BARRIERS & FACILITATORS IN ACCESSING CHILD HEALTH SERVICES AND SOCIAL SUPPORTS: PERCEPTIONS OF INTERNATIONAL GRADUATE STUDENT PARENTS IN NEWFOUNDLAND & LABRADOR

by

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Abstract

It is widely acknowledged that access to health services and social supports is one of the determinants of a newcomer population's health status. It has been observed that research studies typically focus on investigating the experiences of immigrants and refugees. Experiences of other sub-groups of newcomers, such as academic sojourners, have remained overlooked and warrant attention from researchers. Using an interpretive phenomenological approach, the aim of my research was to investigate the experiences of international graduate student parents in accessing child health services and social supports. I examined perceived barriers and facilitators when accessing these services in St. John’s, Newfoundland and Labrador (NL). Through eight semi-structured interviews with these international graduate students, I found that key barriers in accessing services and support were the length of wait time, and participants’ negative experiences in navigating the healthcare system. Additionally, language barriers, participants’ limited interactions with the local population, lack of affordable daycare, and difficulties when it came to obtaining accurate healthcare information, added layers of complexity to their experience when accessing healthcare services. Factors that can facilitate access include professionalism of healthcare workers, child-friendly arrangements in patient waiting areas, and cultural sensitivity in healthcare delivery. These findings enhance our understanding of academic sojourners' access to child health services and social supports. They can also inform health promotion programs and activities targeted toward improving access to child health services and social supports for families of international students in Newfoundland and Labrador.

General Summary

The research aimed to investigate experiences of international graduate student parents regarding their access to healthcare and social supports for their children, and to identify what they perceive as barriers or facilitators in accessing such services. I have conducted semi-structured interviews with eight international graduate student parents. I have demonstrated that the key barriers to access are wait times and challenges with navigating the healthcare system. Additionally, language difficulty, participants' limited interactions with local people, lack of affordable daycare policies, and the participant's difficulty in obtaining accurate healthcare information add layers of complexity to the experience of accessing health services. However, the study also identifies some facilitators that enhance access: professionalism of service providers, child-friendly arrangements in patient waiting areas, and cultural sensitivity. The study provides recommendations to address some of the underlying issues. The findings from this study can inform program and policy development to address the needs of academic sojourner families in the province.

Dedication

To my sister, Saniya

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List of Abbreviations

CBIE: Canadian Bureau of International Education

ER: Emergency Room

MUN: Memorial University of Newfoundland

NL: Newfoundland and Labrador

Glossary of Terms

International students in Canada: “Non-Canadian students who do not have "permanent resident" status and have had to obtain the authorization of the Canadian government to enter Canada with the intention of pursuing an education” (Statistics Canada, 2010; para. 1).

International graduate student parents in Canada: Those who pursue graduate-level education in Canada and have children living with them. They are also sometimes referred to as *academic sojourners* in this thesis.

Child health services: Health services usually refer to the "whole spectrum of care from promotion and prevention to diagnostic, rehabilitation and palliative care, as well [as] all levels of care including self-care, home care, community care, primary care, long-term care, hospital care, in order to provide integrated health services throughout the life course." (The World Health Organization, 2006; para. 2). In this dissertation, child health services include doctor appointments, hospital services, vaccination programs, laboratory and diagnostic tests, and other similar services related to the enhancement and promotion of health and well-being among children.

Social supports: “Support[s] accessible to an individual through social ties to other individuals, groups, and the larger community." (Lin, Dean & Ensel, 1981; p. 74). In this dissertation, *social supports* can refer to informal and formal support such as parenting support programs, nutritional support for children, daycare and babysitting services, non-emergency medical transportation, etc.

Immigrant: “A person who is, or who has ever been, a landed immigrant or permanent resident”. (Statistics Canada, 2019; para, 1).

Refugee: “People who have fled war, violence, conflict or persecution and have crossed an international border to find safety in another country” (UN Refugee Agency, 2020; para. 1).

Chapter 1: Introduction

The literature suggests that children's physical, emotional, and psychosocial needs must be met if they are to grow up healthy and develop to their full potential (Bear & Minke, 2006; Hill & Tisdall, 2014). As children cannot develop their potential in isolation or with limited human contact, they need nurturing social environments to thrive (Bronfenbrenner, 2005, 1998; Siddiqi et al., 2011). It is evident from various studies that families especially parents, have the primary influence (De Figueiredo & Dias, 2012; Grusec, 2007; Hill & Tisdall, 2014). Hence, parental care is considered a crucial element in child development (Center on the Developing Child at Harvard University, 2016; Leininger & Ziol-Guest, 2008; Richter, 2004).

However, parents alone cannot fulfill all their children's needs. Sometimes, they also require assistance from professionals. For example, a child's health and well-being does require professional attention. Studies show that enhanced access to health services is associated with improved health status among individuals and their families (Andersen et al., 2007; Levesque et al., 2013; Newbold, 2009; Racher & Vollman, 2002). Recent studies further suggest that social supports can have a similar impact on individuals, as access to social resources increases the likelihood of maintaining a healthy and meaningful life (Albrecht & Goldsmith, 2003; Berkman & Glass, 2000; Cohen & Syme, 1985; Thoits, 2011; Uchinoa et al., 2019). Therefore, it is recommended that parents should be able to get equitable access to healthcare services and other social resources. However, not all families enjoy the same level of access.

Newcomers, including immigrants, refugees, and international students, have been reported to have different access experiences than the native-born population in any country (Kalich et al., 2016; Newbold, 2009; Yang, 2010). This is because newcomer families are likely to face a broad range of barriers that may restrict their access to health services and social supports (Babitschet al., 2012; Newbold, 2009; Riedel, 1998; Setia et al., 2011). Studies suggest that even experiences in accessing health resources may vary within different newcomer groups (Asanin & Wilson, 2008; Campbell et al., 2014; Newbold, 2009; Setia et al., 2011; Zanchetta & Poureslami, 2006). Asanin and Wilson (2008) and Newbold (2009) have shown that immigrants and refugees, although both newcomer groups, may differently perceive their experiences regarding access to healthcare. Such research indicates that there is a need for exploring experiences of different newcomer groups.

International students have a relationship with the host community that is contextually different from the experiences of immigrants and refugees. Families of international students create different kinds of connections and disconnections with host communities than those experienced by newcomers planning to settle as immigrants. The current literature examining healthcare access of newcomers has primarily involved two populations: immigrants and refugees. Experiences of other sub-groups of newcomers, such as academic sojourners, have remained overlooked and warrant research attention. Particularly, access to health and social resources for international students with children, has remained an understudied topic amongst academics (Brooks, 2015; Doyle, Loveridge

& Faamanatu-Eteuati, 2016; Loveridge, Doyle & Faamanatu-Eteuati, 2018; Loynes & Gurholt, 2017; Myers-Walls et al, 2011; Pinter, 2013).

1.1 International Students as Sojourners: The Canadian Context

International students are often categorized in literature as a type of transnational or sojourner who temporarily resides in a country, other than their own, to attend an academic program (Loveridge, Doyle & Faamanatu-Eteuati, 2018; Schmalzbauer, 2004). Such transnational families maintain a strong tie to their home culture while living in the host community (Myers-Walls et al., 2011; Schmalzbauer, 2004). In immigration friendly countries, such as Canada, many international students become permanent residents, upon completion of their schooling. In the last couple of years, the number of international students enrolled in Canadian post-secondary institutions has not only increased significantly, but it is also growing at a higher rate than domestic students. Canadian Bureau of International Education, CBIE (2018) reported 572,415 international students enrolled in Canadian post-secondary institutions in 2018. This number is almost double the number of international enrolments in 2016-2017, which reported 245,895 students. Of that total, approximately 57% were attending graduate-level programs (CBIE, 2018).

CBIE (2018) further identified three reasons for this growing trend:

a) Many international students consider Canadian education to be of high quality, and therefore Canada is one of their preferred destinations to pursue higher education.
b) There is an overall perception that Canadian society, and the general environment, are tolerant and non-discriminatory.
c) There is a common perception among international students that Canada is a safe country in which to live and study.

Canada welcomes students from all over the world, promising to extend necessary support and assistance to ensure international students have a good experience (CBIE, 2018). A mix of these reasons is perhaps making Canada one of the most desirable destinations amongst overseas students.

1.2 International Students and Their Contributions

International students can prove beneficial for their host country's economy and cultural environment. In Canada's case, international students are of great value to the economy, both as workers and as consumers. International students spent almost $12.8 billion in 2016, translating to 168,860 jobs (Global Affairs Canada, 2018). They have also contributed to the country's economy by working in occupations that require specific skills and knowledge (Global Affairs Canada, 2018).

In addition to this, international students enrich host countries with their heritage, perspectives, knowledge, and cultural diversity (Smith & Khawaja, 2011). Reports suggest that one of the best ways to strengthen Canada's economy and the culture of multiculturalism is by inviting skilled migrant workers and international students from all over the world (Blatchford, 2019; CBIE; 2018). CBIE (2018) further states, "international students in Canada support the excellence and innovation of Canada's education and cultural landscape and are a vital building block for internationalization at Canadian institutions and in Canadian society" (para.1).

Considering both the economic and cultural impact of international students, The Canadian Government has recently emphasized attracting more international students to study and eventually settle in Canada as permanent residents (Blatchford, 2019). At present, almost 60% of the total number of international students have shown interest in applying for permanent residency in Canada, due to welcoming immigration policies (CIBE, 2018).

Although most of these newcomers are found in the larger provinces like Ontario, British Columbia and Quebec, where multicultural settings already exist, higher learning institutions located in other Canadian provinces have also begun to receive an increased number of international students in recent years (Abu-Laban & Garber, 2005; CBIE, 2018). Almost all provinces now have a thriving community of international students from all over the world.

1.3 International Students in Newfoundland & Labrador (NL)

Newfoundland and Labrador (NL) is Canada's easternmost province and has only one degree-granting university—Memorial University of Newfoundland (MUN). As of 2019, around 18,558 students were enrolled at MUN (Sorensen, 2019). Among them about 3400 were international students, of which about 1,613 were graduate students

(Memorial University of Newfoundland, 2021; Sorensen, 2019). International students in NL not only enrich the province's economy and its cultural landscape, but also bring new ideas and innovation with them. For instance, several international students have recently set up technology businesses in St. John's with MUN's innovation hub, Genesis (CBC News, 2019). Realizing the potential contributions of international students, the Government of Newfoundland and Labrador has recently adjusted their immigration policies to allow for an increase in the number of international students in the next few years. As a result, in the last couple of years, the number of international students in both undergraduate and graduate programs at MUN have almost doubled, accounting for 20% of total students (Memorial University of Newfoundland, 2021). A significant number of these students come with their spouses and children.

There is a notable gap in the academic literature that sheds light on the on the experiences of families of international students in accessing health care. This gap in the academic literature needs to be addressed so that we can have a better understanding to enable support for this population.

1.4 Research Question and Objectives

In light of the above observations, I developed the following research question: what barriers and facilitators do international graduate student parents experience in accessing child health services and social supports in NL. To address this question, I had the following research objectives:

- To learn about the types of healthcare services and social supports children of international graduate student parents accessed since their arrival to the province.
- To identify and explore what these parenting students perceive as barriers and facilitators in accessing such services.

1.5 Significance of the Study

Although there have been some studies examining immigrant populations' experiences regarding their use of health services, there is very little research in the NL context studying the experience of academic sojourners with children (Gien & Law, 2009). This study will contribute to filling this gap in the literature. International students, unlike immigrants and refugees, come for educational purposes. As a result, their experiences are different from other migrant groups. Myers-Walls et al. (2011) observed that "this type of transnationalism differs from many other types in that the students may be 'in limbo', not sure if they will remain in the host country or return home" (p. 455). Immigrants, who enter the country to live permanently, are usually prepared for an extended stay as they gradually move toward citizenship. On the other hand, academic sojourners who are parents face the psychological and psychosocial effects of living 'in limbo' and assume multiple roles (i.e., parent, partner, student, and sometimes, part-time worker) which may cause additional stresses on them (Loveridge, Doyle & Faamanatu-Eteuati, 2018). While discussing academic sojourners' responsibilities, Loveridge, Doyle & Faamanatu-Eteuati (2018) include "language difficulties, adjusting to a new culture, feeling depressed or overwhelmed and financial pressures… alongside adjusting to the academic culture, finding childcare and worrying about a non-student spouse" (p. 334). Myer-Walls et al. (2011), in their research, identified similar factors that contributed to stress among international students. It indicates that academic sojourners' experiences can be unique, and it is of academic interest that we investigate their experiences, capturing their voices and interpretations.

In this research, the participants were all international students with children. One of them was a single mother living with her only child in St. john's. I tried to capture their voices, their ways of interpretation, and how they form their understanding of barriers and facilitators in accessing such services. The outcome of this research can help policymakers, health professionals, and social services providers understand the lived experiences of international graduate student parents who have families living with them. As such, an in-depth understanding could be beneficial in designing programs and activities to address the needs of academic sojourner families in our province.

1.6 Organization of the Thesis

The thesis consists of five chapters including the introduction. Chapter two provides a theoretical background on the concept of access, briefly describing the development in our understanding of access in health and how perceptions of access depend on various social factors. The chapter also discusses the experiences of newcomers in NL. Chapter three describes the methods and methodology that I used in conducting the research, including a rationale for choosing Interpretive Phenomenological Analysis (IPA) as the methodology for this research. The chapter further describes my epistemological stance as a researcher. Chapter four analyzes the data, exploring the participants' stories and opinions, demonstrating how they have attached meaning to their experiences. This chapter describes themes on barriers and facilitators to access, as identified by the participants themselves. Finally, chapter five offers a discussion on the findings and further examines the participants’ stories through force field analysis to identify different levels of environmental influence on access. The chapter concludes with strengths and limitations of the study, and further recommendations.

Chapter 2: Literature Review

I organized this chapter into three sections. The first section explores the concept of access and its relationship with various social factors. This provides us with a context to understand the phenomena of access. The second section discusses the ecology of access: how different environments such as families, communities, and the broader socio-economic and cultural context influence children's utilization of healthcare and other services. The third section focuses on the experiences of newcomer groups in NL.

2.1 The Concept of Access

The etymological meaning of "access" refers to the opportunity to enter, visit or approach a person, or a facility (Merriam-Webster, 2021). In medicine, this term is associated with access to services related to people's health and well-being: "[Access within healthcare is] …defined as the opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their needs" (Levesque et al., 2013; p. 1). Therefore, access to healthcare is considered as one of the determinants of health (Advisory Committee on Population Health, 1999; Gulliford, et al., 2002; Koh et al., 2011; Levesque et al., 2013).

In addition to access to healthcare services, extensive research conducted in the last couple of decades has found a strong connection between access to social supports and healthy development (Albrecht & Goldsmith, 2003; Berkman & Glass, 2000; Cohen, Gottlieb & Underwood, 2001; Harandi et al., 2017; House et al., 1988; Reblin & Uchino, 2008; Uchino, 2006; Umberson, Crosnoe & Reczek, 2010; Umberson & Karas Montez, 2010). These studies suggest that families need to receive support in both formal and informal ways. The common idea is that care which is provided exclusively through medical or institutional supports is impractical and limiting (Stewart, 1990; Hildingh et al., 2000; Richter, 2004). Informal social support provided by relatives, friends, and informal groups outside institutional settings can have empowering impact on families' wellbeing (Campbell et al., 2011).

However, the concept of access has also been regarded as one of the most obscure topics in health research (Aday & Andersen, 1974, 1995; Khan & Bhardwaj, 1994; Gulzar 1999; Penchansky & Thomas, 1981; Racher & Vollman, 2002; Saurman, 2016). In the past few decades, the idea of access was confused with the concept of supply (i.e., availability). Recent research has firmly pointed out that knowing the supply of required services is necessary but insufficient to ensure access. Instead, people's experiences of access are likely to be dependent on a mix of factors ranging from individual beliefs to a broader array of socio-economic and cultural circumstances (Andersen et al., 2007; Babitsch, et al., 2012; Institute of Medicine, 1993; Khan & Bhardwaj, 1994; Racher & Vollman, 2002; Riedel, 1998; Yang, 2010). A contextual exploration of access can provide a better understanding of the factors that impact people's utilization of health services. The following section locates access in the light of social and other environmental factors.

Richardson (1969) and Mechanic (1972) studied the relationship between healthcare service utilization and poverty. The latter further argued that the mere availability of healthcare resources is not sufficient to ensure access. A person's willingness is associated with one's attitudes towards health, knowledge about healthcare services, and his/her idea about various definitions of illness. However, both Richardson and Mechanic did not clarify which social factors could influence an individual’s economic status, thus impacting access to healthcare. Donabedian (1973) investigated the socio-organizational and geographical factors that are likely to impact access. By socio-organizational factors, Donabedian meant social and demographic factors that facilitate or obstruct individuals’ ability to seek professional medical support. However, Donabedian’s conceptualization of geographical contexts was somewhat limited. In line with this, one such conceptualization was done by Khan & Bhardwaj (1994), who discussed the spatial (geographic) and aspatial (social) characteristics of access. Aspatial factors referred to non-geographic systems, such as income, socio-economic factors, or insurance; while spatial factors related to geographic factors such as distance or transportation (Racher & Vollman, 2002; Khan & Bhardwaj, 1994; Gulzar, 1999). Khan & Bhardwaj (1994) later posited, if one were to improve a population’s access, there ought to be an equitable distribution of health resources. A more encompassing understanding of access was also provided by the World Health Organization (WHO) in the Alma-Ata declaration in 1978:

> Accessibility implies the continuing and organized supply of care that is geographically, financially, culturally, and functionally within easy reach of the whole community. The care has to be appropriate and adequate in content and in an amount to satisfy the needs of people and it has to be provided by methods acceptable to them (p. 58).

WHO’s description of accessibility emphasizes the influence of economic, cultural, and social contexts on access. Based on WHO’s conceptualization of access, various models examining access to healthcare were formed in later years. Below, I briefly discussed two such prominent models: Thomas & Penchansky’s (1981) dimensions of access and Aday & Anderson’s healthcare utilization model (1974, 1981,1995).

Thomas & Penchansky provided a taxonomic definition of access and described five dimensions of health access: i) availability, ii) accessibility, iii) accommodation, iv) affordability, and v) acceptability. Unlike previous researchers, the authors defined access as "the degree of fit between the clients and the system" (p. 128). Thomas and Penchansky emphasized the need to measure satisfaction levels among users of healthcare services. According to their conceptualization, availability referred to the adequate supply of health professionals, service facilities, and all sorts of care programs. Accessibility is the relationship between service delivery and service seekers' locations, considering time, distance, and reachability to service providers as essential factors to access. Accommodation referred to how healthcare resources are organized, according to the needs and priorities of the help seekers. Affordability encompasses aspects related to cost, health insurance and help seekers' perception about prices and their ability to pay. Finally, acceptability referred to the perception, attitudes, personal behavior, and practice characteristics of both providers and seekers regarding the services and support (Thomas & Penchansky, 1981). Thomas & Penchansky's dimensions of access are considered interdependent and continue being one of the prominent ways to understand access.

Another prominent model that has been in use for some decades is Aday and Andersen's (1995) multilevel health utilization model (Alexander et al., 2015; Babitsch, et al., 2012; Gulzar, 1999). Though this model was first conceived in the early 1970s, it went through several modifications in the mid and late 1990s (Andersen, 1995). Aday and Andersen (1995) pointed out that there is a significant problem in understanding access only in terms of an individual's behavior. Several factors, ranging from demographic orientation to the healthcare system's characteristics, can also influence people's access to healthcare resources. The model proposes that three elements can determine the utilization of healthcare services: *predisposing factors, enabling factors, and needs* (Andersen, 1995; Babitsch, Gohl & von Lengerke, 2012; Racher & Vollman, 2002).

Andersen (1995) refers to *predisposing factors* as the characteristics of the population, such as age, race, and personal beliefs and practices towards health. For instance, an individual who believes in chemotherapy as a treatment for battling cancer is likely to seek service at a chemotherapy clinic. *Enabling factors* refer to the support individuals receive from their families, communities, and organizations (Andersen, 1995). For example, the availability of transportation services may enhance a person’s visit to emergency medical services more expediently. The concept of *need* refers to the level of ailment, as perceived or realized by the individuals or the healthcare system (Andersen, 1995; Racher & Vollman, 2002). Perceptions of services among service seekers play a critical role in understanding the aspects of access, as this model suggests.

All these conceptualizations of access highlight the importance of understanding the health needs of different populations, as factors affecting access are contextual.

Additionally, I would like to emphasize that access has usually been studied as related to healthcare services. However, when children are involved, quality access to social and cultural resources is extremely important. Studies have provided evidence that access to different social supports help children cope with varying levels of stress, anxiety, and other psychosocial issues (Berkman & Glass, 2000; Uchino, 2006). For example, access to playgroups or peer group settings have significant implications in a child's overall development, particularly the development of social skills (Vygotsky, 1978). Recent studies have also confirmed that quality interactions with peers and caring adults can improve a child's cognitive and social skills (Malecki et al., 2000).

Based on above considerations, it is important to study what newcomer parents feel about accessing such services. When newcomers arrive in a new country, their social settings change drastically. They connect and interact with new sets of social actors (i.e., new friends, colleagues, classmates, service providers etc.). These social actors, located in various social environments, influence their parental experiences of access to healthcare and social supports for their young children. In the following section, I discussed the ecology of access and the impact of various environmental factors on access to healthcare resources, contextualizing the positions of international student parents.

2.2 The Ecology of Access

The ecological approach to human development argues that individuals, from birth until death, live in different environmental systems that stretch from their immediate surroundings to broader social and political settings (Bronfenbrenner & Morris, 1998; Bronfenbrenner, 1979, 2005; Garbarino, 2007). As relational beings, these settings can have a significant influence on us. According to this approach, various social factors associated with these different settings influence our behavior, beliefs, and our courses of action. In other words, these environmental systems are spheres of influence that have a profound impact on the way we understand and make sense of our experiences, including our experiences related to access to health and social services. I have created the figure below to help conceptualize Bronfenbrenner's ecological model of human development (1979) in relation to access to resources and support. It shows different environmental systems that can impact a child's access to health and support resources.

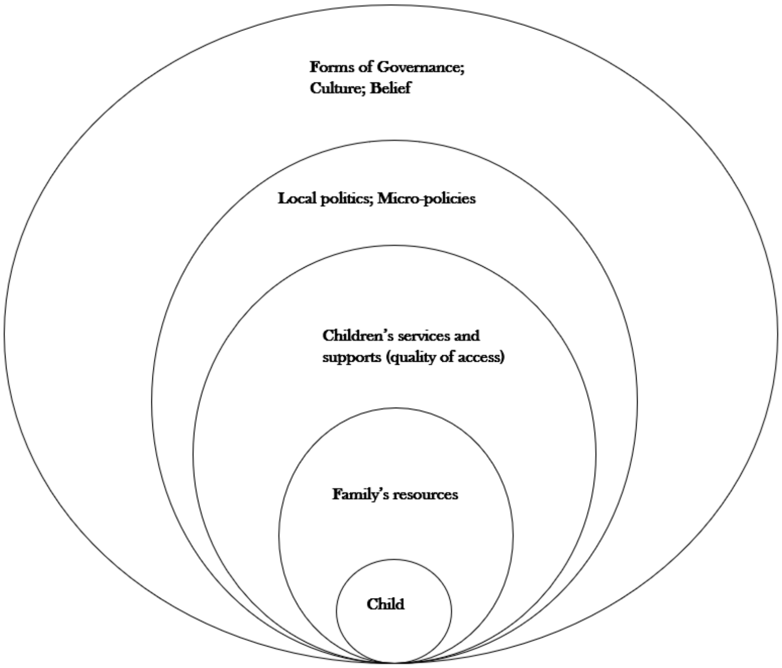

Figure 2- 1: Influences on access

Below, I discussed the four levels of influences that are likely to impact children's access to healthcare and social support. These influences affecting children's access come from a) The family, b) parents' relationships with support providers, c) community and micro policies (e.g., organizational policies), d) broader social and cultural contexts that surround the children and the families. The literature review further illustrates how these environments can influence academic sojourners in accessing child health services and social supports.

2.2.1 Family Influence on Children's Access to Support

Families, the innermost environment, influence children more than any other environmental setting. Siddiqui et al., (2007) has referred to family as:

> A group of people who dwell together, eat together, and participate in other daily home-based activities together. The family therefore includes the nuclear type (composed of a mother and/or father, and their children) but also extended sets of relations, groups of orphans residing together, and the like (p. 35).

The above understanding indicates that the concept of family has no specific definition as family composition may vary. Family structures change over time, and are sometimes replaced by alternative arrangements influenced by culture, economics, changing social values, and norms (Siddiqui et al., 2007). As a result, other types of families are emerging in modern society, challenging traditional perspectives on family compositions. Nevertheless, no matter what the family structure may be, the family environment has always played a vital role in the process of children's development and their access to supports.

Child's interaction with the family: Evidence suggests that it is within the nurturing family environment where children learn their basic communication skills (Bertrand, 2007; Irwin et al., 2010; Jack & Gill, 2003; Vygotsky, 1980). It is within the family environment children usually take their first steps to understand the world, learn the language, and develop the social skills needed to connect with others (Irwin et al., 2010). Families should combine care, love, and a mix of nurturing attributes to address the needs of their children (Mirabelli, 2018). A nurturing family environment is a safe space in which a child's needs are adequately addressed, and within this innermost surrounding, the parent-child relationship is forged (Kellmer-Pringle, 1975; Richter, 2004).

One of the most important benefits of a nurturing family environment is enabling a child’s ability to express and regulate their emotions in a positive manner. Recent studies indicate that children who experience positive relationships with their parents tend to be more assertive about their emotions, feelings, and needs (Brumariu et al., 2012; Morris et al., 2011). Adequate time and experiences with parents help children improve their cognitive and social capabilities (Ginsburg, 2007; Milteer et al., 2012). These studies further suggest that the parents of expressive children are more likely to be sensitive to their children’s needs, including health and social needs.

Parents’ financial conditions: A family’s financial condition deeply influences all aspects of child development, especially during early childhood (Siddiqi et al., 2012). Parents with low income often suffer from increased levels of stress (Santiago et al., 2011) as they have access to fewer resources to deal with adverse life events (Shonkoff & Phillips, 2000). Therefore, parental income significantly affects the family’s ability to make use of resources like healthcare and daycare, which play an instrumental role in a child’s development (Hertzman & Wiens, 1996; Milteer et al., 2012).

Families of international students: The discussion above was for parents in general. However, if we take the case of international student parents, we see they have to deal with another layer of difficulty. Student-parents are usually young parents with many responsibilities. As a result, prioritizing and providing adequate time to address their children’s needs may sometimes be challenging for them (Myer-Walls et al., 2011;

Salle, 2015). Many of the international student parents encounter role conflict, especially when they try to balance their parenting and academic responsibilities (Doyle, Loveridge & Faamanatu-Eteuati, 2016; Myer-Walls et al., 2011). These parenting students often have difficulty in deciding which role to prioritize, causing feelings of inadequacy in performing their role as parents (Myer-Walls et al., 2011). Such stressors can adversely affect their family's well-being and in turn impact the children.

Besides, these parents lack the benefit of extended family, as it is customary in traditional cultures that other family members often help parents to look after the children. Thus, children of academic sojourners do not get the opportunity to spend time with their grandparents and other family members and miss socializing with other caring adults and peers (Myer-Walls et al., 2011).- This may impact their children's well-being as it is important for children to learn social skills from other caring adults.

Several studies have shown that newcomer families, including immigrants, refugees, and academic sojourners, have different socio-economic experiences than the native-born population (Beiser, 2005; Beiser et al., 2002; De Maio & Kemp, 2010; Newbold, 2009; Setia et al., 2011). Studies further reveal that many international students face financial problems (Doyle, Loveridge & Faamanatu-Eteuati, 2016; Myers-Walls et al., 2011; Poyrazli & Grahame, 2007), as they have restricted working hours and are paying higher tuition fees than domestic students (Mori, 2000). Setia et al. (2011) commented that experiencing financial constraints are likely to impact parental access to help and support. An international student who goes through significant financial constraints is expected to experience difficulties and consequent stress in finding affordable childcare, insurance, medical services, and medications (Myer-Walls et al., 2011).

It has been observed that international students often do not come with adequate social connections or sufficient funds (Sherry et al., 2010). Even when they come with adequate funding, many of them develop additional needs as they get settled into the new environment. The effect of acculturation, especially when they want to integrate or assimilate with the host culture, gives birth to individual needs that were not felt or were not as expensive in their home country (Smith & Khawaja, 2011). Many of these needs are borne out of adopting a new lifestyle in the host country. To address these individual and family needs, many international students start to spend more money than what they initially thought. As a result, financial issues become a major concern for them.

On many occasions, insufficient amount of scholarship money and a limited income from part-time work mean struggling financially. Also, international students are a transnational population, thus while living in the host country they maintain strong ties with their home country. So, as part of their culture, transnational individuals may need to send money back home to parents, siblings, or other family members (Schmalzbauer, 2004). The underlying assumption Schmalzbauer (2004) made is that newcomers usually come with insufficient social capital or economic resources. However, there could be other reasons for the struggle to meet basic needs.

Some international student parents reported that their children often talk about the loss of leaving behind their home, family, and friends (Loveridge et al., 2018). To address this, many newcomer parents look for daycare services or playgroups for their children. Access to childcare services allows both parents to work or engage in other activities (Doyle et al., 2016). It gives children a chance to make new friends and experience learning opportunities from other caring adults. However, finding affordable childcare has always been an issue for international student parents (Doyle et al., 2016; Myer-Walls et al., 2011). Children, in this case, not only miss quality time with their parents but also miss the opportunity to meet new friends or caring adults due to limited parental income.

Furthermore, Pinter (2013) observed that many international student parents realize the importance of letting their children learn the host country's language, despite maintaining concern for their first language (mother tongue). These parents believe that learning the host language is beneficial for their children's education. However, many international students do not have sufficient economic resources to take their children to a language learning facility or a daycare due to the high cost of these services. Economic limitations are also tightly related to the quality of parental social resources and supports available (Myer-Walls et al., 2011).

2.2.2 Parents’ Access to Social Resources and Supports

Parents need support too. According to the Center on the Developing Child at Harvard University (2016), parenting adults need to develop core capabilities to “manage life, work, and parenting effectively” (p. 5). It further posits that developing these core capabilities can make parents more focused, aware, and a better performer in fulfilling parental responsibilities. However, parents are not born with such a set of skills. They are either learned from their family/community upbringing or through access to various supports to enhance their social and parenting skills (Center on the Developing Child at Harvard University, 2016). Siddiqui et al. (2007) have commented,

> Families need to be able to access the resources that enable them to make choices and decisions in the best interests of their children, including services such as parenting and caregiver support, quality childcare, and primary healthcare and education.” (p.33)

Children’s well-being largely depends on the types of resources and social support their parents receive (Springer et al., 2009). Access to supports empowers parents, which indirectly enhances their children’s access to healthcare and other support resources. Based on House (1981), Barrea (1986) and Tilden & Weinert (1987), we can categorise types of social support: emotional, instrumental, informational and appraisal supports. Emotional support refers to the provision of love, care, concern, and sympathy to others (Thoits, 2011). Instrumental support refers to addressing more tangible needs through money or labor (House, 1981). Informational support refers to the provision of advice and information in the service of particular needs (Berkman & Glass, 2000; Stella et al., 2005). Finally, appraisal support refers to “help in decision making, giving appropriate feedback, or help deciding which course of action to take” (Berkman & Glass, 2000, p. 145).

One of the most important supports for parents, especially for newcomers, can be opportunities to enhance their language speaking skills and to be able to increase their social network (Newbold, 2009; Myers-Walls et al., 2011; Setia et al., 2011). Having language skills is essential for parents to address their children’s needs. Without language skills, parents cannot communicate with their children's healthcare providers. Newbold (2009) has observed that language barriers are commonly identified as an impediment to social interaction among immigrants in Canada. Many newcomer parents, especially the spouses of international students often find it difficult to access services that are required for their children due to their limited language capacity (Myers-Walls et al., 2011). Furthermore, language barriers can restrict international students' capacity to make new friends and communicate with the local population who could provide them support as a social network (Mori, 2000; Smith & Khawaja, 2011).

In the Canadian context, Asanin and Wilson (2008) have observed that newcomers face different types of barriers in accessing supports. These include broader level factors such as "geographic, socio-cultural and economic barriers" in accessing such types of support (p. 1271). These broader level factors implicitly impact the way newcomers construct their perceptions of access. Therefore, it is imperative to explore the roles of community, society, and culture to understand their impact on access to support.

2.2.3 Access to Community-Level Resources

According to the Center on the Developing Child at Harvard University (2016), "Families function within a physical and social environment that is influenced by the conditions and capacities of the communities in which they live" (p. 12). Theoretically, communities have been defined as a group of people who share a common view or identity, distinguishing them from other groups (Higgs & Gustafson, 1985). There are also residential communities, which refer to localities in which children and their families live (Siddiqui et al., 2007). Such communities provide support to their members based on the resources they have. The Center on the Developing Child at Harvard University (2016) considers community-level resources for children as the “services and organizations dedicated to the promotion of children’s healthy development, as well as the availability of supportive structures such as parks, childcare facilities, schools, and after school programs” (p. 12). Access to such supports is deemed essential for newcomer families to ensure their children’s overall health and well-being. However, access to such resources significantly depends on how well-connected families are with social networks within the host community (Riedel, 1998).

2.2.3.1 Families’ Access to Local Social Networks

As stated earlier, lack of social networks can be a barrier to access. Social networks can provide help to people in navigating the healthcare system and facilitate access to local resources. Berkman & Glass (2000) observed that social networks consist of professional/non-professional people, formal organizations and informal groups that provide support to members of the society. One way individuals become knowledgeable about or are able to access these supports is through these social networks in which people interact amongst each other, forming a social tie (Berkman and Glass, 2000). It is essential that such social networks have adequate capacity to provide services and support to its people. For example, an increase in the capacity of community-level support providers has positive outcomes in the availability of job opportunities, quality housing, access to food markets, healthcare, and other supports (Goldfeld et al., 2015; Leventhal & Newman, 2010; Gyamfi et al., 2005; Heaney & Israel, 2008; Leventhal & Brooks-Gunn, 2008).

Studies suggest that parental interactions with their social networks have a strong influence on their access to healthcare and social resources (Center on the Developing Child at Harvard University, 2016; Heaney & Israel, 2008; Spilsbury & Korbin, 2013). Though children may not interact directly with their parents' social networks, the benefits that parents draw from such social ties can help their children.

For international students, enhancing social network can be challenging during early settlement as they are new to the host environment and community. Since many of them come with limited income, they expect to find affordable housing solutions for themselves. Next, I demonstrated how living in such localities can impact their access to health and other social resources.

2.2.3.2 The Impact of Residential Communities on Access

Newcomers often struggle to find affordable homes in areas where health services and other social supports are more easily available (Asanin & Wilson, 2008). Many international graduate students with family, generally, look for cheap rental opportunities because of their limited income (Smith & Khawaja, 2011). Consequently, residential communities such as neighborhoods where they live can also impact their families' access to healthcare and other supports.

Neighborhoods, especially in the urban context, can significantly impact children's healthy development (Goldfeld et al., 2015; Leventhal & Brooks-Gunn, 2008; Siddiqui et al., 2007). One of the main functions of a quality neighborhood is to provide its residents access to institutional resources such as playgrounds, community centers, libraries, trails, daycare, educational institutions, healthcare, social support, and opportunities for employment (Leventhal and Brooks-Gunn; 2008; Sampson et al., 2002). Studies suggest that people living in low-income neighborhoods may have difficulties accessing necessary services (Goldfeld et al., 2015; Leventhal and Brooks-Gunn; 2008). Location of the neighborhood, availability of quality public transportation to grocery shops, proximity to healthcare facilities and other essential services can play a crucial role in determining a family’s overall health and well-being (Leventhal and Brooks-Gunn, 2008).

2.2.3.3 The Impact of Institutional Barriers on Access

Riedel (1998) observed that newcomers usually experience difficulties when accessing healthcare resources due to structural or institutional barriers. According to the US National Academy of Science's Institute of Medicine, IOM (1993), structural barriers are "impediments to medical care directly related to the number, type, concentration, location, or organizational configuration of healthcare providers" (IOM cited in Riedel, 1998, p. 105). Since newcomers can come from different healthcare systems, they are likely to find it hard to understand the “inner workings'” of the host country's healthcare system, which restricts their access in the first place (Setia et al., 2011, p. 71).

Due to fewer social connections with local people and a poor understanding of institutional policies, many newcomer families struggle to navigate healthcare services. One study showed that immigrant parents tend to have a lower level of awareness about health resources and support services, as they receive less navigational support (Stella et al., 2005). Loveridge et al. (2016) noted that international students often complain about their lack of understanding when it comes to healthcare policies, which ultimately cost them extra money.

Structural barriers may also emerge from a shortage of services – a failure to meet the demand curve. For example, daycare is one of the most critical supports that academic sojourner parents seek out (Springer et al., 2009). However, finding affordable and appropriate daycare is a significant issue for many international students (Loveridge et al., 2016; Loynes & Gurholt, 2017; Myer-Walls et al., 2011). Myer-Walls et al. (2011) commented that due to a shortage of childcare facilities, international student parents, on many occasions, find that there are no open slots available, and waitlists are too long.

2.2.4 The Influence of the Broader Social and Cultural Contexts on Access

Although it may seem beyond the scope of this thesis, an ecological approach to human development views families as a unit of experience deeply rooted in the different levels of environmental contexts influencing the family's access to resources (Bronfenbrenner, 2005; Garbarino, 2017). Thus, access to health and social resources is associated with many macro-level factors such as: how governments prioritize and adopt public policies such as income taxes, transfers of income, healthcare plans, immigration policies, and so on (Siddiqui et al., 2007). For international students, immigration policies, as well as policies undertaken by the university often play a vital role in their utilization of healthcare and other services. For example, universities usually offer daycare and other resources for parenting students, but policies determining the costs and eligibility of being able to use such services impact the way students use these resources.

Besides policies, culture also plays a key role in shaping access experience.

Bornstein (2012) referred to culture as "a set of distinctive patterns of beliefs and behaviors that are shared by a group of people and that serve to regulate their daily living" (p. 212). Bornstein (2012) argued that these patterns of beliefs and behaviors could shape people's perceptions and attitudes towards care practices among parents and caregivers. For example, within newcomers' families, choices are often made according to specific gender norms rooted in their cultural beliefs (Brooks, 2015). Participants in Brook's research were female student-parents coming from traditional cultural backgrounds. These participants commented that they were the primary caregivers to their children. In more traditional cultures, raising children is considered the women's responsibility, usually with the support of other female family members, or paid help. However, when families move to other countries, caring for both the children and the household can become stressful for women due to the lack of formal and informal support they used to have.

International students go through a process of psychosocial and socio-cultural adaptation, which is referred to as *acculturation*. Acculturation is the process by which newcomers become adjusted to their new social and cultural environment (Berry, 2008, 2005, 2003). Berry (2005) suggested that acculturation affects a newcomer in two ways: a) psychologically, as the person struggles to make sense of being healthy and happy in the new environment, b) socio-culturally, as the person strives to become integrated with their new society and culture (Berry, 2005). However, critics of Berry’s conceptualization of acculturation argue that there could be other social factors influencing newcomers’ decisions to acculturation (Kâğıtçıbaşı, 2017).

Alberts & Hazen (2005) have observed that the children of international students, on many occasions, react negatively to their parents because they brought them to a place which they believe is not their actual home. The authors have further commented that many of these children often feel very isolated and withdrawn, which torments their parents. Like their children, parents may suffer from psychological stress in deciding how to balance between the two cultures. Among many international students, researchers have found psychological and psychosomatic health issues that are linked with their attempt to adjusting to new customs and social norms in the host country (Sullivan & Kashubeck-West, 2015; Smith & Khawaja, 2011; Wang & Mallinckrodt, 2006; Zhang & Goodson, 2011). The profound confusion in determining to what extent one should retain the old culture or move towards adopting a new one can be overwhelming for many; some even prefer to discontinue their studies and go back to their homeland because of their children's unhappiness (Alberts & Hazen, 2005). In general, the task of parenting itself poses a challenge to almost all parents but raising children and making daily decisions in a culture different from one's own often creates additional issues and problems (Myers-Walls et al., 2011).

Moreover, the role of culture in shaping help-seeking attitudes among users has been in discussion for decades. When it comes to accessing medical care, language fluency, personal beliefs and cultural beliefs play a significant part in the likelihood of newcomer groups seeking help (Loynes & Gurholt, 2017). Considering this, Riedel (1998) suggested that it is equally essential that medical service providers become culturally sensitive while providing services to newcomers. Riedel (1998) comments:

> Virtually all immigrants require care that is culturally sensitive. Homogenized healthcare that ignores personal and ethnic differences magnifies the inequities in access. Migrant workers, refugees and asylees, and legal immigrants often need language assistance, targeted outreach, and health professionals who are trained to understand special cultural needs (p. 106).

Although Riedel did not include them, it is equally essential that social support and service providers comprehend the magnitude of the cultural issue and train their support staff accordingly.

Providing adequate an appropriate health care to meet the needs of a diverse immigrant population in Canada is a major challenge. Immigrants often have past and ongoing experiences that need to be considered in understanding and addressing specific health care needs. Complex factors are at play, including socio-economic status, employment, length of residence, social networks, education and other human capital levels, language and cultural practices, the effect of health-based selection at immigration, and access to social services that vary geographically. Health care needs vary individually according to these factors as well as demographic factors such as gender and age. Racism is a major factor both in accessing services on the part of individual newcomers and their communities, and as a system factor in the larger society. More research is needed to understand the systemic effects of racism.

Racism and discrimination have been identified as potentially influencing newcomers' access to services (Kobayashi & Deng, 2019). Although there is a lack of research demonstrating how racism may impact international students' access to healthcare, a handful of recent studies have indicated that expressions of racism and discrimination could impact international students' wellbeing in Canada. For example, Houshmand et al. (2014) observed that international students of South Asian origin sometimes feel being avoided and ridiculed for their accents and cultural values when they interact with their local peers. This often made them engage more with their own cultural and religious groups. Houshmand et al. (2014) suggested that there should be more research on the impact of racism on international students.

2.3 Access to Health and Support Services: Newcomers in NL

Several studies conducted on immigrants and refugees indicate that there might be a range of access barriers for immigrants and refugees to Canada (Asanin & Wilson, 2008; Campbell et al., 2014; Kalich et al., 2016; Khanlou et al., 2017; Li et al., 2016; Li, Que & Power, 2017; Newbold, 2009; Newbold & Danforth, 2003; Setia et al., 2011; Woltman & Newbold, 2007). According to Canadian literature, some of the common access barriers are long wait times, language barriers, lack of knowledge about navigating the healthcare system, cultural issues, etc. (Setia et al., 2011). However, there is a lack of research exploring international students' experiences regarding their ability to access healthcare services, housing, employment, finance, and other essential aspects of well-being (Calder et al., 2016). There is no study focused on investigating international student parents' access to child health services and social supports in Canada.

A handful of studies conducted on Newfoundland and Labrador's immigrant population reveal that there could be barriers to some social supports for newcomer families and their children (Burnaby et al., 2009; Li et al., 2017; Li et al., 2016; Sarma-Debnath & Castano, 2008). Many newcomer families report experiencing language barriers, which is a significant impairment for integrating with the host culture (Burnaby et al., 2009). There is a lack of provision for English language lessons for newcomer adults (Sarma-Debnath & Castano, 2008). Consequently, many newcomer parents, despite valuing education highly (Sundly, 2018; Krahn & Taylor, 2005), face difficulties in communicating with their children's teachers (Anderson, 2012). Sarma-Debnath & Castano (2008) observed that parents with language issues are often reluctant to communicate with their children's school and other support staff.

Another challenge for newcomers in Newfoundland is their unfamiliarity with the Canadian healthcare system. (Gien & Law, 2009; Castano-Kutty, 2010). Gien & Law (2009) further found that all the groups of international students they surveyed mentioned that they have limited knowledge about NL concerning its “strengths, opportunities, living conditions” (p. viii). Thus, international students who finish graduate studies in the province face difficulties integrating into the local labor market, which often forces these new graduates to settle in other areas in Canada (Coombs-Thorne & Warren, 2007).

Furthermore, two studies have suggested that immigrants in NL face difficulty accessing health information, as both print and online sources contain less information that address newcomer needs (Reitmanova, 2006; Reitmanova & Gustafson, 2009). These studies highlighted that many newcomer families live in a world of uncertainty, not knowing how to access necessary social and emotional resources. In extreme situations, some newcomers feel reluctant in building their social network, as they are not sure about their stay in the province (Reitmanova & Gustafson, 2009).

In a 2002 study, newcomers in NL reported that they wished to receive more nutritional information and support adopting healthy lifestyle practices (Varghese & Moore-Orr, 2002). They wanted to know how to develop healthy food practices without abandoning traditional meal practices. Although many newcomers consulted dietitians, nurses, and physicians for nutritional information for their diet, 73% of the study respondents reported that they were not adequate (Varghese & Moore-Orr, 2002). The study further recommended that there should be an increased level of community-driven support to address this need of the increasingly diverse population of NL.

In a more recent study, Li et al. (2016) observed that many immigrant and refugee families visiting NL's Association for New Canadians (ANC) liked how the organization helped them with informational support. ANC helped them make informed decisions about their children's "school enrollment, meeting with teachers, translation services, summer camp enrollment and volunteer partnering" (p. 5). In this study, several participants agreed that the association's services were particular and culturally appropriate as they always arranged interpreters, when needed. Li et al. (2016) recommended that the province needs more support services like this as these services could increase newcomer family participation within the local society. However, one of the limitations is that ANC tends to focus on refugee and immigrant families and does not have the capacity to consistently serve other newcomers such as academic sojourners.

However, uncertainty about staying in the province is common among NL's international students (Gien & Law, 2009). Two of the top reasons they do not want to stay in the province are: i) lack of job opportunities and ii) their desire to live among their respective communities in other provinces where the number of immigrants is higher than in NL (Gien & Law, 2009). If this looming uncertainty remains, these young families will not be able to fully enjoy whatever supports are available in the province for them. The outcome of this research will enable us to have a better understanding of how we can improve the quality of international student experience in the province.

Programs and supports for international students in NL: To conclude with this section and following an examiner’s suggestion, I checked again what the Internationalization Office at MUN and the Association for New Canadians (ANC) are currently offering in the form of family and community programs for families of international students. Many of these programs are free for spouses and children of international students. For example, in collaboration with the Student Experience Office and the ANC, the IO offers English conversation circles and ESL classes where family members of the international students can learn and practice English with others (Memorial University of Newfoundland, 2021). The English Café (another program that the IO offers) and playgroups are also open to all parenting students, their spouses, and children (Memorial University of Newfoundland, 2021). A local church offers a conversation circle open to all community members (Memorial University of Newfoundland, 2021). By attending these programs, families of international students can improve their English language skills. Additionally, these programs offer a platform for academic sojourners to develop their social networks.

Chapter 3: Methodology and Methods

I started this chapter with a discussion on the research methodology that I have adopted for the study, including my epistemological stance. Then, I described how I have followed Interpretive Phenomenological Analysis's (IPA) hermeneutic tradition, from data collection to analysis. I concluded the chapter with a statement addressing the ethical standards followed in conducting the study.

3.1 Methodology

As I wanted to explore the lived experiences of international graduate student parents' access to child health services and social supports, I chose to conduct a qualitative research study, which allowed me to capture the multiplicity of participants' perspectives related to the topic of interest (Creswell, 2015; Willig, 2001). Participants in qualitative research share their observations, assumptions, and insights with the investigator in an open-ended interview, creating a pathway for an in-depth and contextual understanding of the phenomenon. By analyzing such accounts, qualitative researchers attempt to make sense of the meanings that participants attach to their experiences (Denzin & Lincoln, 2011). I will start by explaining my epistemological stance, followed by the methodological approach adopted, method selected and the ethical considerations.

3.2 Researcher's Epistemological Stance & Positionality

Epistemology is concerned about developing an understanding of "how we know what we know" (Crotty, 1998; p. 8). In other words, it is about what we believe is the nature of knowledge and how we can make sense of it. For example, some people may believe in the objective nature of truth, assuming that knowledge is independent of human consciousness. In contrast, others may believe in truth's subjectivity, accepting the different meanings people attach to their experiences. Therefore, we can refer to the epistemological stance as the philosophical bearing that guides researchers to adopt a particular belief in the nature of knowledge. This stance is often so powerful that it shapes the entire research process, especially the ways researchers interpret their findings (Maynard, 1994). As a researcher, I am inclined towards constructivism, believing that there is no such thing as objective truth; therefore, inquiries should be focused on learning what meanings people attach to their experiences.

First, being a constructivist with a belief in the subjectivity of truth, I think it is possible to construct impressions of peoples' interpretations of their lived experiences. A constructivist researcher is, in fact, a subjectivist in nature, assuming that “there is no truth to be known” (Hugly & Sayward, 1987; p. 278). A belief in the absence of any objective truth makes researchers interested in capturing the variety of interpretations that people apply to their experiences. Subjectivist researchers believe that the psychological world of the participants cannot be known, yet it is possible to construct an impression of reality as they perceive it (Reiter, 2013).

Second, I believe that a proper understanding of subjective views is not possible without exploring the contexts in which participants locate themselves. My belief is attributed to the Weberian concept of 'verstehen,' meaning "understanding something in its context" (Holloway, 1997; p. 2). My epistemological stance opposes the notion that experiences are isolated, fragmented, and unrelated to their contexts. I believe participants' ways of developing their interpretations are mostly dependent on the socio-environmental contexts participants have lived in, interacting with their ongoing lived experiences. Hence, my role will be to contextualize the participants' narratives and try to find the possible connection between the contexts and their interpretations.

Third, I believe in the argument presented by Green & Thorogood (2018), which claims that interpretive inquiries should be reflexive about how researchers make their interpretations. When researchers begin to make inquiries, they bring in their social and cultural understandings, assumptions, and views into the process of interpreting their participants’ narratives. Therefore, researchers are required to be cognizant of their presence and its impact on participants’ stories. Also, as both researchers and participants do not live outside of the discourse, it makes them practically inseparable from each other. Consequently, I have tried to keep this reflexive stance throughout the whole research process.

I concluded this section by briefly discussing my positionality in this research as part of this reflexive stance. I identify myself as male and Bengali by ethnic origin, hailing from Bangladesh, a South-Asian country with a colonial history. I grew up in Dhaka, its capital, and received my education from both government and missionary schools. I speak several South Asian languages, such as Urdu and Hindi, besides my native language Bengali. After completing my studies in my native country, which included an Honors and a master’s degree, I worked for several years before coming to Canada. I arrived in Canada as an international student. Though I am single, I have been in touch with many international students who are also parents at MUN, especially of

South Asian origin. I am well versed in their native languages, Urdu, and Hindi. Besides, many of my classmates have children, and they often share their parenting experiences with me. Their stories often reflect their expectations, levels of satisfaction, and recommendations concerning the pros and cons of raising children in a foreign country. Being an international student, I often empathize with their stories. The idea of conducting a study on international students emerged from informal conversations with my friends, and I am hoping that this research will shed some light on the types of barriers and facilitators international student parents face in the province.

3.3 Interpretive Phenomenological Analysis (IPA)

Taking into consideration the aims and objectives of the research, I have decided to use Interpretive Phenomenological Analysis (IPA) to conduct the study. In the following section, I briefly discussed aspects of IPA and my rationale for considering it as my research methodology.

According to Smith et al. (2009), “IPA is a qualitative research approach committed to the examination of how people make sense of their major life experiences” (p. 1). Therefore, IPA can be used to understand what meanings participants attach to their experiences and how they construct these meanings. This methodology evolved from the Husserlian concept of transcendental phenomenology, which is about “the world as it is experienced by human beings within particular contexts and at particular times, rather than in abstract statements about the nature of the world in general” (Willig, 2001; p. 51).

Phenomenology emerged as a counter-reaction to the positivist notion which asserted that reality was fixed, ordered, and thoroughly objective (Smith et al., 2009). It challenges this positivist paradigm, by assuming that interpretations are based on personal and subjective realities. Therefore, phenomenology can be considered an inductive, qualitative tradition that infers knowledge from personal views, feelings, judgments, or opinions. There are two distinct types of phenomenological approaches: descriptive and interpretive.

Descriptive phenomenology is based on Edmund Husserl's idea that investigation should be: i) free from all kinds of supposition, and ii) the 'essence' of a phenomenon is mainly dependent on the individual's consciousness and experience (Willig, 2001). For Husserl, the important thing is to learn about the participant's reality, this learning should be free from all preconceived ideas or assumptions that could influence both researcher(s) and participants. Husserl named this process "bracketing," insisting that researchers should be neutral and free from bias. Therefore, they need to bracket preconceived assumptions (Creswell, 2017).

In response to this problem, Martin Heidegger proposed that researcher focus should be on understanding the idea of *being* rather than merely attempting to know the reality. It is almost impossible to separate ourselves from our preconceived notions, thoughts, or assumptions. The ways in which we construct our perspectives we construct our perspectives are not something that transcends our preconceived notions. Therefore, personal awareness is inherent to the human psyche, and it is inseparable from both the researcher and the participant. Heidegger considered interpretations from both participants and researchers as essential in constructing an understanding of phenomena (Smith et al., 2009). He called it interpretive phenomenology, and the process of qualitative analysis based on this tradition later came to be known as Interpretive Phenomenological Analysis (IPA).

In IPA, researchers also take part in interpreting the participants’ narratives, being cognizant about how their thoughts and assumptions might have impacted their interpretations (Smith et al., 2009). In this sense, both researchers and participants are integral parts of the same discourse. It also means that their predetermined thoughts and opinions cannot be ‘bracketed.’ Rather, they should be used to develop a combined interpretation of the narratives. Such a combined interpretation is also known as the double hermeneutic. In IPA, a researcher is “engaged in a double hermeneutic because the researcher is trying to make sense of the participant trying to make sense of what is happening to them” (Smith et al., 2009; p. 12). Double hermeneutic provides a better understanding of the phenomenon by incorporating interpretations from both the researchers and the participants.

I believe IPA is best suited for my study for two reasons. First, I have noticed a lack of foundational phenomenological studies exploring the lives of international student parents and their access to healthcare services and supports. Second, the research explores the participants' meaning-making process, capturing a variety of subjective interpretations concerning their access experience. Using IPA’s double hermeneutic, I constructed a combined understanding of the phenomenon.

3.4 Method: Semi-structured Interviews

3.4.1 Recruitment

The participants' recruitment started after I received ethics approval (Appendix A) from the Health Research Ethics Board (HREB). I recruited participants based on the following criteria:

a) a current international graduate student with at least one child living in NL and,

b) have lived in the province for approximately a year, with temporary status.

c) the participants should have a child aged twelve and under.

The Internationalization Office at MUN closely works with international students, and their families, providing them with counseling and other informational support (IO, 2019). The IO circulated a letter and poster inviting international graduate students to participate in my study through their weekly notification emails. They also displayed the advertisement on their bulletin board at the IO office. Both the letter and the advertisement poster (Appendix B & C) contained the necessary information about the research. Interested candidates contacted me through emails. I carefully reviewed their backgrounds to see whether they met the selection criteria. Then, I sent them the consent form and the interview guide for their review. Some potential participants even called me to learn more about the research. In total, I interviewed eight participants. Seven participants reported that they came to know about my invitation through the IO office’s emails. I recruited one participant with the help of a local social worker.

Phenomenological research literature indicates that it is sufficient for IPA researchers to have studies conducted on a small number of participants (Smith et al., 2009). There is no need for a large sample; instead, efforts should be made to ensure that participants provide in-depth insight into their lived experiences. The reason behind this comes from the notion that IPA is an idiographic approach, which involves an investigation of a lived experience and its surrounding contexts.

3.4.2 The Interview Process

To meet the research objectives, I prepared an interview guide that consisted of several open and expansive questions (Appendix D). The interview guide prepared the participants with regard to what they could expect in the interview. However, I did not strictly follow the set of questions provided in the interview guide, keeping the tradition of semi-structured interviews. This approach allowed me to have a better idea regarding specific nuances of access. The aim of using these dimensions of access is to identify what the participants believe to be barriers and facilitators to access and how they develop these constructions.

I conducted eight interviews that were semi-structured with open-ended questions, suited for the IPA approach. The average time of an interview was about 25 minutes. Participants usually suggested interview venues, and the preferred location was a quiet corner at the university cafeteria, where I conducted six interviews. I completed two interviews in the health science library (HSC) study rooms. When interviewing, I tried to create a relaxed atmosphere with the participants and create an environment where they could clearly recount their experiences. Before starting the interviews, I always asked them, “what pronouns do you prefer?” I tried to remain respectful in all manners. The participants were asked to talk freely about their experiences. At the beginning of each interview, I clarified to the participants that there was no right or wrong answer to my questions. I considered every participant to have experiential expertise on issues related to accessing pediatric healthcare services. I paid close attention to what they said, trying to be an active listener as suggested by Smith et al. (2009). On many occasions, I asked probing questions to clarify specific points of the discussion. The participants seemed to welcome my questions without hesitation. I frequently delved into what appeared to be an interesting point. The following table shows examples of the types of questions I would have asked in an interview:

Table 3- 1:

Types of questions asked to the participants

Type of Questions	Example
Narrative	Would you provide an example of a positive experience when accessing a healthcare service or a social support in NL?
Descriptive	What would you do in case of any health emergency concerning your children?
Prompts	Can you tell me more about it? (I asked this when a participant was not giving an in-depth account of his/her experience.)
Probes	What makes you say that? (When a participant mentioned what he/she thought about the quality of any specific service or support.)

I collected data through semi-structured interviews with graduate student parents, conducted during the winter of 2018-2019. During the interview, I tried my best to avoid sharing any personal experience on the research topic. Though the interview progressed from general to a more specific level of inquiry, I mostly avoided bringing my assumptions and concerns to the discussion. Instead, I listened to the participant's accounts, focusing on how they develop their narratives. Each interview was audio recorded, I transcribed them at a later stage, and both, recording and transcriptions were stored in Google Drive (password-protected).

3.5 Data Analysis Process

IPA focuses on a close study of participants' experiential claims, assumptions, and concerns, though it does not have a specific method for analyzing data (Smith et al., 2009). So, it is essential for the researcher to engage in categorizing emergent themes or patterns in an organized way to illustrate the relationships between converging and diverging themes (Green & Thorogood. 2012; Smith et al., 2009). This process usually requires the reading and re-reading of the texts. The aim is to make sense of the participant's account and develop a structured presentation of themes. However, data analysis should go beyond the simple task of summarizing themes, as suggested by Smith et al. (2009). In interpretive phenomenology, identifying latent themes is essential as they lead to a detailed understanding of the phenomenon. Themes do not only consist of the surface meaning of what participants narrated but also include their underlying assumptions and beliefs (Smith et al., 2009). I have identified themes after carefully reading the original transcript. I also provided textual references of themes and provided direct quotations made by the participants. Below is a step-by-step description of how I developed the analysis and the interpretation of data. The steps have been adapted from the suggestions provided by Willig (2001) and Smith et al. (2009) on data analysis.

3.5.1 Becoming Familiar with the Data

This first step involved becoming familiar with the data. I carefully listened to the audio-recordings of the interviews even before I started transcribing them. It helped me to re-imagine the setting, environment, and voices of the participants. While transcribing, I tried to focus on the participants' narratives, putting aside my own ideas, impressions, thoughts, and observations. In this stage, I concentrated only on the participants' accounts. I maintained a separate notebook to jot down my own perceptions about the transcripts. I went back to these entries later when I started writing a discussion on the data analysis.

Once I finished transcribing the interviews, I read and re-read the text and searched for meanings and patterns to understand both the micro and macro details of events as narrated by the participants. I gained an understanding of the interviews' overall structure, what was embedded in the stories and how they reflect the participants' experiential claims. I added explanatory comments alongside a passage whenever needed.

3.5.2 Identifying Themes

After reading the texts, I identified themes based on the participants' accounts. I wrote them down initially along with the related texts from the original transcripts and added comments to each segment. Smith et al. (2009) asserted that exploratory comments, as they are related to the original script, help reduce the volume of transcript details and give us a concise vision of the different themes and their meanings. Using the guideline provided by Smith et al. (2009), I first attempted to ‘describe’ the content in plain words. It was made in accordance with the IPA’s hermeneutic tradition, combining both the participants’ meaning-making process and mine. I highlighted some of the underlying “assumptions, sound bites, acronyms, idiosyncratic figure of speech and emotional responses” that came along with the spoken words of a participant (Smith et al., 2009; p. 84).

I paid particular attention to the use of certain words or metaphors mentioned by the participant. Smith et al. (2009) consider metaphor as one of the important elements in the IPA. This linguistic apparatus helps the analyst understand the link between the narrative and its context. To develop such contextual understanding, I took heed of: a) the participants’ reflections, b) any interesting features of the participant’s narrative that I thought relevant, and c) the temporal development of the account.

3.5.3 Theme Development

In this step, my primary task was to identify themes by breaking down the flow of participants’ narratives. The task involved working with the explanatory comments included in the original transcripts and the initial notes that I made during the interviews. A careful reading of the transcripts, remarks, and notes helped me to understand fragments of the participant’s lived experiences. Authors on the phenomenological approach often suggest that investigators and participants have important roles in IPA research (Green & Thorogood, 2018; Smith et al., 2009; Willig, 2001). Smith et al.

(2009) remarked that “the themes reflect not only the participant’s original words and thoughts but also the analyst’s interpretation” (p. 92).

3.5.4 Making Connections Across Themes

After identifying a set of themes, the next task was to develop clusters, putting together related themes. This step, according to Smith et al. (2009), is not ‘prescriptive, and the analyst is encouraged to explore and innovate in terms of organizing the analysis” (p. 96). However, the authors did provide two suggestions to organize themes. I preferred to follow one of the recommendations, which Smith et al. (2009) described as the process of eyeballing in which a list of themes would be printed on a paper. Then, the researcher analyzes the list closely to identify and cluster similar themes. Accordingly, I made a list of the themes. Then, I eyeballed the list and moved themes into clusters if they seemed related. In front of me, I had the research aim and objectives printed on a separate piece of paper, which served as a lens, helping me to sort themes according to their relevance to the research objective. Finally, I arranged similar and related themes together, giving the cluster a title.

In sorting out the interrelated themes, I looked at the contextual element within the participants’ narratives. The objective was to frame what the participants wanted to convey as their understanding of any event. Sometimes, the participant moved away from discussing a particular experience to another, making it a little difficult for me to follow. However, on many occasions, I noticed that the participant returned to the same topic after a while. So, I was mindful of the temporal development of the narrative as well.

Next, I moved towards the next participant’s transcript and account, repeating the same procedure mentioned in the beginning of this section. According to Smith et al. (2009), at this stage, the researcher needs to be mindful about preserving the individuality of every participant’s narrative and allow new themes to emerge with every new participant. The scope of my study is mainly focused on barriers and facilitators. I considered all the participants as a relatively homogeneous population (graduate international student parents new to the host environment). Therefore, developing the themes involved clustering them in terms of their commonalities. In general, I selected themes that had been discussed by at least more than a couple of participants.

3.5.5 Writing

Smith et al. (2009) suggested a way of writing the discussion about the analyzed data: “IPA narrative represents a dialogue between participants and researcher and that is reflected in the interweaving of analytic commentary and raw extracts.” The researcher's primary task is to provide an interpretation of this dialogue in such a way that the reader can get a sense of what the data means. Based on this suggestion, I designed the following as a guiding principle for writing about themes.

Taking a theme

↓

Writing briefly about what it is

↓

Presenting evidence from participants to support the theme.

First, I completed the data analysis for each of the eight participants using the methods described in steps 1-3. Second, I consulted the master table of themes, picked one of them, and started writing about it. While writing about a theme, I produced extracts from the original transcript to support my arguments. I also tried to follow a logical sequence in providing my interpretation.

3.6 Ethical Considerations

During each step of the study, I tried to continually attempt to address the perceived ethical issues. From consent to the preservation of data, I followed the guidance provided by HREB and made every effort to secure the privacy of the research participants.

3.6.1 Confidentiality in Contacting the Participants

I expected to receive email/phone responses from the potential participants of the study. The email address that I used for this purpose was password protected. In addition to this, I did not share any details of the correspondence with anyone except my supervisor. Once selected, I emailed the participant the consent form along with the interview guide. Participants were welcome to ask me any questions related to the study.

Further, the study poster contained HREB contact numbers so that participants could contact them anytime they wished. Only after getting their verbal approval, I proceeded to set a time and venue for the interview. The schedule and the place for the interviews were set as per the participants’ convenience. I paid attention to maintaining their privacy at the interview venues, as well. Before starting the interview, I again explained the study and the consent process to the participants. I had two duly signed copies of the consent form. I handed every participant one copy of the consent form and kept the other for myself.

3.6.2 Ethics During Interview Sessions

While doing interviews in the university cafeteria, there was a possibility that people might overhear our conversation. To prevent this, I always chose a table located in the corner of the cafeteria, away from crowds. To maintain further privacy, and to prevent excessive noise, I avoided the cafeteria's peak hours of operation.

3.6.3 Participants' Emotional Risk

Participants did not seem to experience discomfort during the interviews. However, I was prepared for this, as well. I told the participants that they could leave the interviews at any time, if they felt uncomfortable. I had the contact details of NL's mental health crisis line with me during the interviews so that I could refer any participant in case of an emergency.

3.6.4 Confidentiality of Data

I saved the interview and the analyzed data in an electronic format, using password protection. I did not disclose any information related to the study to anyone except my supervisor. The data will be preserved at the office of my supervisor for five years. Afterward, data will be shredded and electronically deleted from the system permanently. No names or identifiers will be retained by the institution or me.

Chapter 4: Data Analysis and Findings

Guided by the research objectives, I analyzed the data collected from eight interviews. First, I identified the types of child health services and social supports that participants have accessed to address their children's health and well-being. Such identification gave us a contextual understanding of the situation. Second, I explored what the participants perceive as barriers or facilitators to accessing these services. Since this research is based on the interpretive tradition of inquiry, I explored the participants' stories and opinions, demonstrating how they attached meaning to their experiences. I started the chapter by describing the participants' socio-demographic information.

4.1 Participants’ Socio-demographic Information

Participants were eight international graduate student parents: four women and four men. At the time of interviewing, all of them were international students at Memorial University of Newfoundland studying in different graduate programs. All participants were temporary residents living in St. John’s with their children. They came from a wide range of countries: Bangladesh (n=2), India, Pakistan, Saudi Arabia, Lebanon, Sri Lanka, and Mexico. Although English was not their native language, the participants seemed to express themselves freely, sharing their inner thoughts, experiences, and observations concerning their access to child health services and social supports in NL. At the beginning of the interviews, they briefly discussed their socio-demographic background. Table 4-1 is a summary of the study participants’ socio-demographic information. I have used pseudo initials throughout the research to maintain the confidentiality and privacy of the participants.

Table 4- 1:

Participants' Socio-demographic Information

Name	Gender	Age Range (Years)	Degree Pursuing	No. of Children	Spouse Employment
A	M	35-40	PhD	3	Unemployed
B	F	35-40	PhD	1	Unemployed
C	M	30-35	Masters	2	Unemployed
D	F	30-35	Masters	1	Unemployed
E	F	30-35	Masters	2	Employed (not living in Canada)
F	M	35-40	PhD	2	Unemployed
G	M	35-40	PhD	2	Unemployed
H	F	35-40	Masters	1	No spouse (Single mother)

4.2 Services Accessed by the Participants

A general review of the transcripts indicated that all participants were aware of the essential medical services available in the province. They accessed these services from time to time based on their children's health needs. Most of the participants highlighted that clinics, hospitals, and immunization centers are some of the healthcare services they often seek to address their children's medical needs. *"I would go to the clinics, primary care clinics…. the ER unit, the vaccinations, that are the most frequent places that I use,"* said one participant when I asked him about the services he accessed when addressing his children's various health needs. When it was an emergency, the participants usually visited the Janeway children's emergency room (ER) as it provides emergency medical treatment to children in the province. Some participants further discussed their experiences in visiting specialist physicians after being referred by their family doctors. Their experiences also include visits to optometrists and dentists. One of the participants, D, said: "*I had an emergency with my child. He broke one of his teeth and we went there. It was amazing [service-wise]."*

The participants further mentioned that they accessed similar services while they were in their home countries. While discussing their experiences with NL's healthcare, they often compared their home country experiences to NL's. Such critical analogy offered by the participants provided a better insight into how the participants have constructed their views on access. For example, participant G referred to his home country's privatized healthcare stating how easy it was for people with money to get admitted into specialized hospitals: *"In my country there is a major hospital in the middle* *of the city and there is a small hospital or a healthcare centers for small issues you can directly go to...but here it is different…it is a problem."* For G, universal healthcare does not guarantee him such a level of access, which makes him critical of the healthcare in Canada. I discussed this phenomenon later in this chapter.

Participants appeared to be more attuned with children's healthcare services than with social supports. To many of them, their children's needs were predominantly medical that should be addressed by physicians. One participant commented: *"…family doctors, I mean physicians, [are] the most important [children's service provider]."*

Some participants recognized the importance of receiving support, other than medical care, for their children's other well-being needs. The most discussed non-medical support was daycare service. According to them, daycare services not only help parents to have more time for themselves, but also provides children an opportunity to interact with their peers. In the words of one participant, *"…here [in the city] child doesn't get a lot of chance to meet other children of their age, so there is one way, the daycare…".*

Besides daycare, a few of the participants mentioned the importance of taking children to playgroups and swimming lessons. To these participants, activities provided in a safe environment are good for their children's mental health. According to them, such services help children learn about the diverse cultural landscapes of their surroundings. A participant summarized her reflections on why parents need these services for their children: *"…to keep my child busy, to socialize her in NL culture, to* *[help her] adapt with the cultural shock, to address their developmental issues positively."*

One parent said they anticipated receiving parenting support, mentioning attending a parenting support program that provided him with *"necessary parenting tips and emotional support."* However, almost all the participants indicated that parenting was a challenging task for them. Receiving parenting support could help them navigate their journey as parents. *"…students should be facilitated; like mothers who are really single and need that [support]",* said one female participant who lives in St. John's with two children.

Although every participant shared their personal stories, I found similarities in their accounts, especially concerning the needs of their children. I described several similarities identified in their accounts. Table 4-2 shows participants and their use of health and support services.

Table 4- 2:

Participants' use of child health services & social supports

Participant	Availed services	
	Child health services	Social Supports
A	Clinics; immunization services; eye specialist; ER; nurses' support	Daycare; parenting support group
B	Clinics; immunization services; ER; specialist	Daycare
C	Clinics; immunization services; ER	Support from friends
D	Clinics; immunization services; ER; dentist	Support from neighbours
E	Clinics; immunization services; ER	Daycare; programs arranged by the MUN's Internationalization Office.
F	Clinics; immunization services; ER; nurses' support	Daycare
G	Clinics; immunization services; ER; dentist	Children's playgroups; swimming lessons
H	Clinics; immunization services; ER; eye specialist	Daycare; neighbours' support

4.3 Participants' Constructions of Barriers to Access

In the following section, I described themes concerning the participants' constructions of barriers to access. These themes are a) issues with the wait time, b) difficulty in navigating the healthcare and support systems, c) limited social interactions with locals, and d) the lack of affordable daycare.

4.3.1 Issues with the Wait Time

One of the frequent themes that emerged from the data analysis is related to the wait time perceived by the participants in accessing medical services. Their accounts suggested that they encountered wait time while a) attempting to get medical/physician's appointments and b) in receiving treatment in the emergency room (ER). Below, I discussed and analyzed highlights from the data describing how the participants narrated their experience with the wait time.

4.3.1.1 Wait Time in Getting Medical Appointments

Children's suffering: The participants indicated that waiting for days or months to get a medical appointment can negatively affect their children's well-being. For example, participant B shared a story of her child, who had developed a skin rash on her neck. B called her family physician, asking for an appointment. However, she had to wait for a week to get an appointment. Finally, when she and her child visited the doctor, she was referred to a specialist, and it was several months before the child was able to get an appointment. Although it was not an emergency, seeing her daughter suffer for months with itchy skin and an irritating rash made the entire wait exhausting to her.

> B: [The family doctor] made a request for [a specialist's] appointment in the beginning of summer and [it was] almost like at the end of the winter [when] we got the appointment. But by that time, her rash was gone. She had to suffer so much for the whole summer with the rash because of the long, long waiting list…It was a very challenging [experience] for me.

The wait time prolonged her child's suffering which made her perceive the wait time as a barrier in addressing her child's health needs. Similar narratives can be seen in other participants' accounts. Participants E and A also shared their experiences regarding their visits to specialists. Participant E expressed that waiting for several months just to get a medical appointment had prolonged her child's misery: *"I remember booking an appointment for my son to address his breathing issues and believe me, it was set for a date after five months!"* She expressed how concerned she was, as she could not provide her child with any treatment during this time. In the case of participant A, waiting to see an eye specialist at Janeway was also difficult, as he saw their child suffering with watery eyes: *"[The issue was] not very heavy (serious) but so uncomfortable… We were referred to the Janeway specialist by our optometrist and then it took almost a year and a half since we got a call… Actually, [it was] disappointing!"*

Different health practice: Some participants expressed that it may take more than a couple of months to get a desired appointment if it is a *"special case."* Whereas in their own country, one can go directly to the specialist for consultation. Participant G asserted that he sees a difference between healthcare practices in Canada and his country of origin. He described why he sees a difference and considers it a *"problem."*

> G: [Here] the problem is especially when you need specialists; they will not accept you without [a referral] request from the family doctor. It is a problem. If I compare it with what happens in my country, [where] you can go directly to the specialists. But here it is different. If you have special issues, needs specialists, it takes a few months to get that appointment... Many times, I called my family doctor for appointment. I find it hard to get it in the same week. Ten days to get an appointment.... There is a difference… a gap between Canada and my country.

Participant G's explanation motivated me to explore how some of the participants perceive this *"difference"* in access to healthcare services. For example, participant H shared her thoughts on what makes the Canadian healthcare system different from that of her own country. She shared that her native country has no universal healthcare. Like B, she expressed that people usually go to private hospitals if they have the means to do so.

> H: We have different types of health providers and not always have to wait for an appointment to consult with. Other than consulting a specialist, we can visit a health professional whenever we need them. This makes things different in several ways- we can consult a doctor immediately; we do not have to wait for an appointment. More importantly, if it is an emergency, we do not have to wait for 6-7 hours to consult a health professional.

I observed that coming from countries with privatized healthcare, some of the participants were new to the universal healthcare system, and they were surprised by the wait time they encountered. Wait time was a relatively novel phenomenon to them and, as newcomers, they did not have enough time and support to fully understand and explore Canadian healthcare. However, the participants had a point of reference about healthcare services, which was based on their experiences in accessing healthcare in their home countries. Later I demonstrated how these newcomers did not get adequate informational support that could have helped them in exploring the healthcare and other support systems more efficiently. This would have helped them in understanding the wait time phenomenon more comprehensively.

When I asked participant B to provide an example of her own experience, she said her child once developed some eating issues, though it was not a severe eating disorder, she wished to consult a specialist to investigate the matter.

> B: The [family doctor] directed us to a physician-specialist. The family doctor requested [for the] appointment and she said you would get a call in the next few months… It took like ages…Six months… That is a very long time…It needs to be shorter…That is the huge difference I see here.

B quickly referred to the differences in healthcare practices between her country and Canada. She indicated that she lacked clarity about how the universal healthcare system works here, pointing out that she received less informational support: *"I [later] came to know that there are other services that I don't know about!"*

4.3.1.2 Wait Time in the ER

Some participants experienced prolonged wait times at the ER. Having such experiences have impacted their perceptions of emergency medical services. For example, participant G’s children had to visit the pediatric emergency room twice in one year, with the children waiting between 4 and 6 hours for treatment. G remarked, *“Sometimes when you [are] waiting for such a long time, it gets very uncomfortable.”* Below I will describe how some of the participants perceived wait time as a barrier to access services.

Impact of second-hand information: Some participants indicated that they did not construct their perceptions of the ER services based on their lived experiences. Participant E lives with her two children in St. John’s. Her husband, who is an engineer, works in another country. This situation makes E remark that her parenting experience in St. John’s is like that of a single mother. Although she did not access pediatric ER services, she shared a story about one of her friends, who had recently accessed the ER with her children and had an unpleasant experience. This friend had been waiting there with her ailing son and his younger brother. She could not leave the other child at home because she did not have anyone to look after him. This story is particularly important as it allowed me to see how second-hand information influenced participant E to perceive wait time as a barrier to access ER services.

> E: ... [My friend] took her child to emergency and then she had to sit there for about three to four hours. And she was fed up. So, even though it was not an emergency, her child was sick, extremely high fever and everything, but the wait over there was so frustrating and her younger kid just… you know just made a hue and cried and he was uncontrollable. So, it was a nightmare for her.

E appeared to be influenced by an image of a tired mother managing her one sick child in the waiting room while the younger sibling is throwing a tantrum. She commented how she empathized with her friend as her family situation was very much like hers.

Participant E’s account refers to one of the practical challenges of being a parent living alone with two young children. She further indicated that she thinks the ER service providers have their own ways of prioritizing patients’ needs, which is not the same way parents usually assess their children’s medical issues. It occurred that she constructed this idea based on what she had heard from others:

> E: I have been told by the people who have been living here for a long time. They told me even if your kid is sick, like stomach-ache or high fever, they are not supposed to take them to the emergency because they will put you in the waiting list and they have their own priorities like some kinds of major accidents, something like which is very serious. If for us it is very important, for them it is not.

This *“us and them”* rhetoric played an essential role in participant E’s understanding of access. She was trying to make her point that professionals and parents might not always be on the same page. There is a need to understand each other’s’ concerns to provide parents with a clear understanding of how to assess children’s emergency medical needs.

Participant H asserted that she has also heard from others that wait time is a significant concern in Canadian healthcare:

> H: Since my arrival, I [have] always heard that the emergency is the worst part of [healthcare] services…Some of my friends mentioned that it may take almost five to six hours to visit a doctor in an emergency. I was new here at that time and I did not have that experience. But this gave a negative impression regarding the emergency services here.

However, what she heard from her friends was not exactly what she experienced herself later. In the sixth month of her stay in St. John's, her daughter woke up one night complaining about some severe pain in her ears. H immediately took her to the children's ER. To her surprise, H and her daughter did not have to wait for long to receive treatment. The ER doctors addressed her child's issue within a reasonable amount of time. This experience changed H's perception of the ER, and she now recognized how much her friends' narratives had influenced her. It reiterates how others' stories may influence people's opinions of services. It also indicates that some of the participants might need proper sources of information concerning their healthcare needs. Both E and H did not receive enough information on supports and services. They depended on informal and sometimes unreliable sources of information.

Sometimes, such apprehension of wait time makes participants set their own rules. For example, participant F shared a story about one of his friends with young children. This friend considers it a *"normal medical rule"* to wait 48 hours before going to the ER or a physician, even if the child develops a high fever. Here is an example of how he had developed this idea:

> F: So, I am just quoting my friend here, not me. His son got high fever starting at night. So according to the normal medical rule, he needed to wait for 48 hours to go somewhere [i.e., family physician] ... If they had to [if it was a medical emergency], they could go to the emergency [ER]…

It is important to note that despite the high fever, participant F's friend waited for 48 hours to take his child to the ER, fearing that it might not be a worthy case for emergency medical attention. Participant F, motivated by his friend's story, seems to have adopted this *"rule,"* although he had never experienced wait times at the ER. Participants E, H, and F formed some of their perceptions about ER services from other people's stories, showing the relevance of second-hand information in the participants' perception of barriers.

Fear of burdening the system: Sometimes, an apprehension about wait time is not the only reason to avoid accessing ER services. For example, participant A felt guilty when he once went to the ER only to find out his child's case was not worthy of emergency attention.

> A: You go to emergency services and there is a long wait, and [at] a point sometimes… like you know you feel guilty when you meet the doctor and the doctor says you are fine. Somehow like you know, involuntarily…you are meant to feel guilty…I went there, used the service and there were other people [waiting].

Participant A made it clear that he feels awkward about burdening the healthcare system with his unfounded worries, implying that he does not want to waste health professionals' time while other patients in critical conditions may be waiting. He wanted to make sure that the case is always worthy of emergency attention. Participant A further shared his experience:

> A: My daughter regularly has nose bleeds. When she had her nose bleed for the first time, we were very concerned, but when we reached the emergency, we were told that it was a common issue here. We were given some basic measures that could be taken such as using a humidifier. Although nothing was said by the staff, but we felt little uncomfortable with the whole situation.

Participant A was particular in saying that no one at the ER criticized him for bringing his child to the ER for such a trivial issue. However, he felt that one should only access the ER when it is necessary. This made me ask this question, how do the participants make the decision to go to the ER?

I observed that some of the participants tried to assess their children's health situation based on their basic health knowledge. After making an initial assessment, they decided whether to take their children to the ER or not. They simply did not want to experience wait times or to overburden the system. For example, participant C once took one of his children to the ER but soon afterward observed that the child was not complaining at all: *"Once I see that he is safe and he can wait for a long time, that means he is okay, and I go home and give him Tylenol… I just walk away."* C walked away as he did not want to use the service for a trivial issue. He did not feel as much guilt as participant A but the intention not to overburden the system was clearly noticeable in C's narrative. As participant E put it: *"You don't burden somebody again and again."*

4.3.2 Difficulties in Navigating Healthcare

The participants' accounts indicate that these newcomers experienced difficulties navigating healthcare services for two reasons. First, they acknowledged that they had a limited understanding of local healthcare and other children's services when they arrived in St. John's. However, the situation did not improve much, even in the following months, as they did not receive significant information support. Second, the participants feel disinterested in browsing websites for information, as they find it difficult to find credible and updated sources of relevant information. Below, I discussed these two disabling factors in accordance with the participants' accounts.

4.3.2.1 Lack of Knowledge

Being newcomers, international students usually have a limited understanding of local health services. Some participants even admitted that they knew nothing about how the local healthcare system worked when they arrived. For example, participant D highlighted, she knew almost nothing about how healthcare operates in Canada, and that is why she feels uneasy in navigating hospitals and other clinical services. *"Probably because I come from another country, I do not know this kind of stuff. They said you have to do this or something else, and that is what I did."* In the first years of her stay in the province, she looked for informational support and guidance to navigate healthcare, however she could not find professional guidance. She listened to other students' advice without knowing the accuracy of such information. With time, she finally made some friends at the university who helped her with information on supports and services. She is mostly dependent on her friends (who are mostly international student parents) for informational support: *“Now I have some friends with children, and they provide me some information.”* However, she still feels the need for professional help who could help her navigate the system efficiently.

Referring to the same concern, participants E and B expressed that they expected more informational support from the university. Both participant E and B asserted that the university should guide international student parents in navigating health services and provide information about not only healthcare services, but also *"the social supports for the kids, either it is a childcare or …other programs."* E felt totally "lost" for not finding anyone who could provide such information when she arrived. While B also remarked that the university should take more responsibility: *"I do not think there was any kind of [informational support] inside the university, directing the students and the parents for any health services. No, I do not think there was any kind of [such informational] support"*.

It is to be noted that participant B did not complain about the availability of programs or services for children. She was asserting her belief that information on such services had not been readily available for them. The university offers services to parenting students, such as daycare and counselling services through the student parents resource center. However, in this case, participant B did not know about the existence of relevant health services in the first few months of her arrival in St. John’s. For example, she did not know about the immunization program for children run by the community health nurses at local immunization clinics. She expected to receive children’s healthcare related information from the university during the orientation program. However, she claimed to have not received such informational support. She later learned about such program from a classmate. Participant B simply said, *“At the beginning, it was difficult, because we didn’t know anything.”*

Similarly, participant F stressed that he did not have a clear idea about how to communicate with healthcare service providers. He asserted that he had less access to information, which often made him confused about where to seek help. The story he shared happened at the time of the birth of his second child. They had missed a couple of immunization dates for their child. F was very particular about mentioning that he did not know where to go for vaccinations or whom to ask: *"I was like I wasn't sure where to go or what to do to cover up this immunization because the communication was disconnected with the nurse."* F made it clear that the nurse at the maternity ward played a significant role in helping him and his wife learn about services and support. That is why he felt worried and disconnected when he could not communicate with the nurse again. Seeing no other alternative, F immediately contacted his family physician who provided him with some information on how to get nursing support. When I asked F why he did not look up websites to find a contact number. He said he could not get the exact keywords to begin his search: *“Yeah like I tried to find it in internet. I figured out most of the information might be available but the key word [the website] uses, the phrasing it uses, was not understandable for general people.”*

Participants expected to receive information about Child health services and supports from the Internationalization Office at MUN. One of their roles is to provide informational support to international students. For example, participant E said,

> E: For social support, when I attended the internationalization office session here, really do not remember them mentioning anything about social supports for the students who are having families with kids of course. I really do not remember.

During the interview, participant E tried several times to remember whether she heard anything on parenting support in the Internationalization Office session. She apologetically said: *"I really cannot remember…What I know that there are not much social supports [available] for the kids… from the university."* It is interesting to note how E constructed her perception. E’s personal evaluation of the Internationalization Office session was not positive, as she thought she did not get the required information from the session organizers. This made her believe that there were not many services offered to parenting students by the university.

Perceived unavailability of services sometimes leads international students to seek help in unconventional places. For example, participant B highlighted the challenges she faced when her child developed cognitive and muscular development issues. However, being a newcomer, she had minimal knowledge about the local healthcare system*: “At the beginning, it was difficult, because we did not know anything… [I was] a brand-new graduate student, and that time there was no anyone directing us for any health services”.* Finding no other option, she asked her academic supervisor to help her find a specialist for her child. As she came from a privatized healthcare system, she did not know that referrals must come from the family doctor. Participant B was very stressed and unable to do her academic work without knowing where to seek help, as at that point, she did not even have a family doctor. She mentioned how she and her husband were so concerned and stressed, unable to fix any course of action:

> B: My daughter was not talking or walking until two years and we did not really know where to ask… what is the problem, where we should go. I remember that I asked my supervisor, I told my supervisor and then she said… you should go to hospital and check her in … [you see] I had to go and ask her. Nobody was directing us.

Participant H's story was not significantly different from B. A few months after their arrival in St. John's, her child woke up in the middle of the night and complained about some severe pain in her ear. H, being a newcomer, had a vague idea about what to do in that situation. She thought about the ER but did not know where it was located. Then, out of desperation, she called one of her classmates and woke him up in the middle of the night. H said: *"I haven't heard about [Janeway children's hospital] before that…"* She even asked him for directions on how to get there. These two examples demonstrate in what ways international student parents often seek help when they do not have adequate information about the services and supports in the area.

While exploring the theme it became evident that international students have less access to information related to healthcare resources. They know that necessary services exist, but they do not know how to look for them. They look for reliable sources, sometimes in unlikely places, to find the right information. In the next theme, we will discuss a reason behind this perceived lack of knowledge.

4.3.2.2 Discomfort in Browsing Websites

I assumed, before the interviews, that there should be adequate information available online for international students concerning healthcare and other supports; and that healthcare and support providers' websites would be a good source of information. To my surprise, most of the participants highlighted that they were not comfortable browsing websites to search for health information. Some of the participants' experiences detailed below explained the reasons for this discomfort:

Confusion and Feeling Lost: Many participants could not help but express their exasperation regarding the unfriendly nature of healthcare websites. According to some of the participants, finding the exact information could be challenging for beginners, which is mostly a navigational issue. For example, participant D felt confused, seeing the amount and variety of information on service providers' websites. She could not locate the information she was seeking.

> D: The first website that I, I mean the first online resource that I looked is the MUN site and the childcare but that didn't work...I have got some information from government websites but I find it a little bit difficult [to navigate], [these are] confusing websites!

Such confusion was felt by other participants too. Participant G had felt *"lost"* trying to retrieve relevant information from the complex websites. I was particularly mindful of these two words, *"confusion"* and *"lost"* said by D and G. One participant, feeling discomfort in browsing websites commented, “*it won’t tell you everything.”* Participant B thinks some information is not meant to be found in websites. One participant expressed feeling uncomfortable browsing the website because she believed herself to be *“not a technical person.”* Knowing how to navigate healthcare websites could have helped these participants, in this regard.

Vocabulary issues: Some participants also mentioned vocabulary issues, as they had problems finding the exact keyword to start searching. Participant F explained the difficulties in navigating websites, as the English terms used in Canada as keywords might be different from the words used for the same thing in his native country. As an example, he referred to the word *“immunization”:*

> F: There is another English word like this [in my country] and we probably use that word, not immunization. We call it vaccination. Now, if I try to search for vaccination in all Canadian websites, I might not get anything. So, there might be a better way.

This is a practical problem, being a newcomer myself, I have dealt with similar problems too. Coming from South Asia, I know we may have words for things that are not used in North America. For example, we call eggplant brinjal which is basically an unused and unknown word for North Americans.

Update Issue: Some participants believe that service providers do not regularly update their websites. While commenting on the quality of local websites on health services, participant H mentioned:

> H: Sometimes [service providers] phone numbers are not updated, sometimes their office hours are not updated, sometimes they do not provide winter office hours –those things are not taken care of.

Instead of surfing websites, participant H believes that it is better to *“have a friend full of information.”* She believes that having an extended social network is beneficial for newcomers. She could not imagine wasting her time due to some misleading information. She would feel more confident if the information is updated and posted regularly.

4.3.3 Limited Social Interaction

Most of the participants indicated that they did not get many opportunities to interact and socialize with the local people. As a result, they do not receive adequate informational support from people who know the local healthcare system better than newcomers. An analysis of the data indicates that there could be three reasons for this phenomenon. First, *Language difficulty* as spouses’ difficulty in speaking English comes as a hindrance to their ability to access healthcare providers. Second, *compatriot affinity* where some participants expressed a strong sense of affiliation to their compatriots living in St. John’s. Although having such cultural affinity has benefits, it could limit their interactions with people from other cultures, such as the locals. Third, *experiencing role conflict* as managing conflicting roles and responsibilities often rob them of spare time, which they consider is a barrier to social interaction. I discussed these themes below:

4.3.3.1 Language Difficulty

Lack of language fluency is another barrier to access. According to some participants, spouses of many international students have difficulty speaking English, which makes them stay home rather than going out and participating in local activities. For instance, participant F thinks that his spouse's inability to speak English fluently creates a communication barrier when interacting with healthcare providers. His wife cannot take their children to the healthcare providers by herself. F said,

> F: My wife doesn't speak English that well. She cannot grasp things well…whenever we need to go and get some support, I must be there… I must go everywhere with my daughter even if my wife is still available, free. She cannot avail it…because of the language barrier.

F finds it inconvenient for the entire family that only one of the parents has limited language skills. He thinks it would have been better if his wife could learn English and communicate with their children's healthcare providers. It would empower his spouse, making her more comfortable in interacting with locals. He gave his example, mentioning what enabled him to communicate with others:

> F: I speak English. I can communicate. That is why many positive things happen to me. It might not be the case if I did not speak the language… if I do not have the ability to communicate with the service providers… [It is a] problem!

F realizes that parents must understand what doctors, or any health professionals say. However, his wife's difficulty speaking and understanding English prevents her from communicating with others, especially with local networks and potential supports.

This language issue was further discussed by participant G, as his wife does not speak English either. Like participant F, G also realizes the importance of learning

English for his partner. G wants his wife to learn the language so that she can communicate with healthcare providers. However, G recognizes that he does not have enough time for family chores, and his wife must take care of most parenting and household works. Both he and his wife feel the importance of having some free time to develop her English skills.

> G: If I get my child to childcare, my wife will get time to engage in the community and learn more and improve her language. Now, she must stay at home with the children. [Having spare time is] a very important point for us.

The family tried daycare to fill this desire but found the service too expensive. G expressed his disappointment and asserted that if daycare facilities were more affordable, spouses of immigrants or international students would have more time to attend language classes. Overcoming the language barrier would have allowed them to interact with the local population and would help them make friends and feel better integrated within the local community.

4.3.3.2 Compatriot Affinity

The participants asserted their willingness to interact with compatriots more than the local people. Many participants believe that people from their own country and culture understand their family matters better than the local native population. Such beliefs are personal, yet they have a profound influence on the way they think. For example, participant D, when she and her ten-year-old son came to St. John’s for the first time, it was all new to them, and they had no friends or family members to help them settle in the new city. Her feeling of loneliness as a parent was echoed in the following account:

> D: When I first came here, yes. I really needed [daycare]. I was here studying. I was very worried about where my son would be when he finishes school as I had classes. My husband was not with me about that time because he was still working in our country. We were alone...

However, she could not get her child into any daycare, as daycares would not usually accept children ten or older. She then asked one of her neighbors if she could pay them to babysit her child. The neighbor declined the request in not very friendly terms: *"It was a hard experience for me. Probably the person who gave me the information was a little bit, well not very supportive."* Judging from this personal encounter, she became somewhat apprehensive when communicating with locals. However, later, she connected with people from her own country, who happened to be close neighbors.

> D: It was good because I had the neighbourhood with the same situation. I had a neighbour who was from the same country. We are Mexicans and they were Mexicans too and I tell then the situation and they say oh! The kid can be with us and if you are in school and you can not take care of your kid, he can be with us. So, that was very good.

D further pointed out why being Mexican, and especially speaking the same language, added more value to this other neighbor's ongoing support with her child, highlighting that sharing the same cultural background might play a significant role in understanding each other. What D does not seem to recognize is that her different cultural background did not allow her to consider that it is unreasonable to expect that a total stranger would assume responsibility for caring for a child. On the other hand, this could also be due to the liability issue that made the neighbor feel disinterested in taking up the responsibility. The neighbor might have been standing in *loco parentis*, realizing the nature of duties and the seriousness of the task of caring for children.

Another participant asserted why having a shared cultural background plays a pivotal role. According to participant H: *"People often seek support from their network as in most cases, sharing the same nationality provides the comfort of sharing the same culture and language."*

In a similar tone, participant G asserted that his social network mainly consists of compatriots who belong to the same culture as him. G said: *"Most of this information I get from my friends…They are Syrians. When I came here, they were here…"* He further indicated that communicating through the same culture can be a critical element in his idea of social interaction. Also, from other comments that he made, I realized that he almost certainly believes that he is unlikely to make non-Arab friends. In his case, having a similar cultural identity plays a crucial role in making bonds with people.

While investigating, Participant C offered a different perspective on why many international students have fewer interactions with the local people. The following conversation unfolds around this observation:

> Abdullah: What do you do when you and your wife both must go somewhere [class or part-time job]. What do you do with your children then?

> C: We rely on friends.
>
> Abdullah: Friends mean neighbors?
>
> C: No, just friends…mostly from university. And mostly friends from back home or backcountry, you know.
>
> Abdullah: What about the local people?
>
> C: No, not yet. I have not tried them as I do not see them out.

C pointed out that he mostly relies on his friends at the university and from his own country. I have observed that MUN's international student community is a small, close-knit community compared to the province's greater student community. C seemed to be quite reserved when it comes to making friends outside of his nationality.

Building social networks demands time and effort. In the previous sections, I have discussed two reasons that hindered the participants from getting more actively involved with their social network which could provide both instrumental and informational supports to them. In the next section, I discussed how managing different role responsibilities curtails their motivation for building a healthy social network.

4.3.3.3 Managing Conflicting Roles as a Constraint

As evident in most of the interviews, student parents often feel overwhelmed in managing conflicting responsibilities attached to their different roles (e.g., parent, student, worker). Their accounts demonstrate how they feel about their struggles to fulfill their responsibilities and how busy schedules keep them away from social interactions with others. The participants reported to have prioritized parenting over other responsibilities, often sacrificing time that could be used to build their social network.

Participants H and E provided a snapshot of how they manage their roles in their busy schedules, sometimes sacrificing some of their other commitments and allowing limited time to socialize with others or to have some free time for themselves:

> H: I always prioritize my child's needs. I often even skip many social events to prioritize my child's programs or schedule. Sometimes my academic tasks like assignments and paper submission get affected by this. I try to work on this late-night when my child has slept. This is how I manage and balance my study and my parenting.

In general, the participants reported that they realize the importance of engagement in social activities, as such engagement could help them develop new relationships and acquire communication skills. However, participant H deprioritized social interaction, considering it an acceptable means of balancing her study and parenting roles.

Participant E mentioned that living like a single parent (as her husband lives abroad) adds more stress to the role of parenting. She, too, like participant H, curtailed her time for social interactions to accommodate other priorities.

> E: Being a single parent of two sons, it is extremely difficult, I go through an extremely busy and difficult routine to manage everything single-handedly… [What] I totally ignore is myself; I have no social life…The price I pay was in the form of [sacrificing] my personal and social life.

Participant E further expressed how she felt about fulfilling her different responsibilities. She acknowledges that she has at least three roles to perform: a mother, a breadwinner, and a student all at the same time. She shared the toll that the different responsibilities have on a student-parent like her.

> E: Everybody here is overburdened, either with studies or with chores or kids or anything ...I am studying, and I have lots and lots of commitments, I cannot afford to have my children at home. So, them going to school is a blessing for me because when he is in school, I can fulfil my commitments, I can go anywhere I wish, because being single here, you have to take care of many things. So, I have a jam-packed schedule.

Her story shows that E feels relaxed when her children are at school, considering it a *"blessing"* for her. Throughout the interview, E indicates that although she would love to spend more time with her children, the commitments of being a mother, student and breadwinner are not letting her enjoy quality time with them as she is always busy managing her conflicting roles. Her account undoubtedly reflected her daily struggles, which are also present in the accounts of other participants, such as D and F.

Both participants D and F clearly expressed that they do not have adequate time for socializing. D said it plainly, *“I do not have much time to interact with people mostly.”* Similarly, F admitted that his life has become so busy that he hardly has time to socialize with his friends. F emphasized that he misses his social life for committing more time to his studies and parenting tasks:

> F: The other thing missing is that more social interaction with the parents of children are [needed]... When I am saying social support, it is not the

> money, it is not the other facilities, but it is the way people interact with each other more. Life is so busy now.

F finds his work schedule so busy that he often thinks it is even challenging to accompany his child to the doctor. He would need to set aside his work priorities, disrupting his daily work routine: *"So, whenever we need to go and get some support, I have to be there. I must cancel my appointments or my studies... It hampers. I have to go everywhere with my daughter".* It seems like these conflicting responsibilities have become a source of stress for him. Previously, participant F mentioned that his spouse has a limited command in English, which makes it difficult for her to take their child to clinics. Managing different responsibilities keeps participant F occupied most of the time.

However, participant A thinks his life would be more comfortable if all healthcare service providers had flexible hours of operation: *"Doctors' office is usually at the same time as the regular office…it is always a challenge that you know if you have a doctor's visit for a child then probably your half day is gone. Half workday is gone!"* He feels that the solution should come from service providers, recognizing the needs of parenting students: *"If there are some extended hours, it would be really helpful."*

4.3.4 Policies Regarding Daycare Services

Most participants reported that they had found daycare costs unaffordable for them. With limited working hours, income, and an obligation to pay a higher tuition fee than local students, these participants feel that the costs of necessary services like daycare should not be a burden. For example, participant C said, *"The childcare if you mean, no way it is a cheap thing. No, it is not. It is a burden, too much of a burden."* Therefore, both C and his spouse try to stay at home most of the time, to take care of their children, curtailing social interactions with friends and colleagues.

Participant E once had tried to admit one of her children into daycare. She felt that she ought to receive a subsidized offer for daycare services, given that she looks after two children alone with a limited income. However, after learning about the cost, she became utterly disappointed. She said in a disheartened voice: *"But if you talk about childcare, [it is] extremely expensive and if you are not getting a subsidy for that...You cannot afford it; it is too much. Very expensive."* She applied for a subsidy and put in an application, mentioning her financial and living conditions. E thinks that although she is married, she lives like a single mother in Canada, as E's husband works in another country. She applied and hoped to get the subsidy, but her application was rejected. Her story gives us an idea about her economic challenges and why a daycare subsidy would be a solution to her problems:

> E: They rejected the [request for] subsidy…Even though we kept on telling them what salary [the husband] is getting from there, just barely enough to you know just to bear my expenditure, for my tuition fee, my living [cost], grocery [cost] and he has to live over there as well and he has to send some money to his parents as well. We have like three houses running at a time.

E believes that the daycare authority should have considered her case. Her husband works in a foreign country and sends money to her every month. However, he also needs to spend a significant portion of his income on his parents living in Pakistan as they have no income of their own. As a result, E must take a significant amount of the financial burden to look after herself and the children in St. John’s.

Participant B and G both shared their deep concerns that daycare costs are not realistic for student-parents. They could not afford to take their children to daycare. B indicated that due to fewer working hours, international students could not earn as much as local students by working: *“It [Daycare service] is very expensive…I think it is way too high.”* Participant G said:

> G: Childcare is not affordable for the international students, it is a big problem... my daughter, her age is four now, there is no daycare support, I mean there is a daycare that is very expensive for me. I cannot afford the price so...in future if there is any daycare with reasonable price or any support it will be very helpful.”

4.3.5 Summary

The participants’ constructions of perceived barriers to access include socio-environmental circumstances in which these international students live, work, and study. First, they are newcomers, mostly coming from countries with privatized healthcare. They are not familiar with the workings of universal healthcare, which often has higher wait times. Experiencing wait time sometimes becomes overwhelming, as a result, many international students consider it a significant barrier to access.

Due to their own or their spouse’s lack of language proficiency they often face difficulties when communicating with their children’s healthcare providers. However, even families that do not have language issues appeared to have inadequate knowledge regarding available services, especially during the first couple of years.

One of the problems is the difficulty of accessing health information from the websites of service providers. Many of the participants mentioned that websites often do not have updated information, nor did they have a clear understanding of how to navigate the local healthcare system and supports.

Living in a world full of unique challenges, these students need customized support as their inquiries often require a detailed understanding of their circumstances. It is also evident, from the data, that parents sometimes did receive health information from their friends, but the extent of their social network is limited as they have minimal contact with the local population. These international student parents often get overwhelmed with their conflicting responsibilities and spend less social time participating in local activities, programs, and social events. As a result, they end up having fewer local friends in their network.

Finally, affordability becomes an issue when they wish to avail of non-medical support such as daycare. Most of these newcomer students have a limited income as they are paying much higher tuition fees and the funds they bring with them often fall short, due to encountering sudden and unexpected life challenges. Below is the summary of perceived barriers to access:

Table 4- 3: *Summary of perceived barriers to access*

Perceived Barriers to Access	Researcher’s Comment

Wait time • Medical appointment • Emergency Room	Wait time for seeing healthcare providers, both primary healthcare and referrals to specialists, were considered a barrier to access. They also found stressful wait times at emergency services. However, this construction seems to be often influenced by stories they have heard. They were concerned about the immediate and long-term consequences for children. In addition to this, the participants were new to the universal healthcare system in Canada. Their point of reference was immediate access to private services, when needed, in a two-tiered healthcare system in their home countries.
Difficulty in navigating health services • Lack of knowledge • Unfriendly websites	During their first year, students reported having inadequate knowledge about health and support services. Added to their lack of communication with the local population, they have problems navigating the healthcare system and other support systems for their children. Also, many of the participants found healthcare websites confusing and lacked updated information.
Less social interaction • Language difficulty • Constraining roles • Compatriot affinity	Due to language barriers, especially in stay-home partners, and a lack of time for socializing resulted in limited interaction with peers and locals. Needing to carry out conflicting roles and responsibilities, participants face difficulties in managing time for their families. Cultural affinity makes easier socialization with compatriots, also limiting interaction with locals.
Policy issue • Lack of affordable daycare policy	Participants find the cost of daycare services unaffordable, as they live on a limited income. Family-friendly policies, such as affordable childcare and support for children's participation in sports and recreational activities, may allow these families to better integrate into local society, as indicated by the participants.

4.4 Participants' Constructions of Facilitators for Access

In the following section, I described themes concerning the participants' constructions of facilitators for access. Based on their accounts, I organized themes associated with the facilitators: a) professionalism in service delivery, b) adequate play resources in waiting areas for children, and c) culturally sensitive health professionals.

4.4.1 Professionalism in Service Delivery

Despite expressing concerns about healthcare wait time, participants indicated that they felt confident about the quality of care they received from healthcare professionals. The participants believe that the quality of care is interwoven with professionalism. Several participants revealed that they liked how service providers treated them professionally, especially physicians and nurses. The participants expressed that their physicians warmly interacted with them, listened to their queries, and acted within the shortest possible time. Hospital nurses played a significant role in bringing positivity, too. Due to language barriers, many international students do not understand medical terms. On many occasions, nurses came to the rescue, explaining medical issues in a comprehensive, yet simple, language. Such empathetic treatment made a positive impact on the participants. Below I discussed these observations with quotes from the transcript.

Informational support by nurses: When participant A was having his second child, his wife faced some complications, which required surgery. A was immensely worried and could not figure out what to do. He went with his wife to the hospital, where he found that the nurses were very welcoming and kept him posted about his wife's condition regularly, repeatedly assuring him that all was well with his wife. Their empathic attitude and words relieved A.

> A: We got good support from the staff and from nurses. As you know, the nurses were very reassuring like I was sitting with my wife like late night…then the nurse came in and said, no she is fine, and you can take a rest and come back tomorrow morning or something like that. You know, I did not need to stay there.

Providing updates to a patient's family might be a regular task for a nurse, but it must have been uttered in a comforting way, to help A feel assured. Participant A further shared another experience when he and his wife consulted with their child's physician. The couple did not clearly understand what the doctor explained to them, however, the accompanying nurse explained the child's health issues in plain words, which helped A and his wife to take further action.

> A: They [the doctors] checked her eyesight and everything and it was there, we learned that my child had some eye issues… the nurse there told us that she was reading the bigger letters fine, but for smaller letters there are some issues and then we decided to follow up with a doctor… the doctor suggested a correction for her eyes.

When A shared the story, he was very particular about mentioning how the nurse helped him understand his child's problem. A's experience with nurses was so positive that after a year, when his wife was pregnant again, he consulted a nurse using the 811-help line. At first, he was not sure about using this service, which indicated his lack of familiarity with the local healthcare system, however, he found relief using the help line service. His account further shows how the services provided by nurses helped him to follow up with the delicate condition of this pregnancy:

> A: When we were expecting our third child, some of the people in the community suggested that we can use nurse's service, like you know calling a nurse [811 helpline] …they take down all the information and they suggest [whether] you could go to the emergency. So that was an option we used during my wife's third pregnancy.

Some participants, such as F, also consider support from medical staff extremely important in the healthcare system. In participant F's case, he received adequate support from the hospital when his wife became pregnant with their child and started having some complications. His wife was admitted to the hospital, which was a great relief for the family. The doctors and other medical staff came to assist him and the family, explaining during the interview that *"…it was really complicated pregnancy for my wife and [she] ended up getting tremendous support from the hospital."* I asked F what was so special about the help he received. According to him, the doctors helped him, and his wife, make an informed decision. The support was available to the family throughout the pregnancy and the delivery:

> F: They took care of everything and one very positive thing I would like to mention, [is] that I never have to worry about…It was all taken care of…I [had] very minimal decisions to take…They give a very good support to me and my family…We didn't have car at the time, and they helped us in

> transportation not only for my daughter but also for all of my family to go to home and come back to [the] hospital…And they kept in touch with us if we needed more support than that. So, these are all very positive experiences...

F emphasized how he never had to worry after taking his pregnant wife to the hospital. The doctor and other medical staff provided adequate care to his wife, gave informational support to him, and even offered the family a ride home. On another occasion, F's wife needed some support from local parenting groups, but she did not know whom she should contact. She decided to approach her physician: *"We received the pregnancy information for the first time from my doctor. Then the doctor referred [us] to some other agencies who then came to us. And then we got to know."* Such informational support facilitated F and his wife to navigate the support system efficiently.

Competent Professionals: The participants felt that healthcare professionals were competent in delivering their services. For example, participant C said: *"Yeah most of the time they are doing their best. That is what I experienced. They always care [for] the patients; they always explain everything. They are so helpful."* Participant C indicated that the physician who takes the time to explain in detail the medical issue with his/her patient provides a quality service.

Participants G and H further added another attribute that they believe a quality health service provider should have – the willingness to listen to the patients. *"They listen to us,"* both participants asserted. Participant H even provided an example. She visited a physician when her child had an ear infection and liked the way the doctor listened to her and clarified everything in a friendly manner, explaining in plain language the child's health issue: *"He [the doctor] explained to me very well [the problem] and suggested ... what to do in the future. That is…[what] I need from the service providers…That was a good suggestion."*

Another aspect of services that the participants liked is how health professionals investigate the relationship between the issue and the possible factors that may have contributed. For example, participant E remembered the incident when her child complained about a stomach-ache, so she took him to a clinic. After making an initial assessment, the physician did not find anything physical that might be causing the pain. However, the doctor did not give up. At some point, the doctor noticed that the child was exhibiting signs of anxiety when talking about school. Such a line of investigation immediately impressed participant E. She insisted that physicians diagnose a health problem using a holistic approach, not merely looking at the obvious.

> E: When I googled online, I found out that stomach-ache is also related to anxiety. So, she [the doctor] was good, you know, in the diagnosis. That was not only about what he eats or what he drinks, it was not something like that, it is related to some psychological or emotional issue as well. So, she diagnosed it.

Such positive experience with the physician made her say, *"I am pretty confident that the doctor I consulted for my kids and for myself...I am confident [in receiving quality health service] ...I am lucky to have her as my doctor."*

In addition to thorough investigation, sometimes child health service providers adopt strategies to break the ice with the child. When F took his daughter to the immunization center, his child was somber at first, but soon she was in a great mood when someone from the staff presented her with a gift. Both F and his daughter were highly impressed with such a welcoming attitude. He shared the story with a tone of amazement: *"At immunization, they provide gifts to the children. They are very friendly with the children. You know, they play with the children."* He compared this attitude with what he experienced in his home country, where he might not have seen similar strategies to make children feel comfortable with their surroundings. F was outspoken about the benefits of such a child-friendly attitude in delivering healthcare services to children. He considers it an effective strategy to lessen children's apprehensions and fears in visiting hospitals or clinics.

While discussing how supportive healthcare providers were to her child, participant D used the word friendly to express her notions. Initially, she was worried about her son being hyperactive all the time. She hesitated to share this with teachers and staff at her child's school, not knowing how they would react to it. However, she later found that the teachers and the staff were very supportive of her child. They assured her, saying, *"It is okay, do not worry, we have people who can manage that, we have professionals."* Learning that the school had resources and trained personnel to take care of her child's issue boosted D's confidence. She further appreciated service providers' empathetic attitude: *"they were actually very kind with us…".*

Other participants also praised such types of supportive attitudes among daycare staff. Although E’s child was at the daycare for only a couple of days, she lamented that she had to pull the child out because of the cost. She thought that the service they provided was excellent and her child loved his time with other children at the daycare: *“My kid was really happy and the officials over there, you know the teachers... they were quite friendly, quite loving, caring, everything. The only reason I had to pull my kid [out] was money”*.

Proactiveness: Proactive support was another attribute observed by some of the participants. For example, participant C mentioned a positive experience with his children’s daycare provider. Once, one of his children experienced some health issues at the daycare, and the staff there quickly noticed it and informed the parent without delay. Such pro-activeness and swiftness shown by the daycare staff impressed participant C to a great extent:

> C: They [daycare staff] came to talk to me about it. And they told me what to do, to whom I should go. So, we [him and his child] went to talk to the family physician and she referred me to the development specialist... The daycare helped me … describing the situation that my kid [was going through]. So, for me the experience was so helpful, they helped me. They even described [it to the doctors] what has happened [with my child].

C clearly showed signs of satisfaction when speaking about the smooth, coordinated work between the daycare staff and the healthcare provider. She indicated that coordination in service providers is critical to enhancing access to health resources.

4.4.2 Child-friendly Arrangements in Waiting Areas

The participants perceived child-friendly arrangements in waiting areas in clinics and hospitals as an enabling factor to access. They highlighted their experience of how children could get bored and sometimes uncontrollable while waiting at clinics and hospitals. The participants found that waiting areas with activities can positively distract their children. They further believe that such positive distraction has a beneficial effect on their children. For example, participant F thinks that a waiting area with children's activities had a psychological impact on his children, believing a welcoming and child-appropriate environment can make children feel relaxed, free of apprehensions and fears while waiting to receive treatment: *"[Because of the child-friendly setting] children enjoyed the place…[If] they provide gifts to the children…Children are not afraid of going to doctors."* Participants A, B, and F commended their service providers' offices and their activities for children. Participant A spoke positively about the interior of the dietitian's office he visited a few months ago. He was overall satisfied with the arrangement, especially providing *"quality engaging educational resources for children,"* something he would recommend for other service providers. Participant B also described her family doctor's setting, and the sort of resources parents with children would usually look for in a clinician's office:

> B: In the waiting room, there is a TV, and their TV has children’s channel, which is good. During the waiting time they can watch the program and there are definitely children’s small desks with the papers, with toys, and

> papers with pictures and pencils and crayons with what the children can draw and paint…Those facilities are definitely good…

Participant C and H added that educational toys and resources for drawing and painting help children stay busy while they wait; TVs with children's educational programs also help them positively distract their attention. C remarked: *"You know the movies that they show on the TV for kids, kids [who are] younger they loved it."* C further indicated that a child-friendly setting in the office that provides healthcare support to his children reflected a cheerful child-appropriate sense of the place.

> C: I have seen them that [the services]. They [healthcare professionals] care about the appearance of the place, those fancy art of the cartoon characters, I have seen it everywhere. I have seen that they care about the children. You would have the feeling that the place you are going to [is] a child caring place. So, mostly yes.

This point was further raised by participant H, who found especially welcoming *"child-friendly environments"* in some healthcare facilities for children. The participant discussed what she meant by a child-friendly environment:

> H: When they [the children] wait for their service, they [the providers] should have a TV over there, cartoons and other things. They [should] have different animation characters and other things, colorful paintings on the wall…. blank papers, pencils, and colors for children. By the time they are waiting, children can do coloring."

4.4.3 Culturally Sensitive Professionals and Staff

Most of the participants seem to consider local healthcare professionals as being culturally sensitive. Participants reported that service providers not only seem to respect their religious or cultural needs but also help them fulfill their religious commitments. For example, participant E asserted that her religion forbids her from having certain foods and drinks. After coming to Canada, E was concerned about finding food that followed her religious convictions, as she did not want her child to eat something that might not be endorsed by her culture and religion. At the same time, she was filling a daycare application form for her child. She noticed a box section where there were questions about the child's food preferences. She felt that by asking questions concerning food preferences, the daycare exhibited their respect for different religious beliefs and cultural identities: *"They do take care of that. So, they are quite sensitive to our needs, to our culture, and I did not see any discrimination".* Echoing participant E, participant B asserted that Canadians are, in general, very respectful about other cultures.

> B: I would say it is very good, definitely. I will credit it high because my experience [is] that Canadians…are very respectful if we say that health professionals definitely…. Well, if I requested for a female doctor, they would definitely… consider it.

Participant G had similar observations when she brought up having female doctors for female patients. G puts it as a cultural norm: *"This is a problem especially when women need to deliver a baby. Here the doctor can be male or female. But in our culture, it is female mostly."* Like G, participant C seems to believe that Canadian doctors tend to ask about these preferences before attending any patient: *"They would always ask [permission] you know. They would always care, and they would always ask if I have any concerns [for] any cultural or personal sensitive things or issues that should be taken care of"*. Participant C believes that most of the professionals he met so far seemed to be aware of his cultural or religious needs.

> C: The last time when my wife was pregnant and, on the delivery, they asked us: do you have any specific requirements for delivery like would you mind if it would be a man in the room, a male physician or not. So yeah, they do care. They know mostly they are careful about these things. So, they would ask.

Most of the participants seemed to be satisfied with how healthcare professionals respect cultural and religious differences. For example, A said: *"I think people [health professionals] here are very much sensitive to the cultural beliefs of different people. And I do not see any issue with that."* He further explained that when his child was born, he needed to perform the Islamic ritual, Adhan – a call to prayer in front of the newborn.

> A: So, I gave the Adhan in my daughter's ears in the operation theatre, not very loudly of course. People were fine with it and I thought I might be embarrassing or might be little...but people and doctors did not mind. Like they just did their own job.

Participant A indicated that he was feeling uncomfortable in performing this ritual in front of others. Being an international student and especially from a different religious background, he was convinced that others might not understand many of his cultural or religious needs, especially those who were born in western countries. However, when he noticed that nobody in the hospital looked at him with judgement, he instantly felt secured and relaxed. He considers such gesture, however small - a facilitator to access.

4.4.4 Summary

The facilitators to access, as perceived by the participants, seem to have emerged from their satisfaction towards specific attributes and characteristics of pediatric healthcare services. Healthcare professionals' supportive and culturally adept ways of interactions helped the participants form positive opinions about the quality of the services. Also, such an empathetic attitude displayed by the trained healthcare professionals helped the participants feel they had good experiences and helped them deal with some of the barriers they encountered when accessing those services. Although they often had to wait for hours to receive services in the ER, the physicians' professionalism always gave them the confidence that they would receive a quality service. All the participants appreciated the ways doctors and other medical staff greeted them and listened to their queries and showed respect. It indicates that having cultural humility and interpersonal skills is essential for healthcare professionals as it enhances patients' experience. The summary of the discussion concerning the facilitators to access is given below:

Table 4- 4:

Summary of perceived facilitators to access

Perceived Facilitators to Access	Researcher’s Comments
Professionalism in service delivery	The participants felt confident in getting quality service because they found health professionals and support staff friendly, interactive, proactive, and overall supportive in dealing with their children’s issues. Further, service providers demonstrated a coordinated effort, assisting the participants in making informed decisions. The combination of these professional attributes could have positively impacted the participants’ experiences.
Child-friendly arrangements	The participants felt that sick children require positive distraction while waiting at clinics and hospitals. They found the interior decorations of waiting areas for children child-appropriate spaces, with activities for children like toys, books, coloring materials, and welcoming staff who greet children, sometimes with gifts. Such arrangements help children to deal with their apprehensions and fears in visiting healthcare providers.
Culturally adept professionals and support staff	The participants felt a sense of belonging when health professionals respectfully allowed them to meet their cultural or religious commitments. They did not notice any unnecessary gazing from the medical staff, making them feel at ease.

Chapter 5: Discussion & Conclusion

5.1 Discussion

The participants' constructions of barriers and facilitators to accessing child health and social support services go beyond the attributes and characteristics of health services and include their experiences within the socio-environmental circumstances in which they live. In this chapter, I discussed the different environmental levels of influences (Bronfenbrenner, 2005) within which barriers and facilitators are located and how they impact access. The different environmental settings are - individual, interpersonal/community networks, organizational, and Governance/Public Policies. Using force-field analysis visualization techniques developed by Lewin (1951), the figure I created below, maps the barriers and facilitators I identified with reference to the four environmental levels suggested by Bronfenbrenner (2005) in his ecological model.

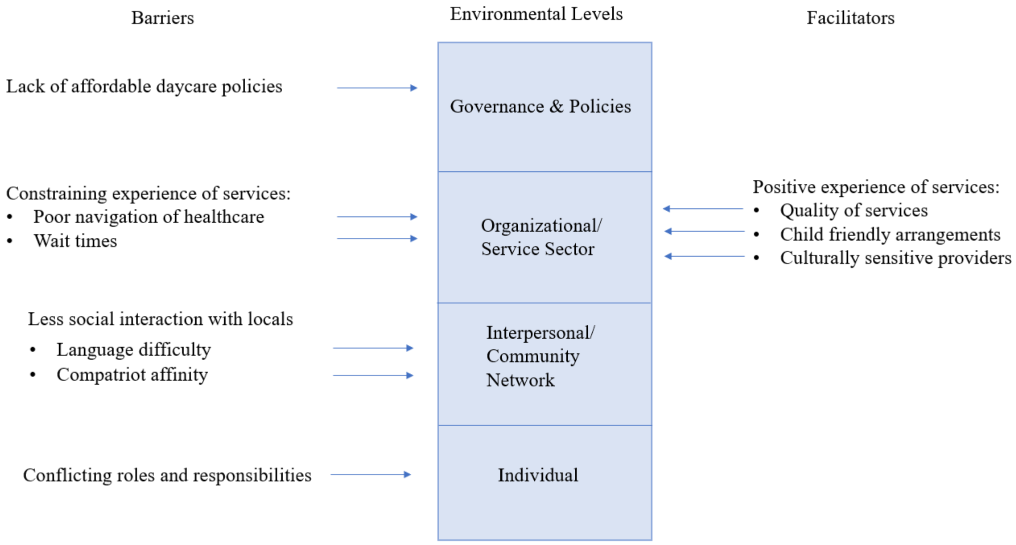

Figure 5. 1: A Force-Field Analysis of the Factors

In the above diagram, we see that the participants' access to child health services and social supports largely depends on how they interact in different social situations within the four environmental levels. These interactions lead to their construction of the barriers and facilitators. Below, I discuss the participants' construction of barriers and facilitators under each of the four environmental levels.

5.1.1 Individual Level

The individual level is the innermost environmental setting in which the participants dwell and is where people try to solve their problems on their own. At this level, the participants tend to internalize their experiences, identify life challenges, and figure out how to deal with them. Many of these life challenges come from the different roles and responsibilities that they encounter in their day-to-day life. The analysis suggests that the ways participants deal with these challenges eventually impact their access to support resources. I have identified that the participants face difficulty in managing different roles–for example of parent, student, employee etc.– that affect their children's access to services. Below I discussed how the participants approach dealing with different conflicting roles and responsibilities affected their access to the social network.

5.1.1.1 Conflicting Roles and Responsibilities

The participants try to respond to certain responsibilities that arise from the roles associated with the statuses they hold. These statuses include that of a student, parent, and employee. Although, participants consider it ethical and moral to prioritize their role as parents, they have other priorities that also require their attention.

Due to financial reasons, and encountering unexpected life challenges, the participants often work part-time jobs to support their families. As a result, they juggle their conflicting roles and responsibilities as parents, and as workers, without exactly knowing how to manage their education at the same time. Participants attempt to balance their time by limiting their interaction with their social network that consists of their friends, colleagues, classmates, support providers, and other people.

By reducing the amount of social interaction, the participants often receive less support. Studies have indicated that regular and meaningful interactions with social networks enhance an individual's access to social resources, which ultimately benefits the whole family (Berkman & Glass, 2000). In addition to this, a healthy social interaction fosters social skills among individuals. Bronfenbrenner (2005) provides evidence in his ecological model that parental interactions with the social network indirectly impact their children's health, well-being, and quality of life. Social interaction with peers, classmates, friends, and support providers also helps children address their social needs (Berkman & Glass, 2000). My research identifies that the participants are reducing their social activities due to their time-consuming involvement with conflicting roles, and to some extent, it affects their children’s well-being. Some of the participants even hinted that, except from taking their children to school and daycare, they could not manage time for social activities for their children. It is their conflicting roles and responsibilities, which make their daily life overwhelming.

There seem to be two explanations for participants experiencing stress due to conflicting roles. The first explanation has to do with their day-to-day finances, and the second has to do with an unexpectedly higher cost of living and restricted working conditions. Before their arrival, international student parents usually budget their finances to meet immigration requirements. However, new needs often arise after moving to Canada. Some participants gave birth to children while in Canada. They experienced the joy of parenthood, but simultaneously they saw a surge in the financial needs associated with child rearing. Children who accompanied them at the time of arrival also grew up during their stay in NL and their needs increased. With this evolving role of a parent, they could not entirely depend on their existing income and funding. Hence, many of the participants, as well as their spouses, try to attain part-time work to meet these additional expenditures.

Mori (2000) identified that international students have restricted working hours and higher tuition fees than domestic students. On top of that, they frequently experience price increases, including increases in their tuition fees and other academic expenses. As time progresses, the funds they brought often fall short. As a result, many international students resort to working off-campus part-time jobs. Just like other residents in the province, the participants of my study also tried to adjust to the growing cost of living. This makes the situation more challenging for them, as they have no other option but to try to increase their income to address their family's growing financial needs.

Encountering financial problems is not uncommon for international students, especially those who maintain a family with children (Myers-Walls et al., 2011). However, it is not that the international student parents are the only ones struggling to maintain a work-family life balance. This phenomenon is also true for local student parents who work part-time jobs to make ends meet. The advantage local students have over the foreign students is that they are familiar with the healthcare system, have a strong connection with the local community, and no restrictions on working hours. As a result, they are more likely to receive adequate information to help them navigate the healthcare system and other social supports.

One way to overcome this issue is by strengthening graduate student parents' social network. However, the hardship of managing time while navigating through conflicting roles and responsibilities do not allow them to be socially active. Overall, dwelling in a busy world surrounded by conflicting roles and responsibilities is one of the barriers to social interaction.

5.1.2 Interpersonal/community level

Participants do not live-in isolation but in social settings. At the interpersonal/community level, the quality of communication one has with the other members of the society play a key role in determining the participants' access to social resources. I have identified that the participants interact less with the locals for two reasons: a) language difficulty and b) cultural affinity with compatriots. In the following section, I discussed how these two factors may limit the participants' access to support.

5.1.2.1 Language Difficulty

Several participants in the study expressed that their spouses often find it challenging to communicate with their children's health service providers. It is mainly because these newcomers either do not speak English or have limited language proficiency. Spouses of many international students often hesitate to take their children to healthcare providers, fearing that they would not be able to understand instructions given by health professionals. It indicates that the availability of informational support may not be the issue always. Service seekers also need to develop their capacity to receive such support. Most of the participants highlighted language difficulty as a disabling factor to access resources. As other studies suggest, language difficulty is common among international students, especially to their spouses who are not students (Myers-Walls, 2011; Smith & Khawaja, 2011).

A study conducted by Newbold (2009) indicates that language barriers come as an impediment to social interaction for newcomers, which may include temporary residents such as international students. Many of these newcomers do not feel comfortable in speaking English due to their limited grasp on the vocabulary. Such inability or discomfort in speaking English often makes their families somewhat isolated from the local community. In my research, I have observed that most of the participants' social relationships are limited to other international students. These students rarely interact with people from the local community. Their unwillingness to be part of the greater community mainly comes from the language barrier. Other studies are in line with this observation where language difficulty is considered one of the major factors impairing international students’ ability to connect with local communities (Doyle et al., 2016; Loveridge et al., 2018; Myers-Walls et al., 2011).

5.1.2.2 Seeking Support from Compatriots only

In the literature review, we have seen that studies recommend newcomers to integrate with the local population and extend their social network. This study has observed another factor that hinders newcomers from accessing the local network at the community level. Some participants believe that people belonging to similar cultures and ethnic backgrounds understand their needs better than the local people. The participants expressed their feeling of cultural affinity towards compatriots, claiming that they feel much more comfortable around them. They seem to place more importance on seeking cultural similarity in people over other considerations.

Cultural affinity makes for easier socialization, which could be considered a favourable driver for newcomers' well-being. However, it limits their social interaction with the local community. We discussed before why it is important to have local people in the social network. Bornstein (2012) asserted that our belief-patterns could influence our ways of social interactions, this includes accessing support. In this case, I have observed how the participants were influenced by their beliefs. Having a strong sense of cultural affinity could be one of the reasons why many of the participants' social relations are exclusively with compatriots. Their strong sense of cultural affinity comes as a hindrance when it comes to interacting with people from the local community.

5.1.3 Organizational level

This is one of the most important environmental level impacting factors for the participants. The participants directly interact with Child health services and social support providers to address their children's needs. At the organizational level, service providers' effectiveness in addressing needs of the families of international students has played an influential role in shaping the participants' access experience. Effectiveness in this regard means how accommodating, qualified, and resourceful health service providers were in delivering the service to the participants. Although participants experienced constraints such as wait time and difficulty accessing information, they expressed their confidence about receiving a quality service. They also felt satisfied with the built environment and resources they have found in hospitals and clinics. I described these attributes at the organizational level below.

5.1.3.1 Wait time & Access to Information

Managing referrals and emergency wait time is mostly an organizational issue. The stakeholders in the Canadian healthcare system are aware of this problem, and they are working to reduce the wait time (Vogel, 2020). However, experiencing wait time can influence an individual’s utilization of healthcare services. One of the common themes that surfaced during the analysis is the participants' experiences of wait time in receiving emergency services or referrals to specialized health services for their children. This observation is in line with the findings from other studies on Canadian immigrant and refugee populations. For example, Campbell et al. (2014) and Asanin & Wilson (2008) demonstrated that newcomers in Canada often find prolonged wait times in receiving desired medical services immensely challenging. Sometimes experiencing such delays makes them doubt the system’s effectiveness in delivering services, making them less confident about receiving the services they seek (Asanin & Wilson, 2008). Some participants did not hide their disappointment on not receiving a timely appointment or referral service for their children's issues. I think that the participants in my study are new to the Canadian healthcare system, they are also new to the universal healthcare concept and the wait time issue associated with it. All of them have come from countries with privatized healthcare systems where there is less wait time for patients. Many participants seemed to feel overwhelmed with encountering wait time for the first time in their lives.

Nonetheless, this is still an issue related to the availability of services. While discussing access, Thomas and Penchansky (1981) emphasized the importance of having an adequate supply of health professionals, service facilities, and care programs for people. Without the availability of resources for the public, access cannot be guaranteed (Khan & Bhardwaj, 1994). Global documents such as WHO's report on early childhood development authored by Siddiqi et al. (2007) collectively state that the provision of support should be readily available for families. There is evidence that the number of overseas students and immigrants has increased significantly in the past few years in the NL (Memorial University of Newfoundland, 2021). Consequently, there is a reason to believe that there has been an increase in demand for health services in the province as well.

Accessing information about service providers did not always come easily for the participants. First, some of them mentioned their difficulties in navigating government/ health service providers’ websites. They often found these websites inadequately updated, sometimes only containing information that was irrelevant to them. This might be true to some extent, but it is also evident from the data that many of these newcomers did not have a clear idea of how to navigate health websites or use an appropriate keyword to begin the search. They felt overwhelmed in accessing these websites and navigating through a myriad of information. Second, many of these participants believe that their cases are unique as they come from different cultures and healthcare systems.

Therefore, they need to understand the ins and outs of the Canadian healthcare system, and the best way to do it is to contact the health agencies directly in person. They prefer to have a personal communication, as we have seen in the data, how participants are appreciative when nurses approached them with informational support. Websites cannot provide such support, as most of the information found on websites deal with general issues. It could be one reason why most of the participants wish to visit service providers in person to get answers to their concerns.

5.1.3.2 Quality Services, Child-Friendly Arrangements & Cultural Sensitivity

The participants' positive experiences have three components: excellence in service, child-friendly arrangements, and cultural sensitivity. In general, the participants were pleased with the quality of the services they received. I have observed that the participants, as they came mostly from developing countries, have preconceived notions about the superiority of Canadian healthcare services. It seems to be almost assumptive from their side to consider Canadian healthcare as one of the world's leading healthcare systems.

When they accessed healthcare in the province, they experienced professionalism in service delivery. Some of the participants in my study mentioned that this professionalism has made them develop a positive attitude towards the services. Their interactions with care providers from immunization to primary healthcare gave them the confidence in receiving a quality service. Studies have confirmed that parental views and attitudes towards healthcare are associated with their children's utilization of healthcare services (Serbin et al., 2014). Therefore, having such confidence is one of the enabling factors for access to pediatric healthcare services.

The child-friendly arrangements in waiting areas have helped the participants view their wait time experiences differently. Activities, child-friendly interiors (i.e., wall paintings), and welcoming attitudes displayed by health professionals have reduced the discomfort during wait times. The participants have observed that children remain calm and happy, if they are occupied with play resources and small gifts while waiting for their turn to see the doctor. The colourful interior and toys allowed children to be more comfortable. Such appreciation of comfortable spaces and child-friendly environments, as highlighted by participants, aligns with the observation with recent studies investigating the influence of the arrangement of waiting areas on children (Corsano et al., 2015; Pati et al., 2011). These authors' research found that the quality of environments and activities for children positively impact the perceptions of wait time among children "by improving environmental attractiveness" (Pati et al., 2011; p. 01). Environmental attractiveness is one reason why the participants have considered child-friendly arrangements as one of the enabling factors to access.

The participants further felt comfortable dealing with health professionals when they were respectful to them and exhibited cultural sensitivity. Interacting with such a culturally sensitive health professional further helped the participants develop a certain sense of belonging. Creating such a sense of belonging is considered essential in bringing down the inequities in health access (Riedel, 1998). Such welcoming and culturally adaptive services have boosted the participants’ confidence, enhancing access to healthcare services. Studies have confirmed that parental views and attitudes towards healthcare are associated with their children's utilization of healthcare services (Serbin et al., 2014). In other words, satisfied parents are more willing to take their children to healthcare services and other support services than parents who are dissatisfied with the quality of services. I think most families of international students are more inclined towards accepting the services rendered by the healthcare system if there is smooth communication between them and the service providers. Therefore, the participants consider having interpersonal communication skills among health professionals to be one of the facilitators to access.

5.1.4 Governance and Policies Level

Governance and policy are at the topmost level of influence, significantly impacting all other environmental levels. Usually, participants do not interact with the policy makers directly, but policies have influence on their experience of support seeking. The participants highlighted a possible link between their families' well-being and the affordability of daycare services. Access to daycare not only provides a group setting environment to children, but also gives parents time to work on developing their skills. The data suggests that affordable daycare services can enhance the children’s engagement with peers. While discussing this level, we will see the implications of daycare policies on the participants' access to social resources.

5.1.4.1 Lack of Policies for Affordable Daycare

Bronfenbrenner (2005) points out that decisions taken by social structures indirectly influence individuals, impacting their perceptions of life and access to resources. In my research, one of the main points highlighted by the participants is the high cost of essential services for children, especially daycare. It indicates that any change in the prices of daycare will require a policy level change.

Even international students' opportunities to work on campus, receive scholarships and other types of financial support are subject to university policies. The participants' access to financial resources largely depends on the policies adopted by the university. The university adopts policies in response to changing scenarios and growing needs. Similarly, student parents' access to daycare also depends on the nature of policies. The current study suggests that present daycare policies are not favourable to parents. As a result, they are finding it difficult to afford daycare services for their children.

Interestingly, this broader environmental level is so influential that it impacts an individual's access to skill development programs. For example, we have previously discussed the importance of spouses of international students joining language classes. The decision to make more language centers for newcomers' families does not come from an individual or organizational level. The decisions must come from the policymakers who work closely with the community leaders. Hence the legislature, community members, and advocacy groups need to push for making such policy changes.

5.2 Conclusion

5.2.1 Concluding Remarks

In the literature review, I demonstrated that due to a lack of research, there is a considerable gap in our understanding of the experiences of international students in accessing child health services and social supports in NL. The study examined the participants' experiences to identify what they encounter as barriers and facilitators in accessing such services. The study revealed some of the ways the participants made sense of their experiences regarding access to child health services and social supports, which are likely to emerge from a complex interplay of behavioral, social, economic, and language factors at different levels of influence. I have demonstrated in the discussion how these factors are all interconnected with each other. For example, the participants' experiences of wait time have been found to be largely shaped by their limited understanding of the Canadian universal healthcare. At the same time, their lack of knowledge about the healthcare has been compounded by their limited interactions with the local support network who could have helped them with informational support.

I have observed that one of the ways newcomer international students can become familiar with the local healthcare system is through enhancing their social network. This can be possible if newcomer international students can have more social interactions with both students and local people. Also, coming from different healthcare systems, international students have a natural tendency to compare Canada's healthcare with that of their home countries. Social interactions and exchange of ideas with their social network can improve these newcomers' understanding of the local healthcare and support systems.

Academic sojourners, when they arrive for the sole purpose of study, expect to receive certain supports that are mostly informational. Therefore, I think by providing these newcomers with adequate informational support, we can facilitate their access to health and other social resources that are available to them. The study identifies that the participants are willing to welcome any instrumental support that may help them enhance their language skills. It indicates that at the interpersonal level, action needs to be taken to help international students and their families to develop their language and communication skills. In the later part of this chapter, I have added two recommendations based on my observation of the data.

5.2.2 Strengths and Limitations of the Study

The study interviewed graduate international student parents coming from different countries in the world. All these participants deliberated about their experiences in accessing child health services and social supports for their children, providing a brief background of their use of such services. My study provided an enhanced understanding of their situations, especially in how they construct their ideas regarding barriers and facilitators to access. It has identified several factors and analyzed how these factors influenced the participants in forming a perspective. My study can serve as a foundation for future research because no such studies have previously been conducted in NL.

The study further shows how academic sojourners' access experience differs from other immigrant groups, acknowledging the unique life situation international students go through. The study highlighted that some of the needs of international student parents are not the same as immigrants and refugees. For example, immigrants may experience conflicting roles, but they have the freedom to work as much as they can. In case of any financial emergency, immigrant, refugee, and citizen student parents can become part-time students working full time to elevate their financial status. However, international students are required to study full-time only. They are not authorized to work off-campus for more than 20 hours a week which contrasts with the experiences of immigrants and refugees who come with full-time work permits (Immigration, Refugees and Citizenship Canada, 2020). International students expect more accessible, subsidized, and readily available child services because they have limited income to support their families. Such simple-looking differences are immensely impactful in shaping academic sojourners' experiences. This study highlights these differences, calling for further investigation in this topic.

The study also reveals some uncommon findings. For example, the impact of others’ stories in forming opinions about the ER seems novel to me as the current literature has mostly overlooked this as a factor. Participants' reluctance to browse websites to seek health information challenges the popular belief that young people are more into technology than older adults. This finding suggests that further research should be conducted on academic sojourners to identify the best ways to disseminate health information.

One of the study's limitations is related to the language that I used in communicating with the participants. Although they could speak English, it is not their native language. On many occasions, I realized that they were having difficulties in expressing their thoughts. I especially noticed how they struggled to express themselves when I asked them to provide a little background to their stories. I often felt that their limited vocabulary might have prevented them from using the right word at the right time.

Lastly, I would like to acknowledge, that being a newcomer myself, I have limited understanding of the Canadian healthcare and social system. This has come as a hindrance in delving deeper into the participants' perspectives, especially during the interview process and at the beginning of the data analysis, which substantially delayed the research process.

5.2.3 Future Directions

The study provides a direction for future research. Firstly, although the study has revealed some unique observations and findings, it did not investigate how the factors impacting access are related to different cultural settings. Using the ecological perspective, further studies can examine these factors within their contextual background to provide a more nuanced understanding of access phenomena. For example, the impact of stories in shaping academic sojourners' perceptions of access has been identified in the research, however, contexts behind forming such stories have not been discussed. Since these stories are embedded in a subtle cultural background, it is important to unfold what role culture plays in influencing the participants' narratives. A cultural study of the experiences of access among international students can reveal new insights.

Secondly, the study did not interview the participants' spouses, though it is essential to capture their voices. Families' access to health resources significantly relies on how partners influence each other in deciding service utilization. Also, the impact of gender on access has not been investigated in this research. Future studies can explore this using a critical feminist framework.

5.2.4 Recommendations

Improvement in ways of disseminating health and social supports information to newcomer student families (pre- and post arrival): The study indicates that many international student parents are inadequately aware of child health services and social supports as perceptual differences and lack of receiving informational support may influence their immediate understanding. Therefore, health related information should be made more accessible and comprehensible to incoming international student parents by the Internationalization Office. During orientation, information provided by the Internationalization Office should include enhanced details of existing child health services and social supports for parenting students. Students should be provided with contacts of resource personnel for queries and parenting concerns, and information should frequently be uploaded to not only the Internationalization Office's (IO) website but to all its social media platforms (e.g., Facebook, Instagram). Professional and personal recommendations should be made available online, creating more user-friendly visual content and infographics. Websites should also have more space for comment sections where people can get socially engaged in virtual discussion. Students should also be encouraged to join local social media groups where they can exchange cultural knowledge with expatriates, other international students with families, and NL residents.

IO can hire current international student parents as part-time moderators for a Facebook group solely dedicated to providing parenting, informational and navigational supports to newcomer international student parents. The moderators will be with diverse backgrounds so that they can represent different ethnic and cultural groups. My research illustrates that many international students prefer to stay in touch with peers belonging to their ethnic and cultural background. Therefore, existing international student parents with experiences of staying longer in the province could be instrumental in understanding needs of other international student parents. Lived experiences of these moderators can illuminate newcomers' understanding of the barriers to and facilitators for access.

Increased social gatherings for families of international students: The study shows that face to face contacts and word of mouth have significant impact on the participants. They prefer to talk about the quality of services with people over navigating health websites. They count on recommendations made by their peers and people who provide support. Consequently, more meet and greet events for new international students arriving with their families would provide a relevant social support in their adaptation process. These family gatherings could include potlucks and cultural activities that accommodate children as well. These gatherings could include active participants' engagement through programmed activities of exchanging stories with one another.

Increased connection with local family networks: This research shows that families tend to remain isolated and that they have limited opportunities to meet local residents. Activities for international student families should include extending invitations to local families with children. The Internationalization Office can arrange for regular and informal meetups between student parents and child health services and social supports providers.

From my own experience as an international student, I opine that the adaptation process to a new environment can be challenging especially with children. However, with increased support and assistance, barriers to access can be addressed and mitigated. I believe that an enhanced level of support to international students will encourage the retention of a skilled labour force and cultural diversity in the province.

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Appendices

Appendix A: Advertisement

Are you an international graduate student with child/children?

Would you like to take part in a research study?

We are looking for people who:

- Are international graduate students with children under 12 years of age and
- Had lived with their children in Newfoundland for at least a year.

We are interested to learn from your experience in accessing child healthcare services and other social supports for children in NL.

For more information about the study or to ask if you can take part, please contact:

Abdullah Omar Saif Email: aosaif@mun.ca Cell: 709-771-3226

If you have ethical concerns about the research, such as your rights as a participant, you may contact the Ethics Office by phone 709-777-6974 or by email at info@hrea.ca.

Appendix B: Ethics Approval Letter

NEWFOUNDLAND AND LABRADOR
HREB
HEALTH RESEARCH ETHICS BOARD

Ethics Office
Suite 200, Eastern Trust Building 95
Bonaventure Avenue
St. John’s, NL A1B 2X5

October 18, 2018
Community Health and Humanities
Faculty of Medicine
Dear Mr. Saif:

Researcher Portal File # 20191782 Reference # 2018.211

RE: "Healthcare and psychosocial well-being among the children of international graduate student parents in Newfoundland "

This will acknowledge receipt of your correspondence dated October 15, 2018. Your application was reviewed by a sub-committee of the Health Research Ethics Board (HREB) via a delegated review process. Your revised application has been reviewed by the Co-Chair under the direction of the HREB. **Ethics approval** of this research study is granted for one year effective October 17, 2018. This ethics approval will be reported to the HREB at the next scheduled meeting.

This is your ethics approval only. Organizational approval may also be required. It is your responsibility to seek the necessary organizational approval from the Regional Health Authority (RHA) or other organization as appropriate. You can refer to the HREA website for further guidance on organizational approvals.

This is to confirm that the HREB reviewed and approved or acknowledged the following documents (as indicated):

- Application, approved
- Research proposal, approved
- Revised interview guide, approved
- Revised consent form dated October 15, 2018, approved
- Revised Advertisement, approved
- Email Invitation letter, approved
- Email to MUN offices, approved

This ethics approval will lapse on October 17, 2019. It is your responsibility to ensure that the Ethics Renewal form is submitted prior to the renewal date; you may not receive a reminder. The Ethics Renewal form can be found on the Researcher Portal as an Event Form.

If you do not submit the completed Ethics Renewal form prior to date of renewal:

☐ **You will no longer have ethics approval**

- You will be required to stop research activity immediately
- You may not be permitted to restart the study until you reapply for and receive approval to undertake the study again
- Lapse in ethics approval **<u>may result in interruption or termination of funding</u>**.

You are solely responsible for providing a copy of this letter, along with your approved HREB application form; to **Research Grant and Contract Services** should your research depend on funding administered through that office.

Modifications of the protocol/consent are not permitted without prior approval from the HREB. **<u>Implementing changes in the protocol/consent without HREB approval may result in your ethics approval being revoked, meaning your research must stop.</u>** Request for modification to the protocol/consent must be outlined on an amendment form available on the Researcher Portal website as an Event Form and submitted to the HREB for review. Please refer to the attached guidance document regarding on-going reporting requirements to the HREB.

The HREB operates according to the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2), the Health Research Ethics Authority Act (HREA Act) and applicable laws and regulations.

You are responsible for the ethical conduct of this research, notwithstanding the approval of the HREB. We wish you every success with your study.

Sincerely,

Joy Maddig

Dr. Joy Maddigan (Vice-Chair, Non-Clinical Trials Health
Research Ethics Board)

CC: Dr. Martha Traverso-Yepez

You Have Received Ethics Approval, Now What?: HREB Reporting Requirements

Once a study has received ethics approval from the Health Research Ethics Board (HREB), there are still associated reporting requirements. In the conduct of approved research researchers are required to report to the HREB, in a timely manner, proposed changes from approved research that affect participants at any stage of the process. This includes, but is not limited to, changes to the consent form, changes to the tasks or interventions involved in the research, or changes to measures to protect privacy and confidentiality.

Any substantive change to the research should not be implemented prior to documented approval by the HREB, except when necessary to eliminate an immediate risk(s) to the participants. Below are examples of post approval documentation that must be submitted to the HREB:

Amendments

Any proposed change in the conduct of a study must be submitted to the HREB, and approved, before the change may be implemented. Such changes might include modification of recruitment procedures, inclusion or exclusion criteria, revised sample size, addition or deletion of study sites, changes to an intervention, consent forms, questionnaires or scripts, etc. If there are changes in project team members or changes to funding source(s)/sponsor(s), there are specific forms to complete to report this to the HREB.

Adverse Events

Serious and unanticipated adverse events that occur within Newfoundland and Labrador are required to be reported to the HREB. Such events may occur in both clinical trials and in other types of research, e.g. collapse during a rehabilitation program, emotional breakdown requiring follow up care during an interview, or breach of privacy during correspondence. Serious adverse events that are fatal or life- threatening are required to be reported to the HREB as soon as the research team is aware of the event.

Protocol Deviations

Deviations from an approved study protocol must be reported to the HREB. Changes that eliminate immediate hazards to participants do not require prior approval, but must be reported soon as reasonably possible.

Safety Reports

Safety reports providing information on all serious adverse events (SAEs) occurring in a clinical trial must be provided by the sponsor to the HREB, normally on a three or six monthly basis (i.e. in accordance with the specified reporting timelines that were outlined in the approved ethics application).

Investigator Brochure (IB) and Product Monograph (PM)

Throughout the course of a clinical trial, changes may be implemented to study documents. All revisions to approved study documents must be submitted to the HREB to ensure the record is up to date. If the revisions include new risk or safety information there may be a requirement to notify research participants.

Ethics Renewal/Study Closure

Ethics approval lasts for one year. Ethics renewal is required annually, on the anniversary of the date of the HREB notification of approval. Once data collection is no longer ongoing, a study closure form is required to be submitted to the HREB for the study to remain active or to be closed in good standing.

Appendix C: Consent Form

HREB Version: May 2016

Consent to Take Part in Research

TITLE: Healthcare and well-being among the children of international graduate students in Newfoundland.

INVESTIGATOR: Abdullah Omar Saif, Graduate Student (Community Health)

SUPERVISOR(S): Dr. Martha Traverso-Yepez, Associate Professor, Division of Community Health and Humanities.

You have been invited to take part in a research study. Taking part in this study is voluntary. It is up to you to decide whether to be in the study or not. You can decide not to take part in the study. If you decide to take part, you are free to leave at any time. This will not affect you or your children’s usual healthcare.

Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

Please read this carefully. Take as much time as you like. If you like, take it home to think about for a while. Mark anything you do not understand or want explained better. After you have read it, please ask questions about anything that is not clear.

The researchers will:

- discuss the study with you
- answer your questions
- keep confidential any information which could identify you personally

- be available during the study to deal with problems and answer questions

Introduction/Background: Many graduate students who come from abroad to study at Memorial, have families and children. Many of these student families have no relatives or friends in the new country to look after their children while they are busy with their work and study. Due to limited earning, a lot of student-parents cannot even afford childcare. Also, parents may not be aware of all the help and supports that we have for children in Newfoundland. The purpose of this study is to get information that may help improve the quality of children’s healthcare and support in Newfoundland.

Purpose of study: The research aim is to learn the international graduate student parents’ experience and expectations in accessing supports and healthcare services they need for their children.

Description of the study procedures: I will ask you to attend an interview with me. The interview will take place in a location that is convenient for you. I will ask a few questions about your experience and expectations of the children’s healthcare services that we have in Newfoundland. I will not ask for any personal questions regarding you or your children’s health conditions.

The interview will be audio recorded. There will be no use of video recording or photograph. You will receive a $10 Tim Hortons gift coupon for attending the interview.

Length of time: The interview will last not more than 30 minutes.

Possible risks and discomforts: There is a risk of emotional upset. If you feel uncomfortable to discuss about your experience during the interview, you can quit anytime you like. Also, I will have the contact details of emergency helplines in case you ask for further help.

[Newfoundland and Labrador’s mental health crisis line: 1-888-737-4668)

Internationalization office’s contact number: +1 (709) 864-8895: Coughlan College Office, or, +1 (709) 864-2330: Director's Office; email: international@mun.ca]

Benefits: It is not known whether this study will benefit you

Liability statement: Signing this form gives us your consent to be in this study. It tells us that you understand the information about the research study. When you sign this form, you do not give up your legal rights. Researchers or agencies involved in this research study still have their legal and professional responsibilities.

What about my privacy and confidentiality: Protecting your privacy is an important part of this study. Every effort to protect your privacy will be made. However, it cannot be guaranteed. For example, we may be required by law to allow access to research records.

When you sign this consent form you give us permission to a) Collect information from you and b) share information with the people conducting the study.

Use of your study information: The research team will collect and use only the information they need for this research study. Your name and contact information will be kept secure by the research team in Newfoundland and Labrador. It will not be shared with others without your permission. Your name will not appear in any report or article published as a result of this study.

Information collected for this study will be kept for five years. If you decide to withdraw from the study, the information collected up to that time will be destroyed. This information will only be used for the purposes of this study.

Information collected and used by the research team will be stored in the office of my supervisor at the faculty of medicine. Dr. Martha Traverso-Yepez, Associate Professor, Division of Community Health and Humanities is the person responsible for keeping it secure.

Your access to records: You may ask the principal researcher to see the information that has been collected about you.

Questions or problems: If you have any questions about taking part in this study, you can meet with the investigator who is in charge of the study. That person is: Abdullah Omar Saif, Graduate Student (Community Health) at Memorial. He can be reached at: 709-771-3226.

Or, you can contact my supervisor(s): Dr. Martha Traverso-Yepez, Associate Professor, Division of Community Health and Humanities. Email: mtraverso@mun.ca

Or, you can talk to someone who is not involved with the study at all but can advise you on your rights as a participant in a research study. This person can be reached through:

Ethics Office at 709-777-6974 Email at info@hrea.ca

This study has been reviewed and given ethics approval by the Newfoundland and Labrador Health Research Ethics Board. After signing this consent you will be given a copy.

Signature Page

Study title: Healthcare and well-being among the children of international graduate students in Newfoundland.

Name of principal investigator: Abdullah Omar Saif.

To be filled out and signed by the participant:

Please check as appropriate:

I have read the consent [and information sheet]. Yes {} No {}

I have had the opportunity to ask questions/to discuss this study. Yes {} No {}

I have received satisfactory answers to all of my questions. Yes {} No {}

I have received enough information about the study. Yes {} No {}

I have spoken to the researcher and he/she has answered my questions
Yes {} No {}

I understand that I am free to withdraw from the study. at any time

without having to give a reason without affecting my future care [student status, etc.]
Yes {} No {}

I understand that it is my choice to be in the study and that I may not benefit.
Yes {} No {}

I understand how my privacy is protected and my records kept confidential
Yes {} No {}

I agree to take part in this study. Yes {} No {}

Signature of participant	Name printed	Year Month Day

To be signed by the investigator or person obtaining consent.

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

Signature of investigator   Name printed   Year Month Day   Telephone number:

Appendix D: Interview Guide

INTERVIEW GUIDE FOR RESEARCH PARTICIPANTS

The research aim is to learn the international graduate student parents' experience and expectations in accessing supports and healthcare services they need for their children; what are the specific supports and healthcare services they consider essential, and in what ways we can provide further help so that they can have easier access to such services.

If you are ready, I will begin by asking you some information about you [Ask participant to complete socio- demographic information or ask them the questions below.]

Participants' socio demographic information :

Gender:

Age range (Please circle the age range applicable to you):

18-28

29-39

39-49

49-59

Ethnicity:

Academic degree:

Employment status:

Family conditions:

Spouse/Single:

Spouse employment:

Children's education:

Please indicate, below, if you are interested on receiving a summary of the research findings. Yes No

Thank you for your interest and participation!

Now I will start with the first interview question.

1. What is your overall experience in accessing supports and healthcare? Or, if you have recently arrived, what kind of expectations do you have regarding children’s support?

2. What types of concerns have you faced in accessing supports and healthcare services for your children?

3. What kind of health and well-being concerns do you have when caring for your child (children)?

4. From your experience, how would you like to address such health issues?

5. What kinds of parenting support do you think could be helpful?

6. What types of services do you want to see in our children’s healthcare services?

7. How would you describe/evaluate your experience when accessing healthcare services for the children?

8. What do you see as barriers (if any, to enhance these services)?

9. Any additional comment or recommendation regarding enhancing children’s healthcare services?