Immigrant Women: Making Connections to Community Resources for Support in Family Caregiving

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The purpose of this ethnographic study was to understand how immigrant women caregivers accessed support from community resources and identify the barriers to this support. The study included 29 Chinese and South Asian women caring for an ill or disabled child or adult relative. All experienced barriers to accessing community services. Some possessed personal resources and strategies to overcome them; others remained isolated and unconnected. Family and friends facilitated connections, and a connection with one community service was often linked to several resources. Caregivers who failed to establish essential ties could not initiate access to resources, and community services lacked outreach mechanisms to identify them. These findings contribute new understanding of how immigrant women caregivers connect with community resources and confirm the impact of immigration on social networks and access to support.

Caring for family members with chronic health problems can affect women's work, social life, and psychosocial and physical health (Pearlin, Mullan, Semple, & Skaff, 1990). Reports of research on social support for family caregivers in non-immigrant populations indicate that support from family, friends, and community resources is beneficial for the health of the caregiver (Braithwaite, 1996; House, Landis, & Umberson, 1988; Kiecolt-Glaser, Dura, Speicher, Trask, & Glaser, 1991; MaloneBeach & Zarit, 1995; Rautkis, Koeske, & Tereschko, 1995). However,

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there is little research on immigrant women caregivers' access to support and the influence of either the immigration transition or the cultural context of the woman's country of origin. Cultural norms determine who should care for ill or disabled family members and who should provide support to the family caregiver (Meleis, 1991). The disruption of social ties associated with immigration can remove culturally expected sources of assistance and diminish available support.

In this article, we report findings from an ethnographic study of Chinese and South Asian immigrant women caring for an ill or disabled family member. The purpose of the study was to understand how the women gained access to support from community resources and identify the barriers to support that they experienced, including those arising from their social and material circumstances. The focus of the study was the experience of support for women caregivers who had experienced migration, not cross-cultural comparison.

The research was informed by an understanding of social support as an evaluation or appraisal of personal relationships within the social network (Funch, Marshall, & Gebhardt, 1986). The informal social network comprises relationships with family, friends, and peers, whereas connections with service providers constitute the formal network (Berkman, 1984; Kahn & Antonucci, 1980). Support from the informal and formal social network is interrelated, as the extent of support available from family, friends, or peers can influence the requirement for assistance from community services (Morgan, 1990).

BACKGROUND

Although host countries offer different formal and informal policies and practices that can either facilitate or inhibit integration, studies of immigrant women family caregivers in countries such as Israel (Slonim-Nevo, Cwikel, Luski, Lankry, & Shraga, 1995), Australia (Gelfand & McCallum, 1994), the United States (Braun, Takamura, & Mougeot, 1996), and Canada (George, 1998) indicate that migrant women in caregiving roles share similar challenges, including economic strain associated with a decline in income on migration. All family members experience acculturative stress. However, as cultural and intergenerational mediators, women are expected to uphold cultural traditions and gender roles while assuming increased responsibility for caregiving in the absence of relatives who would usually assist (Gelfand & McCallum, 1994; George, 1998; Slonim-Nevo et al., 1995).

Throughout much of the world, gender socialization and accompanying gender ideologies support the idea that women are "natural" caregivers (Brewer, 2001), and religious and cultural beliefs further shape and reinforce these sentiments (George, 1998). Thus, although the cultural imperative for women to enact caregiving responsibilities might be widespread, the ability for women in some cultures to relinquish this role to others—in whole or in part—does differ. For instance, although Euro-American caregivers are expected to fulfill family caregiving roles, their adherence to these beliefs and practices appears to be weaker than has been recorded among Americans of non-European backgrounds (Connell & Gibson, 1997). In East and South Asia, women's caregiving responsibilities are framed by the concepts of filial piety and *dharma*, respectively (Chao & Roth, 2000; George, 1998). The notion of filial piety originated in China, and dharma is associated with

Hinduism, but these values have diffused throughout these regions (Braun et al., 1996; George, 1998). Filial piety is a reciprocal arrangement that demands obedience toward elders and those in authority in exchange for their benevolence and care (Holroyd & MacKenzie, 1995; Hsü, 1991), and dharma involves the fulfillment of duty (George, 1998). Both concepts share in the notion that familial and group needs take precedence over individual concerns. In the context of familial caregiving, caregivers are expected to enact their roles and gain satisfaction from their efforts to benefit the family.

For immigrant women caregivers, access to support from community resources is influenced by policies related to both immigration and health care. Since 1976, applicants have entered Canada through either a family reunification or an independent economic category that provided entrance as skilled workers, business class entrepreneurs, or investors (Fleras & Eliott, 1999). In 1998, 35% of immigrant women arriving in Canada entered under the family reunification category, and an additional 38% were dependents of principal applicants in the economic category (Chard, Badets, & Howatson, 2000). Although Canada has a universal health care system, coverage available to immigrant families can vary with immigration status (Fleras & Eliott, 1999) and province of residence. Under the family reunification classification, sponsors assume financial responsibility for their sponsored relative for 10 years. During that time, sponsored immigrants are not eligible for certain publicly funded programs, such as income security (Chard et al., 2000; Simmons, 1990). In addition, the policies and programs that influence the support available to immigrant women from community resources may result in services that lack cultural sensitivity or restrict their access (National Forum on Health, 1997; Stevens, 1993).

For family caregivers, including immigrant women, the need for support from community or institutional sources is related to caregiving demands and to the extent of support available from family, friends, and peers (Morgan, 1990; Orodenker, 1990). Access to support in dealing with primary caregiving demands (arising from the care that a recipient needs) and secondary demands (from other sources, such as family or employers) (Pearlin et al., 1990) is facilitated by social ties to family and friends and by connections to community resources. The social network that surrounds an individual may vary in size, strength of ties, density, homogeneity of members, and geographic proximity or dispersion (Cohen, Teresi, & Blum, 1994). For immigrant women, migration can alter profoundly the structure of the social network and social interaction patterns in ways that affect caregivers' access to support. For example, the family member who would usually provide care may not reside in the same community or country (Anderson, 1991). In addition, other relatives who would normally provide support to the family caregiver may not be available (Dasgupta, 1992; Dhruvarajan, 1988). Other qualitative studies (Legault, Gravel, Fortin, Heneman, & Cardinal, 1997; Lynam, 1985; Rose, Carrasco, & Charboneau, 1998) suggest that immigrant families in Canada rely on access to support from both the informal and formal social networks, relying initially on the informal one. They may use immigrant-serving agencies to locate other community resources (Baker, Arsenault, & Gallant, 1994). None of these studies specifically addressed women caring for an ill or disabled family member, where more extensive caregiving demands might accentuate the need for access to formal services.

METHOD

Ethnographic inquiry (Hammersley & Atkinson, 1995) facilitated access to the family caregivers' descriptions of obtaining support from community resources. We defined *family caregiving* as assuming primary responsibility for providing care, without remuneration, to an ill or disabled family member. Inherent in the ethnographic approach was a commitment to understand and reflect on caregiving issues in the context of everyday life. We adopted an interpretive critical theory perspective (Morrow, 1994) to emphasize cultural and social characteristics of the caregiving context and to locate the individual's perceptions and actions within social and structural settings. To facilitate identification of implications of the research for policy and practice, we also sought the perspective of professionals in health and social agencies. Data for the study included interviews, participant observation, and focus group discussions. An advisory committee was established to help the research team make the study relevant for immigrant women and to select methods of recruitment, data collection, and dissemination that would foster their participation (Neufeld, Harrison, Hughes, Spitzer, & Stewart, 2001). The committee was composed of representatives of the ethnic communities of participating women, immigrant-serving agencies, and mainstream health and social service agencies.

Sample Selection and Recruitment

Twenty-nine women family caregivers who immigrated to Canada from China, including Hong Kong and Taiwan, and India or Pakistan were recruited. We chose Chinese and South Asian women for the study because together, these two groups formed the largest immigrant population in the study area (Lamba, Mulder, & Wilkinson, 2000). Our focus was on women who were voluntary immigrants, as the impact of migration and the experience of support might differ for refugees. We sought to include women who varied in age, income, caregiving situation, facility in English, and geographic area of their country of origin. Initially, the women were recruited through advertisement in participating community agencies and local media. Theoretical sampling guided selection of a subset of women for a second interview, participant observation, and participation in focus group discussions.

In addition, professionals who are policy makers or program managers were recruited through contact with their employing agency for two focus group discussions. To ensure that varied organizations were represented, 15 representatives were selected from private and publicly funded health, education, social, and immigrant-serving organizations.

Data Collection

All women participated in one open-ended interview, and six participated in a second interview in their home that included participant observation of their care for their relative. Two women chose to be interviewed together. We also interviewed two family members who assisted with caregiving. To reduce burden, the interview times and locations were flexible. The immigrant women selected the location for the interview, usually in their home, although some caregivers chose to be interviewed at a public location in the community.

In the first interview, the women were encouraged to tell the story of how they came to care for their family member and to describe a typical day in their caregiving experience. They were asked to discuss what was rewarding in this role and what was difficult. Women were invited to comment on the help they received from family members and community agencies, difficulties they encountered in getting the support they needed, and how the immigration experience affected their caregiving. In a second interview and participant observation of their care for their relative, six women provided detailed descriptions of their caregiving work.

Three interviewers, who were members of the women's ethnic communities, conducted the interviews and participant observation visits. All were members of a health-related profession, and one was completing a master's degree. Each interviewer was fluent in one or more of the first languages of the participating women: Cantonese, Mandarin, and Punjabi. Ability to communicate in the participants' language of choice was an advantage, as women might be reluctant to speak of personal experience through an interpreter. The interviewers participated in training sessions on interviewing in the context of qualitative research. These sessions were given by the team of investigators and included content on principles of ethnographic research; ethical guidelines; interviewing skills, such as establishing rapport, dealing with sensitive issues, using probes, and encouraging expression; and issues associated with cultural variation and translation. The interviewers translated the guiding interview questions into Chinese and Punjabi. Their orientation included tape-recorded practice interviews, with feedback from each other and the principal investigator, and pilot interviews with immigrant women not eligible for the study. We made several modifications to the preliminary interview guide as a result of this pilot work (Neufeld et al., 2001). Fourteen women (8 Chinese and 6 South Asian) were interviewed in their first language.

After preliminary data analysis, two focus groups were held with women caregivers who had been interviewed previously (4 Chinese and 3 South Asian women) and with policy makers and program managers to discuss the implications of study findings for changes in programs and policies. Although we offered focus groups for women in their choice of language, all participating women were fluent in English. Food and expenses for child care and transportation were covered for women family caregivers. The principal investigator facilitated all focus group sessions with the assistance of interviewers from the ethnic communities.

To encourage discussion in the focus groups, we constructed four composite case scenarios written at a Grade 6 reading level. The scenarios incorporated the preliminary findings of the study and reflected variations in the caregiving situations while protecting anonymity and confidentiality. An example of a composite scenario follows:

> Mary and her husband came from Hong Kong 30 years ago. For 5 years, she has been looking after her husband, who has Alzheimer's disease, high blood pressure, and diabetes. Although Mary has three adult children, she and her husband live by themselves. She would like her children to spend more time taking care of her husband because her health is not good. Besides, she believes that taking care of elderly parents is the job of adult children. However, her children say that they are very busy in their work. Her children have suggested sending their father to a nursing home. Mary is very angry at this suggestion. Mary, like many other immigrant women, said that she would like to get more services for her husband. However, she can speak only Cantonese and doesn't know much about health care in Canada.

We developed guiding questions that addressed the issues presented in the composite scenarios, the type of assistance that would be helpful, desired changes in existing resources, and possible barriers to achieving those changes. We explored the same questions and scenarios in the group discussions with professionals and caregivers.

All interviews and focus group discussions were audiotaped and transcribed verbatim. All tapes were reviewed against the transcripts to determine the accuracy of the transcription. Interviewers translated the interviews conducted in languages other than English. The interviewer who did the original translation then reviewed the audiotapes of interviews conducted in a language other than English against the typewritten translation to ensure accuracy. Interviewers maintained detailed field notes for all interviews and observation visits, including comments about relevant social context, cultural practices, or perspectives. They also documented in the field notes any issues identified in the process of translation. We employed these strategies to assist us in interpreting the meaning of the interview data and in understanding cultural variations (Esposito, 2001).

Interviewers met regularly with the principal investigator, attended advisory committee meetings, and participated in research team meetings on data analysis to explore the cultural context and issues present within the ethnic communities. Discussion with investigators who were not from the ethnic communities also helped us to address the potential limitation that interviewers might take for granted cultural aspects of their communities.

Data Analysis

Data collection and analysis proceeded simultaneously using a thematic form of content analysis. All members of the research team reviewed transcripts and met regularly as a team to establish consensus in relation to the coding process. Data segments from multiple sources that pertained to a common idea were assigned preliminary codes. As distinctions among the codes became clearer, these sensitizing concepts (Blumer, 1954) were defined more specifically and used in the coding and analysis. Atypical cases were noted and memos made of all discussions, decisions, and questions for further investigation (Morse & Field, 1995). The Non-numerical Unstructured Data* Indexing Searching and Theorizing (QSR N4) software program was used to manage the data. Analytic procedures, such as generation of matrices, helped to identify linkages among the concepts (Hammersley & Atkinson, 1995). First, we analyzed data for each woman and each cultural group. We then compared data from women in varied situations, including different ethnic groups, income levels, age, and caregiving situations, to examine the possible influence of these variations. Subsequently, we compared the themes identified in the interviews with the participant observation field notes. The focus group data were analyzed by themes in a similar manner.

Ethics

The local institutional ethics review board approved the study. All participants signed a consent form prior to the interview or focus group and were advised that their participation was voluntary and that they could withdraw at any time.

FINDINGS

Profile of Participants

The family caregivers included 18 Chinese and 11 South Asian women. The Chinese women had immigrated from Hong Kong (15), China (2), and Taiwan (1). Two relatives, long-term residents who assisted the woman with care, the father-in-law of a Chinese woman and the sister of another woman were also interviewed. The Chinese women included four recent (<7 years), five intermediate (8-14 years), and nine long-term residents (>14 years). South Asian women came from India (10) and Pakistan (1); all had resided in Canada more than 14 years. Although we included women who varied in their years of residence in Canada, none was in the early settlement period. Most women were in mid-life, but ages ranged from 30 to 79 years. The women represented a range of household incomes, from low (<$20,000 CDN) to high (>$80,000 CDN). Eleven of the women were engaged in full-time paid employment outside the home, and ten worked outside the home part-time. The remaining women did not report paid employment. Ten had Grade 12 or fewer years of education; the remainder had some postsecondary education. The women cared for family members, including a spouse, parent or parent-in-law, or child. Fourteen women provided care to more than one family member. The length of time for which the women had been caregivers ranged from 1 to 22 years, with the largest concentration of women in the 5-to-9-year period.

Adult care recipients had a chronic health condition, such as cancer, diabetes, kidney disease, arthritis, heart disease, or dementia, and children had a developmental delay or cerebral palsy. In most situations, the care recipient lived in the home of the immigrant woman caregiver. One child and two adult care recipients were residents of an institution. Two women cared for relatives who lived independently in the community. With one exception, all care recipients were eligible for universal government-funded health care coverage, including physician and hospital services. Eligibility for assistance from income support and social programs varied with their length of residence, age, and status as a sponsored or independent immigrant.

Professionals participating in the focus group discussions included ten representatives of mainstream organizations, such as regional community health, home care, and educational services, and provincial and federal health and multicultural heritage agencies. There were four participants from immigrant-serving agencies and one representative from an ethnic community agency.

The women faced heavy caregiving demands that often included providing extensive assistance with personal care, in addition to cooking meals, monitoring medications, assisting with housekeeping, taking the care recipient to medical appointments, and trying to maintain social contacts for the care recipient. They required assistance to meet these demands and reduce the risk of a negative impact on their health. Some of the women established connections with community resources, but others failed to establish these essential ties. We describe the ways immigrant women made connections with community sources of assistance, identify a subgroup of women who were unable to do this, and then discuss in more detail the barriers to gaining access to community resources. All the women experienced some of the barriers described; however, some possessed strategies and resources that enabled them to address these issues, whereas others remained isolated and unconnected.

Connecting With Community Resources

Women established connections with services through their social networks, which included relatives, friends, community or church associates, and professionals. Most women had relatives in the same city, other parts of Canada, and their country of origin, but eight made no reference to family members outside of North America. The range of services accessed through different patterns of making connections included speech therapy, respite care for an elder, a school for special needs children, or home care for an elder or child.

Relatives, Friends, and Other Caregivers Facilitate Connections

The most common way for women to connect with community resources was through relatives and friends in their informal social network. Assistance from a friend within the ethnic community who was a social worker, nurse, or physician was common. Friends with professional backgrounds were able to both ensure privacy and interpret expectations and characteristics of community resources in a meaningful way. One caregiver noted that many women who do not have friends in these professional roles do not know what resources are available:

> We have friends who are social workers and who are nurses, who are doctors . . . so, we get to know more about the system, but if you don't know these people . . . sometimes it is really hard to get information. (Chinese caregiver)

Connections also occurred when the caregiver knew other family members or caregivers who required similar services. For example, one Chinese caregiver sought assistance for her child from a local rehabilitation center because her niece/nephew also had a developmental delay and had received services there. When asked how she knew of these services, she responded, "I didn't know anything. It is only because his other cousin went [to an agency] for the assessment."

Another woman, who was caring for a husband with cancer, appreciated a church member's recommendation that she contact a Chinese medical practitioner. She was frustrated with her husband's inability to eat and the difficult challenge of cooking meals he could tolerate:

> He couldn't eat again. He couldn't take the nutrients. . . . He [was] referred by a friend in the Church. . . . We cannot just take the prescription and get the herbal medicine here. If the person in the Church doesn't know the doctor, we won't be able to know this doctor [Chinese medical practitioner]. (Chinese caregiver)

One mother reported asking other caregivers in her ethnic community for information when she needed a wheelchair for her son. These inquiries helped her to identify the advantages and disadvantages of different alternatives. In her case, this informal support supplemented information and advice available from a social worker.

A Chain of Linkages to Community Resources

Some women described a chain of linkages between friends, relatives, other caregivers, health and social service professionals, and community resources. The process involved one contact, sometimes unrelated to caregiving, leading to another contact and, ultimately, access to community resources. For example, one mother described how first a friend in a parenting class and then her child's teacher commented on her child's slow development. Through the teacher's recommendation that she contact her family physician, she was eventually connected with appropriate services:

> They have parenting class, and I attend that and I get some friend, and then get some teachers. They told me he seems to have some problem. They suggest me talk to the family doctor and then the family doctor command me to go to the [rehabilitation center]. (Chinese caregiver)

The aunt of another woman referred her to respite services for her elderly mother; the respite service, in turn, became a link to other community resources. When asked how she discovered these services, she replied, "From the respite home. And this information, actually about the respite home, the aunt mentioned to me. That's how we came to know other departments. And then you come to know more and more" (South Asian caregiver).

Contact with one community resource provided a bridge to other resources through referral, advocacy support, and distribution of information. For example, one mother with assistance from an advocacy association for handicapped children successfully appealed the denial of her application for financial assistance from a government program: "So I talk to them . . . and then they just said you know, if you need it you have to fight because they don't give you that easy . . . they help me to do with the appeal" (Chinese caregiver).

Missing Links: Absence of Network Ties to Community Resources

Although we have described the pathways that linked immigrant women caregivers to community resources, almost half of the women in our study (6 Chinese and 6 South Asian women) did not report making any connections to community resources. These caregivers were particularly vulnerable to lack of access to support and the associated negative impact for their health. Women in this group included caregivers of an adult or child; recent, intermediate, and long-term immigrants; those who were employed or not employed outside the home; and women whose relatives resided in the local community and abroad. Of the 12 women who reported no linkage with outside resources, seven were interviewed in the language of their country of origin. No identifiable pattern in their access to support was associated with these variations, nor was there any consistent difference identified between their caregiving situations and the circumstances of women who connected with community resources.

These women might be an example of the isolation of women caregivers that was noted in all of the focus group discussions of scenarios:

> So, it's not only the language, I think she's isolating herself from everybody else . . . she's only connected to her family . . . I don't think she has friends you know . . . Because friends will tell you, sometimes . . . or neighbors will. (Professional service provider in focus group)

Focus group participants suggested that women may feel trapped, lack connections to others, lack the confidence to make their needs known, or fear disclosure to relatives, who might consider them incompetent. Both caregivers and professionals said that although caregivers needed to take the initiative to seek out resources, community agencies must also adopt initiatives to reach out and connect with immigrant women caregivers. In response to the scenario about a developmentally delayed child, one professional service provider commented in a focus group, "The key question that we have is . . . how . . . programmers reach the parents."

Barriers to Connecting with Community Resources

Next, we discuss the barriers to community resources that immigrant women in this study described. These barriers influenced the strategies that women used to connect with community resources and, for some women, blocked access to supportive services. Barriers included structural ones arising from immigration policies and material circumstances and others related to language facility and personal or cultural beliefs.

Immigration Policies

Caregivers often described a pattern of chain migration through the family reunification policy. For example, one family member came initially as part of the independent economic category and subsequently sponsored two other members. Chain migration disrupts the usual patterns of family care and support. The Canadian policy that family members financially sponsor new immigrants for their first 10 years in Canada limits use of community resources by recent immigrants and creates a potential burden for their relatives. A Chinese caregiver commented, "Since my brother applied us to come here, he's responsible for the expense for us for at least 10 years." This woman elaborated on the inequity she saw between limited resources available to her family under the family reunification policy and the more generous benefits afforded to refugees, who were immediately eligible for social assistance and health care benefits. She compared her experience to people who entered Canada from China as political refugees in 1989:

> As you come from Hong Kong you cannot get any service. And if you work, the tax will "kill" you. But if you got political asylum, you get money. And so we always say being Hong Kong people are less fortunate . . . since you come from a modern city you get nothing. I only got $400 as being janitor per month. I needed to pay tax even and they can receive money and don't need to work. (Chinese caregiver)

In the two cultural groups in this study, the usual family caregiver is the wife or daughter-in-law. Immigration can disrupt this pattern. Professionals in one focus group noted that women who are caring for their own parent rather than their in-laws might fear that their parent's sponsor would withdraw support if they had trouble with caregiving. This could necessitate sending their parent back to their home country. Moreover, sponsorship policies discourage women from seeking community services, despite disruption in availability of support from those normally expected to provide it.

Inadequate Language Facility

Women were hampered in their ability to access services by inadequate skill in English, even when they had attempted to learn the language. Canadian immigration policies provide more limited access for women than for men to English language programs (Boyd, 1997; Ng, 1993). Only one member of a couple, usually the husband, is granted status under the independent immigration category that provides access to language support. This practice occurs even when both husband and wife have comparable education and work experience. In addition, short programs offered to newcomers can be inadequate for acquiring the level of language that is necessary: “When I first came here I went there to learn English for like several weeks, but now I forgot most of it” (Chinese caregiver).

One woman was unable to apply for a walking aid because she could not communicate either her health care number or her name over the phone to the intake worker. Although our primary focus was on initial access to community resources, there is substantial evidence in the data that facility in English is also important in sustaining a beneficial connection with a community service: “If he stays in the hospital or senior center, he needs somebody to speak Mandarin or Taiwanese. If the agent [agency] doesn’t provide such service, he prefers staying in the house” (Chinese caregiver).

In one situation, the family interpreter lacked the complex English vocabulary necessary to understand the medical terminology used by the specialist. Consequently, the caregiver and family were unable to understand their relative’s condition and avoid preventable complications of diabetes. Inadequate skill in English was also a barrier to expressing emotion. As one woman said, “It’s hard to use English to talk about emotional needs.”

Women in the focus group discussions added that inability to speak English could limit the choice of potential professionals, such as social workers. Both women and professionals in group discussions referred to the difficulty in assessing children’s speech and language development accurately when two languages are involved.

Limited Material and Temporal Resources

Limited material resources frequently restricted immigrant women’s access to services. As many elder care recipients did not drive, they relied on their adult children to take them to appointments with health professionals, laboratories, or medical supply services and to participate in social or recreational activities. Some caregivers did not have a car or had difficulty taking time away from work during business hours or from care of their children and household duties. Parking close to health facilities was difficult to locate and expensive, particularly when the care recipient was limited in the distance he or she could walk. The pool of potential friends and relatives who could relieve the caregiver and assist with transportation for the care recipient was also limited. One caregiver insisted that her mother learn to take public transportation. Although the older woman was very hesitant, she did use the bus. Other family members worried about her, particularly in poor weather, and because she could not speak English, another family member made a tag that she carried indicating her name, address, and phone number. However, as the caregiver said,

> This is very essential because it's not good if she stays at home all the time. I rather she takes the wrong bus instead of staying at home all the time. When first arrived, she got really bored as she did not know how to take bus. (South Asian caregiver)

Many women caregivers worked outside the home to support the family and faced overwhelming demands. A South Asian woman, whose only aid was some help from her husband, cared for her in-laws in addition to her full-time job and caring for her children. She describes her situation:

> I get up 3:45 a.m. in the morning. I prepare breakfast and lunch for my kids and in-laws. I leave for work at 5:15 a.m. I give her bath in the evening—usually every second day. Usually my husband helps out. We have no help from friends or any other family member. I come home in the evening, then prepare supper for the whole family, give bath to my small kids, clean the house. (South Asian caregiver)

Lack of time also made it difficult for caregivers to locate or make use of resources and programs that could be helpful:

> Like, there's probably all kinds of programs out there, but for one thing, we don't have time to join. (Chinese caregiver)
>
> We can't take time off from work either. It is very stressful. (South Asian caregiver)

Sometimes immigrant women caregivers had an immediate need for a service but there were waiting lists:

> Well, some services, they have a waiting time . . . but I find it, when you really need it, you sort of need it now. . . . We waited for over a month. To get support—you need to go to so many different places and offices and I just don't have time for that. (South Asian caregiver)

For other women, the time the service was available was insufficient.

Negotiating Access to Resources Congruent With Personal or Cultural Beliefs

Immigrant women's beliefs sometimes restricted access to support from community resources. For example, women who valued privacy were reluctant to disclose personal problems and feelings to a stranger. One caregiver observed that a more indirect form of communication with a friend within her ethnic community, who was also a professional, overcame both the language barrier and concerns about privacy while gaining her access to expert information. For another family, reluctance to disclose the nature of a child's developmental delay because of a concern that this would reflect negatively on the family precluded a request for assistance. The child's grandmother believed that no one outside the family should care for her developmentally delayed grandson: "Sometimes we also ask our relatives to take care of our son. If we cannot find any family member we would pay school teachers . . . my mother-in-law worries if an outsider takes care of the son" (Chinese caregiver). A South Asian woman in the focus group discussion also noted that a child with a developmental delay would stigmatize the whole family.

These women's strong commitment to their responsibility to care for their relatives, often described as filial piety by the Chinese women, also influenced their access to community resources. One Chinese caregiver described her frustration that no home care assistance could be obtained for her parents, who lived with her; they would be eligible only if she evicted them. This policy conflicted with her commitment to care for them: "They're living with me. If I dumped them out, leave them outside on their own, I'm sure they will get some help. But this is my parents I am talking about. You think I can do that to them?"

Conflict between beliefs in traditional herbal medicine and Western medicine generated a dilemma for some Chinese women. The parents-in-law of a Chinese woman were the primary caregivers of her developmentally delayed son for 5 years while she and her husband worked abroad. When she returned, she wanted to consult a traditional Chinese medical practitioner for her son, but her mother-in-law objected on the grounds that the child might have a reaction to any herbs prescribed. Although the mother considered treating the child secretly, she decided that this would reflect disrespect for her parents-in-law:

> Although he is my son, he is also like my in-laws' son. Sometimes my friends referred Chinese medicine to me . . . my mother-in-law would say "Don't give this poor kid any medication" . . . At first I plan to take my son to see this doctor secretly . . . my friends also referred acupuncture to me. I took my son there around one year. (Chinese caregiver)

A Chinese caregiver agonized over her lack of knowledge of Western medicine. Her grandmother had a fall and was treated by a traditional Chinese herbalist for a year without improvement. She later discovered that her grandmother had had a fracture, and it was no longer possible to correct her immobility:

> She could not get up after she fell. Maybe we did not know the bone was broken. We brought her to see the herbalist for one year. At the end she could not walk. I did not know until I work here [nursing unit] that we should not move the old people when they fell.

Previous experience in their country of origin can also affect caregivers' perspectives on community resources. One woman noted that because they were pleased to receive—at no cost—health care services that would not be available in Hong Kong, they did not seek other services. This was reinforced by a professional, who noted in a focus group that families that had been very self-reliant in their home country might not consider seeking help from community services.

DISCUSSION

This study contributes new understanding of how immigrant women caring for an ill or disabled family member access community resources. For some, social ties were a link to community resources, whereas others remained isolated and disconnected. Women's social networks and access to support from community resources were influenced by the process of chain migration and the economic and material constraints associated with migration, resettlement, and family caregiving.

Because they usually entered Canada through the family reunification program, immigrant women caregivers' social networks comprised a few close ties with relatives who immigrated at an earlier time and assisted them during the early settlement period. They lacked diverse social networks that included connections with others holding divergent views. Other research (Grant & Wenger, 1993) confirms that the informal support network is a screening and referral agent for community resources, but suggests that small, high-density networks of strong ties with similar others can act as a barrier to outside help. Homogeneous social networks can be barriers because those with strong ties, such as a common ethnic heritage, often share an overlapping circle of friends and have limited exposure to new information. Conversely, heterogeneous networks of "weak ties" among acquaintances provide important bridges to wider sources of advice and help than is available from members of homogeneous networks (Granovetter, 1973). The influence of the social network derives from the beliefs communicated by influential others and from the strength of the tie (Pescosolido, 1991, 1992). In a study of migration in Taiwan, Pescosolido (1986) found that as contact with others outside the ethnic community increased, migrants eventually adopted views similar to those held by others in their community. For example, those in urban areas accepted Western medicine, whereas migrants to rural areas retained a commitment to traditional practices.

In the absence of strong connections with people outside their ethnic communities, women in this study lacked essential information. Lynam's (1985) phenomenological study of immigrant women in Canada confirmed the importance of diverse social connections for access to community support. She found that mothers had limited support when they restricted their contact to an insider social group consisting of kin from the same country of origin and lacked understanding of the social values or conventions surrounding interactions with outsiders, such as professionals.

The absence of diverse social networks for caregivers in this study may have contributed in part to the dissonance they experienced between their personal values and mainstream professional values with respect to desirable community supports. Dissonance was particularly evident for women caring for elders and restricted their access to community resources. Other researchers have documented similar dissonance in other immigrant populations (Anderson, 1991; Lalond, Taylor, & Moghaddam, 1992; Meleis, 1991; Tabora & Flaskerud, 1997).

To establish diverse social networks of weak ties, opportunities to form such linkages must be available. In our study, women caregivers described expanding their knowledge through contact with health care agencies, language training, professional education programs, and parenting classes. In addition, ties with friends from their ethnic community who were health or social service professionals provided women with broader access to information about mainstream health and social service resources in the absence of access to a diverse social network. These findings confirm those of a Canadian qualitative research study (Rose et al., 1998) that examined the influence of both neighborhood and external linkages on immigrant women's social networks. These researchers identified a range of situations that provided opportunity for immigrant women to form "weak ties" and build a more diversified network. These situations were a gateway to other connections. Included were language courses, the workplace, health and social service agencies, community organizations, including settlement and relief agencies, the church, and the neighborhood, including child-focused school and recreation activities.

Women in the current study also experienced material and social conditions associated with migration that restricted their opportunity to establish diverse social networks through association with either community members or colleagues in the workplace. Immigrant women's ability to participate effectively in social and work life requires facility in English. However, most of the women entered Canada under the family reunification program, which provides less access for women than for men to English language courses (Boyd, 1997). Some women in our study required work outside the home to provide economic resources for their families. Lack of recognition of foreign professional qualifications, compounded with limited language facility, reduced their potential for satisfying employment. Consequently, they worked in low-paying jobs that were inconsistent with their qualifications and failed to meet their expectations.

Migration-related conditions arising from language and employment challenges can affect the timing and nature of the services women require. Some women assumed heavy caring responsibilities at the same time that their economic status was unsatisfactory. This dual challenge accentuated their need for support from community resources that were inadequate. Failure to fulfill personal expectations (e.g., for employment) can contribute to a delayed response to the changes associated with migration and, in conjunction with the long-term nature of the settlement process, result in a continuing requirement for services (Hyman & Dussault, 2000). Although women negotiate the process of family settlement over a period of several years, availability of settlement services is often concentrated in the early settlement period (Rose et al., 1998), resulting in insufficient resources to assist women at the time they are required.

Although exacerbated by issues of immigration and inadequate language skills, the experience of immigrant women in this study is similar to that of Canadian-born caregivers (Harrison & Neufeld, 1997), particularly those who have low incomes, jobs with limited flexibility, and heavy caregiving demands. Employed nonimmigrant caregivers with higher hours of care provision have been identified in other research as at greater risk for adverse effects and difficulty in coping (Gottlieb, Kelloway, & Fraboni, 1994) and were most likely to suffer job consequences such as absences and declined promotions (Gignac, Kelloway, & Gottlieb, 1996). There is a risk of stereotypically explaining the experience of immigrant women based on culture or immigration without considering the influence of other conditions, such as poverty.

The findings of this study contribute understanding of the importance of social networks for immigrant women caregivers' experience of support and barriers to support from community resources. For immigrant women, establishing access to support from community resources was influenced by the impact of migration on their social networks and their material circumstances.

IMPLICATIONS

Immigrant women's experience of establishing access to support from community resources—experience that involves overcoming barriers—can provide direction for programs and policies related to migration and to health and social services. Policies affecting immigration require review to examine the adequacy of support for immigrant women in community, employment, and family roles. At the program level, outreach initiatives are needed to make connections with immigrant women and address the dissonance they experience between their expectations and available resources.

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