Volume 5, No. 1, January 2015

ISSN No. 2231-5454

INTERNATIONAL JOURNAL OF NURSING DIDACTICS

RESEARCH PAPER

Understanding Health Beliefs and Practices in the Cultural Context: Chinese-Born Immigrant Women in the United States

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DOI: http://dx.doi.org/10.15520/ijnd.2015.vol5.iss01.33.31-38

Abstract: Culturally relevant health beliefs about health, health promotion, and health care practice among Chinese-born immigrant women in the United States were investigated using an ethnographic approach. A convenience sample of 15 Chinese-born immigrant women was recruited and a total of 21 interviews and 22 participant observations were completed. Findings indicate that, these women's health beliefs were highly influenced by the traditional Chinese culture; however, their beliefs were also significantly shaped by the immigration. Although sharing beliefs with the other immigrant groups, these women have their unique health beliefs and practices, relevant to the Chinese culture. Findings also indicate that socializing with friends can be an important mechanism through which the Chinese community influences these women's health belief and practice. Culturally competent and community based interventions should be developed to promote these immigrant women's use of health care services.

Keywords*:* health behavior, cultural/cultural competence, ethnography, Asian people/culture, immigrant/migrant

INTRODUCTION:

Health beliefs are defined as "the personal convictions that influence health behaviors" (Anderson, Keith, & Novak, 2002, p. 784). These convictions involve how people view health, health promotion and health care practices (Glanz et al. 2008). Culture and cultural context influences health beliefs (Helman, 2007). Therefore, changes in socio-cultural contexts, for example, immigration to another country, can enrich an individual's cultural experiences and accordingly, modify health beliefs.

As the cultural context changes, Chinese-born immigrant women after immigrating to the United States (U.S.), encounter cross-cultural challenges regarding their health care practices (Helman, 2007). These challenges come from their different cultural beliefs, views, and attitudes about health and health care as well as the systematic and structural differences in the health care system between China and the United States (Helman, 2007, Ajayi, 2008). Considering that the Chinese population has increased rapidly in the United States. in the last thirty years from 1.3 million in 1990 to 3.5 million in 2010 (United States Census of the Bureau, 1990, 2010), and that by 2009, 2 million of them are foreign born immigrants (United States Census of the Bureau, 2009), there is a critical need to understand Chinese-born immigrant women's convictions about health promotion and their cultural health beliefs.

Although a large number of health care professionals have acknowledged the influence of cultural health beliefs on Chinese-born immigrant women's utilization of health care services (Ajayi, 2008), current understanding of these women's cultural health beliefs is limited and draws heavily on expert opinions or clinical anecdotes (Ajayi, 2008). Little is known about how these women view or perceive health and health care practice in the United States. There has been little exploration of the dynamics of cultural influences on health care practices from an ethnographic perspective in previous research. Moreover, studies have not explored how Chinese-born immigrant women understand health and health promotion within their cultural context or the context of an immigrant community. Initial research in this area has only applied survey, focus group, and one-time interview techniques. There are no ethnographies in the literature that inform the influence of culture on Chinese-born immigrant women's health beliefs and health practices from a holistic perspective.

The purpose of this article is to apply an ethnographic approach to explore Chinese-born immigrant women's health beliefs within the context of the local Chinese community, and develop insight into how their cultural health beliefs influence their use of health care services. This article aims to answer the following research questions: (a) how Chinese-born immigrant women view or perceive health or illness within the context of the local Chinese community; (b) how Chinese-born immigrant women view or perceive health promotion or illness prevention within the context of the local Chinese community; (c) how Chinese-born immigrant women view or perceive U.S. health care services including their views or perspectives of health care providers and health care settings within the context of the local Chinese community, and(d) if Chinese-born immigrant women's health beliefs are originated in traditional Chinese culture or shaped by the immigration.

Chinese-born immigrant women, in this article, are any Chinese immigrant women who meet the following criteria: (a) not born as U.S. citizens, but born in China; (b) having completed at least elementary education in China; (c) currently living in the United States; and (d) able to speak and read Chinese (either Mandarin or Cantonese).

METHODS:

Design & Theoretical Framework:

We chose a qualitative design for this article to elicit in-depth data from participants to describe their life experiences about their health beliefs and to give meaning to this data (Burns & Grove, 2011) through a systematic and subjective approach. The appropriate method to guide this study was ethnography, rooted in anthropology, where the researcher studies both cultural patterns and life experiences in a holistic way (Polit & Beck, 2011).

Working as the theoretical framework for the methodology of ethnography, symbolic interactionism emphasizes the impacts of the socio- cultural context on how people perceive or interpret the world in a meaningful way (West & Turner, 2010). The meaning of the world, such as an event, an object, or a behavior is constructed by the people embedded in the socio-cultural context (West & Turner, 2010). Therefore, the meaning can never be separated from the socio-cultural context that people come from because the social cultural context influences people's construction and interpretation of the world (West & Turner, 2010). From this perspective, symbolic interactionism explains why people's interpretation of the world may differ from one group to another and legitimizes why ethnography is useful in terms of cultural research (West & Turner, 2010). Symbolic interactionism guides the study design to understand cultural health beliefs.

Sample:

Between April 2009 and July 2010, the first author collected data from a convenience sample of 15 Chinese-born immigrant women. These women were recruited from a local Chinese church which serves as a community center for ethnic Chinese in a large metropolitan area on the eastern seaboard of the United States. To be eligible for the study, the women had to meet the following criteria: (a) born in China, having completed elementary education in China, and at the time of the study, able to read and speak Chinese (Mandarin or Cantonese); (b) aged 40 or above; (c) living in the large metropolitan area. Among the 15 women recruited, seven were active church members; three were occasional members, and five were referrals. To protect these women's privacy and confidentiality, approval was obtained by the Institutional Review Board (IRB) of a large university in the area.

DATA COLLECTION:

A semi-structured interview approach with open-ended questions and participant observation was the major data collection methods. The semi-structured interviews were chosen to allow some consistency among data; to assure that the specific research questions were answered during data collection; and to allow the flexibility to capture any unanticipated new phenomenon (Patton, 2014). All interviews were conducted in Chinese (Mandarin or Cantonese) and digitally audio-recorded. The encounters were casual and relaxed to foster a trust relationship between the participants and the researcher and to subsequently obtain richer data (Spradley, 1979, 1980). The length of the interviews ranged from forty-five minutes to one hour. A total of six follow-up interviews were conducted when the ongoing analysis indicated a need for a deeper depth of the data. Participant observation involved time spent on observation of each participant's everyday activities, particularly those related to health and health promotion. A total of 22 observations were conducted. Field notes were documented throughout the interviews and during the participant observations.

Among the 20 women who responded to the recruitment, 15 of them agreed to participate in the study and five of them were 50 or older. The participants' demographic characteristics are described in Table 1. All the participants grew up in a middle class family in China. They came to the United States. at different ages, from 24 to 68, for different reasons, such as studying, working, taking care of their children, grandchildren or other family members, or merely coming for United States permanent residence. While all the 15 participants were married, nine of them did not live with their spouses because their spouses either worked in another state in the United States or lived in China. The geographic separation restricted them from getting in-time help and support from spouses. During the recruitment, older women who were aged 50 and above were initially less willing to do participant observation than women under age 50. The participants above the age of 50 became more willing to participate during the interviews as a sense of trust had been developed. All the participants completed initial interviews. Six of them also completed follow-up interviews . Eleven of them agreed to participate in participant observation. The most frequently observed activities were behaviors regarding food choices and daily exercise.

Table 1: Demographic Characteristics of the participants (N=15)

Characteristics	N(%)
Age	
Mean	48.8
Range	40-68
Education	
Associate degree	4(27)
College	6(40)
Graduate degree	5(33)
Employment	
Employed	9(60)
Unemployed	6(40)
Self-reported family income	
< 50000/year	
>=50000/year	7(47)
Religion	8(53)
Christian	4(28)
Buddhist	1(6)
Polytheist	1(6)
No religion	9(60)
Health insurance	
Yes	10(67)
No	5(33)
Married status	
Married	6(40)
Married (live separated from spouse)	9(60)
Use of mammogram	
Yes	9(60)
No	6(40)

Data Management and Analysis:

The first author transcribed all the digital-recorded interview audiotapes and the field notes in Chinese. Data were then

entered into NVivo 8 for management, coding, categorization, and ongoing analysis. The interview data (the interview transcriptions and the interview field notes) and the observation data (the observation data sheets and the observation field notes) were analyzed separately.

The systematic qualitative data analysis approach proposed by Miles et al. (2013) guided the data analysis. The entire data analysis process was inductive and on-going. Before coding, to get a sense of the data, the first author summarized each interview using a contact summary sheet (see Appendix I) adapted from the one proposed by Miles et al. (2013); and summarized each observation using an observation data sheet proposed by Spradley (1980). The details of the observation data sheet were published elsewhere.

During the coding process, the first author did not introduce predetermined codes but instead followed an inductive rather than deductive method. While reading through the transcripts, observation data sheets and field notes, she allowed the codes to develop through her interpretation directly from the data. In the beginning, she developed descriptive codes, which labeled the data straight forward without interpretation (Miles et al. 2013). Words repeatedly appear in the data or key words in the context can all become descriptive codes (Miles et al., 2013). Then, based upon the descriptive codes, the first author began to develop pattern codes including topical codes, which summarized general topics in the data with little interpretation, and interpretation codes which identify the themes or categories that interpreted the data in some way (Miles et al., 2013).

The descriptive codes and the pattern codes were grouped into tree codes (a function in NVivo 8 to group codes in a hierarchical order so that lower-order codes are nested in higher-order codes) as a basic form of data interpretation (QSR International, 2014). Appendix II illustrates how the tree coding technique works in the study. To make the data more comparable for interpretation, the first author organized the codes using within-case and cross-case displays using the *queries* function in NVivo 8 for matrix and *models* function in NVivo 8 for conceptual maps (QSR International, 2014).

The first author kept memos and journals to work as reflective notes and to document changes in the data analysis throughout the coding process. The data were analyzed in Chinese to maximize culturally specific interpretation. Analysis results were then translated to English.

FINDINGS:

Cultural health belief was a major pattern code that helped to interpret Chinese-born immigrant women's use of health care services. For clarity, the authors organized the findings under three categories including cultural beliefs about health and illness, cultural beliefs about health promotion and illness prevention, and cultural beliefs about health care practice, consistent with the categories proposed by Zhao et al. (2010) in their review article for Asian-born immigrant women's cultural beliefs about health and health care.

CULTURAL BELIEFS ABOUT HEALTH AND ILLNESS:

Health with two dimensions. The participants mainly defined health in two dimensions: one is physical health; the other is mental health. To be healthy meant "no illness or seldom getting sick." All the Chinese-born immigrant women in our sample valued mental health more than physical health and emphasized the interaction between physical health and mental health. This is consistent with the dualistic perspectives of traditional Chinese culture that places values/spirits above materials (Helman, 2007). The participants thought that compared to being physically healthy and merely staying away from illness, being happy was a more important basis for health. They also proposed that mental health had great impact on physical health. Unhappiness may endanger physical health or lead to illness, and vice versa.

I think, to be healthy, means, for one thing, we need a good body and should keep the body running normally… there should not be any illness in the body; for another, we should keep our mind healthy…In other words, we have satisfaction or happiness in our hearts…Indeed, the mind is more important than the body. Our strength comes from the mind. The mind determines the quality of our everyday life. If the mind is unhappy, then we are more likely to get sick. Of course, the illness also spoils our mood. That's why we need to maintain both the mind and the body.

Furthermore, the religious influence adds to the richness of cultural influence on these women's health belief, regardless being a Christian or Buddhist. The six participants who were religious addressed spiritual health as part of mental health. They well integrated Christian faith and Chinese cultural heritage. They thought that God helps them to achieve spiritual satisfaction and happiness, which is a source of their health. Therefore, for the purpose of health, spiritual health should not be separated from mental health, and should be valued the same as physical health.

Even if one is physically well, but is not spiritually well, I do not think one is healthy. In my mind, being in a healthy state means having both a healthy spirit and healthy body. Human beings are different from animals. No matter what race you are, human beings have the tendency to worship God. As I mentioned before, one may look all well physically, but is not happy. God helps to cure one's spirit and make one's spirit happy and healthy…So we have this spiritual need. If we are healthy in both spirit and body, then we are healthy.

Moreover, some participants (n=6) stressed the harmony between human being and their environment. They extended the concept of health to healthy diet or healthy lifestyle and considered no or low stress as a part of the concept of health. One participant also perceived that "basic body condition" is a part of health. She thought that one is able to adapt to environmental changes, with a good "basic body condition," which is an indicator of one's healthy status. From her perspective, "basic body condition" is a naturally born body condition and cannot be acquired through efforts.

Basic body condition refers to the state of one's body condition at birth. If the basic body is good, then one's body condition does not change much due to stimulation from the outside world. With a good foundation, one does not easily get sick or have a fever due to sudden cold weather or drastically changing environment… For example, I have a friend who swims a lot and looks healthy, but he suffers stomachache when the weather is cold. He can only drink heated water, but not cold water.

Illness with three dimensions. The participants defined illness through three dimensions including abnormal physical status, abnormal mental status, and the imbalance between "Yin" and "Yang,", which are the two major primary themes in traditional Chinese medicine and represent two opposite but complimentary parts that compose the whole natural world including the creatures (Helman, 2007). The participants identified "something abnormal" as the core of illness. The participants interpreted these abnormal physical status as "having physical symptoms," "having something not normal in the body," or "not energetic." They also interpreted abnormal mental status as "having something not normal in the mind that one cannot live a normal life." One elder participant considered that the imbalance between "Yin" and "Yang" in one's body was also a part of the concept of illness. She believed that everything in the world including human body has two opposite parts of "Yin" and "Yang." One's body was composed of both "Yin" and "Yang" substances. "Yin" and "Yang" substances had completely reversed attributes. Normally, "Yin" and "Yang" substances in one's body remained a dynamic balance. When the balance was broken, it became illness, even though abnormal physical or mental symptoms may or may not appear.

Five causes of illness. The participants proposed five illness causes including congenital defects, unhealthy lifestyles, stress, unhappiness, and environmental changes. Although the participants addressed congenital defects as a source of illness that cannot be neglected, they put more emphasis on unhealthy lifestyles, stress, and unhappiness. They thought that unhealthy lifestyles such as smoking, heavy drinking, staying up late, eating sweetened or fatty food, and doing little exercise all contributed to the development of illness including physical and mental illness. Moreover, they considered unhappiness, especially long-term unhappiness, as one main reason for illness and this is not in conflict with the dualistic orientation of Chinese culture that spirits goes above materials and the Yin-Yang value approach that mind and body needs to be in balance. They also emphasized the impact of stress in the causation of illness. The stress most frequently mentioned was work stress. This was not surprising considering the current U.S. economic recession and a declining job market. Work stress reflected their fear of losing their job and led to a self-imposed pressure to work harder to keep a job.

You know working in the United States is usually very stressful. I have a friend who is working at a University, and he loses twenty pounds in just one month after changing to a new boss. This really makes him vulnerable to getting ill.

Some participants (n=3) addressed illness causation beyond the individual level and considered the environmental changes as a major cause for illness. From their perspective, air pollution, water pollution, or other environmental pollutions were all related to the illness development.

My former boss in Beijing, who died of cancer, did not drink or smoke. I don't know what exactly caused her cancer, but the heavy environmental pollution in Beijing definitely affected her.

CULTURAL BELIEFS ABOUT HEALTH PROMOTION AND ILLNESS PREVENTION:

Socializing with friends. The participants considered socializing with friends, exercise, healthy food, good sleep, and being happy as the five main methods to promote health and prevent illness. The majority of the participants (n=11) believed that socialization with their friends contributed to good health. They considered that people need socialization because one could not live without social contacts with other people. Following the Confucian tradition in China, interpersonal relationships are usually highly valued in society (Tseng et al. 2005). The participants also interpreted how socialization benefited good health. They thought that socializing helped to improve health and prevent illness through the construction of a social network and the acquisition of friendship.

One needs to be more open and make friends. Even though there are people hard to get along with around us, I believe that the number of these people is small. One has to get along with people with sincerity, not pretend to be someone who you are not. I think being open is to be kind to other people. Thus, you may live a happy, fulfilled life. Thus, it may improve your health.

Exercise. The participants (n=12) also believed that doing exercise was one way to improve health and prevent illness. They thought that one's body regained vigor through exercise. Although most of them considered that one's health benefited from exercise regardless of the type or kind of the exercise, they believed that one has to do exercise regularly for good health. They interpreted regular exercise as doing exercise consistently on a daily schedule or a weekly schedule. Older women preferred exercise which is more casual and relaxed such as walking, jogging, and yoga because these types of exercise meet both physical and mental need. Through these exercises, one could get a stronger body and a more relaxed mind. Older women also preferred outdoor exercise because they believed that fresh air is helpful for good health when doing exercise.

I usually jog or walk fast outdoors for exercise early in the morning or evening because outdoor exercise makes me more relaxed. In addition, when doing outdoor exercise in the morning, I can breathe fresher air which is good for the body and makes me more refreshed and energetic. In the evening, I usually walk after dinner for digestion purpose. You know we have an old Chinese proverb 'After a meal, walk a hundred steps and you will live till ninety nine.' I believe it without a shadow of doubt.

Healthy food. The traditional Chinese medicine emphasizes food therapy as a very important avenue to maintain health (Tseng et al. 2005). People get nurtured from products from the nature and these natural products help to keep the balance of Yin and Yang (Tseng et al. 2005). The participants (n=8) proposed that "healthy" food was a main theme for health promotion and illness prevention. Eating "healthy" food meant eating more vegetables and fruits, avoidance of junk food, high calorie food or fattening food, keeping a balanced diet, and eating "natural" food. In their opinion, balanced diet meant that one should eat all kinds of food without a picky appetite, because each type of food has its unique benefits to one's health. Their idea of "natural" food indicated that unprocessed food is better than processed food for health. They also proposed that one should eat at regular times every day and should not eat too much or too little at a time for the purpose of health. They believed that getting up late in the morning, skipping breakfast, and having a big lunch or dinner can hurt one's stomach.

Good sleep. The participants (n=10) considered good sleep as one way to promote health and prevent illness. They interpreted good sleep as sufficient sleeping time with good sleeping quality. They reported that people may experience different sleep quality. One may have a better quality of sleep and therefore need less sleeping time; another may have a worse quality and therefore need more sleeping time. A good sleep meant no matter what sleeping quality one has, one's sleeping time is sufficient for one's health. From their perspective, an indicator for good sleep was that when getting up in the morning, one felt vitalized and energetic.

Being happy and stress relief. About half of the participants (n=7) considered happiness and stress relief as a critical method for health promotion and illness prevention. Again, this is consistent with the holistic Yin-Yang dualism that emphasizes the balance between mind and body (Tseng et al. 2005). They further proposed that stress and unhappiness influenced not only their health for themselves but also their family members' health. Therefore, they conveyed that one should attend activities such as watching TV, doing yard work or traveling that helped to relieve stress and promote happiness for the health of the whole family.

The six participants who were religious also proposed that God may help them to promote health and prevent illness. They believed that they may get strength, happiness, comfort, and health through reading the Bible or praying to God, which were the two main ways for them to talk with God and get God's help. They believed that the Bible indicated what they could do or could not do for the purpose of health.

The Bible can serve as a manual for our behaviors. It offers advices and basic rules. It tells us that even though we committed sin, it allows us to eat meat, though it warns us about the harm of eating meat to our health. It tells us to eat vegetables and fruits. Later on, these theories are proven rather than overthrown by modern medicine.

CULTURAL BELIEFS CONCERNING HEALTH CARE PRACTICE:

From the participants' perspective, health care practice in the United States is different from the health care practice in China. They reported that both of them have their advantages and disadvantages. The participants mainly compared health care settings and health care providers of the two countries (Table 2).

Table 2: Comparison of U.S. and Chinese health care practices

Country	Advantages	Disadvantages
U.S.	More advanced equipment; better environment; Kindness of health care providers, Greater flexibility in choosing providers	Appointment system Referral system Language barrier
China	Timeliness of service; Experienced physicians	Less advanced equipment Long waiting time Noisy, crowded environment

The Chinese tale. The main advantages that the participants identified about the health care in China were the timely health care services and more experienced physicians. They conveyed that it was more convenient to visit a doctor in China because there was no need for appointments. In addition, if a doctor advised them to have lab tests, they could get the tests and the test results immediately. They also reported that doctors in China had more experience in disease diagnosis because they usually had more patients. Therefore, doctors in China offered them more accurate diagnoses about their diseases and were more reliable. They could easily find a "good doctor" in China.

On the contrary, the participants identified the main disadvantages about the health care practice in China as less advanced equipment, long waiting time, and the noisy, crowded environment of the health care setting. They stated that the lab equipments in China were generally not as advanced as those in the United States, except in large hospitals and large cities, where there may be no big difference between countries. They also described the crowded queuing system in out-patient departments and complained that there was a long waiting time to see a doctor in China.

In China, when visiting a doctor, you cannot imagine how many people there are in the hospital. It is too crowded and noisy. They will give you a number and then you need to wait for a long time till they call your number to see the doctor. Even if you arrive at eight o'clock in the morning, there might already be hundreds of people with numbers before your number. That is one reason that I usually avoid visiting a doctor in China. The experience is too painful.

The United States tale. Compared to China, the participants identified more advanced equipment, better environment, kindness of health care providers, and greater flexibility in choosing health care providers as the main advantages of the U.S. health care. They reported that in the United States, clinics were usually cleaner and quieter. In addition, physicians were generally kinder, nicer, and more patient; while in China, physicians usually did not have

much time for the encounter and may be cold to patients when the physicians were getting tired. Moreover, the participants liked having more choices when selecting their U.S. health care providers. In comparison, their choices were limited in China, confined to four or five hospitals due to health insurance rules. The participants also described how more advanced technologies in the United States helped with their health.

In the U.S., I can enjoy the advanced equipment. When I had my eye surgery last year, my doctor introduced the machine to me. It was very advanced, and my surgery was minimally invasive. I am not quite sure if the hospitals in China have this advanced equipment…

At the same time, the participants identified the appointment system, referral system, and the language barrier as the main disadvantages of the U.S. health care. They reported that it was too inconvenient to make appointments to visit a doctor in the United States. They also expressed their worries about the potential delay of illness diagnosis and treatment related to the appointment and referral systems.

You have to meet their time schedule, not your own time schedule. When I first visited my gynecologist, maybe because she is comparatively well-known, and I am her new patient, I could only have my appointment after three months. If I really had something wrong, how could I wait for three months…The referral system is the same as the appointment system, and I do not like it.

The participants further pointed out that language difficulty was still a barrier for their health promotion and illness prevention. Some of the participants, especially older ones, avoided visiting a doctor if they were not really sick because of their limited ability to speak English. Others, although fluent in English, had difficulty with medical terms. They expressed the need and challenge to find Chinese interpreters.

Even if I think my English is fluent, I still have trouble when there are specialized terms during the communication. I think it is better if we have a Chinese interpreter service. I know there is Spanish interpreter service, but not Chinese. Is that because we do not have as many (Chinese) people as Spanish people here?

DISCUSSION:

A major strength of this article is its application of both in-depth interviews and participant observation to explore how Chinese-born immigrant women view health, health promotion, and health care services. Compared to the previous studies, the findings of this study provide new insights into the health beliefs and practices of Chinese-born immigrant women in the U.S. in their cultural context. The results suggest that accurate understanding of Chinese-born immigrant women's health beliefs cannot be separated from their socio-cultural background and their unique social connections to their community, which contributes to a better understanding of these women's use of health care practices. Chinese-born immigrant women's health beliefs are significantly influenced by traditional Chinese culture and shaped by their immigration. The adoption of the concept of health beliefs can help health providers and researchers further understand what may contribute to these women's use of health care practices. This further helps health providers to reframe the design for relevant future research and intervention programs.

LIMITATIONS AND IMPLICATIONS FOR FUTURE RESEARCH:

The sample used was a convenience sample that was recruited from a local Chinese church that located in an area of high concentration of a population with higher education. We did not intend to generalize our conclusion to the relevant larger population. Rather, we interpreted these Chinese-immigrant women's beliefs and behaviors in the context of Chinese culture and the community. This contextually driven understanding will help related theory construction and inspire new hypotheses in this research area. However, we admit that the middle class background and the high percentage of college education women can cast limitation on our theoretical inference. Also some participants are from Taiwan and others from mainland China. There are nuance cultural differences among these two societies. Culture in this article is operationalized as the context and specific and nuance cultural components are not the focus of this article.

Future research can investigate similarities or differences in the cultural health beliefs and corresponding health behaviors between first and higher order generations of Chinese-born immigrant women. Eventually, future research should develop culturally sensitive intervention programs to enhance the Chinese-born immigrant women's use of health care services.

Implications for Practice:

Comparing the findings of this article to those of previous ones on health beliefs among other immigrant groups such as Latinos and other Asian groups, Chinese-born immigrant women not only have unique cultural health beliefs, but also share common beliefs with other immigrant groups (Marinous et al. 2008, Zhao et al. 2010). For example, proper diet such as low fat diet was considered as an effective method to improve health across Chinese, Japanese, Korean, Hmong, and Latino groups (Marinous et al. 2008, Zhao et al. 2010). However, while physical activities and exercises were believed to promote health among Chinese, Filipino, Hmong, Japanese, Korean, and Vietnamese groups, they were less valued among Latinos, especially among Latino women (Im et al. 2010; Zhao et al. 2010). Therefore, health providers, researchers, and policy makers need to acknowledge the similarities and differences between different immigrant groups; and further promote culturally competent programs with regard to health promotion, health education, illness prevention, and health care services.

Some of the findings are congruent with the findings of previous studies. Similar to Japanese, Korean, and Vietnamese, language is still a barrier for Chinese-born women in a suburban southeast area of the United States. to use health care services (Nguyen 2003, Juon et al. 2004, Sadler et al. 2005). The participants considered a Chinese interpreter service a necessity that is lacking during their experiences with the current U.S. health care system. They

also mentioned a need for more Chinese-speaking providers. Based upon these findings, heath providers and policy makers can help to provide a standard multi-language list, including medical terms, medical services, health care providers, health institutions and other relevant information. This list should be well circulated among local Chinese communities. Health providers and policy makers can also help to set up translator services that are medically fluent to help Chinese-born immigrant women better communicate with their doctors. If possible, health providers can also use Chinese when conducting health education. Although the education seminars may not be conducted in Chinese, the handouts or education materials should be written in Chinese.

Moreover, consistent with the literature, Chinese-born immigrant women were more likely to complain about the U.S. appointment and referral systems (Zhao et al. 2010). Health providers should find ways to improve the use of health care services among Chinese-born immigrant women. They can inform them the availability of walk-in clinics and speed up health care services to relieve their worry about diagnosis or treatment delays.

Some of this article's findings are new insights, which have not been reported in previous literature. For example, previous studies did not acknowledge that Chinese-born immigrant women had a need for socializing with friends to promote health and prevent illness. Their social network not only promotes mental health, but also is their major resource for health information seeking. Health providers and policy makers should better understand their social network, and take advantage of this social network to promote health behaviors, prevent illness and encourage the use of health services. Health providers also need to better understand that these women have their own community and unique cultural health beliefs. During participant observation, these women were more likely to interact and socialize with Chinese. Therefore, intervention programs to improve the use of health care practices need to be community based and culturally competent. Considering the importance of socializing with friends, an intervention program within the Chinese community may be more effective compared to a program located in a clinic setting.

Although emotional stress were emphasized among Chinese, Korean, Japanese, and Vietnamese groups (Zhao et al. 2010), Chinese-born immigrant women were the only group that were more likely to value mental health as much as or more than physical health. Their health beliefs are still heavily influenced by the traditional Chinese medicine's dualistic "Yin" and "Yang" perspectives that places values/spirits above materials. As a result, they emphasized the importance of keeping happiness and relieving stress as major means to prevent illness. Moreover, when further explored, one reason that they valued socializing with friends and outdoor exercise to prevent illness was that both strategies helped them to relax and be happy. This should be acknowledged by health providers when conducting health care services. It is also worth noting that they did not consider health providers as a major resource for their mental health. Their strategies for mental health were more self-oriented. Health providers need to educate Chinese-born immigrant women that in addition to self-care, mental health care is available from health care professionals such as advanced practice nurses and physicians.

Finally, a regular checkup was not considered as a major strategy for health promotion and illness prevention. Most participants considered U.S. health providers as less experienced and reliable than providers in China. Even those participants with health insurance considered going back China for a comprehensive check up and other treatments. Health providers need to build a trusting relationship with these women to facilitate their use of U.S. health care services.

CONCLUSIONS:

For health promotion and illness prevention, it is critical to understand the health beliefs and practices among Chinese-born immigrant women in the relevant sociocultural context. The findings of the article reinforce and support the previous research in that, although Chinese-born immigrant women share some beliefs with the other immigrant groups, they also have their unique cultural health beliefs. Findings also shed new insights to Chinese-born immigrant women's cultural health beliefs. Health providers need to be aware of these women's cultural health beliefs to improve quality of care. Health providers or researchers also need to design community based, culturally competent intervention programs to improve Chinese-born immigrant women's use of health care services such as screening mammography.

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Appendix I

CONTACT SUMMARY SHEET

Participant: Date:
Interviewer: Time:
Setting:

1. What were the main issues or themes that struck you in this contact?
2. Summarize the information you got (or fail to get) on each of the target questions you had for this contact.
3. Anything else that struck you as salient, interesting, illuminating or important in this contact?
4. What new (or remaining) target questions do you have in considering the next contact with this participant or others?

Appendix II

ILLUSTRATION OF TREE CODES
Cultural health beliefs
Cultural beliefs about health and illness
Health with two dimensions
Illness with three dimensions
Abnormal physical status
Abnormal mental status
The imbalance between “Yin” and “Yang”
Five causes of illness
Congenital defects
Unhealthy lifestyles
Stress
Unhappiness
Environmental changes
Cultural beliefs about health promotion and illness prevention
Cultural beliefs about health care practice