THE EXPERIENCES OF CHINESE IMMIGRANT WOMEN WITH THE HEALTH CARE DELIVERY SYSTEM IN CANADA

by

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Submitted in partial fulfillment of the requirement

for the Masters of Nursing

at

Dalhousie University

Halifax, Nova Scotia

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DEDICATION

This thesis is dedicated to the 7 Chinese immigrant women who agreed to work with me and shared their personal experiences regarding their interactions with the Canadian health care delivery system. It is also my hope that this thesis is dedicated to my parents, to their love, support and encouragement.

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ABSTRACT

Many research has demonstrated that immigration to a new country has been a stressful experiences. Immigrant women's experiences of immigration have reflected "double discrimination" in Canada, and their stories have seldom been heard in the studies of immigrant populations. Chinese immigrant women have been doubly invisible and doubly silenced socially, politically and economically. This study has attempted to create the knowledge of Chinese immigrant women's perceptions of the health care delivery system from their own perspectives by exploring their experiences in relation to maintaining their health in Canada.

A qualitative approach was taken based on the feminist methodology. Multiple in-depth interviews were employed to collect data and thematic analysis was utilized to generate the themes of the participants' stories. In fact, their primary issues have been related to their interactions with doctors and their perceived experiences with racism. "A doctor is an empire" was an expression employed by these women which represented their relationship with their doctors. A number of factors were identified by the women as the barriers to their comfort when they access health care services in Canada. Their interactions with the health care professionals, specifically with their doctors, were characterized by their feelings of frustration, devaluation and disconnection.

The strategies developed by the women to deal with these challenges reflected Confucian philosophy and Chinese cultures. These strategies enabled the women to regain a sense of self-control and inner equilibrium in their struggles of maintaining health in Canada.

ACKNOWLEDGMENTS

I would like to express my heartfelt thanks to the Chinese immigrant women in Halifax, who so kindly gave their time and shared their very personal experiences with me. By working together, we have gained insight into the social issues that shape immigrant women's live experiences of "double discrimination". I have learned so much from you, and your support and contributions to my work were invaluable.

Thanks to my principle advisor, Dr. Barbara Keddy, for your support, knowledge, and endless patience, with special appreciation to your believing in my ability to succeed, and I could not express how it was important to me, as a international student, to complete this work. Your expertise in feminist research, your understanding and caring altitude made my experiences of working with you grateful, rewardful and most-valuable.

Sincere appreciation to Dr. Herb Gamberg, for working so closely with me, your thoughtful suggestions and valuable feedback. I could not have completed the thesis without your great help in last 2 years. Many thanks to Professor Lynette Mensah, for your interest, the time you contributed and your insightful feedback about my work. Your expertise and enthusiasm made it a pleasure to work with you.

Finally, my thanks go to my family, my husband and my son. Your love, support and encouragement were also invaluable.

CHAPTER I

INTRODUCTION

In recent years there has been a marked increase in the numbers of immigrants coming from different countries to Canada. From 1990 to 1995, the annual number of immigrants to Canada has been maintained at 190,000-250,000 (Statistics Canada, 1996). Among immigrants, about 8% of them are Chinese, and more than half of Chinese immigrants are women (Statistics Canada).

Immigration has played an important role in the growth of the Canadian economy, and immigration policy has periodically altered to meet the changing needs of the country (Estable, 1987). Historically, Canada has selected immigrants from specific ethnic and racial groups: primarily white and European (Estable, 1987). Before the 1960s, Canadian immigration policies directed toward Chinese, and the "head tax", made it very difficult for Chinese immigrants to enter Canada (Baureiss, 1987; Estable, 1987). The Immigration Act of 1967 introduced a "point system" which reflected the economic and labour market demand of Canada in 1960s (Baureiss, 1987). Under this system, most immigrant women enter Canada as a "dependent person" and this structures economic and sexual inequality within the family (Djao & Ng, 1987). Therefore, immigration policies have discriminated against people on the basis of sex, race and class (Ng, 1988).

Although greater individual freedom and economic and educational opportunities are positive aspects of immigration (Tobora & Flaskerud, 1994), research has demonstrated that immigration to a new country has been a stressful experience (Aroian, 1990; Baker, Arseneault & Gallant, 1994; Lee, 1994; Tobora et al., 1993). Upon arrival

in a new society, the immigrant may face stressful experiences due to culture change and conflict; isolation from familiar social networks; economic and social change; language problems and discrimination (Aroian; Kuo & Tsai, 1986; Lee).

The term "immigrant women" refers to women who choose to depart from their homeland legally to establish permanent residence in Canada. Immigrant women, being often non-white, and women, have experienced "double discrimination" in Canada, white and male dominated society (Salmon, 1989). Immigrant women occupy a structured position subordinate to white women in Canadian society, especially in the Canadian labour market (Anderson, Blue, Holbrook & Ng, 1994; Medjuck, 1990).

Anderson et al. (1994) argued that the conditions under which immigrant women live and work can have profound effects on their health. Meleis (1991) asserted that immigrant women should be considered a population that is at high risk for physical and mental distress. However, despite the number of immigrant women and their centrality to the immigration process, they have seldom been heard in feminist studies of women as well as in studies of immigrant populations (Anderson, 1985; Meleis). Very little is known about their life experiences in Canadian society, their health care needs and their health status, their feelings, and their ways of coping with the dilemma of double discrimination (Noel, 1996; Yee, 1987). Chinese immigrant women have been doubly invisible and doubly silenced socially, politically and economically throughout history (Yee, 1987).

To influence health policy and develop strategies to meet the real needs and demands of immigrant women, we have to develop an understanding of their experiences when they interact with the health care delivery system and how they see themselves in

relation to this ethnocentric health care delivery system. Anderson et al. (1994) suggested that health professionals often have not realized and understood the conditions under which immigrant women have lived. Many immigrant women, especially newcomers, have received unnecessarily harsh treatment from health care staff (Brand, 1993). My personal experiences as a Chinese woman, an international student, a mother of a Canada-born infant son, and a friend of new Chinese immigrant women, highlight the issue that Chinese immigrant women often need medical care while they have struggled to understand the health care system, its culture and Canadian society.

The focus of this research was to generate knowledge of Chinese immigrant women's perceptions of the health care delivery system from their own perspective by exploring their experiences in relation to maintaining their health in Canada. As Chinese immigrant women are usually neglected in the nursing research, I believe that this study will provide certain directions for health care professionals to consider for the competent and sensitive care of people from all ethno-cultural groups.

Research Questions

The purpose of this study was to explore and describe the perceptions of Chinese women's experiences with the health care delivery system. The primary research questions addressed were:

1) What are the experiences of Chinese immigrant women when dealing with the Canadian health care system?

2) What are the strategies developed by Chinese immigrant women in response to the challenges they have encountered in their interactions with the health care delivery system in Canada?

CHAPTER II

LITERATURE CRITIQUE

In order to understand Chinese immigrant women's experiences and their activities related to health care seeking, we have to analyse their lived experiences in their socially, politically, economically and historically specific contexts. When talking about immigrants' experiences on an individual level, the mainstream histories of ethnic groups in Canada present an example of the picture painted from the male point of view. As Boyd (1984) asserted, immigrant women have been ignored in research studies because of their dependent status. Although awareness of the need to understand the immigrant women's experiences is growing, the voices of immigrant women have been excluded from feminist research (Anderson et al., 1994; Lugones & Spelman, 1983). As Agnew (1993) argued, white feminist ideology and practice "was of little relevance to the conditions under which Chinese, Japanese, or women from India and the Caribbean were admitted into Canada..., and to the hardships of their everyday experiences" (p. 220). We do not, however, ordinarily see the experiences of Chinese immigrant women in the reviewed literature. Because of the scarcity of primary and secondary materials on Chinese immigrant women in reviewed Canadian literature, the following discussions will include certain studies conducted in the United States.

Chinese Immigration

Leaving little to be proud of, Chinese Canadian history is a history of institutional racism and discrimination (Li, 1988; Yee, 1987). Chinese immigration to Canada began around 1858 (Li, 1988). Chinese initially migrated from the west coast of the United

States in response to the gold rush in British Columbia, and then they came directly from China when the Canadian Pacific Railway was constructed between 1881 and 1885 (Li, 1988). Their initial arrivals were greeted with approval because the Canadian government believed that the Chinese would provide inexpensive and reliable labour (Baureiss, 1987). After that, there was the time when severe immigration restrictions were introduced, such as "head-tax" being levied against Chinese immigrants and the 1923 Exclusion Act which halted Chinese immigration (Yee). Most Chinese men were denied a conjugal family life and were forced to live in a predominantly "married-bachelor" Chinatown (Li, 1988). The Immigration Act 1967 introduced a "point system" according to which immigrants were selected. This system has focussed on the economic aspect of immigration and the need for highly educated immigrants (Li, 1993). It has encouraged Chinese immigration from communities throughout the world, that is, people who had education, professional qualifications, or entrepreneurial and other skills (Li, 1993). According to Li (1993), about 85% of Chinese immigrants came to Canada after 1967. Today, the Chinese have resided in all provinces, with a high concentration in British Columbia and Ontario (Statistics Canada, 1996). More recently, because of the issue of Hong Kong being given back to China, there has been a great number of Chinese immigrating to British Columbia. Only 18% of them had settled in Nova Scotia (Li, 1993). Most Chinese immigrants came from Hong Kong, and others migrated from the People's Republic of China, Southeast Asia and South Africa (Yee).

The Chinese in Canada have been a visible minority. Prior to 1947, Chinese immigrants were legally denied many of entitlements taken for granted by white

Canadians, which included the right to vote, the right to travel freely in and out of Canada, and the right to enter certain professions and jobs (Li, 1988). For almost a century, the Chinese worked and lived as second-class citizens in Canada (Li, 1993). In 1947, the discriminatory legislation was repealed, and Chinese immigrants began to gain basic civil rights (Li, 1993). The enactment of the Canada Multiculturalism Act in 1988 heightened sensitivity towards minority rights. Despite these legislative advances, the Chinese minority remains an occasional target of social distrust and hostility (Li, 1993). Racism affects every facet of the Chinese Canadian's life (Baureiss, 1987). It is clear that although Chinese immigrants played a important role in nation building and in the economic development in Canada, they have not yet to traverse the social barriers to full acceptance into Canadian society (Li, 1993).

Chinese Immigrant Women

Chinese immigrant women's history is notable because of its absence; it is the history of pain and struggle. According to racist immigration policies, Chinese men were not allowed to bring their wives and families to Canada, and there were few Chinese women in Canada before 1950 (Yee, 1987). "But women did come" as Nipp (1986) titled one of the few historical articles available on Chinese Canadian women. Although Chinese women were few in this early period in Canada, their work, in the home and in family businesses, was very important to maintaining the Chinese family and community (Yee). As most Chinese women enter Canada as "family class" immigrants whose livelihood is dependent on the sponsor (Djao & Ng, 1987), Chinese Canadian women face discrimination on the basis of both race and gender, which is called "double

discrimination". Yee argued that racism is more than the individual incidence of names like "Chinky, Chinky Chinaman" or not getting a job because one is Chinese, whereas, sexism refers to "a deeper phenomenon than experiences like being stereotyped as 'a nice, quiet Chinese girl' in school and at work" (Yee, p. 176). Yee argued that sexism and racism are systemic structures of power, which define the parameters of Chinese Canadian women's daily lives and their future opportunities.

Voices of Chinese Canadian Women is a project which began in 1985 by the Women's Issues Committee of the Chinese Canadian National Council, to give voice to their silenced history (Yee, 1990). In this study, 130 Chinese Canadian women across Canada were interviewed, whose ages ranged from 19 to 85 years. This project was completed with the publishing of the book, which has best informed us about the experiences of racism and the struggles against racism and sexism (Ku, 1992). For example, one woman referred to an experience of being sexually harassed by a potential employer. The employer later did not hire her because, according to him, "a Chinese is bad publicity for business" (Ku).

> I still feel imprisoned here. What's so good about our life in this country? We've our traditions and customs-and you can't do anything about it. Now, I can speak and read some English. And it seems like I can mix with the gui lau, but actually it's just superficial. I have no real friends. (cited in Ku, p. 85)

This is a story of a woman known as Kim, who was bitter about her life because of the many sufferings and the discrimination she bore. The sexist and racist oppression she experienced were doubly painful because she had neither friends outside nor inside the family. Her story is representative of a large number of first generation immigrant women

here who came to Canada in the last 30 years and who continue to struggle with this type of alienation. I agree with the findings of this study; it forces Canadian society to recognize and appreciate the presence of Chinese Canadian women (Ku, 1992). However, in this study two-thirds of the participants were Canadian born and most of them came from Hong Kong (Ku, 1992), hence this study cannot reflect the realities of Chinese immigrant women coming from Mainland China. There is a lot of room for exploring experiences of recent immigration Chinese women from Mainland China, because language and cultural issues are different within this group than those from Hong Kong.

The literature on domestic workers in Canada is full of accounts of exploitation (Agnew, 1993). Agnew argued that it is not only individuals who are responsible for this exploitation, but rather policies and programs which institutionalize existing inequalities of race, class and gender. A study conducted in 1991 by the garment worker's union in Toronto found that of 30 Chinese home workers, only 9 earned the minimum wage and one woman earned only $1 per hour (Campbell, 1992). By the 1990s, women from Third World countries have increasingly stepped in to fill the demand for domestic workers in Canada, while some women even have university education or professional training (Agnew).

In Man's (1995) study, the effects of institutional and organizational process of immigration on Chinese immigrant women were examined. Based on in-depth interviews with recent middle class Chinese immigrant women from Hong Kong, the study indicated that these women experienced an "escalation of traditional roles, unequal distribution of household labour, gender and sexual oppression both at work and in the home" (Man, p.

320). These middle class women have struggled with the daily routine of poor paid work, housework and child care (Man).

According to Western feminism, the global oppression of women is due to the universality of male domination within the family (Bourgeault, 1991). Chinese immigrant women must deal with the consequences of sexism coming from the Canadian society, the immigration policy, the labour market, and even from the Chinese community. The study carried out by Chinese Family Service of Greater Montreal indicated that wife-beating became more frequent once they immigrated to Canada and became unemployed (Block, 1995). This study also revealed that cultural isolation makes it more difficult for the victims to seek help (Block). In summary, no matter how long the immigrant women of colour live in Canada, how fluent they become in the official languages, and how educated they are, they still have less status than white males and females. In general, they have less power and lack of opportunity.

Immigrant Women and Health

Several research studies have indicated that migration results in confronting an unfamiliar culture, this in turn becomes stressful, and this has a significant impact on the immigrant's physical and psychological well-being (Lee, 1994; Mirdal, 1984). Meleis (1991) argued that immigrant women's high-risk status is a product of dynamic interplay between the expectations of the women's original country and that of the host country, and they live in two cultures. Pilowsky (1991) supported this view and contended that immigrant women are a population at risk because they live in situations of continuous emotional distress, and the stress often arises from sudden changes in women's roles after

moving to Canada. As immigrant women, they have to help husbands and children to cope with the process of adaptation, and are forced to perform the double task of working both inside and outside the home, while their own well-being is inevitably neglected (Pilowsky). Therefore, the combination of being a woman of colour, a member of a visible minority, an immigrant, a worker in a poorly paid job, and isolated and deprived of social support, contributes to their health risk status (Lee, 1988; Pilowsky). Epidemiological research on the health of immigrants in the United States indicated that some immigrant groups experience higher rates of disease than people born in this country (Klatsky & Armstrong, 1991).

Mental health of immigrant women has been a theme highlighted in the reviewed literature. Pilowsky (1991) suggested that many areas of immigrant women's lives need mental health support. The issues which need to be addressed include: sexual assault, incest, low self-esteem, coping with loss, parenting and anger. The prevalence of depression among Chinese Americans has been found to be equal or higher than that of the general population in America (Kuo, 1984; Ying, 1990). Both studies found that lower levels of depression related to higher education, higher socioeconomic status, higher job status, and male gender (Kuo; Ying). Otherwise, most studies of the effect of acculturation on Chinese Americans are based on personality tests or anecdotal material from a college population (Tobora et al., 1994). They failed to differentiate between foreign- and American-born Chinese, between the different Asian groups, and between men and women (Tobora et al.). The acculturation experience may have a negative

impact on immigrants, and it may result in self-hatred and self-rejection (Loewen, 1988; Sue & Sue, 1987; Tobora et al.).

Lalinec-Michaud (1988) presented case studies of suicide in Chinese Canadian women to demonstrate the influence of culture conflict and increased vulnerability to depression. This study revealed that "social disorientation, the loss of social support, the demand for adaptation to a different value system, and loss of economic and social status" are stressors leading to depression of Chinese immigrant women (Lalinec-Michaud). According to Frans and Faux (1990), long-term Chinese immigrant women had higher rates of depression than recent Chinese immigrant women. It appears that after the immediate crisis of relocation is over, long-term depression sets in.

Help-Seeking and Utilization of Health Care

Help-seeking behaviour is a recent trend in the research on immigrant women's health problems. Several researchers have studied help-seeking pathways of Chinese in Hong Kong, Canada and the United States (Cheung, Lau & Wong, 1984; Lin, 1983; Lin, Inui, Kleinman & Womack, 1982; Ying, 1990). The results showed that the extended family was more involved in the care and help-seeking behaviour of Chinese Americans (Lin et al.), and Chinese Americans had the longest delay between initial symptoms and treatment (Lin et al.). Canadian Chinese were also found to prolong family care, utilize traditional health professionals, and to seek psychiatric care only after using all other resources (Cheung et al.; Lin). Ying's study also found that Chinese American immigrant women who held psychological conceptualization of the problem recommended turning to

self, family and friends, whereas, those who held physical conceptualization of the problem recommended medical care.

Consistent empirical evidence has demonstrated that immigrant women tend to underutilize health care services in general and are least likely to have a usual, familiar source (Becarra & Greenblatt, 1983; Cornelius, 1993; Poss, 1995; Ying, 1990). Weitzman and Berry (1992) investigated the health needs and health care utilization of working poor immigrant women and their children. In this study, 387 female, immigrant home attendants were interviewed. The findings illustrated that poor immigrant women make limited use of American medical care, and face barriers to health care that appear even greater than those faced by the uninsured and the poor (Weitzman et al.). It is likely to be the same in Canada even with free medical care.

Many studies have indicated that the use of formal health care is constrained by the lack of knowledge, limited resources and access to care, and culture differences in illness and help seeking behaviours (Anderson, 1986; Siddharthan, 1991). However, Weitzman and Berry (1992) argued that most studies of immigrants to European nations and Canada have focussed on barriers within immigrants themselves. Their needs and patterns of use are viewed as a function of their own inability to adjust to their new countries (Weitzman et al.). Their views appear to be that of victim blaming wherein the immigrant as an individual is seen to be a barrier rather than the social structures.

Leclere, Jensen and Biddlecom (1994) argued that immigration, access to health care, and physical health are related in complex ways that work to the disadvantage of immigrants. Meleis (1991) suggested that understanding health-care behaviours and

decisions of immigrant women is related to the immigration status. Social, cultural, and economic context influence an individual's decision to use formal health care (Leclere et al.). The following discussion is an attempt to shed light on how social, culture, and economic factors affect immigrant women's decision of utilization of health care and management of their illness.

Language Skills

Perhaps language is the first challenge confronting the immigrants in the host country. Although the selection system in Canada means that most immigrants do have some knowledge of French or English, their accompanying family members may not (Lee, 1994). Language barriers represent a common difficulty for immigrant women in the areas of health care access, employment, education, socialization and the assessment and management of illness (Juarbe, 1995; Lee).

Language barriers have also been identified as one of the most important implications for practice in providing mental health services for immigrant women (Gibson, 1983; Tobora et al., 1994). Because many Chinese Americans do not speak English, language difficulties impede diagnosis and a therapeutic process (Tobora et al.). The use of interpreters often does not help in this situation because interpreters have been found repeatedly to misinterpret information presented by the clients (Sue & Sue, 1987). Dyck (1992) conducted a case study of a 61-year old Chinese Canadian woman which purpose was to elicit the links between immigrant women's everyday social and work conditions and their health behaviours. The study indicated that language difficulty resulted in her dependence on her sons and family-based strategies in accessing health care

and treatment (Dyck). The researcher further stated that clinical observations showed that family interpreters were commonly used to pass on treatment information to clients who cannot speak English (Dyck). Therefore, access to treatment depended on the clients' ability to make appointments that coincided with a family member's time, and this placed an additional constraint on the clients' ability to seek help (Dyck).

Juarbe (1995) suggested that language barriers foster powerlessness by limiting the life choices of Hispanic immigrant women and their ability to acquire knowledge which enable them to make decisions to access or use health care. The language difficulties also keep most immigrant women from understanding the benefits and risks of health-related decisions. Poole (1996) suggested that health care professionals need to slow down, be willing to show, and not only explain when teaching immigrant women who have language problems (cited in Williams, 1996).

Work Force

Historical patterns of systemic discrimination have led to the development of a labour force that is segregated by gender, race and ethnicity (Leah, 1991). Immigrant women have struggled with occupational segregation, wage discrimination, part-time employment or unemployment, and little job security (Leah; Lee, 1994; Meleis, 1991). Anderson's (1990-1991) study revealed that about one-third of Chinese immigrant women were unskilled. Other studies have indicated that some well educated Chinese immigrant women are unable to obtain jobs at similar levels as what they had in their original country, because their credentials are not recognized in Canada (Anderson, 1991; Dusel, 1991). Brettell and Simon (1986) described the conditions under which immigrant women

live and work as: subject to the triple discrimination of sex, birthplace, and class, occupy the lowest levels in the labour market hierarchy, and have little security with few benefits. Moreover, Bolaria (1988) suggested that in Canada, the jobs that immigrants are able to obtain expose them to numerous health hazards. Based on the findings of Anderson and her colleagues's (1991) ethnographic study, Chinese immigrant women's position in the labour force and conditions under which she works can be a major hindrance to the appropriate management of illness. The study revealed that 67% of Chinese immigrant women who were interviewed, kept their diabetes a secret from coworkers and employers, because they feared losing their jobs (Anderson et al.). In order to keep their health problem confidential, they were hesitant to monitor their blood sugar on the job or follow their dietary regiment. However, Euro-Canadian women, fluent in English, were better prepared for jobs in Canadian labour market, and this enabled them to reconstruct their lives to deal with chronic illness (Anderson et al.).

In the American literature, many studies indicated that Hispanic women share similar struggles of discrimination in the labour market in the United Stated (Del, 1988; Juarbe, 1995). Since most part of health care insurance coverage is based on employment status, most Hispanic immigrant women have no work-related medical insurance or sick leave, and they do not receive payment for time lost at work while seeking medical care (Anderson, Lewis, Giachello, Aday & Chiu, 1981). This is also reported in Anderson and her colleagues's (1991) study about Chinese immigrant women. They stated that asking for sick leave meant loss of income for those women, hence, they were hesitant to request time to seek help. They further argued that health professionals do not often realize the

conditions under which working class immigrant women work and live, and how these conditions affect their management of illness (Anderson et al.). Since the Canadian health care system differs greatly from the American system, it will be interesting to see if the situation is the same in a Canadian Chinese context.

Poverty

Poverty is linked both to the development of psychosocial problems and to a higher incidence of illness and mortality (Pilowsky, 1991). Social inequalities, injustice based on class, gender, and race, and sociopolitical, cultural, and economic factors all contribute to poverty (Carney, 1992). According to Pilowsky (1991), a total of 1.5 million Canadian women live in poverty. Even though most immigrant women work outside the home, the average income of immigrant women is much lower than their Canadian counterparts (Women and Mental Health in Canada, 1987). Immigrant women, as a group, rank among the lowest paid groups in the work force, and they earn less than Canadian-born men, Canadian-born women, and immigrant men (Pilowsky & Mor, 1990). Pilowsky (1991) argued that as a group, poor women have less power than other women to make decisions regarding their health care. Leclere et al. (1993) suggested that financial barriers often limited preventive care, which then led to higher levels of utilization at later stages. Zambrana's study (1988) suggested that Hispanic women are often found to live in poverty, and they are more likely to be heads of household, to be in poor health, to have higher risk for chronic diseases, to have large families, and to bear the burden of caring for the health and well-being of all family members.

Culture Difference

Sociocultural forces strongly influence health expectations and health behaviours (Leininger, 1991). To understand the context of immigrant women's health behaviours, health professionals need to investigate their cultural patterns of behaviour (Meleis, 1991). This is particularly significant in mental health and psychiatry (Kuo & Kavaragh, 1994). For example, in Chinese society, mental illness is associated with "shame" or "loss of face", and it can affect the good name of the family for future generations (Kleinman, 1986). Socialized to avoid talking to outsiders about one's private life which related to emotions or sex, many Chinese immigrants are reluctant to access professional mental health care (Lin, 1983). Several studies revealed that there was a tendency among Chinese Americans to have somatic complaints, when they sought help for psychological distress (Cheung et al., 1984; Kleinman). Otherwise, according to Chinese culture, women are thought to be more conservative than men (Kleinman), and they are likely to acculturate more slowly. All of these may increase vulnerability to depression (Tobora et al., 1994). Lalinec-Michaud (1988) concluded that cultural differences in verbal expression and attitudes toward mental illness prevented Chinese immigrant women from seeking help for their mental health problems.

When the majority of Canadians talk about health and health care, they usually view them from a western perspective (Noel, 1996). Anderson et al. (1991) argued that the immigrant women who speaks little or no English is usually excluded from the pattern of thought within the host culture. For example, health professionals may pay little attention to the circumstances of an immigrant woman's life, and her cultural norms and

beliefs (Juarbe, 1995), instead, health staff may simply label them as non-compliant or failing to take responsibility for self-care (Anderson et al.). Juarbe argued that health services and institutions are not designed to take into consideration the sociocultural context of Hispanic immigrant women. Noel suggested that discrepancies between health care professionals' and clients' explanation of health and health care are inevitable. However, as Anderson et al. stated, the issue is not the existence of discrepancies, but rather whether health care professionals can negotiate with their clients so that they can provide care that is acceptable and effective.

Sexist and Racism in Medicine

Begin (1988) suggested that the authoritarian and paternalistic attitudes of doctors and some other health professionals have discouraged women clients and keep some of them from seeking health care. "Physicians, predominately male, have had and continue to have major control over the policies, procedures, and directions of health care" (Noel, 1996, p. 19).

> I seldom ask questions. Usually, if I ask or say anything I get scolded by the doctor. Actually, before even I ask the questions I am scolded by the doctor already. I don't have a chance to ask questions.... Every time he treated me like a kid, because he always scolded me, "now don't eat this, and follow this, and be good'.... He always says if you follow my instructions you will not end up like this. He's been saying the same things over the years, and there is nothing new to say. (cited in Anderson et al., 1991, p. 15)

The story told by this Chinese woman illustrated that the medical care has been firmly embedded within a pattern of caregiving where the doctor prescribed and the client listened. Immigrant women have had difficulties in their encounters with health professionals, thus they were unable to obtain the health care services they needed.

Discrimination against women of colour in the health care delivery system is expressed through stereotyping, inappropriate medical treatment and lack of research in this area (Brand, 1993; Meleis, 1991). Stevens (1994) investigated the health care experiences of racially and economically diverse lesbians; half of the sample were women of colour. One of the important findings of this feminist narrative research showed that "male physicians dismissed women's complaints, failed to provide adequate information, prognosticated with little sensitivity about how women react to bad news about their health, passed judgment on the appearance of women's bodies, diagnosed women's social functioning, and perpetrated sexual harassment" (Stevens, p. 653). Anderson et al. (1991) suggested that health professionals often cannot understand immigrant women's life experiences, working conditions, economic situation, and lack of access to health care resources. Torkington (1995) argued that unless we explore the interconnectedness between social and economic structures within which inequality exist, we cannot understand the health experiences of Black women. It is the same for all women of colour in Canada.

Class, Ethnicity and Feminism

Today, the term of "ethnic groups" primarily refers to immigrants from non-British and non-French backgrounds, especially those from Third World countries (Ng, 1991). Immigrant women have been reported to live at the bottom of society because of their unique experiences of triple oppression, that is, race, gender and class (Thornhill, 1991). Thornhill contended that women of colour are seen as "others", as nonpersons, as dehumanized beings or sometimes not seen at all.

However, much feminist theory has emerged from privileged white women, whose perspectives of reality rarely include experience and awareness of the lives of women and men who live in the margins (hooks, 1984). Medjuck (1990) asserted that it is erroneous to universalize the experience of middle-class white women as the experience of women's oppression without the recognition of the different oppression of women based on race, ethnicity, and class. Kline (1991) supported this view and further contended that emphasis on the commonalities of women's experience not only obscures the particular experiences of women subject to race and class oppression, but also reinforces the racial and class privilege of white middle-class women. She further explained that the complexity of women's experience means that women's interests and priorities are cut across race, class, ethnicity, sexual identity, and so on (Kline). Ng (1992) suggested that feminism has not captivated many immigrant women because it may be viewed as threatening the traditional values of their culture. This is significant among Chinese women. The cultural traditions of the Chinese discouraged confrontation and violence (Yu, 1987), and avoidance often serves as a defence mechanism for the Chinese immigrant women to handle oppression and discrimination (Yu). Campbell (1992) reported that participation in unions is poor because many immigrants women from China have considered unions as being too confrontational. According to Ng, fear of being labelled or socially sanctioned by their own community may also keep immigrant women from supporting the feminist movement.

However, as Dill (1983) stated, we must fight the segmentation of oppression into categories. Women, as a group, share a common concern, a common commitment and a

common goal (Thornhill, 1991). Women will go past the personal and be political enough, if our differences enrich our political and social action rather than divide it.

Summary

Chinese Canadian history is a history of institutionalized racism and discrimination. Chinese Canadian women have lived with the dilemma of being both non-white and women in a white and male dominated society. This makes them doubly invisible and doubly silenced socially, politically and economically. Like immigrant women of colour, Chinese immigrant women have experienced triple systemic oppression: sexist, racist and classist. These experiences have created their feelings of alienation, powerlessness, and devaluation.

Much research has demonstrated that the process of migration involves varying degrees of economic, social, and environmental dislocation, all of which affect the health and well-being of immigrants. Immigrant women should be considered a population that is at high risk for physical and mental distress because of many roles they carry and their hard struggle of systemic discrimination inherent in all aspects of Canadian society. Their access to health care is related to social, cultural and economic context under which they live and work. To deal with the health of immigrant women, health care professionals need to understand the dynamic differences inherent in being a woman, being an immigrant and being a woman of colour. Although increasing studies have investigated immigrant women's health-related beliefs and behaviours, very little is available to explore their experiences in regard to interaction with health care delivery system. In addition, the voices of Chinese immigrant women have been excluded from the nursing literature, as

well as feminist discourse. Hopefully, through listening to their stories, this study could bring forward the Chinese immigrant women's experiences with the health care system.

CHAPTER III

METHODOLOGY

Feminist Methodology

According to Harding (1987), methodology refers to " a theory and analysis of how research does or should proceed" (cited in Webb, 1993, p. 416). Feminist methodology is described as specific doctrines of study which reflect a feminist philosophy (McCormack, 1981). Klein (1983) suggested that feminist methodology means overall conception of doing feminist research and choosing appropriate techniques for this process. Many feminists assert that feminist research is a research on women and for women (Klein). It focuses on distinguishing and surmounting the oppression of women (Webb), and it provides priority to women's experiences. Feminist research is "grounded in actual experiences closely related to social change" (Webb, p. 417). Klein defined research for women as "research that tries to take women's needs, interests and experiences into account and aims at being instrumental in improving women's lives in one way or another" (p. 90). She further argued that research on women "can only be claimed when the methods applied take women's experiences into account" (p. 91). As the purpose of this study was to explore the health care experiences of Chinese immigrant women, feminist methodology was an appropriate choice. I believe that it providesd the focus and flexibilities needed to develop this study, which intended to create an understanding and knowledge of Chinese immigrant women's experiences with health care for both the researcher and the women themselves. Since the aim of feminist research is not only to document the women's experiences, but also to analyse the conditions of

women in society, I believe that research questions developed by feminist methodology had a positive effect on the generation of political struggles of marginalised groups of women of colour (Noel, 1996).

Many feminist researchers argued that much of the research in the past has been done by men and analysed by traditional 'scientific' methods (Harding, 1987; Klein, 1983). Because women and men have had different experiences according to class, race and gender, traditional 'scientific' research methods are not as suitable for investigation of women's experiences, and they do not usually reflect women's realities. Feminists suggest a perspective in which women's experiences, ideas and needs are valued (Klein). Feminist research develops its problematic from the perspective of women's experiences (Noel, 1996). Dubois (1983) stated that women's experiences and lives must be addressed in their own words to create theory situated in the actual experiences and language of women. As Dublin (1996) stated, "only by speaking, using our own words, about what we as women do, think, and feel can our experiences and work become visible and valued" (p. 71).

In 1984, Bernard (cited in Webb, 1993) proposed eight criteria for feminist research:

1. The researcher is a woman;
2. Feminist methodology is used, including research-subject interaction, non-hierarchical research relationships, expressions of feelings, and concern for values;
3. The research has the potential to help its subjects;

4. The focus is on the experiences of women;

5. It is a study of women;

6. The word 'feminism' or 'feminist' is actually used;

7. Feminist literature is cited; and

8. The research is reported in non-sexist language (p. 417).

Dubois (1983) stated that holding of basic feminist principles is more important than specifying a particular feminist research methodology. Many of the feminist methodological principles can be utilized for working with women to create the understanding of the world around them. Keddy (1992) suggested that the integral component in feminist research is the reduction of power inequalities between the researcher and the researched, which may lead to subjective, personal, non-hierarchal, and experiential data. Reciprocal interaction is important to produce mutually shared knowledge (Ribbens, 1989) and to prevent misunderstanding about women's experiences. Hence, feminists should be flexible to modify their methods in order to meet demands of each individual research circumstance. Alteration should be based on the judgement coming from both the researcher and the participant (Dublin, 1996).

In summary, feminist research is research on women, by women, and for women. The issue of feminist research is not just conducting the research from the standpoint of women, but making their experiences more visible and valuable. Through exploration of their experiences of everyday lives, women can recognize and understand the sources of their own oppression and develop personal and political strategies for ending this oppression (Anderson, 1991).

Selection of Participants

I began to consider the idea of this study after I chatted with some of Chinese immigrant women in the Chinese Christian Church. I believed I could interested some of these women to participate in this study, after I saw their concerns, frustration and confusion regarding health care. Because we all speak Chinese (Mandarin) and we are familiar with each other in the Chinese Community, it was much easier for me to access these women. This appeared to relieve some of their anxiety about talking with people they did not know and spoke different language. Once they expressed their interests in this study, I contacted them by telephone to obtain their verbal agreements. Each women I contacted was asked to inquire if any of her Chinese friends would be interested in this study. I also contacted their friends by telephone with previous permission. Thus, I employed a snowball sampling method and selected 7 Chinese women who resided in Halifax, Nova Scotia, as participants in this research. An introductory package was mailed to each participant after obtain their verbal permission by the telephone. Participants choose either to complete the forms and mailed them to me or gave them to me at the beginning of the interview. All of them said that they preferred the interviews to take place at their homes because of transportation problems. I respected their choices and conducted data collection by home visits.

Demographic Information of Participants

I recruited 7 Chinese women who have resided in Halifax, Nova Scotia, as participants in this research. They ranged in age from 25 to 60. All the women were from the People's Republic of China and they all speak Chinese, that is Mandarin. Their length

of residence in Canada and Halifax varied, from 1 to 5 years, but all of them have had experiences with the health care delivery system in Canada. Marital status was not a determining factor in this research. Six of these women were married, and only 1 of these participants was single. The majority have university degrees or post-secondary education. Among them, 4 had pursued post secondary education, one of which is a physician, 1 had a Bachelor's degree before she came to Canada, and 2 were currently graduate students in Canada. These women were at various stages of employment, only 1 was employed in the university, 1 worked in a restaurant, the 5 remaining participants were still seeking employment. Five of subjects were landed immigrants and they had MSI (medical service insurance) health insurance coverage. Two women in this study were visitors and they intended to return home within 2 years.

Data Collection

Feminist interviewing method guided the process of data collection. Dyck, Lynam and Anderson (1995) stated that creating a non-hierarchical relationship in data-collection is an important principle of feminist research. According to Webb (1993), research unavoidably involves some degree of inequality, because it makes participants unprotected through disclosing their private experiences and emotions. Multiple in-depth interviews were employed as a data collect technique in this study. In fact, multiple in-depth interviews have been the principle means by which feminists have sought to achieve success in the collection of data (Graham, 1984). I believed that multiple in-depth interviews reflected the characteristics of feminist research and helped me to reach detailed accounts of women's life experiences and activities in this study. Multiple in-depth

interviews seemed to be more accurate than a single one, for multiple interviews provided me with opportunities to ask additional questions and to verify the data previously obtained. I also believed that multiple in-depth interviews assisted me in establishing a stronger, more intimate relationship with the participants.

The important aspect of the feminist interview is that the interview should be semistructured or unstructured and employ open-ended questions. Reinharz (1992) suggested that semistructured or unstructured interviewing can provide free interaction and a trusting personal relationship between the researcher and the researched. I found the women had difficulties expressing their ideas and our conversations 'got stuck" when I tried to follow the guidelines. Thus, I encouraged the women to talk about their concerns in their own way or in their own words. Through this method, I accessed women's views, ideas, and thoughts in their own words, rather than in the terms of the researcher (Reinharz, 1992). At the same time I believed that the participants expanded their self understanding through the reflexivity process of the interview that will lead to collection of rich data (Anderson, 1991).

Therefore, in this research, I collected data by multiple in-depth interviews, which were open-ended questions. The procedures of data-gathering were as follows. The snowballing technique was used to access potential participants. In fact, many such individuals are already known to me. I contacted the 7 participants by telephone to confirm their interests in this research, and then sent them introduction letters and consent forms by mail or by a personal visit (see Appendices A and B). They returned the forms to me through the mail or I collected them before the first interview as the participant

desired. Because I was familiar with the Chinese community it was easy for me to find these 7 Chinese women who were willing to participate in this research.

Data collection was conducted by visiting participants individually. My knowledge and experiences of living in Canada as a Chinese woman and speaking the same language facilitated a situation of women's talking within the usual culture norms (Dyke et al., 1995). Enhancing an interactive style of interview was not difficult for me. I visited and interviewed these women at their own home as they desired. The interview was like a informal conversation. It was in a series of unstructured or semistructured ways. I only taped some of the interview because some women in this study expressed their feelings of discomfort and fear when I taped the conversations. They preferred for me to take notes rather than taping the discussions. The first interview was approximately 1 or 2 hours in length. My method differed from most interview-based studies, because, instead of directly focussing on specific research topics, I talked with these women about aspects of their experiences about which they have concerns. I also shared my personal experiences with health and health care when I first came to Canada as an international student and as a pregnant woman. This self disclosure created a trust relationship between the participant and the researcher, and it enabled participants to share their experiences comfortably and openly.

As I cited before, the conversations followed the interview guides very loosely (see Appendices C and D). I found that made it easier for the women to tell their stories. During the interview, the participants were encouraged to ask any questions related to their concerns about the Canadian health care system and their own health or that of their

family living in Canada (if they wanted). The interviews were transcribed and returned to the participants for validation during the second interview. The second interview were participant guided, and it provided the opportunity for each participant to read her transcript and then to correct or add anything she wanted. The second interview was arranged approximately 4 months following the first one, and was approximately 1 hour. I arranged the third interview with each participant and shared discussion on themes, findings, and an analysis of the research with them. Unfortunately, 2 participants had travelled back to China by the time of the third interview. Interviews ended when new themes no longer emerge. The reflective nature of data-gathering is an integral component of feminist process research (Noel, 1996).

Thematic Analysis

With a feminist perspective, utilization of thematic analysis method offers a great deal of flexibility and may reduce power inequalities within the research relationship through interpreting women's experiences in their own words. Dublin (1996) suggested that thematic analysis provides the participants an equal opportunity to inspect the issues and apparent themes at an early stage, validates the beginning analysis, refines it, and selects which themes they wanted to address regarding their experiences with the health care system.

According to Dublin (1996), although thematic analysis "is not a high profile method of data analysis" (p.79), it has been employed and described by a few researchers in their studies on health issues. Carter (1989) analysed the themes associated with bereavement following the steps developed by VanKaam (1966), Taylor and Bogdan

(1984), and Van Manen (1984). Reilly (1993) applied a thematic analysis designed by Spradley (1980), called "domain analysis", to describe family experiences, both childhood and later of homeless individuals. In 1994, Stuhlmiller employed similar thematic analysis generated by Benner (1984) to explore rescuers' experiences related to their rescue work in an earthquake and how these past work experiences affect their thought, feelings and activities. In these studies, it seems that the main purpose of utilizing thematic analysis was to identify the commonalities among individuals' stories and experiences.

Thematic analysis has also been used to described the process of data analysis in phenomenological research (Polkinghorne, 1989). Polkinghorne described three types of steps in phenomenological analysis which were developed by VanKaam (1969), Colaizzi (1978), and Giorgic (1975). In this study, I selected some of these guidelines which were congruent with the purpose of this study and feminist perspectives. VanKaam's (1969) 6-step process was explicit, but it required validation of findings with experts. I view this suggestion as inappropriate because I believe that no researcher can be the expert of participants' life experiences. Hence, I took my interpretation back to the women in the study for validation. However, this crucial step, missing in VanKaam's formation, was added in Colaizzi's method of analysis (Polkinghorne). Colaizzi, unlike VanKaam, did not use researcher's judgement in the analysis, instead, he went to each subject and asked for validation. This concurs with the feminist methodology used for this study. Giorgi (1975) used a smaller sample, in-depth interviews, and natural description of women's experiences, but the process of clarification during interviews was excluded. I view clarification as important for the researcher to tell stories honestly, and it is also essential

to create the understanding of women's experiences related to health and health care for both the researcher and the participant. According to Giorgi, researchers should involve their own assumptions, biases, and intentions in the analysis. This also concurs with the feminist approach of this study, that is, the researcher is encouraged to include her perceptions, personal experiences, and biases in data-gathering and data analysis.

Based on feminist methodology, the aims of this study are not only to assist women in the study to examine their essential experiences, but also to help them explore the social structures and norms shaping those experiences. This will lead to their recognition of the need to develop strategies for social change.

Based on guidelines of thematic analysis developed by VanKamm (1969), Colaizzi (1978) and Giorgi (1975) as well as Doblin's (1996) formation, I developed the following steps as guidance in data analysis in this research.

1. Listed and classified different and unique examples of experiences. The list contained every basic different statement made by each woman.
2. Reduced experiences to more precisely descriptive terms, which should be simple.
3. Placing experiences which are not directly related health and health care in another category. No data are eliminated.
4. Generated main themes. This was achieved by a "zigzag" procedure, that is, I moved back and forth between the meaning statements and the list.
5. Validated my identification of main themes with each woman in the study in order to present what participants wanted to address.

6. The process of thematic analysis used in this study reflected feminist methodology and flexible. I also verified my interpretation and discussion with these women.

Ethical Considerations

Each participant received a participant consent form and she signed the consent form if she agreed to participate in the research. Consent forms were issued in both English and Chinese, and the interview was conducted in Chinese, which made the participants more comfortable. Because Chinese is my mother tongue, no interpreters were needed during the interviews.

Only parts of the interviews were taped, because as I mentioned before, some of participants expressed their discomfort about taping the interview. It was important to inform the participants that all the interview tapes would be returned to them after I finished my research. I reassured the participants that confidentiality would be maintained in transcription and in the written form. The names of participants will not be disclosed. The participants were informed that they may withdraw from the study at any time without any penalty.

In addition, I discussed the findings and analysis of data of this study with the participants, so that I could validate with them at each step of the research. In this way I can address issues which were what the women wanted to assert and tell their real stories.

Locating Myself In the Research

It was a non-hierarchical research process that allowed my own experiences to be part of the interactive process. I became subjectively involved in the experiences with these Chinese women and I was able to touch places in their emotions. Actually I was in a

similar situation as these Chinese women. The words 'racist', 'discrimination', 'dehumanization', 'non-compliant', 'confusion', and 'depression' are good expressions of my personal experience with health and the Canadian health care delivery system. I have faced the same problem of underutilisation of health care because of lack of knowledge about health resources, limited financial resources, cultural differences, and the organization of health care settings. I can understand how anxious a woman can feel if her baby is ill at night and she does not know where she could go for help. I also can understand the shame and frustration a woman can feel when she can't express herself clearly about her health problems to the physician. My personal experiences shaped my intention to conduct this study. I hope I can help these Chinese immigrant women tell their stories, make their struggles visible, and see their contributions valued in Canadian society by doing this research. I tried my best to tell their stories honestly, to challenge them to question how their lives have been influenced by social structures (Dublin, 1996), and to help them to realize the need to struggle for ending the oppression of immigrant women. My involvement in this research was never unbiased nor detached. I value the subjective.

CHAPTER IV

ANALYSIS OF DATA

In this chapter I will present the findings and analysis of the themes I extrapolated from the data. I have divided the themes into two sections. In the first section I will discuss their experiences of avoidance with the health care system upon arrival and shortly thereafter. I will then discuss their experiences after they accessed the health care system. This will focus on the barriers to their comfort and the strategies developed by the women to deal with the challenges encountered when they interacted with the health care system. Actually, their stories started with their overwhelming sense of the resettlement which led to neglecting their health problems and avoiding health care. When they accessed health care, their stories began with their frustration of finding a doctor. What follows then were their stories about their interactions with doctors. It is interesting to note that the women equated the health care system primarily with their contacts with physicians. The strategies employed by the women to regain their personal control and inner harmony will be presented lastly.

Newly Arrived

The first year after immigration was particularly stressful for the Chinese women in this study. Culture shock, loss of social status, finding jobs, enrolling children in schools, establishing a new home are common stressors which powerfully affect the women's health. All the women expressed that "they were too busy to think of their health". Avoiding access to health care, fear, and guilt were the emerging themes which represented their experiences when they first came to Canada.

Avoiding Access to Health Care

Many participants spoke of the moment when they arrived at the airport in Halifax where they were totally submerged in an alien environment. This meant a complete rupture between their past and their present life (Baker et al., 1994). One woman said "everything, we had to start from the beginning, language, education and employment". During the first year after they came, these women focussed all their physical and emotional energy on survival and resettlement, thus most of them ignored their own health problems. One woman said "when we first came, I had too many things to worry about, my husband's study, my little daughter's health and education, finding a job to support my family. I had no time to think about myself". Most of these women expressed that they did not have any health insurance (MSI) when they first came (most of participants received MSI health insurance during the second year after they came). They also have experienced unemployment or underemployment, thus, the financial limitation was another major barrier for these women to access health care.

In addition, most of the women indicated that they had a certain degree of preparation before they left their homeland. They brought their own medications when they first came which included both traditional Chinese medication and Western medication. As one woman mentioned "I brought all the medications I needed for the first year. I knew that I would not have money to buy drugs when I first came here". Meanwhile, they might consult friends or doctors in the Chinese Community they had already known, if they had some questions about their health, or if they were not sure about the medications which were brought from China. Therefore, access to health care

was limited by overwhelming resettlement problems, unemployment, poverty, and lack of health insurance during the first year after they arrived.

Fear and Guilt

Among the 7 participants, 2 were grandmothers. As visitors, they came to Canada to help to look after their grandchildren. This made these grandmothers dependent on their children financially, hence their children's socioeconomic status determined the grandmothers' utilization of the health care system. One of these grandmothers had life insurance which only covered accidents. They expressed their feelings of guilt when they needed health care. One woman said:

> I have never had any problems with my teeth in China, but I suffered toothache in last 2 months. My daughter had to take me to see the dentist. That cost her more than 200 dollars. I felt very guilty. I could not go out to work in Canada, and I found I was a burden to them. But I have to stay here because they need me to help them look after their child.

Fear was also a obvious theme expressing their life experiences. As one woman explained "Everyday, and at every minute, I have to tell myself I have no health insurance, I must be careful to do everything, even when I walked on the street. Because if I fell down or had any accident, that would be a big trouble to my daughter".

Both these grandmothers had certain chronic health problems. Although they brought some medications, they still worried that they might need to see a doctor if they could not control their health problems on their own. One woman said:

> I did not have any religion when I was in China. But now I go to church every Sunday, and I started to pray every morning. I hope god can help me, protect me and give me some feelings of security when I stay in Canada. And I do hope I can be back to China as soon as possible, but my daughter still needs my help.

Thus, these grandmothers experienced fear, guilt and insecurity in their daily life. They had less power to make decisions regarding maintaining their health than any other Canadian women, Chinese men or even other Chinese women. It was obviously more difficult for the older women than for the younger ones. Changing from atheist beliefs to a frightened view that perhaps there is a god who looks after people shows the extent to which those women were terrified. Influenced by a Christian ideology of many Canadians, they were quick to embrace any kind of mystical belief which was reassuring. It appears that religion provides a ready resource for the women to cope with life, although it is not a tangible economic resource.

Trying to Access Health Care

Although most of these women tried to manage their health problems during the first year after they arrived, they had to attempt to seek help from health professionals after that. Generally, they started to begin the process of utilizing health care at about the second year for several reasons. First of all, all these women (except 2 grandmothers in this study, because they didn't want to apply) received their PR (permanent residence) documents at this time, thus they were covered by MSI (medical service insurance). Secondly, most women in this study said that all the drugs which were brought from China were used or reached their expired date after the first year. As one woman described: "I couldn't use my own drugs anymore at the second year after I came, because I forgot how to use these drugs. I had to see a doctor". In the next section, I will demonstrate the Chinese women's experiences when they interacted with health care professionals in Halifax, and how these encounters left them feeling frustrated, devalued and discomforted.

"A doctor is an empire" was a frequent expression employed by the women which represented their encounters with their physicians in this city. Many factors were identified by these women as barriers to their comfort when they interacted with the health care providers, particularly with the physicians (see Figure I).

Lack of Knowledge

Lack of knowledge about the Canadian health care system was the first problem these women encountered when they tried to access health care. Language limitation and social isolation were the main factors contributing to their lack of knowledge. Many women in this study expressed their concerns when they wanted to seek help from health care services. Their questions were: Where can they go to see a doctor? Where and how can they find a family doctor? Where can they consult a specialist? And where can they obtain medications? Where were the hospitals or pharmacies? One woman spoke in this way :

> When I had to find a family doctor for my baby I had no idea where I should go. One of my friends recommended me to find a doctor in the yellow pages, and I did. But I really felt uncomfortable and unsafe to find a doctor in this way. I did wish at that time someone could recommended a doctor to me.

Another woman shared her experiences of finding emergency services when her daughter was sick. She said:

> One night, my daughter's nose was bleeding. I tried to manage it by myself, but I couldn't stop bleeding. I was scared and I call the ambulance. It took half an hour for the ambulance to find where we lived. They couldn't stop the bleeding either, so they took us to one hospital which was near where we lived. However, the doctor in the emergency room told me that we should go to the children's hospital. When we arrived at the children's hospital, it was midnight. If I had known which one was children's hospital, I would not waste so much time.

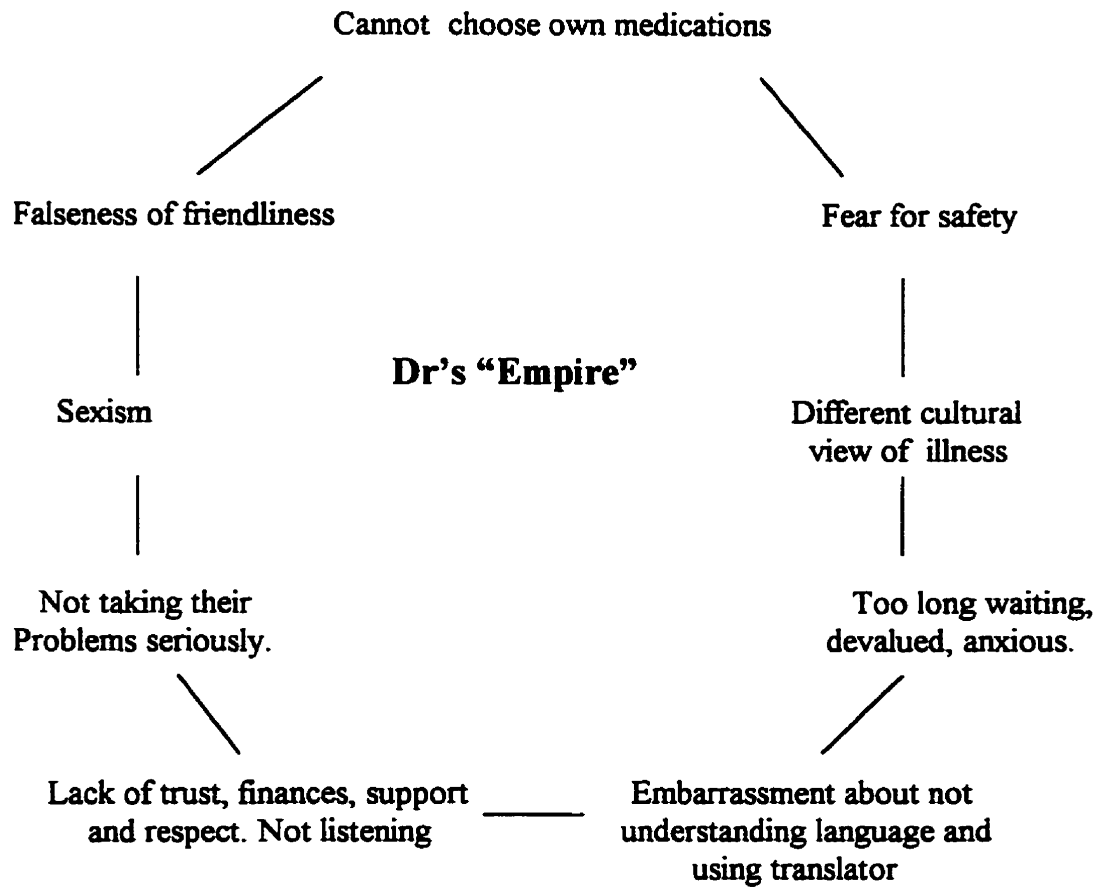

Figure I. Barriers to comfort

In addition, some women expressed that had to rely on their husbands selecting a doctor for them, because they couldn't make a phone call and communicate with health professionals. One woman indicated that "the Canadian health care system was and has been a mystery to me". Although the Canadian health care system was viewed as one of the best in the world, these Chinese immigrant women are still struggling to understand the health care system and it's culture.

Frustration About the Appointment System

The differences existing in health care systems between Canada and their original country made these women feel frustrated and disconnected. In China, all the hospitals, community health services, and small clinics are "walking in" services which facilitated feelings of comfort, convenient, and familiarity. The manner in which they have to make appointments with their doctors here in this city contributed to their feelings of discomfort, inconvenience, and being devalued. Most women expressed that their appointments with doctors must match their husband's schedules, and most of time, they had to wait a couple of days to see a family doctor and wait a couple of months to see a specialist. One woman said:

> I need to see a surgeon referring to my numb arm, but I had to wait for 4 months. I couldn't do anything during these 4 months, I have to quit my job because I couldn't use my arms. My family doctor recommended this surgeon to me. I didn't know where I could go to find another surgeon. I was so upset and anxious, no people could understand me.

Several women in this study described how seeing a doctor liked "seeing an empire". Thus, "a doctor likes an empire" was employed by the women to represent their

perceptions of patient-doctor relationship as well as their frustration when they tried to see a doctor. One woman shared her frustrations.

> Up to now, I still can't understand why it is so difficult to see a doctor. I really experience a headache when talking about seeing a doctor here in Canada. That is my last choice if I have some health problem, because I couldn't stand waiting so long to see my family doctor. Even if you had an appointment, sometimes you still have to wait 1 or 2 hours. A doctor in Canada is like an empire in China.

Thus, their feelings of frustration and anxiety related to the appointment system negatively affected their relationship with the physician.

Confusion, Fear and Anger When Utilizing Emergency Services

Of 7 participants in this study, 5 women have had experiences of utilizing emergency services. As I listened to each of them tell her story about when they utilized emergency services, I was overwhelmed by their common feelings of confusion, fear and anger. I could not tell which interview I was working on as I transcribed them as the stories were so alike.

Confusion represents the first feeling when they entered the emergency room. They did not know whom they should talk with when they enter the emergency room or when they had some questions. One woman shared personal experience in the emergency room.

> When I entered the emergency room, I didn't know where I should go and whom I should talk with. A woman came to me and asked me wait in a small room, and I didn't know who she was. The next was waiting, we waited, waited and waited. No people came to talk to us. My little baby had a high fever. After 2 hours, still no people came to check my baby. I started to fear for the safety for my baby. He was too young and he couldn't wait so long. So I went to a lady (I didn't know if she was a nurse, a clerk or a physician). But she said "you had to wait for another 1 hour. Every person had to wait for 3 hours to see a physician". I was so angry

> and disappointed. I looked at my baby and I felt so guilty because I couldn't help him. I have never felt so dehumanized and so powerlessness.

This women indicated that although anger was a part of their feelings resulting from long waiting hours she tried to avoid directly confronting with health care professionals because of her fear of jeopardizing care for her child. Obviously, supporting, communication, and caring were not a part of these women's experiences when they accessed acute health services. Pilowsky (1991) stated that immigrant women's social experiences of being devalued and their feelings of powerlessness and vulnerability can decrease their self-esteem, which has negative effects on their personal life, social interactions and roles.

"Pure Professional Relationships" with Their Family Doctors

Many women in this study described their relationship with their family doctors as "pure professional relationships". That means they were not treated as a "person", but as a "patient". As one woman explained, the doctor was "very nice" to her, but never talked with her when he met her in the street. She further explained:

> Inside the clinic, the doctor is really nice to me. But outside the clinic, he is like a stranger to me. He even didn't want to say 'Hi' when he saw me on the street. He never ask me any question about my life, my work. He is only interested in my disease.

Lack of respect and not listening is another dimension of the "pure professional relationship". Many women asserted that the physician's view of their own professional knowledge prevented them from listening from women. One woman said:

> When I talked about my son's problems and how I dealt with that in China, the doctor was writing his prescription. I didn't know if he was listening or not. His response of 'that sounds interesting' confirmed to me that he was not interested in

> what I was saying. I felt that I was so stupid and I never said any word again. I told myself 'doctor is a doctor, patient is a patient, I had to follow what he told me to do.

This woman expressed that this lack of respect for her culture and perceptions that have had a negative effect on the development of trusting and comfortable relationship with her family physician. Otherwise, the lack of interest in the women as persons contributed to their feelings of being foreigners and devalued in their relationships with their physicians. These reminders discouraged their attempts to become integrated into Canadian society.

Lack of Trust

Most women in this study expressed their concerns about certain physicians' competence and knowledge when they were told "no problem". One woman shared an experience of being neglected when her son was hurt in an accident and why she lost her trust in the physician who looked after her son.

> After my son had an accident I took him to see my family doctor. She told me 'no problem' and asked me take him back home. I knew something wrong with his left arm because I am a physician in China. So I insisted on taking an X-ray for my son's left arm, and the result showed his left arm was broken. Do you think I will trust this doctor? Of course not. I question this physician's competence and I couldn't trust her any more.

This lack of trust in the physician's competence has been one of important barriers to prevent these women from seeking help from health care professionals. This also created their beliefs that it was useless to see a doctor if their health problems were not multiple, symptomatic, and serious. Many women expressed that to see a doctor was their last choice only if they could not handle the problems on their own or the problem was an

urgent one. This might lead to their delay in seeking helps regarding maintaining their health.

In addition, this woman's story also highlighted the issue of power and authority differential between the physician and these Chinese immigrant women.

Loss of Self-control

These women's feelings of loss of self-control were represented by their experiences of having little or no choice in selecting medications, unfamiliarity with medications, and some management behaviours used in Canada. In China, people can buy all kinds of medications (except narcotics) at the drug store without the physician's prescription. This leads to little limitation for the women in selecting medications and managing their chronic health problems by themselves. However, in Canada, they are not allowed to select certain kinds of medications (such as antibiotics), or they could not decide about their medications because they were not familiar with the name of most Western medications. This contrast left them feeling powerless, vulnerable, and confused. One woman explained:

> I couldn't understand why it was so difficult to get some medications I was familiar with. I used to took one drug for my chronic problem before I came to Canada. But after this drug was used out, I couldn't get it from my family doctor, because he thought I didn't need it. He prescribed a new drug for me which I have never known. When I asked more information about the new drug, he told me the new drug would be good for me, and the pharmacy could give me more information. He treated me like a little kid, and of course, I didn't take them.

Therefore, loss of self-control and lack of information when choosing medications may lead to culturally based resistance to appropriate management of their health

problems. This also led to these women's feeling of disconnectedness. The labelling of immigrant women as non-compliant has to be understood from their cultural backgrounds.

Embarrassment

Shame, loss of face, and embarrassment were these women's expressions related to their communications with the physicians in this city. Because of the language problems, most Chinese women in this research expressed that they needed the translator when they accessed health care. Family members and friends were the main resources. Physicians communicated with these women through a translator, and in the same way, these women depended on the translator (their husbands or their friends) for interpretation of the physician's questions and explanations. The women in this study indicated that this dependence leave them feeling demoralized and embarrassed. But the manner in which the physician communicated with these women when they have translators also contributed to their feelings of discomfort and of being devalued. One woman explained it in this way.

> I remember the first time when I went to see my family physician. The physician just talked with my husband, asked my husband questions. He even didn't look at me because he thought I couldn't understand English. Then they made a joke and laughed. I felt so embarrassed, devalued, and humiliated. I felt I was not existing at that moment.

This woman's encounter with physicians created feelings of incompetence, invisibility, and marginalization. Some participants addressed the issue of feeling devalued when they were accompanied by a translator. The way by which the doctor communicated with the women through the translator directly affected patient-physician's relationship. In addition, lack of language proficiency also led to these women's increased

isolation from society, even from their children, and hence, severely affected their self-esteem.

Conflict with Different Values, Between Two Cultures

Chinese women's perceptions of health and management of illness are grounded in cultural expectations and traditional Chinese medicine. Some of these culturally shaped beliefs conflicted with that of the dominant Canadian culture. According to these Chinese women, medicine is a combination of Western and traditional Chinese medicine. It is widely believed among these Chinese women that Western medicine represents modern technology and expensive biomedical medications, and the effect is "rapid" and "dramatic". Therefore, they all sought out Western medical service if they thought their problems needed to be treated immediately. They did this both in Canada and in China. Due to the impact of their expectations, most these women expressed feelings of frustration when they were not allowed to utilize the advanced diagnostic methods and medications when they thought they needed. One woman shared her experience of having an accident when she was skiing.

> After the accident , I was sent to an emergency room by my friends. The doctor checked me and prescribed some drugs for the pain, and then sent me back home. I worried something was wrong in my chest. I went to see that doctor the next day, and asked to take X-ray. But he told me there was no need to take an X-ray. I couldn't understand why I couldn't take X-ray and I felt very frustrated.

Chinese women view it as unusual to seek health services without receiving a diagnostic procedure or a prescription. For these women, not being able to choose western diagnostic methods led to their feelings of not being treated appropriately and seriously. This also led to their feelings of alienation and being dehumanized, even though

they may not have actually needed a diagnostic procedures. In the case cited above, for example, with fractured ribs little treatment is prescribed. However, this was not explained to the women.

Traditional Chinese medical theory also strongly influences these women's expectation and behaviours related to health care. But some of these ideas conflicted with Western medicine, such as "yin and yang" theory and "wind" theory. This incongruence was very significantly reflected in the management of certain health problems, particularly in maternity care and children's care. For example, according to traditional Chinese medical theory, "cold treatment" was very harmful for pregnant women and women after giving birth. One woman shared her experiences about when she had a baby.

> After a 3-hour push, I delivered a baby girl and of course I was exhausted and sweating a lot. The nurse was very nice to me, but I couldn't accepted the care she provided. I remember that everything she gave to me was cold, cold drinks, cold face cloth, and ice bag. I asked for hot face cloth and hot drinks and she couldn't believe what I was saying. She asked me 'Are you serious?' She was completely confused and I was very embarrassed and I didn't know what I should say. I felt I came from another world.

Shih (1997) argued that most health care professionals "who care for Chinese patients are often unaware of the complex cultural factors that influence their response to professional care" (p. 17). Any kind of care when lack of cultural meaning is inappropriate and not being valued. In addition, these Chinese women are truly living between two different cultures that are pushing and pulling them in different directions. When their beliefs can't be recognized, understood and accepted, they feel alienated and dehumanized.

Financial Limitations

As with other immigrant women groups, Chinese women also experienced stressful economic change due to migration. Most of the women in this study have had professional careers in China. They experienced a loss of economic power because of unemployment or underemployment after they came to Canada. This situation made these women become dependent on their husbands financially. Among the participants, three women's husbands were students and their scholarships were very limited. Most women expressed their concerns when they went to see the doctor, because they couldn't afford the medications. According to Chinese culture, women are responsible for caring for the health and well-being of all family members, they always help husbands and their children to cope with the process of adaptation, and their own well-being is often neglected. Some women in this study felt shame and guilt when they could not fulfil their roles or when they had to spend money on themselves because of health problems.

One woman explained:

> I used to work in an university in China, but I can only work in a restaurant when I first came to Canada. Now I have to go back to the school and I have studied in a Master's program again (she had master's degree in China). Both my husband and I are students and we cannot afford the drugs. If my son needs to see the doctor, I never hesitated to take him to the doctor. But for my self, I always try to manage the problem by myself. I wait until I have to seek help from health professionals. The drugs are too expensive.

Some women in this study expressed that they were hesitant to ask for sick leave or to seek medical care when at work because they had fears of losing money or losing their jobs. Very few employment opportunities have been open to these Chinese women;

they had little sense of job security. Since they were hesitant to request time to seek medical care, this also had deleterious effects on their health.

As I mentioned before, these women experienced loss of support from the extended family, and they were forced to perform the double task of working both inside and outside the home. Most of them are still among the lowest paid groups in the work force. Such situations add further stress to their lives and also lead to these women's feelings of powerlessness and vulnerability when making decisions regarding to their health.

Dealing With the Challenge

In this section, I will discuss the strategies employed by the women to deal with the challenge they encountered when they accessed the health care. The following strategies represent the personal and social processes by which the women regained some a sense of connectedness and inner harmony in a situation which initially made the women feel devalued, frustrated and humiliated (see Figure II).

Relying on Self

Most women in this study expressed that relying on self was their philosophy on health maintenance, and it represents the way in which the Chinese women in this study dealt with challenges they encountered when they sought help from health professionals. Relying on self meant utilizing on their past experiences and knowledge which were obtained in China, and the increased use of "over-the-counter-drugs" instead of going to see their family doctors. For some women it also represented the use of traditional

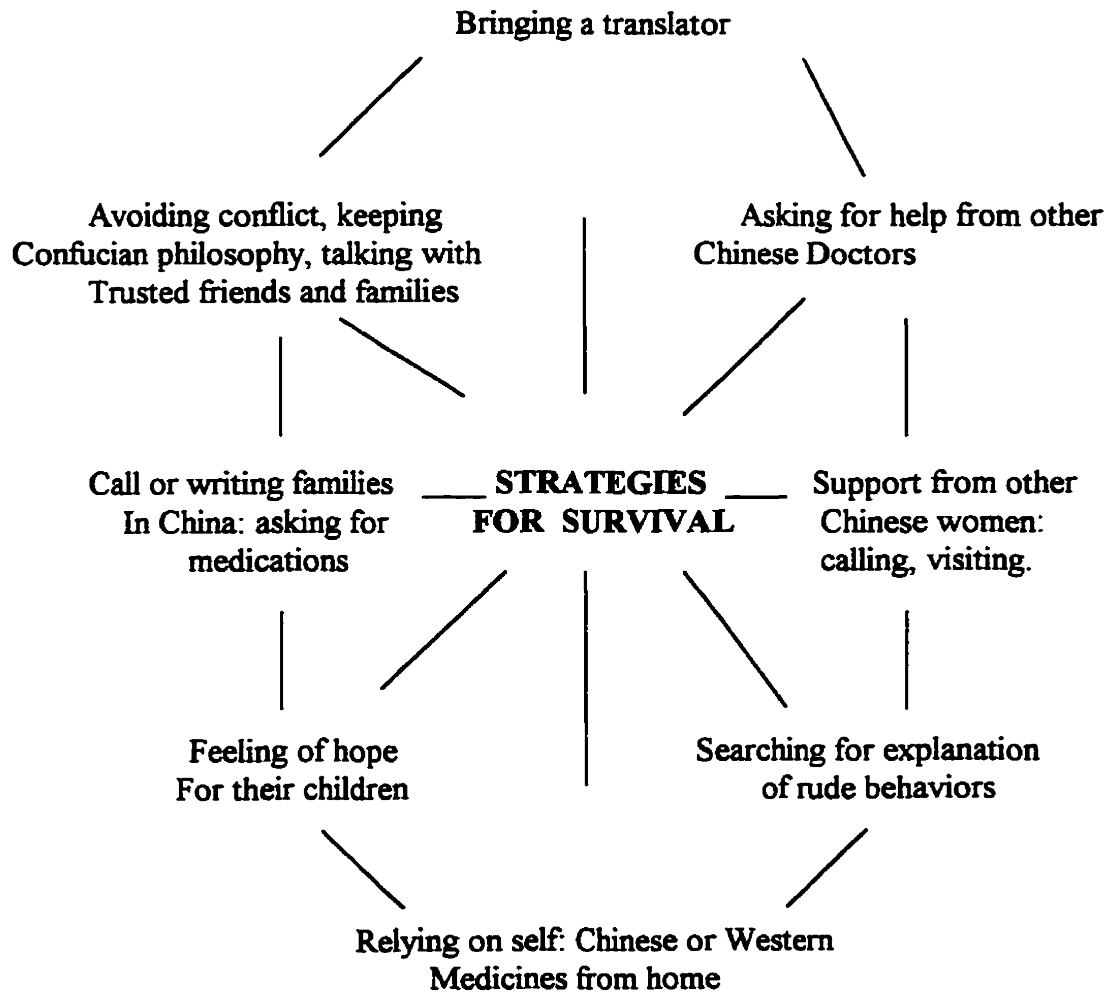

Figure II. Strategies for survival

Chinese medicines which were brought from China or bought from the Chinese stores in this city. One woman commented on the use of traditional Chinese medicine.

> I liked to try Chinese medicine first instead of going to see a physician if I thought my health problem was not an emergency. If I use Chinese medicine, I don't need a physician's prescription, so I don't need my daughter's help. I was quite familiar with most of these Chinese drugs, thus I felt comfortable to use them. Otherwise, some Chinese medicine is cheaper than western medicine. Why I spent more money to use some drugs I have never known?

Another woman expressed that she likes to try "over-the-counter-drugs" first before going to see her family doctor. She said:

> to see a pharmacist was much easier than to see a doctor. I like to talk with them about my problems first, because I didn't need an appointment. They were more patient, listened to me and explained what I need to do. If I was lucky, I could get counter drugs. That really saved me a lot of time. I hated to wait in the doctor's clinic for a long time, and that made me feel very nervous.

Relying on self allowed these women to gain a sense of personal control by making independent decisions to ensure their health needs were met. It appears that pharmacists are more open to patient education then doctors. It could be said that under the unique Canadian health care system of socialized medicine, doctors are not paid for quality but quantity. By contrast pharmacists are either employed by a company or self employed. In either case they are part of the capitalist system which encourages competition among pharmacies. Poor customer relations could result in a lost job or lost profit. This is but one bit of irony in the Canadian health care system, that is, that pharmacists generally are better educators then doctors.

Reliance on Their Families in China

The most significant feature of Chinese social structure is its emphasis on the family and on unanimity within the extended family (Zinn & Eitzen, 1990). Shame is also associated with seeking help from outside the family (Kuo et al., 1994). Thus, it is not surprising to find that most Chinese women in this research seek help from their family and relatives in China when their needs of maintaining health cannot be met. One woman explained:

> Sometimes, after I got the prescription from my family doctor, I called my parents in China and asked for help if my problem was not urgent. They would buy the drugs, and mail them to me. Actually, my parents have bought some commonly used medications and mailed them to me each year. For example, the medications for cold, diarrhea, indigestion and fever. Sometimes they mailed us some antibiotics from China, because I found it was very difficult to ask for antibiotics from the physician here. I could not let my child have a fever for 3 or 4 days without any help from antibiotics. Otherwise, antibiotics are very expensive in Canada, but much cheaper in China. I felt so lucky that I can get some drugs from China, so I can manage some common health problems without seeking help from my family doctor. I still feel nervous to see a doctor, because I found it was difficult to understand medical words.

To the women in this study, seeking help from their families in China has been one of the strategies which helped them to deal with the situations making them feel powerless and helpless. This strategy also provided a way by which these women were able to regain a sense of continuity and stability. It allowed them to have their needs of maintaining health met in a more comfortable way. The negative aspect of this is their indiscriminate use of antibiotics which they can obtain easily in China. As more and more antibiotics are used they become less powerful. The result is that the body builds up a

resistance to these forms and other stronger ones need to be developed. It is an easy victory for the pharmaceutical companies which are extremely profitable.

Asking for Help from the Chinese Doctors

For the women in this study, consulting the Chinese doctors was a resource which also enabled these women to avoid contact with their Canadian doctors or enabled them to gain some self-control when they interacted with their physicians. Most of time, the women could consult the Chinese doctor in an informal way by making a call or a personal visit, and the Chinese doctor whom the women consulted was their friend or the person they had already known in the Chinese Community. One woman speaks about it in this way:

> Every time when I found something wrong with my body I liked to call a Chinese doctor, one of my friends, before I went to see my family physician. I wanted to get some basic knowledge and information about my health problems, so when I went to see my family doctor, I wouldn't look very stupid and embarrassed because of misunderstanding what he said. I felt more confidence and less nervous after I talked with this Chinese doctor.

Therefore, consulting a Chinese doctor in the Chinese community was one of the strategies employed by these women to regain a sense of self-control within the situation. It is a sad commentary on Canadian culture that health care professionals are not educated about Chinese medicine as well as other complementary approaches to health and health care.

Supporting One Another

Most Chinese women in this study expressed that they have frequent interactions with other Chinese women who came from Mainland China. They often got together and

shared the experiences when dealing with the challenges encountered in their daily life, seeking a job, maintaining their health, as well as taking care of their children. Most of the time, they called each other and exchanged information if they felt exhausted at the end of the day. One woman spoke about it in this way:

> I need to talk with my friends every day, sometimes I only want to say "hello" to them. This is really important to me and it becomes a part of my life. Talking with my friends provided an opportunity to express my feelings. Each time when I felt frustrated, or confused after I went to see a doctor, I liked to call my friends. I have a feeling of relief and solidarity after I talked with them. We can support each other because we came from the same background and we can understand each other.

Another woman addressed the issue that socializing with other Chinese women provided her with the chance of education, exposed her to the values of western health providers and had a positive effect on acculturation. She shared her experiences when she was pregnant and gave birth in the hospital. She said:

> I met a Chinese girl in the Chinese Church, and we became good friends because we both were pregnant at that time. She had no language problems and she could understand what the doctor told her very well. She knew that I had language problems and talked with me each time after she saw her doctor. She shared the information with me about the food, what should I do when near the expected time, what would happen in the delivery room. Because she had a baby 2 months earlier than me, she offered me all the information about the hospitalization and delivery procedures. This really had an important effect on reducing my anxiety when the expected time was near by, because I felt I was well prepared when I went to the hospital. In the labour room, I remembered I could guess the meaning of what the health provider told me, since I already knew what would happen to me. I found that was so helpful, so I like share my experiences with any other Chinese women who will have a baby.

Therefore, socializing and sharing with Chinese women coming from the same background provided these women with an opportunity to tell their stories, share their

perspectives, and regain some emotional support and a sense of continuity and understanding.

Bringing a Translator

Language barriers represent a common difficulty for these Chinese women in the areas of health care seeking and the assessment and treatment of illness. It also keeps them from understanding the benefits and risks of health-related decisions. To deal with this problem, the women brought their family members or their friends as interpreters when they went to see their doctors. Although the advantages and the disadvantages of patient-physician communication through the interpreters have been documented in recent research (Poss et al., 1995), Chinese women in this study addressed their needs of using interpreters when they interacted with health care providers. Most of the Chinese women stated that they felt less nervous, less anxious, and more secure if their husbands or their friends could accompany them to see a doctor. One woman said:

> Every time when I went to see my doctor, my husband accompanied to the clinic. I knew this made me become more dependent on my husband, but I have no choice because I cannot understand what the doctor said. I remember once I had to see my family doctor by myself for my diarrhea because my husband was too busy. I couldn't understand what the doctor prescribed to me, but I thought should be helpful. I took the prescription to the pharmacy, and I got a tube of cream. I was so frustrated, and I would never go to see a doctor by myself again. I really felt more safer and less nervous when my husband stayed with me as a translator, but not comfortable because I found I became more dependent on my husband.

She also mentioned that sometimes she had to wait until her husband was available to make an appointment with her doctor, this also led her feelings of loss of self-control and more dependent relationship with her husband. She further addressed the issue that the manner employed by the doctor when communicating with her through her husband or

her friends, the translators, made her feel embarrassed and disgraced. She said "most of time, my doctor only talked with my husband or my friends, because he thought I could not understand English. I felt I was not existing at that moment". Thus, the doctor's altitudes toward the women not only leave them feel hurt but also negatively affected the women's self-esteem and their well-beings.

Only one woman expressed that she also felt more comfortable, if her husband could talk with her family doctor and explain what the doctor was doing. She stated that she felt discomfort if her privacy was discussed through a third person (not her husband). However, she said she felt guilty since she knew her husband was very busy with his work at school.

In addition, some women in this study declared that they felt more comfortable if their friends, that is, other Chinese women could accompany them to see their doctors as translators. One woman said:

> I like to ask one of my friends, a Chinese immigrant woman, as a translator when I went to see my doctor, because she could understand my situation. She was very caring and respected my opinions, even though they might be different with that of the health care providers. This definitely provided me with an opportunity to regain a sense of self control in the situation which initially made me feel embarrassed and powerless.

Bringing a translator represents a strategy employed by these Chinese women which helps them to deal with language problems when they contacted health care professionals. It enables the women to feel less anxious, less confused and more secure when they communicated with their doctors. However, this also placed an additional constraint on the women's ability to seek help because of the translator's availability. In

addition it could be seen as embarrassing if very intimate details of the women's health were discussed through a third party.

Avoiding Conflicts and Accepting

Since harmonious interpersonal relationship are highly valued in Chinese culture, direct confrontation was avoided whenever these women thought it possible. This tendency to suppress their strong feelings is consistent with the beliefs that strong emotion is rude and disgraceful and it can break the harmonious balance of "yin and yang" and cause people to be sick (Kuo et al., 1994). Otherwise, in traditional Chinese society, individuals should behave according to his or her social status. "Father-son alliance" provides the basic model for relationships and it extended to interaction in the society. Thus, "a patient should listen to the physician" is widely accepted among the Chinese community, especially, among Chinese women. The women expressed that they didn't want to express their personal ideas and feelings because of the tendency to minimize the intensity of anger and the view of being an ideal person who should behave with grace and dignity. One woman shared her experiences of suppressing anger when she was waiting in the emergency room.

> I was very angry when the lady told me I should wait for three hours to see the doctor. I want to ask why I should wait for so long, but I didn't because I knew that would be useless and I would be more angry. I told myself, patient is a patient and a doctor is a doctor. That will never change. I asked myself 'do you really want to see a doctor today? If you want, be patient, you had no choice'. Expressing your anger is not nice and it is useless'.

Another women explained how she inhibited her anger when her family doctor made a joke with her husband and ignored her existence. She explained:

> When they were laughing, I was so angry and I really wanted to leave that room. But I couldn't do that. I knew that would make my husband feel shame and loss of face because of my behaviour. I didn't say anything. I didn't want my husband to feel embarrassed and I knew that I needed to see my doctor.

Therefore, the impact of culturally shaped beliefs about self-discipline does create understanding at a certain level that allowed for the maintenance of a pure physician-patient relationship. As Kuo et al. (1994) argued, the cultural demands for self-control serves as an effective coping strategy for reducing anxiety in a conflicted situation, encouraging these women to do as much as possible to lead a balanced life, thus reinforcing adaptive social behaviour. However, the stress of the acculturation process may have a negative impact on these Chinese immigrant women's mental and physical health, such as not to mention the repressed anger at the two males who made jokes at her expense. The contrast between the Canadian women's movement and the Chinese women's movement (or lack of) is very obvious. Many well educated, privileged Canadian women would comment to the doctor about sexist treatment.

Talking with Their Families and Trusted Friends

Many of the women in this study expressed that talking with their husbands and trusted friends provided the women with the opportunity to verbalize their feelings and also facilitated the development of a sense of connectedness and understanding. Sharing their experiences with other Chinese women provided the women with a buffer against their feelings of anger, frustration and disharmony because this made the women recognize that disrespect and depersonalization were not related only to themselves but to other women as well. One woman explained:

> I really need to talk with my husband about my experiences at my family doctor's office. Of course, I complain to my husband about my frustration, because my family doctor always treated me like a kid. Sometimes she finished the prescriptions before I finished talking. She was not patient and she knew I couldn't speak perfect English. I only wanted my husband to listen. I don't need him to say anything to comfort me and I only wanted to ventilate my feelings. After that I felt comfortable.

Therefore, sharing experiences with their families and trusted friends provided the women with a chance to ventilate their feelings, obtain some emotional support, and regain a sense of connectedness and comfort.

Searching for Explanations, Avoiding Intuitively Questioning Racism

Searching for an explanation is another important strategy employed by these women to deal with their feelings of degradation and humiliation. Instead of intuitively questioning racism, these women searched for an acceptable explanation for the rude behaviours they encountered. One woman explained it in this way:

> I always try to avoid connecting some rude behaviours with racism. I didn't considered that he ignored me because I was a Chinese woman. He may be that kind of person, he might have a bad time at home, or he might treat other patients in the same way. I don't think racism automatically, and don't take everything personally. I also try to avoid feeling I am different from other Canadian women. This made me feel more comfortable.

Thus, finding plausible reasons to rationalize the dehumanizing behaviours the women encountered enabled them to decrease emotional distress in a racializing situation. It is a protective strategy which allows the women to regain a sense of inner harmony and personal control in a situation which initially makes them feel humiliated, devalued, and frustrated. The issue of racism in the Canadian health care system is one which has been

explored at great length (Lee, 1994). It is understandable that these women did not feel empowered to tackle the issue of racism.

Orientation to the Future of Their Children

Chinese women are responsible for "managing and supervising their children's education to ensure their success in society" (Man, 1995, p. 317), and they usually view their children as the extension of their own lives, thus thoughts of the future of their children are constant and always tinged by feelings of hope and satisfaction. Most women in this study expressed that they believed living in Canada would provide a better life and bright future for their children than it would in China. Comparing the opportunity for children in China and that of in Canada, the women often raised feelings of hope. One woman expressed her optimism:

> I do believe living in Canada will provide more opportunity for my son's education. I understand that we are first generation immigrants, and of course, we had problems with language, employment. But I believe that my child will not have these problems in future. He will have better life than what we are having today.

Holding on and maintaining their hopes on their children's future is another strategy employed by the women to reconstruct their sense of personhood. It encourages them to think little about exposing racist situations, and motivates the women to cope with the emotional stresses created from that situation. Lastly, it enabled the women to feel comfortable, connected and to have personal control in their lives.

Summary

The findings of this study represent the trajectory of these Chinese immigrant women's life experiences regarding maintaining their health. When they first came to

Canada the women were too busy struggling for their family's survival to consider their own health. They avoided utilizing the health care system in Canada, and self-reliance was the main strategy employed by the women to deal with their health problems. After the initial resettlement period, these women were motivated to adapt and seek help from Western health services. However, their encounters when they interacted with health care professionals, particularly doctors and to a lesser extent nurses, leave the women feeling a lack of respect, frustrated, devalued and humiliated. "A doctor is like an empire in China" reflected their relationship with their physicians, that it was a "pure professional relationship". Language barriers, financial limitations, culturally shaped beliefs and values were the main factors leading to their having less power in decision making regarding to their health care. Most of the dialogue in the interviews dealt with physicians and much less with pharmacists and nurses. Other health care professionals were not mentioned.

To deal with the new challenges encountered, the women in this study developed strategies that enabled them to protect themselves in a racializing situation. These strategies represented the women's efforts both internally and externally which allowed them to regain a sense of self-control and personal harmony. Traditional Chinese culture and Confucian philosophies strongly influenced their struggle to deal with the conflicts that resulted from the differences between their expectations and reality.

CHAPTER V

ANALYSIS, SUMMARY OF ANALYSIS AND FINDINGS, RECOMMENDATIONS, IMPLICATIONS, LIMITATIONS AND FUTURE CONSIDERATIONS

Analysis

In the presentation of the findings I focussed on the participants' interpretations of their experiences with the health care system. In fact, their primary issues were related to their connections with physicians and their perceived experiences with racism. "A doctor is an empire" was an expression employed by these women which represented their relationship with their physicians. While I do not de-emphasize the inherent racism within the health care system, I want to specifically point out that there is also probably a strong element of both classism and sexism in the behaviour of most doctors towards immigrant women, and most likely toward all immigrants in general. It is interesting to note that the focus is on doctors as the primary contact for the health care system. This is congruent with Noel's (1996) study of Carribean women in Fredericton. In Noel's study, the researcher initially intended to explore the perceptions of Caribbean women regarding the Canadian health care delivery system. However, "the concentration on the patient-physician relationship was paramount in the data" (Noel, p. 38). Their stories indicated that the Caribbean women's experiences with the health care system were characterized by their encounters with physicians, which the women found to be dehumanizing and uncaring (Noel).

It would seem that most people identify their relationship with their doctors as meaning the health care system. Therefore, I will just focus for the time being on a brief analysis of what this means, not only in terms of racism which has already been discussed (Noel, 1996), but also in terms of sexism and classism in this particular context. In general most immigrants are treated by western doctors in a chauvinistic fashion. However, it is likely that women are treated far worse than men in these instances. But there is evidence that immigrants are also treated badly by other professionals. Pilowsky (1991) stated that many immigrant women experienced difficulties with anger when they interacted with psychotherapists and other health care professionals, which might lead to women's self-destructive behaviours. Brand (1993) pointed out that some health educators and medical interpreters have witnessed many immigrant women receiving unnecessarily harsh treatment from the health care professionals, particularly doctors. She argued that the women's experiences as newcomers in Canada not only leave the women a traumatized, but also affect their well-beings (Brand).

Although the health care system reflects inherent racism, sexism, and classism of the larger society, there is very little existing on the three factors taken together (Juteau-Lee & Roberts, 1981) in general reviewed literature as well as in the women's literature. Actually, this class issue is crucial in shaping these Chinese immigrant women's experiences. Although racism, sexism, and classism are an inherent part of Chinese culture, the women in this study did not view themselves as victims of oppression in China because of their more privileged class status. Some of the participants expressed that they had a better relationship with their doctors in China. That was not a "patient-doctor"

relationship, but a "friend-friend" relationship. In China, the health care system has been run as a business which does not serve the poor and the powerless. This reality left these well educated and privileged women feeling comfortable and connected in their relationship with their doctors. But for the poorer class people in China, health care as well as their relationships with doctors are different stories. In China health care is not accessible to all Chinese as it was 20 years ago. Now, people pay for health care or, if they have privileged positions at their workplace, most of the health care costs will come from the employers. Obviously, these privileged middle class women could not understand the situation which the poor, less educated people experienced with their difficulties to access health care in China. Therefore these women's privileged social status in China had profound effect on their perceptions about what health care should be like in Canada. This is an implicit class issue as the women in my study have backgrounds of education. However, these women lost their privilege which they had in China because of immigration. Man (1995) indicated that for many Chinese immigrant women, their power and status actually deteriorated when they emigrated to Canada.

All the participants in this study addressed the issue that they all experienced a loss of economic power because of underemployment or unemployment. Many studies reveal that immigrant women are concentrated in a small number of occupations which are often poorly paid and insecure (Man, 1995; Anderson et al., 1994). The major reason for the women's dilemma in Canadian society is clearly class, their positions in the world economy, and their situation as immigrants as well as being women. Juteau-Lee et al. (1981) argued that either gender or ethnicity are usually responsible for being at the

bottom of the class system in Canada. To understanding women's experiences, we must try to understand their experiences as women, immigrants, and as less economically privileged persons. Racism, sexism and classism, the three dimensions of subordination, must be considered as ongoing inequities of the society.

In addition, I also want to address the issue that the participant in this study is a unique and privileged group of women who have experiences that differ from other ethnic and racial politicized groups. These women have highly individualized concerns based upon ambitions to do well. Otherwise, this research was done in Nova Scotia and not a large city where there are more ethnic and racial immigrants who are part of a permanent underclass. Their experiences with the health care system are different from that of the participant in this study.

Summary of Analysis and Findings

In this study, I explored the challenges that Chinese immigrant women experienced when they interacted with the health care system in Canada. "A doctor is an empire" was an expression employed by these women which represented their relationship with their doctors. They equated the health care system primarily with their contact with physicians. The participants identified several factors which contributed to their feelings of not being treated as worthwhile human beings, such as lack of respect and support, loss of self-control, sexism, racism, and falseness of friendliness. They did not equate social class with their treatment by doctors. Cultural differences, language problems, and financial limitations were also the barriers to the women's comfort when they sought help from

health care professionals, specifically doctors. These experiences triggered thoughts of devaluation, confusion, frustration and dehumanization.

The strategies developed by the women to deal with these challenges reflected Confucian philosophy and Chinese culture. Relying on self and avoiding conflict and acceptance were the main strategies employed by the women to regain a sense of personal control and inner equilibrium in the situation which initially made them feel powerless, invisible and marginalised. Although most of the women were aware of the issue of racism in health care as well as in Canadian society, most women in this study were dismayed by it. The women's fear of talking about political issues was influenced by Chinese history and Chinese culture.

The findings of this study supports the argument made by feminist researchers that immigrant women are indeed a population at high risk for physical and mental distress (Meleis, 1991; Pilowsky, 1991). These women are at risk because of the sudden changes in women's roles after moving to Canada. Chinese women take the original responsibilities of raising and educating children, helping husbands and children to adapt, and often performing the double tasks of working both inside and outside the home to support the family. Their own well-being is inevitably neglected. As one woman in this study described "I was too busy to think about my health". This reflected the situation in which the women carry out many roles; most of them were invisible, unacknowledged, and devalued. My findings are also congruous with the argument that immigrant women are at risk because they live between two cultures (Meleis, 1991). The struggles of maintaining their original culture and identity, and attempting to meld themselves into the

Canadian culture shaped the participant's lived experiences. They are living in two worlds, their original country and the host country. In China, these well educated middle class women were privileged within the Chinese health care system, they viewed their relationship with the doctors as more friendly. However, what happens here in Canada is that they lose that privilege that they had in China, especially as it becomes a linguistic issue. Their interaction with the doctor led them feel devaluation and dehumanization. This is an inherent class issue as I mentioned before. Different class status in their original and host countries shapes the women's different experiences when they contacted with their doctors. Unfortunately the women did not think about the classism as another inequity.

During the discussion, these Chinese women expressed their willingness to adopt to the social organizations, behaviours and norms of the dominant white society. However, the existence of sexism, classism and racism within Canadian society created their feelings of alienation, objectification and marginalization.

Regarding their health needs, most of the women indicated that they wanted both traditional Chinese medicine and Western medicine to maintain their health. They believed that traditional Chinese medicine is effective in a gentle way, so it is good for their chronic problems. But they also want to seek help from western medicine, since they believed that the effect of modern medicine is more aggressive. These values are congruent with the political values in China, which emphasizes the use of both traditional and western medicine (Elfert, Anderson & Lai, 1991). Unfortunately, the women's experiences encountered when they contacted the western health care system, specifically the doctors,

leave these Chinese women feeling frustrated, confused and dehumanized. This led to their development of serious strategies to deal with the challenges in order to regain a sense of self-control in maintaining their health.

One of the important strategies employed by the women was relying on self. To a certain extent, relying on self represented that these Chinese women thought back to the values of their original country. They had to rely on: (a) their own knowledge and past experiences; (b) their families and relatives in China; (c) Chinese medicine; or (d) the Chinese health care system. Reliance on self created feelings of regaining self-control; on the other hand, it often led to the women's delaying seeking help from health care professionals in Canada. In short, the women's lack of trust in health care professionals, which resulted from the differences between the women's expectations and the realities, also influenced their delay seeking help.

As I cited before, my findings in this study also demonstrated that traditional Chinese culture and Confucian philosophy strongly influenced the participant's development of strategies to deal with the racialized situation. The women's acceptance of the physician's rude behaviours, searching for explanation of the racist situation, as well as their overt denial of racism, reflected the ancient rituals which demand self-control and self-discipline. "A physician is a physician, and a patient is a patient" was widely accepted among these Chinese immigrant women. This approach also indicates the patriarchal views of Chinese society. Their tendency to suppress strong feelings, such as aggression and anger, is not consistent with the value in Canadian society, particularly with that of health care providers. It is, however, consistent with women's behaviours. It is likely that

many other immigrants respond in same fashion. My findings supports the suggestion that the cultural demanded self-control and self-restrain are adaptive strategies which may reduce the risk for mental illness (Root, Ho & Sue, 1986), since the women in this study have expressed the view that they regained their dignity and inner harmony through their non-resistance. However, other studies indicated that depression is likely to occur among cultural groups that strongly inhibit aggressive feelings (Marsella, 1978). The long-term effect of this cultural self-discipline on the women's health need to be further investigated.

The findings of the women's discomfort with racism concurs with the finding of Noel's study (1996). In her study, Noel explored the health care experiences of Afro-Caribbean immigrant women. She argued that "the women's perception of our society as being inherently racist was quietly and respectfully expressed" (Noel, p. 82). Based on the findings of this study, I argue that these immigrant women have not been empowered to assert the racism issue in the Canadian society. This is consistence with certain feminist literatures. Agnew (1993) argued that immigrant women are reluctant to criticize their new society because of their fearing to provoke comparisons with the "old country" and feelings of alienation caused by consciousness of racial stereotypes. I argue that to understand these women's experiences, we have to understand their lived experiences not only as women, but also as immigrants. We need to understand their situation as members of subordinate groups, their gender and ethnicity (Juteau-Lee et al., 1981). However, women of colour have been ignored even within feminist theory and practice. Until recently women of colour have been neglected in feminist theory and research (Agnew, 1993).

Recommendations

In this section I will discuss the implications and recommendations of this study as they related to nursing. In this study, I addressed the issue that these Chinese immigrant women experienced when they interacted with the health care delivery system which they identified as being doctor driven. However, there are several implications for nursing practice, education and research which can be drawn from these findings.

Implications for Nursing Practice

My findings indicated that socio-cultural factors strongly affect expectations and behaviours related to health and health care. Care that lacks cultural understanding is inherently rasicm. Based on the findings of this study, I argue that culturally sensitive health care has been overlooked and neglected in the Canadian health care system. Physicians, nurses as well as any other health care providers bring their own values and norms which generally represent Western society, and they may completely differ from that among the Chinese community. It is suggested that lack of respect to their experiences of day-to-day life and their culturally formed beliefs fostered immigrant women's feeling of frustration and created their distrust of health care providers (Juarbe, 1995). This concurs with my findings. This issue was significantly reflected in the distrusted physician-patient relationship. As nurses, we cannot change the physician-patient relationship, but we can empower women of colour by understanding their cultural orientation and minimizing cultural misunderstanding during the patient-health professional interaction. Nurses may also promote empowerment by valuing the women's abilities to deal with the challenges they encountered. This means we should value the

capacities that the Chinese women possess to make their own decisions regarding health and health care. It is suggested that sensitivity training of emergency department staff would enable nurses to provide culturally sensitive care. Nurses not only be alert to their own behaviours in order to minimize cultural disruption but also to advocate for the consideration of cultural factors when other health care providers' behaviours interfere in the patient's culturally shaped beliefs (Kuo et al., 1994).

I also argue that understanding the Chinese immigrant women's experiences and health care seeking behaviours is related to their immigrant status. This is in accordance with the argument found in the reviewed literature (Meleis, 1991). According to immigration procedures, prior to an immigrant woman's entry into Canada, her legal status as a dependent is already established (Ng, 1988). But most of the women in this study had to join the paid labour market as wage earners for their families to survive because of their husband's unemployment or under-employment. For these Chinese women, working in the paid work forces did not grant them relief from housework and childcare responsibilities. Most participants said that they had no time or very little time for language training. The woman's position in her family as well as in Canadian society has profound effects on their decision making regarding health and health care. For example, some women in this study explained that an appointment to see a physician must match the schedules of their husbands. Thus, the knowledge of the life circumstances of Chinese immigrant women needs to be utilized by health care providers to assist in identifying the women's health care needs and in providing understanding of the women's help-seeking behaviours. The label 'non-compliant' for immigrant women needs to be

reexamined, for it may not be their choices but the situation of life that contributes to the ways in which they respond to health problems (Anderson et al., 1994). Nurses, as practitioners and advocators, must be aware of the importance of identifying racism, sexism, and classism within the health care system. The boundaries of nursing practice need to be expanded.

My findings also support the idea that providing information regarding the resources and services available will offer Chinese immigrant women the opportunity to make their own decision for health care and, hence, creates a sense of self-control. Many participants pointed out they had experienced frustration, confusion, and helplessness when they initially sought the answers about where, when, to whom, and how they should go for help regarding their health care. Isolation, language barriers and discrimination in the health care system all contribute to immigrant women's lack of knowledge. The participants suggested that the development of the health care promotion programs in immigrant school would be an effective way to provide information regarding the Canadian health care delivery system. Otherwise, the workplace also has responsibility to make health care information available to all immigrants. Nurses could create the information about health care in the form of a pamphlet or brochure. This would reduce the feeling of alienation of immigrants. I believe that it is time nurses advocate for the development of health promotion programs targeted at the new immigrant women. It is time that nurses become politically involved in the issues that relate to health, health policy, and access to health care for immigrant women (Juarbe, 1995).

Ineffective communication between the patient and the health care provider has been documented as a main barrier to keep immigrant women from accessing heath care (Poss, 1995). The participants in this study also asserted that their interactions with health care professionals, particularly with their physicians, left them feeling devalued, disrespected and dehumanized. Although these women brought their own interpreters, inappropriate communication between the physician, the interpreter and the patient also led the women to feel embarrassed and devalued. It is suggested that when the health care providers communicate with patients through the interpreters they should try to communicate with the patient, not the interpreter (Poss). In this situation, the health care providers must realize that it is not only a bilingual problem, but also bicultural (Poss). This will create in the women a sense of being treated as a "person", not as a "patient", and hence increase their trust in the Canadian health care system. Meleis (1991) stated that immigrant women can discuss their health problems and social situation openly only when they sense the attention of the health professionals who are not in a hurry. Participants in this study indicated that they usually sensed the physician's hurry, and this definitely made them realize that describing their problems was useless. As Noel (1996) suggested, without connecting with patients at a human level, "access to holistic health care is limited to a privileged few" (Noel, p. 83).

Implications for Nursing Education

The stories told by these Chinese immigrant women highlight the issue that nursing must consider development of an understanding of immigrant women's daily lived experiences in order to deliver culture-specific care. Empowerment, "a process of helping

people to assert control over the factors which affect their health" (Gibson, 1991, p. 359), is compatible with the principles of culturally sensitive nursing. However, the reality of both nurses' education preparation and the institutional climate in which they practice provide experiences different from these ideas. Nursing students are socialized into nursing in a hierarchical fashion because they learn their initial and ongoing nursing skills in an environment which is run on rigidly bureaucratic lines (Chavasse, 1992). Nursing students, even nurses as a group exhibit controlling behaviors, and they are at the bottom in the hierarchical health care system which reflects racist, sexist, and classist values in the profession. No one in this situation can empower their patients, particularly, when the patient is a immigrant woman who is considered a problem in Canadian society. This challenge raises a crucial question in nursing education about how to empower nursing students. Nursing educators must reexamine the philosophy in their teaching practice which should be congruent with empowerment. Through education, nursing students can learn to see issues related to health care as complex problems with social, cultural and political contexts, thus they are prepared to enable the women to make their own decisions related to health issues.

Another role of nursing educators today is to emphasize culturally sensitive nursing, which views culture as an essential dimension of the patient, in their teaching practice. It is fundamental to introduce the knowledge of different cultures, varying perceptions of illness and health, traditional therapies which differ from the Western medicine, and different social norms in nursing courses. However, nursing schools are dominated by white women in the nursing faculty and student bodies. As a result,

"supporting, mirroring, and perpetuating the power and privilege of dominant structures in our society" (Sherwin, 1992, p. 228) is inevitably existing in nursing education. Noel (1996) argued that recruiting both students and faculty members from non-dominant minority groups is essential in order to "meet the needs of the racially, ethnically, and culturally diverse members of our society" (Noel, p. 85). In addition, reemphasizing nursing education from a multi-cultural perspective to an anti-racist perspective has been addressed recently (Harper & Cavanaugh, 1995). This suggestion will help nursing students as well as nurses "refocusing the emphasis from a multi-cultural health perspective to an anti-racist perspective" (Noel, p. 85). This practice will reflect an combination of the concepts of culture, ethnicity, and race with nursing education and nursing practice. Not addressing this results in nursing students not being prepared to accept and understanding of values in health beliefs which may be completely different from that of the predominant culture in the Canadian society.

Implications for Nursing Research

This study asserted the issue that these Chinese immigrant women's experiences with health care are different from the white Canadian women and even other ethnic groups for the complex cultural, social, economic, and class backgrounds. The women's fear and hesitation of expressing their feelings and their thoughts regarding the power and privilege of the relationship with the health care providers, especially with the physician, not only reflect the cultural issue, but also the issue of racism, sexism and classism in the Canadian society. Although feminist research views women as a source of knowledge and women's experiences as the subject to investigate (Anderson et al., 1994), how to

empower women of color to express their feelings and to address inequities is still an question for feminist researchers. In this study, some participants stated "I do not know how to express that" when we talked about racism in the health care system as well as in the society. Four of the participants refused to be taped during the interview. At the beginning of the study, I could see their initial uncertainty and fear of being punished by the Canadian government in the future. The common culture and life experiences shared between me, a researcher and an immigrant Chinese woman, and the participants provided an opportunity for us to understand each other. I found self-exposure was an effective method to establish a trusting relationship between the researcher and the participants in this study. I talked about my personal experiences related to immigration and health care during each interview, since I believed that if I wanted to know them I must interact honestly with them. I shared my anxiety when I waited in the emergency room, my frustration and confusion when I was in the physician's clinic with my sick baby and my anger when the physician started to write the prescription before I finished telling him or her what my problem was. This self disclosure created a climate which enabled the women to share their experiences comfortably and openly.

Some of the participants expressed that they found it was hard to describe their relationship with health care professionals, particularly with the physician. At that time, I encouraged the women to try to describe their perceptions in their own way or in their own words. So the expression of "a doctor is like an empire in China" used by the women vividly reflected the relationship between the doctor and the women. Because I, as a Chinese immigrant woman, realized that directly criticizing other people is not valued in

Chinese society, I can understand their hesitation and fear and I respect their feelings. Again, in order to understand the health needs of bicultural women, we have to being part of that culture or immerse ourselves in that culture (Meleis, 1991).

Another strength of this study was my ability to communicate with the participants in Mandarin, which facilitated the women's talking between the participants and the researcher. The women expressed that talking with the researcher who spoke the same language, and came from the same background increased their feeling of comfort to disclose their personal experiences. Therefore, strategies employed in this study to help bicultural women who have difficulty in expressing their perceptions and feelings about health related experiences may be useful for other researchers who are interested in exploring lived health experiences with cross cultural women.

In general, the health of women of color has been neglected in the traditional medical, nursing research, even in the feminist literature. Very little is known about Chinese immigrant women, their life experiences in Canadian society, their health needs, their perceptions about the health care system, and their ways of living with the dilemma of double discrimination. I hope this study will enrich the limited studies exploring the experiences of Chinese immigrant women with the health care system, their perceptions, their strengths and survival strategies to deal with the challenges encountered in maintaining their health. As Anderson et al. (1994) argued, "the realities of poverty and marginality may be quite foreign to middle class health professionals" (p. 20), and their perceptions may be quite different from that of immigrant women. I hope this study will

provide certain directions for health care professionals' research to consider for the competent care of people from ethno-cultural groups.

Limitations and Future Considerations

Several limitation are inherent in this study. One limitation is related to the representativeness of the sample because most participants included in this study are well-educated women. Their experiences of health care and their strategies for dealing with challenges in maintaining health may differ from those of less educated Chinese women. Thus, the findings of this study cannot be generalized to all immigrants. Replicating the study with less educated Chinese or other immigrant women may provide further insight into the Chinese women's day to day life regarding health and health care.

The duration of residence in Canada of participants in this study was from 1 to 5 years. They are still newcomers in Canada. Conducting a similar study with older, established Chinese immigrant women, who came Canada a long time ago, would enhance our knowledge about the long-term effects of immigration on Chinese women's health and health care in Canada.

This study was limited to Chinese immigrant women who came from Mainland China, thus, further study should be repeated with Chinese women who came from other Asian countries or with immigrant women from other ethnic and racial groups. Noel (1996) asserted "immigrant women are not a homogenous group" (p. 87). Feminist practitioners and researchers should distinguish women of color's unique ways of experiencing the world (Agnew, 1993).

Another serious concern is related to the exactness of the data. There is a risk of loss of accuracy and cultural meaning in the process of transcription, translation from Chinese into English, and the resultant data analysis based on the English version.

Future researchers are encouraged to explore the experiences of health care providers working with immigrants, particularly immigrant women. This will create the knowledge of the "availability of culturally, racially, and ethnically sensitive care" (Noel, 1996, p. 88) for patients from diverse ethnic groups. I also believe that to explore the attitudes of health care providers toward patients from diverse cultural, ethnic and racial groups will increase their self-awareness of their stereotypes and biases which hinder the patient to access culturally competent health care.

Unquestionably, we need further studies conducted from a feminist perspective which provides theoretical understanding of immigrant women's daily lived experiences, through their own views, related to the process of immigration, acculturation, and the existing racism, sexism and classism in Canadian society. Questionnaires based upon a reductionist view of the researchers are inappropriate for immigrants as they lead to misinterpretation. For that reason qualitative research in also absolutely necessary.

In conclusion, this study reveals the frustration, discomfort and dehumanization experienced by the Chinese immigrant women when they interacted with the health care system and health care professionals, particularly with the physician. It also provides insight to the women's strategies to regain an sense of self-control and inner harmony in the situation which initially made them feel embarrassed, alienated, and devalued. Indubitably, sharing their personal strategies and experiences increased the awareness of

the women to the existence of racism in the dominant society and their capacities for dealing with the issues. I must guard against presenting the women in this study only as victims. This study also indicates the women's creativity in dealing with the challenges related to their health and health care and their great capacity for surviving and moving beyond the barriers.

APPENDIX A

Letter of Introduction

The Experiences of Chinese Immigrant Women with the Health Care System in Canada

(To be translated into Chinese)

My name is Shihua Wang, a graduate student in the School of Nursing, Dalhousie University. I am interested in conducting a study to explore the experiences of Chinese immigrant women (specifically women coming from Mainland China) with the health care system in Halifax, Nova Scotia, Canada. From the reviewed literature, I have learned that there has been an increased interest in the investigation of immigrant women's health problems, which focus on the under utilization of the health care delivery system and other problems with health care. However, very little has been known about their experiences when they encounter health care services. Particularly, Chinese Canadian women's voices have seldom been heard in the health care system as well as in Canadian society in general. I would like to explore the realities of being a Chinese immigrant woman using the health care services in Halifax, Nova Scotia. No health professional care giver's name will be allowed to be disclosed to me.

My concern about this issue arises from my personal experiences as a pregnant Chinese woman, coming to Canada as an international student, now a mother of a Canadian-born infant son, and a friend of some new Chinese immigrant women. These experiences have strongly influenced my personal life as well as that of my family.

Participants will be visited and interviewed several times individually by me during the process of this study, but will not take more than about 3 hours of your time. Participants in this study must understand that the interview will be tape recorded and they will share their personal experiences within the group.

In this study, confidentiality will be assured by assignment of pseudonyms. Tapes will be returned to each participant at the end of the study after I have transcribed them.

If you have any questions or have a friend who are interesting in this research, please feel free to contact Shihua Wang at 429-8842 (home).

APPENDIX B

Letter of Consent

Consent Form

(To be translated to Chinese)

Title of Research: The Experiences of Chinese Immigrant Women With the Health Care Delivery System in Canada

Researcher: Shihua Wang

This is to certify that I, ________________, hereby agree to participate in the research "Experiences of Chinese Immigrant Women with the Health Care System in Canada". The research process has been explained to me by the researcher: Shihua Wang, and I understand my role in this process. I understand that Shihua will interview me about my personal experiences with the health care system and health care professionals in this city. I do not have to answer any questions that I do not wish to. I also understand that personal interviews will be taped and the tape will be returned to me at the end of this study. I have been told that my name will be held in confidence. I understand that I may stop the interview at any time and I may withdraw from the study at any time without any punishment.

Date: ____________

Signed: ____

Signature of participant

____

Signature of researcher

APPENDIX C

Demographic Information

(To be translated to Chinese)

Please complete the following questions before our first interview. You may omit any questions you prefer not to answer. Confidentiality will be maintained at all times.

1. Name: ______________________________

2. Address: ______________________________

____

3. Telephone: ______________

4. Age 15-24 ___, 25-29 ___, 30-40 ___, 41-50 ___, over 51 ___

5. Country of Birth ______________________________

6. Years in Canada ______________________________

7. Years in Halifax ______________________________

8. Years in other parts of Canada ____________________

Where? ______________________________

9. Education in original country ______________________________

10. Education in Canada ______________________________

11. Occupation in original country ____________________

12. Occupation in Canada ______________________________

13. Family members living with you ____________________

14. How well do you speak English? not at all ___, little ___, well ___, fluently ___

APPENDIX D

Semi-structured Interview Guide

I have prepared the following questions that will help me organize the interview and help me understand the experiences of Chinese women in Canada.

Introduction of interview:

1. Repeat explanation of the purpose of the study.
2. Again, reassure the confidentiality of the interview.
3. If the question is too personal or if she feels uncomfortable to answer it, she will be told that she is to feel free to interrupt the interview at any time.
4. Ask permission to tape record and explain the reasons why. Assure her that the tape is confidential and will be returned to her.

Interview Guide - Topics to Explore:

1. How do you define health?
2. How do you view your health?
3. Do you think your health has been changed since you came to Canada? If so, in what ways?
4. How can a Chinese immigrant woman maintain her health in Canada?
5. What personal and social factors do you think influences access to health care in Nova Scotia?
6. Do you have concerns about your health problems?
7. What have you experienced in your interactions with health care professionals in hospitals and in any other health services?

8. Describe your experiences after visits with your family doctors?
9. Do you perceive discrimination toward women of colour in the health care system? In what ways?
10. What strategies have you used to cope with the challenges you have encountered to maintain your health in Canada?
11. How could the Nova Scotia health care system best meet your health needs?
12. What social action could you precipitate to bring about change?
13. What else would you like to add?

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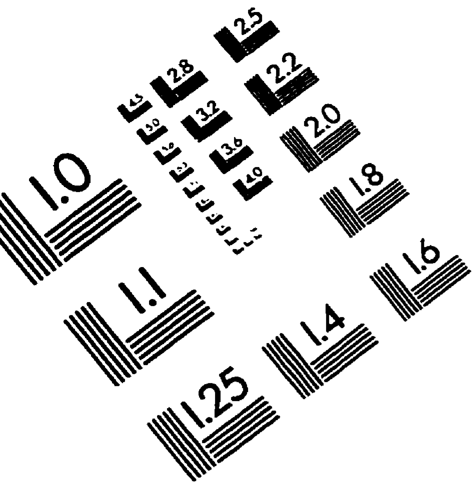
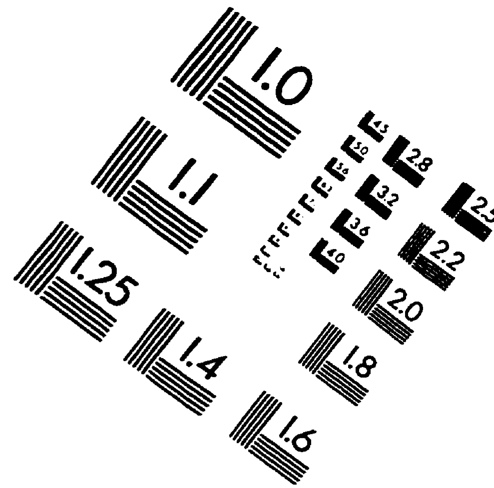
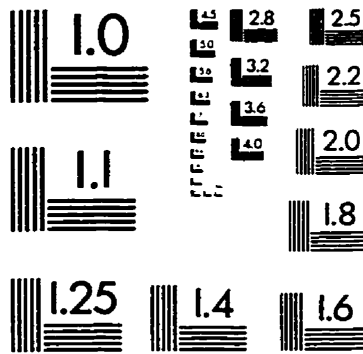
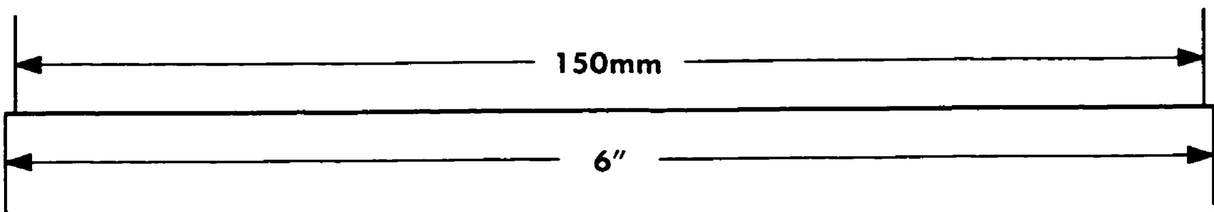
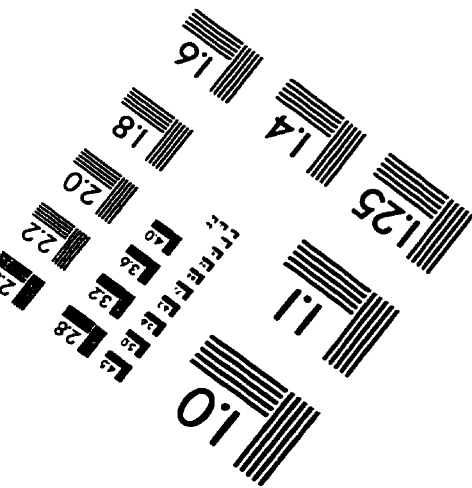
IMAGE EVALUATION TEST TARGET (QA-3)



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