Chapter 1

Introduction

Asian immigration constitutes the single most important feature of socio-economic change in Australia society in the last decade (Hon and Coughlan 1997; Ip 1999). In terms of the makeup of recent Asian migration to Australia, the Chinese from Hong Kong, Taiwan and the People’s Republic of China (PRC) figure most prominently (Ip 2000), among them, PRC has been the top source of Australia’s immigrants since the mid 1990s. The latest census in 2001 recorded 142,720 PRC-born migrants in Australia, among them, 76,180 were females (ABS 2003a). At the time when business and government leaders are beginning to recognize the importance of Asian-Australians in establishing and maintaining cultural and business links between Australia and Asia, it is clear that ethnic Chinese communities in Australia are worthy objects of academic research (Hon and Coughlan 1997).

Although migrants from the PRC, Hong Kong, and Taiwan are ethnically Chinese, each source has its own unique history, and thus distinctive gambit of socio-cultural characteristics. The majority of recent research into Chinese communities in Australia has focused upon Hong Kong and Taiwan business migrants (see, for example, Ip, Inglis and Wu 1997; Ip, Anstee and Wu 1998; Ip, Wu and Inglis 1998; Wu, Ip and Inglis 1998; Ip and Lever-Tracy 1999; Schak 1999), studies on financially less secure PRC-born migrants especially women remain few and far between.
Among few studies on PRC-born migrant women, they all identified stress and reproductive health as major concerns which pointed to significant implications for these migrant women’s health and well-being (Shi 1999; Chu 2002; Yan 2002). Yet they have not examined in-depth factors underpinning such stress nor presented solutions. With both the emergence of the PRC as an important source country for new Australian migrants since the 1990s, and the consequent presence of PRC-born migrant women in Australia, settlement stress will not only affect these migrant women’s but also their families and children’s well-being. Thus it is important to investigate these problems.

This study aims to examine in-depth the settlement experience of new PRC-born migrant women in Brisbane, with a focus especially on their stress, social and health needs and strategies to address these problems. Its aims in turn are fourfold:

1) To examine the PRC-born migrant women’s experience in the early settlement process, and underpinning historical, social and cultural factors;

2) To identify their settlement stress and assess their social and health needs;

3) To analyse their needs; and,

4) To develop strategies to meet with these PRC-born migrant women’s needs, so as to facilitate a more positive process of migrant settlement and integration into Australian society.

What this chapter will outline is the background, rationale, and scope of the study, as well as its organization and presentation within this thesis.
Background

Since the first Europeans arrived in Australia, migration has remained a central aspect of its social, and in varying ways cultural development. Indeed the country today represents one of the most ethnically diverse societies in the world, with a migrant population speaking more than 120 different languages (Chu 1998:125). At the same time, Asian immigration constitutes perhaps the single most important feature of socio-economic change in Australia in the last decade (Hon and Coughlan 1997; Ip 1999). In purely quantitative terms in fact, while the 1991 census identified over 800,000 people born in various Asian countries -- or roughly 4.9 percent of the total population -- by June 1996 the estimated proportion of Asian-born people in Australia had increased to 6.2 percent (Mackie 1997:13).

Pursuant to the Australian government's decision in 1985 to offer places in Australian universities, as well as in English language courses, to non-English speaking, full fee paying foreign students, large numbers of Chinese from the People's Republic of China began to arrive (Ip 1999:149). At the time of the 1991 census, there were 77,799 PRC-born persons in Australia -- representing 2.1 percent of the total overseas-born population -- and a further 28,680 Australian-born persons with either one or both of their parents born in China (ABS 1994). In 1996, the number of PRC-born reached 111,124, which comprised 0.6 percent of the Australian population. From 1991 to 1996, the number of second generation, PRC-born people grew by 41 percent, increasing in real terms from 28,680 to 40,340 (Zhao 2000), while the latest census of 2001 recorded 142,720 PRC-
born migrants in Australia -- an increase of 29 percent in relation to the 1996 census (ABS 2003a).

More generally, while it has been well established that women migrate internationally at nearly the same rate as men (DeLaet 1999:2), in recent decades the majority of migrants to developed nations have in fact been women (United Nations 1994). Congruous with this -- and in contrast to the nineteenth-century 'gold-rush period' of Chinese migration -- the majority of PRC-born persons who entered Australia at the end of the twentieth century were female (Coughlan 1998). Indeed the sex ratio of the PRC-born population in Australia has changed from 113 males for every 100 females in 1991, to 93 males for every 100 females in 1996 (Zhao 2000). With the proportion of female migrants increasing in turn, the sex ratio changed to 87.3 males for every 100 females in 2001 (ABS 2003a). In this way, and in 1996, the total number of PRC-born female immigrants in Australia reached 57,659 (Zhao 2000). These women have many characteristics that distinguish them not only from Chinese migrants from Hong Kong and Taiwan, but also of course from the rest of the Australian population. Yet despite these figures, there remains inadequate research on PRC-born migrant women, both in terms of their settlement experiences and their social mobility (Ip 2000), and as aforementioned their health needs in particular.

As a central aspect of migration studies, the settlement of migrants in their host society has long been a focus of the literature (Schak 1999). The migration of PRC-born Chinese to Australia more recently of course occurred commensurate with its economy's
slowdown overall; in turn, and with high unemployment and intense restructuring, the Chinese, like many others, were confronted with numerous difficulties tied to Australia's changing economic conditions (Ip 1999:150). Hon and Coughlan (1997:154), for example, found that PRC-born workers had the lowest occupational status -- and this in spite of the fact that many of them were highly educated. Remennick (1999:170) accurately surmises such difficulties in downward occupational, and in turn social mobility:

Objective measures of downward mobility among immigrants include the rates of general unemployment and structural unemployment (that is, having a job unrelated to one's training and qualification), their position on the national income ladder, and various indices of affluence (house and car ownership, for example). Immigrants' subjective experiences of downward mobility are shaped by their pre-emigration occupational status and affluence, and the expectations they have developed regarding their work and income in the host country.

In this way, when Australia was in the midst of a major economic recession in 1991 with a national unemployment rate of 11.6 percent, the unemployment rate of PRC-born migrants was significantly higher at 14.9 percent -- and even worse among women at 18.6 percent (Hon and Coughlan 1997:150). These latter were also reported as facing greater difficulties than men in having their qualifications in any sense recognized (Wu et al. 1998:412). In turn, there is little doubt that PRC-migrant women have experienced serious downward mobility in occupational terms, in social terms more generally, and perhaps in terms of sufficient health care and their experience of illness also.
Rationale of the Study

Despite the rapid increase of PRC-born women migrants in Australia, information about their needs and their experience of settlement remains scant. A review of recent research into Chinese communities in Australia indicates most have been concerned with Hong Kong and Taiwanese business migrants (see, for example, Ip, Inglis and Wu 1997; Ip, Anstee and Wu 1998; Ip, Wu and Inglis 1998; Wu, Ip and Inglis 1998; Ip and Lever-Tracy 1999; Schak 1999). While the study by Wu, Ip and Inglis (1998), documenting the settlement experiences of recent Chinese immigrants in Australia, included PRC-born migrants, women were not specifically targeted, and the problems specific to them not a focus. Although recent studies (Ip 1999; Ip 2000; Ip and Lever-Tracy 1999) have outlined some of the settlement experiences of PRC-born immigrants in Brisbane and in other Australian cities, the focus of their studies has been on entrepreneurs; similarly, in spite of making female entrepreneurs the subject of their study, Ip and Lever-Tracy (1999) did not emphasis these women’s health needs during settlement.

In this way, although considerable progress has been made in the study of Chinese migrants, far less is known about women’s health particularly in relation to gender associated with stress and health (Nelson and Burke 2002). Yet women's health is a vital issue, Rice and Manderson (1996:3) surmises three key grounds for its especial significance, and in turn study; firstly, as ill health among women effects their ability to work and thus their productivity, women's health holds important economic value; secondly, reproduction may both compromise and be compromised by a woman's health
status; and thirdly, women's health is vital given their central role as the custodians of family health.

Nevertheless, in the last decade only limited research has targeted gender *vis-à-vis* Chinese migrant women's health. Shi (1999) was the first to focus on studying Chinese migrant women, yet her study was limited to their maternity needs and did not approach PRC-born women in any holistically comprehensive way. Indeed it was only with Ip and Lui's (1999) examination of the social needs of older Chinese in Brisbane that the specific needs of older PRC-born women were highlighted to some degree.

Although my own work (Yan 2002) has endeavoured to target PRC-born women, Chu (2002) has also recently focused on broad Chinese (PRC, Hong Kong, and Taiwan) migrant women, and especially in terms of those who gave birth in Brisbane. In her study comparing these three Chinese migrant groups residing in the latter, women within the PRC group suffered the highest degree of stress. A number of recent studies conducted in Brisbane has also provided preliminary evidence that postnatal depression is a growing concern among Chinese migrant women (Chu 2002; Shi 1999). For these reasons in turn, it is a pressing concern to address PRC-born migrant women’s social and health needs, and from the findings of these studies at least their mental health needs especially.

Although previous studies on migrants constituting other ethnic groups have shown that migrant women often face greater problems and barriers than their male partners
(Remennicks 1999), studies on PRC-born migrant women are obviously rare. And in Australia, very little community-based research into the mental health status of immigrants has been conducted, and this even among the larger immigrant groups (Rissel and Khavarpour 1999:141).

In turn, this study will define PRC-born migrant women’s settlement stress in particular, and examine how historical, social, and cultural factors affect their health. Through assessing their social and health needs, strategies to improve their health status with a focus on prevention rather than disease treatment is imperative. Developing an appropriate and accessible health care system for Chinese migrant women is both necessary and important.

**Nature and Scope of the Study**

This study aims to examine the initial settlement stress and health needs of PRC-born migrant women in Brisbane aged between 30 and 50 years of age, all of whom migrated to Australia during or after the late 1980s. This period of course, and especially the years subsequent to the Tiananmen Square incident of 1989, constitutes a turning point in Chinese emigration to the country, with the number of PRC-born migrants increasing rapidly. Moreover, the 30 to 50 years of age bracket is especially significant in that not only are most PRC-born migrant women in this age bracket, but most also entered Australia either singularly, or alternately with their husbands as students, and have in turn spent these key years attempting to settle in a new country. These former students and
their family members constitute the most important segment of the PRC-born migrants living in Australia now.

In summary, the intention of this researcher has been to use the study as a preliminary step in initiating and stimulating further research directed specifically at PRC-born migrant women. And given the researcher's own status as a PRC-born, female Chinese studying in Australia -- with both a potential to empathise with respondents, and of course bilingual capacity in this regard -- such a focus remains both feasible and apt.

**Theoretical Framework**

Chart 1 illustrates the conceptual framework of the research in its entirety, summarising both the means with which social phenomena can be critically examined, and pertinent data within this process effectively organised. In this way, the model outlines a tentative nexus of PRC-born migrant women, settlement stressors, and health needs on the one hand, and historical, social, cultural, as well as gender based factors on the other.

The starting point in conceptual terms involves a number of major determinants underpinning PRC-born migrant women's settlement stress and health status -- namely, of factors historical, social, cultural, and/or gender based, albeit in actuality more often entwined. Furthermore, the relationship between health and stress is also closely enmeshed, for while stress can often lead to a wider range of health problems, these latter can also engender stress.
Social status on the other hand remains a composite of variables tied to income, education, and labour force participation, and can variously be revealed through community profiling. And while historical factors play a role in social status, as do broader social structural features, both social and historical variables are inconclusive in explaining the relationship between settlement stress and health problems among migrant women without consideration of the role of culture in helping determine beliefs and attitudes relating to health.

Finally, once issues are identified in terms of settlement stress and health problems, a needs assessment study can be conducted. For in order to fully address the social and health needs of migrant women -- in this case those born in the PRC and resident in Brisbane, Australia -- historical, cultural, social, and gender factors need to be part of the equation, each best revealed through qualitative and quantitative inquiry in tandem. In summary, the following model serves as a structural framework to help organise concepts pertinent to this study, and abstractly configure some of the interrelationships between them.
Chart 1: Theoretical Model of the Relationship between PRC-Born Migrant Women, Settlement Stressors, and Health Needs

- Migration Historical Factors
- Social Factors
- Cultural Factors

Gender Roles

PRC-Born Migrant Women

Health
- General Health
- Reproductive Health
- Mental Health

Settlement Stressors

Needs
- Social needs
- Health needs

Appropriate & Sensitive Strategies
Organisation of the Thesis

Based on the theoretical framework, this thesis consists of three parts, and within them thirteen chapters. Following the introductory chapter, Part I summarizes the literature on Chinese migrants, issues of women's health, and issues of culture. Part II encompasses the research methodology and findings. Part III integrates issues highlighted in the study and solutions.

Part I contains five chapters. Five areas of literature are discussed: chapter two reviews the history of Chinese migration to Australia; chapter three summarizes women’s health problems in terms of a focus on gender roles, the variable of culture and immigrant women’s health; chapter four examines the Chinese culture and health beliefs of PRC-born migrant women, and how they affect these women’s health practices in terms especially of reproductive health; chapter five discusses current theories of stress and mental health in the existing literature; and finally, chapter six reviews health promotion strategies and women’s health.

Part II consists of four chapters. It begins with chapter seven which outlines the methodology and research design employed in this research, chapter eight provides a social profile of PRC-born migrants, and especially women, in Queensland and in Brisbane; while chapter nine reports the findings from key informants' interviews. Chapter ten also features findings from in-depth interviews and focus groups, in which needs are in turn identified.
Part III contains three chapters. Chapter eleven discusses issues identified and surmises four key kinds of needs. Chapter twelve proposes a set of recommendations for developing appropriate meditative strategies aimed at empowering recent PRC-born women migrants to cope with their settlement stress and meet their needs -- ones which might promote and facilitate equity, access, and quality of health care for PRC-born migrant women. The concluding chapter presents a summary of the research findings, highlights its key implications, and offers a number of tentative directions for future research.
Part I

Literature Reviews

The history of Chinese emigration to Australia provides a backdrop to understanding the settlement needs of PRC-born migrant women in the early twenty-first century. To this end, chapter two outlines firstly how the early Chinese migrants fared during the gold-rush era. In turn, while chapter three highlights and summarizes findings from recent literature on women’s health problems in terms of questions of gender and issues of culture and immigrant women’s health, chapter four highlights how Chinese culture and health beliefs affect PRC-born migrant women’s health practices. Chapter five outlines the questions of stress and mental health as dealt with in relevant literature, while chapter six considers the literature on health promotion and migrant women’s health.
Chapter 2

The History of Chinese Emigration to Australia

The aim of this chapter is to look at the history of Chinese emigration to Australia, and the ways Australian immigration policies have affected the influx of Chinese migrants. This chapter firstly outlines early Chinese migration to Australia, reviews post war emigration to the country in turn, and summarizes finally those recent waves of Chinese immigration through a comparison of Hong Kong, Taiwan, and PRC-born Chinese migrants.

Early Chinese Migrants

The earliest Chinese emigration to Australia goes back more than 150 years, with the first recorded presence of Chinese in the country dating to 1827 when a few Chinese domestic servants and labourers were brought to Australia (BIPR 1994). By 1846 there was a Chinese village in Sydney, with the number of Chinese estimated at around 1,000 when Lieutenant Charles Mundy arrived in the colony in the same year (Hornadge 1976).

The reasons for Chinese emigration to Australia during the last half-century of the nineteenth century related to the domestic situations of both Australia and China. Due to the abolition of the slave trade in all British colonies in 1833 (Coupland 1964), there was a severe shortage of labour in Australia. In fact between 1840 and 1851 the problem was so serious that it not only affected wool production, but the general prosperity of New South Wales was in effect under threat. Given that the Treaty of Nanking of 1842 had
already permitted European businessmen to enter China, and similarly allowed Chinese to travel overseas (Wang 1978), it was not surprising that Chinese coolies -- 100 adults and 20 boys recruited from Amoy -- were bought to New South Wales and arrived on October 2, 1848 (Godley 1992).

However, it was the discovery of gold in New South Wales and Victoria in 1851 that in key ways triggered the first sizeable wave of Chinese emigration to Australia. At the same time, the Taiping Rebellion in China -- spread over eighteen provinces, lasting fifteen years (1850-1864), and causing an estimated 20 million deaths (Wang 1978:13) -- was also an important factor. Following this rebellion, severe famine and flood also occurred in China, with such disasters encouraging many Chinese to leave their country in search of better economic opportunities elsewhere. When the news that gold was found in Australia reached southern China, many farmers, artisans, hawkers, storekeepers, and merchants did not hesitate to go to Australia (Wang 1978:266). These early Chinese migrants mostly worked on the goldfields of Victoria and New South Wales initially, and later in Queensland (BIPR 1994). In turn, by 1861 there were 38,258 Chinese persons in Australia (ABS 1994), while in Victoria the growth in Chinese settlers was most conspicuous, with a total of 42,800 Chinese entering Victoria by sea between 1850 and 1890; indeed in many ways Chinese immigration peaked in 1855 with 11,500 entering Victoria in that year alone (Melaren 1985).

This great influx of Chinese finally led to riots throughout the Australian colonies, and prompted the governments to respond with policies to restrict any further influx of
Chinese migrants. Not surprisingly, the first colony to take action was Victoria, passing *An Act to Make Provision for Certain Immigrants* in 1855 which set a fee of 10 pounds on each Chinese arriving in Victoria by sea (BIRP 1994). Indeed rising anti-Chinese sentiments, combined with an economic downturn, finally led to a decline in gold production. In turn, and as the opportunities for making a better living dwindled for the Chinese in Australia, many decided to return to China, and the tide of Chinese emigration to the country began to ebb. In some ways in spite of this, in 1901 the Federal Government of Australia passed the *Immigration Restriction Act* which required new migrants to undertake a dictation test of 50 words in any European language. This provided the legislative basis subsequently for the White Australia Policy.

As a result, the number of Chinese migrants in Australia rapidly declined -- from 36,311 in 1891, to 20,775 in 1911. This trend reached its peak shortly after the Second World War, where in 1947 there were fewer than 7,000 Chinese residing in Australia (Choi 1975).

**Post-War Chinese Emigration to Australia**

In many ways, the Second World War marks a turning point in the history of immigration in Australia. After the war Australia had to re-orient its strategic, economic, and political goals -- a process guided by imperatives of rapid industrialization and demographic growth, both of which could only be achieved through mass immigration (Castles 1992).
In this way, the first motive for large-scale immigration was a strategic one; at the culmination of the Second World War, the Australian government realized it had too small a population, and that the country was in many ways both under-protected and vulnerable (Ip 1994:11). Just as Arthur Calwell, the first minister of Department of Immigration declaimed, “we must fill the country or lose it” (Collins 1988:21), for Australia's biggest problem at this time was one of 'populate or perish' (Bates and Linder-Pelz 1990).

Another motive for the immigration program was the labour shortage, for economic prosperity after the war depended heavily on the establishment of modern manufacturing sectors which required additional workers (Castles 1992). At the same time, Australia’s domestic market was too small to support large-scale public works and infrastructure -- including hydro-electric dams and irrigation schemes, the modernization of road and rail systems, and the need for labour in primary agricultural and mining industries (Ip 1994). In turn, and in 1946, Arthur Calwell announced that “the days of our isolation are over … and more people will come from overseas to link their fate with our destiny” (DIEA 1988:27).

To begin with, and in accord with the White Australia policy, programs of mass immigration aimed initially to attract migrants from Britain -- something soon and at the same time of course generating insufficient numbers. In consequence, the first East Europeans, and subsequently South Europeans, were recruited (Castles 1992). Since workers from Asia were still regarded as unsuitable to meeting Australia’s labour needs,
the number of PRC-born persons did not increase in any real way until a couple of decades later.

By the early 1970s, and due to mounting pressure from international communities, as well as more generally emergent concerns about racial discrimination, the Australian government finally abolished its White Australia Policy -- in 1972 under the Whitlam government, the Minister for Immigration AI Grassby declared that Australia was a multicultural society, and since then multiculturalism has remained an official policy of both labour and liberal governments (Ip 1994). Nevertheless, although the barriers to Chinese emigration to Australia began to crumble, PRC-born migrants remained slow in coming to the country, with most ethnic Chinese migrants emanating from Indonesia, Malaysia, Singapore, and Hong Kong. According to the 1976 census in fact, the PRC-born population in Australia was only 19,500, amounting to less than 0.2 percent of Australia's population (Zhao 2000). In turn, it was not until the late 1980s that Australia experienced a significant wave of mainland Chinese emigration once again.

The rapid growth in Chinese emigration to Australia from the late 1980s to the early 1990s was the outcome of changes in both Australian policies, as well as the product of complex international developments (Ip 2000b). In Australia to begin with, the share of manufacturing in the gross domestic product (GDP) declined from 28 percent in 1965, to 17 percent in 1985 (David and Wheelwright 1989). Primary industries once again increased in importance, while the services sector took on a new significance (Castles 1992) -- in 1988/89, its service sectors accounted for 41 percent of GDP, more than twice
its manufacturing industries (Anstee 1995). At the same time, economic developments in Europe meant there were few Europeans seeking to migrate to Australia, hence during this period Australia actively sought highly educated and skilled professionals from Asia (Ip 2000b). Indeed the new immigration categories introduced in 1989 were designed to increase the economic focus of immigration, and to attract migrants who were young, highly qualified, and immediately employable (Castles 1992).

The new wave of Chinese emigration to Australia from the late 1980s has been regarded as an indication of a 'new' form of Asian immigration more generally, for unlike early Chinese migrants, who were mostly poor 'coolies' and who came to Australia more often as 'sojourners', those coming in the 1980s were derived from upper-middle or middle class backgrounds, and held either professional skills or considerable capital resources (Inglis et al. 1992; Inglis and Wu 1994; Inglis, Ip and Wu 1996; Ip and Wu 1996; Ip and Wu 1996: Ip, Wu and Inglis 1998, Ip 1999). Even for those who came from the economically less well-off PRC, many were at the same time of obvious middle class backgrounds in terms of their education, occupation, and even income (Ip 1999). Within this, the proportion of highly skilled PRC-born women migrating to Australia has been increasing at a faster rate than men (Coughlan 1998).

In key ways in turn, there have been three waves of post-war Chinese emigration to Australia. The number of Chinese immigrants from Hong Kong increased rapidly since 1983, which represented the first wave of post-war Chinese emigration to Australia (Ip et al. 2002). Some have attributed this sudden influx to Business Migration Program (BMP)
that was launched by the Australian government in 1981. However, the fact that in 1983 the British government agreed to return Hong Kong to China in 1997 -- subsequently triggering fears of an uncertain political and economic situation among the Chinese in the British colony -- should also not be underestimated. Furthermore, the Tiananmen Square incident brought an increase in anxiety and uncertainty to Hong Kong people (Zhao 2000), importantly furthering an exceptional wave of Hong Kong Chinese emigration to Australia which peaked in 1991/92 -- a year in which Hong Kong ranked as the second largest source of Australia's immigrants after the United Kingdom (Pe-Pua et al. 1996).

In total, from 1984 to 1996 settler arrivals from Hong Kong numbered 75,480, and represented moreover the largest source of skilled Asian migration to Australia during this period (ABS 2003a). Indeed many Hong Kong Chinese migrants came to Australia as independent, skilled migrants, with a significant proportion of them business migrants (Ip et al. 2002).

Nevertheless, the largest group of business migrants have emanated from Taiwan, which until the early 1980s in fact was not a significant source of migrants to Australia (Endrey 1993). In turn, and between 1981-1982 and 1991-1992, the number of Taiwanese settlers jumped from a mere 125 per annum, to 3,172 (see Table 2.1). Moreover, between 1991/2 and 1995/6, around 61 per cent of skilled settler arrivals from Taiwan settling in Queensland entered under the business migration category (Ip et al. 1998). This surge of Taiwanese migrants represented the second wave of recent Chinese emigration to Australia (Ip et al. 2002).
Table 2.1: Chinese Settler Arrivals in Australia, 1981-2002

<table>
<thead>
<tr>
<th>Year of Arrival</th>
<th>PRC-Born Person</th>
<th>Hong Kong-Born Females</th>
<th>Taiwan-Born Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>1981-1982</td>
<td>1,503</td>
<td>1,295</td>
<td>125</td>
</tr>
<tr>
<td>1982-1983</td>
<td>1,193</td>
<td>2,040</td>
<td>132</td>
</tr>
<tr>
<td>1983-1984</td>
<td>1,650</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1984-1985</td>
<td>3,163</td>
<td>3,296</td>
<td>241</td>
</tr>
<tr>
<td>1985-1986</td>
<td>3,138</td>
<td>3,117</td>
<td>381</td>
</tr>
<tr>
<td>1986-1987</td>
<td>2,690</td>
<td>3,398</td>
<td>804</td>
</tr>
<tr>
<td>1987-1988</td>
<td>3,282</td>
<td>5,577</td>
<td>1,146</td>
</tr>
<tr>
<td>1988-1989</td>
<td>3,819</td>
<td>7,307</td>
<td>2,100</td>
</tr>
<tr>
<td>1989-1990</td>
<td>3,069</td>
<td>8,054</td>
<td>3,055</td>
</tr>
<tr>
<td>1990-1991</td>
<td>3,256</td>
<td>13,541</td>
<td>3,491</td>
</tr>
<tr>
<td>1992-1993</td>
<td>3,046</td>
<td>6,520</td>
<td>1,434</td>
</tr>
<tr>
<td>1993-1994</td>
<td>2,740</td>
<td>3,333</td>
<td>785</td>
</tr>
<tr>
<td>1994-1995</td>
<td>3,708</td>
<td>4,135</td>
<td>794</td>
</tr>
<tr>
<td>1995-1996</td>
<td>11,247</td>
<td>4,361</td>
<td>1,638</td>
</tr>
<tr>
<td>1996-1997</td>
<td>7,761</td>
<td>3,894</td>
<td>2,180</td>
</tr>
<tr>
<td>1997-1998</td>
<td>4,338</td>
<td>3,194</td>
<td>1,518</td>
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<tr>
<td>1998-1999</td>
<td>6,133</td>
<td>1,918</td>
<td>1,566</td>
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<tr>
<td>1999-2000</td>
<td>6,809</td>
<td>1,467</td>
<td>1,699</td>
</tr>
<tr>
<td>2000-2001</td>
<td>8762</td>
<td>1,541</td>
<td>2,599</td>
</tr>
<tr>
<td>2001-2002</td>
<td>6708</td>
<td>931</td>
<td>1,715</td>
</tr>
</tbody>
</table>

Sources:
2. ABS, Migration, various issues.

The very high proportion of recent Chinese migrants born in Hong Kong or Taiwan indicates that the majority have been wealthy, or have been part of a wealthy family (Coughlan 1997). Nevertheless, and despite being less financially secure, the most significant Chinese migrants since the mid-1990s -- at least numerically -- have been those from the PRC, constituting in turn the third wave of recent Chinese emigration to Australia (Ip et al. 2002).
Recent PRC-Born Chinese Settlement in Australia

The latter half of the 1980s saw a massive influx of PRC-born Chinese students into Australia; to account for this, this section firstly analyses the push factors (from mainland China), and pull factors (from Australia), which underpinned the arrival of PRC students.

The strongest factor which pushed the Chinese to migrate to Western countries was by no means China's political reform, in terms especially of its 'Open-Door Policy' subsequent to Chairman Xiaoping Deng's decision to open the country to the outside world in 1978. While this policy on the one hand made it easy for many of China's skilled and educated to travel to the West for professional training, on the other it only benefited those who had degrees and were called 'knowledgeable people', including scientists, teachers, doctors, and the university educated. In order to implement economic reform, Deng called for four 'modernizations' -- of agriculture, industry, defence, and of science and technology -- and initiated new economic policies in 1978 (Gamer 2000). Since then, China’s economy has grown continually at exceptionally high rates. Although peasants, party bureaucrats in coastal provinces, and urban workers who could form cooperatives were most readily helped by Deng’s reforms, students were one of the most harmed groups (Gamer 2000); the salary of a university graduate was far below a restaurant boss or a bicycle repairer.

Aside from China’s official policies, and such instances of low pay, there were still many other push factors which helped engender emigration among Chinese students in the late 1980s. These included not being free to seek jobs, the fact that only students with good
connections could obtain real opportunities, and the poor living conditions a product of housing shortages. In turn, many decided to take advantage of new opportunities, with the Tiananmen Square incident a further instigative factor. In this way, the number of PRC-born, self-funding overseas students in Australia increased from only two persons in 1980, to a peak of 16,642 in 1990 (Andressen 1997).

At the same time, pull factors in Australia have also been important, for the recent rapid increases in PRC-born Chinese settlement in Australia can equally be attributed to Australia's changing social policy also. Being allowed to travel to Australia to attend English language classes -- as the Australian government decided to open up places in universities, and provide English language classes to non-English speaking overseas full-fee paying students -- was one key factor. Indeed unlike the United States, who accepted only university students who had achieved high TOEFL (Test of English as Foreign Language) scores, as students of ELICOS (English Language Intensive Course for Overseas Students) in Australia mainland Chinese needed only to pay tuition fees, along with living expenses, without worrying about English proficiency (Fung and Chen 1996). Furthermore, in 1987 it was rumoured that the Australian government would grant an amnesty to all illegal migrants as part of the Bicentennial year -- a widespread rumour in China which pushed migration to Australia to a new peak (Fung and Chen 1996).

There were also many other pull factors in Australia, including things such as political and personal freedoms, Western culture, its beautiful environment and unique flora and fauna, its pleasant weather and so on. As it turned out, the number of PRC ELICOS
students jumped dramatically from 273 in 1986, to 13, 142 in 1990 (Fung and Chen 1996).

PRC-born Chinese students in Australia could be divided into two broad categories. The first comprises scholars and university teachers sponsored either by the Chinese government and institutes, by the Australian Government or Australian universities, or by international organizations such as the World Health Organization or the World Bank. The second category consists largely of full-fee paying students. Since many of the PRC-born students thought that both themselves and their children would have a better future in Australia, only a small number wanted to return to China after they completed their courses in Australia.

The Tiananmen Square incident gave PRC Chinese students a good chance to extend their stay in Australia. When the incident took place in 1989, some 19,000 PRC-born students were in effect 'stranded' in Australia (Hon and Coughlan 1997). The Australian government decided to grant them temporary residence for four years, although a further 25,000 students came to Australia in the course of the next two years (Ip 1999). A total of 37,614 PRC-born Chinese, including mostly students and their dependents, refugees, and highly qualified people, were subsequently given permanent residence, and became eligible not only to stay but also to sponsor their family members to migrate to Australia under family reunion provisions (ABS 1998b). Not surprisingly, between 1995 and 1996 11,250 PRC-born migrants arrived in the country (ABS 1998b), making them the third largest group of permanent arrivals. In turn, emigration from the PRC was strong
throughout the latter half of the 1990s, and remains the third largest source of migrants arriving in Australia (see Table 2.1).

Most PRC-born migrants who entered Australia after the late 1980s fell under either the Family Migration or the Skilled Migration category (see Table 2.1.2). In 1995/96, 88 percent of all PRC-born settlers were permitted to enter the country under the Family Migration category, and of these 95 percent arrived as preferential migrants (sponsored by spouses, fiancées, parents, dependent children, etc). The remaining five percent arrived as Concessional Migrants sponsored by non-dependent children, siblings, nieces, nephews, and so on. In this period, nine percent of PRC-born settlers were skilled migrants (ABS 1998b).

Moreover, in 2002 there were 14,156 PRC-born students who entered Australia, making the total number resident in the country 33,595 (ABS 2003b). Furthermore, many students have applied for, and many been granted permanent residency after their graduation, and together with changes in immigration policy giving priority to skilled/business/technical migrants, while restricting family reunion migration, there has been a dramatic increase in the number of skilled migrants (Ip 2000) (see Table 2.2).
Recalling in some ways the 'gold rush period' of Chinese emigration to Australia in the nineteenth century, students from the PRC have often come to the country in search of opportunities and the chance for a better life. Indeed some have termed it the “Second Gold Rush”, with many Chinese moving en masse to the West harbouring “golden dreams” (Fung and Chen 1996:5). Nevertheless, with tuition fees alone constituting an astronomical sum for most Chinese even in the early 1990s, many reported borrowing heavily to finance their journey, their fees, and their living expenses while studying (Ip et al. 1999). Moreover, many in fact assumed that they could pay back their debts over a period of time by working in Australia, with finding a job and making money taking precedence over learning English properly (Fung and Chen 1996).

Unfortunately however, arrivals from the PRC have often found themselves hardest hit due to their other qualifications and work experience remaining unrecognised. This,
along with their poor proficiency in English, has often made it difficult for them to get ahead (Pitt 1996; Ip 2000; Ip 2002). In this way, although PRC-born Chinese students came to Australia full of hope and optimism of succeeding in the country, many have found they over idealized the opportunities, and their 'golden dreams' have often turned to 'gray realities' soon after arrival (Forth 1994). In consequence, many have resorted to illegal work practices to earn a living, while others work long hours in poor conditions for low wages (Endrey 1993).

**Summary**

In summary, this chapter has reviewed the history of Chinese emigration to Australia. While there are definite differences between the earliest Chinese migrants and those at the end of the twentieth century, there also remain a number of parallels. For most PRC-born migrants have fewer financial resources than Chinese migrants who emanate from Hong Kong or Taiwan, with those who arrived during and after the mid-1980s to study English even less financially secure (Ip 2000). In turn, financial barriers have made their settlement in Australia ripe with difficulties.

The next chapter aims to review the literature on women's health, with a specific focus on gender as one facet within a broader framework of culture and culturally specific values.
Chapter 3

Women and Health

The aim of this chapter is to highlight and summarize findings from recent literature on women’s health problems. It firstly analyses women’s health in terms of gender and roles women play. It then conflates women’s health with issues of culture and the way in which culture influence their health. Finally, this chapter focuses on immigrant women’s health, especially women from non-English speaking backgrounds. It examines immigrant women’s health beliefs and highlights problems faced by immigrant women.

While certain variables relating to health can affect both men and women in common, each encounter unique problems and questions of well being which affect and define their quality of life in particularistic ways. In turn, there are a variegated range of factors which play a role in determining women's health, and the relationship between these factors is often complex and closely intertwined. However, since the cultural construction of gender is a key facet encompassing both the experience and understanding of variables of health, this chapter focuses predominantly on this changing sphere of human life as opposed to the more obvious biological differences between women and men.

Worldwide, women live longer than men but suffer poorer health. In purely enumerative terms, and in almost all countries, the average life expectancy of women exceeds that of men who share similar socio-economic circumstances (Östlin 2002; Broom 2002); on
average, most women live six and a half years longer than men (Doyal 1995). At the same time, while women often live longer they also experience poorer health during the course of their lives (Goldman and Hatch 2000; Broom 2004); women report higher levels of psychosomatic symptoms and poor mental health, have higher rates of acute illness and more chronic health conditions, and use more health care services as well as prescriptions (Jenkins 1991; Broom 2002; Nelson and Burke 2002).

In actuality of course, and as the product of a combination of biological, social, cultural, and historical factors, the experience of health can differ due to fairly constant biological differences between males and females, to physiological differences that are a consequence themselves of the differing cultural construction of gender and gender roles, or in sum by a combination of sorts of both these sets of factors (Krieger et al. 1993; Krieger et al. 1997; Hogue 2000). In general, poorer and minority group women suffer worse health, with a 'dose-response' relationship between the degree of disadvantage and the extent of health problems (Hogue 2000); importantly within this then, poorer women have far less access to effective health care than the wealthy (Davis and Huber 2004).

At the same time, and although high socio-economic status is associated with better health for both women and men, gender is an important variable in relation to such socio-economic inequalities and the experience of health (Östlin 2002). As questions of health are consistently tied to variables of gender then, and to race and ethnicity and social class within differing socio-cultural settings in tandem -- and as women’s health is not simply a
'medical' issue in isolation -- the construction of health needs in relation to broader socio-cultural attitudes towards women remains in key respects central.

**Health and the Role of Gender**

Despite dramatic changes in social, economic, political, technological, occupational, and health conditions in the course of the twentieth century, and despite women’s ever greater participation in the paid workforces of Western societies especially -- all of which might indicate that equality between the sexes has indeed been realised -- in key respects traditional gender roles concerning women's responsibilities in the home and to the family have not altered concurrently (Lundberg and Parr 2000). Indeed 'gender equality' as a popular aspiration overall by no means equates to 'equal status' in actuality (Pearson 1995).

At the core of this, and as distinct from the biological differences between men and women -- the chromosomal, chemical, and anatomical features that is which make people male or female (Kimmel 2004) -- gender refers to *socially* learned behaviours and expectations associated with each respective sex (Watkins and Whaley 2000). In this way, while sex as a classification denotes male and female in the most straightforward of terms, gender is that which refers to the socio-cultural construction of femininity or masculinity, and that which in turn defines the meaning of 'maleness' or alternately of 'femaleness' (Östlin 2002; Kimmel 2004; Cleveland *et al.* 2000; Unger and Crawford 1992).
In Western cultures hitherto, masculinity has often been defined by character traits including technical competence, competitiveness, dominance, aggressiveness, and rationality (Nelson and Burke 2002; Franklin 1984). The stereotypical traits of femininity on the other hand have been things such as emotionality, nurturance, passivity, warmth and intimacy, and a concern with issues beyond the material such as that of social relationships (Nelson and Burke 2002; Cleveland et al. 2000; Mckee and Sheriffs 1957).

Moreover, and whatever their actual representativeness across Western societies, the term gender is complex and finds manifestation on three differing levels: the individual, the interpersonal, and the societal (Urger and Crawford 1992). In this way, such Western notions of masculinity and femininity define conceptions of gender on an individual level. At the interpersonal level however, gender informs us how to behave 'properly' when interacting with others, while at the societal level gender can serve as one element in a system of power relations by reflecting and reinforcing social classifications and ultimately social status (Cleveland et al. 2000). In terms of the latter of course, gender can importantly influence one’s ability to access both greater power, as well as wider resources more generally (Urger and Crawford 1992).

In fact gender continues to remain of paramount importance within the hierarchical ordering of societies vis-à-vis wealth, power, and prestige, and which generates in turn inequalities in terms of the distribution of resources, of benefits, and of duties and responsibilities also (Östlin 2002). In many respects then, gender is a multifaceted and multileveled concept, part and parcel of things such as state policies, institutional
organisations, and the 'cultural inheritance' of contemporary societies overall, as well as the psychological development of individuals in a context of ongoing socialisation (Wang 1998).

In consequence, gender relations find expression through the playing out of gender roles (Mann and Kato 1996), which are themselves perpetually consolidated upon and reinforced through socialisation (Nelson and Burke 2002). At the core of this, gender stereotypes are socially shared beliefs about the 'defining' characteristics or attitudes of men and women in general, which influence our perceptions of individual men and women in turn (Cleveland et al. 2000). These gender roles are first transferred in childhood, with children acquiring 'lessons' concerning gender from their parents, from teachers and from textbooks, as well as from their experiences in the playground -- all of which become the basis of stereotypical gender roles (Kuhn 1978; Witt 1997; Wang 1998), and which progressively and increasingly sequester girls and boys as they mature. In this way, gender role stereotypes not only mirror cultural values, but provide an important means to persuade children to accept these values also (Wang 1998).

However socially beneficial such a process might at times have been, gender disparities in terms of health are often striking, with families investing less in girls than in boys in terms of nutrition, health care, schooling, and vocational training. Indeed ongoing and often subtle sex discrimination, and the poor social status of girls and women in turn, frequently results in poor physical and mental health later in life, in physical or emotional
abuse in terms of relationships, and in poor levels of self-determination more generally, and in terms of women's sexual and reproductive lives in particular (WHO 2004a).

Nevertheless, while biological sex is for the most part set, gender patterns are dynamic. Kimmel (2004: 2-3) has surmised four significant forms in which this becomes manifest: firstly, the meanings of gender vary from one society to another; secondly, the meaning of masculinity and femininity varies within a culture over time; thirdly, the meaning of masculinity and femininity will change as an individual matures; and fourthly, the meaning of gender will vary among differing groups of women and men within a certain culture at a particular time. Not surprisingly, and in the face of such variation and fluidity, examining the relationship between health and gender remains a challenging task.

This being said, gender constitutes such a significant dimension of people's experience of health that it should in no way be underestimated, and certainly not dismissed. Within this especially, women face a variety of relationships, and varying forms of responsibility which permeate their lives -- among them, and this often commensurately, those of wife, mother, employee, daughter, care giver, and perhaps also student. Moreover, with the increasing numbers of women joining the labour force in Western societies especially, it is vital to examine the impact of all these roles on women’s health; the following aims to provide a conspectus of these varying roles.
The Role of Wife and Mother

According to Australia's current Prime Minister, John Howard -- and this as the 2004 document 'Violence Against Women: Australia Says No' at least attests -- “Families are the backbone of a strong and healthy community, and loving, supportive relationships are at the heart of happy, well functioning families” (Howard, 2004: 1). Of course many women throughout the world regard themselves part of a family recognized by their community and by their peers (Kimmel 2004). In turn, their roles within the family as wives, mothers, workers, sisters, children, and much more, frames the choices, concerns, and issues they face (Conway-Turner and Cherri 1998); moreover, while many women experience a great deal of joy in their family, they also carry a good deal of concern about the multiple roles they often have to play.

To begin with, marriage is one of the few seemingly 'universal' social institutions (Kimmel 2004), and it is well known that marrying in general is beneficial to both mental as well as physical well being by building economic resources, along with a basis of emotional and social support for individuals. At the same time of course, the degree to which such benefits materialize depends on marital quality; indeed married women with poor marital quality often suffer higher rates of psychological distress than those who stay single (Williams and Umberson 2000), with domestic violence the most explicit source of mental and in turn physical ill health (Williams and Umberson 2000). Of course violent contexts -- such as those during wars or revolutions -- can often compound more 'common' experiences of sexual harassment and wife beating which prevent women
from both being and feeling secure, as well as realizing their potential and contributing to that of their family (Conway-Turner and Cherrin 2002).

Furthermore, marriage can often be disadvantageous to women in more subtle ways. For example, while marriage increases the emotional dependence of both men and women, emotional reliance for men is often offset by an increase in spousal social support, with this less likely to lead to depression (Nelson et al. 2002). Indeed wives are more frequently the recipients of their husbands’ stresses and strain than vice versa; Westman (2002) summarised three groups of findings that support this contention: firstly, women experience higher levels of distress, and are therefore more resilient when facing the stresses and strain of their husbands; secondly, women are more empathetic to the stress of their husbands, and therefore also more vulnerable; and thirdly, women often prove more effective as providers of social support.

Moreover, and despite an increase in the equality of gender roles, women still hold primary responsibility for household duties and the care and upbringing of children (Conway-Turner and Cherrin 1998; Cleveland et al. 2000; Nott and Morris 2002; Nelson and Burke 2002; Kimmel 2004). Before the birth of children of course, and due to the fact that both husbands and wives often hold employment outside the home, domestic responsibilities tend to be shared between the partners in most social settings. With the coming of children however, the situation it seems suddenly alters, with most men believing childrearing to be a women’s responsibility in fundamental ways (Kimmel
2004). In turn, an unequal distribution of household labour more often than not is a particular source of stress for women.

At the same time, many women work hard to fulfill dual commitments in the home and at work, as women today not only provide much of the physical and emotional needs of their families, but contribute to family income also. Rather than experiencing merely the stress of childless employees however, much of the stress which women experience tends to emanate from their key role as mothers (Barnett and Baruch 1985). Indeed this often begins to occur as soon as women become visibly pregnant, as in the eyes of many Western societies at least pregnant woman are already expected to be 'model' mothers, while they may at this point be experiencing postnatal depression already (Morris 2002). Even if women stop work for some years after giving birth of course, most of their time is consumed in child care in terms of grocery shopping, cooking, and diapering; in dressing, bathing, and ferrying children to and from school as well as other activities; and in sum simply watching, teaching, and playing with their kids for most of the day. Indeed the parenting of young children is a significant source of stress in itself not only for single women, but for married women also. Within this, making arrangements for childcare is one of the major parenting strains which not only requires substantial amounts of time and effort, but is also often accompanied by concerns about the costs and the quality of care (Gaitley 2004; Williams and Umberson 2000; Bird 1997; Ross and Van Willigen 1996).
More generally in fact, as children often incur major increases in household expenditure, financial and economic strains are an important source of stress for many mothers (Williams and Umberson 2000); frequently in fact, the burden of childcare often prevents younger mothers from obtaining higher pay and greater job security (Davis and Huber 2004). As the difficulties of merely balancing the demands of multiple roles remain significant then, working women with dependent children often experience extra stress from assuming the roles of both worker and mother (Williams and Umberson 2000). With a heavy burden both physically and emotionally of course, chronic tiredness, fatigue, and emotional stress are working mother's most common complaints.

In these and other key respects then, marriage has varying effects on women’s lives. While marriage may provide emotional, social, and economic support for both men and women, married men have been found to experience lower rates of psychiatric disorders than married women (Sachs-Ericsson and Ciarlo 2000), and other studies have also found that marriage may in many ways be more beneficial to men than to women (Gove 1972; Cleveland et al. 2000). At the same time, through marriage women can gain economic benefits, while men in a merely differing way obtain greater interpersonal support (Sachs-Ericsson and Ciarlo 2000; Cleveland et al. 2000; Westman 2002), as well as an either neutral or somewhat advantageous asset in terms of their career (Cleveland et al. 2000). In contrast, marriage for women -- and especially those with children -- can often amount to one of the most limiting factors in terms of building a career (Larwood and Gutek 1987; Cleveland et al. 2000).
Women and Employment

One of the most significant social and economic changes in the past two decades has been the escalating number of women entering the labour market. However, attitudes and social patterns mean that employment, and especially managerial employment, still appears to be associated predominantly with masculinity (Fielden and Cooper 2002). In every society of course, at least a portion of work is allocated on the basis of gender, which amounts in sum to a sexual division of labour to some degree (Broom 2002). Nevertheless, and while there are unequal job opportunities for women in most societies, women are also more often to be found in low-skill, low-pay, and less prestigious jobs, and furthermore always encounter greater obstacles in developing a career (Jick and Mitz 1985; Cleveland et al. 2000; Broom 2002; Karambayya 2002; Nelson and Burke 2002).

Within this, women’s career development often differs from that of men’s, for unlike the latter women's experience of employment can depend heavily on attitude, on role expectations, and on socialisation (Gustafson and Magnuson 1991). Cleveland, Stockdale and Murphy (2002) surmised four key reasons for the difference: firstly, there are different expectations for men and women regarding the appropriateness of specific jobs; secondly, husbands and wives differ in their willingness to accommodate to each other’s careers; thirdly, the parental role is defined differently for men and women; and finally, women face more constraints in their workplaces.
Furthermore, research consistently reveals that working women experience higher levels of stress than men (see, for example, Cox and Harquail 1991; Powell 1993; Walters 1993; Roxburgh 1996; Malone et al. 1997; Lundberg and Parr 2000; Williams and Umberson 2000; Fielden and Cooper 2002; Nelson & Burke 2002; Gaitley 2004). Especially significant within this is stress relating directly to the variable of gender, including sexual harassment, discrimination, and the perpetuation of certain stereotypes in the workplace (Gutek and Larwood 1987). For example, women all too often find themselves treated 'as women' in the first instance and as workers in the second (Conway-Turner and Cherrin 1998:131). Moreover, employers at times assume that once a woman has had a child, her commitment to her career takes second place; from this perspective, mothers are often seen as 'second rate' employees (Nelson and Burke 2002).

Sexual harassment is another significant concern, and at times serious obstacle, faced by working women. Although it has been more than twenty years since the Equal Employment Opportunity Commission (EEOC) published guidelines on sexual harassment in the workplace in 1980, it remains a chronic and severe problem for working women in many countries (Bell et al. 2002). As the EEOC (1980:33) defined it:

Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment when (1) submission to such conduct is made either explicitly or implicitly a term or condition of an individual’s employment, (2) submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individuals, or (3) such conduct has the purpose or effect of substantially interfering with an individual’s work performance or creating an intimidating, hostile, or offensive working environment.
In these terms, it has been estimated that nearly 50 percent of women were sexually harassed during their course of work or their academic lives (Bell et al. 2002), with over 90 percent of reported cases in the workplace involving male harassers and female recipients (Cleveland et al. 2000). In key respects, sexual harassment is a major problem not only for working women themselves, but for their organizations also; it has been seen to affect morale, job satisfaction, and to increase health care costs, being associated with negative physical and psychological health complaints, with the experience of stress overall, as well as other negative ramifications (Bell et al. 2002).

**Role Conflicts**

As aforementioned, many women today play multiple roles including those of wife, mother, and daughter, and more often also employee. In consequence, the complexity of such roles often engenders irreconcilable demands on one person, where role conflict can in turn occur (Barnett and Baruch 1987; Barnett 1995; Gaitley 2004). Greenhaus and Beutell (1985:77) have defined work-family conflict as “a form of inter-role conflict in which the role pressures from the work and family domain are mutually incompatible in some respect … participation in the work (family) role is made more difficult by participation in the family (work) role”.

Of course role conflict emerges as a significant problem when the participation of women in the workforce increases; more often than not, women not only view themselves, but are viewed by their families and by others more generally, as the primary house maker whether employed or not (Sachs-Ericsson and Ciarlo 2000; Cleveland et al. 2000;
Greenglass 2002; Kimmel 2004). Within this, many women deeply want not only a job or a career to enhance financial independence, but also to be a mother and to help build a strong and lasting relationship with their partner (Kimmel 2004). Nevertheless, marriage and children often interfere with women’s career opportunities, and this even more than vice versa (Cleveland et al. 2000).

Furthermore, work-family conflicts have been identified as a key stressor associated with several dysfunctional outcomes -- ones which result in lower occupational well-being and decreased job satisfaction (Greenglass 2002), as well as being linked to anxiety, depression, to somatic complaints and hostility among working women, and all these even worse for women who have children (Beatty 1996).

If anything, migration further compounds the complexity of women's roles, and this especially for non-English speaking women who migrate to English language societies. Moreover, the necessity of familiarizing with Western values in such social contexts is also associated with increases in role conflict. In this way, and in their research on Chinese migrant women in British Columbia, Lee and Cochran (1988) found that adjusting to Canadian society for these women meant facing a range of potent conflicts in day to day situations -- ones including the polarity of Chinese and Western values at times, the need for personal development, and the fear of social isolation. In many respects, the variable of culture is central in impacting upon and shaping women's lives.
The Variable of Culture

Culture plays an important role in people's understanding of health and illness, in terms of the latter's perceived causes, as well as people's approach to treatment; to some extent in fact, health and illness can be seen as socially constructed categories, with differing cultures manifesting very different understandings of both good and ill health (Broom 2002).

In the most general terms, culture refers to a shared, collective system of meanings -- including beliefs, knowledge, values, symbols, and ways of life -- which emerge in the course of group experience and are transmitted from one generation to another (Chu 1998). In this way, Cross et al. (1989:3) define the notion as an “integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups”. Not surprisingly then, cultural beliefs affect how changes in health status are perceived, recognized, interpreted, and acted upon (Ferran et al. 1999).

As no exception to the rule, a women's culture provides her with ideas and concepts by means of which she can classify matter, explain and establish causation, estimate consequences, and draw guidelines for action (Chu 1993). Within this, cultural values, knowledge, and beliefs play an important role in mediating women's experience of health and the outcome of their health practices (Harkness 1987). Indeed responses to illness, to pain, and to their treatment are often linked to traditions centuries old (Davis and Huber 2004), with cross-cultural analyses revealing that the way pain is perceived and dealt with
is often very different depending on one's cultural 'origins' (Broom 2002). In this way for example, Greek and Italian mothers vocalize pain during childbirth more than mothers of Vietnamese cultural backgrounds; and even more importantly, this has at times led nursing staff to conclude that the former merely exaggerate their pain, while the latter somehow feel less pain altogether (Manderson and Reid 1994).

Cultural beliefs and practices of many immigrants are markedly different from those of Western health providers. In turn, these differences in culture and expectations can cause difficulties and misunderstandings when dealing with certain health problems and using services (Rice 1993; Rice 1999; Rice, et al. 1999; Douglas 1999; Vose and Thurecht 1999; Shi 1999; Small, et al. 1999; Jirojwong and Manderson 1999; Manderson 1999; Chu 2002; Rice and Watson 2002). Not all differences between migrant women and Australian-born women are due to culture, however, cultural beliefs and practices remain important in pregnancy and birth amongst NESB immigrant women (Manderson 1999). It is necessary to appreciate, explore and document the cultural meanings and social relationships that shape the health care systems (Sargent and Marcucci 1988: 79).

**Immigrant Women’s Health**

A large number of immigrants settle in Australia every year. Thus the health of immigrants is not only related to the general population health, but also related to the healthcare system. Meanwhile, the increasing ethnic diversity of Australia’s population has created new challenges in the delivery of health care services (Cape 1999:101). Although there has been increasing attention to the health of immigrants, structural
inequalities in Australian health care system still exist (National Health Strategy 1993:20). People from NESB are difficult to have voices heard and their views presented (Rice 1999).

NESB immigrant women are double disadvantaged within the current health care system (HDV 1991; Chu 1998). Although pregnancy and birth following migration may be women’s first significant contact with the health services of the host country (Manderson 1999), researches indicated that maternity services were failing to meet the needs of many NESB communities (Rice 1993). The NESB woman is in a uniquely vulnerable within the mainstream of maternity care. Whatever the cause, the experience for NESB can prove to be stressful and highly unpleasant (Vose and Thurecht 1999:53). It is viewed that newly arrived immigrant women from Asia are ‘at high risk’ in terms of pregnancy and birth (Rice 1999).

Many problems faced by immigrants to Australia, particularly NESB immigrant women have been identified by some recent researches. Among these problems are: social isolation; communication breakdown and language barriers; cultural barriers; lack of information on how to use health services; services inaccessible; services inappropriate (Bates and Linder-Plez 1990; Rice 1993; Plunkett and Quine 1996; Yelland, et al. 1998; Ip and Lui 1999; Rice 1999; Rice, et al. 1999; Vose and Thurecht 1999; Shi 1999; Small, et al. 1999; Jirojwong and Manderson 1999; Chu 2002; Rice and Watson 2002).
Migration has long been acknowledged as a stressful experience which requires considerable adjustment effort (Thomas 1999: 117). Several studies indicate that isolation from the host society contributes to mental ill health amongst immigrant women (Cox 1989; Matthey et al. 1993; Minas et al. 1996). Matthey et al. argues that it is likely to be profound in culturally dislocated groups (1993). Barclay and Kent assumed that the high rates of misery experienced by most new mothers in contemporary Western society are socially and culturally induced (1998). For NESB women in a new country of settlement, their experiences in Western health and social systems are very different from their expectations of childbirth. These women are often socially isolated in their new country. Moreover they are alienated from health service system and separated from their normal birth and postpartum practices (Barclay and Kent 1998). Thus, it is not surprising that women from NESB find it is difficult and stressful to become a mother in Australia.

The language and communication barriers have been shown to be major factors affecting the use of health services for NESB immigrants (National Health Strategies 1993; Rice 1993; Small et al. 1999; Jirojwong and Manderson 1999; Quine 1999). For NESB immigrant women, their language ability affects not only their access to resources and information, but also their access to health care. Small et al indicates that a woman’s ability to communicate freely with caregivers affects her satisfaction with her care (1999).

For most migrants bring to their new home a wealth of cultural beliefs and practices relating to health maintenance, to illness, and to healing methods, in which the influence of such beliefs and practices differs itself to begin with depending on the migrant group
(Rice 1999). In turn, cultural barriers to accessing health care include expectations of the health care system, conceptions of health and illness, and varying levels of success in health care seeking behavior (Kramer 1999). Moreover, just as the inadequacy of language can cause misunderstandings and mismanagement in terms of health care, differing cultural beliefs and practices can also result in miscommunication and misinterpretation between physicians and patients (Kramer 1999; Rice 1999).

For example, that the body is holistic and should always be kept in balance is a foundational health belief of many Southeast Asian cultures; in turn, postpartum women are seen to be in a recovery period which is considered 'cold', requiring a 'hot' treatment to prevent further cooling and further imbalance (David and Huber 2004; Chu 1993; Pillsbury 1982; Topley 1976). In consequence, many Southeast Asian women do not shower or bathe, avoid all cold water, and abstain from drinking cold fluids or eating cold foods, always keeping warm and avoiding wind for a period following childbirth. Not surprisingly, such beliefs and practices can cause friction between maternity patients and healthcare providers unfamiliar with Southeast Asian culture (Davis and Huber 2004).

Barriers in communication and languages, lack of social and emotional support, lack of privacy, low social class, and different cultural expectations between women clients and health professionals may explain NESB immigrant women’s lack of use of health services (Bates and Linder-Plez 1990; HDV 1991; Rice 1993; Plunkett and Quine 1996; Townsend and Rice 1996; Yelland, et al. 1998; Ip and Lui 1999; Rice 1999; Rice, et al. 1999; Vose and Thurecht 1999; Shi 1999; Small, et al. 1999; Jirojwong and Manderson 1999).
If there is little social or cultural difference between clients and providers, the use of services would be higher. For example, Townsend and Rice’s research shows how Cambodian women make sense of the birth process while living in a harsh environment as refugees in a Thai-Cambodian border camp. The midwives there share social and cultural norms with their clients and provide emotional and physical support throughout pregnancy and childbirth, resulting in women’s greater use of services (1996).

In conclusion, the relationship between gender and health is a complex one, for gender is not only an aspect of everyone’s individual experience, but also a reflection of one’s social and cultural context. Within this, the multiple roles of women can often lead to work-family conflicts, with women suffering more psychological distress than men at key times. Furthermore, culture and cultural values play an important role in the perception and interpretation of health, and the various means to cope with illness. In turn, and in order to more fully understand what determines PRC-born migrant women's health beliefs and behaviours -- and this especially in terms of questions of reproductive health -- not only are historical and economic factors important but cultural ones need to be considered also. To this end, the next chapter provides a synopsis of Chinese health beliefs as a key facet of Chinese culture.
Chapter 4

Chinese Health Beliefs and Chinese Culture

In historical terms, Chinese culture has provided the framework for Chinese people’s health beliefs for about five thousand years. In key ways in turn, the question remains not so much whether Chinese migrants in Australia will continue to be influenced by such cultural traditions, but rather of the degree to which they resonate, and at times contrast importantly with the cultural traditions surrounding health in the West. This chapter profiles key aspects of Chinese culture vis-à-vis conceptions of health and illness, outlines the approach to and nature of the family in Chinese society, examines women’s status within Chinese culture more generally, and reviews Chinese health beliefs in terms of women's reproductive health in particular.

In key respects, the notion of family remains a fundamental social, economic, and cultural unit in almost every society. Moreover, while a convivial and supportive family environment can be central to a worthwhile and productive life, families which ultimately undermine the individual personalities of their members can be extremely harmful (McDonald 1994). Furthermore, not only are many women’s lives especially orchestrated to the confines of family, community, and societal structures, but the former institution in particular can often vitally explain the circumstances of many women’s lives. In turn, and as both men and women first encounter socio-cultural norms and values in a context of family life, to understand Chinese health beliefs within a
framework of Chinese culture it is essential to firstly consider the nature and structure of Chinese families.

The Chinese Family

A family can be defined as a group of persons related to one another by blood, marriage, adoption, or a consensual decision to live together, who consider themselves a more or less stable and coherent unit, and who provide acknowledged emotional, and at times financial support to one another (Conway-Turner and Cherrin 1998). Within Chinese culture overall, the family has long been acknowledged to be a pervasively important, highly solidaristic institution (Whyte and Parish 1984). In many respects in fact, loyalty to one’s family takes precedence over all other obligations (Whyte and Parish 1984; Bossen 2000; Zang 2000), inseparably tied to the respect and care of elders, to familial piety, to the upbringing of young children, and to familial collectivism. In this way, while hierarchical social relationships and gender inequality is a traditional, albeit longstanding facet of Chinese culture (Whyte and Parish 1984; Tang and Dion 1999; Zang 2000), it also strongly emphasizes harmony in family relationships and the avoidance of conflict in lieu of more or less peaceful cohabitation (Ikels 1998; Tang and Dion 1999). In turn, a concern with losing 'face' -- meaning reputation, dignity, and prestige as a key element of Chinese social psychology (Gunde 1992) -- continues to be of central importance (Ikels 1993), with this bringing shame to a family as a whole as opposed to the individual or individuals in question.
Needless perhaps to say, Chinese culture differs from Western cultures in numerous ways. To begin with, sexuality remains 'taboo' in traditional Chinese culture, with a survey in 1990, for example, revealing that over half of its respondents never discussed sex openly with others (Zhao and Geng 1992); still today it seems many people avoid talking about sex or sex related issues either privately or in public (Zang 2000). Likewise, prejudice against people with mental disorders is both common and widely accepted, with the generic term 'mad person' (fēng zǐ) applied to all sufferers indiscriminately; not surprisingly, as soon as one member of a family is considered 'mad', the family as a whole loses 'face' altogether.

Beyond these more obvious, and in comparison to the West idiosyncratic characteristics of Chinese family life and health, migration itself can alter family structures in important ways; these in turn can affect migrants' lives and their health needs in a new society.

**Family Structure**

From a sociological point of view, most families adhere to one of four basic categories: the nuclear family, consisting of a couple and their unmarried children, albeit also including family units with a single parent or childless couples; secondly, families which incorporate an aged parent or parents, one married child and his or her spouse, as well as grandchildren also; thirdly, a form which has two or more married siblings living together, with their children and often one or both grandparents resident; and fourthly, extended families which include almost all relatives by blood as well as by marriage. Beyond these, an additional category of single person households -- including the unmarried, the
widowed, or the divorced living alone -- as well as other alternate arrangements (Whyte and Parish 1984), constitutes a final category in sociological interpretations of the family.

In China, extended family structures are a commonplace phenomenon, with young couples often choosing to live with their parents and obtain 'free' childcare, or with housing shortages alternately forcing larger families to occupy the one household (Zang 2000). Indeed in Chinese culture it is completely normal for parents to live with their son and daughter-in-law in particular, and one way or another, many parents live with a child either to receive help, to provide it, and at times to accomplish both simultaneously.

Furthermore, the number of extended families has stabilized in step with -- or even increased for that matter -- the implementation of China's one-child policy in the early 1980s (Greenhalgh 1993). And in general, urban residents have accepted the one-child policy, with Ma (2000) surmising firstly that equal education and work opportunities for women have encouraged fewer of them to have many children; secondly, that a system of pension has made people less worried about the need for children to support them after retirement; thirdly, that the expenses relating to upbringing have escalated rapidly; and finally, that if parents wanted their child to enjoy a satisfactory and beneficial childhood and adolescence, it was simply too difficult to have more than one child anyway.

Nevertheless, the Chinese family has undergone a great deal of change during the course of the twentieth century, with one of the most significant variables being the fluctuating, and yet progressively emerging status of women. Indeed the long and arduous struggle
for women's liberation from traditional norms, for equal status with their husbands, and
for a productive and valued role as individuals outside the bounds of the household, has
contributed to fundamental changes not only in terms of Chinese families, but in key
ways Chinese society overall (Gunde 2002).

The Status of Chinese Women

For most of its history, Chinese society has been overwhelmingly patriarchal, with
women at all stages of their lives subordinate to their fathers, husbands, and their adult
sons (Whyte and Parish 1984; Tang and Dion 1999; Bossen 2000; Zang 2000). In this
way, while sons have traditionally been considered more important than daughters, and
received in consequence the most schooling, men have been predominant in positions of
authority, in owning property, in obtaining prestigious occupations, in receiving the bulk
of familial inheritance, and been in general the benefactors of a range of other unequally
held powers (Whyte and Parish 1984; Queensland Health 2000).

During the course of the twentieth century especially however, the status of women in
China began to change, remaining in many ways at present in dynamic transition. For
while the Communists first rise to power in 1949 involved an early phase of women's
'liberation' (Gunde 2002), many women in China today obtain a far more comparable
education to men, and enjoy a far greater scope of work opportunities in which in urban
areas especially it is more unusual for young women not to work than vice versa. Indeed
the greater exposure of mainland Chinese to international standards has not only
introduced a range of material innovations, but to varying degrees change in both
approaches to education and culture overall. In consequence, a growing number of young Chinese women have received university degrees abroad, often returning with markedly new views sympathetic to the agendum of various forms of Western feminism, along with those of human rights more generally (Bossen 2000).

Women in China of course -- as with those in some other societies -- have always held a certain prestige a product of the love and affection they receive from their children; indeed being at the nexus of the family's communication network lends them a certain subtle, and yet significant status in domestic terms as the intermediary between a more 'unchallengeable' father and both spouses' children (Jankowiak 1993; Zang 2000). Moreover, while men more often remain the main breadwinner in terms of family income, women are also prominent in managing such funds vis-à-vis their core responsibilities of food purchasing, preparation, and consumption (Whyte and Parish 1984).

At the same time however, China’s strictly enforced one-child policy still results in pressure to have sons, and this especially in terms of the preference for the latter among aging, prospective parents. In this way, China’s long historical traditions of male dominance and patriarchy are deeply embedded, and in no easy or simplistic way merely 'redundant' in step with a certain process of 'modernization' (Bossen 2000).

**Chinese Health Beliefs**

Although both Western and Chinese health practices co-exist in most Chinese communities today, most people in China still adhere to what remains a quintessentially
holistic conception of individuals *vis-à-vis* their well being. For according to traditional Chinese cosmological ideologies, the primary factor across an inseparable individual/environmental nexus is the balance of *yin* and *yang*, and more specifically within this the interplay of five key elements -- metal, wood, water, fire, and earth -- collectively termed *wu-xing* (Lee 1980; Chu 1993).

Still today then, the principle of *yin* and *yang* as developed in China as early as the sixth century B.C. is widely recognised as the core theoretical foundation of Chinese medicine, and a major tool as such in the approach to and classification of medical and health phenomena (Needham 1970; Chu 1993). In its inception, the *yin* and the *yang* referred to degrees of exposure to the sun -- the 'southern' side, with greater exposure, was termed *yang*, while the northern side with less exposure *yin*. Over time however, the idea of *yin* and *yang* received a much broader application in terms of human physiology, the nature in turn of people's daily lives, and the character of all that with which they interact; with this, *yin* came to represent a 'cold' energy force, while *yang* denoted the opposite (Li and Jiang 1999; Zhan 1999). In turn, and by extension, foods and illnesses are themselves classified according to the degree to which their effects are 'hot' or alternately 'cold' (Yang 1964; Lee 1980; Chu 1993; Li and Jiang 1999; Zhan 1999; Gunde 2002).

In short, the optimum in terms of health is a scenario in which the *yin* and *yang* are in balance. In contrast, if too much energy is displaced in either direction, one inevitably falls ill; in this way, if *yin* dominates *yang*, one generally feels cold, weak, pale, void of spirit and energy, and susceptible to cold sweats as well as dizziness, while if *yang*
becomes overly preponderant, one feels hot and feverish, thirsty, restless, short tempered, and susceptible to things such as a sore throat or insomnia (Yang, cited in Chu 1993).

In turn, and in order to understand Chinese dietary practices more fully, it is essential to comprehend the *yin-yang* principle as applied to food (Anderson 1975; Manderson 1979; Chu 1993; Gunde 2002). To this end, and based on cross-cultural research focusing on the reproductive health beliefs and health practices of Chinese and Australian women, Chu (1993) surmised in relation to the approach to food by the former that *yin* (cold) foods are usually considered black or white in colour, grow underground, are bitter, salty, or sour in flavour, 'wet' in terms of their level of 'moisture', and are usually eaten either raw, steamed, or boiled in water. Alternately, *yang* (hot) foods are those which are red or green in colour, grow above ground, are sweet, spicy, or peppery in flavour, are considered 'dry' in terms of their 'moisture' quotient, and are either barbequed, baked, roasted, deep fried, or stir fried prior to eating. As Chu (1993) highlighted in this way then, for Chinese women good health -- which means keeping the *yin* and *yang* in balance -- depends on eating an appropriate and comparable ratio of food in each category.

Furthermore however, while food in this way is largely inseparable from medicine *per se*, its effects can vary depending on the age and sex of each person, their health overall, the weather, and the social circumstances of people also. In turn, women who have given birth are considered overwhelmingly *yin* dominant, and need to eat extremely 'hot' foods to help them redress their imbalance. In contrast however, if a child were to eat such foods he or she may suffer from illness the product of too much 'heat' (Chu 1993).
That such integral and pervasive beliefs regarding health and illness might accompany Chinese migration is unsurprising. Indeed many Chinese migrants are likely to employ a variety of traditional healing therapies -- including acupuncture, herbs, nutrition, meditation, and a form of meditative exercise used to improve the flow of energy throughout the body called *qi gong* -- to maintain health within their new country of residency (Williams 1995). Likewise, the overwhelming majority of PRC-born migrant women continue to attach a great deal of importance to traditional Chinese medicine, regarding their body and well being overall a holistic matter still defined in the last instance by the principle of *yin* and *yang* (Li and Jiang 1999).

Given the centrality and significance of the latter to most Chinese migrant women in fact, the whole approach to health and illness many encounter in the West can be both puzzling and problematic. According to Shi (1999) for example, while Chinese migrant women who give birth in Western countries are often offered cold water to drink -- something completely at odds as aforementioned with the fundamentals of *yin* and *yang* -- to not appear rude or ungrateful many have felt compelled to comply. In doing so however, many also harbour genuine concerns for their own well being given the very different approach to questions of health in their new country.

Given reproductive health remains a vital aspect of many women's lives more generally, establishing the nature and influence of traditional health beliefs among migrant women in this regard is essential.
Reproductive Health

Beyond pregnancy and birth, with the exception of family planning programs, women’s reproductive and sexual health has received little serious attention, and women’s health consequently remains poor (Jacobson 1991: 57). Reproductive and sexual health are not only fundamental to individuals, to couples, and to families more generally, but to the social and economic development of communities and in turn nations (WHO 2004a). By definition, reproductive health is a state of complete physical, mental, and social well being -- as opposed to merely the absence of disease or infirmity -- in all matters relating to the reproductive system and its functions and processes (UN 1994).

However, issues of reproductive and sexual ill health account for 20 percent of the global burden of health problems experienced by women (WHO 2004b), and remain significant not merely in terms of their impact on women, but in terms of their broader social costs overall (Rice and Manderson 1996:3). Furthermore of course, a woman's knowledge of, beliefs about, and behaviour in relation to such issues, are importantly shaped by wider cultural patterns themselves (Cosminsky 1982). While migrant women as any other then share certain reproductive concerns and needs in common, they nevertheless experience a range of diverse challenges the product of cross-cultural differences between their country of origin, and their subsequent country of resettlement.

Menstruation

The onset of menstruation constitutes an important milestone in the life of any woman, and the beginning for most women of their biological ability to reproduce. While
menstruation is a natural and inevitable part of a woman’s experience throughout her reproductive life however, it is something strongly infused with the cultural, ethnic, and family values relating firstly to reproduction (Davis and Huber 2004). Furthermore, although menstrual disorders are a common complaint among women worldwide, there are a variety of determinants which can affect menstrual function, including a woman's weight, level of physical activity and physical and mental stress, diet, and exposure to varying occupational and environmental conditions (Harlow 2000).

As far as menstrual pain and disorders are concerned, Chinese people have their own unique approach to treatment. To begin with, and as both females and female blood are associated with yin, compounding this by eating 'cold' foods is often seen as that which causes period cramps (Chu 1993). In turn, menstruating women often avoid eating icy and 'cold' foods as well as bathing in cold water, and are encouraged to wear warmer clothing and consume a ginger and red sugar soup well known as a quintessentially 'hot' food in China.

**Maternal Health**

Maternity, along with menstruation, represents another directly related concern of women more generally, and migrant women in particular. For birthing practices and the experience and interpretation of both pregnancy and the postpartum period vary widely from culture to culture (Queensland Health 2000). In this way, while Chinese women share similar views on pregnancy with Western woman for example, their perception of the postpartum is quite different.
In Chinese culture traditionally, women who have given birth are considered to be both physiologically weakened, and in turn more vulnerable to ill health, with a period of recuperation normally taking around one month (David and Huber 2004; Chu 1993; Pillsbury 1982; Topley 1976). During this period Chinese women are considered to have special needs, and are encouraged to rest and relax, receive particular kinds of treatment and support, and are often given special types of food to eat to properly recuperate and help them regain their strength (Chu 1993, 2002). As some of the deleterious consequences associated with neglecting this important period of a women's health include long term ailments such as arthritis, asthma, and anaemia, family members of the new mother especially play important roles in facilitating her return to balanced health (Chu 1993).

However, on migrating to Western nations such as Australia Chinese women often lose to begin with a good deal of their support network, holding significant implications for their experience of pregnancy and motherhood. As both Chu (2002) and Shi (1999) have highlighted recently in fact -- in the course of community needs assessments conducted in Brisbane -- postnatal depression in particular is a growing concern among Chinese migrant women. In surmising a broader picture moreover, Shi (1999) identified many of the key problems facing Chinese migrant women when they give birth in non-Chinese social settings such as Brisbane.

As aforementioned, cardinal among these is the absence of support from extended family members, for in China a woman's relatives -- including among them parents, parents-in-
law, and often sisters -- usually volunteer for various tasks during and after the birth of children. This of course not only frees the mother from various household duties, but also ensures that she has a healthy diet, and eats foods that have been especially prepared for her during the postpartum period. As Shi (1999) pointed out however, in Brisbane many Chinese migrant women have only their husbands to help, while even for those who migrated along with family members, traditional practices are not always easily transferred to a differing social context and very different set of circumstances. Moreover, even relatives who visit have often found it difficult to obtain ingredients and prepare traditional recuperative foods for the mother, while many also find the approach to looking after newborn babies in Australia at odds with certain important practices adhered to in China. As Shi (1999) further highlighted in fact, in certain cases the visiting siblings or relatives themselves can require assistance just to provide a level of support for new mothers and their newborn children.

For many Chinese migrant women, language difficulties are a common obstacle, and this especially in regard to giving birth in local hospitals and dealing with health professionals. For although many migrant women can get by in everyday conversation, they lack the more specialized vocabulary needed to communicate with these latter; further, many can become intimidated by authoritative figures such as medical doctors, too easily complying with advice in order to appear agreeable. Within this, the cultural differences between Chinese and Western medical systems is paramount, with many Chinese migrant women feeling reluctant or ashamed to ask for special help even when they particularly needed it. In this way, many often simply concede to the judgments of nurses and
doctors, however much they contradict traditional Chinese health beliefs and practices. And while many Chinese migrant women face these and similar problems, some lack real information on the availability and provision of health services in Australia in the first place, including those specifically targeting migrant women.

Not surprisingly perhaps, previous studies have revealed that NESB women in Australia and especially those with low incomes, those who occupy poor housing, who have little access to transport, who engage in hazardous paid work, have little information on public health services, or have poor social support overall -- suffer a higher chance of physical morbidity during their pregnancy and childbirth than Australian women as a whole (Chu 1998; Alcorso and Schofield 1991). Whether this applies similarly to recent migrant women from the PRC however has yet to be determined.

**Menopause**

Perimenopause and menopause are both significant transitions in women’s reproductive lives, affecting them physically, psychologically, emotionally, and socially. Perimenopause, which typically begins in the early to mid forties, is often characterized by phenomena such as irregular menstruation, hot flashes, sleeping difficulties, mood swings, night time sweating, fluctuations in libido, and a decline in memory and the ability to concentrate and focus (Condon and Bock 2004; Hales 1999). Moreover, the levels of stress associated with many women's lives today can often exacerbate these very real physiological changes, a product of or combined with too many responsibilities,
insufficient autonomy, too few and supportive relationships, a poor diet, as well as a lack of exercise (Condon and Bock 2004).

While women can often benefit from remedial measures such as hormone replacement therapy, the use of acupuncture and herbs to treat menopause has a history of thousands of years in Chinese medicine. Still today in fact many Chinese women prefer such naturalistic treatments to help balance and maintain female hormone levels, to improve their blood circulation and qi, and achieve some fundamental solutions to common menopausal symptoms overall. Importantly of course, that many Chinese migrant women in Australia either entered as students, or followed their husband's migration during or after the late 1980s, many at present are reaching the age of perimenopause, and face questions of which remedial avenues might best be taken.

As this chapter has attempted to outline, the long history of Chinese culture provides something of a stable template for the health practices and beliefs of Chinese people. In terms of migrating to new and differing social contexts however, the impact on Chinese migrant women of varying, culturally specific approaches to health -- and the ways this cross cultural divide constitutes a quandary to be negotiated -- remains palpable. To further this synopsis, the next chapter surmises recent and directly related literature on the specific issue of Chinese migrant women, mental health, and stress.
Chapter 5

Mental Health and Stress

Social and psychological circumstances can cause long-term stress, and stress in turn impacts deleteriously on physical health. This chapter firstly reviews issues concerning mental health, and then focuses on those more specifically associated with stress, including its relationship to particularistic scenarios such as migration and unemployment.

Mental Health

Mental health has as its core emotions, thoughts, and their related behaviours. In straightforward terms, a person with good mental health is generally able to competently handle day-to-day events and obstacles, work towards their goals, and function effectively and actively in society.

Given its designation at both State and Federal levels of government in Australia as one of five 'National Health Priority Areas', its social and public importance in this country at least has acquired official recognition. For minor mental health problems alone not only affect an individual's ability to accomplish everyday activities, but impact adversely both their family and the wider community (ABS 1998c). As the economic and personal costs of mental illness constitute a major social and public health issue, in 1992 Australia's Commonwealth, State, and Territory governments endorsed a National Mental Health Strategy (NMHS 1992) aiming to:
· Promote the mental health of the Australian community;

· Where possible, prevent the development of mental health problems and mental disorders;

· To reduce the impact of mental disorders on individuals, families, and the wider community;

· To assure the rights of people with mental disorders.

To monitor the initiatives of the NHMS, and to provide a baseline in Australia against which future activities might be compared and evaluated, a national survey of mental health and wellbeing was conducted in 1997. Among some of the findings, it revealed that although many Australian adults enjoy good mental health, almost one in five (18 percent) experienced mental problems in the twelve months prior to the survey; that women aged around 35 years were more likely to suffer mental health problems than men; that women overall were more likely than men to experience anxiety disorders such as Panic Disorder, Agoraphobia, Social Phobia, Generalised Anxiety Disorder, Obsessive-Compulsive Disorder, and Post-Traumatic Stress Disorder -- at twelve percent compared to 7.1 percent -- as well as affective disorders such as Depression, Dysthymia, Mania, Hypomania, and Bipolar Affective Disorder -- at 7.4 percent compared to 4.2 percent; and that the highest rate of anxiety disorders (16 percent) was observed among women aged 45 to 54 years old.
Furthermore, Australia's national mental health policy has long acknowledged that people of non-English speaking backgrounds have special requirements which need to be recognized in the planning and delivery of public mental health services (Long et al. 1991). And evidence also suggests that the incidence of mental illness within NESB communities is generally higher than in Australian-born communities (Long et al. 1999). Due in important ways overall, according to Chu (1998), to the stress of migration and the loss of family support which relocation usually entails, as Long (1999:13) more specifically surmised migrants are more likely to suffer from mental problems the result of one or a number of factors, among them:

- Downward mobility and low socio-economic status;
- Low educational status;
- Unemployment in their new society;
- Language difficulties;
- Difficulties in adjustment due to old age;
- Rejection of previous work experience or academic qualifications;
- Cultural isolation;
- Experiences of torture, trauma, and related stress prior to migration;
- Difficulty in adjusting to the new country; and,
- Experiences of prejudice and discrimination in the host society.

According to international studies, depression and anxiety are the most common mental disorders among women (Escobar 1992; Kessler et al. 1996; Tracy and Mattar 1999), with twice as many suffering from depression than men worldwide (WHO 2002). And
higher mental morbidity is more common among double-disadvantaged female migrants, coupled with the deterioration of traditional support networks (Anderson 1985; Beiser and Wood 1986; Buijs 1993; Remennick 1999). Their lower social status, poorer employment opportunities, and unequal responsibilities in marriage -- including holding most responsibility for childcare and household duties -- contribute to their negative life events; in sum, these negative life events lead to greater rates of depression among women in comparison to men (Sachs-Ericsson and Ciario 2000).

Although evidence suggests that the rates of mental illness in NESB communities are generally higher than in the Australian-born community, there is a lower rate of use of community mental health services (Long et al. 1999). If anything, Chinese communities are no exception, with many Chinese migrants feeling uncomfortable about accessing mental health services and evincing very low utilization rates (Stolk 1999). This may be due to the fact that many Chinese do not want to talk to outsiders about their problems, and especially their psychosocial ones. In this way, and as a clinical service coordinator in the Queensland Transcultural Health Centre (TCCS), Nip (2002) outlined a profile of those clients of a Chinese background referred to the Transcultural Clinical Consultation Service in the eighteen months from mid 2000 to the end of 2001. The main stressors/risk factors associated with mental health problems as identified by Chinese migrants included language barriers, a lack of social support, cultural barriers, family relationship problems, marital problems, parent-child relationship problems, a lack of family support, employment and financial difficulties, pressures to achieve academically, and pathological gambling.
The TCCS has also recently been involved in a research project entitled ‘Patterns of Cultural Adjustment Among Young Former-Yugoslavian and Chinese Migrants to Australia’ (Sonderegger 2002). The project revealed that young Chinese people experience significant stress in relation to issues of acculturation especially, and that when compared to young people from the former Yugoslavia, young Chinese scored higher levels of anxiety, post-traumatic stress, and lower levels of 'Australianism' (Nip 2002). Moreover, female migrants exhibit significantly higher levels of anxiety than their male peers, with adolescent females found to exhibit greater levels of hopelessness, and a poorer general and emotional conception of themselves than the latter also (Sonderegger 2002).

Culture is one of the most important barriers to people accessing mental health services, and in Chinese society especially as aforesaid, mental illness brings with it a strong sense of shame. In this way, the NESB Youth Mental Health Needs Assessment Project conducted nine interviews with Chinese migrant youth in Brisbane, with the majority of respondents using the terms 'stressed' or 'depressed' when discussing their mental health problems. Many also pointed out that social isolation was the major cause of their problems, with language barriers, the breakdown of friendships, being left alone in Australia, and experiencing difficulties at school, all resulting in increased stress and pressure to their lives. Importantly, none of the young people interviewed had accessed service providers to discuss their mental health issues, and almost half of them did not know such services existed at all (Youth Affairs Network Qld 2004).
Stress

The issue of stress has invoked a broad area of study and knowledge encompassing numerous disciplines, aiming variously to describe, understand, and predict stressors and their consequences for health and wellbeing (Werner and Frost 2000). Since it was first studied in the 1950s in fact, it has become public knowledge that stress, along with things such as smoking or drinking too much alcohol, can have adverse effects on both physical and mental health (Stroebe 2000). In this way, while stress is a natural part of people's lives, it can of course become a serious problem (Selye 1976).

At the same time, the fact is that there is no real, clear-cut definition of 'stress' adhered to in the literature. In spite of the variations within and between theories of stress however, it has become the dependent variable in stress research since Selye (1956:12) defined it as “the non-specific response to any demand”, and a stressor as “that which produces stress”. Factors that initiate the stress response are generally defined as events that pose a threat, or exact excessive physical or emotional demands (Schooler 2000). Furthermore, many descriptions and explanations of the relationship between stress and illness/disease remain based on Selye’s model of stress, known as the 'General Adaptation Syndrome' (GAS) -- essentially, a model outlining the physiological response pattern to stress.

For stress causes a number of changes in the structure and chemical composition of the body, all of which can be accurately appraised. Selye (1976:38) called this syndrome general, because “it is produced only by agents which have a general effect upon large
portions of the body”. He also called it *adaptive*, for “it stimulates defence and thereby helps in the acquisition and maintenance of a stage of inurement”. Finally, he termed it a *syndrome* as “its individual manifestations are coordinated, and even partly dependent upon each other”.

Furthermore, for Seyle (1976) GAS developed in three key stages -- that of the alarm reaction, of resistance, and a final stage of exhaustion. It is well known of course that the adrenal glands are the anti-stress glands of the body, and the reserve tank in effect which the body falls back upon when faced with stressful situations (P.I. Health Service 2003). In this way, when a noxious stimulus is encountered, the alarm reaction gives a generalized call to defence, which involves an enhanced amount of adrenal activity *vis-à-vis* hormone production. Upon continued exposure to a noxious agent in turn, a stage of resistance follows where supplementary physiological changes take place, and the adrenals furthermore begin to adapt and reconstitute themselves; their increase in size and function forms the basis of the resistance stage. Nevertheless, this adaptive mechanism has also been associated ultimately with the occurrence of diseases such as hypertension, arthritis, and cancer (Lyon 2000).

In the course of a normal human life of course, many people go through these two stages repeatedly. If exposure is severe or prolonged however, and when the adaptability of people's defence mechanisms is irreversibly used up, general exhaustion can follow (Seyle 1976). At this stage, the body has little or no ability to resist further stress effectively (P.I. Health Service 2003).
As can be seen, Seyle’s GAS theory focused on physiological reactions to stress. While this response definition has been preponderant in biology and medicine, it gives little scope for a psychological level of analysis. In consequence, during and after the 1960s psychologists shifted the focus somewhat from physiology, and from Seyle’s 'stress as response' model in particular, to one of ‘stress as stimulus’.

Stimulus definitions of stress focus on events in the environment, and include things such as natural disasters, noxious environmental conditions, or being laid off work (Lazarus and Folkman 1984). In this way, these approach certain life events as stressors, to which a person responds on levels more than the physiological. At the same time however, stimulus definitions embody a key limitation, turning on the fact that if there is no stress response, a stimulus cannot be defined as stressful. Furthermore, stressful events and conditions acting on the individual incur responses which are also a product of the individual’s particularistic characteristics and circumstances (Hornblow 1988).

Among the chief proponents of this view over several decades has been Richard Lazarus, with Lazarus and Folkman (1984) developing a widely accepted definition of stress in the early 1980s. They defined stress in psychological terms as “a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being” (Lazarus and Folkman 1984:19). In this way, this definition emphasized the relationship between the person and the environment, which takes into account characteristics of the person on the one hand, and the nature of the environmental context on the other. In sum, stress is
experienced when individuals appraise a situation as potentially harmful or threatening, as it exceeds their coping resources (Lazarus and Folkman 1984). However, according to Lazarus and Folkman’s relational definition of stress, the extent of the stress experienced in a given situation does not depend solely on the demands of the situation or the resources of the person, but on the *relationship* between demands and resources *as perceived* by the individual (Stroebe 2000). In this way, the two central and critical processes in their theory that mediate a person/environment nexus, are cognitive appraisal and coping.

To some extent of course, the health consequences caused by physical stressors are mediated by the same changes in endocrine, immune, and autonomic nervous systems (Selye 1976). However, psychological stress can firstly affect health directly through changes in the body’s physiology, and in turn through changes in individual behaviour. For example, negative changes in health behaviour -- such as smoking, alcohol consumption, or other drug use -- contribute to the stress/illness relationship. In this way, stress is often a result of people’s lifestyles in a successively accumulative fashion (Stroebe 2000), with the psychological paradigm in sum focusing on identifying individual factors assumed to contribute toward an individual's experience of, and/or susceptibility to, stress and stress related illness and disease (Ham 1987).

While physiological and psychological approaches largely dominated the literature on stress from the 1950s to the 1970s, a more sociological approach to the study of occupational and organizational stress emerged in the 1980s. In fact stress in
organizations has been an increasingly important concern in both academic research and in organizational practices in the past two decades. Based on a concern with the social structural and organizational sources of stress, Schuler (1980:189) early on for example asserted that stress is a dynamic condition in which an individual is:

a. Confronted with an opportunity for being/having/doing what (s)he desires, and/or;
b. Confronted with a constraint on being/having/doing what (s)he desires, and/or;
c. Confronted with a demand on being/having/doing what (s)he desires, where while the resolution is perceived to be uncertain, it is also perceived to result in important outcomes.

In this way, Schuler’s definition of stress turned on several important areas of research in the medical and health sciences, as well as in organizational behaviour and industrial psychology.

More specifically however, Beehr and Newman (1978:670) -- and this pursuant to an extensive review of research on job stress -- erstwhile suggested that “job stress is a condition wherein job related factors interact with the worker to change (disrupt or enhance) his/her psychological or physiological condition such that the person (mind and/or body) is forced to deviate from normal functioning”. By extension, Kimball (2000:533) more recently defined job stress as “the harmful physical and emotional responses that occur when requirements of the job do not match the capabilities, resources, or needs of the worker”. All told however, there are three perspectives with which to view job stress: firstly, the personal characteristics perspective, which focuses
on the character traits of people thought to cause or contribute to ill health (or alternately
good health); secondly, an environmental perspective which sees contextual factors as the
causal agents of stress-health events; and thirdly, a dual person/environment perspective,
effectively consolidating key elements from both (Beehr and Newman 1978).

At times of course, stress can be beneficial, and shorter bursts can improve memory as
well as heighten energy levels. However, if stress is chronic and prolonged it will greatly
affect the human body, as documented within a good deal of recent literature (see, for
example, Black 1994; Glaser and Kiecolt-Glaser 1994; Ader et al. 1995; Flinn 1999;
Stroebe 2000). Many problems, including high blood pressure, heart attack, peptic ulcers,
migraines, neck pain, certain types of asthma, toxicomanias, alcoholism, and excessive
obesity or leanness due to abnormal dietary patterns -- have long been considered
diseases directly tied to excessive stress. Moreover, stress can worsen existing medical
conditions such as asthma, diabetes, and depression (Health Care 2002).

As a whole however, the general symptoms of stress can be classified into three main
categories: the physiological, the psychological, and the behavioural (Beehr and Newman
1978). Physiological stress is generally indicated by heart rate, respiration, headache,
ulcers, high blood pressure, heart attack, and lymph deduction, while psychological stress
is commonly expressed in aggression, negativism, boredom, dissatisfaction, uncertainty
about whom to trust, a loss of ability to concentrate, and irritability. Thirdly, behavioural
stress can be seen in individuals manifesting a loss of appetite, a sudden and noticeable
loss or gain in weight, breathing difficulties, or sudden changes in smoking habits or the use of alcohol.

In sum, in organizational settings stress among individuals is manifested in low performance, low job involvement, a loss of, and/or loss of awareness of responsibilities, and a loss of concern for organization as well as for one's colleagues (Schuler 1980). While many of the above perspectives and definitions attempt to surmise stress and health in broadly overarching terms of course, particularistic groups of people experience stress differently; as the next section attempts to adumbrate, this is no less the case for women.

**Women and Stress**

From a quintessentially sociological point of view, women experience greater stress than men due to the impact of gender as one expression of a broader socio-cultural framework. Whatever its ultimate origins however, women experience differing degrees and types of stress based on the particularistic roles they play when compared to men (Kolander et al. 1999), a product of varying factors including the nature of appraisal, of coping methods, and of the reporting of stress-related symptoms themselves (Schooler 2000). Moreover, chronic stress is often expressed through various psychosomatic complaints -- including fatigue, headaches, sleep and mood disturbances, as well as lower back and bone pains -- for which conventional biomedicine it seems has no straightforward answer (Remennick 1999).
To begin with however, numerous studies have found that working women experience higher levels of stress than men due to such things as inequities in pay, overwork, role conflicts, gender stereotyping, gender prejudice, less engaging work, fewer mentors and female support groups, less attractive career blocks, fewer opportunities for mobility and influence, and an under-utilization of skills and abilities (see Cox and Harquail 1991; Powell 1993; Walters 1993; Roxburgh 1996; Malone et al. 1997; Lundberg and Parr 2000; Williams and Umberson 2000; Fielden and Cooper 2002; Nelson and Burke 2002; Karambayya 2002; Gaitley 2004). Overall it seems, job stress is more directly related to women’s experience of role conflict than that of men’s (Greenglass et al. 1989), with one of the most common sources for women remaining sexual discrimination in the workplace (Powell 1993; Cleveland et al. 2000; Lundberg and Parr 2000). Furthermore, working women have had to face unique stressors in their non-work lives, often carrying the bulk of family responsibilities such as childcare and care of the elderly, as well as other family related duties such as grocery shopping, cooking, and cleaning. Such dual pressures have contributed to work overload and a lack of time, and to conflicts in responsibility between work and non-work roles (Karambayya 2002).

Moreover, many women are particularly likely to be exposed to sex segregation in the labour force (Williams and Umberson 2000), in which high levels of routine and a lack of substantive complexity in terms of tasks are often associated with psychological ill health (Pugliesi 1995). Also, women report higher total workloads, which includes vocational and domestic, as well as paid and unpaid work (Nelson and Burke 2002). Evidence further suggests that stress hormones such as epinephrine, norepinephrine, and cortisol
remain at higher levels in women hours after finishing work, all of which can lead to feelings of fatigue and ultimately to ill health (Lundberg and Frankenhaeuser 1999).

In terms of non-work responsibilities, and contrary to commonly accepted perceptions, motherhood is a most stressful experience for many women, and this in spite of the fact that having a baby is also one of the most rewarding events in many women's lives. For pregnancy not only brings with it radical changes to the female body, but can induce things as varied as serious mood swings, along with apprehensiveness vis-à-vis self-confidence and self-worth (Health Care 2002). Furthermore, childbirth is a stressful time overall owing to the great changes and adjustments families have to make to accommodate a new baby, and women in particular may experience stresses a product of increased isolation, financial difficulties, and an unexpectedly difficult birth. Indeed motherhood overall by no means comes 'naturally' to all women, with John (1989:5) among others dispelling the notion of the 'naturalness' of parenting per se:

Parenting to date, has been largely perceived as a 'natural and instinctive' role. This is a myth that needs to be broken by alerting the community that parents do not cope instinctively, but by having developed a complex matrix of social learning, networks and support systems, and that when these systems have not existed or breakdown or falter due to family violence, child abuse, unemployment, financial difficulties, bereavement etc., then coping as a parent can be all the more difficult.

Moreover, while the causes of postnatal mood disorders are not yet clearly known, many women also fall vulnerable to emotional upheavals which can induce varying degrees of depression (Milgrom et al. 1999); indeed it is a combination of the biological, psychological, and social factors associated with childbirth which significantly increase
the risk of depression and anxiety at this time, with women more likely to develop psychological disorders in their first postnatal year than at any other time in their lives (Cox 1994).

Furthermore, while postnatal depression (PND) is commonly experienced by women in developed countries (Welburn 1980; Bar 1996), it also remains a "serious, underestimated, misunderstood women's health issue" in Australia (Carter 1994:4). In fact current estimates indicate that PND is likely to affect around 14 percent of women giving birth in Australia (Beyond Blue 2002), and one of the most striking features of PND is not only the direct impact it has on women, but on their infant and partner also (Milgrom, et al. 1999). For research has indicated that PND can hold negative repercussions for infant attachment and infant development in both early and later life (Murry and Stein 1989), while higher rates of depression have further been reported for partners of depressed women during the postnatal period (Ballard et al. 1994).

Of course the symptoms of postnatal depression take on a particular significance not only due to the need for women to recuperate physically, but also because of the presence of an infant during this important period (Milgrom et al. 1999). Among the many general symptoms which women with PND manifest -- such as mood swings, anxiety, and negative or obsessive thoughts -- Milgrom et al. (1999) have more specifically observed that depressive symptoms include feeling low and sad, being tearful or crying uncontrollably, feeling generally worthless, suffering anxiety to the extent of experiencing panic attacks, feeling self-blame and guilt, having excessive concerns about
their own health and that of their baby's, suffering from a lack of energy, and thinking, speaking, or moving lethargically. Many of these can also be accompanied by agitation and/or hyperactivity, a loss of interest in sex, appetite disturbances -- including eating too much or too little -- irritation, a reduced ability to concentrate and make decisions, sleep disturbances, confusion and forgetfulness, as well as persistent pessimism culminating for some in obsessive thoughts about death and/or suicide.

**Migrants and Stress**

Migration has always been a complex and stressful process, in which migrants experience particularistic stress the product of challenges brought on by adapting to new social environments, and coming to terms often enough with culturally distinct social groups (Berry 1991). Given migration can variously involve assimilation, integration, separation, or marginalisation, stress for many migrants it seems is inevitable (Berry 1992; Minas *et al.* 1996). Indeed for ethnically distinct migrants acculturation is a two-dimensional process, in which both their own cultural heritage and that of their host community must similarly be considered (Berry 1997). For while many migrants attempt to strive for cultural identity on the other hand, most have necessarily to come into contact with and participate in their new society (Tang and Dion 1999). In this way, and this as Eisenbruch (1989:577) pointed out, “the stress that is caused by uprooting and acculturation are seen clearly, especially in immigrants with language and cultural barriers and those without family or social support, and adverse health consequences can follow”.
Not surprisingly, these stresses often find articulation in lower rates of good mental health, feelings of marginality and alienation, and heightened psychosomatic and psychological symptoms (Berry 1992). Moreover, the need to adapt can also lead to a process of adjustment, reaction, and withdrawal, and this especially when a migrant is socially isolated, and experiencing a loss of social networks which formerly provided both emotional and instrumental support (Al-issa 1997).

Furthermore, migrant workers also experience a broad range of stressors which Selye (1976) erstwhile termed 'culture stress', involving a lack of friendly social contact, as well as an unfamiliarity with local customs, foods as well as approaches to nutrition, housing, and even the weather (Malone et al. 1997). Of course traditional migrant work has long been considered to be among the least desirable forms of employment among the established host community, most often marked by poorer working conditions, lower-status jobs, and intermittent albeit recurrent spells of unemployment (Barling et al. 2002).

Gender further complicates and plays a role in the acculturation process, as well as in the extent to which cultural conflicts are respectively experienced (Tang and Dion 1999). In this way, Ip and Lui (1999) for example found that older Chinese migrants in Brisbane, and older Chinese migrant women especially, suffered a great deal from social isolation due to their English language problems, difficulties in accessing transport, and the extent to which traditional family relationships deteriorated. Similarly, Chu (2002) has revealed that a lack of suitable work or employment opportunities, poor work environments, irregular income, concerns over migrant children's education, transport and language...
problems, as well as loneliness and racial discrimination, were all major sources of stress experienced by Chinese migrant women.

**Unemployment/Racial Discrimination and Stress**

As Vanden Heuvel and Wooden (1999:14) importantly note, “an important aspect to successful immigration and integration into the Australian community is often related to gaining employment”. Without a doubt in fact, unemployment constitutes a significant source of stress among migrants, with unemployment and underemployment some of the most significant problems experienced by PRC-born migrants to Australia in particular. As aforementioned, given that poor English language proficiency, along with the non-recognition of overseas qualifications, are two major contributing factors to PRC-born migrants congregating in labouring and factory jobs, it is unsurprising that many have little opportunity to interact with non-Chinese Australians (Ip et al. 1999; Ye 1996; Inglis 1999; Ip 1999).

Furthermore, the variable of ethnicity can affect the degree of stress experienced by migrants, with race remaining a significant predictor of both levels of social support, as well as occupational stress, among migrant women in particular (Kolander et al. 1999). Moreover, while Australia is a relatively tolerant society, discrimination is commonly experienced by NESB migrants. According to Ip et al. (1992) in fact, over 50 percent of Australia-born respondents surveyed in their study in Brisbane and Sydney perceived Australians to be basically racist. Not surprisingly, and given Australia’s former White Australia Policy especially, racial discrimination is an obvious concern among Asian
migrants. All told, Wu et al. (1998) found that migrants from the PRC experienced the highest levels of discrimination in terms of verbal abuse, inequitable treatment at work involving the allocation of tedious jobs, and extreme difficulties in obtaining employment in the first place.

While stress is a significant health concern for women, and migrant women in particular, the degree or otherwise of their address in health promotion campaigns, as well as in women’s activities globally, constitutes an ancillary topic of concern to be addressed in the next chapter.
Chapter 6

Health Promotion and Women’s Health

As a key underlying concern of this study is to consider some of the ways PRC-born migrant women in Australia might enjoy better health through preventative measures during settlement process. As opposed to disease treatment, to develop health, health promotion provides both knowledge and skills. This chapter will firstly outline the history of health promotion, then summarize four major international women's conferences which are milestones of women’s movements and affect empowerment of women; it also emphasizes two key action frameworks, for health promotion is the Ottawa Charter action framework (WHO 1986), and for women’s health is empowerment framework developed by Chu (1996). Both of them have implications for women’s health.

Along with a range of social, economic, and cultural changes since the 1970s, health promotion has arisen in a significant way to respond to perceived challenges in public health. From the first global conference in Ottawa on health promotion in fact, as sponsored by the World Health Organization, health promotion emerged to become a multi-disciplinary pursuit concerned in varying ways with the advancement of health, with equity, and with sustainable human development overall.
The History of Health Promotion

According to the World Health Organization (WHO), health is defined in the WHO constitution of 1948 as “a state of complete physical, social and mental well-being, and not merely the absence of disease and infirmity” (Health Promotion Glossary 1998:1). Whatever its definition however, health remains the most fundamental resource for everyday life, and in analytical terms a positive concept intimately tied to personal and social resources as well as physical capability (WHO 1986). Health promotion however constitutes a process centrally concerned with enabling people to increase their control over, and ultimately improve their health (WHO 1986); in this way, and in terms of the objectives of health promotion specifically, health is less an abstract state than a means to an end, and one which can be expressed in functional terms as that source which permits people to lead individually, socially, and economically productive lives (WHO 1986).

As aforementioned, the first International Conference on Health Promotion was held in Ottawa, Canada, in 1986, producing the now widely known Ottawa Charter for Health Promotion. This conference emerged primarily however as a response to growing expectations for public health around the world; was importantly focused on achieving equity in health; and considered health promotion importantly in turn as something aiming to reduce inequities in health, health opportunities, and health resources, thus enabling all people to realise their full health potential. In short, and according to the Ottawa Charter, action in terms of health promotion meant building effective public policies, creating supportive social environments, strengthening community action, reorienting public health services, and developing personal skills directly tied to people's
experience of health (WHO 1986). Moreover, Ottawa charter stressed the facilitation skills for health promotion as: advocacy for health; enabling people to achieve their fullest health potential; and mediation between differing interest in society for the pursuit of health (WHO 1986).

The Ottawa Charter for Health Promotion is a comprehensive, holistic, and integrative action framework which aims to address health by undermining the 'victim blaming' and 'individualized' undercurrents which have often recurred in considerations of women's health in the West. The detail of the action framework highlighted in the Ottawa Charter is as the following:

- **Building Healthy Public Policy**
  
  Health promotion goes beyond health care, and puts health on the agenda of policy makers in all sectors and on all levels, directing them to be aware of the health consequences of their decisions, and accept responsibilities for public health.

- **Creating Supportive Environments**
  
  Modern societies are complex and interrelated, and health cannot be separated from other goals inextricably linking people. Within this, the environment constitutes the basis for a socio-ecological approach to health. The overall guiding principle for the world, for nations, for regions, and for communities alike, is the need to encourage reciprocal maintenance -- to take care of one another, our communities, and our natural resources throughout the world, as a global responsibility.
● **Strengthening Community Action**

Health promotion works through concrete and effective community action, directed at setting priorities, making decisions, planning strategies, and implementing them to achieve better health. At the heart of this process is the empowerment of communities -- of their ownership of and control over their own endeavours and destinies.

● **Developing Personal Skills**

Health promotion supports personal and social development by providing information and education on health, and enhancing life skills. In doing so, it increases the options available to people to exercise more control over their own health and their own environments, and to make choices conducive in turn to good health.

● **Reorienting Health Services**

Responsibility for the health promotion of health services is shared among individuals, community groups, health professionals, health service institutions, and governments. Each must work together toward a health care system which contributes to the pursuit of better health.

The Second International Conference on Health Promotion, held in Adelaide, Australia, in 1988, further explored one of the major themes of the Ottawa Charter -- namely, that the core aim of public health policy should centre on creating a supportive environment enabling people to lead full and healthy lives. In a like and summary sense, Mahler (1988) to this end advocated a closing of the health gap between social groups and
between nations, a broadening of the possibilities of people to make healthy choices, and the establishment of supportive social environments. In particular however, four key areas for immediate action were identified at this conference: supporting the health of women; improving food security, safety, and nutritional value; reducing the use of tobacco and alcohol; and creating supportive social environments to underscore public health (WHO 1988).

In turn, the latter constituted the major theme of the Third International Conference on Health Promotion held in Sundsvall, Sweden, in 1991. This conference further highlighted four aspects of supportive public environments -- the social dimension, the political dimension, the economic dimension, and the need to recognize and utilise women’s skills and knowledge in all sectors to further public health (WHO 1991). It was especially significant however in highlighting the link between health promotion and the health or otherwise of physical environments.

Following more than eleven years of verification and refinement, the strategies set down in the original Ottawa Charter were still considered broadly relevant at the Fourth International Conference on Health Promotion held in Jakarta, Indonesia, in 1997. Nevertheless, by this stage many participants felt some review was timely, and that some reorientation was needed to attempt to meet new global health challenges, enmeshed importantly with the nature of urbanization, of ageing populations, and of increasingly global threats such as the occurrence and spread of HIV/AIDS at the end of the twentieth century. In turn, the 1997 Jakarta conference focused on partnerships in health, and
began to examine the processes of globalisation which were in interpretive terms increasingly coming to the fore (Baum 2002). Subsequently, the Jakarta Declaration identified five key priorities for the development of health promotion in the twenty-first century: promoting greater social responsibility in terms of health, bolstering investment in health development and advancement, expanding partnerships in terms of health promotion, securing the infrastructure of health promotion, empowering both communities and individuals, and further securing an infrastructure for health promotion (WHO 1997).

More recently still, the year 2000 set the stage for 'The Fifth Global Conference on Health Promotion: Bridging the Equity Gap', held in Mexico City, Mexico, which was specifically concerned with addressing the increasing divide in public health throughout the world, and that of underdeveloped and/or developing nations especially (WHO 2000). Most significantly, the Mexico Ministerial Statement on Health Promotion stressed the need for stronger human and institutional capacity building in order to ensure the effective implementation of health promotion, thus calling on all countries to prepare nationwide plans of action for promoting health (Baum 2002).

As may be evident from this brief history of health promotion conferencing during the late twentieth century, in coordinating each the World Health Organization has played a key role in facilitating international development vis-à-vis this important vehicle for public health. For in many ways, each conference manifests something of a step forward
in thinking about, and developing practical strategies to implement, the key objective of health promotion on an international scale.

**Health Promotion in Women’s Area**

Although women are the primary health promoters in many parts of the world, the inequity between women and men still exists. Thus the Second International Conference on Health Promotion identified supporting the health of women as a key area. Furthermore however, the United Nations itself has also sponsored four international conferences concerned specifically with women and women's development. The first of these -- the 'World Conference on Women', held in the Year of Women in 1975 in Mexico City, Mexico -- officially inaugurated a 'Decade for Women' which was to turn on the respective themes of equality, development, and peace. In turn, while the second International Conference on Women was held in Copenhagen, Denmark, in 1980 -- with overall themes of employment, health, and education -- the 'Decade for Women' culminated in a third international conference held in Nairobi, Kenya, in 1985, in which strategies for the advancement of women worldwide to the year 2000 were adopted, with a particular focus on the most vulnerable and underprivileged (Lund 1985).

Many such international women's conferences often bring over a hundred thousand women from around the world to establish agenda for women's advancement internationally. Indeed each of those aforementioned has drawn increasing numbers of women from NGOs in particular, who often inspire as well as learn from one another, and further form beneficial alliances and interrelations (Bolen 2004).
More recently, and as part of the fourth International Conference held in Beijing, China, in 1995, thirty thousand women attended a non-governmental organization's (NGO) forum in Huairou, while almost 17,000 people participated in the official United Nation's conference conducted in Beijing. A 'Platform for Action' established at this conference constituted a comprehensive plan stipulating action in twelve key areas impeding the advancement of women -- namely poverty, violence, structural economic factors, power sharing, health, education, training, marital and sexual rights, and political, economic, and social empowerment as a whole (Navarro 2004).

Since women’s health always links to powerlessness, these conferences all emphasized empowerment. In order to improve women’s health and gain better control of factors affecting their lives, it is necessary to empower women, especially disadvantaged women, to enable them to act in their own interests (Chu 1994a). While much of the Ottawa Charter is a dominant general influence on approaches to health promotion to the present (Richmond 2002), in terms of the strategies that might best serve migrant women in particularly, 'Empowerment' constitutes a framework especially suitable and apt.

Power is defined by Giddens as “the ability of individuals or groups to make their own concerns or interests account, even where other resist” (1993: 54). In general it could be said, power can be defined as the ability to influence others -- often acquired through access to scarce and/or important resources (Cleveland 2000) -- with power most importantly engendered through the process of empowerment itself (Allan 2003). While empowerment aims to reduce the number of people who are powerless (Baum 2002),
Israel et al. (1994:153) consider that “empowerment in its most general sense, refers to the ability of people to gain understanding and control over personal, social, economic and political forces in order to take action to improve their life situation”. More specifically, in health promotion empowerment constitutes a means by which people gain greater control over both those decisions and actions which affect their health (Health Promotion Glossary 1998), standing in this way for a social, cultural, psychological, or political process through which individuals or social groups become capable of expressing their needs, presenting their concerns, devising strategies for involvement in decision making processes, and achieving political, social, and/or cultural action to meet those needs (Health Promotion Glossary 1998).

Within this, essentially two dimensions constitute empowerment -- one involving the individual, and another the community as a whole. While the former refers primarily to an individual's ability to make decisions and have control over their personal life, the latter of course entails individuals acting collectively to gain greater influence and control over the determinants of health, and the quality of life as a whole, which affect their community (Health Promotion Glossary 1998). Labonte (1990:3) detailed the elements of personal empowerment as:

- Improved status, self-esteem, and cultural identity;
- The ability to reflect critically and solve problems;
- The ability to make choices;
- Increased access to resources;
- Increased bargaining power;
- The legitimation of people's demands by officials; and,
- Self-discipline and the ability to work with others.
Furthermore, while Benn (1997) has observed that a person's ability to gain control over their situation, or to change their circumstances, is centrally affected by their access to information, to decision making, to networks, and to other resources. Based on Benn’s findings Chu has developed an operational model of empowerment which has been implemented successfully in series of reproductive health in China (Chu 1994a). Chu (1996: 5) defined empowerment as “the process of enabling individuals and communities to gain access to information, networks, resources, and decision-making”. Thus the model consists of four key components: information, networks, resources, and decision-making. The 'Empowerment Action Framework' will be discussed in the following:

1) Information:
To help a community gain greater access to useful information, it needs to be assessed for its relevance to needs, delivered with effective methods of communication, and implemented appropriately once again vis-à-vis the use of language, cultural sensitivity, and so on.

2) Networks:
A supportive network is important to individuals enabling them to feel interrelated with others, to have a secure sense of belonging, and to stem feelings of isolation and/or alienation. More importantly, through networking people gain access to information, to resources, and to decision-making processes, all of which help them to control factors directly or indirectly related to their experience of health.
To help enable a community to enhance and cultivate networks, actions can include:

- establishing reference groups for community consultation;
- producing a community resource directory;
- supporting the formation of self-help groups and community clubs;
- producing a community newsletter;
- establishing community based programs in which volunteers attempt to reach isolated members;
- creating an environment and social functions conducive to social interaction and networking; and
- employing appropriate techniques sensitive to language, to cultural idiosyncrasies, and to differing customs and sets of ethics.

3) **Resources:**

The provision of a supportive environment, and the availability of human resources, money, time, equipment, space, and transport, remains vital. For programs demanding community change without a supportive environment and the necessary resources, are destined to failure. For example, community members often litter if there is no garbage bins available, hygiene practices become problematic if there is a shortage of water, utilisation rates will be low if health services are not user-friendly, and poor people may not be able to afford fresh foods if they become expensive.
4) **Decision Making:**

Allowing people to have a say in the decision-making process helps to create a sense of ownership and control, which in turn inspires voluntary, and often sustained community participation.

To enable a community to gain access to decision-making processes, measures can include:

- establishing an election process to choose who will occupy official positions;
- incorporating genuine community consultation into established decision-making processes;
- establishing community reference groups or advisory committees to deal with program planning, implementation, and evaluation; and
- conducting community needs assessment to identify local views and concerns.

In this way, while no one can effectively grant real power to another, people can assist one another to retain, or alternately regain a measure of empowerment. Moreover, and as Forster (1995) has surmised, through the latter people are more likely to become masters of their own health by being encouraged to:

- Express their feelings;
- Identify and set realistic goals for themselves as individuals and as members of groups and/or communities;
- Increase their knowledge and awareness of issues of health;
· Choose how to develop life-skills which promote health; and,

· Seek to influence and change their environment.

While these may be commendable goals however -- and in an Australian context of multiculturalism aiming to promote 'equitable participation' especially apt (National Health Strategy 1993) -- it is unlikely these can be achieved in the short term. And in terms of NESB migrants in particular, more than a decade ago the Poverty Commission in Australia identified four key problems -- communication breakdowns, inadequate access to services due to a lack of information, culturally inappropriate services and discrimination, and an inadequate involvement of migrants in improving health services (Chu 1998; Rice 1999; Bates and Linder-Plez 1990). Moreover, these problems it seems are no less common among Chinese migrant women today, the focus in sum of this research and its investigative concerns.

Nevertheless, health promotion is still gaining ground in the new millennium, and in particular there is a growing awareness among researchers that it is crucial to promote women's health given the inequities their findings reveal (Stanton et al. 2000). In sum, a health text dedicated specifically to women is imperative (Kolander et al. 1999), with Stanton et al. (2000) suggesting for example that a most useful conceptual model for promoting women's health should:

(1) Take into account the potential interaction between biological, psychological, and social factors which determine women's health;
(2) Include multifaceted outcomes incorporating both pathological and optimal indicators of health in manifold spheres such as the physical, psychological, and social; and,

(3) Be grounded in carefully developed theories that account for the diverse contexts of women's lives.

Furthermore, Remennick (1999) has also suggested that mainstream society pay greater attention to the cross-cultural differences in terms of gender roles, and develop effective measures for mitigating problems experienced by new immigrant women. For as Chu (2002) among others has noted, for many migrants it is crucial they integrate with Australian society without surrendering their cultural identity, while among many Australians furthermore, a healthy, multicultural society brings with it many benefits and incentives.

At the core of this, good health is a major resource for social, economic, and personal development, and an important dimension of course of quality of life. As migrant women's health is a major concern within this -- and as it has become an important and seemingly worldwide concern to develop appropriate and accessible health care systems which cater effectively for women -- the second part of this thesis will outline the research methodology applied in this study, and present in turn the research findings, which constitute together the practical investigative agenda of this thesis.
To sum up the theoretical framework, I have provide an illustrative chart in chapter 1, here, I shall conclude this part –part I by employing the same chart and applying the findings from literature review to it (see chart 2).

Chart 2: Theoretical Framework: Findings from Literature Review

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<thead>
<tr>
<th>Migration historical Factors</th>
<th>Social Factors</th>
<th>Cultural factors</th>
</tr>
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<tbody>
<tr>
<td><em>Downward mobility</em></td>
<td><em>Lack of social network</em></td>
<td><em>Traditional Chinese health beliefs and practices</em></td>
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<tr>
<td></td>
<td><em>Low social-economic status</em></td>
<td><em>Cultural conflicts between host and home countries</em></td>
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<th>Gender Roles</th>
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<tr>
<td><em>Role conflicts worsen by traditional Chinese culture twisted gender role expectation</em></td>
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</tbody>
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PRC-Born Migrant Women

Health
- General Health
- Reproductive Health
- Mental Health

Settlement Stressors

Needs
- Social needs
- Health needs
Settlement Stress and Health Needs of Migrant Women from the People’s Republic of China in Brisbane

Appropriate & Sensitive Strategies

Part II

Research Methodology and Research Findings

The investigative core of this study aims to define settlement stress, and consider the social and health needs of PRC migrant women in Brisbane. Its methodology utilizes a combination of methods, and it attempts to employ a culturally sensitive approach to their implementation. In this way, both qualitative and quantitative methods have been used to obtain in-depth data from PRC migrant women themselves, and secondary data from a broad literature review outlined in the preceding chapters; more specifically, quantitative data was obtained from the literature review and census data, and qualitative data gathered from key informant interview, focus group and in-depth interviews from the PRC-born migrant women detailing their relevant life experiences vis-à-vis migration, health, and stress.

Chapter seven begins this second part of the thesis by defining its research questions and outlining the research methodology employed in this needs assessment, while chapter eight in contrast provides a profile of recent PRC-born migrants, and especially women, in both Queensland and in Brisbane. The following chapter sets out the stakeholder
analysis and findings obtained from key informant interviews. In turn, chapter ten features data collected from PRC migrant women informants in terms of in-depth interviews and focus groups.

Chapter 7

Research Methodology

This chapter discusses the methodology and research design employed in this study. Firstly, it defines the research questions. Secondly, it presents the needs assessment model and methodological framework this study adopts. Thirdly, it explains how multiple methods are used for assessing the needs of PRC-born migrant women, and how a combined quantitative and qualitative approach is most appropriate for this study.

Research Questions

The aims of this investigative study are fourfold:

1. To identify historical, social, cultural factors which affect the PRC-born migrant women’s settlement in Brisbane through literature review;

2. To examine their settlement stress and social and health needs through both qualitative and quantitative methods;

3. To analyze these migrants' needs in terms of normative, expressed, comparative, and felt needs by using comprehensive needs assessment model; and,
4. To develop strategies to meet their needs and to improve their quality of life in Brisbane by using the health promotion strategies namely, as the empowerment framework and the Ottawa Charter action framework.

Given these objectives, the main research questions this study raises are as follows:

1. What are the historical, social and cultural factors underpinning PRC-born migrant women’s settlement experience?

2. What are their settlement stress and social and health needs?

3. What are the gaps in health services?

4. What effective strategies might realistically assist them in overcoming their problems, and meeting their most pressing needs above all?

Needs Assessment

If central to the investigative agendum of this study is a concern with the needs assessment, a brief synopsis of what constitutes this key facet vis-à-vis questions of health is necessary to further clarify its methodological focus and rationale.

Needs assessment can be defined in various ways. According to Witkin and Altschud (1995:4), it constitutes “a systematic set of procedures undertaken for the purpose of setting priorities and making decisions about programs or organizational improvement and the allocation of resources”. Alternately, for Reviere et al. (1996:6) it embodies “a systematic and ongoing process of providing usable and useful information about the needs of the target population, to those who can and will utilize it to make judgments
about policy and programs”. At its core, needs assessment remains a tool vital to purposeful health planning and management, providing information indispensable to effective planning and decision-making, facilitating good community participation by involving communities in the decision making process, and helping to prevent costly mistakes (Chu 1994).

To return to the core notion of needs per se however, McKillip (1987:10) has suggested it importantly entails a “value judgment that some group has a problem that can be solved”, thus the concept of values themselves elevates the question of needs onto another level altogether (Reviere et al. 1996). As these latter among others have pointed out in fact, “values are ideas about what is good, right, and desirable” which, while remaining fundamentally abstract, nevertheless form “a central basis for judgment and behaviour”, and underscore in turn that “gap between the real and ideal conditions … acknowledged by community values and potentially amenable to change” (Reviere et al. 1996:5). What this entails is that actual and ideal needs can often be mutually far removed, and that the question of community members optimising their health and wellbeing requires some negotiation and clarification of the respective character of both.

Nevertheless, and broadly speaking of course, community needs in terms of health can best perhaps be defined as “those states, conditions or factors in the community which, if absent, prevent people from achieving … optimum physical, social and mental health” (Hawe et al. 1990:7). Moreover, while there have been many attempts to define different types of needs, a central contribution in the area of public health remains that of Bradshaw (1972). For in his appraisal, needs might best be separated and identified in
accord with four key categories -- the normative, felt, expressed, and comparative -- and respectively summarised according to Robinson and Elkan (1996) as follows.

**Normative** needs constitute what the expert, professional, or administrator defines as a need in some particular situation, and may change as a result of developments in both knowledge and shifting values. Fundamentally, normative needs reflect the value judgments of professionals and experts.

**Felt** needs are defined by community members themselves, in which the requirement or otherwise for services is determined by asking people if they feel a need for them. In turn, felt needs embody the values of individuals within communities.

**Expressed** needs are essentially felt needs translated into action. In short, such expressed needs are evinced when community members demand services or facilities.

**Comparative** needs finally are those revealed through the study of recipients of a service, approaching needs through an assessment of the differences in services and facilities between comparable geographic areas.

To qualify of course, as normative needs are those defined by professionals, many are prone to be paternalistic; felt needs may well represent wants rather than genuine needs; expressed needs can often translate merely into demands; and comparative needs illustrate only the differences in terms of service between two comparable groups.
(Reviere et al. 1996). In sum however, these four types of needs provide a useful framework to underpin needs assessment studies.

**Methodological Framework**

In order to understand social and health needs as well as the stress encountered by PRC-born migrant women in Brisbane, a needs assessment framework needed to be developed and this is presented in Chart 3. And in order to identify issues at the core of their social and health needs in their settlement process, the researcher employed qualitative as well quantitative methods involving in-depth data obtained from individuals and secondary data obtained in censuses.

As indicated in Chart 3, this study involved four phases. Phase I was consisted of two components – the identification of stress in the settlement process and the social and health needs for dealing with such stress through a literature review, and also via a stakeholder analysis with empirical data. In turn, Phase II constituted the needs assessment, Phase III involved data analysis and data interpretation, while phase IV constituted the study's concluding recommendations.

This study was conducted from July 2001 to July 2004. The timeline was divided into four phases:

Chart 3: Methodological Framework of the Study

Phase I
Settlement Stress Issues & Needs Identification

Phase II
Literature Review & Stakeholder Analysis & Data Collection

Phase II

Normative Needs
- Secondary data analysis
- Key informant interview

Comparative Needs
- Secondary data analysis

Expressed Needs
- Secondary data analysis
- Key informant interview

Felt Needs
- Focus group
- In-depth interviews

Phase III
Data Analysis
In order to assess social and health needs of PRC-born migrant women, the use of a variety of methods of data collection has been deemed most appropriate. Moreover, and according to Brewer and Hunter (1989) in fact, the benefits of using multiple methods can be numerous, with Little (1991) also advocating the merits of what he termed 'methodological pluralism'. Indeed for the latter the social sciences should be seen as a variety of differing and yet related enterprises, encompassing in turn a diversity of areas and methodologies as opposed to pigeonholing their investigative potential to a restricted set of doctrinal approaches.

In employing a variety of methods in turn, this study aims not merely to obtain a comprehensive picture of PRC-born migrant women in Brisbane, but one founded on a sound methodological basis to bolster the accuracy and quality of data collected. To this end, while in-depth interviews form an important basis for the latter, these importantly require further verification and clarification through the supplemental use of focus groups; moreover, the consistency and reliability apparent or otherwise in both, also benefits from an ongoing reconsideration of secondary data during the process of new data collection.
Quantitative and Qualitative Methods

This study employed both quantitative and qualitative methods of inquiry. While the former derives from a positivist approach to epistemology that asserts there is an objective reality which can be expressed numerically -- with many quantitative approaches as a consequence being experimental in nature, and preoccupied with measurement and correlation (Glatthorn 1998) -- the latter emphasize a phenomenological stance which advocates the value of sensory perception, and often focus in turn on the meanings of recurrent situations (McMillan 1996).

In particular however, qualitative methods offer the opportunity to probe an issue or question in depth, and to explore respondents' views and perspectives in their own terms and from their own point of view (Berkowitz 1996). In this way, qualitative research has long been considered the most effective means to revealing the context in which people attribute meaning to their experiences, and the implications and impact these experiences have on their lives (Rice and Ezzy 1999). Moreover, a qualitative approach is especially apt at exploring the viewpoints of persons and groups whose assumptions differ from those of mainstream culture, and who have a particularistic viewpoint, and perhaps also set of needs (Berkowitz 1996). Not surprisingly, when properly implemented qualitative methods can play an indispensable role in research on migrants and migration.

Qualitative methods are particularly important to the public health system, and since the 1980s especially research methods have been progressively broadened, and the position of epidemiology as the core method of public health increasingly challenged. Within this,
qualitative methods have emerged to become more widely used in public health research (Baum 2002), their usefulness aptly surmised by Baum (1995:464):

To explain the economic, political, social and cultural factors which influence health and disease; to gain an understanding of how communities and individuals within them interpret health and disease; and to study interactions between the various players who are relevant to any given public health issue.

Moreover, the National Health and Medical Research Council (NH&MRC 1995:13) have further defined four key objectives of qualitative research methods in relation to public health:

- To study and explain the economic, political, social, and cultural factors that influence health and disease in more depth ways than is possible through a survey or through other quantitative methods. For example, surveys can tell us how many people participate in community activities in a given community, yet interviews are needed to explain why they take part in such activities;
- To understand how people interpret health and disease and make sense of their experiences;
- To elaborate causal hypotheses emerging from epidemiological and clinical research; for example, experimental and quasi-experimental research explains the link between tobacco smoke and lung cancer, yet not why people continue to smoke despite evidence about the adverse health effects; and,
- To provide contextual data to improve the validity and cultural specificity of quantitative survey instruments.

There are in sum three kinds of qualitative data (Patton 1990, cited in Baum 2002:164). Firstly, in-depth open-ended interviews with individuals or groups; secondly, direct observation and description of people's activities, behaviours, actions, and interactions, with this including the analysis of audio and videotaped material, written data such as excerpts, quotations, or entire passages from organisational, clinical, or program records,
as well as of personal diaries, official records, and publications; and thirdly, open-ended written responses to questionnaires. The main methods used to collect these data are case studies, participant observation, and in-depth interviews and focus groups. In the study undertaken here, the last two methods figured centrally.

At the same time, and notwithstanding the many differences between qualitative and quantitative methodology, Morgan (1997) for example notes that these two approaches can be employed in tandem in four essential ways, termed the quantitative primary/qualitative first; the quantitative primary/quantitative first; the qualitative primary/quantitative first; and the qualitative primary/qualitative first. For combining qualitative and quantitative approaches in the same study benefits from the respective advantages of achieving greater depth and breadth, greater understanding and the capacity to infer, a greater intimacy with contexts overall, and standardization across relevant settings (Berkowitz 1996).

In the first stage of the data collection, quantitative method uses secondary data analysis only to develop a profile of the PRC-born migrant women in Brisbane and Queensland. It provides an overview of the demographic and social-economic characteristics together with a description of resources available in the community.

Following the review of recent and relevant literature, interviews with key informants were conducted to strengthen the identification of normative and expressed needs,
followed by the organization of a focus group and the implementation of in-depth interviews.

Based on methodological framework, a stakeholder analysis was conducted at the beginning of the needs assessment to familiarise with the key issues encountered by PRC-born migrant women in Brisbane.

**Stakeholder Analysis**

As an important research technique employed at the beginning of many needs assessment studies, a stakeholder analysis was firstly conducted to familiarize with the key issues and background pertinent to the group in question. In this way, stakeholder analysis may be defined as a means to identify with the key stakeholder groups within a community, and indicate their respective roles, interests, and how these may be pertinent to subsequent planning and implementation (Chu and Harris 2003). Stakeholder analysis provides a starting point for collaboration by identifying the community groups to be worked with, the mechanisms through which this might best occur, and the operational circumstances within the community.

A community's key stakeholders can include individuals, groups, or more broadly institutions, and constitute a subset of the larger audience of the findings which, in turn, comprises the totality of all those with some stake in the needs assessment study (Reviere *et al.* 1996). Indeed in order to be successful, a program should aspire to involve as many 'interested' parties on as many levels as possible.
There are four key functions as well as roles of stakeholder involvement: the exchange of information, working interactively on problems, assuring that public views are taken into account, and ensuring that legal requirements or social norms are satisfied (John and Meiller 1987; Reviere et al. 1996).

Stakeholder analysis employed in this study aims to provide information on the general problems PRC-born migrant women face, as well as any existing services or otherwise they access and/or need. A total of eight informants came from main stakeholders were invited to participate in key informants interviews. Their characteristics will be described in chapter nine.

**Focus Groups**

Focus groups aim to describe and understand the perceptions, interpretations, and beliefs of a group of people in order to properly comprehend certain issues and questions from the perspective of their participants (Khan and Manderson 1992). The emphasis of the focus group interview is on the interaction between participants in the group (Rice and Ezzy 1999). As a research technique, focus groups are now commonly used in health promotion needs assessment (de Koning and Martin 1996), as well as in both exploratory and theory-building research within the area of public health (Baum 2002).

More often than not, a focus group constitutes the interview of, and/or a discussion with, up to ten people on a certain select topic (Chu 1994), enabling a fuller and more in-depth range of issues to be grasped through the medium of group discussion. Usually, this
group of people come from similar social and cultural backgrounds or shares particular areas of concern (Rice and Ezzy 1999).

A focus group interview can provide a rich and detailed set of data about perceptions, thoughts, feelings, and impressions of people in their own words (Stewart and Shamdasani 1990: 140). Importantly, many of the results obtained in focus group meetings can seldom be achieved through the interviewing of individuals (Ip and Lui 1999). For this reason especially, focus groups constituted one of the key methods employed in this study.

A total of seven PRC-born migrant women were obtained to conduct the focus group interview. All the participants were obtained through researcher’s personal network. All of them firstly entered Australia as students. All of them hold both Chinese and Australian degrees. Their ages were between 28 and 35. Since these participants had similar social and cultural background and similar experiences, this group was a homogeneous group. These women were all researcher’s friends, the focus group interview was conducted at researcher’s home to let them feel comfortable talking to each other and talking freely. The discussion had taken one and a half hours.

The purpose of conducting focus group interview in this study is to encourage PRC-born migrant women who firstly entered Australia as students to express their views in subtle yet direct manner. Through their participation that effective and appropriate strategies to address needs can be developed. The limitation of this focus group was that information
gathered could only represent the perspectives of the participants. Although focus groups can generate in-depth information, they cannot explore the complex beliefs and practices of an individual person, as can be obtained from and in-depth interview (Rice and Ezzy 1999: 92). Following this focus group interview, thirty in-depths interviews were conducted.

**In-Depth Interviews**

Interviewing constitutes one of the most common and effective methods utilized by researchers to comprehend human affairs (Fontana and Frey 1994). At the same time, interviews can in fact take many forms -- from highly structured ones proceeding on a predetermined set of questions, to semi-structured and unstructured ones where no questions are established beforehand. In qualitative research of course, the standard form of interviewing tends to be unstructured or semi-structured and in-depth (Chu 1994), characterized in short by “asking questions, listening, expressing interest and recording what was said” (Neuman 1999:371).

All told, in-depth interviewing is one of the most widely applied methods of data collection. According to Taylor and Bogdan (1984:77), in-depth interviews are “repeated face-to-face encounters between the researcher and informants directed towards understanding informants’ perspective on their own lives, experiences, or situations as expressed in their own words”. Not surprisingly, the in-depth interviewer must endeavour to promote an atmosphere of trust and rapport so that respondents feel sufficiently at ease to reveal their knowledge and/or experiences (Neuman 1999). Nevertheless, and when conducted properly, in-depth interviews are an important means
to gain fruitful perspectives on women's experiences in ways that more structured forms cannot (Olesen 1994).

In turn, and rather than developing a specific interview schedule -- or alternately none at all -- Burns (1997) has suggested that an interview guide may be developed in which only specific themes are established to help direct the interview in a meaningful way. In doing so, this still permits an important degree of flexibility, as well as more spontaneous and valid responses from informants. In this study, face-to-face, semi-structured in-depth interviews were carried out which turned to begin with on predetermined, structured questions designed to encourage a level of rapport and trust. This was followed however by the use of flexible questions aiming to realise spontaneous reactions, and instigate a flow of ideas and comments from informants.

Furthermore, Oakley (1981) points out that there is in fact 'no intimacy without reciprocity' in interviewing, which includes believing the interviewee, a commitment from the researcher to enter into a relationship, and willingness on the part of women to participate with sincerity in female interviewing. Moreover, in-depth interviewing is a skilled process that can only really be carried out by people who are familiar with the research purposes and aims, which usually means the researchers also responsible for most of the analysis and writing (Baum 2002).

In sum, and according to Glesne and Peshkin (1992), the factors that more often contribute to successful interviewing include anticipation, establishing a rapport, taking a
naive position, being analytic, being paradoxically bilateral, and patiently probing.

Finally, and this as Seidman (1991:56) has noted, “the hardest work for most interviewers is to keep quiet and to listen actively”, hence one of the most important skills an interviewer must learn and implement is that of remaining silent (Rice and Ezzy 1999). As interviewers should strive to avoid introducing bias into responses themselves, it is essential they interject little and do not encourage certain responses over others.

A total of 30 PRC-born migrant women constituted the in-depth interviewees of this study. All respondents were aged between 30 and 50 years. In order to ensure successful interviews in this study in turn, a natural and comfortable environment for informants was essential. For this reason, all interviews were conducted at the homes of informants, while to further encourage an easier, more spontaneous and natural, and better articulate flow of ideas, interviews were conducted in Mandarin guided by some sample questions (see appendix 1). Each interview took between one and two hours. Most informants were interviewed once, however, several of them were visited for a second time to obtain more information.

All those who participated in the study were born in the PRC, and resident in Australia from four to fifteen years. The majority of informants were married, while one alone had never married, six were divorced, and one was widowed. Of the former, five had married in Australia, with the remainder marrying in the PRC, and all but two of their spouses were also born in the PRC. Also, none of the respondents had large families, with five having no children at all, another fourteen a single child, ten with two children, and one
with three. A third had had their children while still in the PRC, with only nine giving birth in Australia; for the rest, their children were born in both the PRC and Australia.

In terms of education, the majority (15) held bachelor's degrees, while a further eleven also held a post-graduate degree; the remainder had obtained some form of undergraduate diploma. Among the respondents, nine had obtained their highest degree in Australia. Most informants (24) had entered Australia under the 'independent migrant' category, and only five had done so without their husbands. Six had migrated to Australia under the 'family reunion' category.

While none of the participants held religious beliefs while living in the PRC, a third converted to Christianity after migrating to Brisbane, and attended church on a weekly basis. The majority however stated no religious affiliation whatsoever. Finally, in terms of accommodation the majority of informants either owned a property, or were in the process of buying their own home; only eight still rented.

As aforesaid, almost all of these informants were accessed through a snowballing approach to sampling, which offered the most reliable and appropriate means available given the lack of any alternate sampling frame for recent PRC-born migrant women in Australia. Known also as chain referral, snowballing turns of course on obtaining suitable respondents by successively asking each to nominate others as potential informants (Biernacki and Waldorf 1981). As a technique it is most productive when eligible members are readily identifiable and know others who fit the criteria defining the
study, when the relationship between respondents is clearly unambiguous, and of course when respondents are open and cooperative (Rissel and Khavarpour 1999).

The use of snowball sampling technique was intentional as an appropriate sampling frame of recent PRC Chinese migrant women is not readily available. However, the sample that results may have distinctive characteristics that should be taken into account. The characteristics of the initial respondent or respondents will shape the structure of the sample (Rice and Ezzy 1999: 45). In this way, it should be noted that the samples obtained in this study may not be consummately representative of the PRC-born migrant population in Australia as a whole, and given that the sampling method employed was not random, that the findings are not productively open to widespread generalisation.

While a limitation of the research implemented here, this study aims to redress some of the many gaps in research on migrants and health in Australia, and may if anything best stimulate further inquiry into this important area of public health.

**Validity and Reliability**

Traditionally reliability concerns with replicability. In this research, reliability, however, is less about replicability than dependability, that is, whether the research results would make sense and generally agreed upon. Hence, in improving reliability, the researcher made every effort to ensure her potential personal biases were minimised, and the data collection process rigorous and well thought out so that the steps and procedures used in the research could be replicated by others in future comparative studies. As Baker (1999) commented,

In terms of reliability, there is concern about the trustworthiness of the data being gathered, which can become
more dependable if the researcher has kept careful notes and audit trail.

In terms of validity, the major concern researchers face is whether the research instrument employed would be able to measure what it intends to investigate accurately to reflect 'reality'. However, according to Baker (1999), some researchers argued that qualitative research, because it stays closer to the real meaning of social existence than research that produces numerical findings, has higher validity, they reject validity as a goal of the social world, and they also claim that validity is impossible to produce. Nonetheless, it is still necessary for researchers to ascertain their attempts in data gathering, particularly when they employ triangulation or multi-methods, to ensure there is some convergence of the data. Of course it is difficult to gauge whether what researchers set out to measure actually reflect people’s perceptions and notions of the world, or what appears to be true, rather than what actually is true. It is in this context that the employment of multi-methods in this study is helpful for checking the responses of participants and the interpretations they make. Furthermore, as a measure to increase validity of the data, the interviewing questions were piloted at least three times prior to the interviews were carried out.

Secondary Data Analysis

Given the small size of the samples, the limitation of the research is obvious—the finding could not be seen as a generalization of the recent Chinese migrant women in Brisbane. For this reason, the issue of reliability and validity needed to be checked against by a secondary analysis (Neuman 1999: 35). This was conducted by comparing findings from the interviews against a profile of PRC migrant women compiled from existing Census data as well as with data from recent studies related to PRC migrant women in Brisbane and several publications on other groups of Asian immigrants.
Data Analysis

The purpose of analysing data of course is to derive some meaning from what it provides, a process involving the systematic arrangement and presentation of information so that comparisons, contrasts, and insights might be both deduced and in turn demonstrated (Burns 1997). Within this, the first stage involves coding, in which material is classified according to certain themes, issues, topics, concepts, and/or propositions (Burns 1997), something achieved in qualitative research vis-à-vis grounded theory (Strauss and Corbin 1990). While the codes are established to summarise, synthesise, and sort out the tics of informants' responses (Charmaz 1994), themes, concepts, and other meanings are also constructed, classified, and preferably examined in detail (Burns 1997).

The process of coding is at the heart of ground theory and thematic analysis (Rice and Ezzy 1999). Coding represented the operations by which data are broken down, conceptualised, and put back together in new ways (Strauss and Corbin 1990: 57). Strauss and Corbin (1990) describe three main coding procedures: opening coding, axial coding and selective coding. Open coding involves comparisons between events, action and interactions (Rice and Ezzy 1999: 195). During opening coding the data are broken down into discrete parts, closely examined, compared for similarities and differences, and questions are asked about phenomena as reflected in the data ((Strauss and Corbin 1990: 62). Once open coding has been done, next stage-axial coding has been developed. Axial coding puts those data back together in new ways by making connections between a category and its sub-categories ((Strauss and Corbin 1990: 97). Selective coding is the last stage. The process involved in selective coding are much more the same as in axial
coding, but at a higher level of analysis. Thus, the process of selecting the core category, systematically relating it to other categories, validating those relationships, and filling in categories that need further refinement and development (Strauss and Corbin 1990: 116). Just as same as the study done by Rice and Watson (2002: 305), this study employed a thematic analysis approach to derive patterns in the informants’ responses. The transcripts were examined for explanations relating to the concept concerned. First, all transcripts were read through in order to examine emerging themes. These initial themes were then re-examined for consistency and clarify and from these, the several themes derived were presented. Verbatim quotations were used to illustrate responses on relevant themes.

To sum up the methodology, Table 7.1 presented the relationship between types of needs and needs assessment methods adopted in the study.
## Table 7.1: Relationship between Four Types of Needs and Needs Assessment

### Research Methods

<table>
<thead>
<tr>
<th>Needs Type</th>
<th>What</th>
<th>Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Quantitative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Qualitative</td>
</tr>
<tr>
<td><strong>Normative needs</strong></td>
<td>Experts’ opinion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Standard (such as Pap smear and Breast screen)</td>
<td>Secondary data analysis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Key informant interviews</td>
</tr>
<tr>
<td><strong>Comparative needs</strong></td>
<td>Needs of Hong Kong and Taiwan Chinese communities and migrant women from Thailand in Brisbane</td>
<td>Secondary data analysis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Expressed needs</strong></td>
<td>Health and community services use records and Epidemiological data</td>
<td>Secondary data analysis</td>
</tr>
<tr>
<td></td>
<td>Experts’ observation of service utility</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Key informant interviews</td>
</tr>
<tr>
<td><strong>Felt needs</strong></td>
<td>PRC-born migrant women’s own experiences and views</td>
<td>Focus group and In-depth interviews</td>
</tr>
</tbody>
</table>
Ethical Considerations

In conducting this research, the researcher was required to follow a set of guidelines for ethical clearance as set out by the University. This included the consideration of issues related to consent, confidentiality, and freedom to withdraw from the study, risk assessment and security of data storage. Specifically, informants of this study were first approached by a telephone call to obtain their consent for participating in the study. Appointments were made only after their informed consent has been obtained. At the beginning of the interview, informants were briefed of the objectives and aims of this research. They were reassured of confidentiality of the research as well as their identity. At the end of the transcriptions, the original recording of all interviews had been destroyed so that the true identity of informants are protected and cannot be traced. They were also assured that they would not be physically and mentally endangered. Identities, locations of individuals and places are concealed in published results. The data collected has also been stored in the university server accessible only by the researcher. Ethical clearance has been obtained and granted from Griffith University Human Research Ethics Committee and that the research was conducted in accordance with the protocol granted (PBH/01/03/hec).

Summary

This chapter has defined the research questions of the study, and outlined the methodology employed in their investigation. Quantitative data has been used to provide a social and demographic profile of PRC-born migrant women. Furthermore, and in order to obtain a detailed picture of how these people experience and explain their world,
key informant interviews, focus groups and in-depth interviews were all employed, as qualitative research helps explain why people behave as they do, as well as how historical, social, and cultural factors come to impact upon their health.

The next chapter aims to provide a community profile of PRC-born migrants, and especially female migrants in Brisbane and Queensland, through which we can deduce a socio-economic and demographic picture of the PRC-born community more generally, and PRC-born women in particular.
Chapter 8

Community Profile

This chapter establishes a socio-demographic profile of PRC-born migrants in Queensland and in Brisbane, contrasting and drawing comparison in particular between migrants, and especially female migrants within this group, with those which emanate from either Hong Kong or Taiwan. Through the community profile, the social-economic characteristics of PRC-born migrant women can be ascertained.

The number of PRC-born Chinese in Queensland has been relatively insignificant until recent years. In the 1996 census, of the 3,368,854 persons resident in Queensland 0.2 percent (7,268) were born in mainland China, with 53.3 percent females (ABS 1998a). Furthermore, a majority of the PRC-born migrants -- 5,432, or 74.7 percent of all PRC-born Chinese in Queensland -- live in Brisbane (see Table 8.1).

<table>
<thead>
<tr>
<th>Year of Arrival</th>
<th>Queensland No</th>
<th>Queensland %</th>
<th>Brisbane No</th>
<th>Brisbane %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-1981</td>
<td>2,341</td>
<td>33.1</td>
<td>1,334</td>
<td>29.6</td>
</tr>
<tr>
<td>1981-1985</td>
<td>616</td>
<td>8.7</td>
<td>390</td>
<td>8.7</td>
</tr>
<tr>
<td>1986-1990</td>
<td>1,929</td>
<td>27.2</td>
<td>1,294</td>
<td>28.7</td>
</tr>
<tr>
<td>1991-1992</td>
<td>699</td>
<td>9.9</td>
<td>470</td>
<td>10.4</td>
</tr>
<tr>
<td>1993-1994</td>
<td>563</td>
<td>7.9</td>
<td>377</td>
<td>8.4</td>
</tr>
<tr>
<td>1995-1996</td>
<td>787</td>
<td>11.1</td>
<td>561</td>
<td>12.5</td>
</tr>
<tr>
<td>Not Stated</td>
<td>148</td>
<td>2.1</td>
<td>80</td>
<td>1.8</td>
</tr>
<tr>
<td>Total</td>
<td>7,083</td>
<td>100.0</td>
<td>4,506</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: 123

In more specific terms, and in key respects to begin with, migrant women from the PRC differ importantly from Hong Kong, Taiwanese, and South East Asian Chinese. Firstly, most PRC-born migrant women enter Australia under the family reunion category, and most are of an older age group when compared to other Chinese migrant women; within this group, a higher proportion (20.5 percent) are aged 65 and over, while a lower proportion (4.3 percent) are aged 14 or under (see Table 8.2). In comparison, Hong Kong migrant women have a younger age structure, with this community strongly represented by young adults and young dependent children -- in 2001, only 17.5 percent of Hong Kong migrant women were aged 45 or over (Zhao 2002). Similarly, and according to the 1996 census, the Taiwanese migrant population has also been dominated by young adults, with a total of 78.3 percent aged between 15 and 49 (Walmsley et al. 1999). In contrast, in 2001 the median age of PRC-born migrants as a whole was 40.9 years -- compared with 35.6 years for all Australia -- with the corresponding age of Hong Kong-born and Taiwan-born at averages of 33.9 and 26.2 years respectively (ABS 2003a).

<table>
<thead>
<tr>
<th>Age Group (Years)</th>
<th>No</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>18</td>
<td>0.5</td>
</tr>
<tr>
<td>5-14</td>
<td>149</td>
<td>3.8</td>
</tr>
<tr>
<td>15-24</td>
<td>212</td>
<td>5.5</td>
</tr>
<tr>
<td>25-44</td>
<td>1,546</td>
<td>39.9</td>
</tr>
<tr>
<td>45-64</td>
<td>1,159</td>
<td>29.9</td>
</tr>
<tr>
<td>65+</td>
<td>793</td>
<td>20.5</td>
</tr>
<tr>
<td>Total</td>
<td>3,877</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Secondly, as those who arrived in the late 1980s had few financial resources -- with this further confirmed in the 1991 census -- over half of the PRC-born migrants lived in rental accommodation; in contrast, over two-thirds of the Hong Kong and Taiwan-born Chinese lived in dwellings they either owned, or were in the process of purchasing (Coughlan 1998).

Thirdly, in 1996 close to half (44.1 percent) of all PRC-born migrant women aged fifteen years or over held some form of post-secondary qualification. Moreover, the proportion of these with tertiary qualifications, whether a Higher Degree, Postgraduate Diploma, Bachelor Degree, Undergraduate Diploma, or Associate Diploma, was 28.5 percent -- significantly higher than the Australian population as a whole (at 16.7 percent), as well as other overseas-born persons. Nevertheless, females had lower levels of education than their male counterparts; among those aged 15 years or over, 30.7 percent had higher qualifications, or some form of skilled vocational qualification, well below their male counterparts at 40.7 percent. This being said, and for those without higher qualifications, more females than males were enrolled in some form of further education -- 46.2 percent for the former, as opposed to 39.4 percent for the latter (see Table 8.3).
Table 8.3: Qualifications of PRC-Born Female Migrants in Australia in 1996 (Aged 15 years or over)

<table>
<thead>
<tr>
<th>Level of Qualification</th>
<th>No (Female)</th>
<th>%</th>
<th>No (Male)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher Degree</td>
<td>1,537</td>
<td>2.9</td>
<td>3,298</td>
<td>6.7</td>
</tr>
<tr>
<td>Postgraduate diploma</td>
<td>623</td>
<td>1.2</td>
<td>557</td>
<td>1.1</td>
</tr>
<tr>
<td>Bachelor Degree</td>
<td>7,102</td>
<td>13.2</td>
<td>8,614</td>
<td>17.5</td>
</tr>
<tr>
<td>Undergraduate Diploma</td>
<td>3,004</td>
<td>5.6</td>
<td>2,264</td>
<td>4.6</td>
</tr>
<tr>
<td>Associate Diploma</td>
<td>3,014</td>
<td>5.6</td>
<td>2,586</td>
<td>5.2</td>
</tr>
<tr>
<td>Skilled Vocational</td>
<td>1,164</td>
<td>2.2</td>
<td>2,738</td>
<td>5.6</td>
</tr>
<tr>
<td>Basic Vocational</td>
<td>796</td>
<td>1.5</td>
<td>512</td>
<td>1.0</td>
</tr>
<tr>
<td>Not Stated</td>
<td>6,483</td>
<td>12.1</td>
<td>5,149</td>
<td>10.4</td>
</tr>
<tr>
<td>Total Qualified</td>
<td>23,723</td>
<td>44.1</td>
<td>25,718</td>
<td>52.2</td>
</tr>
<tr>
<td>Attending educational</td>
<td>4,847</td>
<td>9.0</td>
<td>3,901</td>
<td>7.9</td>
</tr>
<tr>
<td>institution</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not attending educational</td>
<td>24,804</td>
<td>46.2</td>
<td>19,400</td>
<td>39.4</td>
</tr>
<tr>
<td>institution</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total No qualification</td>
<td>29,651</td>
<td>55.2</td>
<td>23,301</td>
<td>47.3</td>
</tr>
<tr>
<td>Not Stated</td>
<td>359</td>
<td>0.7</td>
<td>264</td>
<td>0.5</td>
</tr>
<tr>
<td>Total</td>
<td>53,733</td>
<td>100.0</td>
<td>49,283</td>
<td>100.0</td>
</tr>
</tbody>
</table>


According to the 1996 census, most PRC-born migrants in Brisbane resided in the southern suburbs around Sunnybank Hills, Runcorn, Sunnybank, and MacGregor -- an area also favoured by Hong Kong and Taiwanese migrants (see Table 8.4).

Table 8.4: Top Ten Suburbs of Residence for PRC-Born Female Migrants, Brisbane 1996

<table>
<thead>
<tr>
<th>Suburbs</th>
<th>Number (Females)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunnybank Hills</td>
<td>117</td>
</tr>
<tr>
<td>Runcorn</td>
<td>84</td>
</tr>
<tr>
<td>Sunnybank</td>
<td>61</td>
</tr>
<tr>
<td>MacGregor</td>
<td>61</td>
</tr>
<tr>
<td>Eight Mile Plains</td>
<td>60</td>
</tr>
<tr>
<td>Carindale</td>
<td>55</td>
</tr>
<tr>
<td>Robertson</td>
<td>48</td>
</tr>
</tbody>
</table>
In terms of English proficiency, and according to the 1996 census, 49.2 percent of PRC-born migrant women in Queensland aged five years or over spoke English either 'not well' or 'not at all'. This was comparable to those living in Brisbane, with 43.9 percent of PRC-born migrant women speaking almost no English, or speaking it poorly. Although it should also be noted that 55.7 percent reported they could speak English 'very well' or 'well' -- with a small number stating that they spoke only English at all times -- the census data still revealed that English proficiency among PRC-born Chinese was far behind their Hong Kong and Taiwanese compatriots, with 74.4 percent of the former and 65.4 percent of the latter speaking English either 'very well' or 'well' (Walmsley et al. 1999) (see Table 8.5).

<table>
<thead>
<tr>
<th>English Proficiency</th>
<th>Queensland</th>
<th>Brisbane</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speaks English Only</td>
<td>4.9</td>
<td>4.1</td>
</tr>
<tr>
<td>Very well and Well</td>
<td>44.8</td>
<td>51.6</td>
</tr>
<tr>
<td>Not Well</td>
<td>31.7</td>
<td>29.6</td>
</tr>
<tr>
<td>Not At All</td>
<td>17.5</td>
<td>14.3</td>
</tr>
</tbody>
</table>

Sources:

As aforesaid, most PRC-born migrants have fewer financial resources than the Chinese from Hong Kong or Taiwan. In some ways, the fact that many had little previous experience in a free-market economy outside the PRC may explain the low self-employment rate of PRC-born migrants in 1991 (Pitt 1996) (see Table 8.6). Furthermore,
an overwhelmingly large proportion of PRC-born migrant women (83.1 percent) were
employed as wage/salary earners.

Table 8.6: Employment Status (%) of PRC-Born Migrants in 1991

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wage/salary earner</td>
<td>81.6</td>
<td>83.1</td>
</tr>
<tr>
<td>Self-employed</td>
<td>8.8</td>
<td>8.6</td>
</tr>
<tr>
<td>Employer</td>
<td>9.0</td>
<td>6.4</td>
</tr>
<tr>
<td>Unpaid helper</td>
<td>0.6</td>
<td>1.9</td>
</tr>
</tbody>
</table>

Source: ABS, 1991 Census, Table No. CSC6035

In terms of unemployment, and in comparison to other Australian states, the rate for
PRC-born migrants in 1991 was lowest in Queensland at 12.5 percent (BIPR 1994). Ten
years down the track the unemployment rate for this group had dropped to 10.2 percent --
still significantly higher however than the national average of 7.4 percent, as well as the
average for Hong Kong-born migrants at 7.7 percent (ABS 2003a). Between these years
however, 1996 saw an unemployment rate of 7.7 percent for PRC-born migrants in
Australia, while Queensland was lower at 6.2 percent (Zhao 2000). Moreover, in this
year the unemployment rate of females in Brisbane was 5.8 percent, which stood
significantly lower than that for males at 7.2 percent (see Table 8.7). In key ways
perhaps, this may be due to the fact that PRC-born women are often prepared to take any
job than stay unemployed, regardless of how dissatisfying it might be.

Table 8.7: Labour Force Status of PRC-Born Migrants, by Sex, in Australia and Brisbane in 1996 (Persons aged 15 years and over)

<table>
<thead>
<tr>
<th></th>
<th>Australia</th>
<th>Brisbane</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour Force Status</td>
<td>Males(%)</td>
<td>Females(%)</td>
</tr>
<tr>
<td>Employed</td>
<td>58.3</td>
<td>37.4</td>
</tr>
<tr>
<td>Unemployed</td>
<td>7.7</td>
<td>7.2</td>
</tr>
</tbody>
</table>
According to the 2001 census, of those PRC-born migrants who were employed 20.3 percent worked in an unskilled occupation. In contrast, the corresponding rate for the total Australian population, for the Hong Kong-born, and for Taiwan-born migrants, was 18.6 percent, 11.4 percent, and 15.3 percent respectively (ABS 2003a). In Queensland, many PRC-born women held positions in intermediate clerical, sales, and service work, in intermediate production and transport work, as well as in elementary clerical, sales, and service work; alternately, in 1996 only sixteen percent worked as labourers or in some related type of work (see Table 8.8).

Moreover, although most PRC-born women hold low status, unskilled, blue-collar occupations, the number of those holding highly skilled, professional jobs also increased during the 1990s. For example, in 1996 more than 35 percent were employed in either professional or associated professional positions. At the same time, and in general terms, while their occupational status still remained lower than that of their male counterparts, the proportion of men working as tradespersons or as related workers was higher than that of women. Moreover, in Queensland in 1996 there were more PRC-born women in positions designated managerial or administrative, professional, or associated professional than in either New South Wales or Victoria.

<table>
<thead>
<tr>
<th></th>
<th>Not in the Labour Force</th>
<th>32.8</th>
<th>54.2</th>
<th>39.2</th>
<th>58.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Stated</td>
<td></td>
<td>1.2</td>
<td>1.2</td>
<td>1.1</td>
<td>0.9</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source:
Table 8.8: PRC-Born Occupations by Sex, Queensland 1996
(Employed persons aged 15 years and over)

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Male (%)</th>
<th>Female (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managers &amp; Administrators</td>
<td>9.4</td>
<td>2.9</td>
</tr>
<tr>
<td>Professionals</td>
<td>20.8</td>
<td>18.2</td>
</tr>
<tr>
<td>Associated Professionals</td>
<td>23.4</td>
<td>16.9</td>
</tr>
<tr>
<td>Tradespersons &amp; Related Workers</td>
<td>17.9</td>
<td>6.6</td>
</tr>
<tr>
<td>Advanced Clerical &amp; Service Workers</td>
<td>0.2</td>
<td>4.3</td>
</tr>
<tr>
<td>Int. Clerical, Sales, Service Workers</td>
<td>4.6</td>
<td>16.2</td>
</tr>
<tr>
<td>Int. Production &amp; Transport Workers</td>
<td>4.8</td>
<td>6.1</td>
</tr>
<tr>
<td>Elem. Clerical, Sales, Service Workers</td>
<td>3.4</td>
<td>9.1</td>
</tr>
<tr>
<td>Labourers &amp; Related Workers</td>
<td>11.4</td>
<td>16.1</td>
</tr>
<tr>
<td>Inadequately Described or not Stated</td>
<td>4.1</td>
<td>3.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>


In terms of employment by industry, in 1996 most PRC-born migrants worked in manufacturing (25.6 percent), or alternately in accommodation, cafes, and restaurants (15.8 percent). In comparison, the figures for all employed Australians in this year and in these industries stood at 12.9 percent and 4.7 percent respectively (Zhao 2000). Of the employed PRC-born women in Queensland, many worked in accommodation, cafes, and restaurants (19.3 percent), in the retail industry (19.3 percent), in manufacturing (10.8 percent), or in health and community services (10.1 percent) (see Table 8.9). Furthermore, the total percentage of PRC-born migrant women employed in one of these industries was higher than that of the Australian female population as a whole (Zhao 2000).
### Table 8.9: PRC-Born Migrant Employment by Industry and by Sex, Queensland 1996 (Employed persons aged 15 years and over)

<table>
<thead>
<tr>
<th>Industry</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture, Forestry &amp; Fishing</td>
<td>1.7</td>
<td>2.2</td>
</tr>
<tr>
<td>Mining</td>
<td>0.4</td>
<td>-</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>11.0</td>
<td>10.8</td>
</tr>
<tr>
<td>Electricity, Gas &amp; Water Supply</td>
<td>0.2</td>
<td>-</td>
</tr>
<tr>
<td>Construction</td>
<td>5.6</td>
<td>1.4</td>
</tr>
<tr>
<td>Wholesale Trade</td>
<td>4.0</td>
<td>2.1</td>
</tr>
<tr>
<td>Retail Trade</td>
<td>15.4</td>
<td>19.3</td>
</tr>
<tr>
<td>Accom., Cafes &amp; Restaurants</td>
<td>25.8</td>
<td>19.3</td>
</tr>
<tr>
<td>Transport &amp; Storage</td>
<td>3.0</td>
<td>2.1</td>
</tr>
<tr>
<td>Communication Services</td>
<td>0.7</td>
<td>0.2</td>
</tr>
<tr>
<td>Finance &amp; Insurance</td>
<td>1.5</td>
<td>3.3</td>
</tr>
<tr>
<td>Property &amp; Business Service</td>
<td>9.9</td>
<td>8.9</td>
</tr>
<tr>
<td>Government Admin. &amp; Defence</td>
<td>1.9</td>
<td>0.8</td>
</tr>
<tr>
<td>Education</td>
<td>8.7</td>
<td>10.5</td>
</tr>
<tr>
<td>Health and Community Service</td>
<td>3.3</td>
<td>10.1</td>
</tr>
<tr>
<td>Cultural &amp; recreational Services</td>
<td>2.2</td>
<td>2.6</td>
</tr>
<tr>
<td>Personal &amp; other Services</td>
<td>1.3</td>
<td>2.1</td>
</tr>
<tr>
<td>Non-Classifiable Economic Units</td>
<td>1.6</td>
<td>1.6</td>
</tr>
<tr>
<td>Not Stated</td>
<td>2.1</td>
<td>2.8</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>-No. Persons</td>
<td>1,843</td>
<td>1,287</td>
</tr>
</tbody>
</table>


At the time of the 1996 census, 58.3 percent of PRC-born persons reported a gross income of less than $300 per week. This was higher than the proportion for all overseas-born persons -- with 52.8 percent in this income category -- as well as the Australian population in total (50.8 percent) (Zhao 2000). However, PRC-born women earned significantly less; in Queensland in 1996, 67.9 percent of all PRC-born working women earned less than $300 per week, with a further 23.8 percent earning less than $80 a week.
In this year in fact, only 5.6 per cent of PRC-born women earned more than $700 each week.

### Table 8.10: Weekly Income of PRC-Born Migrants by Sex, Queensland 1996 (Persons aged 15 years and over)

<table>
<thead>
<tr>
<th>Weekly Income</th>
<th>Males(%)</th>
<th>Females(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $80</td>
<td>13</td>
<td>23.8</td>
</tr>
<tr>
<td>$80-$159</td>
<td>16.5</td>
<td>19.6</td>
</tr>
<tr>
<td>$160-$299</td>
<td>18.9</td>
<td>24.5</td>
</tr>
<tr>
<td>$300-$499</td>
<td>23.4</td>
<td>15.7</td>
</tr>
<tr>
<td>$500-$699</td>
<td>11.5</td>
<td>6.5</td>
</tr>
<tr>
<td>$700-$999</td>
<td>7.6</td>
<td>3.9</td>
</tr>
<tr>
<td>$1,000-$1,499</td>
<td>3.7</td>
<td>1.1</td>
</tr>
<tr>
<td>&amp;1,500+</td>
<td>1.9</td>
<td>0.6</td>
</tr>
<tr>
<td>Not stated</td>
<td>3.5</td>
<td>4.3</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>


In Queensland, Cantonese is the most common language spoken at home by PRC-born migrants (41.8 percent) (Zhao 2000); however, those aged between 5 and 14 years spoke mostly Mandarin (63.9 percent). Furthermore, Mandarin is also the most common language spoken by 25 to 44 year olds, with 41.1 percent using this language at home (see Table 8.11). This could be due to the fact that the proportion of older PRC-born migrants has increased dramatically in recent years.

### Table 8.11: Language Spoken at Home by PRC-Born Migrants, by Age, in Queensland 1996 (Persons aged 5 years or over)

<table>
<thead>
<tr>
<th>Language</th>
<th>5-14</th>
<th>15-24</th>
<th>25-44</th>
<th>45-64</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>English Only</td>
<td>6.1</td>
<td>2.2</td>
<td>6.4</td>
<td>14.3</td>
<td>14.3</td>
</tr>
<tr>
<td>Chinese-</td>
<td>12.5</td>
<td>53.7</td>
<td>34.4</td>
<td>49.2</td>
<td>47.3</td>
</tr>
<tr>
<td>Cantonese</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chinese-</td>
<td>63.9</td>
<td>34.4</td>
<td>41.1</td>
<td>13.5</td>
<td>10.3</td>
</tr>
</tbody>
</table>
As has been seen, the changing profile of PRC-born migrants over successive census years indicates that increasing numbers of new settlers during and after the 1990s have been women. Furthermore, and as may in part be apparent, this brief socio-demographic profile of recent PRC-born migrant women in Queensland suggests that their settlement experiences may often have been problematic.

To draw further comparison among Chinese migrant women more generally, those from Hong Kong may likewise set this further in relief, proffering both similarities as well as differences. For in key respects, members of both these groups can be described as representative of a new 'middle class' Chinese migration; for example, statistics from the 1996 census indicate that 29.9 percent of Hong Kong-born migrant women hold high qualifications -- as do migrant women from the PRC, with 28.5 percent similarly educated -- considerably higher than those for the Australian population as a whole. Similarly, middle class suburbs such as Sunnybank Hills and Carindale were both popular places of residence for PRC and Hong Kong-born women migrants alike.

At the same time, and in terms of the problems of settlement common to migrants from both these groups, Ip and Chui (2002) targeted the settlement experiences of Hong Kong-born migrant women through in-depth interviews with five Chinese social work migrants; commonly negative feelings and emotions were reported by all five participants. For example, feelings of isolation and homesickness were mentioned, even though their
migration was well planned as well as voluntary. Furthermore, language barriers were an ongoing problem, even though these particular migrants all graduated from universities in Hong Kong. Finally, employment problems, including the difficulty of finding work and a certain lack of confidence in joining the labour force, was persistent (Ip and Chui 2002).

Moreover, although many Hong Kong-born women would like to work in Australia, their role more often than not as the sole carer of children compounds the problems of obtaining employment. Indeed on this key issue, the phenomenon of 'astronaut families' must be mentioned as a not uncommon arrangement resorted to by Hong Kong-born migrants (Pe Pua et al. 1998); in many such migrant families, the bread-winners often migrate to Australia while continuing ultimately to work in Hong Kong, either to run a worthwhile and ongoing business interest, due to the difficulty of finding a suitable job in Australia, or simply as the pay in Hong Kong is comparatively better. In addition to the need for ongoing cross-cultural adjustment, the separation this entailed within the family often adds greater emotional stress to women; indeed women experiencing this arrangement often suffer from a sense of helplessness in leading and guiding the family, and in readily making day-to-day family decisions without their husbands contribution (Pe-Pua et al. 1998).

In sum, and by comparing the experience of three Chinese migrant groups -- those from the PRC, from Hong Kong, and from Taiwan -- with all three demonstrating differing histories and circumstances of migration, as well as certain alternate socio-economic characteristics and support networks, Chu (2002) summarized a number of key sources of
'settlement stress': a lack of suitable work and opportunities for employment; work stress, or an unstable income from running a small business; problems with children’s education, transport, as well as language; and feelings of loneliness as well as a lack of support emanating from increased family conflict.

At the same time, and even more importantly given the concerns of this thesis, Chu (2002) noted that the PRC-born group -- the one with the highest levels of education and occupational qualifications in fact -- often suffered the greatest degree of downward mobility.

Summary

This chapter has provided a snapshot of the PRC-born migrant community in Brisbane, presenting some of the key characteristics which define a socio-economic and demographic profile of PRC-born migrant women. Among some of the palpable social factors which might deleteriously affect their settlement and health needs, the PRC-born group is more often less financially secure, less able to develop beneficial social networks, and prone to significant downward mobility.
Chapter 9

Stakeholders and Key Informant Interview Findings

In order to familiarise with the key issues encountered by PRC-born migrant women in Brisbane, a stakeholder analysis was conducted. This involved identifying key stakeholders and cultural resources, as well as conducting in-depth interviews with a diverse group of informants aiming to elicit the differing perspectives of key players.

Stakeholders and Cultural Resources

For many migrants, both ethnic and religious organizations are crucial in providing social and cultural activities, as well as welfare and other care services (Ip 2003). Not surprisingly, in Queensland the number of multi-function, voluntary associations servicing the Asian population have flourished in step with Asian immigration over the past two decades (Ip 2000a).

In this state, the Mainland China Society of Queensland (MCSQ) is the largest organization servicing PRC-born migrants, and constitutes a non-political and non-profit association established in 1996 as the number of PRC-born migrants in Queensland increased significantly. At present it has around 400 members, and aims to establish a productive environment to effectively utilise the latter's professional knowledge and skills, as well as aid the prosperity and progress of Brisbane's wider economic and social
environment. In particular, it aims to engender greater communication between both groups and organizations within the Chinese community, as well as those within other migrant communities and mainstream society overall; provide social welfare and community services to people in the Chinese community; promote multiculturalism in Australia as a whole; and help further strengthen and consolidate the Chinese community by promoting Chinese culture and Chinese traditions (MCSQ online 2004). In terms of the latter in fact, the MCSQ has organized various activities and functions since its inception, among them a celebration of the 1997 handover of Hong Kong to China, parades during the Moon Festival, and an annual Chinese New Year festival. It has also facilitated four Brisbane Chinese Cultural Festivals since 1998 (MCSQ online 2004).

In terms of churches catering for the local PRC-born migrant community, the Antioch International Church located in Sunnybank Hills in Brisbane's south has both a Chinese and English department, and nearly a hundred participants with Chinese backgrounds, including migrants from Malaysia, Singapore, Indonesia, Hong Kong, Taiwan, and mainland China. This church endeavours to maintain contact with both its regular members and visitors via regular prayer meetings, social gatherings and gospel dinners, while church members also often visit and dine with one another from time to time. Moreover, the number of PRC-born members actually increased rapidly once a new PRC-born pastor from Melbourne joined the church in early 2004.

One of the more recent changes directly relating to Brisbane's Chinese community has been the growth in community-oriented newspapers. At present there are six local
Chinese newspapers and magazines distributed for free in Chinese groceries and supermarkets in Brisbane -- the *Queensland Asian Business Weekly* has the longest history, being established in the late 1980s, while *The World News Weekly* only emerged in the late 1990s. This latter however was soon followed by *Bridge* -- a lifestyle magazine published monthly -- by the *Migrant Mirror News Weekly* and *Queensland Chinese News* which appeared in the early 2000s, and by the *Asian Community News* established most recently. These newspapers and magazines not only provide international, national, local, and of course community news to local Chinese, but also economic, political, social, and cultural information aiming to enrich the lives of migrants.

The *Migrant Mirror News Weekly* however is the most popular among PRC-born migrants due to its owner's PRC-born background, and provides local, national, and international news, information about medicinal products, travel, jobs, restaurants, and immigration, and incorporates a classifieds section also. Furthermore, the MASQ and the *Migrant Mirror News Weekly* are closely associated and mutually beneficial associations, often sponsoring or organising social activities for Chinese migrants in tandem.

In terms of radio programming, the largely government funded 4EB provides the most programs servicing Brisbane's local Chinese community. Many of these function as a source of community information -- addressing issues especially relevant to Australian Chinese -- as well as providing news from China, Hong Kong, and Taiwan, and light entertainment also (Ip 2000a). In a related medium, the development of satellite
technology has enabled some Chinese migrants to view television programs from mainland China, Hong Kong, and Taiwan.

As highlighted early on, many Chinese migrants in Brisbane tend to congregate in the southern suburbs of Macgregor, Robertson, Sunnybank, Sunnybank Hills, Calamvale, Runcorn, and Eight Mile Plains; in consequence, and due to the high concentration of Chinese, as well as the large number of Chinese owned and/or run businesses in the area, Ip (2000a) for example effectively considers the area Brisbane's 'new Chinatown'. For shopping malls such as Sunnybank Plaza, Sunny Park Shopping Centre, and the smaller Market Square are all owned by Chinese migrants, and contain restaurants, fast food outlets, herbal stores, bakeries, hair salons, news agencies, butchers, supermarkets, real estate agents, souvenir stores, and medical centres, either owned or run by Australian Chinese.

Chinese media and community groups make it easier for migrants to obtain information on news, social services, activities, jobs, and so on, and the number of Chinese-run businesses in Brisbane has helped many Australian Chinese sustain some of their key cultural traditions and habits.

**Stakeholder Interview Findings**

A total of eight key informants were obtained vis-à-vis stakeholder analysis, and interviewed respectively by the researcher. These respondents included among them one health promotion officer employed by the multicultural public health division of Queensland Health; two Chinese herbalists with a medicinal business in Brisbane's south;
one pastor from the most popular Christian church attended by PRC-born migrants; one Chinese-English interpreter who has worked for varying hospitals for over ten years; one multicultural inclusion facilitator; one committee member of a Chinese organization; and one female general practitioner catering especially for a Chinese clientele (see Table 9.1).

<table>
<thead>
<tr>
<th>No</th>
<th>Sex</th>
<th>Post</th>
<th>Type of Work/Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>F</td>
<td>Health Promotion officer</td>
<td>Queensland Health</td>
</tr>
<tr>
<td>2</td>
<td>M</td>
<td>Chinese Herbalist</td>
<td>Private Practice</td>
</tr>
<tr>
<td>3</td>
<td>M</td>
<td>Chinese Herbalist</td>
<td>Private Practice</td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>Pastor</td>
<td>Christian Church</td>
</tr>
<tr>
<td>5</td>
<td>F</td>
<td>Interpreter</td>
<td>Hospital</td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>Multicultural Inclusion Facilitator</td>
<td>Multicultural Queensland</td>
</tr>
<tr>
<td>7</td>
<td>F</td>
<td>Committee Member</td>
<td>Community Organisation</td>
</tr>
<tr>
<td>8</td>
<td>F</td>
<td>General Practitioner</td>
<td>Private Practice</td>
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</table>

In particular, the interviews aimed to identify some of the general problems facing PRC-born migrant women, what resources if any are available, what gaps in services perceived, and what role community organizations and churches play in assisting their members to overcome obstacles. The interview findings were assessed and organised along the lines of three key dimensions -- social isolation and downward mobility, language and cultural barriers, and access to health services.

**Social Isolation and Downward Mobility**
For the pastor, the multicultural facilitator, and the community organization member, social isolation and downward mobility is common among PRC-born migrant women. In recounting his experience of such women in Brisbane, the pastor noted that:

Many sisters in our church came from mainland China. Most of them still have a low social status, especially those students or the student's relatives who came to Australia after 1989. They have few social activities and few friends. Although most of them graduated from universities either in China or in Australia, seldom have professional jobs. They are happy to attend activities we organise, but our activities are not just for social networking. We aim to strengthen their beliefs through social activities. We have a women's group, but none of the PRC migrant women attend, maybe due to language problems or time shortages. Women's group activities are held on weekdays, but nearly all of the PRC women must go to work.

Similarly, the community organization member asserted that:

Taiwanese migrant women, they have a Taiwan Women's League of Queensland, and Hong Kong women, they have a Cantonese Opera Association. These groups are active in providing social activities and entertainment. But there is no special organization for PRC women. Due to financial difficulty, we can't arrange activities especially for women or provide a service for these women. A lack of community support, financial burdens, broken networks and household chores, mean PRC migrant women are really isolated.

For the multicultural inclusion facilitator -- whose current work turned on a program on diversity in childcare in Queensland -- more social workers were urgently required by PRC-born migrants:

The transition to a new host society creates many conflicts in families. And a husband's addiction to gambling only makes things worse. Kids from such families are always teased by other kids and rejected in their new environment. If there were enough social workers to mediate their family relationships, and provide support to build new networks, their process of adjustment would be better.
While the factors underpinning social isolation and downward mobility among PRC-born migrant women are undoubtedly numerous, for the pastor migrants themselves hold a great deal of responsibility:

One important reason is that many Chinese don't participate in the activities of the host society. For example, sometimes there are quick surveys on TV, in which all you need to do is call and show your opinion. Even such simple things, we are reluctant to do. We think that's not our business, and yet it is as we are Australian, and should really call Australia home. We shouldn't just keep our own culture and refuse to accept the new culture altogether.

**Language and Cultural Barriers**

Language and cultural barriers were considered significant by all stakeholder informants, with the former considered especially problematic in terms of the ability of PRC-born migrant women to access health services. In this way, the Chinese-English interpreter felt that:

Language problems affect Chinese women's access to health services deeply. Due to China's one-child policy, many migrant women from the PRC who arrived after 1989 gave birth to their second child here. I have helped many pregnant women in recent years, for although hospitals provide free antenatal classes for pregnant women and their husbands, very few Chinese really participate due to language difficulties. Normally, you can't get an appropriate interpreter unless you make an appointment in advance. And due to poor English skills, many know little about existing services for patients. While Australia has many hot lines for women, I've never heard of Chinese people using them.

The general practitioner who has worked in Brisbane's south for more than five years concurred:

It is difficult for Chinese women to understand and talk about medical conditions even though many are relatively well educated. Even those who have an Australian degree in fact still wait for me every time they come to the medical centre. Although there is usually a long waiting list, Chinese people are patient to wait, as they don't want to misunderstand or
be misunderstood. Of course when it comes to specialists, they ask for a bilingual one. It's really difficult to find an appropriate one however, as bilingual specialists are not as numerous as GPs.

Furthermore, cultural barriers make their access to appropriate health services even worse.

The Chinese-English interpreter in this way observed that:

Women from the PRC are afraid to have showers after labour, so I always need to explain to them. But I just give my opinion, and do not force them to do so, as traditional cultural beliefs are not easy to surrender. Another problem is that PRC migrant women are reluctant to let doctors know their real conditions, especially in terms of mental health. For example, I have helped a PRC woman with mental problems several times. She is forty years old, and has lived here with her two kids for four years. Her husband is still working in China, and with the isolation, financial burdens, and the new environment giving her much stress, she eventually fell into depression about a year ago. And although she has used medicine already, every time the doctor asks how she is feeling and whether there are any adverse effects of the medicine, she simply answers 'well' and refuses to elaborate. She hides her real feelings, so I really worry about her.

Furthermore, the Chinese doctor felt that:

Due to financial problems, many women will not come to see a doctor unless the problem is serious. For PRC migrants do everything to save face. Unlike Hong Kong women, those from the PRC do not tell you their real problems, and especially if it relates to sex or mental health. I have opened a Chinese herbal shop for five years, and met only one PRC women who told the truth -- conflict and disharmony between her and her husband had made her sick. So medicine is not always the best, and sometimes counselling is more useful as one's spirit is very important.

According to a Chinese herbalist furthermore:

Actually, in mainland China traditional Chinese herbalists are not the first choice of prospective patients. Most people in fact can go to hospital and easily see specialists. In Australia however, language barriers, cultural barriers, and the GP referral system especially, change their medical behaviour. For here they actually prefer to see Chinese herbalists first due to the nature of the GP referral system.
**Access to Health Services**

The health promotion officer interviewed in this study is the only Chinese-English language bilingual staffer in the Brisbane Southside Public Health unit. From her experience, services for Chinese migrants are unsatisfactory:

Although there are some projects in Queensland Health targeting NESB migrants, there is no special program for Chinese migrants. There should really be special programs however, such as a 'prevent diabetes among Chinese migrants' for example, as the morbidity rate among Chinese migrants from this disease is higher than the Australian total.

Nevertheless, many existing services are under-used by PRC-born migrant women, among them Pap smears and breast screening. In this way, the GP pointed out that:

PRC migrant women seldom come to see doctors for their own health concerns. They come to see me more often as their kids are sick. And they are always disappointed if antibiotics are not given. Although the government provides free Pap smears and breast screening, they are reluctant to undergo the examinations. Firstly, they don't want to discuss sex related problems with me. Secondly, they think they will not get cervix cancer and breast cancer, as many have only had one sexual partner. Here the cultural barriers and misunderstandings become clear, for not only is it difficult to persuade them to undergo regular check-ups, but even when they do they do not follow them up -- they just throw the reminder letters away. The government should employ some culturally sensitive methods to promote women's participation and strengthen their awareness about existing services.

**Stakeholder Interviews in Summary**

As each of the key informants revealed, social isolation and downward mobility, language and cultural barriers, and the lack of proper health care access, are all major issues affecting these PRC-born migrant women in Brisbane. The overall impression the responses give is that many of these migrants are reluctant to engage with mainstream Australian society, and that this impacts in manifold ways on their health and wellbeing.
Moreover, something amounting to a culture of silence among PRC-born migrant women is central, derivative of both the traditional cultural conventions and roles which migrant women adhere to, and the lack of appropriate, culturally sensitive information in both hospitals and clinics.

In summary, this chapter has adumbrated the key findings obtained through stakeholder interviewing; the next chapter will detail findings from both the focus group discussion and in-depth interviews.
In order to understand how PRC-born migrant women both experience and interpret the particular factors that impact upon their health, both face-to-face interviews and group techniques were employed. This chapter considers findings from the focus group and in-depth interviews, in which needs in turn were identified.

**Focus Group Findings**

A total of seven women were obtained to conduct the focus group. All of them entered Australia initially as international students, and while four were married in China, all arrived in the country on their own, with the former following their husband's earlier migration. For those married in China, two had divorced while in Australia, and among the three single on arrival one had no spouse, while two had since married. All held bachelor's degrees obtained in China, and all had further acquired master's degrees while in Brisbane, with one gaining no less than two. Their settlement time was between five and fourteen years. The focus group interview ran for approximately one and a half hours. Their discussion was focused on three major area guided by some sample questions. Table 10.1 presents a summary of the research focus that were highlighted in the focus group interview.
### Table 10.1 Research Focus of the Focus Group Interview

<table>
<thead>
<tr>
<th>Sample Questions</th>
<th>Issues Emerging</th>
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<tbody>
<tr>
<td>What kind of problems had you met?</td>
<td>Social Issues</td>
</tr>
<tr>
<td>What worried you most?</td>
<td>• Social isolation and homesickness</td>
</tr>
<tr>
<td></td>
<td>• Employment problems</td>
</tr>
<tr>
<td></td>
<td>• Pressures to achieve academically</td>
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<tr>
<td></td>
<td>• Marital problems</td>
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<tr>
<td></td>
<td>• Language problems</td>
</tr>
<tr>
<td></td>
<td>• Transport problems</td>
</tr>
<tr>
<td>Did you have any health concerns?</td>
<td>Health Issues</td>
</tr>
<tr>
<td>Why or why not did you go to see a doctor?</td>
<td>• Lack of trust of Western doctors</td>
</tr>
<tr>
<td></td>
<td>• Different medical systems</td>
</tr>
<tr>
<td>What can help you to cope with the problems?</td>
<td>Solutions</td>
</tr>
<tr>
<td></td>
<td>• Build Chinese associations</td>
</tr>
<tr>
<td></td>
<td>• Information about relevant services</td>
</tr>
</tbody>
</table>

The following themes documents their experiences as new migrants during their first five years of settlement.

**Social Isolation and Homesickness**

All participants agreed that social isolation and homesickness was the most serious concern. While their study overseas was both voluntary and planned, all participants reported negative feelings and experiences when recalling their first five years in Australia; feelings of helplessness, loneliness, and homesickness were all recurring themes. Each of the following is representative in this regard:

> On the second day after my arrival, I was surprised to find I needed to go to university by myself for the first time. My home-stay mother left me at the bus stop where I was to transfer buses. The problem was that I didn't know I should press the button when wanting to alight the bus, so the driver didn't stop at my stop on my trip home from university. So I was
lost in a totally strange shopping centre, with all the shops closed, no one passing by, I had no coin to use for the telephone, and after more than an hour's walking back and forth I almost gave up hope. Fortunately my home-stay father passed by coincidentally, and I was picked up. I cried for the whole night.

This feeling was shared by other informants in the focus groups. For example, a student informant who came from Beijing found that the differences between living in Brisbane and Beijing were too great for her to endure. The feeling of loneliness arising from living in a dormitory suburb in Brisbane struck her most immediately since the first day she arrived.

Compared to Beijing, Brisbane is a quiet city. It was even quieter when I arrived six years ago. At that time I lived in Algester, which was a very quiet suburb far away from the university. It became dark around six o'clock in the afternoon, and walking home alone by myself in the evenings I hurried everyday. With the cars passing quickly by me, I felt lonely and without hope, and sometimes cried while I walked.

Other respondents who also came around the same time in 1989, however remarked that their financial difficulties had made things worse.

I cried each day for the first month I was here, I missed my family so much. Every time I picked up the phone to talk to them, I just kept crying. Due to financial difficulties, I did not return to China during my first six years, and moved from place to place without friends or family. For those two thousand days, I was suffering instead of living a life, piled up with tears, fear, hopelessness, helplessness, and loneliness. I just felt left far behind.

With none of their old social ties, a lack of friends and social networks in Australia, and the significant cultural differences and worries over financial hardship, many harboured a great deal of pessimism early on:

As I was single without a boyfriend or a husband to support me, I felt I had to try to survive by myself. I worked as a waitress in two restaurants from 7am to 4pm each day, and went to university in the evening. I was
so tired sometimes I fell asleep in the classroom. While life was busy however it was also boring and meaningless, and several times I thought about giving up. But you know it wasn't easy to go abroad, so I persisted.

In the course of the focus group discussions, gradually the informants came to a consensus that living in Brisbane for them seemed a mixed blessing altogether. On the one hand, they felt they really enjoyed the open space and the natural environment of Australia. On the other hand, however, they dreaded the fact that the open space and distance had made it difficult to re-establish a much needed social support network. In turn, extreme loneliness, boredom, helplessness and isolation seemed to take over their lives. As one of the informants indicated:

I found it difficult to find friends here. Many Chinese people who migrated to Australia earlier than me always began with 'I can help you' and so on, but when you really needed help, it wasn't often genuine. One person for instance told me all the advantages of her property and persuaded me to rent it, but I soon found out how bad it was after moving in. Another couple, when they knew I needed some basic pieces of furniture, sold some old items to me they originally planned to throw out. I was very disappointed, and decided to never trust anyone too easily.

While discussing their difficulties in getting help or support, the issue of religion also came up. It became apparent to all informants that none had any religion when they were in China. And it was the lack of social support and loneliness they experienced eventually motivated them to seek solace in religious organisations and activities. In fact, a majority of the participants felt strongly that the church was a most important focus for providing them with social support and a basis for establishing friendship network:

There was no real PRC community when I first arrived. Although there is one now, providing help to newcomers is still not its major aim. While I had no religion in China, I became a Christian soon, for at least I could find spiritual and emotional support with the church.
Employment Problems

Employment was another recurring problem these migrant women faced, for while all held some form of Australian diploma, it was still difficult for them to find suitable work. Almost every participant had a sad story to tell. All participants were unsatisfied with their job except one. In fact only this person was lucky enough to find a well paying job related to her major at university, and she held both an MBA and a master's degree in information technology, and still spent a good deal of her time teaching Chinese.

Another informant felt worse and complained to the researcher that

Although I hold an Australian doctoral degree, I still could not find a job. I haven’t had even one interview since I graduated. I had to look for a job in a small town very far away from Brisbane. Eventually I found a job but, three years later, I lost my job when the contract expired.

Moreover, one was still effectively a cleaner after six years of settlement in Australia; although a small business owner, only herself and her husband constituted the cleaning business, and accomplished all the things needed to run it. In the end, in terms of the obstacles to finding appropriate work, all agreed that language difficulties, gender discrimination, and cultural differences as especially problematic.

Pressures to Achieve Academically

As Nip (2002) among others has noted, Chinese people place a high value on education and academic success, aiming to become professionals with good incomes, other benefits, and a certain status the product of a competitive education system. When such 'elites' migrate to Australia however, they forfeit not only their customary lifestyle, but also their social networks and influence (Pe-Pua et al. 1998). Moreover, faced with both an
unfamiliar physical and social environment, as well as a very foreign culture, all respondents considered both the need to gain qualifications in Australia, and to succeed academically, very hard. Specifically, one informants commented that:

Before I arrived in Australia, I knew little about life here. I soon however found it difficult to adjust to campus life, and language problems as well as different styles of teaching and learning made me very nervous. I didn't know how to carry on a discussion with either teachers or classmates, and when they talked I simply kept quiet. While there was a lot of group work required in my course, I found it very difficult to join groups and felt very much apart.

Responding to the comment, another informant concurred and elaborated that:

While on the one hand I was studying at university, on the other I had to work to support my studies. The pressures both financially and academically really made me crazy. And while I tried to complete the courses successfully, at the same time I kept thinking about the opportunities for finding a good job. In fact I changed my course of study several times because of my concerns.

**Marital Problems**

There were other problems encountered by the informants. Many married respondents suggested they had experienced significant marital problems living in Australia, but for the few singles they also found it difficult to meet prospective spouses and establish a family. In fact, one 35 year--old informant regretted that she was still single. In particular, those who had married in China felt the financial hardship part and parcel of their migration had caused significant conflicts in their family, with two in fact divorcing after several years of settlement. As one informant in particular recalled:

When I was studying at university, my husband was the main support of the family. Although he was a university teacher in China, working in a Chinese restaurant was the best job he could find here. I knew he toiled day and night, but sometimes I felt we needed to buy some nutritional food for our daughter. Once I picked up a small bag of mushrooms in the
supermarket and he shouted at me and ordered me to put them back. Of course I felt embarrassed and ashamed in front of all the other customers. Financial difficulties contributed to many conflicts like that, and we divorced soon after I graduated.

Language Problems

Although none of the respondents found language a problem in everyday situations, in the course of the group discussions, they considered it their major barrier to finding good positions and integrating with mainstream society -- even though many had gained degrees in Australia as aforesaid. While all were very conscious of the need to improve their English proficiency, for many the assignment writing required by their studies proved especially difficult. In this way, one recalled that:

I needed to submit eight assignments during my first semester at university, and it almost drove me crazy. When I was in China, my training only involved writing short articles with samples for the TOFEL test, and I certainly didn't know how to write academic essays. I was always very nervous and often worked entire nights, because if I didn't pass my courses I would need extra money. That was a large amount for me, and quite impossible to obtain.

Transport Problems

As the focus group discussions went on, the informants also came to the realisation that almost all were surprised by how much they had underestimated the difficulties in accessing public transport while having to rely on it as their sole mode of transportation during their initial years of study and work. While the cost was considered expensive, they also found services both inefficient and infrequent:

From where I live, there is no bus servicing the university on weekends, public holidays, or school holidays. If I needed to go to the university on
these days, transfers would always take a lot of extra time and money. In hindsight, perhaps the best thing for me would have been to walk.

When they recalled the experiences they had, some still had a vivid memory of the difficulties they had to endure and remained critical of the infrequent public transport services particularly in the evenings.

Most of my lectures were in the evening, but there was no direct bus service after 6 pm. I would have to transfer buses in the evening, which proved really inconvenient for me. I was also very scared to wait for the bus for more than half an hour after 9pm by myself, so most nights I just ran back home. It was too quiet in the evening, with only myself walking fast or running in the street. While all this happened several years ago, I can still feel my heart beating today.

Another informant further commented that her unfamiliar with transport services cost her not only time but also money.

The transport system here is quite different from in China. If you miss one bus here, you may need to wait for a whole hour before the next. And although I went to university and back by myself from the first, my home-stay mother hadn't given me enough information about transport. The worst thing was becoming lost several times, but I also didn't know I could use the same ticket to transfer buses within two hours, so I ended up wasting a lot of money on transportation in the beginning.

**Health Issues**

Surprisingly, none of the informants reported serious health problems in the focus group discussions, yet they were both worried and stressed on a daily basis during their initial settlement, with academic pressures especially making things worse. For many, this triggered intermittent menstrual problems, and importantly few seldom visited doctors which they considered either too slow or of little real help, or were alternately concerned about the high costs of prescriptions. As one informant observed:
The medical system here is quite different from in China. Once I got an acute skin allergy and went to see a GP, and was told to make an appointment with a specialist. I did, but could only see one a month later. In the end of course I didn't, as the problem had already subsided by then. Even I felt uncomfortable with this, and since then have avoided visiting GPs.

However, another informant responded that emotional distress was another major concern for many Chinese migrant women at that time. Many said that they had suffered from insomnia, hair loss, depression, tearfulness, and a loss of appetite. One recalled:

Most of the time I cried constantly, and felt I might have a breakdown. My home-stay was with a relatively poor family. Even though I paid a fair amount of money, they only prepared a simple dinner for me during weekdays, and on weekends the situation was worse as these were my home-stay mother's rest days. And the cultural differences made me feel very isolated. In spite of the fact that my English needing improving, I decided to move out after a month. Following that, I shared an apartment with two other PRC students, and since we could talk to one another freely and share our experiences, I started to feel better.

Three other participants also said that lack of trust to Western health services was another reason made the low use of health services among these students. One explained:

Even though I had a menstrual disorder, I didn't intend to see a doctor. I was afraid that the doctor might give me some hormone pills, which would have been terrible. I trusted Chinese medicine in treating such complaints, as herb products usually have no adverse effects, and are good at regulating such things. I couldn't even see a Chinese doctor however due to my financial woes.
Potential Solutions

As a way to round up the focus group discussions, the participants were asked to talk about what could be done for them. In answering to this question, all seemed to agree strongly that they would like to see some community organization specifically set up for PRC Chinese migrant women to be established in Brisbane so that they could have a base for accessing information about services and social activities, and a place for meeting other migrant women for friendship and sharing their experiences. Specifically, they all seemed to agree that information on essential services was very important. For example, a majority suggested that where to obtain assistance in translation, interpretation and from Justice of Peace was problematic. Six informants suggested at the same time that they would like to see information brochures about social services translated in Chinese widely distributed in various locations in the Chinese community. Nonetheless, one respondent did not agree and as she explained:

We could not always rely on the government to meet our needs. We need to improve our English proficiency and that is the only way to get information timely and access appropriate services when we need them.

In-Depth Interview Findings

Of the thirty PRC-born migrant women which participated in in-depth interviews, ten helped out in small businesses run by family members, which included restaurants, a café bar, and a beautician; five were agents acting on the behalf of insurance companies, real estate firms, health food companies, or loan companies; five were waitresses or kitchen hands; three were teachers instructing singing or Chinese; two worked in computer businesses; and one remained a full-time student. The remaining four did not work at all,
with three looking after their children at home, and a sole housewife who had never
worked since migrating to Australia.

**Employment**

Excepting the one informant who had never sought work in Australia, all respondents
found employment a serious problem. Moreover, since most of the informant's husbands
were students themselves after migrating, many of these women became their family's
sole income earner. Not surprisingly, many resorted to all sorts of work to make ends
meet, and this especially since their overseas qualifications went unrecognized. Many of
their frustrations became readily apparent. Typically one informant told the researcher:

> I have worked as a waitress since the second day I arrived in Australia. Although a tiring and boring seven-day-a-week job, for a long time I had
to try and keep it. For my husband's situation was even worse, as he always ended up losing his job. Fortunately today we own a small café
bar after ten long years of struggle, although we still do almost all the
work ourselves, and have only one part-time helper.

Despite her privileged status in China, another respondent recalled the great difficulties
she had in finding a job:

> I have been here for more than ten years, and although I was a university
lecturer in China, I have had to take many jobs -- I've been a waitress,
cook, cleaner, clerk, salesperson, you name it! Of course none have
related to education in the slightest.

A majority of the informants seemed to agree that even an Australian degree could not
help them to find a suitable job. Many believed that language problems, cultural
differences, discrimination were common factors contributing to their predicament. As
one informant admitted:
Although I've gained two master's degrees in Australia, an MBA and one in IT, I haven't found a sound job since I graduated two years ago. In China I taught Chinese languages at a university, and surprisingly still depend on teaching Chinese for a living today. While my qualifications in this field are often recognized within the Chinese community however, they aren't by the Australian government. And the frustration in getting a suitable job has lowered my self-esteem. Today I have little confidence left at all.

However, as many PRC migrant women who came to Australia before the mid-1990s were financially less secure, they had to work long hours to support themselves and their families. According to some of our respondents, marital break down was most common and added more misery in their lives. As one informant confessed:

I was an actress in China, but soon realized that life wasn't going to be easy here. For my husband abandoned both me and our eleven-year-old daughter, and I did all sorts of jobs to try and support us. All my relatives couldn't believe that I cleaned toilets in a restaurant for a living, but I simply had to keep working hard as nothing was certain or secure.

However, there was a more fortunate case in our sample. She received a postgraduate degree and was lucky enough to get a good job after her graduation. Still, she considered her own experience atypical of her contemporaries:

I held two part-time jobs, as a waitress and a cleaner, when I studied at university. I think I was very lucky to get a well paying job in a large company after I received my master's degree. But good luck does not fall on everyone. Many of my university friends are still working as kitchen hands, cleaners, and labourers, despite holding tertiary qualifications.

**Social Contacts and Isolation**

Given the vast majority of informants were busy making a living most of the time, few had the chance to socialize and build strong friendships; most seldom entertained others.
at home, or visited friends for social occasions. While some met up with acquaintances at the Chinese language school where their children mutually studied on Sunday afternoons, they also found it difficult to know and meet real friends in Australia. Furthermore, financial difficulties often make such migrants see friends not only as emotional, but as material help also, whether in terms of sharing transportation, accommodation, or childcare:

It seems the longer you stay here the less friends you have. The only real friends I had I've lost touch with over several years. While I have the time sometimes, I often don't even know whom I should contact.

About four years ago, I went back to Beijing to visit my parents. There was a program on TV recounting the lives of some overseas students in Japan. When they talked about their loneliness, I basically starting crying, and my relatives were really surprised at my reaction. You don't really know what loneliness means unless you go abroad and lose all your social networks.

The sense of helplessness could be further heightened when informants were met with unexpected difficulties. One informant articulated this sentiment well:

I divorced several years ago, and live with a boyfriend now. Just when my life was going better, a disaster occurred in which someone claiming to build a business with us cheated us out of 30,000 dollars. It was really hard to save that kind of money, and I basically collapsed. I went to see a doctor, but felt helpless anyway, and ended up lying in bed for nearly a month in which none of my friends came to visit or even telephoned. I didn't know whom to talk with, and fell into a serious depression. Fortunately, a young couple came to see me shortly after they heard my bad news, and it was then I knew what appreciating a friend really meant.

Marital Problems

On the issue of marital problems, two informants recounted that:

My husband was an actor when we were in China, and the difficulty of his finding a job here, along with financial worries, led him into a gambling
addiction. After losing all the money we had brought with us to Australia, he left us and lived with a Taiwanese woman who effectively provided him with capital. My marital failure and my low status jobs made me really disappointed with life, and several times I even contemplated suicide.

Financial worries and child minding responsibilities caused many conflicts between my husband and I. As my husband lost his job and was out of work for a long time, he forced me to keep my job no matter how unwell it seemed to make me. And now that my husband has found a job in a small town outside Brisbane, our separation only adds more stress to our marriage.

According to the respondents in fact, Chinese men can often encounter more difficulties in job searching than women. Moreover, since in traditional Chinese culture income earning remains a male domain, some husbands feel very uncomfortable at the role reversal that can at times ensue. Most important of all it seems was the multiple roles which many of the respondents played; one for example recounted that:

I worked as a chef in a restaurant six days a week, and yet my family only had one car. Every morning I had to firstly drop my husband at his workplace, and then my two daughters at two different schools, before going to work. And during my two and a half hours break in the afternoon, I picked them up before returning and working till late in the evening. On my only rest day, I had to wash clothes, clean the house, and do the shopping, so I felt constantly tired. The situation grew even worse when my husband lost his job, remaining unemployed for nearly two years. The only money he could earn was by working as a family teacher, and his temper grew really bad to the point where we quarrelled on a daily basis.

**Discrimination**

All the in-depth interview respondents had experienced some form of discrimination after settling in Australia. Indeed most perceived the non-recognition of their Chinese qualifications as no less than a form of discrimination itself, while others indicated they had encountered particular difficulties in finding employment due to their ethnicity. Still
others felt that they were unfairly treated at work for the same reason, and many had been
the object of racially abusive remarks and comments. Nevertheless, many also admitted
that cultural differences themselves might have made them overly sensitive and prone to
misunderstand certain things, with language difficulties part and parcel of the problem.

Several times I was promised a job at the job interview but such promises
were never kept afterwards. Sometimes I wonder whether racism is
involved because one of the prospective employers told me he did not
realise that I am an Asian woman before my interview.

Language Difficulties

As a representative response, one of the informants characteristically noted that:

   English was the biggest problem for me. I just didn't know what to do
   without help from my husband. I was afraid of picking up the phone, as
   my English was so poor I thought it would lead merely to
   misunderstandings. Consequently I had no choice -- I had to take
   whatever job I was offered, such as doing dishes or cleaning toilets, as I
   couldn't get anything better given my poor English.

Interestingly however, the language difficulties reported by these respondents not only
revolved around ones concerning English, but also Cantonese, for the latter remains the
most common language spoken by Chinese restaurateurs and chefs in Brisbane. Many in
consequence felt that working in the kitchens or waiting in such restaurants saw them
become objects of ridicule and verbal abuse, with one in particular recalling that:

   I was told to perform more heavy and dirty work in the kitchen than
   anybody else, and the chef always shouted at me when I did something
   wrong. I decided I had better learn to speak Cantonese quickly.

And another similarly recounted that:

   Once I got a job as a receptionist in a real estate agency. Not all the
   clients spoke Mandarin though, with many using either English or
   Cantonese. Yet both my English and Cantonese were not good enough to
answer calls, so I always became nervous when the phone rang, and even grew scared of picking it up. I was eventually fired from this job, and find life very difficult, as I speak neither English nor Cantonese well.

In this way, although all the informants attended English classes -- and felt also that their language skills had in fact improved -- many continued to speak a good deal of Mandarin in their daily lives. Many perceived language difficulties continued to either subtly, or not so subtly impede their interaction with other Australians.

**Family Relationships**

Along with a range of marital problems and marital discord, most respondents admitted experiencing difficulties in communicating with their children, and this no matter how hard they tried. And some in fact reckoned that their children had become too 'Westernized'. As one informant explained:

"My daughter is almost fifteen years old now. She always goes out to parties on the weekends, and as I don't like her doing that, we always end up quarrelling."

In another situation, another informant could not understand why her relationship with her daughter could be so volatile and the only explanation she could think of was that her daughter had bad manners rather than seeing her becoming more Westernised and embracing the values of individualism.

"My daughter is nearly eighteen. Once some friends came to our house to have dinner, and when our daughter found the guests using some of 'her' crockery, she almost became abusive. At that moment all of us were very embarrassed, as this kind of behaviour is just bad manners in Chinese culture. Here however it may well be normal."
Sometimes such cultural gaps between the parents and their children made their communication even more difficult.

My two children are speaking English at home, while I like to speak Chinese. They told me they prefer to talk between themselves in English, rather than talk to me in Chinese. In my family, our own culture and language are falling by the wayside.

Transport Problems

Most of the respondents still relied heavily on public transport, even though many had learnt how to drive. As with participants of the focus group, they also agreed that public transport in Brisbane was inconvenient, inefficient, and infrequent by Chinese standards, and that it had grown even more expensive when monthly and weekly passes were discontinued. As one of the informants in particular pointed out:

I spent more than a hundred dollars a week on buses in order to travel to the Sunshine Coast for work. That amounted to a quarter of my earnings. And although I could always get a seat on the bus, it was tiring waiting for transfers. I'll have to find another job that is closer to Brisbane as soon as I can.

Likewise, another respondent found it absurd that:

It takes me more than an hour to go to work by bus, and yet it takes only twenty minutes by bicycle.

Health Problems

Other than two of the informants, most believed they had no serious health problems, although many also felt they were not as healthy as before. All agreed that they experienced significant stress in the course of their daily lives, with recurrent headaches, dizziness, stomach upsets, menstrual disorders, insomnia, and chronic fatigue.
commonplace complaints. Most felt that the health care system and their experiences with childbirth presented them with the greatest difficulties.

When not feeling well, all preferred to visit a doctor who speaks Mandarin, and although it was easy to find a GP with the language, when it came to specialists it was difficult. And English proved to be an intimidating barrier for the respondents when they attended a clinic or hospital. In turn, while most informants felt they needed to have an annual check-up, few were willing to see a doctor for minor complaints. Moreover, they were most unsatisfied with the referral system needed to access specialists, as they felt this vitally delayed their diagnosis and treatment. In this way, most preferred to use Chinese herbal remedies they can prepare at home, as opposed to visiting a general practitioner. One informant complained that:

About three years ago, I lost consciousness and fell down suddenly. I went to the emergency ward, and yet only the routine checks such as temperature and heart rate were made. They then asked me to make appointments with two specialists, the earliest of which I could see in a month. After the syndrome occurred again, and after a series of examinations lasting over a year, I have yet to be either properly diagnosed or treated.

Most also never availed themselves of preventative health services; for example, a third of them had never had a Pap smear performed, while only three who had done so actually followed recommendations and had a check-up every two years. None had had mammograms, and none in fact knew the appropriate age when they should start doing so. There were valid reasons why they did not use such services. One reason was the lack of information and understanding about the services provided. Notably some of the comments were:
I did have a Pap smear once after an abortion, but did not follow it up. I don't think I need to do that. I'm faithful to my husband. Why should I get that disease?

I think that kind of disease is a dirty disease. Only dissipated women contract it. If you are a good woman, you needn't worry about it.

Another reason was their dissatisfaction with the services provided as they had expected the Australian health system operating the same way as the Chinese one. When they found out the two systems were so different, they felt disappointed and did not want to use the services. As one woman said:

I had a Pap smear at one point, but haven't followed it up as I'm very busy. To have a Pap smear requires special arrangements and wastes too much time. And I don't like the medical system here as you can't get anything done without a GP's referral. Even if all you want is a basic medicine, it still means a long time waiting.

Another woman also complained that she was unhappy with how she was treated by Western general physicians:

I haven't had a Pap smear done at all, and nobody can just 'tell' me to do it. GPs here normally offer no time to talk to you and ask about your concerns, and provide a more personal recommendation.

However, another admitted that language and cultural barriers had prevented her to use the service:

I haven't had a mammogram, and while I have heard some advertisements for them I have no interest in having it done. One reason is that I feel embarrassed, and the other is that my English is so poor, so I don't dare do anything.
Childbirth and Childcare

Two-thirds of the informants had given birth in Australia, and many felt that the loss of their extended family was particularly hard on them at these times. In spite of the kind words and congratulations they received from nurses, they also felt somehow lonely and helpless. And for those who had had a child in China, they reminisced about the care they received in the postnatal period:

We were happy to have our daughter here even though we didn't plan it. Yet I felt tired and helpless after giving birth, and it was very different from the time I gave birth to my first daughter in Beijing where my mother was always ready to help look after the baby, and take good care of me also. Here I had to do everything myself when my husband went to work and my elder daughter was already in primary school. I couldn't sleep or eat well in fact, and was nervous and moody during the first week. I was better after one month however, and took my baby to work, putting her on the floor next to me. It was difficult for all of us in the family.

Others however were more concerned about their postnatal health conditions, especially when the common Chinese practice of “sitting the month” is not generally accepted and they received little assistance and support after experiencing the trauma of giving birth to a child in Australia.

I was unable to rest fully after giving birth. I was busy and became exhausted everyday. I didn't have the luxury of 'sitting the month'. I think my health has deteriorated since then because I feel my joints and bones aching.

Their worries were not helped by their language problems and the difficulties in getting appropriate language interpreting assistance in hospitals when they could not communicate effectively with midwifery staff during birth.
I couldn't understand what the doctors and nurses said to me. I didn't know what they really wanted me to do during labour. Fortunately I had given birth before in China so I knew what to do.

Worse still, they were known to have strong attachment to traditional Chinese childbirth practices (Liem 1999) and knew very little about giving birth in a Western environment. The anxiety and worries many Chinese migrant women were well articulated by one of the informants:

Due to a lack of time and transport problems, I had not attended the prenatal class. When labour signs occurred, we didn't know what the right time to go to hospital was. We came to hospital a little early, and the nurse put me in a cold, air-conditioned room. I had to stay in that really cold room for about twenty hours until my baby son finally arrived. They also gave me a cup of iced water to drink and an ice bag to put on the wound soon after childbirth. I felt too self-conscious to refuse, so I accepted. But I was seriously worried about that, as in Chinese culture we try to avoid all kinds of cold things at this time. I'll be having another baby soon, and plan to refuse to do things I don't think are right.

In a more specific case, a woman explained her grave concern about her losing blood during giving birth and she believed that one’s health would be weakened. Particularly if one was not kept warm. Consequently, her worries gave her recurring headaches:

I had an abortion about one year ago. In our culture, we should keep warm during and after the operation. Unfortunately the operation room was so cold that I felt frozen, and after that I got a serious migraine. Now it recurs each time I have my monthly bleeding.

Not surprisingly for many Chinese migrant women, they tended to see the staffs in the hospitals were generally unsympathetic and unhelpful, and made no attempt to understand their needs.
After childbirth, my husband was not permitted to stay in the ward after 7pm. And unfortunately my son got a fever in the first night. The nurse asked me to bathe him around midnight, and take him to see a doctor in another ward. That was just terrible for me as I was so tired and in pain, and I was sad to see the little one undergoing a check-up and a blood test. He cried loudly and I cried too.

The issue of diet, in this context, became a major issue (Rice 1999a) because Chinese migrant women believed that they had to eat warmed, nutritious food, supplemented by various herbs that could clean out their ‘dirty blood’ as well as facilitating their lactation (Tham 1999). When they found what was provided by the hospital did not conform to their health beliefs, they were disappointed and unhappy.

I gave birth to my daughter about eight years ago, and my husband hadn't enough time to bring me three meals in hospital. And while every time I ordered the large size, I still felt hungry. The food they provided was salad, potato, carrots, a small amount of meat, fruit, and a cold drink -- quite different from our traditional food for new mothers. So I tried to leave the hospital as soon as I could.

Although none of the informants suffered from serious postnatal depression, over ninety percent experienced emotional, tearful, anxious, and/or irritable times after giving birth.

One woman recalled that:

After childbirth I felt very tired and in pain. Yet all of our relatives were overseas, and none of our parents could come and help. One of our friends in China however visited us at that time. My husband had to keep working to earn money, and most of the time it was just the baby and I at home. The baby always cried, and as I was a new mother I didn't feel in control at all. I constantly worried about my health and that of my baby's, and often began crying. Sometimes I'd cry for no reason at all, which kept up for about a week.
All the informants further agreed that while there are services provided for pregnant women and new mothers, including antenatal classes and physiotherapy after childbirth, these were either difficult to access, or at odds once again with some of their fundamental beliefs concerning health and the postnatal period:

If you want to access those kinds of services, you really need time, energy, as well as money. While the antenatal class itself is free, you need time to get to the hospital, you must pay for either public transport or parking, and you still need to walk quite a bit. And if you want your husband to go with you, he must ask for leave, which means losing money.

I think postnatal physiotherapy is very inappropriate. First of all, once you get home from the hospital, you're very busy with the baby. So even if you want to do it, who will care for the child? And in our culture, during the 'sitting the month' period women are very reluctant to go out.

Not surprisingly, performing a check-up on the baby five days after its birth was similarly unwelcome by the respondents, with all noting that Chinese women simply do not want to go out soon after delivery:

Although we had made an appointment, we still had to wait for more than half an hour at the check-up clinic. It was terrible for me and my little baby, sitting and waiting in a cold, air-conditioned room for such a long time.

It is not surprising to find that home visits by infant welfare sisters were most welcomed by these informants as they could obtain emotional support and learn more about themselves and how to look after their babies in the Australian way without leaving home.
Childcare proved to be another significant problem for these women, and its arrangement, even when possible, a major source of postnatal stress. To begin with, waiting lists for childcare centres in Brisbane are very long -- and this especially so in recent years -- requiring even more time to find an acceptably suitable one. A second issue was the perceived differences between Chinese and Western approaches to caring for children, followed once more by concerns about the costs:

My two-year-old daughter was always sick after visiting the childcare centre. But I had no choice at the time as I had to look after both her and my six-month-old son on my own. I was feeling very tired, lonely, and vulnerable, and felt as if I’d been totally abandoned by society. And due to the pressures of supporting our whole family, my husband was always short tempered and impatient. Sometimes he even beat the kids, and often quarrelled with me. I felt an overwhelming sense of helplessness and became depressed.

In an extreme case, one informant confessed that when financial difficulty became so severe that she had no choice but to leave her child at home by herself while she had to go to work.

Several years ago when I was studying at university, the academic pressures were huge. I needed to attend university nearly every night of the week, and my husband held a full-time job in a Chinese restaurant. Because of this, my six-year-old daughter had to stay at home in the evenings by herself. And while I knew it was illegal in Australia, I had no other alternative as nobody could help us. When I recall those days, I feel very sad.

Finally, on the issue of mental health all the informants agreed that they experienced significant stress on a daily basis during their initial years of settlement. At the same time however, all would avoid confiding with doctors on issues relating to their mental health. One informant's comments in this regard stand representative:
Being Chinese, we don't talk about mental problems openly. And if I would go and see a mental health doctor even once, all of my friends would soon know about it and think I was mad. I know I would experience isolation and lose face.

**In-Depth Interview Findings in Summary**

As may be apparent, all the in-depth interviewees felt it was very difficult to negotiate and overcome a range of obstacles within Australian society, and especially those idiosyncrasies or otherwise part and parcel of Australian culture.

To begin with, most found it very difficult to obtain good jobs no matter how educated they were, and felt that the non-recognition of their overseas qualifications was very unfair. In turn, they felt that only a few, extremely well educated people could have a chance of really getting ahead, and that their own downward social mobility after migrating was a major source of their unhappiness. At the same time, language difficulties either directly contributed to or exacerbated their negative experiences, while caring for and supervising children in an Australian context greatly contributed to their experience of stress and feelings of hopelessness.

In consequence, many experienced problems in their marriage and/or family life in general, with significant increases in conflict between both spouses and between parents and children. And while many conceded they needed to have more genuine friends and a wider social network, they also felt it was difficult for Chinese women to join appropriate clubs or associations, and that in any case there was none in Brisbane catering especially for PRC-born migrant women at all. In consequence, many felt they lacked both
information particularistic to their circumstances, as well as resources of both an emotional and practical nature, both of which should really be a part of a local PRC-born Chinese community.

Importantly then, cultural barriers proved to be a major obstacle to their accessing health care services in Brisbane, and this especially in terms of reproductive health. Many further believed that a lack of awareness of Chinese cultural practices and beliefs in both hospitals and clinics had unnecessarily placed their own, as well as their family's health in jeopardy. Moreover, most not only found the general practitioner referral system in Australia very different from the system of health care in China, but that it was neither especially useful to them due to cultural differences, and that in any case the time involved in properly addressing, diagnosing, and treating their complaints was simply too long. Chart 4 is employed to sum up the findings of the needs assessment and conclude the part II.
Chart 4: Theoretical Framework: Findings from the Needs Assessment

Migration historical Factors  
*Downward mobility*

Social Factors  
*Lack of social network*  
*Low social-economic status*

Cultural factors  
*Traditional Chinese health Beliefs and practices*  
*Cultural conflicts between host and home countries*

Gender Roles  
*Role conflicts worsen by traditional Chinese culture twisted gender role expectation*

PRC-Born Migrant Women

Health  
*Barriers to access health services*  
*General Health*  
*(Unfamiliar with Different health care systems)*  
*Reproductive Health*  
*(Culture conflicts)*  
*Mental Health*  
*(Stigma to mental health)*

Settlement Stressors  
*Social isolation and loneliness*  
*Employment, language problems*  
*Cultural barriers*  
*Lack of support*  
*Marital and familial conflicts*  
*Academic pressures*  
*Public transport utilising problem*

Needs  
*Social needs*  
*Health needs*  

*Appropriate & Sensitive Strategies*
Part III

Discussion and Recommendations

Part III consists of three chapters. Chapter eleven highlights issues identified and summarizes the four pertinent kinds of needs to be introduced shortly -- the normative, felt, expressed, and comparative -- to set these in relief. In order to contribute to the empowerment of recent PRC-born migrant women, chapter twelve proposes a set of recommendations for developing appropriate strategies. For in the interest of developing a more sustainable and healthy society, all health providers should participate in promoting and facilitating equity, greater access, and greater quality of health care for migrant women. The concluding chapter presents a summary of the research findings, and offers a number of tentative directions for future research.
Chapter 11

Discussion

This chapter firstly represents findings in relation to other literature on the health needs of migrant women other than Chinese. It then highlights and discusses issues raised by this study. Among them, those of downward mobility, various barriers to access social and health services, as well as language barriers are recurrent and persistent problems experienced by PRC-born migrant women. Following a discussion of each of these in turn, this chapter further considers these vis-à-vis four key categories drawn from Bradshaw’s comprehensive needs assessment model from which needs can be assessed.

The social well being of migrant women in Australia has been the subject of research for many policy makers as well as academics. The literature review presented in the early chapters of this thesis has indicated that their health needs, particularly in terms of improvement of their health status and access to health services (Rice 1993), though recognised as urgent yet still remain unmet. This is because their health needs are not simply a simple matter of health but are related to a host of disadvantages they face, especially among the more recently arrived. Their cultural and language barriers, unfamiliarity with the Australian health system, and lack of support networks (HDV 1990), for example, are regarded as the most significant factors in the declining health status of migrant women, in particular among those from Asian background (Rice 1993, 1999, 1999a; Cape 1999; Yelland, et al. 1998; Rice and Naksook 1998; Jirojwong and

Rice (1993), for example, based on his study of a number of migrant women of non-English speaking background who had their babies delivered in Victorian hospitals, found that these women had experienced tremendous difficulties in accessing the health system. Because of their language barriers, not only they could not communicate well with the health care providers, they were also treated by these health care providers with little understanding and sympathy. Consequently not only they had problems following the instructions from health care providers, many remained ill informed and not listened to by health workers, and ultimately had limited access to health care information and services. Rice concluded that it is the responsibility of health care professionals to be more understanding of the needs of migrant women so that more culturally sensitive health care services, especially in the birthing area could be developed and delivered (Rice 1993).

Five years later, Rice and Naksook (1998) conducted further study on a group of 30 Thai women and their experiences of receiving pregnancy care and giving birth in Melbourne. They found that although these women were satisfied with the services provided, they remained critical of the support they had received from midwifery staff. Specifically, found the “nurses” rude, unsympathetic and uncaring. They also did not receive adequate information about health care. Similarly, in another study on childbearing, childbearing and cultural beliefs and practices among Southeast Asian communities in Australia based
on interviews with 23 Hmong women and eight Vietnamese women living in Melbourne, Rice (1999a) realised that many of the concerns he had in his previous studies repeated themselves. In particular, the complaints about the cultural insensitive practices and attitudes among health care providers, the lack of planning for developing more culturally appropriate services in maternity hospitals, the lack of bilingual health workers and availability of interpreter in maternity hospitals and community health centers seemed to be persistent.

More recently, Cain and Miralles (2002) also reconfirmed much of Rice’s early findings – that the barriers experienced by young refugee and migrant women from culturally and linguistically diverse background continued to hinder their access to appropriate health services. They argued that given awareness of the full range of health services among migrant women in the region was low, unless such information is made available to them in the appropriate language, their awareness and use of the health services would not be increased. For this reason, they recommended that specific campaigns needed to develop for specific target groups, with special communication strategies catering for young women from culturally diverse communities. In their view, health providers should also be proactive in recruiting young migrant women into their management committee to develop feasible management practices as well as to ensure privacy and confidentially for migrant women.

These studies, though focused on migrant women, yet are mainly on their reproductive rather than general health status. Moreover, none specifically involved any migrant
women of Chinese ethnic background. In fact, research on the health status of Chinese migrant women in Australia has been conspicuously inadequate. Even in the 1990s when Ip and Lui (1999) examined the social and health needs of older Chinese persons in Brisbane, their study did not exclusively target women, but included both older men and women. Still, based on the findings from five focus groups, they were able to identify the problems faced by older Chinese migrant women, which revealed a consistent pattern similar to other earlier studies of migrant women of other ethnic backgrounds.

Specifically, social isolation and loneliness, the need for an appropriate venue for social activities and support, the need for language assistance and interpretation services, increasing conflicts with their spouses and children, difficulties in accessing public transport and financial concerns were considered by them as major problems. At the same time, the study also found their use of services provided by hospitals and doctors was low, especially in terms of mental health services, breast-examination or screening, Pap smear or pelvic examination. Their findings also coincided with the results from an earlier study by Shi (1999) on PRC Chinese women in Brisbane where she found the lack of social support, language barriers, difficulties in understanding and dealing with the Australian medical system and health professionals, and the lack of awareness of health services and provisions had made it difficult for them to improve their postnatal health conditions.

It is in these contexts that the present study decides to examine systematically the general health needs of Chinese migrant women from the PRC. From the findings detailed in this study, a range of recurrent and often persistent health problems were experienced by
PRC-born migrant women during their initial years of settlement in Brisbane. And while some of the issues and problems raised may well find common ground with migrant resettlement experiences more generally, others also appear quite particularistic to PRC-born migrant women attempting to settle in a country such as Australia. Combined with other researchers’ findings, issues raised by these PRC-born immigrant women are of great concerns for other NESB women.

Of the various issues raised however, those of downward mobility, of various barriers to access health services, as well as problems centering on language difficulties, are especially ubiquitous.

**Downward Mobility**

Downward mobility appears to be a significant problem experienced by PRC-born migrant women in a country such as Australia. Among the pertinent variables closely tied to such a problematic are a range of historical, social-cultural, and gender-based factors. Whatever their varying sources however, these found especial manifestation among the participants of this study through serious difficulties in finding suitable work, a lack of support at the level of the family, as well as an absence of sufficient social networks.

To begin with, while PRC-born migrants might be less financially secure than others, they often at the same time hold many of the credentials of so-called 'middle-class' migrants of the last two decades -- and this in terms especially of their Chinese
educational levels and occupational status, albeit also in terms of their income levels prior to emigration. Nevertheless, language and communication difficulties, as well as their qualifications going largely unrecognized in Australia, mean the problems of finding suitable employment on migrating loom large in their initial settlement experiences. Indeed while many PRC-born migrant women have significant vocational backgrounds in areas such as education, medicine, and management, most are concentrated in low status and low skill occupations in the years following resettlement.

Closely tied to the experience of downward mobility is the loss on emigration of a supportive family network, something especially apparent during the time of childbirth, and subsequently childcare. For in China as alluded to earlier, not merely parents, but more often a range of extended family members assist both the mother and her children, and this along with the ease of finding suitable nannies from many rural areas of the country. In turn, the absence of support from extended family members after migrating to countries such as Australia -- along with the comparatively high cost of childcare of course -- holds significant implications for PRC-born migrant women's experience of pregnancy and motherhood. Compounding this, many also need to work to support and/or supplement their family's income, and this often without the support of family and kinship resources that not only play an important role in mediating between the individual and society, but also in affecting the successful economic adaptation of individuals, and ultimately of groups (Inglis and Wu 1992).
Finally, social networks of varying kinds pervade most women's lives in China, importantly providing information about shops, schools, banks, recreational activities, as well as emotional support. In consequence, the very real loss of social networks contributes to the downward mobility of many PRC-born migrant women, who also often feel an overwhelming sense of hopelessness without an effective and enduring network of social support. And it is readily apparent that the inability to build and consolidate social networks after immigration is a key contributor to the stresses PRC-born migrant women experience.

Barriers to Access Health Services

In terms of reproductive and mental health especially, socio-cultural beliefs -- as well as associated factors tied to gender and gender roles -- hold important implications for PRC-born migrant women's access to, and ultimately use or otherwise of, available health services.

Symbolic of this was the notable underutilization by participants of Pap smear services as well as breast screening, in which many expressed embarrassment about the procedures involved, and this above all when performed by male doctors. In turn, many for example felt that if they needed a vaginal examination, all strongly preferred a female doctor. Furthermore, and in regard to childbirth, recommendations they take frequent showers, being offered cold water as well as 'cold' foods, finding themselves too often in cold, air-conditioned spaces, and the need of many to handle heavier loads too soon after giving birth, were all strongly unwelcome due to these women's differing cultural traditions.
Likewise, issues of mental health proved to be another problematic concern. For while all agreed they experienced a great deal of stress in their daily lives following resettlement, rarely did they concede to seeing a consultant and utilizing mental health services. Importantly, many still considered such a process would bring shame upon themselves, and above all upon their families.

Above all of course, many such health beliefs proved difficult to maintain on resettlement in Australia. Among the most significant was the 'sitting the month' period -- the four weeks of complete rest after childbirth -- which was facilitated neither by health service providers in Australia, nor by the fact once more that there was nobody else to care for the newborn baby, and importantly to prepare its diet in accord with traditional Chinese dietary beliefs. In this way, such experiences were a product not merely of conventional Australian health provider's lack of knowledge of, and at times acceptance of differing cultural beliefs, but of the migrant's difficulties themselves in maintaining such knowledge without both the actual, and importantly sympathetic support of extended family members.

Nevertheless, three kinds of services directly related to childbirth were considered in varying ways inappropriate. The first of these was the antenatal class, which most participants found too difficult to access due to either a lack of time, or alternately of sufficient financial resources. Moreover, those who did attend such classes considered them somewhat useful, albeit in other respects insufficient as well as inadequate. For
example, many felt the information they obtained in such group meetings was too general, and did not address some of their particularistic issues and concerns.

Secondly, many of the participants also felt hospital physiotherapists were sent to teach women postnatal exercises too soon after giving birth, as well as encouraging them to return and undertake physical activities too soon after leaving hospital. In fact according to Chinese cultural beliefs, not only should physical activities be avoided in the weeks following childbirth, but women who carry heavy loads soon after childbirth could suffer both persistent lower back pain in the future, as well as the effective collapse of reproductive organs.

Finally, the recommended check-up of newborn babies and mothers five days after childbirth was similarly unwelcome by informants, with all affirming the Chinese cultural belief that both the mother and baby must avoid wind and cold soon after delivery.

**Language Barriers**

Difficulties with language are by no means a ubiquitously significant obstacle to the effective integration of NESB migrants into English language societies. However, language barriers do seem to be a particular problem faced by PRC-born migrant women in three key respects.

The first of these revolves around mitigative social and historical factors, tied to the fact that many PRC-born migrant women who emigrated to Australia spent years initially as
students, and thus had few financial resources to help further their English learning. Indeed many of these migrants most pressing financial, as well as time consuming responsibilities turned on supporting themselves, along with at times another family member or spouse, which eroded their possibilities for learning English properly. And having to often take low status jobs by no means provided a work environment conducive to bettering their English.

Secondly, the fact that many PRC-born migrant women often became mothers and wives compounded the language difficulties they faced on migrating to Australia. For as many were of childbearing age, these very same became recent migrants especially reliant on mainstream health services. Importantly, their notable lack of proficient English skills also contributed to less confidence to begin with to seek out available health services.

Finally, a number of underlying cultural factors also play an important rule in introducing further stress to language difficulties, and this especially once more for those who migrated to Australia and studied. For in traditional Chinese culture, women do more housework than men, while men engage in more social activities. Yet on arriving in Australia, these female student's better English skills in comparison to their husbands saw them burdened with a range of tasks normally the lot of the latter. With women assuming a more significant social and economic role, they felt a great deal of stress in often leading the family, having to make day-to-day decisions, and being the primary intermediary between their family and mainstream society. At the same time, while their English may have been comparatively better, it still was a burden in their fulfilling of
these new duties, with this among a range of complex developments crucial to understanding these women's needs in terms of changing family patterns on migration.

**PRC-Born Migrant Women’s Needs**

In terms of the findings of this study, the issues raised above might further be considered in light of those four key categories from which health needs can variously be assessed -- the normative, expressed, comparative, and felt. The following briefly discusses each of these in turn to set the preceding findings and discussion in relief.

**Normative Needs**

All sexually active women from the ages of 18 to 70 should have a Pap smear performed every two years, with the most common type of cervical cancer usually taking ten years to develop (Healthier Living online 2004). And while the exact causes of cervical cancer remain unknown, the risk for women increases significantly when such tests are not performed biannually, when a woman has been infected with certain types of the human Papilloma virus, when they smoke, or when they use oral contraception. Furthermore, the Queensland government provides free examinations, with a reminder system in place facilitating regular checks tied either to the normal or abnormal results women obtain (Pap Smear Register 2003).

Likewise, Queensland Health's 'Breast Screen Queensland Program' offers free mammograms, as well as follow-up services, for women aged between 50 and 69, while women in the 40 to 49 year old age bracket, as well as the over 70s, can also utilise it if
they wish (Breast Screen Queensland 2003). With around 1,400 women diagnosed with breast cancer in this state, of which an average of 430 die from the disease, breast cancer screening can importantly reduce the number of deaths by between 25 and 30 percent. As is the case with Pap smear examinations, health professionals recommend that women be routinely tested every two years (Queensland Health 2004).

In this way, the need for both more culturally appropriate, as well as gender-sensitive health screening programs, is obvious. For in this study, a lack of appropriate information, along with the non-participation of PRC-born migrant women in the decision-making process, were found to be two key factors contributing to their under-utilization of Pap smear tests as well as breast screening.

**Expressed Needs**

Although all migrants need to be in reasonably good health in order to enter Australia, according to a number of studies many migrant women experience a decline in health and well being following their immigration (Remennick 1999; Rissel and Khavarpour 1999). In fact many soon find themselves in situations of downward social mobility, as well as experiencing cultural disorientation part and parcel of having to adjust to a new society (Remennick 1999).

While many migrant health issues are poorly understood and ill documented, Queensland Health (2003) has recently summarized some of the health problems of Chinese women in Australia. In their view, the use of hospitals and doctors by Chinese women is low,
and they also revealed that Chinese women prefer to see female doctors, and this especially on issues of reproductive health. They also found that exercise among migrant women tends to decrease due to a lack of time and/or too few exercise partners, and that this is especially pronounced the older the woman. Similarly, language difficulties, a lack of information about facilities and services, and too few properly developed support networks, has also contributed to the particularistic difficulties Chinese women face during and after pregnancy and childbirth. And while NESB communities as a whole utilise less mental health services than the average -- with the prevalence of mental health problems among them no less perhaps (McDonald and Steel 1997) -- within Chinese communities many people feel inhibited and avoid speaking about mental health per se (Torrico 2000).

Furthermore, while Asian women have a higher cervical cancer rate, for example, than Australian-born women (Jelfs 1995), many PRC-born migrant women are unfamiliar with the conventions and recommendations associated with both Pap smear examinations and breast screening. In this way for example, after interviewing 151 Chinese migrant women in Melbourne, Kung et al. (1997) found that even compared with the rate of Pap smear and general breast examinations, mammography was the least used screening service. Moreover, although the incidence of breast cancer among PRC-born migrant women is in fact lower than the Australian-born average, their risks of developing the disease on migration increases two to five fold when compared with women in China (Grulich et al. 1995).
As revealed above, a significant contributor to the expressed needs identified in this study turned on a lack of information, networks, and other resources.

**Comparative Needs**

To draw some comparison with PRC-born migrant women, the number of Thai people to migrate to Australia has also increased steadily in the past two decades. And as with migrants from the PRC, many of these have in fact been women.

In turn, and based on a descriptive study involving 139 Thai-born migrant women living in Brisbane, Jirojwong and Manderson (1998) addressed some of the problems and issues which directly or indirectly affect their health status. Among other things, these latter included the women's low participation in preventative health programs, behavioural issues and issues of lifestyle, perceptions of health services, and the availability of social support during times of illness. Some of these women also elaborated on the problems they encountered in seeking health care from general practitioners, and that both this and their understanding of health education and sources of information was significantly impeded by their poor English language skills. As Jirojwong and Manderson (1998) revealed in fact, language difficulties in combination with the cost of medical care in Australia -- and this in contrast to the lower cost and perceived efficiency of Thai medical practitioners -- meant some of these women delayed medical attention until their return visits to Thailand.
Similarly, and this in comparison to both Hong Kong and Taiwanese Chinese migrants in Brisbane, PRC-born migrant women are significantly less financially secure. Furthermore, both Hong Kong and Taiwan-born migrant women have their own organizations and social centres; for the latter, the Taiwan Women's League of Queensland, which organises numerous activities, and for the former several Cantonese Opera Associations for example within which many Hong Kong women meet. As noted earlier, there is neither social organizations nor a social centre catering especially for PRC-born migrant women in Brisbane. In this way, and compared especially with Chinese migrant women from Hong Kong and Taiwan, PRC-born migrant women appear to lack a range of resources, and have poorer networks overall.

**Felt Needs**

Due to a variety of historical, cultural, economic, and socially engendered barriers, PRC-born migrant women in Brisbane experience many stressful hardships, a product and expression of, for example, social isolation, language barriers, financial difficulties, a lack of supportive families, pressures to achieve academically, and marital and/or familial conflicts. Among those identified in this study, some of the issues and problems of health for these women turn on a serious dissatisfaction with the general practitioner referral system, and in terms of reproductive and mental health in particular, the way cultural taboos and embarrassment tied to sex related diseases as well as mental well being often translates into a pronounced under-utilisation of a range of important health services.
### Table 11.1: Relationship Between Types of Needs and an Empowerment Framework

<table>
<thead>
<tr>
<th>Types of needs</th>
<th>Normative needs</th>
<th>Expressed Needs</th>
<th>Comparative Needs</th>
<th>Felt Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information</td>
<td>♣</td>
<td>♣</td>
<td></td>
<td>♣</td>
</tr>
<tr>
<td>Resource</td>
<td></td>
<td>♣</td>
<td>♣</td>
<td>♣</td>
</tr>
<tr>
<td>Networks</td>
<td></td>
<td></td>
<td>♣</td>
<td>♣</td>
</tr>
<tr>
<td>Decision-making</td>
<td>♣</td>
<td></td>
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<td>♣</td>
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</tbody>
</table>

In summary, above Table (Table 11.1) depicts the relationship between the different types of needs, and an empowerment centred framework. In this way, in order to fulfil the felt needs of PRC-born migrant women as identified in this study, it is imperative such migrant women become empowered by obtaining access to information as well as a range of resources, enabling them to re-establish networks and begin to participate in decision-making processes.
Chapter 12

Recommended Strategies

Before a set of recommendations are offered, it is necessary to recapitulate the findings from this study once again more succinctly in the following two tables. The first, Table 12.1, summarises the problems PRC-born Chinese migrant faced in their process of settlement process. The second, Table 12.2, summarises how the findings are related to the empowerment and Ottawa charter frameworks.

Table 12.1 Problems of Settlement among PRC-born Chinese Migrant Women

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Issues</th>
</tr>
</thead>
</table>
| Social           | • downward mobility  
                   | • social isolation and loneliness  
                   | • lack of support network  
                   | • language barriers  
                   | • employment problems  
                   | • pressures on academic achievement  
                   | • lack of help to deal with family conflicts  
                   | • public transport problems  
                   | • unawareness of social services |
| Health           | • need to increase facility to access health services (such as transport, childcare)  
                   | • lack of information on general health  
                   | • communication and language barriers  
                   | • cultural barriers  
                   | • need privacy  
                   | • unawareness of health services |
| Gaps of Health Services | • lack of cultural appropriate and sensitive services  
                              | • inadequate involvement of immigrants in improving health services  
                              | • services inaccessible |
### Table 12.2 Findings and Health promotion Framework

<table>
<thead>
<tr>
<th>Issues</th>
<th>Empowerment</th>
<th>Ottawa Charter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Downward mobility</td>
<td>Network, information, resources &amp; decision making</td>
<td>Healthy policy, supportive environment &amp; increase personal skills</td>
</tr>
<tr>
<td>Social isolation and loneliness</td>
<td>Network, information &amp; resources</td>
<td>Supportive environment</td>
</tr>
<tr>
<td>Lack of support network</td>
<td>Network</td>
<td>Supportive environment</td>
</tr>
<tr>
<td>Language barrier</td>
<td>Network, information &amp; resources</td>
<td>Supportive environment &amp; increase personal skills</td>
</tr>
<tr>
<td>Employment problems</td>
<td>Network, information &amp; resources</td>
<td>Healthy policy, supportive environment &amp; increase personal skills</td>
</tr>
<tr>
<td>Pressures on academic achievement</td>
<td>Information &amp; resources</td>
<td>Supportive environment &amp; reorientation of health services</td>
</tr>
<tr>
<td>Lack of help to deal with family conflicts</td>
<td>Network, information &amp; resources</td>
<td>Supportive environment</td>
</tr>
<tr>
<td>Public transport problems</td>
<td>Information &amp; resources</td>
<td>Supportive environment</td>
</tr>
<tr>
<td>Unawareness of social &amp; health services</td>
<td>Information</td>
<td>Health services, community participation &amp; supportive environment</td>
</tr>
<tr>
<td>Need to increase facility to access health services</td>
<td>Information &amp; resources</td>
<td>Supportive environment &amp; health service</td>
</tr>
<tr>
<td>Culture barriers</td>
<td>Information &amp; decision making</td>
<td>Reorient health services &amp; supportive environment</td>
</tr>
<tr>
<td>Lack of cultural appropriate and sensitive services</td>
<td>Resources</td>
<td>Reorient health services</td>
</tr>
<tr>
<td>Inadequate involvement of immigrants in improving health services</td>
<td>Decision making</td>
<td>Community participation</td>
</tr>
<tr>
<td>Services inaccessible</td>
<td>Information &amp; resources</td>
<td>Supportive environment &amp; reorient health service</td>
</tr>
</tbody>
</table>
Based on the settlement experiences, and the directly related health needs of new PRC-born migrant women in Brisbane as identified in this study, many potential remedial measures become apparent.

Among them, these could include forms of assistance to help new PRC-born migrants overcome feelings of isolation and loneliness; by extension, a common venue to provide a focal point and meeting place where new migrants can associate with people from Brisbane's PRC migrant community; interpreting services to help new settlers overcome language problems, and this especially in public hospitals, and importantly for women during and after pregnancy as well as childbirth; a more culturally as well as gender sensitive health care system, and within this more appropriate and diverse avenues of health care service; advice and counselling to help families better deal with times of conflict; and lastly, an improved public transport system which tailors somewhat to the heavy dependence of many new migrants on this form of transportation.

This being said, many of the underlying causes of the problems identified in this study are by no means one-sided, nor even clear cut, and neither should their potential resolution be considered a matter merely of altering governmental and public policies, and aiming to instigate change merely from above. For in dealing with, and potentially addressing these migrant's particularistic needs, a multifaceted and integrated effort is essential, entailing coordinated action in the form of governmental initiatives on the one hand, and inputs from the PRC-born migrant community on the other.
In turn, as a good many ethnic minorities, and certainly new migrants constitute comparatively disadvantaged groups, empowerment is a useful tool from many points of view. This could well constitute in fact a defining goal of Brisbane's PRC-born migrants, and perhaps PRC-born migrants elsewhere in Australia also, and infuses the following tentative recommendations.

**Recommendations for PRC-Born Migrant Communities**

Empowerment is a 'bottom up' strategy. Among the empowerment strategies potentially beneficial to PRC-born migrant communities, and PRC-born migrant women in Brisbane especially, four main themes organize the material adumbrated below: networks, information, resources, and decision-making.

**Networks:** According to relationship theory, women's sense of self and self-worth is grounded in their ability to make and maintain the relationships that not only help shape their families, but key spheres of society *per se* (Barski-Carrow and Condon 2004). Moreover, social support has long been recognized as a powerful factor partially determining both physical and mental health, and when strong can not only reduce perceived stress, but engender feelings of satisfaction and self-esteem, and thus contribute positively to wellbeing. As many migrants’ old social networks often end with their migration, establishing new networks, and/or building on partially extant ones, is an important and effective means to lessen the stress and health impacts of the initial years of settlement. In turn, it is beneficial to:
• Encourage leaders in the PRC-born community in Brisbane to help organise and establish a social centre where social networking between migrant women from the PRC could develop, and where social activities and services specifically organised to cater for Chinese migrant women could gain momentum.

• Encourage bilingual volunteers from the PRC-born community to work with new PRC-born migrant women and improve their English skills, and longer settled PRC-born migrant women to provide support, and/or assistance, during and after childbirth.

• Encourage social workers from the PRC-born community to provide assistance in terms of childcare, and to help families deal with domestic conflicts.

Information: As a lack of appropriate information is a problem for new PRC-born migrant women, as well as constituting a barrier to full services access, it is essential to:

• Encourage members of the PRC-born community in Brisbane to inform new migrants of better and more accessible interpreting services. In working with government on all levels, this should also include the installation of multilingual signage on public transport and in hospitals, of multilingual government printed matter, and a greater availability of free interpreting services to new migrants.
• Encourage the PRC-born community and governmental service providers to make better use of ethnic minority radio programmes, migrant community newspapers, and the Special Broadcasting Services (SBS) for information dissemination.

**Resources:** Members of the PRC-born community in Brisbane need to strive to improve their own health, as well as the health of each other, with assistance from health departments and initiatives at various levels of government. It would be beneficial to:

• Encourage governments and members of the PRC-born community to establish supportive social services -- such as family counselling and help lines -- tailored especially for migrant women *vis-à-vis* domestic conflict and disharmony at home.

• Encourage government to employ bilingual and bicultural health care professionals from the Chinese community, aiming to increase the perceived acceptability, and in turn use of health services.

• Encourage the government to resolve problems in the existing medical system, and achieve faster, more effective, and importantly culturally sensitive services to migrant women.

• Encourage community groups to find out more about funding to support health related, as well as other community initiatives and activities. In terms of PRC-born migrants overall, funding the establishment of a Chinese School to help
maintain their cultural heritage, and especially language abilities, would be beneficial to migrants by encouraging a sense of both belonging, and yet change, across generations.

- Encourage members of the PRC-born community to make submissions to the Brisbane City Council to review its present public transport services, and to highlight the needs of regular users, including importantly new migrants.

**Decision-Making:** Instead of continuing to complain about and lament their downward social mobility, PRC-born migrant women should try to improve their personal skills, and engage more with members of their new society. This could involve initiatives aiming to:

- Encourage PRC-born community leaders and community organizations to provide multiple health education seminars to empower Chinese migrant women, for when they come to comprehend some of their own limitations, they may be able to take greater steps to redress them.

- Encourage PRC-born migrant women to become directly involved in the assessment, planning, implementation, and evaluation of health promotion strategies.

- Encourage PRC-born migrant women to take the opportunity to further their education in Australian institutions.
• Encourage PRC-born migrant women to participate in the activities of key entities such as childcare centres, school committees, and local governmental committees, in order to express their needs and help find viable solutions.

Recommendations for Service Providers

In order to promote greater equity, access, and a better quality of health care for migrant women, key recommendations by using the Ottawa Charter action framework still are relevant to improving service provision. These involve the building of sound public health policies, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services, each successively summarised in point form below.

Building Sound Public Health Policies

• Establish public policy aimed at reducing inequalities in terms of the distribution of health resources;

• Develop and implement health promotion programmes targeting Chinese migrant women in particular;

• Increase the emphasis on community-based programmes of health care for migrant women;
• Develop a more comprehensive strategy for migrant women's health, with particular attention to mental health, as well as the prevention and treatment of reproductive health complaints;

• Encourage migrant women's participation in policy and programme development, and policy implementation and evaluation; and,

• Seriously address the issue of gender equality in all health promotion programmes, aiming to improve women's physical, psychological, and social wellbeing.

Creating Supportive Environments

• Provide bilingual information on health issues, social activities, and health services through PRC-born migrant women's networks, via community organizations, herbal stores, supermarkets, medical centres, and so on;

• Provide more bilingual and bicultural interpreters in hospitals and health clinics;

• Make use of educational pamphlets, posters, and stickers, manuals and booklets, as well as ethnic minority media such as newspapers and radios, to advocate services such as Pap smear examinations and breast screening. In terms of mental health, such media can play a significant role in not only informing the public, but
also altering Chinese cultural beliefs vis-à-vis the stigma attached to mental problems; and,

- Provide safe, convenient, and relatively cheap public transport to not only facilitate general mobility, but access to health services and social activities in particular.

**Strengthening Community Action**

- Provide seminars and workshops on health issues particularly relevant to the Chinese community, serving not only an educational purpose, but giving participants the opportunity to ask questions;

- Facilitate Chinese community participation in health programme design, and of the establishment of community-based programmes; and,

- Encourage members to give social support to one another, and to obtain support from government provided services.

**Developing Personal Skills**

- Increase people's awareness of existing services; and,
• Provide cross-cultural awareness training for PRC-born migrant women, thus eroding cultural barriers.

Reorienting Health Services

• Promote good health and prevent illness through the medium of general practitioners. GPs should provide information about Australian health care services, and encourage migrant women to use these services appropriately;

• Make services more appropriate for, as well as more responsive and sensitive to, those who use them; and,

• Establish group bookings in which women can arrive together and discuss their health problems and concerns.

To qualify of course, it should be noted finally that all these recommendations are necessarily idealistic, and that many require a good deal of further consideration to explore their feasibility, as well as their propensity to be genuinely beneficial.

I shall conclude part III by employing the same theoretical framework and applying findings of this study and recommended solutions (see chart 5). The results demonstrate that the theoretical framework is useful not only in organising and presenting data, but
accurate in its assumptions regarding the relationships between PRC-born migrant women, settlement stress and health needs.
Chart 5: Theoretical Framework: Needs and Recommended Solutions

**Migration historical Factors**
Downward mobility

**Social Factors**
- Lack of social network
- Low social-economic status

**Cultural factors**
- Traditional Chinese health Beliefs and practices
- Cultural conflicts between host and home countries

**Gender Roles**
Role conflicts worsen by traditional Chinese culture twisted gender role expectation

**PRC-Born Migrant Women**

**Health**
(Barricers to access health services)
- General Health
  (Unfamiliar with different health care systems)
- Reproductive Health
  (Culture conflicts)
- Mental Health
  (Stigma to mental health)

**Settlement Stressors**
- Social isolation and loneliness
- Employment, language problems
- Cultural barriers
  - Lack of support
  - Marital and familial conflicts
  - Academic pressures
  - Public transport utilising problem

**Social & Health Needs**
- Normative needs: Lack of information & decision-making
- Expressed needs: Lack of information, resources & networks
- Comparative needs: Lack of resources & networks
- Felt needs: Lack of information, resources, networks & decision-making

**Appropriate & Sensitive Strategies**

**Recommendations for service providers**
The Ottawa Charter action framework
- Building public health policies
- Creating supportive environment
- Strengthening community action
- Developing personal skills
- Reorienting health services

**Recommendations for PRC-born migrant communities**
The empowerment framework
- Information
- Resources
- Networks
- Decision-making
Chapter 13

Conclusion

Substantive and successive changes to Australia’s approach to immigration have seen a wave of Hong Kong and Taiwanese skilled and business migrants arrive since the mid-1980s. At the same time, Australia’s decision to export educational services to Asia has also resulted in a large number of Chinese students from the PRC residing in the country either temporarily, and for some permanently. The Tiananmen Square incident of June 1989 of course gave many such students the unusual possibility of achieving the latter if they wished; even more importantly however, this in time triggered a chain migration from China hitherto unseen in Australian immigration history.

Despite the burgeoning numbers of PRC-born Chinese in Australia however, only a handful of studies have attempted to explore and document their settlement experiences. Furthermore, attempts to investigate the settlement experiences of PRC-born Chinese women in particular are even more diminutive. Yet in the early twenty-first century it is timely to properly explore the nature of their integration into Australian society or otherwise, and how this might reflect in turn on the social and cultural mandates of multicultural Australia.

This study investigated in-depth the PRC-born migrant women’s settlement experience, analysed the historical, social, cultural and gender based factors underpinning their settlement stress and health problems. It identified their social and health needs and
provided solutions. This study also provided a conceptual framework to explain the relationship between underpinning factors, settlement stress and needs, and solutions. Thus, apart from the first chapter which discussed the fundamentals of the study, its purpose, background, rationale, nature, scope and theoretical framework, the organization of this study also divided into three parts each dealt with a particular component of the theoretical framework. Part I summarized the literature on Chinese migrants, issues of women’s health, issues of culture, and issues of stress. Part II provided the research methodology and presented findings. Part III integrated findings and suggested solutions.

More specifically, Part I provided five chapters for reviewing different areas of literature pertaining to the understanding of historical, social, cultural and gender based factors which mediated the settlement experience of PRC-born migrant women’s in Brisbane and Southeast Queensland. Chapter two began with a review of the history of Chinese emigration to Australia. It then highlighted both the pull and push factors underpinned the more recent arrival of PRC students in Australia. In particular, just when universities in Australia discovered a lucrative market in offering English language classes and full-fee paying courses to overseas students, those in the PRC were determined to take advantage of the opportunity to study abroad as a way to better their lives. Ironically while most of these aspiring PRC students were of middle class background, a vast majority of them had only limited financial resources to settle in Australia and many also suffered significant level of downward mobility because of their language and cultural difficulties.
Chapter three explored further into the problems women, and especially migrant women, faced because of their gender roles and cultural background. Specifically, the multiple roles they held often led to role conflicts, causing them greater psychological distress than that normally experienced by men. Migrant women encountered even more complex problems in their gender roles because they also had to cope with cultural differences, and the subsequent extra burden they had to shoulder in terms of their social and domestic responsibilities in the process of settlement.

Chapter four focused particularly on the relationships between traditional Chinese culture and health beliefs of PRC-born migrant women and how these ideas were articulated in the health practices of these women especially in terms of reproductive health. Frequently many of these beliefs were not understood by Western health practitioners and thus in many instances, these migrant women not only experienced conflicting cultural norms, confusion and consequently massive stress which they found difficult to communicate to others out of a sense of shame and helplessness. Not surprisingly their health and social well-being were deeply affected.

Chapter five delved deeper into the connections between stress and mental health, especially as a health concern for migrant women of non-English-peaking background. The literature surveyed suggested that the stress migrant women suffered were not only derived from social isolation, lack of suitable employment opportunities, but also from unexpected difficulties they found in giving childbirth. The accumulated and often compounded stress experienced by migrant women in turn led them to experience greater
fatigue and a heightened sense of anxiety. Some even developed insomnia, high blood pressure, and ultimately hypertension, mental problems and in some cases, cancer.

At the end of Part I, chapter six reviewed the history of health promotion and health promotion for women particularly. The chapter highlighted that good health was not only a pre-requisite for personal development and quality of life, it was also the foundation for a healthy society without which social and economic development would not be possible. For this reason, two key action frameworks, the Ottawa Charter action framework and the empowerment framework were considered most significant for promoting and improving women’s health.

Given these backgrounds, the four chapters in Part II proceeded to explain the research design and methodology before the findings were analysed. Chapter seven first delineated the rationale and the benefits for adopting a multi-methods approach for this research. It also provided a description of the framework that justified the use of both quantitative and qualitative approach for implementing a thorough need assessment. Specifically, the various methods of data collection were proposed: historical data was obtained through a literature review, quantitative data through the literature review and from census data, and qualitative data from in-depth interviews, key informant interviews, and a focus group. The snowballing sampling method for selecting the informants was also discussed.

As part of the process to identify the normative needs of PRC-born migrant women, chapter eight offered a community profile that described the demographic and socio-
economic characteristics of PRC-born migrant women in Brisbane as compared to Queensland. This provided not only the necessary background for understanding the problems many PRC-born migrant women encountered in their settlement in Brisbane, but also a verification of validity and reliability of the previous findings on PRC-born migrants suggested by the current literature. The profile reaffirmed that unlike other Chinese migrants from Hong Kong and Taiwan, many PRC-born migrant women were found concentrated in unskilled occupations, often working harder and longer hours to overcome their obstacles tied to a serious lack of socio-cultural and financial capital.

Chapter nine further examined the responses from key informant interviews. As each of the informants revealed, many PRC-born migrant women had faced serious social isolation and downward mobility. They also had numerous language and cultural barriers, and subsequently had little access to proper health care and assistance in Brisbane. Their need for accessing appropriate, culturally sensitive information in both hospitals and clinics was paramount.

Findings from individual in-depth interviews and focus group meeting were presented in chapter ten. Responses from these interviews found that certain stress was particularly common and recurrent among the PRC-born migrant women. This was especially associated with problems of social isolation and loneliness; difficulties in getting employment; downward social mobility; negotiating language difficulties and cultural barriers; having little or no support prior to and after childbirth, and especially in relation to childcare assistance. In some cases, these problems caused further conflicts in both
marital and familial relations; inability to cope with their academic studies. In others, some could not access health services because of their difficulties in utilising public transport. These problems and the subsequent stress they faced ultimately were detrimental to their health and social well-being. Some even began to show symptoms of poor mental health, and this was particularly prominent among the longer settled PRC-born migrant women.

Part III examined the implications of the findings and their meanings for recommended strategies. The four types of needs were first discussed holistically in chapter eleven to highlight the urgency and priority of the needs identified. Specifically, downward mobility, various barriers to access health services, as well as language difficulties which closely tied to a range of historical, social, cultural and gender-based factors were seen ubiquitous among PRC-born migrant women.

Chapter twelve followed on to make recommendations for meeting the needs as indicated by the informants in this research. In particular, utilising the empowerment framework, PRC-born women should be empowered to retain their control over health by strategies aiming to increase their access to information, networks, resources and decision-making. Moreover, as suggested by the Ottawa Charter action framework, governments and services providers should also be committed to promote equity, access and quality in health care for migrant women.
Since immigration has irrevocably altered Australian society, Australia’s well-being is intrinsically linked to the health of migrants. Findings from this research have provided a convincing case showing that many plights faced by the PRC-born migrant women in fact were not unique to them, but was commonplace for migrant women of other non-English speaking backgrounds. Both government and service providers should realise that in the long run, it pays to commit themselves to assist migrant women to mitigate the stress they face in the process of settlement. For the development of a sustained healthy, multicultural society will reap benefits for all Australians.
References


Settlement Stress and Health Needs of Migrant Women from the People’s Republic of China in Brisbane


221


Settlement Stress and Health Needs of Migrant Women from the People’s Republic of China in Brisbane


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Appendix 1: Sample questions of in-depth interviews

1. When, why and how did you migrate into Australia?
2. Can you describe your life during the first five years of your settlement in Australia?
3. What worried you most?
4. If you feel stressful, what do you think were the causes of stress?
5. If you needed help, whom did you turn to for support?
6. If you had health concerns, whom did you seek to help? What were your beliefs about health and illness?
7. What was the difference between health service systems here and in China?
8. Where and how did you get information about social activities and services?
9. What difficulties did you face and what services did you find helpful in assisting you in coping with the problems you had?
10. What kind of health services did you know or receive?
11. If you had given birth here, what worried you most when you were pregnant, during and after childbirth?
12. What should be done to help you access information and supportive services?