

# Bbkayi (Baby Plus 2)

## Project Report



Providing a cultural understanding of the barriers and enablers that exist within the transition into parenthood



Whitehorse Community  
Health Service Ltd.





# Bbkayi (Baby Plus 2)

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## Final Report

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**Suggested citation:**

Wong M. 2012. *Bbkayi (Baby Plus 2)*. MCWH: Melbourne.

**An electronic version of this publication can be found on the WCHS & MCWH websites. For any queries about this publication, please contact:**

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## **Acknowledgements**

The Multicultural Centre for Women's Health (MCWH) was commissioned by the Whitehorse Community Health Service (WCHS) to undertake this project with funding from the Department of Health, Eastern Region.

The project would not have been successful without the help of a number of representatives from numerous agencies, groups and organisations who made invaluable contributions to the project. In particular, thank you to Regina Quiazon (MCWH) and Olive Aumann (WCHS) for their guidance throughout the project; Katrina Stevenson (Box Hill Hospital) and the midwives at Birralee Maternity Service; Pam Heselev (City of Whitehorse) for organising focus groups within the City of Whitehorse; and Angela Murphy at the Burgess Family Centre who was continuously supportive of recruiting participants for the focus groups.

MCWH's three Chinese bilingual health educators, Dongmei Zhang, Rebecca Heli and Yuki Murdolo contributed to the project with their own experiences and knowledge. Thank you to Yuki and Dongmei who facilitated focus groups, checked translations, and for their overall enthusiasm and contribution to the project. More importantly, thank you to all the Chinese women who participated in the study and to the service providers who contributed their time, knowledge and assistance towards the project. The participation of all individuals has increased understanding of Chinese women's limited accessibility to maternity services and parent support programs in the Whitehorse Community of Melbourne, Australia.

## ACRONYMS

ABS	Australian Bureau of Statistics
BHE	Bilingual Health Educators
BM3	Baby Makes 3
DIAC	Department of Immigration and Citizenship
LGA	Local Government Area
LOTE	Language Other Than English
MCWH	Multicultural Centre for Women's Health
NES	Non-English Speaking
PRC	People's Republic of China
WCHS	Whitehorse Community Health Service

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**Definition of Chinese:** The term *Chinese* covers a diverse range of communities including those who come from People's Republic of China, Hong Kong, Taiwan and countries with a high population of ethnic Chinese such as Malaysia—which has an ethnic-Chinese population of 24.6% (Bureau of East Asian and Pacific Affairs, 2012), and Singapore—which has an ethnic-Chinese population of 74.1% (Bureau of East Asian and Pacific Affairs, 2011). Ancestral heritage is sometimes the only characteristic in common amongst the Chinese populations from these countries while other factors, such as religion, cultural beliefs and practices may differ.

## Executive Summary

The Multicultural Centre for Women's Health (MCWH) was commissioned by Whitehorse Community Health Service (WCHS) to implement the *Bbkayi* (Baby Plus 2) Project in response to WCHS's *Baby Makes 3* Program. *Baby Makes 3* (BM3) is an evidence-based program that provides healthy relationships among new parents. It is a primary prevention program that seeks to prevent violence against women before it occurs by promoting gender equality and reducing adherence to rigid gender roles among first time parents. During the initial stages of the program, it became apparent that women from Chinese communities were not accessing antenatal and maternity services at the same rate as other women in the Box Hill Hospital area in Melbourne, Australia. In response to this limited access, WCHS instigated *Bbkayi* to understand the enablers and barriers for Chinese women accessing antenatal, maternal and parent support programs during the transition to parenthood and the cultural practices and expectations that surround pregnancy and childbirth. Through understanding the needs and expectations of first time Chinese mothers and parents, the project aimed to build the capacity of health service providers working in the City of Whitehorse through the provision of good practice principles that ensure culturally-appropriate methods for working with the Chinese community in a health setting.

Research, including a key stakeholder consultation, focus groups with the Chinese community and literature review, was undertaken to gain an understanding of the

experiences and support needs of Chinese women living in the Box Hill Hospital area. The consultations were also utilised to determine the stakeholder's level of understanding, awareness and sensitivity towards Chinese traditions and practices regarding pregnancy, childbirth and health seeking behaviours, and to determine health promotion strategies for the Chinese community. Twenty-eight interviews were conducted with representatives of health provider organisations, as well as relevant health and community professionals. Four focus groups and one telephone interview were conducted with a total of 26 Chinese mothers and grandmothers. MCWH Chinese bilingual health educators facilitated and transcribed the focus groups.

The resettlement experience, lack of familiarity with the complex Australian health system, and lack of consideration of the health and spiritual beliefs of different cultures can make it difficult for Chinese couples, and for other immigrant and refugee communities, to access health services. For example, the role of the family and Chinese cultural practices such as the 30 day confinement period play an important part during pregnancy and childrearing stages and influence how Chinese women access antenatal, maternity and parent support programs and services. Loss of social support networks, structural and environmental barriers, language and cultural barriers, isolation, lack of awareness of health services and a lack of culturally and linguistically appropriate services are also contributing factors towards limited access to health

services.

A multi-faceted approach is required to improve the Chinese community's access to pregnancy-related health services and to implement culturally appropriate health promotion strategies for both Chinese parents and grandparents who play a major role in childcare. Governments—local, state/territory and federal—should provide funding for antenatal education classes, health promotion programs and parent groups that cater for immigrant and refugee communities. Orientation upon arrival to Australia should link immigrants into the support services and health systems that are available. Health service providers also need to assume responsibility for the implementation of these programs and services which should include utilisation of interpreting services, language, culture and gender-specific health and service education sessions, and distribution of multilingual written health information.

This report is divided into five chapters:

- Chapter 1 provides an introduction to the *Bbkayi* Project;
- Chapter 2 provides a project background which includes an overview of the *Baby Makes 3* Program, a literature review of the transition to motherhood for immigrant and refugee women and a wider demographic review of the Whitehorse and Manningham area;
- Chapter 3 covers the methodology of the *Bbkayi* Project and the

demographic of focus group participants;

- Chapter 4 highlights the project findings which includes themes and sub-themes drawn from consultations and focus groups;
- Chapter 5 provides recommendations for culturally appropriate implementation into maternity services and parent support programs.

# 1. Introduction

The Whitehorse Community Health Service (WCHS) was funded by VicHealth to conduct a 3-year primary prevention of violence against women initiative called *Baby Makes 3 (BM3)*, which aims to promote the safety and wellbeing of new mothers and babies. The *BM3* built capacity in the area of violence prevention and raised awareness in new families about the importance of equal and respectful relationships for first-time parents during the transition to parenthood.

*BM3* engaged antenatal women who attended the Box Hill Hospital Birralee Maternity Service (BMS), and worked with staff to build their capacity to identify and address family violence. As part of this phase, it became evident that women from Chinese communities were not accessing antenatal and maternity services at the same rate as other women. Chinese women experience significant barriers accessing health care and more importantly maternity care. WCHS' findings suggested that some cultural practices may make it difficult for Chinese women to access mainstream maternal child and health and other services outside the home in the initial post natal period and seeking support outside the home for family violence and relationship issues may be taboo in parts of Chinese culture. In addition, there are limited local new mothers groups or support networks for Chinese women, and the current services in place may not be culturally and linguistically appropriate.

In response to this limited access, WCHS commissioned MCWH to instigate *Bbkayi* and engage with antenatal and first-time Chinese

mothers in the Whitehorse Local Government Area (LGA) in Melbourne, Victoria.

The Multicultural Centre for Women's Health (MCWH) is a women's health organisation committed to improving the health of immigrant and refugee women across Australia. The centre is for all immigrant women, including refugees and asylum seekers, women from emerging and established communities, and women temporarily settled in Australia.

As part of its mission to improve the ability of immigrant and refugee women to assume greater control over their health and wellbeing, MCWH provides health education and information to women in workplaces and community settings. The Centre's health education program follows a holistic, peer education model known as the woman-to-woman approach, which is participatory in design and respects women's experiences and knowledge. Trained bilingual health educators (BHEs) conduct health education sessions for women in the preferred languages of the participants, covering a range of women's health issues, with a focus on sexual and reproductive health. The Centre provides health education to women in over 20 languages. The Centre also undertakes research on issues relevant to immigrant and refugee women, with the aim of improving culturally-appropriate service delivery and increasing women's capacity to improve their health and wellbeing.

*Bbkayi* aimed to understand the changing relationship needs in early motherhood and to assist Chinese couples in identifying services

and support that they may need to ensure positive relationships, development, safety and wellbeing. The Project name, which translates to 'Baby Plus 2', refers to a time of major relationship changes as couples increasingly focus their energy and attention on their baby. In many families, particularly within the Chinese community, children are the wealth of the family and couples are more likely to centre their attention on the newborn, while paying less attention to their changing relationship. In addition, the desire to be a 'good mother', along with the increased workload that occurs under many stereotypical mother roles, can lead to a decline in women's health and wellbeing.

The Project aimed to provide recommendations to WCHS for culturally appropriate and effective ways of working with diverse women, and Chinese women within a health setting. More specifically, the project objectives were to:

- Understand the issues and experiences of Chinese women before, during and after pregnancy;
- Understand Chinese cultural beliefs, practices and expectations about respectful relationships;
- Gain an understanding from Chinese women transitioning to first-time parenthood about their awareness of the transition to parenting challenges on lifestyle and relationships;
- Identify the barriers and enablers for Chinese women to access support

and services before, during and after pregnancy;

- Identify service and/or program gaps and culturally appropriate responses aimed at promoting equal and respectful relationships; and
- Build capacity within the Box Hill Hospital Birralee Maternity Service and other support services to promote the importance of parent support programs aimed towards preventing family violence using culturally appropriate methods.

The project findings from the key stakeholder consultations and focus groups with Chinese women are presented in Chapter 4. Although they have been categorised into separate key themes and sub-themes, the findings will overlap and intersect across all themes.

## 2. Project Background

### 2.1 Baby Makes 3 Program

*Baby Makes 3* (BM3) is an evidence-based program that provides healthy relationships among new parents. It is a primary prevention program that seeks to prevent violence against women before it occurs by promoting gender equality and reducing adherence to rigid gender roles among first time parents. Beginning in 2008 and working with the City of Whitehorse Maternal and Child Health Services, the project built capacity in the area of violence prevention, and raised awareness in new families, about the importance of equal and respectful relationships for first-time parents in the transition to parenthood. First time parenthood is recognised as a key target group for primary violence prevention during which time it is possible to effectively engage with both men and women when traditional notions of parenthood have an influence on their parenting roles (Flynn, 2011).

One of the project objectives is to give first time parents an understanding of the level of equality within a relationship and to acknowledge and value the contribution of the stay-at-home parent and to share parenthood tasks and responsibilities more equally. Based on a three-week discussion for new parents, the program covers topics associated with lifestyle and relationship changes following childbirth. Overall, the program has had a high success rate, with 90% of participants rating it at either very good or excellent. It has been a successful and unique primary violence prevention program for a number of reasons; through *Baby Makes 3*, participants have gained a greater awareness of how traditional

attitudes are enforced on gender and parenting roles, they have a greater understanding of their partner's role and a greater support for gender equality in new families, and some participants have implemented changes within their relationships that increase equality (Flynn, 2011). The *Baby Makes 3* program was successful in influencing people's attitudes and behaviours in relation to gendered roles, norms and expectations around the transition to parenthood. The program was awarded a 2011 VicHealth Award for Outstanding Achievement in Health Promotion in the category of participation and skill development.

WCHS plans to implement *Baby Makes 3* into other local government areas and across specific target groups which include immigrant and refugee communities. To successfully implement this program into diverse groups, it is important to first understand the complexity of issues, needs, cultural beliefs, practices and expectations around pregnancy, first-time parenthood and equal relationships for each group. Based on WCHS' initial project findings, it was noted that cultural groups such as the Indian and Chinese communities are not well represented in New Parent Groups despite being well represented in the City of Whitehorse. It was also evident that women from Chinese communities were not accessing antenatal and maternity services at the same rate as other women. This is significant given the City of Whitehorse is one of the top ten most culturally diverse local government areas (LGA) in Victoria, with an overseas-born population of 23% (ABS, 2006), and the

Chinese population being the second largest ethnic population following the Anglo-Australian population.

It was therefore important MCWH conducted research for *Bbkayi* to explore Chinese culture and expectations in a health setting and to provide recommendations for health providers to implement more culturally appropriate services in a meaningful way.

## 2.2 First Time Parents and Family Violence

First time parenthood and its relationship to the onset of family violence was the key focus of the *Baby Makes 3* primary violence prevention program. Therefore, the possibility of family violence was acknowledged during the implementation of the *Bbkayi* Project which included exploring the needs, expectations and experiences of first time Chinese parents in the City of Whitehorse.

Although the birth of a first child and the transition to parenthood is a unique experience for all parents, the experience also produces a number of challenges to a couple's lifestyle and relationship that can lead to a decline in relationship satisfaction. Within the first 12 months of the post-partum period, it is common for women and men in heterosexual relationships to assume traditional gender roles as 'mother' and 'father' (Parker & Hunter, 2011). The 'stay-at-home' mother and 'breadwinner' father are the most common gender roles for many new parents, however, these traditional roles impact negatively on the level of equality within a relationship. The new structures of a relationship, combined with the stress and expectations associated with the birth of a new baby inevitably produce significant changes to a relationship, and these changes often go unnoticed. In comparison to men, women are particularly more vulnerable to the impacts of new parenthood as the changes to their lifestyle include limited personal freedoms, a loss of financial independence and greater social expectations. They also take on the burden of additional and undervalued housework, as well as primary responsibilities for the care of the new baby (Flynn, 2011). During pregnancy and the

period following childbirth, the increasing or exacerbated pre-existing inequalities are known to escalate the occurrence of violence against women within the family.

Violence against women is a significant global public health issue that impacts negatively on the physical and mental wellbeing of women and children. It refers to any incident that involves an attempt or threat of physical, sexual or psychological harm that in most cases occur in the home and are often perpetrated by a male known to the victim (Durey, 2011). Unequal power relations between women and men support gender inequality, discrimination and oppression of women and these inequalities increase during the transition to parenthood (Poljski, 2011a). In addition, the socioeconomic factors, such as financial pressure, drug and alcohol abuse and lack of communication between family members increase the occurrence of domestic violence (Partnerships Against Domestic Violence, 2000).

For immigrant and refugee women, their vulnerability to violence is compounded by pre-migration experiences, competing priorities and difficulties, which include language and cultural barriers, unemployment, access to safe and suitable housing, financial issues associated with migration and low-paid employment, visa status, social exclusion and isolation. Other issues within ethnic communities include forced early marriage and childbearing (Poljski, 2011a). Domestic violence cases tend not to be reported by immigrant and refugee women due to factors including the limited availability of interpreter services, cultural or religious shame around

domestic violence, religious beliefs about divorce and the fear of being deported (Bartel, 2010). In addition, some definitions of domestic and sexual violence differ with diversity. It is therefore important for the complexity of immigrant and refugee women's experiences to be addressed with culturally-appropriate strategies for improving gender equality and the status of women within relationships.<sup>1</sup>

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<sup>1</sup> For further information on violence against immigrant and refugee women and primary prevention strategies, please refer to MCWH's report, *Poljski, C. (2011) On Her Way: Primary prevention of violence against immigrant and refugee women in Australia.*

## **2.3 The Transition to Motherhood for Women of Immigrant and Refugee**

### **Backgrounds**

The birth of a first child and the transition to motherhood is a critical stage in a woman's life where the care and support provided during the pregnancy and postnatal stage has a significant impact on the wellbeing of both mother and child. While there has been adequate research on the experiences of new mothers and their transition to new roles and responsibilities, research on the experiences of immigrant and refugee women in their new homeland has been limited and there is little data that sheds light on the impact cultural differences in beliefs and practices have on immigrant and refugee women's experiences of care or on their birth outcomes. There is also limited research or good evidence on the observance of traditional practices among immigrant women or the extent to which communication difficulties have an impact on women's experiences and birth outcomes (Small et al., 1999).

For immigrant and refugee women, compounding pre-migration and migration experiences such as war, civil unrest or dislocation, as well as socio-economic and structural barriers present different experiences of adaptation to new roles and responsibilities. Migrant mothers are not only transitioning to first time motherhood, but their cultural transition of migration includes loss of familiar environmental and social support networks and language barriers. Many migrants come from countries where great importance is placed on strong family social support networks, particularly during childbirth and childrearing where childcare is viewed as

the role of the family as opposed to the state (Liamputtong, 2001). With limited or no social support networks, language barriers and difficulties negotiating the health system, first time motherhood for immigrant and refugee women is undermined by feelings of loneliness and anxiety.

The experience of pregnancy and childbirth is embedded with variations of cultural beliefs and expectations. It is a time where women are more vulnerable to significant changes in their health and wellbeing, particularly when a desire to achieve the ideal image of a 'good mother' creates a number of challenges and hardships. Ideologies of motherhood are socially constructed in each society based on individual or collective beliefs, expectations, rituals and norms. All women, including Australian-born women, have traditional practices associated with childbearing that bring comfort and assurance in a new and changing environment. Whilst, Australian healthcare utilises childbearing practices, techniques, knowledge and support that are considered 'best practice', these often leave little room for diversity. Having a child in the Australian health system, where postpartum techniques, knowledge and support are assumed by service providers to be adequate across diverse populations, can make it difficult for immigrant and refugee women to observe their own cultural practices concerning childbirth. Being unable to carry out traditional practices increases anxiety and the occurrence of health problems (Liamputtong, 2006). These practices may

include ideas around showering, the type of food eaten, and the amount of rest. Furthermore, the complexity of the Australian health system can be confusing for women who may come from countries where it is customary to have direct access to specialised health systems and there is more focus on treatment rather than prevention (Poljski, 2011b). As a result, immigrant and refugee women may be discouraged from accessing maternity services and parent support programs. Global data indicates that immigrant and refugee women are at a greater risk of suffering poorer maternal and child health outcomes. Based on MCWH's 'Sexual and Reproductive Health Data Report' (2010), non-English speaking women are less likely (or not at all likely) to access antenatal care before 20 weeks gestation when many risk factors could be addressed.

Adequate maternal health care is an important factor in the prevention of adverse pregnancy outcomes and declining health and wellbeing of immigrant and refugee women (Chen, Short, & Entwisle, 2000). While acknowledging that socioeconomic, demographic, cultural and environmental conditions impact on women's access to maternal and child health services, a lack of cultural awareness and sensitivity within health settings forces clients to compromise their own values and beliefs to adapt to mainstream concepts, or limit and discourage them from accessing services, both of which create negative experiences that can be detrimental to the health of immigrant and refugee women.

Past studies on new Chinese mothers and their utilisation of health services and childbirth

expectations in both Australia and internationally indicate the particular issues and needs of the Chinese community. Chan and Quine's (1997) study explored the utilisation of Australian health services by Chinese migrants from Hong Kong and China. The findings indicated a strong preference for Chinese-speaking general practitioners, insufficient interpreter services, low use of preventative services, and lack of knowledge about the existence of ethnic health workers. In addition, factors such as cost, accessibility and language had an influence on migrant's access to health care services, with language barriers being the major factor. However, it is important to note that Chinese communities are not a homogenous group, and the findings from this project provide an overview of the experiences of Chinese women's access to maternity and parent support programs that are specific to the City of Whitehorse and Manningham.

## 2.4 Wider Demographic Review of Whitehorse and Manningham

This demographic review was conducted before the commencement of focus groups and provides insight into the key groups residing in the Box Hill Hospital catchment area, with a particular focus on the Chinese population. The Box Hill hospital catchment area is situated within the City of Whitehorse and borders the City of Manningham, therefore this review will focus on the statistics of both Local Government Areas (LGA). City of Whitehorse is situated between 12 and 22 kilometres east of the Melbourne CBD, surrounded by adequate public transport including tram routes and two metropolitan train lines. One of the major features of Whitehorse is the Box Hill Hospital (City of Whitehorse Community Profile, n.d). As of 30<sup>th</sup> June 2010, the Whitehorse population was 156,797 people (ABS, 2011). In comparison, the City of Manningham is situated between 12 and 20 kilometres from the CBD with a population of 119,190 (ABS, 2011). Females in the Eastern Metropolitan make up 50.9% of the population while males make up 49.1% (Womens Health East, 2010).

country of birth for females from NES countries with 4.3% in Whitehorse and 4.4% in Manningham (Womens Health East, 2010).

### **Country of birth: gender specific**

In terms of country of birth, the most diverse LGA in 2006 where females were born overseas in Non-English Speaking (NES) countries were Manningham (28.5%), Monash (33.9%) and Whitehorse (23.0%). Table 1 shows the population percentage of females in Whitehorse and Manningham who have either been born in Australia, born overseas in an English speaking country, or born overseas in a non-English speaking country. Table 2 shows that China was the most common

**Table 1: Females born in Australia and overseas 2006**

<b>Birthplace</b>	<b>Manningham</b>	<b>Whitehorse</b>
<b>Australian Born</b>	60.7%	66.2%
<b>OS Born English</b>	6.0%	6.2%
<b>OS Born NES</b>	28.5%	23.0%
<b>Not Stated</b>	4.9%	4.6%
<b>Total</b>	100%	100%

Source: ABS, 2006

**Table 2: Top ten NES birthplace countries of females in 2006**

<b>Country of birth</b>	<b>Manningham</b>
China	4.4%
Italy	3.4%
Greece	3.0%
Hong Kong	2.5%
Malaysia	2.5%
India	0.9%
Vietnam	0.9%
Singapore	0.6%
Iran	0.6%
Germany	0.6%

Source: ABS, 2006

<b>Country of birth</b>	<b>Whitehorse</b>
China	4.3%
Malaysia	2.0%
Vietnam	1.4%
Greece	1.4%
India	1.3%
Italy	1.3%
Hong Kong	1.3%
Sri Lanka	0.9%
Germany	0.6%
Indonesia	0.5%

## Age of demographic

The median age of the Whitehorse population as of 2006 was 35-39 years, while the median age for the City of Manningham was 40-45 years (Womens Health East, 2010). The age distribution of those born overseas reflects the different waves of migration that has occurred in Australia. While a mid to older group of overseas-born populations may represent those who migrated during the post-war years, a younger group of overseas-born populations represents those who have migrated recently. In the city of Boroondara, Monash and Whitehorse, females born in countries such as China, Malaysia, Singapore, Hong Kong and India have a higher representation of people aged 15-24 years and 25-54 years. Additionally, females born in Taiwan and Indonesia have an even higher representation of people aged 15-24 and 25-54 years with a percentage greater than 70% (Womens Health East, 2010).

Women's Health East (2010) identified four

key life stages that correlate with women's experiences of health and wellbeing. These are defined as

- Younger years (15-24)
- Young to mid years (25-54)
- Mid to older years (55-74); and
- Older years (75+)

This demographic review will focus on the population that falls within 'young to mid years' as this age group encompasses a range of experiences that include long-term adult relationships, motherhood and the demands of working both paid and unpaid work.

Tables 3 and 4 illustrate the age distribution of females born in NES countries where there is a high ethnic Chinese population. Women within the 'young to mid' years (25-54) are widely represented across all relevant countries presented in the tables, which means there is a large percentage of women in the child-bearing or motherhood stage living within Whitehorse and Manningham.

**Table 3: Age distribution of females born in NES countries, 2006, City of Manningham**

	0-4 Year s (%)	5-14 Year s (%)	15-24 Years (%)`	25-44 Years (%)	45-54 Years (%)	55-64 Years (%)	65-74 Years (%)	75-84 Years (%)	85+ Years (%)	Total (No.)
<b>China</b>	0.3	2.4	15.2	36.7	18.7	11.6	8.6	4.7	1.8	2483
<b>Hong Kong</b>	0.3	3.2	16.1	32.6	29.0	13.7	3.6	1.3	0.2	1428
<b>Malaysia</b>	0.5	3.3	11.0	32.5	27.1	17.5	6.2	1.7	0.2	1415
<b>Singapore</b>	0.8	12.7	11.6	33.7	21.3	13.8	4.1	1.9	0.0	362

Source: Women's Health East, 2010

**Table 4: Age distribution of females born in NES countries, 2006, City of Whitehorse**

	0-4 Years (%)	5-14 Years (%)	15-24 Years (%)`	25-44 Years (%)	45-54 Years (%)	55-64 Years (%)	65-74 Years (%)	75-84 Years (%)	85+ Years (%)	Total (No.)
<b>China</b>	0.5	3.0	22.2	41.1	14.7	6.2	6.5	4.2	1.7	3246
<b>Malaysia</b>	0.7	4.3	16.3	35.7	22.7	12.5	4.7	2.2	1.0	1500
<b>Hong Kong</b>	0.8	2.6	29.4	35.0	18.2	8.9	2.7	1.3	1.0	959

Source: Women's Health East, 2010

### **Language**

While country of birth and age distribution provide good indicators of cultural diversity within communities, statistics regarding 'languages other than English' (LOTE) and the proficiency of spoken English also urge the importance of tailoring health programs and services so that they are accessible and appropriate to diverse communities. The key LOTE of the City of Whitehorse in 2006 were Cantonese (4.7%), Mandarin (4.4%), Greek (3.4%), Italian (2.1%), and Vietnamese (2.0%) (ABS, 2006). Mandarin is the official language of China and is widely spoken in People's Republic of China (PRC) and Taiwan. Cantonese is spoken in Hong Kong, the Guangdong province of the PRC, Vietnam, Malaysia, Singapore and Christmas Island (Abbato, 2011).

Table 5 and 6 highlights the proficiency of spoken English by sex and those who speak Chinese in Whitehorse and Manningham. Overall, there is a high proficiency of spoken English by Chinese speaking people living in the City of Whitehorse and Manningham. There is also a relatively high number of

people who can speak English not well or not at all, which contributes toward language barriers in the health system where appropriate services, such as interpreters, might not be made available.

In both LGAs men have, on average, a 5% higher proficiency in English than women. This is important to note in terms of the onset of family violence, the capacity to make informed decisions and independence. Men's higher English proficiency can create a power imbalance, particularly when women access health services and receive or give information. Often in these cases, men may be asked to translate for their partners or speak on behalf of their partners in decision making.

**Table 5: Proficiency in spoken English by sex for Chinese language, City of Whitehorse**

	Speaks English Very Well or Well %		Speaks English Not Well or Not at All %		English Proficiency Not Stated (%)		Total (No.)	
	Females	Males	Females	Males	Females	Males	Females	Males
Chinese Languages	73.4	78.4	25.9	20.7	0.7	0.9	7503	6453

Source: Women's Health East, 2010

**Table 6: Proficiency in spoken English by sex for Chinese language, City of Manningham**

	Speaks English Very Well or Well %		Speaks English Not Well or Not at All %		English Proficiency Not Stated (%)		Total (No.)	
	Females	Males	Females	Males	Females	Males	Females	Males
Chinese Languages	75.2	80.2	24.0	18.9	0.8	0.9	7112	6352

Source: Women's Health East, 2010

### **Visa on arrival**

Data received from the Department of Immigration and Citizenship (DIAC) settlement reporting facility represented only permanent migrants who have arrived in Australia on permanent visas. Therefore, data was available for each LGA on the number of Chinese migrants who had arrived on skilled, family and humanitarian visas, while data for student and temporary (457 subclass) visas was only available for each state, directly from the DIAC. In the last 5 years from June 30 2012, Victoria received a total of 7431 men and women from PRC on 457 subclass visas, and a total of 110,337 men and women arrived on student visas (DIAC, 2012a). Considering City of Whitehorse and Manningham are in close proximity to a number of tertiary educational institutions such as Deakin University and Box Hill Institute of TAFE, and on the basis of the age distribution demographics, we can assume that a large proportion of Chinese students live in both these areas. In addition to the barriers immigrant and refugee women may experience accessing

antenatal and maternity services, it is important to note that international students may encounter a number of additional difficulties in accessing pregnancy-related services that relate to the complexity of their visa entitlements and overseas student health cover policies (Poljski, 2011b).

According to the statistics available for each LGA, a total of 4409 men and women have settled in Whitehorse on permanent visas from PRC in the last 5 years from June 30 2012. Of these, 37% are women on skilled visas and 18.3% on family visas while fewer men have arrived on skilled (33.6%) and family (10.3%). Manningham received half of Whitehorse' permanent visa arrivals with a total of 2129 people, and a similar distribution of females on skilled and family visas (34% and 20.8% respectively). Similarly, fewer men had arrived on skilled and family visas (32.8% and 12.2% respectively) (DIAC, 2012b).

**Table 7: Number of 457 Visa and Student Visa arrivals from PRC between June 30 2007-2012, Victoria**

<b>Visa on Arrival</b>	<b>Total</b>
<b>457 Subclass</b>	7431
<b>Student visa holders</b>	110, 337

Source: Department of Immigration and Citizenship, 2012a

**Table 8: Visa on arrival from PRC between June 30 2007-2012, City of Whitehorse**

	Skilled Visa (Total no. 3114)		Family Visa (Total no. 1261)		Humanitarian Visa (Total no. 34)	
	Male	Female	Male	Female	Male	Female
<b>No. of people</b>	1482	1632	456	805	16	18
<b>Percentage of total number of people who arrived on permanent visas</b>	33.6	37	10.3	18.3	0.4	0.4
<b>Total number of people who arrived on permanent visas</b>	4409					

Source: Department of Immigration and Citizenship, 2012b

**Table 9: Visa on arrival from PRC between June 30 2007-2012, City of Manningham**

	Skilled Visa (Total no. 1423)		Family Visa (Total no. 702)		Humanitarian Visa (Total no. 4)	
	Male	Female	Male	Female	Male	Female
<b>No. of people</b>	698	725	260	442	4	0
<b>Percentage of total number of people who arrived on permanent visas</b>	32.8	34	12.2	20.8	0.2	0
<b>Total number of people who arrived on permanent visas</b>	2129					

Source: Department of Immigration and Citizenship, 2012b

### 3. Methodology

The Multicultural Centre for Women's Health follows a feminist and social model of health within its programs, projects and research framework. Utilising a woman-to-woman approach, research methods are participatory in design and allow for immigrant and refugee women to be active contributors towards empowerment and change by exchanging their own knowledge, experiences and choices in a non-hierarchical manner and in their own language.

#### **Ethics**

Ethics approval from Eastern Health was required to run focus groups with antenatal women accessing the Birralee Maternity Service (BMS) at Box Hill Hospital and within their Cantonese antenatal classes. Despite a successful application granted by Eastern Health, BMS were reluctant to support the project because the number of antenatal projects they were supporting had already reached capacity. As a result, the project was only able to recruit focus group participants from maternal and child health centres.

#### **Consultations**

The *Bbkayi* project involved both consultations with key stakeholders working within the City of Whitehorse and Manningham, and focus groups with the Chinese community attending services in the Whitehorse area, as well as consultation with past *Baby Makes 3* participants. Extensive consultations with key stakeholders were undertaken to: identify current understanding and knowledge of Chinese beliefs, practices and attitudes around pregnancy and motherhood; ascertain factors that contribute to Chinese women's limited access to services, and understand stakeholder's practices and capacity

working with Chinese women. Overall, the consultation involved 28 participants (see Appendix 1 for a list of represented organisations). One group consultation and 5 interviews were conducted with professionals who work with the Chinese community in Whitehorse. Nursing, midwifery, health education and community development were the main disciplines represented in the consultation. Appendix 3 contains the questions discussed during the consultation.

#### **Focus Groups**

Four 2-hour focus groups were also conducted with new Chinese mothers and grandmothers living in the City of Whitehorse and Manningham. Each focus group consisted of 5-10 participants and was conducted in Mandarin by MCWH's bilingual health educators who are appropriately skilled and experienced to facilitate culturally-appropriate focus groups and to report findings back to the MCWH Project Officer. The Project Officer, who was also of Chinese background, attended all focus group sessions to take notes. Focus groups were tape-recorded with the permission of participants, and were then transcribed into English by the BHEs.

One telephone consultation was also conducted by the Project Officer in English with a previous *BM3* participant of Chinese background.

A total of 26 Chinese mothers and grandmothers participated in the focus group and consultation.

Focus group questions (see Appendix 4) covered three themes:

- Beliefs, values and expectations around pregnancy and parenthood;

- Information seeking behaviour and access to health and services; and
- Suggestions for improving health services and access for Chinese community.

If any major issues arose, the bilingual health educator was prepared to refer participants to relevant support services and organisations.

### **Survey**

Participants also completed a brief survey designed to collect data on basic demographics, visa status, education and family support. A participant demographic review is highlighted in section 3.1.

It was initially anticipated that participants would be recruited from both new mothers groups and from the Birralee Maternity Service (BMS) to incorporate both antenatal and first-time parent's experiences into the findings. However, recruitment of antenatal women from the Box Hill hospital was not possible without the approval of BMS. Although it is not clear what projects BMS already supported, more services and organisations are needed to support projects that aim to build capacity for provision of culturally appropriate programs and services within a health setting. Nevertheless, four focus groups were conducted with new mothers, covering issues extensively.

Participants from new parent groups were recruited with the assistance of the City of Whitehorse Maternal Child and Health coordinator and the Burgess Family Centre who were running Mandarin-speaking play groups and allowed the Project Officer and BHE to introduce the project to new Chinese parents and invite participants to attend the focus groups.

Invitations were also advertised at Burgess Family Centre and distributed to neighbourhood houses, churches, and other organisations. Although partners were invited to participate in the focus groups, only grandmothers—who often play an equally important role in childrearing and decision making—participated, in addition to new mothers. The lack of partner involvement was a limitation perhaps partly because focus groups could only be held in the daytime when partners may have been at work. However, many new mothers were dropped off by their husbands who either waited outside or did other errands. In other cases, grandfathers arrived with both mother and grandmother but did not stay for the focus group. Despite being invited and welcomed in by BHEs to join the focus group discussion, men declined to participate. This may have been due to the gender stereotype that playgroups are women-only spaces. Nevertheless, an all women focus group promoted a safe and comfortable environment in which participants could share personal experiences and discuss sensitive issues that may not have occurred in the presence of men.

The project was limited to exploring only the experiences of participants who were new mothers and grandmothers. It is therefore acknowledged that the project only presents the findings of this particular group and recognises that experiences vary across and within cultures and locations, emphasising that the Chinese community is not a homogenous group.

### 3.1 Demographic of Participants

A total of 26 women participated in the focus groups and phone interview, which comprised of 17 new mothers, 8 grandmothers, and 1 *BM3* Chinese mother participant. All participants originated from China and chose to participate in a Mandarin-speaking focus group, except the phone conversation which was conducted in English.

22 demographic surveys were completed by the participants. Table 10 provides a demographic background of the cohort of participants in the focus group and interview. Table 10 demonstrates that more than two-thirds of these women were aged from 25-30 years (36.4%) and 37+ years (36.4%); and less than one-third were aged 31-36 years (26.2%). More than half had lived in Australia 0-5 years (59.1%) and over half had arrived on skilled migration visas (52.4%); less than one-third arrived on family migration visas (14.3%); and student visas (14.3%); or other (19%).

There was almost an equal percentage of participants who do (55%) and do not have family living (45%) in Australia. However, it is important to note that the data is a combination of both mother and grandmother (who were visiting family) responses; and if recorded independently of one another, the percentage of mothers without relatives in Australia would be greater.

The majority of participants also had a high level of education where 42.9% had a university/tertiary degree and 47.6% had a master's degree. The two participants who had no schooling were the grandmothers.

**Table 10: Demographic background of cohort of participants in focus groups and interviews**

	<b>New Mothers and grandparents (n=21)</b>	<b>BM3 Participant (n=1)</b>	<b>% of participants</b>
<b>Age</b>			
18-24 years	0	0	0
25-30 years	8	0	36.4
31-36 years	5	1	27.2
37+ years	8	0	36.4
<b>Country of birth</b>			
China	21	1	100
<b>Years in Australia</b>			
0-5 years	13	0	59.1
6-10 years	6	0	27.3
11-15 years	2	1	13.6
16-20 years	0	0	0
21 years or more	0	0	0
<b>Visa On Arrival</b>			
Skilled migration	11	0	52.4%
Family migration	3	0	14.3%
Refugee/Humanitarian	0	0	0
Student	2	1	14.3%
Long-stay business visa	0	0	0
Other	4	0	19%
<b>Relationship Status</b>			
Single	0	0	0
In a relationship	1	0	4.5%
Married	20	1	95.5%
Separated/Divorced	0	0	0
Other	0	0	0
<b>Who do you reside with?</b>			
I live alone	0	0	0
Partner only	9	0	42.9%
Partner and parents	3	1	19%
Partner and in-laws	2	0	9.5%
Partner, parents, and in-laws	1	0	4.8%
Other	5	0	23.8%
<b>Relatives in Australia?</b>			
Yes	10	1	55%
No	9	0	45%
<b>Occupation</b>			
Employed (full or part time)	6	0	27.3%
On maternity leave	3*	0	13.6%
Student (full or part-time)	3	0	13.6%
Parenting duties	5	1	27.3%
Other	7	0	31.8%
<b>Highest level of education</b>			
No Schooling completed	2	0	9.5%
Primary school (or equivalent)	0	0	0
Secondary (or equivalent)	0	0	0
University/Tertiary	9	0	42.9%
Masters Degree	9	1	47.6%
Doctorate	0	0	0

\*The number is inclusive of participants who checked 'employed', therefore the sum does not equal 100%.

## 4. Project Findings

Findings from the stakeholder consultations and focus groups are reported in this chapter.

### 4.1 The Migration Experience and Its Influence on Culture and Parenthood

While the transition to motherhood presents a number of challenges and changes for all women, the loss of familiar environmental and social support networks, visa status and language and cultural barriers presents additional difficulties for Chinese women adjusting to new roles and identities (Liamputtong, 2001). This may produce feelings of isolation, anxiety and create a vulnerability to violence. Newly arrived migrants share common issues including settlement demands such as education and employment; financial issues; difficulties accessing affordable and suitable housing; limited English; inaccessible transport options; lack of access to suitable and affordable childcare; difficulties navigating the health system; and limited awareness of or suitable parenting support services (Poljski, 2011a). The majority of Chinese who migrate to Australia arrive on skilled migration, family migration or student visas. From 2006-2010, 23.4% of skilled migration visas, 13.6% of spouse visas, 40% of parent visas, 19.5% of bridging visas and 27.7% of student visas were issued to Chinese women (DIAC, 2011b in Poljski, 2011a). Each visa status is bound by different regulations and entitlements and these will impact on individual experiences within health and support systems. While some health organisations and service providers may provide services to all women regardless of their visa category, others restrict their services to those permanently settled in

Australia (Poljski, 2011a). The complexity and confusion of these services can discourage immigrant and refugee women on temporary settlement from accessing pregnancy-related services and may then influence how pregnancy, childbirth and childrearing are experienced by Chinese women and their families.

#### 4.1.1 Loss of environmental and social support networks

*“There are two kinds of Chinese women: one is heavily supported by family, and the other is isolated and lonely because they don’t have families here and most of their partners are at work in restaurants so they don’t have time for them...they’re really by themselves. If they’re young, their mothers and fathers are still working and can’t come to help look after them. They don’t drive so they can’t get to services.” (Key Stakeholder)*

The birth of a child can be an isolating experience for a first time Chinese mother who is not yet familiar with Australia’s health and support services, public transport, social support networks, has limited English proficiency and experiences difficulties practicing cultural traditions associated with pregnancy, childbirth and childrearing.

In traditional society, Chinese women gave

birth at home and received advice from the elderly who ensured new mothers carried out the *zuo yue zi* period. *Zuo yue zi*, which will be described in more detail in section 4.2, is Mandarin for 'sitting the month' and refers to the 30 day confinement period that many Chinese women follow after birth to replenish their health and energy that has been lost during pregnancy and childbirth. The 30 day period requires rest and consumption of certain types of food to assist in restoring energy and health. As it was traditionally the job of the elder in the family to prepare nutritious foods for the new mother and the responsibility of the whole family to take care of the baby while mother rests, it can be difficult for new mothers to follow the same traditional structure in Australia without familiar social support networks (Liem, 1999). Although many grandparents visit from their countries of origin and live with new parents as primary child carers for the length their visa will allow, not all families can afford to do that and have limited family support. In comparison to Australian citizens and residents who are entitled to social security benefits, baby bonus, and paid parental leave, the majority of Chinese migrants rely on employment as their only source of income. Fathers generally return to work or study shortly after birth, working long hours, while mothers spend equally long days alone with the baby with little or no family and service support. This can be very isolating for new Chinese mothers who usually rely completely on their husbands for transport to attend doctor's appointments and other activities; may live too far from public transport; or are not aware of available support services. A few project participants had walked at least an hour to attend the focus groups,

which sheds light on the difficulties they experience with transport, as well as their eagerness to participate in social activities outside the home. People from immigrant and refugee backgrounds are more likely to attend services that are closer to home or public transport (Australian Government: National Health and Medical Research Council, 2005)

*"Women are lonely and their extended family who come to Australia to help feel equally lonely" (Mother)*

The birth of a child can be equally lonely for the new mother and for the grandparents who visit from China. They experience significant cultural transition which includes difficulty speaking the language, loss of familiar social support networks and services, and a generation gap where their past experience of childbirth cannot be shared with their children's childbearing experience because it is in a completely different cultural context to their own. Similar to new mothers, grandparents are usually housebound, the likelihood of meeting other people in the community is limited, and they too have difficulties accessing and navigating the transport and health system. In circumstances where both parents have returned to work or study, the grandparents take responsibility of childcare which includes taking children to doctors' appointments and other services. However, grandmothers said they do not access services because they cannot drive, read the road signs, or communicate with people. One grandmother said she could not visit her daughter in hospital because she could not drive or take public transport.

*"I cannot read (English) and I cannot find the place...My daughter and my son-in-law are both busy and cannot take me places". (Grandmother)*

Often, grandparents are still quite young and have their own parents living in their country of origin. They are torn between their life in Australia and in their home country as they feel responsible for taking care of both their children and their parents.

*"I don't know what to do. My father is in China and he is 90 years old. My mother-in-law is in her 80s. I feel that we are responsible for them...I don't know how to drive in Australia, I can't speak the language and cannot communicate with other people." (Grandmother)*

Being able to carry out traditional practices can bring assurance and well-being in a new and changing environment. It can also reduce the anxiety and isolation felt by new Chinese mothers. However, where service providers are not culturally informed or sensitive, Chinese women have often been forced to compromise their cultural traditions and practices to prevent limiting themselves from access to health centres and services within the 30 day confinement period. Although some nurses and midwives are culturally sensitive to the *zuo yue zi* period and are happy to visit women in their homes, there have been other cases where Chinese mothers have had to negotiate traditional practices over healthcare appointments. Women may experience distress if not given a choice between cultural traditions and Western practices (Liamputtong, 2006).

*"The nurse came to my house during the confinement period. It's very important for the midwife to understand that belief and to visit at the house. Second time around, I was asked to visit the maternal child and health centre during my confinement. I did not want to do that and was not very happy, so I had to postpone and make an appointment to go after my 30 day period. If they can make the time to come out, that would be an improvement I think. They said they usually don't come out...I said the first time the nurse came. The nurse said they may do different practices." (BM3 Participant)*

#### **4.1.2 Conflicting cultural barriers**

Conflicting cultural barriers impact on Chinese parents' level of access to health and support services and the relevance of information provided. Cultural conflict may occur between parents, grandparents and health services, or between parents and grandparents. Traditionally, new mothers learn parent modelling behaviours through their elders and are expected to follow traditional practices. However, practical constraints mean that many Chinese women opt for childrearing which combines both Australian and Chinese practices. For example, migrant mothers in Australia learn about breastfeeding from nurses in the hospital where discussing such an intimate matter, in addition to possible language barriers, may cause discomfort for Chinese women (Liem, 1999).

Service provider's limited awareness about the importance of cultural traditions, specifically the confinement period, can lead to negative perceptions of the practices associated with

these traditions and insensitive treatment towards Chinese women's practices. It was common in consultations for service providers to identify Chinese women's cultural practices as factors that prevent women from gaining 'best practice' knowledge, while ruling out other methods for accommodating these traditional practices.

*"A lot of the grandmothers say the mothers are not to do anything. I had a grandfather yesterday who wouldn't let the mother do anything. The grandfather did it all so they [mothers] don't do hands on care of the baby and that's why it's difficult with the breastfeeding because they choose instead to rest so the grandparent can feed the baby with the bottle." (Key Stakeholder)*

Greater understanding and acknowledgment of different cultural practices amongst service providers, as well as provision of cultural and language specific education programs could increase breastfeeding rates and reduce co-sleeping amongst Chinese and other immigrant and refugee communities (Multicultural Centre for Women's Health, 2010).

*"During the last month of pregnancy the grandparents will come from overseas and help with preparing the household and cooking. First month of confinement, they do everything—cooking and washing. After that they take it in turns to stay with us and make sure we don't have to send kids to childcare because we believe it's in the kid's best interest to be raised by their own family. If there is*

*no help from grandparents, I can't take care of my two kids...I would have to send them to childcare which may be too early for them." (BM3 participant)*

Working Chinese parents prefer not to send their baby to childcare because it is too expensive and they are worried about the quality of care and language barrier. The conflicting cultural practices of childrearing also act as a deterrent from utilising childcare services because families may fear that their culture and language will be lost. Working parents therefore rely on their grandparents to take care of their children. One study based on Asian-American grandparent caregiving role found that the typical form of assistance grandparents gave to family is childcare with grandmother acting as substitute parent when both parents are working (Chen et al., 2000; Kataoka-Yahiro et al., 2004). When both parents are busy with full-time work, study, or dealing with financial pressures, and grandparents are unable to receive extended visas in Australia, grandchildren are often sent to live in their parent's country of origin with their grandparents.

*"...they might send a child who might be 8 months back to China and the child stays there for 2 or 3 years and then comes back, so the grandparents can look after it while the family here go to work or do their course and study. Then we have issues—we get a 3 or 4 year old who's been brought up in China and speaks Chinese but doesn't speak English and they're thrown into kindergarten or childcare, and it's really difficult." (Key Stakeholder)*

Service providers who participated in consultation stated that this was an issue of concern in terms of children's mental health and wellbeing and their development, as children are usually returned to Australia at 3 years old to attend kindergarten, they experience cultural shock, language barriers and emotional detachment from their grandparents. However, this is the reality for many immigrant and refugee communities who are unable to afford childcare costs and do not have the social support networks in Australia to assist them with juggling between work and family.

Although the presence of grandparents can alleviate the stress experienced by new parents, it can also increase stress associated with a couple's transition to parenthood. Tension and disagreement is common between families and within relationships, particularly when grandparents are living with new parents and come from different cultural backgrounds that have conflicting beliefs around child development. Their children are living in a new country with different concepts around pregnancy and childbirth, and many wish to raise their children the 'western way' while grandparents feel they have no control when traditionally they would have played a greater role in childrearing. The importance of filial piety in Chinese culture requires mothers to follow the advice of their parents, which results in increased tension on new parent relationships. New parents are often placed in difficult positions where they must choose to listen to their parents' advice or their partners' advice.

*"One woman said her husband and her*

*mother disagreed on sleep training when the baby was a newborn. Her husband insisted on sleep training and the baby cried for prolonged periods over three days. Her mum went back to China and said 'I am not coming back. I cannot cope with that (sleep training).'" (BHE)*

*"The kids have come to a new country and they've (the grandparents) got no control where traditionally, they have a big say over what happens to the grandchildren and they're not having any say." (Key Stakeholder)*

Additionally, Liem (1999) suggests that Chinese migrant mothers experience internal conflict with their beliefs regarding upbringing of children. Migration presents different ways of thinking to the mother and she must consider advice given by Western experts and from elders. On the outside she may seem ok, but on the inside she may be worrying about what is the best way to approach caring for her child. Family is often the only source of support for new Chinese parents, so rather than risk losing childcare and other support, many aim to minimise conflict with their parents.

*"You're torn between the 'do you stand up for what you believe is right because it's your baby or do you just be silent and say, I don't want to say anything because it will impact on my husband's relationship with his family but then I'll lose my childcare cause I've got to work.'" (Key Stakeholder)*

*"The mother had a uterine infection and the grandmother wouldn't let her go for*

*an ultrasound so that was a major conflict. The father wanted the mother to get the ultrasound but the grandmother didn't want her daughter to get the ultrasound because she didn't want an invasive procedure. Luckily the GP gave her some antibiotics and things cleared but it could've been a major disaster...it could've been a medical emergency. So there was a whole conflict of the mother between what her father was saying and what her mother was saying and she felt obliged to listen to her mother. So there is a huge conflict between the partner, what his mother's saying and what her mother's saying if they're all together."*  
(Key Stakeholder)

Many service providers believe that although new Chinese mothers are very receptive to the pregnancy-related information they receive

from nurses and midwives, it is difficult for them to implement the information because the contradictory advice they receive from the grandparents takes precedence. While nursing professionals may value autonomy and decision-making, some families rely heavily on other family members, such as the grandparents, to make decisions for the patient. This can be perceived negatively by nurses who feel they are having difficulties communicating with women when their parents are there. Since family play an important role in decision making within Chinese culture, it is important for service providers to communicate with new parents about the involvement of grandparents throughout the prenatal and postnatal stages, and to provide culturally appropriate information sessions for the grandparents as well. These sessions would also be beneficial for visiting grandparents to develop social support networks with other grandparents and families.

## 4.2 Beliefs, Practices and Attitudes around Pregnancy, Childbirth and Postpartum Period

Giving birth is common among all cultures, but there is no universal experience of pregnancy and childbirth. Each woman's experience is determined by the culture with which she identifies and the culture in which she gives birth (Greene, 2007). Culture refers to the learned beliefs, values and practices that influence an individual's thinking, decision making and actions (College of Nurses of Ontario, 2009). Each individual has their own definition of health, well-being and quality of life. The acknowledgement of cultural sensitivity within the concept of care is important and relevant for all interactions associated with pregnancy and childbirth because it impacts on how an individual perceives and prepares for childbirth. The varying beliefs, practices and attitudes surrounding pregnancy and childbirth affect how an individual accesses health services; the importance they place on these services; and the relevance of information provided by health-care providers. When cultural differences are encountered within Australian health settings, a plethora of experiences are produced for patients from diverse backgrounds. Unfortunately, many service providers assume that childbirth and postpartum techniques, knowledge and support are adequate across diverse populations. Some women may find it difficult to follow their traditional practices as they are unknown or not understood by those caring for them (Greene, 2007). A lack of cultural sensitivity within health settings may force women to compromise their own values and beliefs to adapt to mainstream concepts, or

limit and discourage them from accessing services, both of which create negative experiences that are detrimental to the health of immigrant and refugee women.

For immigrant and refugee women, there may be other difficulties that prevent them from accessing health care such as cultural norms regarding movement in public spaces; restrictions on education and employment which place women in a dependent position where they do not know the language or their rights; and cultural imperative to see a female health care provider (Australian Government: National Health and Medical Research Council, 2005). Although it is difficult for service providers to familiarise themselves with all cultural beliefs, practices and attitudes around pregnancy and parenthood, it is still important to be aware of cultural diversity and to provide appropriate care that is sensitive to the cultural needs of diverse clients. Culture and tradition are highly valued in Chinese communities and it is particularly important to promote a space where communities feel comfortable identifying with their own culture to ensure positive experiences of pregnancy and childbirth in Australia. Beliefs and practices are not homogenous for all Chinese groups; however there may be similarities across different cultural groups.

### 4.2.1 "Zuo yue zi"—Sitting the month

*"In China if you are having a baby, there will be so many people around to help you out. After childbirth, you can hire a professional woman to look after the*

*baby; one is for the woman who just had the baby, and there are still two grandmothers in the house. The mother can just rest and do nothing.” (Mother)*

“*Zuo yue zi*”, Mandarin for “*sitting the month*” refers to the 30 day confinement period that is followed by many Chinese women after birth to replenish the health and energy that has been lost during pregnancy and childbirth. The Chinese believe that “*qi*” (energy flow) in the body is maintained by the balance of *Yin* (cold/negative state) and *Yang* (hot/positive state) which is important for good health. An imbalance of *Yin* and *Yang* can disrupt the harmony of organs in the body and affect one’s health by causing illness. Although pregnancy and delivery of a baby is not an illness, many women assume a sick role because it is believed that an imbalance has been created in the body. If the imbalance is not addressed, it is believed a woman will suffer consequences to her health in the future (Tham, 1999). After childbirth, the loss of blood causes the body to lose heat; therefore a postnatal mother must be protected from the cold to regain balance in her body. To regain energy and restore health, one must eat certain types of food classified as ‘hot’ and restrain from practicing certain activities that may cause injuries to a woman and make her ill or bring bad luck to the baby and family, e.g. showering, crying, sexual intercourse, keeping away from draught and winds. ‘Hot’ foods, which restore the body by cleaning out dirty blood and increasing milk production, include lots of ginger, pork feet, eggs, meat and fish. These practices provide emotional and maternal support that strengthens a new mother’s self-esteem and reduces the stress

she may feel in the transition to parenthood (Holroyd, Lopez, & Chan, 2011). Many of the rituals or practices performed during the 30-day confinement period are maintained by the extended family and enforced by female family members.

There are a number of benefits of the confinement period suggested by Tham (1999):

- It forces the woman to rest;
- The food they are given usually has good levels of nutrients;
- Herbal teas may have medicinal value;
- Confinement of mother and baby can reduce infection; and
- Confinement can enhance the relationship between mother and mother-in law. The attention the mother receives can also decrease her chances of post-natal depression.

*“I had my first baby in China, during which time there was one woman to help look after the baby, and the others all looked after me. So I had a very good confinement period without worrying about my baby. The second baby was born in Australia. There was only my mum who came to help me. She looked after the elder child and my husband and I had to look after the baby by ourselves. One day during the confinement period, I was breastfeeding my baby without something covering my back. Since then I constantly suffer from back pain. I tried to use acupuncture and cupping but it doesn’t work. (Mother)*

Some of the beliefs associated with “*zuo yue*

zi” include fear of the new mother suffering from back pain or arthritis in the future if she does not strictly follow the practices of the sitting the month period. For example, it is believed that exposure to wind and draught can cause illness or future back problems, therefore many women are strictly confined to the home during the *zuo yue zi* period (Holroyd, Lopez, & Chan, 2011). The degree to which this tradition is practiced varies across families; therefore some will be stricter than others and access to health will vary. The majority of the focus group participants had followed the confinement period, while very few had not.

“Sitting the month” is not specifically a Chinese tradition. In fact, many cultures across the world, including countries where Chinese have settled, practice sitting the month in different forms and to different extents which coincide with the length of various religious observations. Sitting the month allows for protection, expression and cultural identification for a person during a time when their vulnerability is posed by childbirth (Holroyd, Lopez, & Chan, 2011) .

There is limited understanding amongst health practitioners of what the confinement period implies and means for a Chinese woman accessing and receiving healthcare. Both the reactions of health practitioners, and the cultural practices of women are important factors that impact on how Chinese women access services before, during and after pregnancy.

*“Don’t you feel a bit sorry for the grandparents though, because they*

*come from a lack of knowledge and are very ignorant? They’re still coming up against western medicine and best practice.” (Key Stakeholder)*

*“I think that they [Chinese women] probably see themselves to take on that illness role. I don’t necessarily understand that—if it’s coming from a Chinese medicine point of view, or if it’s coming from a cultural [point of view] whereby it’s information that has perhaps been passed down and it’s not evidence based.” (Key Stakeholder)*

During consultations, many nurses did not understand the benefits of Chinese medicine given to women after birth, or beliefs regarding the 30-day confinement period. There was seemingly implicit ethnocentrism towards Western medicine where its practices were often considered to be the ‘right,’ most practical method within health settings, while Chinese medicine was considered alternative, less practical and not evidence-based. In some consultations, the practices were viewed negatively, and perceived to be irrelevant because they lack evidence-based information, while some believed that the practices were not healthy for the baby, such as diet, overheating and co-sleeping. Some nurses said the brew given to mothers was not good for the baby and that it is difficult to encourage breastfeeding while they are in the stage of rest. There is a need for regular intensive workshops to be provided for health service providers that discusses the varying cultural beliefs and practices of different communities and utilises good practice

principles for implementing culturally appropriate working habits and programs.

Some key stakeholders provided examples of how they overcome cultural barriers and accommodate traditional practices such as explaining hygiene to women, and the risk of overheating babies.

*"Their beliefs—the majority of them will not like to have a shower because they find by having a shower they'll catch a cold, it's not very good for them. So basically, emphasis of hygiene, they don't have to take a shower if they don't want to, just need to clean herself and just explain to them in Australia we have heater and hot water so it's very safe to have a shower."* (Key Stakeholder)

*"They will have 4 to 5 layers of clothing on them [the baby] when it's a hot day, and part of that is the cultural thing that they don't want the baby to get a cold without realizing that you're actually making this kid overheat. The way I usually explain to them is the child will burn off a lot of calories therefore want to feed more because it's trying to keep itself cool."* (Key Stakeholder)

#### **4.2.2 Role of the family in childrearing**

*"They (the grandparents) all come. I have written letters of support every three months for different families. So one mother goes back after 3 months and the other one arrives and then she goes back after 3 months and the other one arrives,*

*but generally they are here for 12 months"* (Key Stakeholder)

*"The external family are happy to help out in different ways; most grandparents will come to Australia to help out in the early days of childhood. I am happy to have them around to help me out. In China, there will be more grandparents who can help out."* (Mother)

Traditionally, Confucian and Taoist philosophy have influenced the social behaviours of Chinese people, emphasising harmonious relationships among individuals, family and society. Strong, cohesive bonds are highly valued among family members, and individual feelings, values and behaviours are regarded as representative of the collective qualities of the family to achieve societal goals and appreciation of one's cultural heritage (Ip et al., 2003; Julian et al., 1994). The concept of filial piety is a significant and important virtue in Chinese culture, which denotes a duty of respect and obedience to the elderly who are valued for their wisdom and experience (Wong et al., 2011) Often this means the relationship between parents and children takes precedence over the relationship between couples; therefore parents are expected to follow the advice of their elders in child rearing as a form of respect.

Children are considered to be the wealth of the family in Chinese society whose community-focused culture relies on family as a source of support during the transition to parenthood. While parents are the primary carers in many cultures, Chinese grandparents play an equally important role in childrearing and

decision making, particularly during the *zuo yue zi* period and for parents who are both working.

In comparison to other societies, the retirement age in China is much lower (between 50-55 years old); so many grandparents are available to devote time to the carer role (Chen, Short, & Entwisle, 2000). During the *zuo yue zi* period, grandparents will do most of the housework, prepare food and look after the baby to ensure traditions are carried out appropriately. Child care is considered to be the role of the family as opposed to the state, making it common for children to live with the grandparents while their parents go to work or study. Many grandparents will spend more time with the children than the parents and are often responsible for taking children to medical check-ups and other childcare duties. The focus group participants perceived the external family to be more important in Chinese society than in Australia.

*"The external family is very important when you have a baby. I got my mother to come to Australia to help when I had my first birth. [She] was very good at housework and looking after the baby and myself. I would have postnatal depression if she was not here."*  
(Mother)

*"[The external family has a big influence on the relationship and parenthood] because they are a great help. They take turns to take care of the grandchild to help because I wouldn't be able to take care of them myself. My parents and in-*

*laws take it in turns."* (BM3 participant)

Support from the family and social support networks are important for new mothers as they can allow mothers to break down barriers and isolation and allow mothers to become familiar with Chinese traditions and practices where information is lacking. However, in some cases—depending on the length of time Chinese mothers have been living in their new country—traditional practices can make mothers feel restricted and isolated from any existing social networks or outside support (Lam, Wittkowski, & Fox, 2012). Many mothers, during the focus group, regarded the support they received from the external family as invaluable, particularly for those who do not have any other source of support within Australia.

Based on focus group findings, family members are usually the first port-of-call for gathering health-related information or other information regarding childbirth and childrearing before seeking information from elsewhere. This could be explained by the respect children must show for the elderly with regards to their experience and knowledge.

#### **4.2.3 Pregnancy and childcare practices**

*"Every time I asked the midwife (during home visit) she said you should persist with breastfeeding. I didn't think of asking for a second opinion as I was too exhausted. Women all feel pushed to breastfeed. My midwife said to me 'formula is rubbish.'" (Mother)*

*"...while they're in that recovery phase*

*they believe that if they feed the baby they will further jeopardise their own health. But in western culture, the belief is that you feed your baby straight after birth, and so I know that then they [Chinese parents/grandparents] would revert back to giving baby formula, and we are very concerned about that because we see formula as a foreign protein.” (Key Stakeholder)*

The World Health Organisation recommends that infants are breastfed exclusively up to 6 months of age. Research suggests that breastfeeding reduces a baby’s susceptibility to infection and disease, protects mothers against premenopausal breast cancer and osteoporosis and helps the mother’s body return quickly to her pre-pregnancy state (ABS, 2001). However according to 2001 Australian data, only 32% of Australian babies were breastfed exclusively to 6 months of age or less, and in a Victorian study, women from immigrant and refugee backgrounds were considered one of the groups at high risk of not breastfeeding (Multicultural Centre for Women’s Health, 2010). Findings from the *Bbkayi* key stakeholder consultations suggest a low rate of breastfeeding amongst Chinese women in the City of Whitehorse, and a greater preference for using baby formula. This may be due to Chinese women’s lack of awareness of the benefits of breastfeeding as a result of social isolation, language barriers and limited culturally appropriate antenatal classes that promote breastfeeding; lack of family support, particularly within Chinese communities where the role of family in childbearing is highly valued; and the influence of the 30 day confinement period

where women are required to rest. Studies conducted both in China and in Canada suggest that perceived breast milk insufficiency, women’s increased participation in the workforce and education, inconvenience, and feeling uncomfortable breastfeeding incline women to use baby formula as an alternative (Agnew et al., 1997; Xu et al., 2009). The introduction of infant formula reduces breastfeeding rates and consequently breast milk production, leading to a reliance on formula. In some cases, infant formula is encouraged by older generations because it is perceived to be easier than breastfeeding especially during the period of rest.

Some Chinese women may also feel embarrassed to breastfeed in public. Chinese women who participated in a study in Perth, Western Australia were aware of the health benefits of breastfeeding for both themselves and their babies and preferred breastfeeding over infant formula unless work or study made it difficult to juggle the two. However, over half of the interviewees believed women should not breastfeed in public and were too embarrassed to do so themselves (Li et al., 2003). Findings suggest women are more likely to breastfeed when they have a positive view towards breastfeeding and believe it to be healthier, easy, convenient and conducive to freedom.

#### **4.2.4 Awareness of lifestyle and relationship changes**

*“I found it was hard to find some time just for ourselves...I just ignored him (husband) and put all my attention on my*

*children. Also, since the baby we have had arguments. It rarely happened before. Most of the time, the arguments are around the children.” (Mother)*

*“We are both focusing on our baby. I would feel guilty if I spent some time with my husband since now I am studying full time. So I am away from my baby during day time, when I am at home I really want to spend more time with her [baby,]” (Mother)*

When focus group participants were asked if they had experienced any changes to their relationship after having a baby, many women said that they had predominantly assumed a housewife role and happened to spend less time with their partner. Couples had seemingly shifted their attention from upholding a positive relationship to focusing on the needs of the baby, with one woman claiming to feel guilty for spending time with her husband. New mothers confirmed that they argued more as a couple after the birth of a baby, which was likely to be aggravated by less time spent together or less importance placed on the relationship, as well as the stress of coping with a newborn.

*“We always compromise by action. If we have an argument, we try to calm down by ourselves and one would do some housework to show his/her apology.” (Mother)*

Some focus group participants indicated that in the event of an argument, couples were more likely to ignore the issue and less likely to communicate with each other to resolve the

problem, while potentially enforcing stereotypical gender roles. For example, rather than working through an argument, some Chinese couples preferred to make ‘compromises’ that might consist of one person doing more household chores to calm the other one down. In doing so, the focus of attention is shifted from addressing the factors that may be contributing to arguments and could potentially worsen in the future. Currently, some of the methods used to cope with the challenges of a new baby include having the grandparents there to help and to stay positive.

*“One woman said it depends on how prepared the couples are before they have the baby. If they are prepared and understand what is going to happen, then they’ll cope a lot better and understand each other.” (BHE)*

*“Women said Western women go to counselling if there are any disputes between the couple, however they [Chinese] all try to sort it out themselves.” (BHE)*

Participants agreed that they do not discuss issues with non-family members and friends, and do not place particular importance on counselling services. This view may be based on the importance of the family unit where couples are more likely to discuss any disputes with extended family. Previous studies based on female migrants from Hong Kong to Toronto suggested that women or couples may not seek help outside of the home, particularly when there is lack of information about the services, cultural

differences on how help-seeking or relationship problems are perceived, and lack of accessibility to services (Chiu, 2004). Further studies in Taiwan confirm Chinese parents to be more self-reliant and prefer informal over formal professional help. Chinese cultural beliefs perceive family problems to be personal matters and consider it shameful and embarrassing to seek external help. Such matters are expected to be solved either by oneself, or by other family members. Marital conflict, badly behaved children, or partner infidelity are also commonly perceived as signs of failure to be a good mother (Chiu, 2004; Shek, 1998).

Based on discussions within the focus groups, Chinese couples would benefit from programs like *Baby Makes 3* as it would build their capacity to cope with the changing relationship during the transition to parenthood, in addition to reducing gender inequalities and balancing the duty of care for the baby with time spent maintaining a healthy relationship. However, a program like *Baby Makes 3* will only be successful amongst and accessible to Chinese couples, or other culturally diverse populations, if it is adapted according to language, cultural appropriateness and relevance.

### 4.3: Access to Maternity and Health Care Services

As mentioned earlier, little research has been conducted on Chinese women's childbirth expectations and experiences. Chan and Quine's (1997) study explored the utilisation of Australian health services by Chinese migrants from Hong Kong and China. The findings identified a strong preference for Chinese-speaking general practitioners; insufficient interpreter services; low use of preventative services; and lack of knowledge about the existence of ethnic health workers. In addition, factors such as cost, accessibility and language had an influence on migrant's access to health care services, with language barrier being a major factor. It is important to note that the experiences for those from Hong Kong, particularly in terms of interpreting service usage, were different to those from mainland China, emphasising the point that the Chinese community are not a homogenous group and may need varying strategies of accessibility to health services.

Each individual has expectations that impact on how they experience health, illness, treatment or recovery. In terms of pregnancy, childbirth and parenthood, expectations are affected by numerous factors including support networks, access to services, and provision of appropriate information and an understanding of the experience from their own cultural background. To ensure sensitive, effective and positive experiences of healthcare, it is important to consider the concept of care in different cultural contexts and in the context of community and family. Integrating culture into care, which includes being openly aware of differences, will

reduce negative experiences of medical care that have been a result of poor communication and impersonal approaches (Brathwaite & Williams, 2003). A study with Chinese women reported that they expect different types of social support than Western women; they have high expectations of receiving emotional and social support from both their partners, mothers or midwives during labour and delivery. Women who have lower expectations on their ability to cope with pain will also experience increased levels of anxiety around childbirth and have poorer psychological outcomes (Ip, Chien, & Chan, 2003). To reduce these anxieties and to better prepare women and their partners for childbirth and new parenthood, it is essential that culturally and linguistically appropriate programs, such as antenatal education classes, are implemented into health care practices.

#### 4.3.1 Accessibility to information and health services

*"I went to see a Chinese doctor and he didn't even give me a prescription. Same thing happened to my husband. You can make the GP responsible for any mistakes as they have prescription and diagnosis, but a Chinese doctor does not have any of that." (Mother)*

*"If you go overseas to a medical clinic, like for example Malaysia, it's very different to how we go and see a doctor here. You go to a doctor and you get your check and your medications all from*

*a GP. You don't go to a pharmacist to get your medication, and you queue. You don't ring up for an appointment. And it's even like that in Hong Kong...there are different layers of health care for different clients. So you come to Australia where health care is relatively the same if you've got access to it, so it must be confusing for them.*" (Key Stakeholder)

Chinese women possess limited understanding of the Australian health care system. For many immigrant and refugee women, primary care and health promotion may be difficult concepts to understand because of their experiences with the health system in their country of origin. Many immigrant and refugee women come from countries with specialised health care systems that put less emphasis on primary care, and more focus on treatment than prevention. Australia, on the other hand, has a greater focus on primary care and prevention which is provided by GPs, as opposed to specialists. As a result, migrant women may believe the capacity of GPs cannot fulfil their health needs, while only specialists can provide high quality care (Poljski, 2011b). According to *Bbkayi* consultations, Chinese women value treatment over prevention and prefer 'Western' doctors to Chinese doctors because they are more likely to prescribe medication and are seemingly more knowledgeable. If a doctor does not prescribe medication, they may be considered less qualified, lacking experience and unable to fulfil medical needs. Some women also believed that prescribed medicine can be used as evidence for correct

or incorrect diagnosis.

However, not all Chinese women expect to receive prescription medicine. In fact some women said that 'western' doctors overprescribe medication and they would prefer natural methods of healing.

*"In terms of medicine, I prefer naturopath instead of taking Western medicine. Food or vegetable or herbal abstract—we prefer that to medicine. Personally, I think Western doctors...every time we go there with the kids they prescribe antibiotics. They think only antibiotics will cure anything, and we believe natural is a better alternative."* (BM3 Participant)

Chinese women's limited understanding of both the Australia health care system and the importance of particular services also contributes towards how they access health services, which is not always sufficient.

*"One woman said she doesn't have a GP and will go to hospital emergency and wait for a long time in the queue."* (BHE)

Some mothers mentioned that they have experienced difficulties finding a good medical practitioner and are switching GPs all the time, while other women may go to the hospital emergency and wait in a queue for long periods to see a doctor for minor check-ups, as opposed to making an appointment. It is not clear whether women were not aware they could make an appointment or if they believed better treatment and care would be received from a hospital. It was consistent throughout all

focus groups that participants felt they had difficulty identifying when the 'right' time was to go to hospital during labour, with many of them stating they were sent home for arriving too early.

*"In China, if you are expecting a baby, you would get your bed in the hospital even if you were not staying overnight. You can choose whenever time to come to hospital, but in Australia you have to wait for the 'right' time to go to hospital. It is hard for the first time parent to identify when is the right time." (Grandmother)*

Formal and informal antenatal care has a long history that involves preparing women for childbearing and childrearing. While a few focus group participants had attended antenatal education classes, the majority had not. Many women with extended family looking after them in Australia may not access services because they have care at home. However, a number of other factors, such as language and cultural barriers, cost and lack of awareness of the services, may prevent or limit women from accessing health care during or after pregnancy. This can affect their preparedness for childbirth and how they approach further health services. Inadequate communication between mother and service provider, and/or lack of multilingual resources may also account for women's limited preparedness during childbirth.

Many of the participants preferred the postnatal care to the antenatal care (which they may not have been aware of) and suggested a group similar to mother's groups

be held during the antenatal period where they could meet other Chinese women, gain extended social support networks, learn about Chinese traditions and practices during and after birth, and share information to prepare them for parenthood. This suggests that they were either not aware of the antenatal services, or the services did not meet their needs, linguistically, culturally or financially.

*"It's not that they can't speak the language, they can often speak the language or understand it quite well. It's more of a cultural thing. So when we have the Chinese groups, we're inundated so they come to that but they don't tend to come to the normal routine one." (Key Stakeholder)*

*"A few women came to the centre for English mother's group and then found out about the Chinese group. Women prefer to have a Chinese mother's group and playgroup due to cultural differences...Women all feel that there are cultural differences in child rearing and feel more comfortable communicating with Chinese mothers." (BHE)*

For many of the new mother participants, language was not always a barrier for accessing services, although in many cases it is amongst immigrant and refugee women. Although some Chinese women may have a good command of spoken English, services and programs presented in English do not always suffice. It is sometimes the cultural aspect of pregnancy and childbirth, where

practices differ to mainstream Australian practices that present barriers for Chinese women and couples accessing services. Chinese mothers may feel more comfortable discussing their childrearing experiences and practices with other Chinese women who share similar beliefs and experiences.

*"The Baby Makes 3 is too Western culture oriented. What would help them is by definitely having a Chinese speaking version of it. Once you have a Chinese speaking version, it'll automatically be converted to culturally appropriate content. It will encourage them [Chinese parents] and let them know about it widely in public. If they know about the course and language, and if it's free I'm sure they will go." (BM3 Participant)*

During consultation with service providers, it was apparent that Mandarin-speaking women at Box Hill Hospital were at a greater disadvantage because there are no culturally and linguistically appropriate antenatal classes for them to attend. Mandarin-speaking antenatal classes were previously offered at Box Hill Hospital, however due to limited funding and few Mandarin-speaking staff, the classes could not continue. Currently there are only antenatal classes conducted in English and Cantonese; therefore the utilisation of these services by Mandarin-speaking couples is low. According to service providers, Chinese mothers are more frightened and less prepared about childbirth when they have not attended antenatal classes. One key stakeholder discussed the benefits of antenatal classes when she was previously involved in

facilitating them.

*"I would have at least 6 or 7 couples [at the classes] and I find that by having the classes, they were much more prepared for childbirth and they were less frightened. And usually they do well. Majority of them come in and they are very frightened. It's very difficult for their support person, like their partners or mother in law or mothers, because they are from a different era and different country and we do different things here." (Key Stakeholder)*

Although service providers mentioned that Chinese women generally do not attend antenatal classes, predominantly based on costs, it is clear that they currently have a lower access rate due to other factors such as language and cultural barriers. Previously, during the availability of Mandarin-speaking antenatal classes, there was a higher access rate of Chinese couples because they may have felt more comfortable attending with other Chinese couples who share similar values, beliefs and practices.

*"Those who are Mandarin speaking, obviously, will not attend the classes. From my experiences and observations that's what I find is lacking...they have not attended childbirth education so they do not know what is pregnancy, what is childbirth, what is involved in the whole parenting process." (Key Stakeholder)*

A lack of bilingual and culturally aware workers available in health service delivery further disadvantages and marginalises

immigrant and refugee communities from participating equally in services that would have beneficial impact on their health and wellbeing (Wong M., 2011). Greater access to antenatal classes that are language and culturally relevant would provide women with valuable information regarding pregnancy, and prepare them for more positive childbirth experiences. It will also prepare the couple for difficulties that occur during the transition to parenthood. However, until greater priority is given to quality culturally appropriate services by hospitals, health services and government who fund them, Chinese couples, and other immigrant and refugee communities will continue to miss out on education and services that would otherwise increase their capacity and confidence to make informed decisions about pregnancy-related issues, as well as other concerning health issues.

*"Is it possible to have a group for pregnant women before childbirth? I am happy to join. I had no idea where I could get the information about having a baby in Australia. So I went to my GP, searched on the internet, asked friends etc. it would save me so much time if there were a group I could join." (Mother)*

Participants reported that they were not sure where to go for information besides their GP and midwives. When they did receive information, they found medical opinions to be confusing and would have liked to have a Chinese-speaking contact for a second opinion. They were also not aware of their right to negotiate or object to advice provided by practitioners and reported that they were

often afraid to question or say anything at the hospital during birth. This suggests that they are unfamiliar with the health system and unaware of their rights within health care. It also impacts on their ability to make informed decisions.

*"They would like to know about their rights in the hospital. One woman said if she knew what to expect in hospitals, then she would have been able to speak up for herself rather than being too scared to ask for things." (BHE)*

#### **4.3.2 Structural barriers**

*"They struggle with the services. The difficulty I've found with these families, one is because the lack of language, they won't attend parents groups, even if you suggest a Chinese playgroup, or Chinese mothers group. From that point of view it's looking at transport. It's ok to have them, but how do you get them there when they live on the other side and there's no bus, or there is a bus but you can't read the timetable. So again, it becomes that isolation." (Key Stakeholder)*

For immigrant and refugees who speak limited English, language barrier is one of the major factors affecting their use of health care services (Wong M., 2011). However, despite the implementation of culturally and linguistically appropriate services, there are other structural barriers which limit Chinese women from accessing services, such as transport and cost. Chinese women who rely on their partners to drive to appointments are often not able to access services during

normal business hours because their husbands work full time. They may not be familiar with, or live close to public transport, and for recent arrivals, they may not yet have familiarised themselves with the environmental surroundings. In many cases, women walk long distances or may not access services at all, particularly in bad weather.

*“They’re aware that we have childbirth education classes for Cantonese speaking but I don’t think there are a lot of people attending because you have to pay. Last time when I did Mandarin speaking classes, the most I had was 7 couples, and the majority when you ask them why don’t you want to come...basically they can’t afford to come because they have to work or they have kids to look after or it’s inconvenient (Key Stakeholder)*

Cost is another factor that deters Chinese women and couples from accessing services. Antenatal education classes are not free and can be expensive for couples experiencing financial difficulties from both migration and settlement, particularly if they are not eligible for social security benefits including the baby bonus payment, paid maternity leave or if they are students and are limited to 20 hours work a week. Couples may also not be aware of the benefits of attending antenatal classes, and therefore feel less inclined to spend money on services that they believe are not important. Affordable services or an availability of more cultural appropriate services require funding and more

resources, as well as the recognition that the needs of diverse groups are equally important.

#### **4.3.3 Communication**

*“You find that it is helpful when you speak the language, especially in birth when they’re about to have the baby, they convert into Chinese even if they speak English. You can go there and they can listen to your voice and then listen to the Chinese, because they comment ‘o thank god somebody can speak Mandarin’, and they feel more relaxed so it does help.” (Key Stakeholder)*

Speaking in their mother tongue is comforting and reassuring for many Chinese women, particularly during childbirth. It is also the only communicating option for many visiting grandparents who do not speak English. Although interpreter services are provided to public services for use with people from non-English speaking backgrounds, some service-providers do not always use them. Where interpreter services are used, there may be a shortage of accredited interpreters, particularly in new and emerging languages and when a female interpreter is required.

All general practitioners are provided with access to interpreters, but utilise the service inconsistently and at an inadequate rate. Both service providers and focus group participants said Chinese women were not aware that the interpreter services were free or available to use when utilising health services. Information, particularly health-related information, should be given and received in a language that can be understood by the patient and in an appropriate manner. Women have reported cases where relatives and young children have been asked to translate for doctors in place of a professional interpreter (Wong M. , 2011). This is unethical and unfair for both women and their relatives, as well as disempowering for women who may have lower proficiency in English and are further disadvantaged in making informed decisions.

Discussing medical issues relating to women's health and body can be discomforting for women in the presence of family members. Some service providers said that the best ways for sharing information with Chinese women depended on how well they spoke English, implying that they do not utilise the available interpreting services. In other cases, interpreting services have been refused by Chinese couples where the husband has a higher proficiency in English and is able to translate the information. This can be problematic, particularly when service providers want to conduct a family violence screen.

For written material, there is often limited funding for health providers to translate all information. Very often, information is translated directly from English and so may lack cultural relevance, awareness and sensitivity (Australian Government: National Health and Medical Research Council, 2005). Women from immigrant and refugee backgrounds may also come from lower educational backgrounds and could find it difficult to understand formal text provided by service providers.

*"I usually ask the mums, "what is it that you would want me to do? I don't understand your culture, so tell me about it. What is going to be appropriate for you in this time and space, how can we modify it." (Key Stakeholder)*

In addition to understanding or being aware of Chinese practices and beliefs during the pregnancy process, it is also important for service providers to do a preliminary assessment which asks Chinese women what they want and what traditions they may follow because each individual will have their own beliefs, practices and traditions that they follow. It cannot be assumed all Chinese will have the same expectations and each individual culture will vary. One service provider mentioned that she asks families about their traditions and practices so that she can modify her own practices in a culturally appropriate way.

*“One woman said the hospital did not want to admit her even though she was already in labour. Her waters broke and she was 4 centimetres dilated but was told to go home and was given panadol despite intense contraction. She went home and ended up calling the ambulance and was admitted to the hospital as a result. An hour after she got into the labour ward, she gave birth. Another woman had a better experience. She went to the hospital at midnight and was 5 centimetres dilated and was admitted to the labour ward straight away.” (BHE)*

Antenatal education classes can prepare a woman for childbirth to a certain extent; however when a woman is in the early stages of, or during labour, she is in a vulnerable state, and can provoke anxiety when in the context of an unfamiliar culture. Some Chinese women, particularly those who speak limited English, may find hospitals the safest and most comfortable place to be during this time and therefore rely on the expertise and care of midwives and nurses. Those who have not had access to antenatal education classes will not know what to expect from hospitals or what procedures to take during labour. There are a number of issues that could be factored into the woman's negative experiences within the hospital. A lack of, or inadequate communication between midwives, nurses and the Chinese woman could have led the woman to feel uncertain about the quality of services; about what is happening to her body and anxieties around her pregnancy.

Communication is very important, especially for women who are in distress and speak limited or no English; however one must also understand the cultural aspects of communicating—a nurse's idea of good communication may not be adequate for a diversity of cultures. Expressing, or not expressing pain, is a form of communication and feelings of intense pain can impair one's ability to make decisions and think clearly. Chinese women generally do not display signs of pain during childbirth because they believe it will dishonour themselves or their family. Women may respond silently and refrain from informing the nurse or midwife of the intense pain they may be experiencing. For effective treatment and to minimise misunderstanding of women experiencing pain, nurses and midwives must consider interpreting pain responses according to the woman's cultural beliefs. Communicating with the woman in a way that connects with her culture (for example emulating women's style of communicating) will facilitate comfort in a vulnerable situation (Weber, 1996).

Although the woman described in the case study above was experiencing intense contractions, the nurse may not have been aware of this if he or she had not considered the appropriate communication methods. A lack of resources and beds within the hospital may have been another reason the woman was sent home, as well as limited staff available to attend to women who are considered not to be ready for birth.

#### **4.3.4 Quality of Services**

*“I do not know if I would have found the*

*course (antenatal) if I had not gone through the information one by one. I tried to call the number on the pamphlet but no one answered. I finally enrolled in the course after I contacted with the midwife who was in charge of the course. She also mentioned to me there were no resources in Chinese any more due to limited funding supply. I found the information from the course was useful, but the cost was expensive.” (Mother)*

Many Chinese women are not aware of the services provided in their area, and many learn about them through word of mouth, often when it is too late. Participants from the focus group who accessed Mandarin antenatal classes at other hospitals said it was useful and they were more prepared and felt more confident for birth. Other women said that because antenatal classes were not free or were too expensive, they missed out on education and help when they were pregnant.

*“I found the postnatal care is better than antenatal care here. We had midwives coming to our home to check the baby. Also my daughter would go see the midwife continually after childbirth.” (Grandmother)*

The quality of postnatal care received by women in the focus groups was more positive than antenatal care, especially considering access to antenatal education classes were limited and provided at a cost. Chinese mother’s groups were highly valued, especially for grandmothers because they help reduce isolation, increase community

participation and information sharing, and provide social support amongst the Chinese community. However women would have liked the sessions to extend over a longer period, as opposed to one day a week for four weeks. Focus group participants also suggested that it would be beneficial if hospitals collected the ethnic backgrounds of mothers so that women could contact other new mothers after birth to organise their own Chinese mother’s groups.

*“...the new parent program we do is too soon, because we get them at about 4-6 weeks, [when] they’re at home with grandma, so we miss them there. I’m also prepared to do one on one stuff with women who come through with interpreters in the antenatal setting as such” (Key Stakeholders)*

*“We don’t have home visits in China after childbirth. We need to stay at home for a month after birth, and the midwife said in that case I’ll come and see you.” (Mother)*

*“Nurses need to understand the confinement period more.” (BM3 Participant)*

During consultation, key stakeholders said there was a poor attendance by Chinese communities to some new parent groups because they were held during times when women were in the confinement period and unable to leave the house. They suggested more funding would allow maternity services to provide regular parent groups or antenatal services for the Chinese community, especially in areas with a high

Chinese population.

Some midwives reported that they were prepared to spend time with Chinese women who are unable to attend antenatal education sessions and that it was important for hospitals to provide language-specific contact persons as well as written information. Home visits by midwives after birth was widely appreciated amongst participants, although one participant said her nurse would not visit during her confinement period. Women also said they could not find anyone to contact after business hours and that they were not aware of the maternal and child hotline until after they had read the information pamphlets. They suggested that it would be helpful if all services were explained to them by the time they left hospital, and if pamphlets regarding antenatal and postnatal services would be provided in Chinese.

*"I hope to see some pamphlets in Chinese telling us where/how to access services, what services we can have during antenatal and postnatal care (Mother)*

*"They chuck the booklet on you when you leave the hospital...but you don't have time to read it." (Mother)*

One of the issues of concern for Chinese women was that they were discharged too early from Box Hill Hospital, often the day after delivery. Although early discharge may be common practice in hospitals, this can conflict with the *zuo yue zi* practice that

requires women to rest because their bodies are considered weak and in the recovery stage. Low rates of access to antenatal classes by Chinese women means they may not have had hospital practices (such as early discharge after childbirth) or birthing expectations explained to them, and therefore the care they receive may come as a shock.

## **5. Recommendations: Good Practice Principles for Culturally Appropriate Implementation within Maternity Services and Parent Support Programs**

Healthcare within maternity services and parent support programs within the City of Whitehorse currently lack sufficient resources for Chinese communities, and possibly for other immigrant and refugee communities. Culturally appropriate and relevant antenatal education classes, written education materials and new parent support programs are integral for improving health and wellbeing, but current efforts do not meet the needs of Chinese women and their families in terms of accessibility, availability, culture and language appropriateness or awareness that such services may exist. There is also a need for capacity building amongst health service providers for understanding and accommodating cultural differences, and working with groups from immigrant and refugee backgrounds in a culturally appropriate and meaningful way.

Before health services provide care to the community, they must first consider Australia's multicultural society, and that a 'one size fits all' approach will not provide adequate health care to all individuals. To promote better health knowledge amongst minority groups and to reduce health service inequities that further marginalise cultural groups, health services must approach all health education initiatives from a diversity framework. The following best practice principles are informed by a human rights approach—that is, access to healthcare that meets the needs of every individual is a basic human right. These principles will not

succeed unless there is mutual respect and the responsibility to provide such services is shared by the community. Approaches that respond effectively to cultural differences within health settings aim to strengthen the quality of care provided by health service providers and promote positive experiences for patients from diverse backgrounds. These good practice principles include:

### **1. *Participatory and Empowerment Approach***

A participatory and empowerment approach acknowledges and respects the knowledge that women from immigrant and refugee backgrounds and ethno-specific organisations have about their health, cultural practices, and migration experiences. It allows immigrant and refugee women and their communities to be active contributors towards change by exchanging their own knowledge, experiences and choices in a non-hierarchical manner and in their own language.

#### **Indicators:**

- Immigrant and refugee communities and their representative groups and organisations are at the forefront of increasing community capacity building and developing cross-cultural training with health professionals and relevant service providers. Approaches require community development, capacity

building, and peer education to strengthen capacity for immigrant and refugee individuals to liaise with health sectors and to raise awareness of the available services to their communities;

- Regular community consultation. Immigrant and refugee communities should be consulted individually to learn about cultural norms and appropriate strategies; to ensure written translations are culturally relevant and responsive; to identify leaders that can engage with their own community and increase capacity of women to access services;
- Acknowledge the importance of involving family in decision making and support groups amongst some immigrant and refugee communities. This will build the capacity for women to make informed choices;
- Uniqueness of experiences, needs and aspirations of each individual woman is respected and acknowledged.

## **2. Collaboration and partnership**

Collaboration is needed between ethno-specific, multicultural organisations and mainstream health providers in order to share information and best practice ideas. Collaboration also ensures that women are well-linked with their local, women's and ethno-specific health and welfare services.

### **Indicators:**

- Working in partnership with immigrant and refugee communities as well as ethno-specific and multicultural organisations to learn and exchange health care needs and delivery; provide cross-cultural training with health professionals and service providers; provide culturally appropriate and relevant education sessions during antenatal and postnatal stages; develop a service information guide in Chinese for new parents; as well as other programs or activities that improve health and wellbeing;
- Regular capacity building program for nurses and midwives need to be delivered, in collaboration with ethno-specific organisations that includes discussion on culturally sensitive issues, appreciating and understanding culture, advocacy strategies for increasing attendance rates for Chinese women and other unrepresented communities. The program should include a list of Chinese community groups or services that can be used for appropriate referral. Professional development should also be required for interpreters who may not have a health education background, but are working with health service providers;
- Development of an information kit that is provided to health organisations upon completion of

cross-cultural training or capacity building programs. This kit would provide information on the aims of culturally responsive health care, roles/responsibilities and how to provide this care;

### **3. Cultural and linguistic appropriateness**

Accommodating cultural differences is about being responsive to immigrant and refugee women's cultural and linguistic needs, recognising the complex nature of women's multiple identities and the impact of migration, settlement and socioeconomic context on cultural identity and language needs. It also ensures information is accurate, and relevant to the needs of all women, and is communicated in women's own language utilising bilingual workers and/or interpreters.

#### **Indicators:**

- Commitment to providing adequate multilingual educational materials (both written and visual), interpreting services and referrals to agencies and community groups that are specific to the Chinese community, or other highly represented communities within the area. Health service providers must also advocate for more resources that support their ability to provide culturally appropriate services, information and care;
- Community education in ethnic communities that utilise appropriate education strategies such as ethnic media and bilingual health education

which focus on sexual health and reproduction, family unit and respectful family relationships;

- Recognition by service providers that cultural sensitivity is integral to health services and their ability to provide health care for people of immigrant and refugee backgrounds. This would involve committing to cultural and linguistic diversity amongst all staff, utilising bilingual and bicultural workers in the delivery of antenatal and postnatal services for immigrant and refugee communities which will maximise knowledge, attitudes and behaviour around cultural diversity and provide more support to health professionals;
- Encounters are non-discriminatory and non-judgemental, and conducted in a safe, non-threatening environment.

### **4. Access and Equity**

Immigrant and refugee women experience a number of structural, cultural and systemic barriers to accessing health services. Based on human rights principles, immigrant and refugee women have the right to access affordable and culturally appropriate health care. Specific structures and policies need to be put in place in order for women to exercise their right to access affordable health services that meet the needs of diverse women.

#### **Indicators:**

- Local, state/territory and federal governments should provide greater funding for health services to be resourced with multilingual written health information and for delivery of multilingual health promotion programs such as antenatal education classes and a greater number of new parent groups across LGAs that are easily accessible. More funding directed towards implementing regular cross-cultural training for service providers, as well as for community organisations and parent groups to organise community events that promote health and raise awareness of available services;
- Health care providers must devote adequate time towards regular evaluation of their services and the implementation of cultural sensitivity within the health setting which would include developing a cultural assessment survey that asks questions such as: “Does the service environment allow for cultural differences?”; “Do staff members make disrespectful comments about patients or their cultural beliefs when they are not there?”; “Are differences respected and accommodated?”; “Are interpreters utilised when needed?”; “Are there adequate multilingual education resources?”;
- It should be a requirement that all health service providers undertake a cultural assessment of patients from diverse backgrounds in the initial stages of treatment, healthcare and provision of services and information to identify similarities and differences of cultural beliefs and practices so that appropriate methods of care can be applied. A set of culturally relevant questions must be developed, while avoiding assumptions that all individuals from the same cultural background will share the same insights, beliefs and practices.
- Development of a database that records information on health and accessibility outcomes according to ethnicity (country of birth, visa on arrival, language spoken, mother’s age during birth) to build on evidence based information and to establish priority groups;

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## **APPENDICES**

## **APPENDIX 1: Consultation participants, bilingual health educators, contributing individuals, agencies and organisations**

### **Consultation participants**

Consultations were undertaken with key stakeholders who provide health and pregnancy-related services to Chinese women in the Whitehorse community, or who possess an understanding of the enablers and barriers for Chinese women accessing antenatal and maternity services, to identify the key issues affecting first time Chinese mothers and to determine culturally-appropriate health promotion strategies for the Chinese community. A total of 28 stakeholders participated in consultations. The following organisations and services were represented in the consultation:

1. Birralee Maternity Service
2. City of Whitehorse
3. Whitehorse Community Health Service
4. Burgess Family Centre
5. Mercy Health O'Connell Family Centre

### **Bilingual Health Educators**

The following MCWH bilingual health educators contributed to the project either through focus groups or by providing information throughout the project to the project officer.

1. Rebecca Heli
2. Yuki Murdolo
3. Dongmei Zhang

### **Contributing individuals, agencies and organisations**

The project was commissioned by WCHS and funded by VicHealth. The project would not have been successful without the help of a number of individuals and organisations who provided additional input to the project including their time, knowledge and assistance. The following individuals, agencies and organisations contributed to this project:

1. Olive Aumann, Whitehorse Community Health Service
2. Natahl Ball, Birralee Maternity Service
3. Eastern Health
4. Pam Heselev, City of Whitehorse
5. Sally Kronk, Whitehorse Community Health Service
6. Patricia Kunek, Birralee Maternity Service
7. Gillian Lang, Whitehorse Community Health Service
8. Angela Murphy, Burgess Family Centre
9. Janelle Russ, Box Hill Hospital
10. Katrina Stevenson, Box Hill Hospital
11. Carrie Wong, Manningham Community Health Services

## APPENDIX 2:

## Bbkayi/Baby Plus 2 Project

### CONSENT FORM

I understand that:

- I am participating in a 2 hour focus group in \_\_\_\_\_ run by a Health Educator of the Multicultural Centre for Women's Health;
- I am free to speak my preferred language;
- I can say as much or as little as I like during the focus group;
- I can stop participating if I feel uncomfortable;
- personal information will be collected, but this information will always be kept CONFIDENTIAL;
- everything that is said in the focus group will be kept totally CONFIDENTIAL;
- the focus group will be recorded to enable the Health Educator to take notes of the sessions afterwards, but these notes will be kept totally CONFIDENTIAL;
- the notes taken during or after the focus group are for the purpose of learning what issues and needs should be addressed to improve health services and programs for the Chinese community in Whitehorse;
- only the Health Educator, the Project Worker at the Multicultural Centre for Women's Health, will see these notes and know I attended the sessions;
- the Health Manager from Whitehorse Community Health Service may also read the notes, but will not know the names of the women attending these sessions and the Health Manager will also keep the notes CONFIDENTIAL;
- the information collected during the focus group will be presented in a general way in a report to help the Whitehorse Community Health Service and other organisations learn about the best way to provide culturally appropriate services and programs to Chinese women and other communities;
- my contribution to the focus group may help the development of health promotion for Chinese women and other immigrant and refugee women.
- if I would like written information in my language regarding health and wellbeing, the Health Educator and Project Worker will try to find suitable information, but they cannot promise that this information can be found;

I FULLY UNDERSTAND THE INFORMATION GIVEN TO ME ABOUT THE FOCUS GROUP AND I AGREE TO PARTICIPATE.

---

**Write your name here**

---

**Sign your name here**

---

**Date**

---

Bilingual health educator to complete:

Participant did not want to sign consent form but wants to participate in focus group

☐

### **Appendix 3: Key stakeholder consultation questions**

1. Can you tell me about your role at \_\_\_\_organisation? How long have you worked in this role?
2. What proportion of your clients would you estimate are of Chinese origin? Approx. how many Chinese clients (male and female) do you have/see in this service?

#### **Theme 1: Beliefs, practices and attitudes around pregnancy and motherhood**

3. Commenting on beliefs, practices and attitudes, what are the key issues for Chinese women/couples around pregnancy, maternity and parenthood?
4. To what extent do Chinese women recognise the importance of antenatal and maternity care to their overall wellbeing and their transition to parenthood?
5. How might the migration experience have an effect on women's transition to motherhood and/or men and women's transition to parenthood?
6. In your experience, how has culture influenced Chinese women's knowledge, practices and attitudes around pregnancy and motherhood?

#### **Theme 2: Information**

7. How and where might Chinese women seek pregnancy and maternity-related information in Australia?
8. What types of pregnancy and birth care options do Chinese women/couples usually opt for?
9. In your experience, what are the best ways to share information with Chinese women?

#### **Theme 3: Access to services**

10. What are the possible barriers and enablers for Chinese women/couples to access support and services before, during and after pregnancy? Eg. Family support programs, new parenting programs, playgroups.  
Prompt: cultural beliefs and traditions, language, transport, dv
11. What are some of the challenges you face working with Chinese women and families? How do you approach or overcome these challenges?
12. What strategies could be employed to improve health service accessibility for Chinese women and their families before, during and after pregnancy?
13. What might encourage Chinese communities to participate more in maternal child and health care or other health services?
14. Any additional comments?

## **Appendix 4: New mother's group focus group discussion**

### **Theme 1: Beliefs, values and meanings**

Discussion about family and new parenthood

Discuss personal beliefs, interpretations and experiences

- Brainstorm what are the roles of men and women in a relationship? What are your roles in the relationship?
  - **Prompt:**
  - What are the societal and familial expectations of men and women roles in a relationship? Do these roles change during pregnancy and after?
  - Do the roles of men and women in Australia differ to what you are used to?
  - What are the roles of mum and dad in the relationship?
  - What influence does the external family have on your relationship and parenthood? (grandparents expectations etc.)
- Brainstorm the lifestyle changes that occur as a result of becoming a new parent
  - **Prompt:**
  - What challenges do these changes pose on your relationship?
  - What methods have you used to cope with the challenges of first time parenthood
  - How does having a child in Australia impact on your experiences as a new parent as opposed to having a child in your home country (if applicable)?
- What are your beliefs and traditions around family, pregnancy and motherhood?
  - **Prompt:**
  - Do/did you follow any cultural and traditional beliefs during and after pregnancy? (eg. What does the 30 day confinement period imply?)
  - What activities, if any, are new mothers/parents restricted from during pregnancy and after birth? How does this impact on your ability to access pregnancy/parenthood related services?
  - What are the roles of your parents/in-laws during pregnancy and parenthood?

### **Theme 2: Access to health and support services**

Pregnancy and parenting information-where, what, how?

**Prompt**

- Where do you get your information from regarding first time parenthood?
- How clear and sufficient is the information?
- If you need parenting support, where do you and your partner go for help? Do you find it helpful and culturally appropriate?

Access to health services-where, what how?

Discuss experiences and expectations

- What do you and your partner look for in a health care provider? What do you expect from them? (prompt for Chinese health care practitioner, gender, TCM, acupuncture?)

- What health and support services have you accessed before, during or after pregnancy in Victoria? (Prompt: do you access alone or with someone else, quality of service, cultural appropriateness, would you recommend it to other Chinese couples?) What has discouraged you from accessing services?
- What have been your experiences accessing antenatal and maternity services? How do they differ from services provided in your country of origin?
- Have you experienced any difficulties accessing antenatal and maternity services in Victoria?
- What might be the reasons new Chinese parents do not access services as much as other communities?

### **Theme 3: Suggestions for improving access to services**

- What might encourage the Chinese community to access antenatal and maternity services? Parent support programs?
- What might encourage Chinese couples to access new parenting groups such as Baby Makes 3?
- Is there a need for more cultural sensitivity provided by health and parenting services before, during and after pregnancy? Why?
- What services would you like to see?
- Any other comments?

## **Appendix 5: *Baby Makes 3* participant focus group discussion**

### **Theme 1: Beliefs, values and meanings**

Discussion about family and new parenthood

Discuss personal beliefs, interpretations and experiences

- Brainstorm what are the roles of men and women in a relationship? What are your roles in the relationship?

**Prompt:**

- What are the societal and familial expectations of men and women roles in a relationship? Do these roles change during pregnancy and after?
  - Do the roles of men and women in Australia differ to what you are used to?
  - What are the roles of mum and dad in the relationship?
  - What influence does the external family have on your relationship and parenthood? (grandparents expectations etc)
- Brainstorm the lifestyle changes that occur as a result of becoming a new parent
- Prompt:**
- What challenges do these changes pose on your relationship?
  - What methods have you used to cope with the challenges of first time parenthood
  - How does having a child in Australia impact on your experiences as a new parent as opposed to having a child in your home country (if applicable)?
- What are your beliefs and traditions around family, pregnancy and motherhood?
- Prompt:**
- Do/did you follow any cultural and traditional beliefs during and after pregnancy? (eg. What does the 30 day confinement period imply?)
  - What activities, if any, are new mothers/parents restricted from during pregnancy and after birth? How does this impact on your ability to access pregnancy/parenthood related services?
  - What are the roles of your parents/in-laws during pregnancy and parenthood?
  -

### **Theme 2: Access to health and support services**

Pregnancy and parenting information-where, what, how?

**Prompt**

- Where do you get your information from regarding first time parenthood?
- How clear and sufficient is the information?
- If you need parenting support, where do you and your partner go for help? Do you find it helpful and culturally appropriate?

Access to health services-where, what how?

Discuss experiences and expectations

- What do you and your partner look for in a health care provider? What do you expect from them? (prompt for Chinese health care practitioner, gender, TCM, acupuncture?)

- What health and support services have you accessed before, during or after pregnancy in Victoria? (Prompt: do you access alone or with someone else, quality of service, cultural appropriateness, would you recommend it to other Chinese couples?) What has discouraged you from accessing services?
- What have been your experiences accessing antenatal and maternity services? How do they differ from services provided in your country of origin?
- Have you experienced any difficulties accessing antenatal and maternity services in Victoria?
- What might be the reasons new Chinese parents do not access services as much as other communities?

### **Theme 3: Suggestions for improving access to services**

- What might encourage the Chinese community to access antenatal and maternity services? Parent support programs?
- What might encourage Chinese couples to access new parenting groups such as Baby Makes 3?
- Is there a need for more cultural sensitivity provided by health and parenting services before, during and after pregnancy? Why?
- What services would you like to see?
- Any other comments?

## Appendix 6: Demographic survey for focus group participants

<p><b>1. How old are you?</b></p> <p>18 – 24 years      <input type="checkbox"/></p> <p>25 – 30 years      <input type="checkbox"/></p> <p>31 – 36 years      <input type="checkbox"/></p> <p>37 years or more   <input type="checkbox"/></p>	<p><b>2. In which country were you born?</b></p>
<p><b>3. How long have you lived in Australia?</b></p> <p>0 – 5 years      <input type="checkbox"/></p> <p>6 - 10 years      <input type="checkbox"/></p> <p>11 – 15 years    <input type="checkbox"/></p> <p>16 – 20 years    <input type="checkbox"/></p> <p>21 years or more <input type="checkbox"/></p>	<p><b>4. What visa did you arrive on?</b></p> <p>Skilled Migration (Permanent)      <input type="checkbox"/></p> <p>Family Migration (Permanent)      <input type="checkbox"/></p> <p>Refugee/Humanitarian      <input type="checkbox"/></p> <p>Student      <input type="checkbox"/></p> <p>Long-Stay Business Visa (Temporary)   <input type="checkbox"/></p> <p>Other      <input type="checkbox"/></p> <p>Please specify:</p>
<p><b>5. Are you:</b></p> <p>Single      <input type="checkbox"/></p> <p>In a relationship (not married)      <input type="checkbox"/></p> <p>Married      <input type="checkbox"/></p> <p>Separated/Divorced      <input type="checkbox"/></p> <p>Other      <input type="checkbox"/></p>	<p><b>6. Who do you live with?</b></p> <p>I live alone      <input type="checkbox"/></p> <p>Partner only      <input type="checkbox"/></p> <p>Partner and my parents      <input type="checkbox"/></p> <p>Partner and my in-laws      <input type="checkbox"/></p> <p>Partner, my parents and in-laws      <input type="checkbox"/></p> <p>Other, please specify _____</p>
<p><b>7. Do you have relatives in Australia? If so, who?</b></p>	<p><b>8. What is your occupation? (You can tick more than one box)</b></p> <p>Employed (full or part-time)      <input type="checkbox"/></p> <p>Are you currently on maternity leave? If so, how much time have you planned to take off?</p> <p>_____</p> <p>Student (full or part-time)      <input type="checkbox"/></p> <p>Parenting duties      <input type="checkbox"/></p> <p>Other      <input type="checkbox"/></p>
<p><b>9. What is the highest level of education you have obtained?</b></p> <p>No Schooling completed      <input type="checkbox"/></p> <p>Primary school (or equivalent)      <input type="checkbox"/></p> <p>Secondary (or equivalent)      <input type="checkbox"/></p> <p>University/ Tertiary      <input type="checkbox"/></p> <p>Masters Degree      <input type="checkbox"/></p> <p>Doctorate      <input type="checkbox"/></p>	

## **Appendix 7: Focus group invite**

This invite was translated into both Mandarin and Cantonese and sent to various organisations and handed out to new mother's groups at the Burgess Family Centre:

### **Are you of Chinese background who is pregnant, a new mother or the partner of either?**

The Multicultural Centre for Women's Health has been commissioned by Whitehorse Community Health Service to conduct research that aims to help them provide more culturally sensitive services and programs for the Chinese community in Whitehorse. This project will explore the experiences of Chinese women during the transition to first time parenthood and the barriers they may experience accessing support services before, during and after pregnancy. A key component of this process is obtaining important input from women and their partners in the Chinese community regarding their experiences of pregnancy and first time motherhood in Victoria. We will be holding focus groups from in the City of Whitehorse area to hear from those who would like to participate. These focus groups will be held in Mandarin or Cantonese.

The goals of each focus group are:

- To understand the issues and experiences of Chinese women before, during and after pregnancy
- To understand Chinese cultural beliefs, practices and expectations about respectful relationships
- To gain an understanding from Chinese women transitioning to first-time parenthood about their awareness of the transition to parenting challenges on lifestyle and relationships;
- To identify the barriers and enablers for Chinese women to access support and services before, during and after pregnancy
- To identify service and/or program gaps and culturally appropriate responses aimed at promoting equal and respectful relationships;
- To build the capacity for services/programs such as the Birralee Maternity Service at Box Hill Hospital to provide culturally appropriate services to Chinese women and other communities.
- To build capacity within the Box Hill Hospital Birralee Maternity Service and other support services to promote the importance of parent support programs aimed towards preventing family violence.

I would like to invite you to be part of a focus group of Chinese participants. The 2 hour focus group will include approximately 5 to 12 participants and will be facilitated by myself and one of our Chinese bilingual health educators. These focus groups will take place at the Birralee Maternity Service in Box Hill between 7-9pm from February to April. Participants' privacy and confidentiality will be maintained in the focus groups and whilst information will be collected in written and audio-taped format; no participant will be identified in any way in any collation of the research or report.

Light refreshments will be provided and if you have any specific needs related to your participation please let me know so we can accommodate them.

You can call me on 94180915 or email at [megan@mcwh.com.au](mailto:megan@mcwh.com.au) to confirm your participation or to request additional information. Please specify which language group and a suitable day for you to participate. I appreciate your consideration of this important opportunity to improve the health and welfare services for the Chinese community in Whitehorse and I look forward to hearing from you.

Kind Regards,

Megan Wong

*Health Promotion and Research Project Officer*