence from previous research that program staff may inadvertently exclude fathers when they first introduce the program to the clients. Consider the quote below as an illustration:

> "In one program evaluation, it was found that Head Start staff addressed only the mother in the intake process, even when the father was sitting right there. When asked why the father wasn't addressed also, the staff was not aware that he was being excluded" (U.S. Department of Health and Human Services, 2004, p. 15).

Thus, staff of programs for infants might be bound by certain cultural expectations about the involvement of fathers in their programs and send the message to clients accordingly, knowingly or unknowingly. A related observation from my data is how one man referred to programs for parents with infants as "mother gatherings", when talking about programs recommended by PHNs. However, it is unclear whether this was how the PHNs presented programs for parents with infants or whether this was his interpretation. Going back to the cases of the two fathers who would have had an opportunity to attend programs with their infants, but did not, this could be due to cultural expectations about father involvement accepted by fathers themselves. There is a common view (so common that it is difficult to find a reference in research to support this claim) that men are not socialized to be nurturers. At least, this is true of the traditional role of the father in the Chinese

society (see Jankowiak, 1992). Furthermore, these two men could have felt uncomfortable joining programs for infants, because it was predominantly or possibly exclusively a women's environment. Notably, when talking about the program provided by the church (with which many of the participants were affiliated), the participants referred to attendees as "other moms", rather than "other parents". It seems that there were, indeed, no men among them.

According to Father Involvement Research Alliance (as cited in Hodgins, 2007, p. 7), a Canadian research and practice initiative on father involvement, "regardless of background, dads are involved or want to be involved in the lives of their children and are eager to talk about their experiences". Yet, it is unclear if most men in my study wanted to attend programs for parents with infants. Only one man expressed such an interest. He wanted to attend a parenting class, but could not find one.

Social services were not frequently used by women. In contrast to health care services, which were used frequently, and at all times, social services were used infrequently by women, and at Time 2 and Time 3 only. Some women did not use any social services at any of the time points, or used them at Time 3 only. In particular, some women reported social service use as a one-time event. Only two women were attending programs for parents with infants regularly (from once to several times a week). However, the data indicate that limited use of programs for infants was not their preference. Half of the women stated that they would like to use programs for parents with infants more often, but were experiencing barriers. In particular, one woman indicated that Edmonton's cold winter and not

having a car and not being able to drive were significant barriers to attending programs:

> "I very, very want to go out or but you know the weather, it's very, very bad … . I worry [infant] get colder. … If I can drive and I will bring my baby every day, go outside!"
>
> Mother

By Time 3, this woman had learned how to drive, but had already returned to work, and thus, could not attend programs for parents with infants, which typically run on week days during daytime hours. Similarly, another woman stated that she could not attend more programs/more often because they run on weekdays during business hours when she is at work:

> "I would expect more programs for the weekend. Because I work full-time from Monday to Friday, …but almost all the program I find that give it on workdays… I take time off. … I use my vacation times, …so I find that is the one difficulty for me … . I would prefer that there are some program for weekends, so that way it's easier to plan."
>
> Mother

Another woman, who did not attend such programs at all, commented that she was not able to find information about them:

> "…I really want that some help from program. … I know they have lots program. have new mom, have child, have family. I know, but I just couldn't find it."
>
> Mother

This is how this mother explained her lack of knowledge about available services:

> "…we get two problem. … For first one, we don't get enough information from the program. … second one, it was still my problem, …'cause of English no good … sometimes I make phone call but not any people is very nice or very kind. … Sometimes they don't …want to listen, to explain or you speaking slowly ... So that's why I …don't get too much support from the program."
>
> Mother

The above two quotes might suggest that this mother was aware that services for new mothers, children, and families exist, but she did not know further details about such programs, such as location and schedule. It could be that she attempted to find additional details by phoning a program provider, but could not communicate effectively with the individual on the other end of the line.

In sum, findings indicate that limited use of programs for parents with infants by women in this study may be due to barriers, such as lack of transportation, cold weather, inability to find information about them, and program scheduling that is problematic for parents employed full-time during daytime.[19]

Reasons for Seeking Human Services

The second research question focused on the reasons for which participants turned to human services. In asking this question, I wanted to know what led the participants to seek services, what kind of issues/needs they had, or what it was that they wanted from services. I found that the reasons for which the participants of this study sought human services included: (1) physical health-related issues, including more immediate and less immediate issues, (2) a development opportunity for the infant, and (3) a socializing opportunity for the mother. I discuss these reasons in detail in separate sub-sections. In each subsection, where applicable, I also discuss the extent to which participants tried to meet their needs through informal sources, that is, the participants' peers, own parents, and reference sources (books and Internet).

[19] This type of scheduling might have been established with the assumption that interested clients would not be employed and/or with the convenience of providers in mind.

Physical Health-Related Issues as the Primary Reason for Using Human Services

The predominant or the most frequently cited reason for which the participants in this study used human services was help with an issue related to physical health. The emerging distinction was that these issues were represented by two types, (a) more immediate/more serious health-related issues, and (b) less immediate/less serious health-related issues. This was an intuitive distinction that was obvious to me from the beginning of my analysis. An example of an immediate/more serious health-related issue is the infant's fever, which is potentially a fatal condition, or the mother's pain while breastfeeding, where pain conveys the immediacy of a problem. An example of a less immediate/less serious health-related issue is the infant's unsettled behavior, as exemplified by continuous crying or sleeping less than usual for that infant, or the infant's rejection of certain foods. I recognize that this classification of health-related issues is rather crude, and the meanings of "immediate", "serious", and "urgent" (as well as "usual") are not precise. However, I think that my categorization is adequate in the sense that it does justice to the data, at least for the purpose of this study.

Notably, it was more immediate/more serious health-related issues, rather than less immediate/less serious health-related issues that accounted for the bulk of episodes of service use recalled by participants. Furthermore, I found that depending on the immediacy of a health-related issue, participants chose different courses of action as to what type of services they used. For this reason, I will

discuss these two types of health-related issues separately. What follows is a discussion of human services as a source of help with more immediate/more serious health-related issues, followed by a discussion of human services as a source of help with less urgent health-related issues.

Human services as a source of help with more immediate/more serious health-related issues. At Time 1, the use of health care services for more immediate/more serious health-related issues such as elevated blood sugar, an episode of vaginal bleeding, and elevated blood pressure was common. Most women in this study (four of six) experienced such issues. In particular, elevated blood sugar was an issue experienced by two women. For this problem, one woman received care from an obstetrician and a dietician as she was diagnosed with gestational diabetes. The other woman accessed her family doctor as her blood sugar returned to normal levels without further intervention. Vaginal bleeding was reported by two women. With this problem, one woman sought help from the PHN who was teaching her prenatal class, whereas the other turned to her family doctor. Elevated blood pressure was experienced by one woman. She discovered the problem even before she became pregnant when she checked her blood pressure at a pharmacy. She then went to a walk-in medical clinic to have her blood pressure re-checked. The doctors at the walk-in clinic did not proceed with a treatment. The blood pressure problem was confirmed during her pregnancy after a fellow church goer, who happened to be a physician, accepted her as a patient.

At Time 2, when health care services were used, it was either for the mother's, or for the infant's immediate, physical health problems. However, health care use for the infant's problems was by far more common than it was for the mother's problems. Such problems included the infant's fever, skin rash/eczema, conjunctivitis, and elimination concerns, the latter of which was the most common problem reported at Time 2. Participants were concerned about the frequency of the infant's elimination. They were not familiar with what was considered "normal", and turned to health care services for answers:

> "…first time we don't know how many times babies poo-poo is okay. Because my son poos a lot. Then we just called. They have a hotline. We called them, they told us as long as baby's poo is soft, it's okay, it's okay, no matter how many times. We didn't know. [chuckles]"
>
> Father

All couples who reported such concerns, sought help from Health Link. For two couples, the problem was resolved with advice from a Health Link nurse, but one couple sought further help from other services, including ER, the pediatrician, and PHNs in charge of the infant's immunizations.

At Time 2, when women reported seeking health care services for their own health-related issues (as opposed to their infants' health issues), it was only for breastfeeding concerns, such as inadequate breast milk supply, painful or tiring breastfeeding, or/and obstructed breastfeeding (a blocked duct). Health care professionals' help for these problems was sought by half of the women. Inadequate breast milk supply was reported by two women. One woman experienced this problem in hospital after delivering her infant. She was worried about her infant being hungry and sought help from hospital nurses. During the

first days after discharge from hospital, she also had a blocked duct. She sought help for this problem from Health Link. The other woman had a persistent breastfeeding problem, inadequate milk supply, during the first month after discharge from hospital. Her PHN instructed her to let the infant breastfeed even in the absence of breast milk in order to stimulate lactation. Breastfeeding this way was exhausting for this mother. In addition, the infant caused her physical pain while breastfeeding. She was distressed by her inability to provide her infant with enough breast milk. She also felt guilty and discouraged because of her breastfeeding problem.

> "…that's why I feel so depressed at the beginning because I have no milk and … my parents and my husband they feed the baby the bottles. So everyone said that breast milk is the best food for the babies so I feel guilty. … and really frustrated at the beginning because I had no milk."
>
> Mother

This mother called upon her PHN to help her deal with the feelings of guilt and exhaustion. Similar to this woman, another reported painful breastfeeding. She feared that the pain indicated a serious health problem, specifically, cancer. She addressed this concern to PHNs.

At Time 3, when health care services were sought, this was exclusively for the infants' health-related problems. The list of such problems at Time 3 was not much different from that at Time 2. Use of health care services at that time period was reported by members of three couples. In particular, one father reported going to the pediatrician for his infant's nasal congestion. A mother tried to see the pediatrician when her infant developed a fever, but could not get an appointment.

The couple then turned to a walk-in medical clinic. Finally, another father reported getting care for his infant from a pediatrician for unspecified concerns.

Human services as a source of help with less urgent health-related issues. Help with less urgent or less acute health-related problems was another major reason for which participants sought services. However, overall, episodes of seeking help from services for such problems were much more infrequent in comparison to episodes of seeking help from services for acute problems. The less immediate physical health-related problems, for which participants sought services, were exclusively their infants' problems. These included the infant not sleeping well and/or crying (unsettled behavior), and the infant's rejection of certain foods. One pattern that emerged with regard to these two common problems is that they were addressed to either health care or social services. For instance, one father reported that his infant did not sleep well and cried a lot, habitually. He was worried that the crying was a symptom of an illness, and the couple turned to their PHN. Similarly, a mother noted that her infant did not sleep well (when he was around six months old). She addressed this problem to peer attendees of a program for parents with infants who provided recommendations on how to "sleep-train" her infant. With respect to food rejection, this mother turned to peers in the program for parents with infants (just like she did for the infant's sleep problem), while another mother sought advice from PHNs and the pediatrician.

What is notable about such issues, as the infant sleep and feeding problems, is that for most of the participants who reported them, the issues caused

participants a significant amount of preoccupation. It seems that it was the distress that led the participants to seek help. For instance, one mother talked about how the infant's sleep problem interfered with her and her husband's sleep and caused them chronic fatigue. Other participants reported that they were anxious, frustrated, and/or confused about their infants' sleep and/or feeding problems. Consider the quote below from a mother at Time 3 talking about her frustration and confusion about dealing with some of the behaviors of her 18 month old child related to feeding and sleep routines:

> "…sometimes I don't know how to discipline him. … I feel so confused. [For instance], when he is crying and sometimes he don't follow my instructions. …Sometimes I let him eat much he don't want. He spit out the food. I don't know how to deal with him. … Sometimes I will cry because he don't want to sleep."
>
> Mother

Although this mother used an opportunity to discuss such issues with peers in the program for parents with infants offered through her church, it does not seem that these issues were anywhere near resolution for this mother.

Informal sources of help with physical health-related issues. As far as help for health-related issues is concerned, I found that participants sought out not only services, but also informal sources, such as friends. Friends' advice was sought both for immediate and less immediate physical health problems. This was common at all three time points. For instance, at Time 1, one woman, upon discovering her elevated blood pressure problem, called her friend in China who was a doctor. Furthermore, it was not uncommon that for health-related problems, participants sought help from friends and (health care) services at the same time.

For instance, a mother turned to the family doctor and her friends for advice about the infant's allergy at Time 3.

In contrast to friends, it appears that participants' own parents were rarely a source of advice on treatment of a health-related problem, especially for the infants' problems. This finding is somewhat surprising because one would expect some interaction between participants and their parents about health-related problems, considering that all families had their parents living with them during an extended period of time at some point during the study, which means that technically, participants' own parents would be witnessing the health problems experienced and could be asked for or/could give advice. Although none of the participants explicitly commented on why advice on health-related problems was not sought from their own parents, there is reason to speculate that participants did not trust their own parents in infant-related matters. Several participants made statements that together, suggest that they preferred professionals' advice over their parents' advice: participants deemed input received from "professionals", that is, health care and other type of service providers, as superior to input from their parents. In particular, two women indicated that they trust advice from health care professionals more than their own parents' input regarding infant care, particularly, feeding and responding to their infants' crying and sleep routines:

> Mother: "…In …China when the baby was … [infant]'s this age, they will give the baby … something like a juice and some salty food …because they think the baby old enough eat that. But here, the doctor and also the nurses, they all say the baby do not eat anything except the breast milk until he is 6 months. So, she sometimes thinks the baby needs to eat [food other than breast milk]". Interviewer: "…and you say, 'No, no, no.'". Mother: "Yeah."
>
> Mother

> "[Maternal grandmother]'s holding the baby all the time. …But [PHN] says 'oh, you cannot holding the baby all the time'. When he gets older, my mom still holding the baby when [son] is six months old. [PHN] says when baby like four months old, you can train him to … sleep on his own. That's really good for us. Whenever baby cry … pat him for a couple of minutes and baby will sleep again. No need to pick him up right away. … My mom always, whenever baby cry, always picking him up. … spoil the baby. When the baby gets older, it's really hard for us… . So that's … their way. I really don't like that."
>
> Mother

Interestingly, the husbands of these women also made statements about advice from professionals as being more credible and more desirable compared to advice from their own parents. In particular, one father expressed this stance regarding advice on parenting his infant. He was at a loss about dealing with the infant's problematic behaviors, such as throwing his cell phone into the toilet. When asked if he and his wife sought advice on their parenting issues from their own parents, he stated that they "don't talk to them [about their parenting issues] because they are not professionals". When the interviewer introduced the idea that advice from grandparents might be valuable because they have experience, this father emphasized that "[t]hey have experience, but they don't have professional knowledge". When asked about what kind of "professionals" he would like to get help from, he stated that they might "need to take some parenting classes". A similar attitude was expressed by another father, although it was not regarding infant-related matters. He talked about a situation when his wife experienced an episode of vaginal bleeding during pregnancy and how they called their own parents in China to consult about the situation:

> "… what happened, what we can do? I want to get to the professional advice. Because although we get the information from our parents, I don't think it's very good and accurate advice."

Father

Furthermore, some participants explained why input from their parents, specifically, in infant-related matters was not seen as valuable. For instance, a mother dismissed her in-laws' advice on dealing with the infant's sleep problem as "superstitions", and therefore, inadequate:

> "… for example, if the, if the baby don't sleep [in-laws] say maybe …because they passed away ancestors …are coming to see the baby, so that's why make the baby cry. … so [father-in-law] said oh, you need to [burn]…some Chinese blend …[to keep the ghosts away]. … that's superstitious. … So we cannot follow that advice! It's really funny sometimes".
>
> Mother

Similarly, another mother expressed a sense of distrust towards infant care ideas/ways regarding the infant's feeding and sleep routines advocated for by her mother-in-law because she saw them as dated:

> "…my mother-in-law, because she is old and …when she do something, she always use [her] old …ways to do things, sometime I don't think that's good for baby… when [infant] was very young, he cannot sleep very well. …if he doesn't like to go to sleep, [I would] just leave him in bed and let him cry, but my mother-in-law, she don't think that's a good idea".
>
> Mother

This mother also said that sometimes she argues with her mother-in-law about the best approaches to infant care. With regard to input from health care providers versus input from their own parents, Chinese immigrants in this study were similar to those of Mexican immigrant women in the US in a study by Sherraden and Barrera (1996) in that both groups were getting conflicting messages regarding health-related matters from their own parents(-in-law), on the one hand, and health care providers, on the other hand. However, unlike the Mexican immigrant women, the Chinese immigrant women and men in my study did not hesitate to

follow the advice from service providers rather than that from their own parents(-in-law). In terms of trust the participants had in medical authority, they were similar to the Muslim women in Tsianakas and Liamputtong's (2002) study, who followed their physicians' suggestions about prenatal testing uncritically.

While the participants did not seem to seek and use their parents'(-in-law) advice in health-related matters, it does not mean that the parents'(-in-law) did not provide support. In fact, they did the bulk of house chores, such as cooking and cleaning, and helped with child care, for instance, getting up in the middle of the night to soothe the crying infant, so that the mother's sleep was not interrupted. Doing physical work emerged as a major way in the participants' parents(-in-law) supported the participants, especially, mothers. Interestingly, having one's mother or mother-in-law to help with physical chores after the birth is part of the "sitting in for the month" tradition. Among other prescriptions of this tradition are avoidance of exposure to cold (e.g., cold water, cold wind), and a specific diet (Cheung, 1997). However, most women in my study did not comment on whether or not they followed the traditional Chinese ritual of "sitting-in for the month". One woman particularly stated at Time 1 that she had no intention to follow the ritual as a PHN told her that it was not healthy. However, the participant did not specify what aspect of the tradition was considered unhealthy. Yet, another woman expressed her regrets at Time 3 about not having adhered to the ritual. She perceived that this circumstance had had a negative impact on her health. In addition, a few women found certain aspects of the ritual inappropriate for them, for instance, the requirement to avoid exposure to water (as in taking a shower or a

bath). Thus, the data from this study suggest that (1) women might be skeptical about some aspects of the ritual, but not others, and (2) some participants might believe in the benefits of the ritual for the health of a new mother.

Human Services as a Development Opportunity for the Infant

In the previous section, I discussed the findings pertaining to physical health-related issues as the primary reason for which the participants used human services. A second reason why human services were sought was a development opportunity for the infant. This was associated predominantly with social services, specifically, programs for parents with infants. Almost all women who used such programs talked about them as a development opportunity for the infant, as the quotes below indicate.

> "Yeah, I want bring my boy. Go outside and play with other children…"
>
> Mother

> "…baby can look at everything. He's very happy! [chuckles] …And then also baby there. I guess he like baby."
>
> Mother

> "…recently I tried several programs because uh she's getting older and uh can perform some uh like singing or dancing …"
>
> Mother

None of the participants talked about health care services as a socializing or development opportunity for the infant, except one woman. One couple had moved to the US by Time 3. When asked whether there was something missing in terms of services, the mother replied that when living in Edmonton, she used to take her infant to the nearby Public Health Centre to socialize with other children as there was a play area there. She wished that such Public Health Centre would be available in her community in the US.

Human Services as a Socializing Opportunity for the Mother

Finally, a third reason for which a few participants sought human services seems to be a socializing opportunity for the mother. I found that this was associated solely with social services, particularly, programs for parents with infants, rather than other types of services. However, using programs as a socializing opportunity did not emerge as very common among women as only two of the mothers talked about such programs in this way. The benefit of programs for parents with infants was most articulately illustrated in the following quote:

> "… we [mother and her infant] go to the local library very often. And …the programs there are very, you know, supportive. … they gave us a time and a place to know the mom. …the moms that …are similar, …the kind of same experience mom … . So we can share a lot and we can talk a lot."
>
> Mother

This mother also talked about how connecting with local women through library programs for parents with infants helped her "to merge in to the local life".

Quality of Experiences with Human Services

In this section, I report my findings regarding the quality of participants' experiences with human services. The quality of their experiences was assessed along the following lines: (1) extent to which human services met participants' needs, (2) ease of access to human services, (3) personal attributes of individual providers, and (4) ease of communication with providers.

Extent to Which Human Services Met Participants' Needs

I found that participants' experiences were generally positive, and that services met participants' needs. This was manifested in two ways: (1) services resolved participants' issues, and (2) input from service providers was adequate. Below I illustrate these two scenarios with examples and quotes from participants. I should note that most of the examples and quotes to follow pertain to health care services. This is not by accident as participants talked much more about heath care than about social services. However, despite the fact that there was very little discussion about social services, it seems that overall, participants' experiences with them were positive as well, as far as the extent to which they met the participants' needs.

Services resolved issues. As discussed in the previous section, the primary use of human services by participants was when they sought help with their health-related problems, concerns, and/or questions. I found that overall, providers were able to resolve participants' issues. I encountered numerous examples of participants reporting episodes of certain health-related issues that were addressed to health care providers and were resolved by them. For instance, one mother turned to PHNs for advice on the treatment of her infant's dry skin, and was offered a solution that proved to be effective:

> "[PHNs] give us lots of uh help too …[PHNs] give us uh some advice, buy the kind of uh cream. It's very work."
>
> Mother

Similarly, another two participants, fathers, reported how their concern about their infants' elimination was addressed to Health Link and resolved. In both cases, the

parents did not know what was normal in terms of infant elimination and were advised on that by a service provider, as one of the fathers noted:

> "[Health Link] did help. Because … [infant] about four or three or four days, no - no poo. {chuckles}So we are nervous and uh even the pee. Not much uh, so we phone the nurse line. The nurse line said that that's normal. But if no pee, she said uh, that's big problem. She said you must be very, very careful that you know."
>
> Father

Also, apart from and/or instead of reporting specific episodes of issues that were resolved by providers, many participants stated that their experiences with certain providers were consistently positive in terms of being resolved. For instance, one father stated that their pediatrician was always able to resolve the infant's problems:

> "The doctor [pediatrician] is awesome. …She can answer every questions. … And the answer is really, really helpful. And once my daughter is sick, every time when she sees doctor, she is good. She is back and everything is gone."
>
> Father

Similarly, his wife stated that when she turned to PHNs with questions, they always gave her answers:

> "…sometimes we go to [a public health centre] [for immunizations]. … I always take very long list, ask her. … [The PHNs] answer all [her questions]. [The PHNs] [have been] …very, very good."
>
> Mother

It is noteworthy that none of the participants ever complained about PHNs. Many participants, both women and men, expressed satisfaction with the support they received from PHNs. This contrasts with the findings reported by Reitmanova and Gustafson (2008). The Muslim immigrant women in their study did not have anything good to say about PHNs who were in charge of their postpartum care.

For instance, these women perceived that PHNs were concerned about the infant only and not the mother. However, from Reitmanova and Gustafson's study, it is not clear if the participants did not have their issues addressed by PHNs at all, or whether PHNs did address maternal issues, but just had a tendency to prioritize the infant's issues. Nevertheless, participants in my study seemed to be satisfied with support from PHNs.

The finding that health care services were able to meet the participants' needs is consistent with findings by Loiselle et al. (2001) in their study with immigrant women in Montreal, most of whom also perceived that their physical health problems were addressed by health care services. The satisfaction of the Chinese immigrant participants in my study extends beyond maternal physical health issues and includes the infant's more immediate and less immediate health-related issues.

Some participants in my study also solicited and received help for health-related issues from social services. For instance, one mother talked about how she had her infant's sleep problem resolved by peers in a program for parents with infants that she attended:

> "… when [infant] was like 6 months or 7 months, he has very big bad problems with his sleeping. He cannot sleep well, he always wake up at night. So …at that time we were very tired. And then we ask [peers in the program], they give us some suggestion. …they told me how to train him. So now, he's very good."
>
> Mother

Despite the fact that participants' experiences with human services were predominantly positive in terms of issue resolution, exceptions to this pattern are worth mentioning, too. For instance, one mother had an unsatisfactory experience

with hospital nurses after she delivered her infant. She had not established a good supply of breast milk, was uncertain about the adequacy of her breastfeeding technique, and was worried about her infant being hungry. She sought help for these concerns from nurses, both "general" nurses and a nurse specializing in lactation, but was not satisfied with the help she received from them. As to the lactation consultant, the timing of her visit was an issue that was seen as having interfered with this mother's ability to comprehend information:

> "…the [lactation] consultant, I don't quite remember because I had a C-section in the evening and at night she came and tell me what to do because I'm kind of not that awake. Because the drugs they use and the painkillers … I just remember that she just tell me and my husband let the baby to suck. And she came one other time and asked do that and other than that I didn't get any information or help from her so that's kind of bothered me. Because it's kind of disappointing."
>
> Mother

As for other hospital nurses, this mother stated that she did not get the help that she hoped from them either:

> "…I have problem with breastfeeding and I don't know who can help me. I ask the nurse and the nurse just let me feed the baby and I ask them if the baby is okay for the amount she ate … just didn't get much information. And their answers quite different…"
>
> Mother

Another example of not having an issue resolved by a provider was offered by a father. His infant developed a rash which neither the family doctor, nor the pediatrician managed to cure. The pediatrician referred the couple to ER. In contrast to the mother quoted above, this father did not express frustration about this circumstance.

Satisfactory input from providers. I found that even in the cases when service providers' input was not solicited by participants, participants still received

it well or found it useful. The sense of welcoming information/input was expressed in connection with various types of providers, that is, both nurses and doctors, and various types of services, for instance, prenatal classes, the postpartum visit, immunization appointments, and pediatrician appointments. In particular, most of the participants who attended prenatal classes described the content as useful or congruent with their needs. For instance, one father indicated that it helped prepare him for his wife's hospital delivery:

> "We don't know how to delivery a baby. [laughs] So we get information we want. And then we …also … had a tour to the [hospital], so we familiar with the environment, in hospital. If there's an emergency, I will rush to the hospital, and a no panic. I know …where …should I go. …That's good…"
>
> Father

Similarly, another two participants, fathers, appreciated directions from PHNs about infant care:

> "…when the baby was young, a [PHN] came and gave a lot of information which was very helpful. How to feed the baby, what kind of position you should hold, and when the baby is sick where you should go, so which is good…"
>
> Father

> "…we get some advice from [PHNs in charge of the infant's immunizations]. … [The experience] [is] good. Because … they try to teach you … lots of experience. … Like clean his teeth. …that's helpful."
>
> Father

As far as social services are concerned, participants expressed a similar sense of the adequacy of services to their needs. For instance, a mother appreciated a good pace of a singing and dancing program for infants provided through a Chinese ethno-cultural organization:

> "… recently we are going to …a Chinese uh community sponsored program. … for moms and babies and .. I find out that program is

> good…it's also about singing and dancing and …they repeat everything … several times…"
>
> Mother

Notably, what made her appreciate the pace of the Chinese community program is a negative experience with a similar program provided through a public library. It should be noted that no other participants apart from this mother reported negative experiences with social services as far as their fit to the participants' needs.

> "I went to the library once for a program. But …I didn't like it. It …sponsored by the Early Learning for children with difficulties. For sign language. And …it's, it's too fast, like …it's singing things and dancing but …all the sign language come with it. Even me as I thought I cannot remember. And uh my daughter didn't like it."
>
> Mother

In summary, overall, participants were able to get their issues resolved by service providers. Situations when issues were not resolved were rarely reported. Furthermore, not all of the participants who reported such experiences expressed dissatisfaction about this. In the same vein, I encountered numerous examples of participants expressing the sense that input from providers was valuable. And, none of the participants reported receiving input that they deemed useless or irrelevant.

Ease of Access to Human Services

Ease of access to human services was another aspect of the participants' experiences with services. With regard to the apparent accessibility of human services, I found that there was some variation in the participant's experiences. Some services/providers appeared to be easy to access, while other were not. In addition, there were a few services that were easy to access at one time, but not at another time. In particular, participants did not seem to have trouble accessing the

PHNs who provided post-partum support. At least, none of the women reported this. Also, two women explicitly stated that their PHNs were easy to access. As to another commonly used service, Health Link phone line, participants' experiences were mixed. For instance, one mother found that the service was easy to access during the first two months of the infant's life, but difficult to access after that point:

> "…the first time my husband always call them. … But after two months it's very difficult to call. I need to wait almost one hour."
>
> Mother

Her experience reflects the fact that the Health Link phone line service has a separate sub-service for parents of infants under two months, which she was aware of and used. She recalled an episode when she and her husband gave up before they had a chance to talk to a Health Link nurse and left a message instead. Their call was returned on the following day, which she appreciated:

> "I remember my one time … I waited almost uh – after more than one hour, then we had no patient to wait so I so we – leave the message. But they are very good and tomorrow they call us."
>
> Mother

In contrast to services provided by nurses, services provided by doctors were often reported as difficult to access. This finding applied first and foremost to pediatricians. All participants who reported using a pediatrician commented that it was difficult to get an appointment. For instance, one mother was dissatisfied with having to wait "for a while" to get to see the pediatrician. She reported using her family doctor as an alternative:

> "One thing bothers me is like, it's difficult to see the doctor for my child when I have questions. I have to book appointment and wait for a while. … So sometimes I go to see my family doctor directly."

Mother

Another mother also reported that it was not easy to see the pediatrician on short notice. The couple's strategy was to go to a walk-in clinic instead:

> "… when [infant],… had a fever or something like that. … we usually go to the walk-in clinic. And they would give me some suggestions like drink more water or something like that. … if you make appointment [with the pediatrician], that will take three days … But like usually in three days, he already good."

Mother

Similarly, another mother reported that she and her husband could not access the pediatrician quickly for their infant's elimination problem. The couple first went to ER for this concern. After two hours in the waiting room, they were told that it would take another two hours to see a doctor. The couple then decided to leave as it was getting very late. After returning home, the couple called their pediatrician to make an appointment for the following day, but could not get in:

> "but [the pediatrician] has no time tomorrow, she need to make appointment …after some days. … I think …it's not too good. Because in China, when you [need help], …you go to doctor but in here you need make appointment first and doctor is ... always busy."

Mother

However, this mother was able to see a PHN within two days from the onset of the problem and discuss her concern with her, which by that time, resolved on its own. The mother then cancelled the appointment with the pediatrician:

> "…fortunately, the day after tomorrow we bring him to do immunization. Then the nurse told us don't worry and – a baby poo five times also is normal. … Is happy, is smiling, …not lose weight, … no crying, … he's okay. And then went back home I think he's okay. …… So we cancelled our appointment. I think after some days my baby get better, why I go there?"

Mother

It seems that the experiences of the Chinese immigrant new parents in this study with regard to access to pediatricians and family doctors, in general, is not at odds with the experiences of the general population in Edmonton community, based on my personal knowledge of the community, information from unofficial Internet sources and local media. For instance, Edmonton contributors to a popular website for rating medical doctors (www.ratemds.com) often complained about the wait time to see their family physicians. This complaint is consistent with the information provided by the Alberta Government. In *Alberta's occupational demand and supply outlook 2009-2019*, physicians are among occupations for which a shortage in supply was anticipated (Government of Alberta, 2009). The shortage of physicians appears to be a nation-wide phenomenon. According to the local TV news channel, CTV News, "it [has] become more difficult to find a G.P. because only about 30 per cent of the physicians in Canada are family doctors and many of them work in walk-in clinics or hospitals" (CTV News Edmonton, 2009). Thus, the inability of study participants to see their pediatrician on short notice seems to reflect the shortage of family doctors (including those specializing in pediatrics) in Canada, not just in Edmonton.

What is noteworthy and somewhat surprising is the sense of urgency and/or dissatisfaction expressed by the participants in this study about being unable to see their pediatricians on short notice, despite certain "mitigating circumstances". First, the participants wanted to see the provider on quite a short notice. Second, there was an alternative source of help that they used: a walk-in clinic in the case

of one couple, a family doctor in the case of another couple, and a PHN in the case of a third couple. Third, more often than not, the problem for which participants wanted to see the pediatrician so desperately got resolved on its own or with little intervention. Yet, even in retrospect, and despite the fact that alternative sources of help were available and/or that the problem was minor, the participants still were dissatisfied about being unable to access their pediatricians. A possible explanation of this finding is the sense of (uncontrollable) anxiety about their infants' health. Two participants, mothers, made an explicit connection between their anxiety and their decision to use a service, as soon as possible. For one of these mothers, it was a decision to go to the family doctor, instead of waiting for a pediatrician appointment:

> "I don't need to book appointment [to see the family doctor], I can go directly and wait. That makes me, like kind of relieved because sometimes you know, moms just worry and couldn't wait for a while to see the doctor."
>
> Mother

In the other mother's case, anxiety motivated the couple's decision to take the infant to ER:

> "… it's very hard and it's so long, it's emergency. … I think my baby is nothing, he's very good, but you know as parents we don't know. We are very worried about, we are new parents, we no experience so um everything in our eyes … is bad. What happen? We don't know. So we are very worried."
>
> Mother

In other words, it seems that it was important for participants to receive help from health care professionals immediately because they were very anxious about their infants' health. This finding aligns with concerns that participants (women) had about the health of their unborn infants during pregnancy, more specifically, about

the implications of their own health problems for the fetus. Among common problems experienced by the women in this study during pregnancy were vaginal bleeding, elevated blood sugar, and feeling stressed or depressed. Although these problems were located in the woman's body, participants were worried about how they would affect the health of the fetus, rather than about the woman's own health per se, as a quote from a woman, who had gestational diabetes, illustrates:

> "… because I get diabetes, it's a very hard time for me because I'm very scared. But doctor just let me know about [it] one month later. … if he let me know early, maybe I can do some better stuff for me and the baby because I worry about hurting baby."
>
> Woman

Personal Attributes of Individual Providers

Apart from the extent to which service providers met the participants' needs and the ease of accessing them, the participants sometimes commented on personal attributes of providers with whom they interacted. It should be noted that it was only health care services providers, rather than social service providers, whose personal qualities were discussed by the participants. Most of the time, participants' impressions of service providers were positive. They most often commented on providers' pleasant manner and/or caring attitude. Interestingly, such comments were associated with nurses, rather than doctors. For instance, a father who stayed with his wife at hospital for several days to help care for the infant (as the mother developed complications after her delivery), was satisfied with the manner of the hospital nurses:

> "Yeah, [hospital] nurses pretty good, were very good actually. Very friendly and helpful and they did everything they can. So we really appreciate that."
>
> Father

Similarly, a mother had a positive experience with the hospital nurse who assisted in her delivery. She particularly appreciated the nurse's caring manner against the back drop of not-so-friendly hospital staff in China:

> "[the hospital nurse] was nice. She's really helpful. … the experience there is very, very good. … [The hospital staff in China] just working right, so they just …have that working face. … But [in Canada] … the nurse … talk to you nice and try to calm you down. … so yeah, it's different."
>
> Mother

Also, a woman described the nurses in the diabetes clinic that she was attending during pregnancy as "nice". She was appreciative of them for taking extra effort to alleviate the language barrier for her:

> "… [the nurses at the clinic] are very nice. .. when I don't understand something, they explain very slowly and carefully …, even I'll ask two time or three times …"
>
> Woman

She had positive experiences with all of the health care providers she interacted with over the course of the study, except one, her obstetrician. This woman perceived her obstetrician as somebody who did not care about her. Two reasons underpinned her judgment. One reason was that the provider informed her of her diabetic pregnancy later rather than sooner:

> "I think maybe [the obstetrician] don't care about me. … because I get diabetes, it's a very hard time for me because I'm very scared. But doctor just let me know about [it] one month later. … if he let me know early, maybe I can do some better stuff for me and the baby because I worry about hurting baby …"
>
> Mother

The other reason was that the obstetrician delivered her infant by means of a cesarean section, while she herself perceived that she could have had a vaginal birth:

> "… If they just …give us little bit help, maybe I can deliver baby by myself. But they don't. But I almost done because it's very maybe difficult for doctor decide. But he can try. …But he didn't do nothing. Just say okay, go. …I don't know why, so I think maybe doctor tired?"
>
> Mother

She was very distressed about the obstetrician's decision at the time of her delivery. She noted that the provider did not say anything to make her feel better:

> "…for me, it's first time. So I'm worried. But if he say something, "don't worry, it's okay, you'll get fine, nothing else, is very normal", maybe I can feel it's okay. – No."
>
> Mother

Her experience with her obstetrician, whom she perceived as uncaring and inattentive, is strikingly similar to the experiences documented by Wang (1998) of other Chinese immigrant women in Canada with physicians (often, family physicians). The women in Wang's study, too, reported that the providers did not show interest in them as human beings, and did not bother to explain their rationale for decisions. Similar to the mother's experience in my study, the Chinese immigrant women in Wang's study were not proficient in English. Their negative experiences with doctors seem to resonate with the findings of the study by Small et al (2002) conducted in Australia, which showed that immigrant women who did not speak English very well were less likely to be very happy with their care during labor and birth among other things, compared to immigrant women who spoke better English.

However, it should be noted that the one mother's negative experience with a doctor is an exception in this study. She was the only participant who reported an experience with an inattentive/uncaring provider. Furthermore, in contrast to the participants in Wang's (1998) study, the participants in my study did not complain

about their family physicians. To reiterate, in contrast to Chinese immigrant women in Wang's study who reported feeling frustrated, devalued, and disconnected when interacting with health care professionals, the participants in my study typically perceived their providers as pleasant to interact with.

Ease of Communication

Participants' experiences with providers in terms of ease of communication with providers, particularly, the exchange of information, were more variable than their perceptions of service providers' interpersonal qualities/manner. Participants' discussions about the ease of communication with service providers focused on English versus Mandarin as the language of communication. It is noteworthy that participants discussed the role of language in their experiences with health care services only (including providers, facilitators, and/or attendees of such), and not with social services. Half of the participants discussed how the language in which the service was offered enhanced or detracted from their experience of the service. Most of them commented on the importance of language for communicating *health-related information* specifically, rather than on the experience of a generalized language barrier. In particular, some participants, particularly one couple, appreciated the fact that the prenatal class offered through their ethno-cultural organization was taught in Mandarin. It should be noted that this couple attended two prenatal classes, a prenatal class in Mandarin and a prenatal class for the general public taught in English. The couple had a positive experience with the Mandarin class, but a negative experience with the English one:

> "… the instructor [of the English prenatal class] talk a lot of thing… I still can't understand. …because … there are lots of medical term. … so the Chinese class is very good for us. We can understand totally."
>
> Mother

> "[The prenatal class] teaches us in Mandarin, that's good, because we also went to a prenatal class, nurse is speaking English, so …some medical terms we don't [understand] totally. …So we need to go to the Chinese one. [laughs]"
>
> Father

Interestingly, the rest of the participants did not comment on the language of instruction of their Mandarin class as an important feature of it. It is possible that they saw it as a given, because they did not have an opportunity to compare, unlike the one couple.

Also, some participants including the couple quoted here appreciated the opportunity to be able to communicate with a PHN in Mandarin in the context of postpartum support.

> "…[in English], it's difficult to find a good word to explain some …symptom of the baby. But in Chinese, oh, it's very easy… . I think it's fortunate for us that the community nurse know Chinese and we communicate very clearly."
>
> Father

> "[The PHN] gave us her number, and say, 'If you have any concerns and uh problems, questions, give her a call. … she speaks Chinese, which is a kind of better, for us to communicate. Because … it's easier for me to describe in baby's problems, in Chinese. Cause sometimes in medical terms, I really have to consult in the book."
>
> Mother

Similarly, a mother noted that she had good communication with her Mandarin-speaking family doctor:

> "My family doctor give me very support for, he is the Chinese. We have good communication…"
>
> Mother

One woman faced a significant language barrier in her interactions with services. During her pregnancy, she was diagnosed with gestational diabetes. It was often the case that she needed to ask questions about her illness to the staff of the diabetes clinic where she was getting care. In order to ask those questions, she had to go there in person, rather than making phone calls, because communication in English on the phone was challenging for her:

> " For me I, I just go there directly and ask them. It's not from the phone call because the English no good. …I don't like the phone because they don't know [that my] English no good so they speak very quick and fast."
>
> Mother

This mother commented, however, that the staff at the clinic made an effort to alleviate the language barrier for her when interacting with her face to face. Interestingly, the clinic staff seemed to be accommodating to her language needs in the context of an in-person encounter, but not when communicating on the phone. It is noteworthy that she did not talk about the need to go to the diabetes clinic for asking a question, instead of making a phone call, as an inconvenience. However, elsewhere in the interview, she noted how it was tiresome to take the bus to appointments. It does not seem that she held the service providers responsible. On the contrary, she saw the language barrier as her problem:

> "I think … it's my problem. … You speak English, it's not very well. People can't … understand. But some words you don't know how to say so they don't know …how help you. So it's big problem, but not for them, it's for me."
>
> Mother

Her view of the language barrier is very similar to the view expressed by immigrant Mexican women in the US (Sherraden & Barrera, 1996). These women

noted that because of the language barrier, doctors did not explain things to them and did not reassure them. However, this was not seen as doctors' fault.

In summary, based on the data from participants reporting a language barrier, it appears that there were two distinct types of barriers, generalized and specific to health-related vocabulary. Only one participant seemed to experience a generalized language barrier. She had difficulty understanding heath care providers, because they spoke too fast, and she also had difficulty expressing herself. In contrast to this woman's experience, for other participants who commented on a language barrier in their experiences with services, the issue was health-related vocabulary only. One father also talked about how he made a request to his parents in China to send him some books about pregnancy and/or infant care in Mandarin "because the English book is not that well for [him]".

Summary of Findings

This study generated findings about experiences of Chinese immigrant first-time parents with human services during the transition to parenthood. These findings pertain to (1) the types and prevalence of human service use, (2) reasons for using human services, and (3) quality of experiences with human services. Key findings are highlighted in the following summary.

The use of health care by Chinese immigrant men and women during their transition to parenthood was common, whereas their use of social services was limited. As far as health care services are concerned, participants used a range of types of services available to expectant/new parents through the Canadian public health system. In contrast, the use of social services was limited to programs for

parents with infants, and those were not used very commonly. Men did not use any social services, in contrast to women, and were less likely to use health care services than women.

When participants sought help from human services, it was mostly for their infants' health-related issues. The bulk of the health-related issues for which help was sought from services were the infant's immediate health-related issues. Furthermore, it was not uncommon that help with health-related issues was sought from peers in addition to seeking help from services. At the same time, participants almost never turned to their own parents for advice on health-related issues. Moreover, they preferred professional advice over their parents' advice, specifically in infant-related matters.

Overall, participants' experiences with human services were positive. Human service providers seemed to meet the participants' needs ad-hoc, that is, by responding to the participants' issues, and proactively, by providing valuable information. Also, participants did not seem to have problems accessing most of the services, with the exception of short-notice appointments with pediatricians. Overall, participants had positive interpersonal interactions with service providers. A language barrier in communicating with services providers was not a very common and pervasive experience, which likely contributed to the overall positive nature of participants' experiences with services. Nevertheless, many participants also appreciated the services that were provided to them in their native language, Mandarin.

CHAPTER 5

DISCUSSION AND CONCLUSIONS

Contribution to and Implications for Research

This study has begun to address the gap in the research on the use of human services by Chinese immigrants during their transition to parenthood in Canada. In fact, as far as I can determine, it is the first study to explore and provide findings on the patterns of and experiences with human service use by Chinese immigrants in Canada who are expectant/new parents. My study also contributes to the transition to parenthood research on immigrants in general. First, it adds to the limited research that has considered experiences beyond the first month after the birth of an infant. Second, it adds to the even more limited literature that incorporates the perspectives of expectant/new immigrant fathers.

As discussed in the *Introduction* (Chapter 1), there is a concern on the part of policy makers and researchers that immigrants might underuse services that they need (see Baker & Benjamin, 1995; Chu, 2008; Fleury, 2007). In the same vein, the literature on immigrants indicates that access to services by immigrants, especially new immigrants, might be compromised by a number of barriers, such as language barriers, unfamiliarity with human service systems, ineligibility, and cultural inappropriateness of services (see Bowen, 2001; Fowler, 1998; Katz & Hofer, 1994; Ngo-Metzger et al., 2003; Stewart, 2003). Below I discuss my findings in light of the above problematic.

First, contrary to previous research pointing to the possibility that immigrants might be underusing services, the participants in my study used a

variety of services as needed. In particular, as far as health care use, Chinese immigrant parents and their infants accessed many of the public health services established to promote the health of mothers and infants, such as the prenatal classes, a health care information phone line, a post-partum visit by a PHN, and infant immunizations.

Lack of information on available health care services as a barrier to care did not seem to be a concern for the participants of this study. Their use of the aforementioned services implies that they had received information about available services through service providers and/or from alternative sources, such as friends and the Internet. In fact, my observation from the data is that friends were identified as a source of information about available services more often than the Internet. This probably reflects the reality that participants in my study had an established network of friends who could assist them as new parents. It makes sense that the participants, despite their high level of education which assumes ability to use the Internet for information searches, would rely on their friends, rather than Internet for information about services, as friends might have first-hand experience with services. In any case, the question of how (Chinese) immigrants access information about services is important and merits further research as such knowledge has implications for service providers in terms of the need/best ways to disseminate information about services.

Also, the participants did not seem to experience prohibitive language barriers to services, contrary to the suggestions in the literature (see Fowler, 1998; Katz & Hofer, 1994, for instance). No participants reported being unable to use

needed services because of language barriers, as for instance, was the case for refugee mothers in a study in Montreal and Toronto who could not receive post-partum support offered by PHNs because they did not speak either of the official languages (Merry et al., 2011). It seems that the participants in my study were in fact able to communicate with service providers effectively, despite the fact that not all of the participants spoke English very well. Furthermore, many of the participants in my study had the benefit of receiving some health care services, such as prenatal classes, post-partum support by PHNs, and family doctor-provided health care, in their native language. Some participants were receiving multiple health care services in Mandarin.

One of the key findings from my study is that typically, the participants were able to have their problems, concerns, and questions resolved by service providers. These findings are consistent with the literature suggesting that services meet childbearing immigrants' needs (see Loiselle et al., 2001), and contrast with some research suggesting that childbearing immigrants might be receiving sub-optimal care (see Katz & Gagnon, 2002; Reitmanova & Gustafson, 2008). Another notable finding from my study is that, overall, the participants had positive interactions with service providers and perceived them as pleasant to interact with. These findings contradict previous research that explored the interaction aspect of Chinese immigrants with health care service providers, documenting salience of negative experiences (see Wang, 1998).

It should be noted, however, that the overall positive nature of experiences of the Chinese immigrants in my study could be related to their relative

proficiency in English (proficient enough for the study interviews to be conducted in English) and a high level of education. I will first discuss the link between English proficiency and quality of experiences with services, and then the link between the level of education and quality of experiences with services.

The presumption that the level of English proficiency has a bearing on the quality of experiences with services is supported by findings from my study as well as from previous research. In particular, previous research has established a link between the quality of care as perceived by immigrant women and their proficiency in English (see Small et al., 1999). In fact, this link was corroborated in my study as well. It was the woman whose English speaking and reading ability was lower than that of most participants who reported the most negative experiences with service providers. What is unclear though is the "mechanism" that links the level of English proficiency to the (perceived) quality of experiences with services. One possible explanation is that a person who is not proficient in English is not able to communicate his/her needs to service providers. Thus, the person's needs go unmet, hence dissatisfaction with a service. An alternative explanation is that inability to express oneself and not understand service providers may make a person feel insecure and frustrated (see Schott & Henley, 1996, for instance).This sense of insecurity and frustration might precipitate negative perceptions of services providers and the quality of services. Explicating the connection between the level of proficiency in the "dominant" language and satisfaction with services is a task for future research.

The speculation that the quality of experiences with services could be influenced by the service user's level of education is more tentative. Among the key findings of my study is that the participants were receptive toward input from health care providers and actually followed their recommendations. It is possible that such receptivity primed the participants for positive experiences with service providers. The receptivity toward input from service providers on the part of the Chinese immigrants in this study could, in turn, be determined by their high education attainment. Additional research is needed to explore a possible link between the level of education and receptiveness toward service providers and whether/how these influence the quality of experiences with services.

The findings of this study also add to the existing evidence that the choices made by immigrants with regard to childbearing-related services (and childbearing options in general) are within the biomedical model of childbearing (see Cheung, 2002; Tsianakas & Liamputtong, 2002). The participants in my study did not explain their rationale for the childbearing choices they made. Considering that immigrants' decision making with regard to childbearing options has not been systematically explored even in the broader literature on childbearing in the context of immigration, this is a gap for future research to address.

A special comment is due about certain topics on which I expected to find something in my study, but did not. When I started working on my thesis, the review of the literature on the use of services by Chinese (childbearing) immigrants sensitized me to two cultural phenomena that seemed to be essential in health care behavior and childbearing experiences of Chinese people, in particular,

the Chinese traditional childbearing practice of "sitting-in for the month" and the use of traditional Chinese medicine (see Chapter 2, *Literature Review*, for details). These did not emerge as major topics in the participants' discussions.

The "silence" of the participants in my study on the topics of the Chinese "sitting-in for the month" tradition and the use of traditional Chinese medicine could be interpreted in different ways. One interpretation is that they did not talk about these traditional practices because these phenomena were not part of their experiences. Another possible interpretation is that they were indeed part of their experiences, but they did not bring these up because they were not asked about these topics in the interview. Still another plausible interpretation is that the participants "silenced" these topics intentionally.

The latter interpretation is grounded on a number of observations from the data in this study combined with "leads" from the literature. As far as the "sitting in for the first month", the major type of support that the women received from their parents(-in-law) (primarily, their mothers and mothers-in-law) was support with chores, such as cleaning, cooking, and more often than not, with infant care. This support is consistent with the "sitting-in" tradition prescribing that women after childbirth be spared from physical work. However, most of the participants did not comment on the purpose of their parents'(-in-law) coming to Canada around the time of the infant's birth, that is, on what justified the sacrifices that the family members had to make, such as financial expense, social isolation, intergenerational conflict, and potentially, other sacrifices that the participants did not identify. Only one woman explicitly stated that the purpose of her mother's

coming to Canada was to help her practice the "sitting-in" tradition. She was also the only participant who stated her trust in the tradition, but admitted to feeling somewhat ambivalent about it, too.

The sense of ambivalence about traditional Chinese childbearing traditions on the part of Chinese women is also evident in the literature. Chinese women might denounce Chinese childbearing traditions as superstitious, but practice some of them nonetheless (see Cheung, 1997). In my study, one woman stated that she did not intend to practice "sitting in for the first month" because it was not healthy, but her mother-in-law came to Canada and supported her by doing house chores. To me, the above observations point to the possibility that Chinese immigrants might be self-conscious about identifying with traditional Chinese childbearing practices and/or beliefs, and probably, more so, when talking with non-Chinese researchers.

As far as the use of traditional Chinese medicine is concerned, it is possible that the participants chose not to reveal information about this as well. Previous research suggests that Chinese immigrants (among other immigrant groups from Asia) are sensitive to a lack of understanding of their traditional medical practices on the part of Western health service providers (see Ngo-Metzger et al., 2003). It is likely that Chinese immigrants might be withholding information related to all kinds of traditional health care practices, childbearing or not, in their communications with "westerners", for fear of being misunderstood or disapproved of. It seems to me that these two topics deserve further investigation in order to determine to what extent Chinese immigrants follow the traditional

ritual of "sitting-in for the month" and to what extent they use traditional Chinese medicine. Knowledge about these topics is important. For instance, there is an increasing concern in medical research about potential interaction between herbs, which are a mainstay of traditional Chinese medicine, and therapeutic drugs (Sawa, Baharia, Anga, & Limb, 2006). The possibility that immigrant Chinese women might be taking, but not revealing their use of, herbs (alone or in combination with therapeutic drugs) during pregnancy and when breastfeeding augments the concern about possible side effects of herbs as it is not only the woman's health that is at stake, but also that of the fetus/infant. If use of herbs by Chinese women remains "hidden" from health professionals, then potential risks or possible alternatives cannot be addressed.

Among other topics that I expected to explore in depth, but found very little about was the participants' experiences with social services as they did not talk much about these. This could be because use of social services was not a major focus in the study from which I accessed my data. Another possibility is that the participants indeed did not extensively use social services. What makes the latter explanation plausible is previous research that documented that many recent Chinese immigrants, especially those who were more educated, did not use social services designed for new immigrants from China (see Ma & Chi, 2005). What previous research has not addressed is whether Chinese immigrants used mainstream social services (i.e., social services designed for the general public rather than services for immigrants). In the immigration literature, there is some discussion of how certain mental health services might be culturally inappropriate

for immigrants (see Ngo-Metzger et al., 2003, Stewart, 2003). The lack of conclusive findings on the use of *social services* by the participants in this study and in previous research implies that more research is needed to determine to what extent Chinese immigrants use social services, including mainstream, immigrant-oriented, and services provided through their ethno-cultural organizations, and to what extent they find such services to be culturally-appropriate.

Although my study provides new knowledge about Chinese immigrants' experiences with human services, its limitations should be kept in mind. First, the study research questions were answered on the basis of a re-analysis of existing data from a study for which the topics explored in my study were peripheral. Second, the sample in my study was rather homogeneous in that participants were very well-educated, were functionally proficient in English, and most were members of or connected to the same ethno-cultural organization (church). Future investigations of the experiences of Chinese immigrants with services during the transition to parenthood would benefit from including a more diverse sample of Chinese immigrant new/expectant parents in terms of level of education, English proficiency, and level of integration into their ethno-cultural community.

Implications for Practice

Some of the findings from my study have important practice implications associated with language, access to pediatricians, and, to some extent, access to programs for parents with infants. I discuss these implications below.

Although participants did not report a prohibitive language barrier to services, many experienced a specific type of language barrier, a language barrier

to healthcare *information* in English, communicated to them directly or indirectly (e.g., in books). The participants reported having trouble understanding and using health-related vocabulary in English. This finding suggests that Chinese immigrants who are expectant/new parents could benefit from educational materials (e.g., leaflets, brochures, etc.) translated in Mandarin. I would also recommend that plain language be used, if the information is communicated in English, in the written or oral form. I would like to draw attention to the fact that as a group, the participants in this study were proficient in English (at least proficient enough to have interviews with them conducted in English), and well educated. Their education level and English proficiency may, in fact, be higher than those of the general population of recent Chinese immigrants. Thus, it seems that availability of information materials in plain language and/or translated in Mandarin could enhance experiences with human services for recent Chinese immigrants, and more so for those who are less educated and have lower English proficiency.

The second implication for practice relates to the participants' experiences with pediatricians. The participants reported having trouble accessing pediatricians, which also seems to be the experience of the general public. This fact itself does not merit a recommendation as participants were able to access care from other health care services. What warrants a recommendation is the finding that the participants were so desperate to see pediatricians and seemed to perceive that they were wronged by the "system" when they had to seek care from sources other than pediatricians. It seems that recent Chinese immigrants who are

expectant/new parents could benefit from assurance that pediatricians are not necessary for many of infant health concerns and there are alternative services already in place to help with infant health concerns, such as PHNs and Health Link.

Furthermore, the data indicate that it was parental anxiety about the infant that led them to seek health care services for minor ailments of the infant, and precipitated their sense of desperate need to see pediatricians. Many of the participants stated that as new parents, they were anxious about the infant's health and wellbeing. Some made an explicit connection between their "new parent anxiety" and decision to seek services for their infants. The concept of "new parent anxiety" is quite intuitive as one could expect first-time parents, regardless of their ethnic background, to be anxious about the health and wellbeing of their child, especially during the first months of his/her life. However, to my surprise, I was not able to find any literature, qualitative or quantitative, to support the idea that feeling anxious about one's infant's health and wellbeing is a common experience of first-time parents. At best, I was able to locate a few quantitative studies concerned with measurement and prevalence of anxiety, defined in psychiatric terms, in expectant and/or new mothers (see Phillips, Sharpe, & Matthey, 2009, for instance). Furthermore, this literature indicates that at least some anxieties are more prevalent in expectant and/or new mothers compared to the general population (see Ross & McLean, 2006). In making a recommendation related to new parent anxiety as identified by participants in my study, I limit my comments to Chinese immigrant new parents, rather than new parents in general. Thus, it

appears that expectant/new parents who are recent immigrants from China might benefit from support to help them address anxieties about their infants' health. Such support should include affective support and importantly, relevant information regarding the infant's common ailments, as well as information about normal infant physiology, growth and development. Also, it might be beneficial to provide this kind of information proactively. This kind of support could prevent unnecessary visits to physicians, as well as help parents avoid the frustration associated with inability to make appointments on short notice. The possibility that such information would be welcomed by Chinese immigrant expectant/new parents is very high, given the participants' receptiveness towards input from service providers. The participants looked to health care service providers for authoritative health-related information, and actually followed service providers' advice. Importantly, participants were skeptical of input from their own parents in infant-related matters. In fact, typically, they opposed the Chinese traditional infant care practices promulgated by their own parents, and were successful in enforcing infant care practices as promoted by Canadian health care providers instead. The implication of these findings is that the compliance of Chinese immigrant expectant/new parents with best infant care practices as recommended by public health is not a concern. However, the other side of this is negative family dynamics. There is an indication from my data that non-adherence to traditional Chinese infant care practices on the part of the participants was associated with conflict, overt or covert, between them and their parents(-in-law). It seems that

new Chinese immigrant parents and grandparents might benefit from guidance and support regarding family dynamics, relationships, and conflict resolution.

A final implication for practice relates to the finding that some participants experienced barriers to programs for parents with infants, as discussed in the *Findings* chapter. Some of these barriers, such as lack of time or lack of transportation, may belong with the individual, over which service providers have no or little control, whereas inflexible scheduling of programs is a barrier originating with services themselves, and thus is systemic in nature. The findings from my study indicate that mothers who work full-time would attend programs for parents with infants more often, if they were offered on weekends.

Conclusions

The purpose of this study was to explore the experiences of Chinese immigrants with human services during their transition to parenthood in Canada. Overall, the findings of this study paint a rather positive picture with regard to Chinese immigrants' access to and experiences with human services. In particular, they accessed many of the public health services established to promote the health of mothers and infants. Also, the participants of this study had overall positive experiences with services in terms of "outcomes" and the "process" of using a service. In particular, the participants felt that services met their needs, and service providers were pleasant to interact with. Furthermore, participants were receptive to input from service providers. Together, these findings indicate that immigrant Chinese expectant/new parents, specifically those who are well educated and have good English proficiency, might be enjoying very good access to services,

particularly, to health care services, for their infants and themselves, and might have positive experiences with services, which bodes well for their health and wellbeing in the future and their adjustment to parenthood.

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Appendix A – Scientific Summary of the *MIS* study

FACULTY OF NURSING
UNIVERSITY OF ALBERTA

MOBILIZING INTERGENERATIONAL SOCIAL SUPPORT DURING THE TRANSITION TO PARENTHOOD

SUMMARY OF RESEARCH[1]

Dr. Kaysi Kushner, Dr. Deanna Williamson, Dr. Miriam Stewart, Dr. Nicole Letourneau, Dr. Denise Spitzer, Dr. Gwen Rempel, & Dr. Rhonda Breitkreuz[2]

PURPOSE

This study examines how first-time mothers and fathers seek and experience social support to manage responsibilities in family and paid work. Strategies for mobilizing support exchange between parents and grandparents, and implications for family well-being during the transition to parenthood will be explored. Gender, socioeconomic, and cultural influences on intergenerational social support for low-income, immigrant, and middle class families will be explicated.

BACKGROUND

The transition to parenthood is experienced by most couples. This transition challenges new parents' ability to deal with family and paid work demands. Grandparents provide social support to their adult children by sharing knowledge, experience, and caregiving. Most men and women in Canada, however, become grandparents during midlife and must deal with their own multiple demands from family and paid work. Social expectations about the availability of family support for new parents are challenged by employment, geographic mobility, and policy conditions that may be out of step with traditional images of grandparents ready to provide assistance.

Social support is a protective factor which facilitates the development of family strengths to deal with everyday, as well as extraordinary challenges. Social support can be provided informally by the natural network of spouses, partners, family, and friends, and formally by professionals and through programs and policies such as parental leave and employer-provided family benefits.

Several major knowledge gaps will be addressed. Limited attention has been directed to support exchange between generations, particularly during the transition to parenthood. Research has mainly focused on women's experience and has largely overlooked men's experiences of social support particularly during the transition to fatherhood. Moreover, there is limited understanding of the intersection of social support, employment, culture

[1] This research project is funded by the Social Sciences and Humanities Research Council of Canada (SSHRC).

[2] Drs. Kushner, Stewart, & Rempel, Faculty of Nursing; Drs. Williamson & Breitkreuz, Human Ecology, University of Alberta; Dr. Letourneau, Faculty of Nursing, University of New Brunswick; Dr. Spitzer, Institutes of Women's Studies and Population Health, University of Ottawa

and gender ideals for new parents and grandparents in diverse population groups. The socio-economic and political context in Alberta, including a recent decade of social system reforms, recession followed by the current boom economy, and population growth double the national average primarily from international and inter-provincial immigration, provides a unique setting in which to study social support and family transitions.

DESIGN & METHODS

The study uses a prospective, critical ethnographic approach in the sociological tradition. The purposive sample includes women and men who are first-time parents, are employed at least 15 hours/week (at least one member of a couple), live in the Edmonton area, speak English or can be interviewed with assistance of an individual to translate interactively, and have at least one parent available for face-to-face or telephone interviews. We recruited 21 families who reflect economic and cultural diversity in Alberta, specifically families who (a) live on low income; (b) immigrated to Canada in the past 15 years; or (c) are middle or high income. Initial individual interview were completed during the 2nd or 3rd trimester of pregnancy and one or two follow-up interviews were completed between 3 and18 months after birth (in relation to grandparent visits for immigrant families and to mother's decisions about returning to paid work for all families). Documents will be collected to examine federal, provincial, and participant workplace programs and policies that enhance or detract from social support mobilization during the transition to parenthood.

IMPLICATIONS

The findings of this study will provide information useful to health and social service professionals in tailoring programs and policies that support the transition to parenthood for parents and grandparents.

For more information, please contact Margo Charchuk (492-6099; margo.charchuk@ualberta.ca) or Dr. Kaysi Kushner (492-5667; kaysi.kushner@ualberta.ca)

Appendix B – The *MIS* study interview guide

FACULTY OF NURSING
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Mobilizing Intergenerational Social Support during the Transition to Parenthood
Initial Interview Guide for Parents: 20 June 2007

Preamble

Before we begin, I want to assure you again that what you tell me in the interview will be kept confidential and not shared in any way with other family members we interview as part of the study (e.g., spouse, grandparents). That is also true of other family members – I cannot talk with you about anything they might have told me. The ecomap that you completed will also be kept confidential. The genogram that was completed separately is the only document that will be shared, since this contains only factual background about family members such as age and kin relationship.

We will start the interview with a general question to help understand your daily experience, then we will talk about social support experiences, and we will end by talking about becoming a parent.

Introduction

1. Please tell me about a "typical day" for you at home and at your job (if employed), as you prepare for the birth of your first baby. (Open description, no probes at this time)

Social Support Experience

2. Who and what has been supportive or helpful to you as you prepare for the birth of your baby? (Probe re: who: own parents and in-laws; also include other family, friends, employer, health professionals, health care or social service agencies; Probe re: what: policies – maternity leave, work place policies, programs, work schedule, medical coverage from work).
3. Now I will ask about experiences during this time that you have found to be supportive or helpful and not so much. What is one example of an experience that you have had during this time that you think was
    a. most supportive or helpful to you? What made this example helpful?
    b. least supportive or helpful to you? What made this example less or possibly not helpful?

    (May be able to probe re: specific example cited in previous question.)
4. As you look ahead to the birth of your baby, what support or help would you like
    a. to receive from your partner (if involved) and from your parents and in-laws (if involved)?
    b. to give to your partner (if involved) and to your parents and in-laws (if involved)?
5. What support or help would you like to receive from others?
    a. Probe re: other family, friends

   b. Probe re: workplace, health and community services, programs, or provisions or benefits (e.g., parent leave)

6. Now I'd like to talk about how you go about getting support. How do you decide when and what support or help you need while you prepare for the birth? (Focus: deciding as thinking and considering alternatives – to stimulate descriptions that get at the process of decision making, not just the moment of choice. Probe re: specific example cited during interview. Or ask for specific example, if above is not that informative.)
   a. What choice was made (to ask for, to accept, to seek out, etc)
   b. Is this usual way of acting or interacting in relation to support or help?
7. Once you decide what you need, how do you go about getting support? (Probe to clarify from whom, where, what)
8. What might make getting needed support easy or difficult for you? (Probe re: comfort in asking for or accepting support; access to workplace or health benefits such as paid leave; access to health or social services; expectations about what it means to be a good parent or grandparent)
9. What does support mean to you?

Becoming a Parent Experience

10. What does parenting mean to you? (Alternate wording: What does it mean to you to be a parent?)
11. As you think about "becoming a parent", how do you think support will affect
   a. your adjustment (to becoming a parent)?
   b. your ability to deal with multiple responsibilities?

Before we finish the interview:

12. Is there anything about preparing for first-time parenthood or support that we have not talked about that you would like to tell me before we finish this interview?

Affirming Consent: Now that you know what you have talked with me about, are you willing to have the interview be used for the study?

Appendix C – Ethics board approval

From: hero@ualberta.ca
Sent: Friday, April 16, 2010 10:24 AM
To: Kaysi Kushner
Subject: HERO: An Amendment or Renewal has been Approved

Amendment/Renewal to Study has been Approved

Amendment/Renewal ID:	Pro00003449_REN2
Study ID:	MS2_Pro00003449
Study Title:	Mobilizing Intergenerational Social Support during the Transition to Parenthood
Study Investigator:	Kaysi Kushner
Description:	The amendment/renewal to the above study has been approved. Click on the link(s) above to navigate to the HERO workspace. Please do not reply to this message. This is a system-generated email that cannot receive replies.

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