ISSUES OF CHILDREARING AND POVERTY AMONG ASIAN IMMIGRANTS

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BROTHERHOOD
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INTRODUCTION

Australia has a long history of Asian immigration with cities such as Melbourne having had their Chinatowns since the nineteenth century. Recent immigration from Asia however has brought a great diversity of both place of origin and of immigrant and economic status. On the one hand there are refugees from Vietnam, Cambodia and Laos who have fled lives disrupted by war and trauma in their homelands. On the other hand there are immigrants from the more prosperous backgrounds of Hong Kong and Singapore. Refugees and economic immigrants alike come with a wide range of education, professional and language skills. Many new arrivals find gaining employment difficult and have to live on low incomes. The recession of the early 1990s has seen many longer term immigrants unemployed as well. Economic restructuring and the recession have lead to substantial reductions in the labouring and manufacturing jobs traditionally taken by newly arrived immigrants with little English.

This paper considers some issues of childbirth and childrearing for a group of Asian immigrant and refugee families from diverse backgrounds and income groups, but with a particular focus on those living on low incomes; that is, incomes below or near the poverty line. It looks at the effects of low income on the health and well-being of these families with young children.

The paper draws on the first stage of the longitudinal Life Chances Study undertaken by the Brotherhood of St Laurence and looks at the situation and experiences of 33 Asian-born mothers with young babies. Other reports of the Life Chances Study have included:

- an analysis of issues of poverty and disadvantage for all the non-English speaking background families in the study (Taylor & MacDonald 1992);
- a report on the services used by the mothers of different income groups (Gilley 1993); and
- a study of the employment situation of the families over time (Gilley 1994).

This paper revisits some of the material presented in the earlier reports, including some of the comments made by the mothers who were interviewed, to draw together the experiences of the Asian families.

THE LIFE CHANCES STUDY[1]

The Life Chances Study is a longitudinal study of 167 children born in two inner Melbourne suburbs in 1990. The study aims to explore the life chances of the children in relation to a range of social and economic variables and to follow the children over a number of years. The inner suburbs selected have a very diverse population in terms of economic situation, housing tenure and ethnic background.

The study was planned as a census of all children born in selected months in two adjacent municipalities. Mothers of the children were approached to participate in

[1] The Life Chances Study has received funding support from the Victorian Health Promotion Foundation and from the Bureau of Immigration and Population Research.)

the study through the Maternal and Child Health Service which is notified of all births. Some mothers were unable to be contacted as they had left the area without a forwarding address and some declined to participate. Overall, 66 per cent of children born in the selected months participated in the study and these can be seen as generally representative of all those born in these inner suburbs.

The children in the study included 33 whose parents were both born in Asia, 48 with at least one parent born overseas elsewhere than Asia and 86 whose parents were both born in Australia. The mothers were interviewed for the first stage of the Life Chances Study when their children were about six months old. Interviews were conducted by bilingual interviewers (Vietnamese, Cantonese or Hmong) as appropriate. The 33 families in which both parents were born in Asia are the main focus of this paper.

THE ASIAN FAMILIES

The situation of the children in the Asian families was influenced by a variety of factors including:

- the parents' birthplace;
- their length of residence in Australia;
- their reasons for immigration;
- their education, training and English ability;
- their employment and family income; and
- factors such as family size, structure and functioning and support networks.

Some of the children could be seen as very disadvantaged when factors such as low family income, social isolation, marital conflict and poor health combined, while other children lived in healthy, happy families with strong social supports and an adequate income and others again experienced a mixture of advantages and disadvantages.

The Asian-born mothers in the study came from a variety of birth places. The largest number came from Vietnam (21 mothers) and included both ethnic Vietnamese and Chinese. Other mothers included Hmong hill tribe women from Laos (4), women from China (4), from Hong Kong (2) and from Malaysia and Singapore (2).

Many of the mothers were relatively recent immigrants. At the time of the interviews when their Australian-born babies were six months old the mothers had been in Australia between one and 12 years. One third of the mothers had been in Australia for less than three years. The Hmong mothers, those from China and eight of the Vietnamese had been in Australia for three years or less.

The children's fathers typically came from the same birthplace as the mothers. A number of the fathers had lived in Australia for longer than the mothers, the fathers' length of residence ranging from one to 24 years. Some of the mothers had rejoined their husbands in Australia under the Family Reunion scheme.

Coming to Australia had a range of advantages and disadvantages for the Asian families. While some mothers emphasised greater employment and educational opportunities in Australia, many also spoke of loss of support from relatives and of their loneliness especially around caring for their young babies. To quote one Vietnamese mother on the difficulties of settling in Australia:

> Different climate, different language, loneliness. I miss my old mother. I used to work very hard in Vietnam, but there were a lot of relatives and friends around. Here, most of the time I stay at home, confined to four walls, busy looking after the baby, doing all the housework. (Vietnamese) (Taylor & MacDonald 1992, p.45)

The mothers' ages ranged from 18 to 44 years with the Hmong women as a group being typically the youngest (average age 22 years) and the women born in China typically the oldest (average age 38).

The number of children in the families ranged from one to five with 14 of the families having only one child.

Four of the mothers (all born in Vietnam) were sole parents. These included two young single mothers with their first child and two women with four and five children who were separated from their husbands.

The mothers' English ability varied widely with most having only limited English and saying that they spoke English 'not at all' (7) or 'not well' (19). Only a few said they spoke English 'well' (5) or 'very well' (2). The mothers' English ability was related to both length of time in Australia and education. Of the seven mothers who spoke English well, five had been in Australia seven years or more and five had post-secondary education. They comprised the mothers from Malaysia and Singapore, one from Hong Kong and four from Vietnam. In contrast, of the mothers who did not speak English well, half had only primary schooling or, in two cases, no schooling at all. Many were recent arrivals, but some who had been in Australia eight or nine years had considerable difficulty with English.

Twenty-one of the families lived in high rise public housing estates, seven in private rental accommodation and five were buying or owned their own house. A number of families were sharing accommodation with relatives. For some sharing brought social support, but there were difficulties as described by a mother or three children sharing a flat:

> At first the baby and I slept in the living room. But then I had to get up early before the friend got up. Now my husband sleeps in the living room, I and three children in one room. (Vietnamese) (Taylor & MacDonald 1992, p.51)

The majority of the fathers were employed although ten were not in work. The fathers typically worked in clothing or car factories or in restaurants although a small number worked in more skilled occupations and had trade or other qualifications. Very few of the mothers were employed when their babies were about six months old. Most of the five mothers who were in paid employment, worked as machinists in family businesses, while one worked as a nurse.

INTRODUCING SOME OF THE FAMILIES

To illustrate something of the diversity of the families the situation of some are outlined below at the time when their children (born in 1990) were about six months old.

A couple from Malaysia with their first baby

They are well established and own their own home which they paid off when they were both working. The mother is now on maternity leave. She found the first month at home with the new baby difficult because of the 'non stop parenting', 'I didn't realise it is so hard work', but she could talk to friends with children. She describes herself as happy and managing well. (Not poor)

A recently arrived Hmong couple from Laos in their early 20s with three young children

They live in a high rise flat with relatives in a household of nine. The mother is happy with the living arrangement. She hopes to return to work and the grandmother would mind the children. She gets good support from local services and describes herself as managing very well with her child. The father earns a low wage in a factory. (Below the poverty line)

A Vietnamese family with four children

The family's early years in Australia were happy but over the last two years things have deteriorated. The last two children were unplanned which caused tension. The father has been unemployed and has been drinking and gambling and has been quite violent. The mother says she is unhappy and having quite a few problems managing with her child. (Below poverty line)

A Vietnamese couple with their first child

The mother is a recent arrival having been sponsored to Australia by her fiance. She has limited English. She is happy with the baby and gets good support from her husband who she describes as a loving father. She has social contact with his large family of relatives. He is unemployed although he does some casual work. She describes herself as happy and managing quite well. (Below the poverty line)

FAMILIES IN POVERTY

The Asian families were typically living on low incomes and were much more likely to be in that situation than were the other families in the study. While not all the Asian families were poor almost three quarters of them were living on incomes below or near the Henderson poverty line. The Henderson poverty line is a widely used measure of income poverty which takes into account family size, structure and work force participation. At the time of the interviews the poverty line for a family with two parents and two children with the head in the work force was $351 per week, while for a sole parent not in the work force with one child it was $204 per week. In contrast, at the same time average weekly earnings were $589 per week (full-time adult male ordinary time earnings) (Taylor & MacDonald 1992, p.38).

Of the 33 Asian families 58 per cent were living below the poverty line in contrast with 27 per cent of other immigrant families and 8 per cent of the families with both parents Australian-born (see Table 1).

Table 1 Life Chances Study: family income in relation to the poverty line by parents' birthplace

Family income in relation to the poverty line	Parents' birthplace: Both Asian %	Other[a] %	Both Australian %	Total %
Below the poverty line	58	27	8	23
Between the poverty line and 20% above the poverty line	15	13	9	12
Over 20% above the poverty line	27	60	83	65
Total	100	100	100	100
Number of children	33	48	86	167

a) Families in which one parent was Australian-born and one born overseas of in which both were born overseas but were not from Asia.

The 19 Asian families living below the poverty line included the four sole parent families, nine families in which the husband was unemployed and six families in which the father was working, but received a low wage that did not raise the family income above the poverty line. The families living below the poverty line included half the Vietnamese families (12), all the Hmong families (4), half the Chinese-born (2) and one of the Hong Kong-born.

The reasons for low incomes of these families were generally associated with lack of employment or with low wages. These in turn were associated for many with lack of English and limited education or training.

The loss of the mothers' wages where mothers had left the work force to have their babies was a factor that meant that these families at this time were particularly likely to have low incomes.

Many of the families felt that they were worse off than they had been three years previously. Unemployment was the most common reason for being worse off. For some this reflected the father's unemployment, for some the mother's leaving the work force because of the baby. One mother who was worse off commented:

> You know, we've been here for over ten years. We worked. We could save some money. But now we are unemployed. My children are too small, we saved some money, but if we continue living like this, money will be used up. (Vietnamese) (Taylor & MacDonald 1992, p.44)

Poverty can be a relative concept. How people view low income and other family circumstances are often related to previous living conditions as was illustrated by some of the comments of the low-income Asian families. For example, one family arrived in Australia three years previously after a horrific boat journey from Vietnam and four years in a refugee camp. They now have three young children and, except for some casual work have been unemployed since their arrival. In terms of

Australian income levels they are poor, however their unemployment benefit and the controlled rent of their high rise flat give them relatively more security than they had in the past. In the words of the father:

> We are neither rich nor poor but we are mentally secure. The only problem is language. (Vietnamese) (Taylor & MacDonald 1992, p.45)

Some of the recent immigrants were quite positive about the economic advantages of being in Australia in spite of the hardship low income brought them. Some saw their low income as temporary and to be improved when the baby was older and the mother able to return to work. However, others were very concerned about the lack of employment associated with the wider economic situation and the recession.

What did living below the poverty line mean to these families? The families on low incomes often described their financial situation as insecure, they did not have enough money to pay their bills and some mothers reported that they sometimes had to miss meals because there was not enough money. Some mentioned difficulty affording formula for their babies, some the cost of clothing and medication, including Chinese medicine. Some found such costs difficult, others found, at times, that they simply did not have the money for formula, nappies or clothing for their babies.

THE BIRTH OF THE CHILDREN

The mothers were asked a range of questions about the health and other services they used around the birth of their babies and about the informal support they received. Table 2 presents some of the differences between the experiences and use of services of the Asian mothers and the other mothers in the study.

Table 2 Life Chances Study: mothers' experiences around the birth

	Parents' birthplace	
	Asia % [b]	Other [a] %
Attended prenatal classes	27	61
Difficulties with birth	49	53
Breastfed baby	39	86
Contact with Nursing Mothers Association	3	35
Number of children	33	134

a) Families with parents born in Australia and those born overseas elsewhere than Asia.
b) The percentage of mothers in Asian families reporting each activity.

PRENATAL CLASSES

Only a quarter (27 per cent) of the Asian mothers attended prenatal classes in contrast to 61 per cent of the other mothers in the study. Some of these Asian mothers had attended only one class. The mothers mentioned classes on breathing and exercise classes. Some of the Vietnamese mothers had attended classes with Vietnamese-speaking nurses and with videos. Some of the mothers did not know of such classes and some were not given information about the classes in a useful way.

For example:

> A Vietnamese mother said that she did not know about the classes, but when her husband reminded her that she had been given some pamphlets to bring home she commented 'Oh yes, but I didn't read them'. She had recently arrived, had little English and had little education in her own language and had a child 11 months old at the time of the birth of her second child. (Taylor & MacDonald 1992, p.55)

Another Vietnamese mother, in contrast, commented on how helpful she found written material. However she missed out on her prenatal class:

> I came to Australia when I was 6 months pregnant. I went to ... Hospital. The Vietnamese interpreter there was very good. He gave me some handbooks (in Vietnamese) about child care. Later on (after moving) I went ... Hospital on 5th April. I knew that there would be a prenatal class on 20th April. On 12th April I gave birth to my baby. I didn't have the opportunity to attend that class ... This is my first child. I didn't have any experience.

All the 9 Asian mothers who attended prenatal classes said they found them helpful. One mother commented:

> The first time we had nutrition class. The second time we were shown round the hospital. I found it very useful. Even though this is my third child, she is 8 years from the second child. Hospital here is different from that in Vietnam ... The third time we were recommended things to buy for the baby. (Vietnamese) (Taylor & MacDonald 1992, p.55)

The mothers' experiences highlight the importance of prenatal classes, even for third time mothers, but also the difficulties in providing classes in appropriate languages and at appropriate times and then of informing mothers about the classes.

THE BIRTH

The Asian mothers' experiences of giving birth to their babies in Australian hospitals were diverse. Approximately half (49 per cent) of the Asian mothers reported difficulties with the birth, a similar proportion as for the other mothers in the Life Chances Study (53 per cent). Some reported positive experiences, some negative and some were able to compare the birth with the birth of their older children in their country of birth or in refugee camps.

The Asian mothers who were happy with the birth commented on the helpfulness and kindness of the nursing staff. Some of the Vietnamese mothers were appreciative of there being Vietnamese-speaking staff available. Comments included:

> They were very helpful in taking care of me and the baby. Good meals. They were always cheerful and helpful and patient, never complained. (Vietnamese)

> Hospital staff was very kind and good. They knew that I can't speak English so they got a worker from another ward to ask me about my health, my diet. I could have rice with my meal. (Vietnamese) (Taylor & MacDonald 1992, p.55)

Some of the Asian mothers who were unhappy about their experiences giving birth described feelings of helplessness and hopelessness, some spoke of the difficulties of not having anyone who could interpret at the birth, some were critical of doctors' late arrival and treatment and some felt that nursing staff expected too much of them after the birth.

> Dr ... was negligent. He turned up very late the day my baby was born. I had to hold on because the doctor was not available to deliver the baby. This gave me a lot of pain. I will not use him again ... He was also very rough and gave me a lot of pain when he examined me. (Vietnamese)

> As far as I understood the placenta didn't go out all after the baby's birth. I don't know what happened but I stayed in the labour ward for about 3 hours. After that my feet felt numb for some hours. I had a feeling of helplessness even though this was not the first baby. (Vietnamese)

> I do not like ... Hospital. Two days after the birth, the nurse required me to look after the baby. She had not given me much assistance. I was tired and felt sick. She still insisted that I look after the baby myself. (Vietnamese)

FEEDING

Significantly fewer of the Asian mothers breastfed their babies than did the other mothers in the study. Of the babies born to Asian mothers only 39 per cent were breastfed in contrast to 86 per cent of the babies born to the non-Asian mothers.

Some Asian mothers were positive about breastfeeding for reasons including convenience, cost and nutrition.

> It saves me time and money and it's good for the baby ... Mother's milk is good for a baby. (Vietnamese)

Reasons for bottlefeeding included the mothers' plans to return to work or to attend English classes after the birth of the baby.

> I bottlefeed so I can go to English class and shopping. I can leave him with a friend for a longer period. It's convenience, but the milk formula is very expensive now. (Hmong) (Taylor & MacDonald 1992, p.62)

> My health in general is not very good. I can faint easily. Sometimes I feel chilly in my backbone. Still I want to go to work. If I breastfeed him it would by difficult to change to bottlefed. All my children are bottlefed. (Vietnamese)

At least two Vietnamese women did not feel their milk was good enough for their babies. One commented that her milk was 'hot', a concept from traditional Chinese medicine:

> I think my milk is hot. It's not good for the baby. My (older) daughter is still small and she requires a lot of care and attention. I am worried and sad, if I breastfeed him there won't be enough milk. (Vietnamese)

One mother talked at length about her problems in feeding her baby in hospital and in communicating with staff:

> I gave birth to a baby boy at about 2 p.m. I told them I wanted him to have a mixed feeding (breastfeed and bottlefeed). During the first night, my breasts hadn't produced milk, the baby cried. I told anybody who came into the ward 'My baby hungry' 'I no milk'. They just listened and went away. The baby was a big boy (over 4kg) so he was hungry and cried all night. I was worried. I gave him sugar and warm water. I made him suck my breast. It hurt but I still had no milk. The next day a friend of mine visited me. She had two children born at in the hospital so she knew everything. She took me to a room where milk and bottles were kept. I brought a bottle back to my ward and the baby drank the whole bottle. My friend also told me 'whenever your child is hungry get milk from that room, but don't let them know'. But I forgot in my confusion. That afternoon a nurse came to my room while I was feeding the baby. She asked me where I got the bottle and who allowed me to do so (I guessed from her voice and appearance). She squeezed my breast to extract milk, it hurt, but no milk. She looked upset. I was upset too, so I told my husband to take me home the following day. (Vietnamese)

Support with breast feeding is also available to mothers through the Nursing Mothers Association, a voluntary organisation that provides free advice and support with breast feeding. Only one of the Asian mothers had contact with this service in contrast to 35 per cent of the other mothers in the study.

The Maternal and Child Health Service

The Maternal and Child Health Service is funded by the Victorian State Government in conjunction with local government and provides a free service available to all families with young children. The Maternal and Child Health nurses are bases in small centres in local neighbourhoods. They are notified of all births in their municipality and generally make contact with mothers within a few days of their return home from hospital.

All the mothers in the study used the Maternal and Child Health Service on their return home from hospital after the birth. Many of Asian mothers found the service very helpful. They appreciated the advice about their babies given by the nurses and also their kindness and concern. The availability of interpreters on a regular basis in at least one of the Maternal and Child Health Centres was of particular importance. Mothers were also appreciative of the nurses' home visits and their role as a point of referral to other agencies.

> The centre provides an interpreter once a week. The nurse can really understand our problem and try to help us. If she cannot help, she is always prepared to refer us to the places that can give help to us. She not only works as a maternal nurse, but as a social worker as well. (Hmong) (Taylor & MacDonald 1992, p.56)
>
> They do care for me and the baby. She was born in winter time. It was so cold the sister came here to visit us twice. (Vietnamese)
>
> They discuss things with you. They are considerate. They are willing to explain is you have worries or concern. (Vietnamese)
>
> You get advice for both baby and mother, you get the support as well emotionally and psychologically, you go to the classes to meet other mothers, where people talk. They monitor the baby's health and can give you advice for a minor problem or referral for major problem. So whenever you have a problem you think of the Maternal and Child Health. (Hong Kong)
>
> Very approachable, I can discuss anything about my baby with them, they are so helpful. Going to (Maternal and Child Health nurse) is more helpful than going to the G.P. because she has dealt with a lot of babies and mothers and her experience is really very rich. I find that she has more insight into the babies, into their well-being and their welfare. I prefer going to her before going to the G.P. (Singapore)

One Chinese mother felt she had not been helped by the Maternal and Child Health Service as the nurse just weighed the baby, 'I had not got much out of their service'.

HEALTH AND OTHER SERVICES

While most of the babies were generally in good health, many of the mothers had to take their babies to the doctor. Many doctors in the inner suburbs bulk bill their patients so cost was not a barrier. A number of the Vietnamese and Chinese mothers in the inner suburbs in which the study was based were able to take their babies to general practitioners who spoke their own language and understood their health beliefs, although this was less possible for the Hmong families. Some mothers were very positive about the help they received from their doctors. For example:

> Dr T was attentive and spent a lot of time to clarify points for me. He also cared for my well-being. (Vietnamese) (Taylor & MacDonald 1992, p.56)

Some mothers reported the success of traditional health practices such as cupping.[2]

> He had a runny nose and high temperature, sometimes reflux. I brought him to the family doctor. I had vacuum cupping for him twice. It worked. (Vietnamese)

A few of the children had serious health problems and five had been admitted to hospital since their birth. Some of their parents found the hospital care very good.

> (The staff at the Royal Children's Hospital) showed that they truly cared for their patients. They comforted me when I was worried and sad. (Vietnamese) (Taylor & MacDonald 1992, p.56)

Some of the Asian women consulted Chinese herbalists about their children's health and about their own and found them helpful although one had felt that her use of Chinese medicine had stopped her milk supply.

HELP RECEIVED AFTER THE BIRTH

The mothers in the Life Chances Study were asked what help they received with their baby in the first weeks after the birth. Most mothers received help at this time, although the Asian mothers were slightly less likely to receive help than the other mothers in the study (see Table 3)

Table 3 Life Chances Study: help received by mothers after birth of baby

	Parents' birthplace	
	Asia	Other[b]
Source of help[a]	%	%
Baby's father	61	68
Relatives	39	60
Friends	12	22
Services	-	33
Total received help	85	94
Mother relies on father 'a lot'	18	57
Total	100	100
Number	33	134

a) Mothers could state more than one source of help.
b) Families with parents born in Australia and those born overseas elsewhere than Asia.

A similar proportion of mothers, about two thirds, received help from the baby's father although this was slightly less for the Asian-born mothers than for those born in Australia and elsewhere.

However the Asian mothers were much less likely to say that they relied 'a lot' on their husbands for help.

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[2] Cupping is a procedure in which a cup is placed on the patient's body and heated to create a vacuum. It can cause superficial bruising which could be misinterpreted by health providers unfamiliar with the practice

Some of the Asian mothers spoke warmly of the help they received from their husbands.

> Because I had a caesarean I had to stay in bed most of the time. He took care of the baby, cooked the meals, comforted me. (Vietnamese)

Some of the mothers had limited help because their husbands worked very long hours.

> He looked after the children for two weeks during and after my hospitalisation. At present he gives me some practical help after work, but he is often too tired after work to help me much. (China)

Others found their husbands' help less direct.

> He is very responsible for the baby. He supervises me in looking after her. When she cries, he gives her to me. He thinks the baby does not prefer to be looked after by him. He does not like to do housework or child minding. (Vietnamese) (Taylor & MacDonald 1992, p.60)

The Asian sole parents reported the difficulties of bringing up children alone, although for some at least this was preferable to the unpredictability and stress of living with husbands who gambled and drank.

> I'm used to being a single parent. But sometimes when I'm tired, I have backache, and I wish there could be somebody around to help me with the baby. (Vietnamese)

> Now that I am not working I can manage looking after four children. But I felt depressed and irritated when they screamed and made a lot of noise. (Vietnamese)

Only 39 per cent of Asian mothers received help with their baby from relatives in contrast to 60 per cent of other mothers in the study. While some of the Asian families lived in extended family households and others had relatives living nearby, there were some families who were very isolated with no relatives to provide support. The mothers particularly valued help and support from their own mothers and missed it when it was not available. Sisters and sisters in law were also mentioned as being helpful at this time. Relatives provided emotional support as well as practical support such as child minding. A number of Vietnamese women mentioned that their mothers or sisters cooked them the special food that was appropriate for them in the first month after the baby's birth. The mothers' comments about the help they received from relatives included:

> Cooking mainly, especially cooked food for post-natal women. Very important for the first month (help from mother and sister). (Vietnamese)

> I stayed at my sister's house in the first month. She cooked special food for me and helped me take care of the baby. She talked to me as well. (Vietnamese)

> My mum cooked special food for me. She and my husband helped me take care of the baby. She gave me advice on childrearing. Now I'm working, my mum stays home with the baby. My husband works evening shift. He can help mum with the baby too. (Vietnamese) (Taylor & MacDonald 1992, p.52)

Many of the Asian mothers' own mothers lived overseas. Some nonetheless provided support through phone calls while others had little contact.

Help from friends was valuable when received, but only 12 per cent of the Asian mothers said they had received help from friends in the weeks after the birth of their baby. In contrast 22 per cent of the other mothers in the study said they were helped by friends. The Asian mothers commented on the importance of being able to discuss experiences with friends.

> She shares her experiences of handling her baby. I only have her to talk to. She has a baby about the same age as mine. She teaches me ways to look after the baby. (Vietnamese)

> My friends are the same age like me. They haven't got much experience but we have the same feelings, the same problems. It's good to talk to them. (Vietnamese)

> They've been here for a longer time than me. They have more children. We speak the same language. It helps me a lot. (Vietnamese)

A number of mothers found their friends were too busy with their own work and families to be able to give a much time.

One third of the non-Asian mothers reported receiving help from services such as home help or family support workers after the birth, but none of the Asian mothers did so. Some of the Asian mothers said they would have liked home help although one who was offered home help declined because she spoke no English and would not be able to speak to the home help. There was a belief among service providers at one local council at the time that for cultural reasons the Asian mothers would not accept home help but the mothers' comments did not suggest this was necessarily so.

> Because of heavy housework and factory work I had enlarged and bulging veins on my legs and feet. I wished I had some home help after the birth and during pregnancy. (Vietnamese)

The local community health centres were attended by a number of the Asian mothers. The centres had bilingual workers and ran Indo-Chinese women's groups as well as medical, dental and other services. The women's groups played an important social role, especially for some of the mothers who had no relatives or friends nearby, and also provided an opportunity to learn about available services. The range of support provided by her local community health centre is outlined by one mother:

> They are all very good. There are workers there who can speak my language. They are very kind and caring. They tried to help me overcome the language difficulty (by) introducing me to a home tutor and encouraging me to join the women's club. It has a child-care service where I go to the dentist. The ethnic worker there is very kind and sympathetic. (Vietnamese) (Taylor & MacDonald 1992, p.57)

Since these interviews took place the state government funding for these inner urban community health centres has been halved and their services reduced.

FAMILY FUNCTIONING

Family relationships and the parents' capacity to deal with stresses provide an important context for childrearing and one in which there was great variation among the families in the study. Mothers were asked about stresses in their lives. Thirty per cent of the Asian mothers reported serious disagreement with their husbands in the past 12 months and 21 per cent said they had major problems with their health. This was a similar response to that of the non-Asian mothers in the study (28 per cent of whom reported marital conflict and 18 per cent health problems).

The mothers were also asked about whether they had felt low or depressed since their babies' birth. The Asian mothers were significantly less likely to say they had been depressed than were the other mothers. Thirty-six per cent of Asian mothers said that they had felt 'low or depressed' since the birth compared with 72 per cent of the other mothers. This large difference, especially given the relative lack of support received by the Asian mothers suggests cultural or possibly translation factors. While the Asian mothers were less likely to describe themselves as having felt low or depressed since the birth, when they were asked to rate their overall happiness they were significantly less likely than the other mothers to describe themselves as happy or very happy (48 per cent of Asian and 84 per cent of other mothers) and more likely to say they had mixed feelings or were unhappy (52 per cent of Asian and 16 per cent of other mothers). They were also more likely to say they were having problems in managing the baby (21 per cent of Asian and 3 per cent of other mothers). Some mothers' feelings of depression, isolation and fatigue were compounded by crying babies, noisy older children, lack of support and marital tension. The effect at times was irritation or anger with the baby and a small number of mothers reported having hit their babies. Mothers' comments about their feelings of depression included:

> I don't know if it's the kind of depression you have after a child's birth or it's because you are confined in the flat all day long. Sometimes I feel very sad. (Vietnamese) (Taylor & MacDonald 1992, p.59)

> I felt very down. My husband didn't pay attention to the baby. I did everything by my self. I didn't have sexual interest ... Sometimes I got angry with (the baby) but then I felt sorry for him. (Vietnamese)

The mothers who had recovered from their depression often spoke of the support they received from their partner or relatives. This in turn highlights the problems of those who do not have such supports.

> A lot of support from my family, that has really helped. Offers of help from my mother to look after (the baby). (Vietnamese)

> I did not understand why she cried. She seemed to have given me a lot of problems. I was also worried I could not manage a new baby. Sometimes I gave her a few slaps on her bottom and scolded her, but I love her because she is my daughter. I was irritable then. I talked to my husband. He helped me to look after her. He helped to reduce my problems and anxiety. It lasted two to three months. By the fourth month, I felt better. (Vietnamese) (Taylor & MacDonald 1992, p.59)

FAMILY SIZE

The number of children in the families had an important impact on their financial situation which in turn influenced the families' future plans. The Asian families tended to be larger than the other families in the study and they also were more likely to plan to have larger families. A number of the Vietnamese and Hmong mothers wanted large families and spoke of the support brothers and sisters could give each other in later life.

> I want three sons and two daughters. I want to have a large family so when they grow up they'll have many relatives to help each other. (Hmong)

However some parents had decided they could not afford the large families they had originally hoped for, perhaps indicating in part a transition from their traditional values in the face of the different constraints and opportunities of Australia.

A number of Asian mothers in the study said that their most recent child had been unplanned and unwanted by at least one parent. This had created considerable marital conflict in some families as well as financial difficulties. Mothers were not asked specifically about family planning services, but accessible services are always needed. The family planning service in these inner suburbs had been offering reduced services and subsequently has been closed by the state government.

LOW INCOME, CHILD BIRTH AND CHILD REARING

While not all the Asian families in the Life Chances Study were on low incomes, the large majority (73 per cent) were living on incomes below or near the poverty line. As outlined above their low family income was associated with high unemployment, low wages and family separation. The parents' limited English and education and the economic recession and restructuring of the early 1990s all made obtaining adequate employment and income elusive for many families. The mothers' employment opportunities were further limited by their recently having given birth and by their child care responsibilities. The relatively large number of children in the Asian families also meant that their low incomes had further to stretch.

The experiences of the mothers in the study indicate that their low income has a wide range of impacts on their child bearing and child rearing.

The most direct effect was the lack of money on occasions to buy food for themselves, formula, nappies, clothes or medication for their babies.

Low income also meant limited choice in housing, so that some families lived very crowded households, some in high rise flats were they could not let older children play outside and some in neighbourhoods in which they were fearful for themselves and their children. However the availability of public housing did provide secure and relatively affordable accommodation in contrast to the private rental market.

Low income limited choice of health and other services. These mothers did not have the choices around the birth that others had. The health services that the families could use most readily in terms of cost were public hospitals, the Maternal and Child Health Service, community health centres, doctors who bulk billed and these often served their needs well. They were much less able to use medical specialists, private hospitals or any services on a user pay basis. They did not have the option of paid housekeeping or child care support that some of the higher-income families made use of, nor of prenatal classes for which there was a fee.

Low family income, the struggling to make ends meet and to provide for their children, caused considerable stress to families and in some of the families this stress was related to severe marital conflict and to mothers' depression and reduced the mothers' capacity to care for their children.

The effects of low income outlined above were common to both Asian and non-Asian low-income families. However for many of the Asian families their lack of choices resulting from low income interacted with their lack of choices because of language difficulties, their lack of knowledge of services as recent arrivals, their lack of social supports as families with relatives overseas and the trauma of their refugee experience. These factors combined to produce a situation of multiple disadvantages which need to be taken into account by health care providers.

IMPLICATIONS FOR HEALTH CARE PROVIDERS

The diversity of the situations of the Asian mothers in the study and in the wider community provides a challenge to health service providers. The situation of the mother who is an English-speaking qualified nurse from Singapore is very different in many respects from the Hmong hill tribe mother with almost no schooling or English, but they may share the absence of their own mothers' support at the time of childbirth because their mothers are overseas and they may share the desire to maintain their own culture and to bring up their children knowing about their heritage.

While situations of Asian families are so diverse it is important for health service providers to take account of that diversity both in planning services and in working with individuals. Questions which need to be taken into account include the following:

Family income

- Is the service accessible to low-income families?
- Can the family afford any proposed referral, treatment or medication?
- Do the families know of income support to which they may be entitled?

Language ability

- Is the service accessible to women who cannot speak English?
- Is information available in languages other than English?
- How is information best provided to women who read neither English not their own language?
- Are health service providers trained and comfortable in the use of interpreters?
- Will interpreters be used?

Social supports

- Does a particular mother have the support of a partner or of relatives?
- What supports can be offered to the isolated mother?

Cultural practices

- Do health service providers have an understanding of the health practices of the ethnic groups with whom they work?
- Do they have an understanding of the diversity of health practices and beliefs within any ethnic group?
- Are they able to avoid ethnic stereotypes and assess what issues are crucial to individual Asian mothers?

The experiences of the Asian mothers in the Life Chances Study showed that some were very satisfied with health services with which they had contact while others had quite distressing accounts. To reconsider some of the services used:

Prenatal classes

While relatively few Asian mothers attended classes those who did found them helpful. Issues for service provision include ensuring expectant mothers know of the classes, and finding ways that the classes can be provided in an appropriate language. Having some classes based in local community health centres seems an appropriate model. Issues of transport and child care need to be addressed. The provision of information on childbirth on videos in appropriate languages would help meet some mothers' needs.

The hospital birth

The Asian mothers had diverse experiences. A number praised the caring attitude of the nursing staff, but some were quite distressed by the lack of understanding they received compounded by lack of a common language in which to communicate. Issues include the use of interpreters during the birth and also in discussions about establishing breastfeeding and an increased understanding by staff of Asian beliefs and practices around giving birth.

Breastfeeding

A relatively small number of the Asian mothers breastfed their babies. Information in prenatal classes, effective communication within the hospital and appropriate support on early discharge are all crucial for the mothers and their babies. The economic and cultural factors influencing the mothers' decisions about feeding need to be understood.

Family planning

A number of the Asian mothers spoke of unplanned and unwanted pregnancies. Family planning advice and services need to be available that are local, affordable and culturally sensitive.

Home help

None of the Asian mothers in the study had local council home help although some of the non-Asian mothers in the same areas had. Some of the Asian mothers expressed their need for such support. Information and language issues need to be addressed.

Maternal and Child Health Service

This was used by all the mothers and most found it very helpful because of the skills and understanding of the nurses, the ready use of interpreters, the referral to other services and as a point of contact with other mothers and children informally and in mothers' groups and playgroups.

Community health centres

These provided a range of medical, dental and support services which were particularly accessible because the centres were local, free and had bilingual workers and regular interpreter services. Of particular value to some of the Asian mothers were Indo-Chinese women's groups which were a source of information and of social contact.

The findings of the study, such as the low rate of attendance at prenatal classes, the low rate of breastfeeding and the mothers' reports of unwanted pregnancies, indicate a considerable need for the creation of extra opportunities for information and education to be provided to low-income and non-English speaking Asian mothers.

In summary, the exploration of the situation of the Asian families with young babies in inner-Melbourne in the Life Chances Study highlights their diversity of country of origin, language, education, employment, family size and structure, social

supports and use of services. It also highlights the large proportion of Asian families with very low incomes and the constraints and stresses their low income places on their childbearing and childrearing. While some of the families have support from extended families this is by no means universal and a number of Asian mothers are very isolated. The families whose income poverty is compounded by lack of social supports and lack of English provide a particular challenge to health service providers. The provision of services which appropriately meet the childbearing and childrearing needs of such families will make a significant contribution to the health and well-being of Australia's families.

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