

Popular health promotion strategies among Chinese and East Indian immigrant women

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ABSTRACT

Purpose: To advance understanding about the popular health promotion strategies and factors associated with the successful transfer and uptake of health messages among Chinese and Indian immigrant women.

Methods: Eight focus groups were conducted with 46 immigrant women, 22 from Mainland China and 24 from India, who had lived less than 5 years in Canada. Audiotaped data were transcribed, translated and analyzed by identification of themes and subcategories within and between groups.

Results: In both ethnic groups, discussions on promoting health messages had five major themes, i.e., sources, barriers, facilitators, credibility and ways to improve access along with group specific sub-themes. Despite identification of several diverse sources of health information in the adopted country, Indian and Chinese immigrant women perceived most strategies as not very effective. The reasons of perceived ineffectiveness were barriers to accessing and comprehending the health messages; and limited prior exposure to institution based or formal health promotion initiatives. These women were more familiar with informal means of obtaining health information such as social networks, mass media and written materials in their mother tongue.

Conclusion: Existing health communication and health promotion models need to be re-orientated from a one-way information flow to a two-way dialogue model to bridge the gap between program efficacy and effectiveness to reach underserved immigrant women. An “outside the box” approach of non-institutional informal health promotion strategies needs to be tested for the studied groups.

Key Words

Immigrant; Women; Health promotion; Strategies; Focus groups

INTRODUCTION

The provision of preventative health information to the community is a priority for health promotion programs. However, bridging the gap between efficacy and effectiveness of health promotion initiatives is a challenge when aiming to reach underserved groups such as immigrants (Green 2001). Although immigrants are often healthier than the general population of the adopted country due to the ‘healthy volunteer’ bias and pre-immigration health screening, studies report that the ‘healthy immigrant effect’ is lost over time (Chen, Ng, & Wilkins 1996; Donovan et al. 1992; Stephen et al. 1994). Certainly, the need to convey effective preventative health messages to immigrant populations is crucial, particularly at the intersection of gender, ethnicity, and culture.

Studies reveal that recent immigrant women (IW) from traditional cultures are vulnerable to impeded access to health information and services due to their multiple roles and unshared family responsibilities

(Anderson et al. 1993; George & Ramkissoon 1998). The dual workload of IW combined with settlement and adjustment challenges often result in lack of time for preventative health practices and self care when health benefits may appear to be in the distant future (Choudhry 1998; Hoeman, Ku, & Ohl 1996). Women's unwelcome role expansion is known to be associated with compromised health when they are unable to choose their roles and balance competing demands (Verbrugge 1986; Muller 1986). Although recent efforts have been directed towards the development of health promotion programs for IW, there is nonetheless a dearth of knowledge about the modes of health promotion that are more or less popular among IW themselves.

This is a salient concern for countries with a higher proportion of immigrants. One such example is Canada where 18% of the population is a first generation immigrant and one out of five women is an immigrant (Statistics Canada 2000). In addition, sources of immigration to Canada have rapidly changed in recent decades. Half a century ago, most immigrants came from Europe. Now, most newcomers are from Asia (Statistics Canada 2003). Since 1996, Chinese and South Asian (India, Pakistan, Sri Lanka or Bangladesh) immigrants are the top visible minority groups in Canada. Between 1996 and 2001, the number of Chinese immigrants increased 20% while the number of South Asians rose by 37%. This is explained by the historical context of their immigration. Early immigrants from Mainland China came in 1880s from Guangdong province to build the Canadian Pacific Railroad. Likewise, Indian immigrants from Punjab arrived in the early 1900s as industrial workers. During this era, family members of non-European migrants were not permitted. By the 1950s immigration rules eased and permitted limited family immigration from non-European sources. In 1967, immigration policy moved towards a point system based on qualifications and, hence, eliminated preferential support to white immigrants. This led to a greater influx of skilled South Asian and Chinese immigrants and their families in the 1970s.

Despite increasing numbers, studies identify Chinese and South Asian ethnic groups as "disadvantaged" with respect to health-information access and use of preventive health services such as cancer screening (Pham & McPhee 1992; Jenkins et al. 1990; Lu 1995; Choudhry, Srivastava, & Fitch 1998). More importantly, little is known about their experiences and perceptions about the effective means of promoting health information. Nor do we know about similarities or differences that may exist within immigrant groups. Our study aimed to identify popular preventive health promotion strategies within Canada and in

the home countries of Chinese and Indian IW by gathering their opinions, experiences and perceptions. It also aimed to explore factors associated with successful transfer and uptake of health messages. We hope to provide a foundation for a broad health promotion research agenda that addresses how health can be promoted in increasingly diverse communities (Rootman & Hershfield 1994). Findings from this study will help guide the development of culturally appropriate and effective health promotion programs.

METHODS

The study used the focus group qualitative research method. This methodology is especially useful when it involves people with limited power and influence, such as ethnic minorities (Morgan 1998). Furthermore, focus groups allow for participant interaction which creates a cueing phenomena leading to greater insight as to why certain beliefs and opinions are held. This unique feature of focus groups is not found in face-to-face interviews or questionnaires (Kreuger 1994).

For this study, focus groups were conducted with immigrant women (IW) at least 18 years of age who came to Canada from Mainland China or India within the last 5 years. The latter criterion was established to gather experiences and perceptions of recent immigrant women. Following approval from the appropriate research ethics board, participants were selected through client lists of the immigration and settlement community organizations within the Greater Toronto Area. Four focus groups were organized with each of the targeted groups in their first language (Mandarin or Hindi) at collaborating community centers. Prior to the focus groups, women were informed about the study purpose, procedures, risks and benefits of their participation and written consents were obtained. Bilingual moderators and assistant moderators facilitated the discussions using an open-ended discussion guide. To create a comfortable environment, refreshments were served during each session. All discussions were audio taped and field notes were taken. Participants were also asked to complete a one-page background questionnaire.

The focus group data were transcribed verbatim by bilingual research assistants. Translation challenges were resolved by discussions between bilingual research team members and data transcribers. The transcripts were read into QSR NUD*IST for summary and as an aid to analysis and interpretation (Meadow & Dohendorf 1999). The method of constant comparison was used to identify relevant themes and cate-

gories that emerged from the empirical data (Strauss & Corbin 1996). Thematic analysis was conducted by systematic reading of the text and its organization into categories or preliminary codes. Further interpretation and coding followed rereading of the text sorted by preliminary codes (Crabtree & Miller 1999).

The data quality was augmented by the process of *member checking*, *debriefing* and *triangulation* (Nicholas & Pope 1995). The member check was accomplished by asking focus group participants to verify the moderators' interpretations at the end of each focus group. For debriefing, the focus group moderator and moderator-assistant reviewed statements and themes after each focus group. Finally, focus group findings were compared to the review of existing research literature for the participant immigrant groups to achieve the process of triangulation.

RESULTS

Overall, eight semi-structured focus groups were conducted with 46 IW; 22 from China and 24 from India. The IW in two groups were similar in most of their sociodemographic characteristics (see Table 1). However, Indian IW were relatively more recent arrivals in Canada, with more university education on average but lower perceived social support, compared to the Chinese IW.

Women in the focus groups were asked to express their opinions on a women's health issue that was a major concern to them. It was anticipated that under a specific health issue identified by women themselves, their experiences and perceptions about sources of information in their home countries and in Canada would be gathered. Interestingly, across all group discussions in both ethnic groups, women were unable to reach a consensus on a single physical health issue of major concern. However, compromised mental health and dissatisfaction with health-care services emerged as the most important health concerns after immigration. In both groups, discussions on promoting health messages had five major themes, i.e., sources, barriers, facilitators, credibility and ways to improve access along with some group specific sub-themes (see Table 2).

Health Concern After Immigration

For Indian IW, compromised mental health emerged as an overarching health concern after immigration. Women's verbal expressions included, 'stress,' 'tension,' 'loneliness,' 'depression' and 'feelings of doing noth-

TABLE 1. Sociodemographic Characteristics

<i>Variable</i>	<i>Chinese IW (n = 22)</i>	<i>East Indian IW (n = 24)</i>
Age, mean	33 (25 to 47)	34 (18 to 69)
Marital status, %		
Married	83.3	90.9
Separated/divorced	8.3	4.5
Single, never married	8.3	4.5
Had children, %	62.5	81.8
Education, %		
Less than elementary	12.5	13.6
High school completed	20.8	22.7
College/university some	33.3	13.6
University completed	25.0	27.3
Post graduate	8.3	22.7
Number of years lived in Canada, mean	2.0	1.7
Current employment %		
Not employed	62.5	71.4
Part time	12.5	9.5
Full time	8.3	9.5
Volunteer	16.7	9.5
Perceived English ability,* mean	2	2
Perceived social support,* mean	2.8	2.4
Perceived health,* mean	2.7	3.5
Had family physician %	70.8	86.4

* Scale 1 to 5: Poor to Excellent

ing' while physical indicants included frequent headache, back pain, joint pain, hair loss and fatigue. For Chinese IW, mental health did not appear to be a direct or significant concern though some symptomatic indications were back pain, stomachache, insomnia, fatigue, and musculoskeletal problems. It is possible that Chinese IW were less vocal, as discussed subsequently. Participants of both ethnic groups were similar in having a holistic view of health with an emphasis on balance between physical and mental health for their general wellbeing.

If your mind is not good it will affect your body, you don't feel like eating, you don't feel like going out . . .

TABLE 2. Themes Across East Indian and Chinese Immigrant Women (IW)

<i>Theme</i>	<i>East Indian IW</i>	<i>Chinese IW</i>
Major health concerns	#1 Compromised mental health #2 Dissatisfaction with health services	#1 Dissatisfaction with health services
Popular sources of health information Before immigration	#1 Social Networks #2 Television, newspaper, magazine, posters & other printed material #3 Doctors	#1 Newspapers, books, health magazines #2 Doctors
After immigration	#1 Social Networks #2 Links at work, school, religious & community centers #3 Doctors	#1 Workshops at community centers or religious places #2 Brochures, medical books & magazines #3 Doctors #4 Modern sources: Internet, library, hotlines & drug stores
Barriers to health information	#1 Loss of social networks #2 Language barrier #3 Work demand and time #4 Transportation difficulties	#1 Language barrier #2 Limited knowledge #3 Work demand and time
Facilitators to health information	#1 For benefit of children #2 Perceived need of self-awareness	#1 For benefit of children #2 Perceived need of self-awareness
Credibility of health information	Language ability, relevance of message, trust in advisor	Language ability, relevance of message, trust in advisor

For Chinese IW, dissatisfaction with the health services emerged as a major health concern after immigration, while it was secondary to the mental burden among Indian IW. A major source of dissatisfaction for women of both groups was the long waiting time in hospital emergency departments and to see specialists with no priority for sick children. The perceived reasons for this systemic inefficiency included an absence of a private sector and the shortage of health professionals. Also, Chinese IW were dissatisfied with the doctor-patient relationship, particularly about the doctor's quality of care, poor listening skills, lack of explanation, and limited time.

. . . Here when seeing the family doctor, he seems not to explain much detail. He seems to be in a hurry since there are many people waiting. He hastily will write the prescription, or if no prescription, hurriedly asks you to go home and rest . . .

Also, majority of the Chinese IW discussed their English language difficulties in communicating with doctors, which may partially explain their dissatisfaction. It seems that participants' lack of familiarity with the healthcare system due to their novice status (our study recruitment criteria) contributed to the intensity of dissatisfaction. Some Indian and Chinese IW who had lived relatively longer in Canada expressed more satisfaction with the healthcare system.

Yes, the medical system here is really better. If you have the money or not, if you are poor or rich it is the same thing. For everyone it is the same.

Sources of Health Information

A variety of methods to obtain health information were identified both in participants' countries of origin and in Canada. Both groups identified more ways of acquiring information in Canada than in India or China, suggesting many outreach initiatives are in place to help newcomers. Indian IW obtained health information in India from family and social networks, television programs, posters, newspapers, magazines, other printed materials, gym and yoga centers and doctors. After social networks, television was the most popular source of information followed by newspapers and magazines. Workshops were not very popular in India.

You get more information there (India), just sitting at home you learn so much. If someone else had it they tell you or a friend and we just talk about it.

The seminars or lectures are not as popular as they are here (in Canada).

Among Chinese IW, identified sources in China were doctors, written materials (health magazines, books and newspapers), public health workers and elders. They frequently discussed reading various types of health materials. Doctors were described as an important source of health information due to the ease of getting an appointment and availability of health pamphlets in clinics.

Also there are many family doctors that teach us how to stay healthy and prevent getting sick.

At home we subscribe to magazines, and I read some books. Also, if there is anything in the newspaper (then) I will cut it out.

After immigration, Indian IW identified health information sources as friends and family, community centers, doctors, Centers for Language Instruction for Newcomers, TV programs, ethnic television, temples, and the workplace. Some participants identified receiving health brochures at the airport upon arrival. Among Indian IW, friends and family members remained a popular mode of obtaining health information after immigration. Also, women who had lived more years in the adopted country perceived their children as an important source of information.

TV and newspapers we read from there. Also, at jobs friends discuss these topics or if you are enrolled in a class or something.

Also, teachers in the schools teach our children about health issues and they come home and tell us, so we learn from our children as well.

Chinese IW also identified many similar sources of health information after immigration. However, it seems that the multiplicity and diversity of identified resources was more among the Chinese than the Indian IW. Also, compared to the Indian IW, social networks were not

discussed frequently by Chinese IW before or after immigration. The identified sources of health information after immigration included: workshops, community centers, written materials (brochures, medical books, health magazines), doctors, information booths at malls, Internet, government hotlines, library, schools, radio, and drug stores.

Barriers to Health Information

Women in both groups perceived that obtaining health information was easier in their countries of origin though multiple resources were identified in the adopted country. However, the two groups were not alike in attributing their difficulty in obtaining health information after immigration.

For Indian IW, loss of extended social networks leading to limited knowledge of resources seemed to be the primary reason for experiencing difficulties in accessing health information. This was followed by language barrier, which compromised their understanding of health information.

In India, I think that through your social circle you learn many things. Here if you know someone but they don't know the answer then who else can you ask?

The thing is, we are newcomers so we do not know too many people and they do not know us. That is why we cannot have that much communication here, as much as there should be.

Among Chinese IW, language seemed to be the dominant barrier in accessing and understanding health information, while lack of familiarity with the environment leading to limited knowledge of resources was a secondary factor.

Mostly it's the language problem, it'll be better to have more information in Chinese.

Because we just came here and we are not familiar with Canadian policies and requirements, we need to know these. But we have no way to know because when we want to find out we need someone's help (due to language) to call the government office.

Across both groups, the language barrier extended to several sources of information in the adopted country. Many women described having

limitations to understanding the complete content of television programs, health workshops, Internet, newspapers and in communicating with doctors. Hence, women in both groups perceived that the usefulness of several health information resources was decreased as the messages remained unclear. One Chinese participant felt that language insufficiency should motivate newcomers to learn the language of the adopted country. Certain sources of information that were perceived as important by many women in their countries of origin, such as doctors, became less accessible after immigration due to language difficulties.

Like the advertisement every night they tell people to get the flu shots, do we have to pay for it . . . I watched that advertisement many times, and I don't even know if it is free or not?

Here, if someone does not speak English at all, or that well, then that person can hardly get any information. What can you do? Nothing, you can't do anything.

If something happens to us, how are we to tell the doctor? How can we explain to the doctor.

Another reason hindering women's timely access to health information across both groups emerged as inadequate time and work demands stemming from women's multiple roles and feelings of job insecurity along with financial concerns.

. . . I always know that there are often workshops, however their times and mine. . . .

(difficulty to access health information) That is because we are too busy with our job and home, all we do is work and take care of the home. That is the life here, job, job, come home do work and that's it.

Some Indian IW perceived transportation difficulties as an obstacle to accessing health information. The main obstacles were the cost of traveling, not having a car and feeling fearful of traveling in a new country due to lack of familiarity and the inability to communicate in English.

Facilitators to Health Information

Despite several barriers to accessing and understanding health information, women's concerns in both groups about their children's health

and future motivated them to obtain more information and take care of their own health.

Especially with the kids you have to be more aware. In India, we didn't have much of a problem but when we came here we got shocked with everything and realized that we have to become more conscious and take care of ourselves better, especially with the children.

Surely we are not used to this place. Nevertheless . . . I feel that I'm doing this for the next generation.

Likewise, participant women's strongly perceived need of self-awareness about the health problems common in the adopted country motivated them to seek more information. For instance, many Indian IW felt that educating themselves about health issues was imperative since the types of health problems they encountered in Canada differed from those in India.

Sometimes we get these diseases that we have never heard of . . . and sometimes you do not even recognize or realize that you have these diseases because you don't know the symptoms. Until you go to the doctor you do not know what is wrong or that you have this disease. So if you know the symptoms before, you can be more conscious and help yourself more.

Credibility of Health Information

Across both groups, credibility of health information was related to women's ability to understand the message, the relevancy of the message and trust in the advisor. Women had a strong sense of trust in physicians regardless of their country of residence.

We would follow the advice in Canada if we understood.

We will think it through, and see if the advice really will help us.

In India we would always ask our physician about everything, and we do the same here.

However, many Chinese IW discussed not being able to obtain adequate health information from doctors in Canada due to their language barrier and the limited number of Chinese speaking physicians. One

woman described relocating her residence closer to a Chinese-speaking physician.

I was first living in a small town, but I felt that going to the doctor was very (difficult) perhaps due to the language barrier. I couldn't find a doctor, in the end we had to move back to the city to find a Chinese doctor. . . .

Some Indian IW who were relatively recent arrivals, mentioned having stronger trust in people who had lived in Canada for relatively longer periods.

If the person is experienced, or has been living here for a long time, we will listen to them.

Ways to Improve Access to Health Information

Women of both ethnic groups wanted health information in their first language through ethnic newspapers, television, Internet, workshops, health workers, pamphlets, and displays at family physician clinics. Some Chinese IW suggested including health information in a welcome package for new immigrants upon landing. For the Chinese IW, the preferred mode of receiving health information appeared to be printed materials while Indian IW emphasized ethnic newspapers and television. Suggestions were made to improve ethnic newspapers by expanding health sections, providing comprehensive information in a regular manner and specific to women and children.

It is easy and you take more interest if it is in your own language.

Yes, they (newspapers) should have an article about how these diseases can affect women. So, let's say they are talking about arthritis they should give the complete information such as what you do if you have arthritis, and what the doctors recommend. . . .

Some Indian IW also expressed an interest in learning through regular seminars, lectures and group discussions as long as they were offered at easily accessible locations.

You could also have more lectures or seminars in our own languages, more in community buildings and temples.

DISCUSSION

Despite identification of several diverse sources of health information in Canada, Indian and Chinese IW perceived most strategies as not very effective. The underlying reasons of perceived ineffectiveness were limited prior exposure of the participants to institution based health promotion initiatives, and barriers to accessing and comprehending health messages.

Approaches to health promotion and communication can be broadly categorized as institutional or formal and non-institutional or informal. The institution based or formal initiatives include workshops, seminars, and counseling while the non-institution or informal strategies include mass media and social networks. In our study, Indian IW were more accustomed to obtaining health information from informal social networks and mass communication in their home country, and this pattern continued after immigration. The Chinese IW frequently discussed written materials as a popular mode of obtaining health information in China and this tendency persisted after immigration. However, women in both groups had difficulties in accessing these popular informal modes of health promotion in their adopted country. Women's suggestions to improve ways of communicating effective health messages predominantly included informal networks and mass communication. Also, most of the participants felt that having health messages in their native language helped them gain a better understanding of the content and seek more information.

Overall, a gap seemed to exist between the expected and available sources of health information in Canada. This disparity is alarming particularly when the current era of health promotion emphasizes not only 'targeting' but 'tailoring.' Tailoring refers to the development of health interventions, materials and messages according to the cultural milieu and the characteristics of the targeted population without which interventions can produce only incomplete results (Pasick, & Otero-Sabogal 1996; Vega 1992). Our study indicates a need to tailor health promotion strategies to include non-institutional informal means of promoting health messages, such as written and visual ethnic media and more linkages with community groups. Future health promotion research should develop and test informal means of communicating health messages (Ahmad, Cameron & Stewart, in-press). Such an approach is likely to improve the effectiveness of health promotion initiatives within the studied groups.

Although our study participants gave high importance to making oneself aware of various health conditions in the adopted country, many had individual, systemic, or cultural barriers to obtaining and comprehending health information. There were some similarities and differences in the expressed barriers between Indian and Chinese IW. For instance, difficulty in obtaining health information due to limited social networks was the most significant barrier for Indian IW though they continued to recreate connections through community centers and workplaces. Nonetheless, family orientation was a strong feature of both groups. Linguistic issues were important barriers across both groups but more heavily discussed by Chinese IW. A possible explanation may include a higher reliance on written sources of health information among Chinese participant women. In addition, the education system in Mainland China uses Chinese as the primary language of instruction while English is popular in the Indian education system due to its colonial history. Other common barriers across both groups included limited knowledge about available resources and environment, and inadequate time and work demands. These findings highlight the need to investigate systemic differences in the countries of origin, across various immigrant groups, prior to development of health promotion programs.

Additionally, many participants expressed limitations in having meaningful discussions with physicians primarily due to linguistic difficulties, time pressures, and differences in the healthcare systems of the countries of origin and the adopted country. However, physicians were viewed as important and reliable sources of health information. Despite many barriers, women's concerns about the wellbeing of their children motivated them to continue health information seeking and promotion efforts. However, perceived barriers seem to outweigh participants' motivational resources. Collectively, the perceived barriers contributed to women's perceptions of the Canadian health promotion initiatives as being less effective. Other studies with Chinese and Indian immigrants report similar barriers to accessing health services (Choudhry 1998; Jang, Lee, & Woo 1998; Ma 2000). This cumulative evidence stresses the continued need to address these obstacles for optimal effectiveness of health information and services in reaching these groups.

Both immigrant groups in our study discussed non-physical health issues as their major health concerns after immigration while the boundaries between mental and physical health, and one's own and children's health were diffused. Women viewed mental and physical health in a holistic manner with a need for equilibrium between the two. This finding is in accordance with the healing framework popular in the East. For

instance, Indian Ayurvedic and Traditional Chinese Medicine view that body, mind, emotion and spirit are one reality and the wholeness and harmony among these bring health (Helman 2000). In contrast, the typical biomedical model view the human body as a series of body parts, and health as the absence of disease or abnormal state. Hence, addressing healthcare concerns of Chinese and Indian immigrants solely within strict biomedical framework would benefit from incorporating a wider perspective that does not compartmentalize mind and body health but uses a holistic diagnostic and treatment approach where emphasis is on each person within the life context. Such integrative approach is vital in planning successful health messages and programs (Brugge et al. 2002).

Furthermore, participants of both ethnic groups could not separate their own health concerns from their children's health. According to the individualism-collectivism framework, ambiguity of boundaries between one's own health and the health of significant others is a reflection of the strong interdependent self and family orientation among Indian and Chinese cultures (Hofstede 1980; Triandis 1989). In addition, the cultural gender hierarchy often leads these women to ignore or deny their own symptoms (True & Guillermo 1996). In terms of health promotion programs, this finding highlights the significance of incorporating social and familial contexts to convey the health messages in a meaningful and effective manner for Chinese and Indian ethnic groups.

Although women in our study had difficulties in identifying a major post-immigration health issue of concern, dissatisfaction with the healthcare services emerged as a dominant health concern for the Chinese and compromised mental health for the Indian IW. A few other studies also report major health concerns of South Asian IW, such as physical pain, worry and uneasiness, but not in reference to their immigration experiences (Bottorff et al. 2001). Some studies report feelings of loneliness and depression among elderly South Asian IW as primary concerns (Choudhry 2001). Our study finds a similar pattern among recent younger Indian IW and, hence, it seems vital to address mental health issues of recent Indian IW regardless of their age. Descriptive data in our study also indicate that Indian participants had lower social support compared to Chinese participants. Reinforcing ties with the community is likely to facilitate adaptation into a new country and alleviate feelings of stress, isolation, and depression. Future research should investigate community outreach models such as peer educators, ethnic media and host-family programs that follow the principle of empowerment and enhance social support.

In contrast, Chinese IW did not discuss their mental health burden openly except for a few symptomatic indicators such as chronic back pain, muscle aches, fatigue, insomnia and a general feeling of discomfort. Other studies report that mental health burden among Chinese immigrants could be expressed as multiple somatic symptoms and chronic fatigue (Lee et al. 2001). In light of our literature review, it is possible that Chinese IW in our study perceived high stigma in talking about mental health (Lin & Lin 1981) or had sufficient resources or resilience (Bagley 1993; Lai & McDonald 1993) with which to combat the stressors of immigration. Due to the qualitative nature of our study, lack of an extensive discussion on mental health issues among Chinese IW cannot be interpreted as an indication of their low mental health burden. Other cross-sectional studies in North America report a higher prevalence of depression among Chinese Asians than their white counterparts (Franks & Faux 1990; Kuo 1984). Further quantitative studies would help in advancing our understanding of the emergent difference in the mental health burden or its expressions between Indian and Chinese IW.

Dissatisfaction with the healthcare services was the most important health concern among Chinese immigrant participants who identified multiple cultural, individual, and systemic level reasons for their dissatisfaction. Hence, a comprehensive approach is required to address these issues such as increased awareness about the healthcare system itself, and establishment of family-centered multilingual health services. As the level of dissatisfaction abated with longer residence in Canada, these programs should be specifically tailored to meet the needs of new arrivals.

CONCLUSION

The results are suggestive of a need to re-orientate existing health communication and health promotion models in the pluralistic society of Canada. Study participants had a broad view of critical factors limiting their meaningful access and use of available health information. However, our findings imply that most of the health communication and promotion initiatives that participants experienced after arriving in Canada followed a one-way information flow model with inadequate regard to the social context of recipients. In accordance with recent work by Lee and Garvin (2003), this style of health communication and promotion exemplify an information *transfer* monologue model as opposed to an information *exchange* two-way dialogue model. Our study

indicates a need to involve community participants actively in the development of health promotion programs to bridge this gap between program efficacy and effectiveness when aiming to reach underserved immigrant women from traditional cultures. Future health promotion interventions need to address the sociocultural and day-to-day life context of the targeted communities.

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