Examining the Health-Seeking Patterns of Immigrants South Asian Women: Family Members’ Influence

by

Sukhdev Kaur Grewal

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Department of Nursing

The University of British Columbia
Vancouver, Canada

Date Aug 13, 2003
ABSTRACT

Immigrant South Asian women living in Canada are not only at increased risk for health problems and experiencing unnecessary illnesses, they also face barriers to culturally appropriate and safe health care. There is a paucity of research exploring the health beliefs, practices and health-seeking behaviours of this vulnerable immigrant population residing in Canada.

The purpose of this study was to examine the influence of family members on immigrant South Asian women's decision making related to their health concerns and their health-seeking behaviours. This study also sought to identify suitable strategies to facilitate their access to culturally appropriate and safe health care.

This qualitative study was part of a larger study that examined the health-seeking practices of South Asian women living in the Lower Mainland of British Columbia. Using ethnographic methods, data was collected through face-to-face individual interviews with immigrant South Asian women. The sample included women of a variety of ages and religious backgrounds. Their years of residence in Canada ranged from 10 months to 31 years. Interviews were conducted in the language of the women's choice, and included Punjabi, Hindi, Gujarati, Urdu, Kutchi and English.

Analysis of the translated and transcribed data revealed that the women did not make health decisions in isolation but in consultation with other family members. Overall, family members were perceived to be supportive in assisting women with their decisions regarding health issues. Family members provided both indirect and direct assistance and often responded positively to women's needs. The women were expected to fulfill their traditional roles and responsibilities as wives, mothers, caregivers,
housekeepers, dutiful daughters, and daughters-in-law. These roles and responsibilities often affected the decisions they made with regards to their health. This way of living was shown in this study to be both positive and negative for the women in terms of their health.

The findings from this study suggest implications for nursing practice, education, administration, and research. Health care providers should ensure that there are adequate resources available and that there is a provision of culturally sensitive, appropriate, and safe care for this special group of women. Health care providers should be equipped to provide care to South Asian women taking into account the women’s relationships with their family and that the women are not alone in making health care decisions. Cross-cultural courses should be integrated into nursing education.

Future research needs to focus on replication of this study with a second-generation population. In addition, research is needed to examine the effect of arranged marriages on women’s health.
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DEDICATION

My father, the late Mr. Banta Singh Dulay who had the courage to go against traditional norms and treated his daughters with respect, trust and gave them the freedom to make their own choices in life. This is also dedicated to my mother Bishan Kaur Dulay. Her one and only wish was for her daughters to achieve higher education. Despite the fact that she never received any formal schooling, she taught herself to read and write not only Punjabi, but some English, too.
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The profile of a South Asian woman

The Silenced Minority

Do not abandon the vows of womanhood taken by you.
You have to follow your mother, grandmother, and great grandmother. You have to mind the hearth and the children. 
Do not ask odd questions. 
Do not exceed the boundaries.
Do not abandon your vows of womanhood.
Do not speak with your face up. 
Be inside the house.
Wash clothes, clean the utensils. 
Clean the leftovers and remove the soiled plates.
Sew and embroider.
Sweep and draw designs on the floor. 
Water the Tulsi plant.
Circumambulate the scared tree.
Observe fasts and perform vratas.
Bend your neck downwards.
Walk without looking up.
Do not let your eyes wander.
Do not abandon your vows of womanhood.

From the play Mulagi jhali Ho (A Girl is Born)
CHAPTER ONE

INTRODUCTION

In the last few decades we have seen a dramatic transformation in Canada's
population profile as a result of immigration. The Canadian population has become
extremely diverse due to increases in immigration from South East Asia and decreases
from European countries. India, Mainland China, and Taiwan are now the top three
source countries for new immigrants (Statistics Canada, 1998). Recent statistics indicate
that many immigrants are making their home in Canada, particularly in British Columbia
(BC). The ethno-cultural profile of Vancouver differs significantly from the rest of BC.
At present, 45% of Vancouver's population consists of visible minority groups (Statistics
Canada, 1996). According to 1996 statistics, 56% of the new immigrants were from
India, in particular from the Punjab. In Delta, in BC municipality, 11.7% of the
population identified their mother tongue as Punjabi (Statistics Canada, 1996). The
region's diverse population is expected to increase 3.3% between 2000 and 2003
(Vancouver/Richmond Health Board, 1999), and 50% of this increase will be the result of
international migration. One of the largest new groups of immigrants is expected to be
South Asians. British Columbia is a most desirable place of residence for new
immigrants. For example, from January to December 2001, 18.1% of the new Indian
immigrants chose BC as their home compared to the rest of Canada (Statistics Canada,
2002).

The majority of South Asians immigrating to Canada is from India, Pakistan, Sri
Lanka, Bangladesh, East Africa, and Fiji. South Asian immigrants from countries other
than India commonly have ancestral links with India or were born in India. These connections with India are the basis of common beliefs and practices among South Asians residing in a number of countries including East Africa, Fiji, and England. As such, to understand the experiences of immigrant South Asians in western countries such as Canada, it is common practice to draw on descriptions of India and its cultural life.

India is a vast subcontinent with an area of 1,262,000 square miles. In spite of its large amount of land, India is overpopulated. In 1995 the population of India was 930 million, and it grows by 17 million annually. If this trend continues with each couple having only two children on average, India will reach a population of 1.7 billion by 2001-2006 (Family Planning Association of India, 1995). Over 70% of the working population of India is engaged in agriculture, using age-old cultivation techniques based on human or animal power. Most of these farmers are living in small villages; they have few resources available to them and are hardly able to provide a base subsistance for their family. Therefore, immigration to western countries has become a desire shared by many South Asians.

The focus of research on immigrant South Asian women's health has been mostly on individual lives and on examining the beliefs, values, and experiences of women. While this has been helpful, there is a need to broaden this focus to include the family and how the influence of the family can impact the decisions women make about their health and the actions they take to maintain their health. South Asian women often live within an extended family system. Strong family ties provide a wide kinship network, which, in fact, is the backbone of the South Asian family (Mayor, 1984; Shams, 1992). Actions that South Asian women take to address their health concerns are enmeshed in
family life and influenced by the members of their family. Family members, family structure, the support of family members, and cultural norms regarding appropriate behaviours have been identified as important influences on South Asian women's health (Bhopal, 1986; Bottorff, Johnson, Venables, Grewal, Popatia, Hilton et al., 2001; Chen, Kuun, Li, Guthrie, & Zaharlick, 1991; McAvoy, 1992; Nilchaikovit, Hill, & Holland, 1993; Uba, 1992). No studies were found that fully explored the influence of family members on health decision making among the immigrant South Asian women living in Canada.

Immigrant South Asian women are prone to problems such as depression (Bowes, & Domokos, 1993; Jagannathan, 1996; Karkal, 1996; Thompson, 1987), heart disease (Victoria Declaration, 2000), diabetes, anemia, problems related to complications of pregnancy (Bhagat, Johnson, Grewal, Pandher, Quong, & Trioleit, 2002; Patel & Capoor, 1996), hypertension, and cancer (Bottorff, Balneaves, Sent, Grewal, & Browne, 2001; Hislop, Mumick, & Yelland, 1995; McAvoy, 1992). These health problems have been linked to a variety of factors, including lack of access, language barriers, cultural norms, lack of family support, social isolation, and stress associated with the immigration process (Bhopal, 1998; Chen et al., 1991; Jan & Smith 1998; Ministry of Health and Ministry Responsible for Seniors, 1995; Nilchaikovit et al., 1993; Roy, 2000; Uba, 1992). Experiences related to the process of immigration and adjustments to a new culture have significant health implications (Choudhry, 2001; Dhruvarajan, 1994; Ervin, 1981; Ghosh, 1981; Meadows, Thurston, & Melton, 2001). As new immigrants, South Asian women often carry dual roles of homemaker and paid worker. In their jobs they often work long hours at low rates of pay (Anderson, 1990; Choudhry, 2001; Gathoskar, 1997; Freund,

The lives of immigrant South Asian women are complex. Their roles are shaped by a background of living in a patriarchal society in their home countries where women have very little decision-making power, not only with regard to their own health but also with concerns of general day-to-day living (Conklin, 1981; Gupte et al., 1996; Jagannathan, 1996; Karkal, 1995; McAvoy, 1990; Victoria Declaration, 2000). After immigration, many South Asian women experience increased levels of oppression due to lack of knowledge of the English language, social isolation, and increased dependency on others (Abraham, 1995; Choudhry, 2001; Dhruvarajan, 1994). In addition, they face barriers to accessing health services because they lack knowledge of the health care system and lack awareness regarding the importance of preventive health services.

South Asian women value their roles as wives, mothers, and caretakers. They often defer decision making to their husbands or extended family with regard to family affairs, including their health concerns (Ahmed, & Watt, 1986; Dasgupta, & Warrier, 1996; Gupte et al., 1996; Jagannathan, 1996). A better understanding is needed about how South Asian women's health concerns and actions are negotiated with and
influenced by family members, in order to identify ways to support women in maintaining their health.

Research Problem and Purpose

To date, very few research studies have been conducted on the health-seeking behaviours of immigrant women, particularly South Asian women. No research studies were found that explored the influence of family members on health-seeking behaviours and decision making regarding health among immigrant South Asian women residing in Canada.

The purpose of this study is to examine the influence of family members on immigrant South Asian women's decision making related to their health concerns and their health-seeking behaviours.

The Research Questions for this Study

1) What is the influence of family members on immigrant South Asian women's health seeking and decision making?

2) Which family members do immigrant South Asian women turn to with their health concerns and problems?

3) How do family members impede and support immigrant South Asian women's health?
CHAPTER TWO

LITERATURE REVIEW

Introduction

The following examination of the literature is organized around key concepts related to South Asian culture, including the position of women in society, the family's influence on health-seeking behavior and decision making, factors that influence women's health choices, and the impact of immigration on women's health and health decision making.

The Position of South Asian Women in Society

The status of South Asian women in their countries of origin and the factors that influence their status are topics that have been examined by many (Badawi, 1971; Bhopal, 1998; Bolaria, & Bolaria, 1994; Hale, 1989; Korson, 1981; Menon, 1981). South Asian women are ranked far below men in social status, and this is reflected in their lack of autonomy in decision making and by the limited degree of access they have to the outside world (World Bank, 1996). For example, India has a patriarchal system where women are undervalued. Men's control over valued resources makes women dependent on men and powerless in everyday decision making (Hale, 1989; Karkal, 1998; Karkal, Gupte, & Sadgopal, 1995; Ralston, 1988; World Bank, 1996). This results in women's confinement to roles that revolve around domestic duties and reproduction. India's patriarchal male dominance has deep socio-cultural and religious roots. Despite the growing awareness and activism among middle class and educated women, the majority of Indian women still accept secondary status in their homes as well as in the community (Dasgupta & Warrier, 1996; Gupte et al., 1996, Huisman, 1996; Karkal, 1995; Ralston,
There is some evidence to suggest that, following immigration to western countries such as Canada and England that women's social status and roles do not change significantly (Basran, 1993; Choudhry, 2001; Choudhry, Jaundu, Mahal, Singh, Sohi-Pabla, & Mutta, 2002).

Segregated and asymmetrical gender relations are present throughout the life cycle of South Asian women in their home countries. Women in those countries face discrimination at each stage of their life (Patel, & Capoor, 1996; Karkal, 1995). This gender discrimination can even start before birth. For example, many pregnant women are forced to have an ultrasound screening to determine the sex of their unborn child and if the fetus happens to be female, they often are required to undergo abortion (Dhruvarajan, 1995). There are cases where a woman can have as many as 10 to 15 abortions in order to produce a male infant (Dr. Gupta, February, 1999, personal communication). Due to the strengths of the patriarchal structure of Indian society, sons not only represent social security but also bring prestige, improving the woman's status within the family as well as within society. The birth of a son is celebrated, whereas women receive condolences on the birth of a girl child. Daughters are considered a liability due to the dowry system and the fact that parents have to protect the daughter's virginity until marriage (Dhruvarajan, 1995).

As patriarchy operates on an age and sex hierarchy, age improves a woman's place and status (Karkal, 1995). For example, mothers-in-law hold more power and status than daughters-in-law. Young daughters-in-law are expected to respect and obey the older mothers-in-law. Traditionally, young girls were married at an early age; ten to eleven years of age was the norm (Menon, 1981; Weiss, 1999; World Bank, 1996). At
present, the average age of marriage in India is twenty years of age. Marriages in India are normally arranged by parents and other relatives and are not the union of two individuals (as is the norm in western culture), but represent the alliance of patrilineal kin groups. Moreover, young girls are often married to men far senior in age and end up submitting to traditional gender roles. Early marriages not only rob adolescent girls of years of education and development, but also are harmful to their health because childbearing starts soon after girls start menstruating. Although there have been changes in this practice of early marriage due to more and more women becoming aware of their rights through education, in rural areas of India this issue remains of concern, and there is room for improvement.

Traditionally held views give women very few legal rights, such as property inheritance or ability to publicly contradict or challenge their respective husbands (Miller, & Goodin, 1995). Furthermore, wives are not permitted to mention their husband's name in public or to even address him by name. Once again this is because husbands are considered superior to their wives. In some parts of India, Muslim women practice purdah, which is veiling of the face and body (Menon, 1981). This practice involves hiding a woman's face from public to ensure only the woman's husband sees her face. Again, this very old custom functions to protect the husband's property.

For South Asians, the family is the most important social support unit (Assanand, Dias, Richardson, & Waxler-Morrison, 1990; Dua, 1992; Shams, 1992). In Canada, as in India, the majority of South Asians often live as an extended or joint family system (Assanand et al., 1990; Ames & Ingles, 1973; Dua, 1992; Drakulic & Tanaka, 1981; Rajwani, 1996). The extended family unit may consist of grandparents, married sons and
their families, unmarried sons, unmarried daughters, widowed female relatives and others. Upon marriage, a woman becomes a member of her husband's family; therefore, the lifestyle is interdependent and collective, with individualism and autonomy being discouraged (Assanand et al., 1990). Although changes are starting to occur, marriages are generally arranged (Ames & Inglis, 1973; Naidoo & Davis, 1988; Ralston, 1988), with wives considered the property and possession of husbands (Assanand et al., 1990).

The hierarchical structure of family units consists of males having authority over females, parents over children, and the elder family members having authority over the younger members (Ames & Inglis, 1973; Nilchaikovit et al., 1993). The general structure is patriarchal in nature, where the eldest male is the head of the family and, needless to say, the final decision-maker (Rajwani, 1996). In addition, the elder male is responsible for financial support and decision making, ensuring care of the elders (Nadioo & Davis, 1988), making health care decisions (Assanand et al., 1990; Rajwani, 1996), and guiding family relationships (Drakulic & Tanaka, 1981).

Women's roles are clearly defined socially (Nilchaikovit et al., 1993; Rajwani, 1996; Wickramasinghe, 1993) and encompass homemaking (Basran, 1993) and child nurturing (Bhopal, 1998; Dasgupta & Warrier, 1996; Mayor, 1984; Nadioo & Davis, 1988; Wickramasinghe, 1993), adherence to strict behavioral norms (Hale, 1989; Ralston, 1988) and passive loyalty, obedience and deference within the family hierarchy (Hale, 1989; Dua, 1992). The mother-in-law is the woman's immediate authority figure (Bhopal, 1998) and is responsible for the happiness, well-being, and smooth functioning of the extended household.
Family Influence on Immigrant South Asian Women's Health-Seeking Behaviours and Decision Making

Health care choices are determined and/or strongly influenced by the cultural context. Generally, in day-to-day living, people's lives are influenced by many factors, including beliefs, values, cultural practices, surroundings, and family members. In the case of immigrant South Asian women, there is some evidence to suggest that the extended family's influence can be very powerful and, at times, may be detrimental to the women's health and health care decisions.

In South Asian culture the role of women as wives, mothers, and care-givers is idealized (Ghosh, 1981; Jithoo, 1991; Karkal, et al., 1995; Rajwani, 1996). Women are very committed to these roles and responsibilities (Naidoo & Davis, 1988). Upon immigration, many South Asian women's responsibilities are extended to include work outside the home to satisfy their families' basic material needs. Commitment to traditional family responsibilities of child rearing, childcare, and domestic tasks, as well as commitment to work outside the home have the potential to put South Asian women at higher risk for health problems.

In Canada there have been few studies that have focused on immigrant South Asian women's beliefs, values, and practices about a variety of health issues. Health issues that have been studied include breast health (Bottorff et al., 1998; Bottorff et al., 1999; Bottorff et al., 2001; Choudhry, 1998; Choudhry & Srivastava, 1993; Choudhry, Srivastava, & Fitch, 1998; Johnson, et al., 1999; Johnson, Bottorff, Browne, Grewal, Hilton, & Clarke, in press); cervical health (Bottorff, Balneaves, Sent, Grewal, & Browne, 2001); prenatal health (Bhagat, Grewal, Sandhu, & Patel, 1995; Bhagat,
Johnson, Grewal, Pandher, Quong, & Triolet, 2002; Dhari, Patel, Fryer, Dhari, Bilkhu, & Bains, 1997; Lynam, Gurm, & Dhari, 2000); and use of traditional health practices (Hilton et al., 2001). The above mentioned research suggests that many factors, including family structure, norms regarding appropriate behaviour, traditional practices, modesty surrounding women's problems, and women's attitudes towards illness, have profound influences on health choices made by South Asian women. Language, transportation, and lack of extended family support have been identified as barriers to accessing health services by South Asian women.

A study conducted in Western Canada examining the health-seeking practices of South Asians found that women's health concerns are tied to their family roles and responsibilities (Bottorff et al., 2001; Hilton et al., 2001; Johnson et al., in press). South Asian women are often found to be reluctant to share their concerns outside the family. To promote physical and mental well-being, some women rely on traditional health practices, while others combine western and traditional practices (Hilton et al., 2001). In addition, the decision to use or not to use western and traditional health practices is often influenced by the nature or severity of the condition, previous experience, cultural beliefs, and family members. Bottorff et al. (2001) suggests that South Asian women's health concerns are similar to those of women in mainstream society. What is different for South Asian women is how they experience health care, their understanding of these health problems, and the ways in which these health concerns are communicated to, and shaped by, their interactions with others, particularly family members (Bottorff et al., 2001).

South Asian women often put their families before their own needs. This is
reflected in their desire to please others and to fulfill their roles as wives, mothers, and care-givers (Bhopal, 1998; Dasgupta, & Warrier, 1996; Freund, 1991; Jagannathan, 1996; Jithoo, 1991; Karkal, Gupte & Sadgopal, 1995; Ralston, 1991; Shams, 1992). For South Asian women, survival, and well-being of their families take precedence over their own needs, desires, and health (Dasgupta, & Warrier, 1996; Jagannathan, 1996). In Canada, as in the women's home countries, the family's well-being is a priority for women, and it influences their decisions about the use or non-use of health services for themselves, as well as their health-care decisions.

The Canadian studies of South Asian women's health seeking practices described above have provided important insights. The systemic evaluation of the influence of families on women's health-seeking practices, however, is lacking.

The Impact of Immigration on Women's Health

Immigration to western countries is desired and seen as an opportunity to advance one's fortune and improve the future for oneself and one's children. However, the immigration process is often accompanied by many stresses, which have the potential to result in negative health outcomes (Hattar, Pollara, & Melies, 1995). Firstly, women are uprooted from their traditional culture to live in a new, strange western culture (Choudhry; 2001, Meadows et al., 2001). In their new homes women often lack and miss the support of the extended family unit that they were so familiar with in their home country. Social isolation can affect women's physical as well as psychological health (Thompson, 1987). Many of the newly arrived South Asian women are new brides who have come to join their husbands through arranged marriages. This may well be the woman's first meeting with her future husband and his family. Therefore, the stress of
marriage and adjustment and adaptation to a new family, as well as the new culture, may lead to health problems.

Many immigrant South Asian women are not used to working outside their homes. In order to fulfill their families’ basic material needs and to support reunification of the extended family members, they are required and sometimes forced to seek employment following immigration. This results in dual roles of housekeeping/child-rearing and outside employment (Ghosh, 1981; Shams, 1992). Outside employment can cause a number of new problems for women. First, a gender role reversal occurs (Ervin, 1981), in part due to immigration where women are working outside the home. As women become empowered by gaining knowledge outside the home, they begin to question decision making by their husbands, resulting in family conflict and sometimes domestic abuse (Basran, 1993). In addition, men may have to share household responsibilities, which are not what they are brought up to do in a patriarchal society; again this can result in conflict within the family.

A second problem created by the need for women to be employed in paid work is that new immigrant South Asian women often have difficulty finding employment either because their qualifications are not recognized in Canada or because they lack specialized skills. Therefore, women often find employment on farms, in canneries, sewing factories, or in the cleaning industry. They work long hours for low pay under poor working conditions (e.g., no paid sick leave, no lunch break, no paid holiday time, and no benefits of any kind). Those working on farms are exposed to a variety of pesticides and herbicides (Jagannathan, 1996), which may have serious effects on their physical health. After working long hours, these women go home to perform domestic duties of cooking,
cleaning, and care giving. Besides physical health problems, some women may experience stress, anxiety, and other mental health problems. Women may sacrifice their own health in order to save enough money to sponsor family members from their home country. The presence of the family is vital for the well-being of the women; support of the extended family can act as a "buffer" with regard to vulnerability to physical and mental illness (Arorian, & Spitzer, 1996).

Immigration can also pose health risks for elderly South Asian women who are sponsored by their children under "family reunification" (Choudhry, 2001). In India elderly members of the family are valued, honoured, respected, and taken care of by their children. The role of elders in India is that of (1) teaching the children the correct manners of addressing the elder, older and younger members of the family and community; (2) promoting cultural values and practices; (3) counseling, and (4) ensuring that ascribed tasks and roles are fulfilled by each member of the family (Mayor, 1984). Upon immigration, this role seems to change, resulting in elderly South Asian immigrant women facing social isolation, loneliness, and loss of status that was bestowed on them in their country of origin. These women are further isolated due to lack of language skills and transportation. This is not the old age to which they looked forward. Instead of being cared for, they are being told what to do and how to do it. In addition, they are often burdened with child-care and household duties. At times they are afraid to cook or clean because a simple kitchen item may be foreign to them (personal communication, Mrs. Mohinder Sidhu November 10th 2001).

Racism is another issue faced daily by South Asian women in Canada. Dua (1992) alleges that for South Asian women the family unit becomes even more important
after immigration because they face racism among other stresses. Women begin to view their family as a place of "refuge against racism" (p. 8).

In summary, the health of immigrant South Asian women is directly influenced by a complex array of factors. A common thread connecting all of these factors is the influence of the family. Family members can provide important sources of support for women, and in some situations family dynamics and expectations can undermine women's health. There is little systematic study of how extended family members and husbands influence South Asian women's health and health-seeking practices. Health care providers need this information in order to provide effective, culturally appropriate, and culturally sensitive health care.

**Summary of the Literature**

A literature review has illustrated that there is a paucity of research examining family members' influence on South Asian women's health decision making and health-seeking practices. Researchers have identified many cultural and social factors that influence South Asian women's lives prior to and following immigration. Women's lives are directly shaped by family expectations and family dynamics. A fuller examination of women's health concerns and health-seeking patterns in this context is necessary. Research is needed to examine the influence of family members on women's health.
CHAPTER THREE

METHODS

Introduction

This section describes the research design of this study: its sampling method, data collection procedures, data analysis, means of ensuring rigor, and procedures for protection of human rights.

Research Design

An ethnographic approach to qualitative research was the research design chosen for this study. Anthropologists have traditionally used ethnography, a descriptive approach to research; however, more recently the social science researchers and nurse-anthropologists focusing on culture and its effects on health have employed this method (Morse & Field, 1995).

Ethnography is the most common qualitative research approach used to study any cultural group where the researcher is trying to make sense of everyday life events (Hammersley & Atkinson, 1993). Moreover, it is a method of social research in which "the ethnographer participates, overtly or covertly, in people's daily lives for an extended period of time. Watching what happens, listening to what is said, asking questions. In fact, collecting whatever data are available to throw light on the issues that are the focus of the research" (Hammersley, & Atkinson, 1993, p. 1). In essence, the researcher is trying to “paint a portrait of people” (Burns & Grove, 1997, p. 76). Burns and Grove (1997) state that the ethnographic approach to research tries to “tell the story of people's daily lives while at the same time describing the culture they are part of” (p. 32). The ethnographic approach allows the researcher to explore any phenomenon from an
insider's point of view. The usefulness of this research approach has been recognized for studying immigrant women.

To hear women truly, we must come to them without fixed agendas and as free of cultural bias as possible. This means the methods we use and the information we obtain must principally be qualitative in nature. When research is of a quantitative nature, the questions and the categories for possible responses are predetermined. This research is appropriate once we have allowed women to define appropriate questions and response categories. However, at this stage in development of women's health programs, so little is known and so much of the subject matter sensitive that survey instruments will not allow us to hear what women really want to say. (Brems, & Griffiths, 1993, p. 266)

The research described here is part of a larger qualitative study of South Asian women's health-seeking behaviours (Hilton et al., 1999). The purpose of the larger study was to:

(1) Describe the health-seeking processes used by the South Asian women living in the Lower Mainland of British Columbia.

(2) Identify and describe culturally suitable strategies in order to increase their participation in promotion of their health.

(3) Refine a framework for the development and evaluation of culturally suitable interventions
Sampling Method and Description of Sample

Gaining the trust of the South Asian immigrant community was very important to the success of the main study. Like any other immigrant population, the South Asian community is reluctant to participate in any research for fear of being investigated (personal communication, Dosanjh, June 20th, 1999; Pandher, August 16th 2000). Lack of awareness regarding the need to conduct research studies and language barriers are the other contributing factors that affect study recruitment.

Purposeful and snowball sampling procedures were used to obtain participants for the individual and focus group interviews. The participants were identified by research assistants who were members of the local community and by the South Asian co-investigators. Many of the participants were recruited by word of mouth. Often new participants were referred by the women who participated in this study or in a previous study conducted by the same team of researchers. The women had come to know and trust the team and felt comfortable participating in the study and recommending their friends.

The sample for the main study included 80 women who identified themselves as South Asian. They were representative of various sub-groups and religions, including Sikhs (49), Hindus (12), Muslim (14), Christian (3), and not specified (2). They had come from countries such as India, Pakistan, Bangladesh, Fiji, East Africa, and England. One woman was born in Canada. The women’s ages ranged from 20 to 80 years, and included women who were single, married, widowed, and divorced. The women were mainly urban dwellers and had lived in Canada from 10 months to 31 years. Some women were professional or semi-professional, while others were employed as farm
workers, or worked at home caring for children or family, and some were retired.

Fifty women participated in individual open-ended audiotaped interviews, and 30 additional women participated in twelve audiotaped focus group discussions. In addition, seven individual open-ended interviews and seven focus group discussions were also conducted with health care professionals who were known to have extensive experience in providing care to South Asian women. Health care professionals were selected to represent a variety of occupations, including family medicine, nursing, psychiatry, social work, pharmacy, and laboratory technology. Both male and female health care professionals with a variety of ethnocultural backgrounds, including South Asian, participated in either individual interviews or focus group discussions.

For the purpose of this study, analysis was limited to interview data from immigrant South Asian women. This resulted in the exclusion of three women, one from England, one who was born in Canada, and another who did not specify where she was born. The remaining 47 women were the focus of this study.

Data Collection Procedures

In the main study data were collected using three data collection strategies. First, individual face-to-face, open-ended interviews were conducted with women from the South Asian community living in the Lower Mainland of BC. Second, focus group discussions were held with various groups of South Asian women. Third, interviews with health care providers who provided health services to the South Asian community were conducted, as well as community meetings with the South Asian women. In addition, transcripts from radio talk shows that focused on health concerns among the South Asian community were used to supplement the data. The findings were then taken
back to the women of the South Asian community for validation by inviting women to
two community meetings.

Specially trained South Asian female interviewers collected the data. All the
interviews were audio taped and were conducted in the language of the woman's choice,
for example Punjabi, Hindi, Gujarati, Kutchi, Urdu, and English. Interviews were
conducted at a place of the woman's choice, most often at the woman's home. During the
interviews and focus group discussions women were asked to share their experiences in
accessing and obtaining health services as well as their beliefs and perception of health
and self-care practices. Health care professionals discussed their experiences of
providing health care services to South Asian women. In addition, their perception of the
difficulties women encountered in obtaining and accessing health care was also shared.
These audio taped interviews were translated into English and transcribed verbatim.
Translation was done by the research assistants and checked for accuracy by the South
Asian team members. For this secondary analysis, only the transcribed individual
interviews with the immigrant South Asian women were used.

Data Analysis for the Larger Study

Initially, in the larger study the transcribed interviews were read to get a sense of
the whole picture and also to become familiar with the text (Morse & Field, 1995). The
data analysis was initiated by a careful line-by-line review to highlight important words
and phases. Open coding followed this. The research team met to discuss and identify
central themes, and a coding guide was developed to ensure full coverage of major
emerging themes. The next step was to code the transcripts. Using the coding guide
developed by the research team, all data were coded. The research team held regular
meetings during the coding phase. A computer software program NUDIST was used to facilitate retrieval of the coded data. Emerging themes and questions arising from the analysis guided data collection in focus group discussions and subsequent individual interviews.

Data Analysis for this Study

For the purpose of this research, data segments relevant to this study were retrieved using the coded data. All data coded in the following categories were used: (1) seeking help or assistance from families for health concerns (included whether they sought or family offered assistance); and (2) family influence in dealing with health problems, including type of factors/barriers, and facilitators encountered in dealing with the situation. The latter category included both positive and negatives factors; family members as advisory and informative (giving information to the women), as well as descriptions of those they received information and advice from related to health. In addition, a text search was carried out using the terms "family," "children," "mother," "father," "son," and "daughter" to ensure all relevant data were available for analysis.

The first step undertaken in data analysis involved a careful reading of data segments to become familiar with the data. All data segments were reviewed line-by-line, highlighting important ideas and writing possible codes in margins. In particular, at this stage of analysis, attention was paid to "rich points" or segments of data that contained cultural knowledge or experiences that reflected cultural practices, patterns, inconsistencies, and surprising comments. Views of different participants were compared and contrasted. Each code was examined in order to classify it into a particular category by noting similarities and differences and looking for any sub-categories (Hammersley &
Atikins, 1993). This first level of analysis was used to identify major themes or categories. The data were sorted into these categories using a cut and paste system; each labeled paragraph or sentence was cut and placed in a file for manual sorting. In the final phase, data in each category were further analyzed to clarify the meaning of each theme.

Ensuring Rigor in this Study

In qualitative research, measures used to ensure reliability and validity are unique and different from those used in quantitative research. According to Lincoln and Guba (1985), there are four factors used in the naturalistic-qualitative paradigm of inquiry to establish trustworthiness of the data. These factors are credibility, transferability, Dependability, and confirmability.

Credibility refers to the confidence the researchers and individuals have in the truth of the findings. Credibility was addressed by: (a) supporting interpretations with direct quotations; (b) drawing on data from discussions with South Asian women, health care professionals, and female South Asian community leaders, to verify interpretations, and (c) drawing on personal experience as a South Asian immigrant and extensive clinical experience in providing health care services to women and families of South Asian background.

According to Sandelowski (1986), transferability is enhanced when the results are not context bound. Transferability is supported because the sample included women representing a wide range of ages (20-80 years old) and also included new immigrants as well as women who had been in Canada for most of their adult years. The sample was also diverse with respect to a variety of characteristics including language, education, employment status, and marital status. Nevertheless, it is acknowledged that the findings
may not be transferable to all immigrant South Asian women, such as those who
immigrate to rural towns or other settings where social and economic factors and health
care services may differ from the setting where women in this study were recruited.

Dependability was supported with an audit trail to document choices, decisions,
and insights. The audit trail was maintained through systematic and detailed recordings.
A personal diary was kept to document biases, feelings, hunches, and thoughts.

To address and support the confirmability, which is concerned with the
interpretational objectivity of the data (Lincoln & Guba, 1985), all possible explanations
of data were explored thoroughly. Reflexivity was addressed by being aware of this
author’s orientation to this research and how her background and position as a South
Asian woman and a nurse shaped this investigation.

Ethical Considerations

In the original study participants’ rights were protected in several ways. Written
approval was obtained from the University of British Columbia Office of Behavioral
Ethics Committee. Since this author was a co-investigator in the original study and since
addressing these research questions for master’s thesis research was encompassed in the
original research questions, a request for approval to conduct this analysis was not
required. Written and informed consents were obtained from all participants. Consent
was translated into Punjabi, Hindi, and Gujarati and included permission to audiotape the
interviews. Participants were given written information, which summarized the purpose
of the study and the focus of the data collection, and explained the means by which
confidentiality of the data would be protected. They were informed that their
participation in the study was voluntary and that withdrawal from the study was possible
at any point without consequence to the health care services they would receive. Identities were protected through the use of numerical codes. The coding system was shared only with the research team. In addition, participants were asked to refrain from identifying any one by name. Audiotapes and transcribed interviews were kept in the possession of the principal investigator in a secure and safe place. Transcripts were shared only among the research team members.

Summary

The qualitative research method of ethnography was chosen for this study, because it is appropriate for examining cultural groups from the participants' perspective. The influence of family members on the health-seeking practices and decision making of the South Asian women living in Lower Mainland of BC is the phenomenon under study question.
CHAPTER FOUR

FINDINGS

Introduction

In this chapter the findings of the study are described. This section begins with a description of the main themes. Integrated throughout this section are quotes from the participants that illustrate and substantiate the researcher's interpretations. Major themes that emerged from discussions with the participants were: (1) family relationships: patterns of influence on women's health; (2) women in need: family members' responses to women's health concerns; (3) fulfilling family expectations and needs: influences on women's health; and (4) family as a barrier to women's health.

The family was the centre of their life for many of the South Asian women who participated in this study. For these women, their identities, the actions they took or did not take, their conduct, and their emotional and physical well-being were essentially tied to their families. Therefore, the everyday lives of women were directly and indirectly influenced by family. Family influences took many forms and were often perceived by the women as positive and supportive. Women's particular roles, responsibilities, family duties, and their relationships with family members influenced how they made decisions about their health. The women valued various degrees of trust in particular members of their extended family, and this generally determined whom the women turned to in times of need. In addition, their relationships with family members influenced from whom they sought advice for health concerns and whether they acted on that advice.
Women in the Context of Families

To understand the experiences of the South Asian women who participated in this study and the themes that emerged, it is important to understand the usual patterns of immigration and the common pre-immigration and post immigration experiences by drawing from the literature and observation of the community in Vancouver. Therefore, this section presents the typical pre-immigration family structure, the significance of the family, and the post-immigration family structure.

The Pre-immigration Context of Family Experiences

Family influences on the health care decisions and health status of South Asian women living in Canada need to be understood in the context of growing up in multigenerational, patriarchal systems in their countries of origin, where women are often bound by values and obligations to their extended families. For example, in India, women highly value their roles as wives, mothers, and caretakers, and they assume major responsibility for the well-being of their children and families. They are expected to be obedient and self-controlled (not to show emotion and expression). Furthermore, women in India are commonly expected to live within an extended family system where they are taught to respect all those who are senior to them not only in age but also in position and status within the household, as well as the men of the household. Loyalty to one’s family is highly valued because family units provide an important network of support and basis for economic security. Women are expected to maintain familial harmony and ensure that the families do not lose “izzat” (honour or face) in the community (Wickramsinghe, 1993).
Thirty of the 47 South Asian women in this study came from South East Asia. Twenty-five of the thirty women were from India. Four others originated from Pakistan, and one from Sri Lanka. These are all countries that are characterized by strong patriarchal systems (Assanand et al., 1990) that do not encourage women, especially young women, to participate in day-to-day decision making within the household or to be politically active. In addition, women in these countries are often economically dependent on the men since property is inherited by and transmitted through the male heirs. This patriarchal system is starting to change in some countries because more women are becoming educated, and government policies have been introduced that support dividing property among children of both sexes. The remaining study participants came from countries other than India. Fourteen women were from East Africa, and three others originated from Fiji. Although these women came from countries other than India, their values, beliefs, and practices were similar to those from India, and members of their extended family heavily influenced them. Many of the South Asian women in this study who lived within extended or joint family systems in their countries of origin continued to maintain this way of life after immigration to Canada. However, the structure of the extended family varied due to changing circumstances and the impact of immigration.

Most of the women in this study lived within an extended family environment following their immigration to Canada. This often included three generations living together in one household. As is common in the countries of origin, the joint families usually pooled their resources and had a common property. The women in this study recognized many advantages to living in such an environment. Not only did this practice
provide social support and minimize the isolation often experienced by new immigrants, but living in an extended family also provided women with financial security and assistance when they needed it. One young woman emphasized this:

There are a lot of benefits for us when we live together. Like today, I have come to work. Then the kids, if I left them somewhere else [babysitter] then I would have to pay money. Then I have to pick kids up and leave their stuff there. For this reason, at home the kids are happy. I am happy. And I don’t worry. I come to work. I start work at 4 o’clock [pm] and I finish at 11 [pm]. At 12, I go home and sleep. I don’t have to wake up early in the morning because the grandmother [husband’s mother] is there to look after the children. 
[Age 33 years, Punjabi Sikh, married, in Canada 11 years].

In addition to the extended family, the women were often connected to extra-family kinship networks, which included all individuals who could trace their relationship to a common ancestor. Maintaining close contact with family members was sometimes a challenge, particularly for families separated by great distances due to immigration. Although some women felt isolated from family members who remained in their countries of origin, others found ways to maintain contact and to be updated on family news. One participant who had been in Canada for a year and a half shared her experience:

I go to my sister to meet her and talk. She often phones my mother and father [in Africa] so I get the message. I don’t phone my father or mother daily. My sister phones them daily. She has their messages, so I go to her place, sit with her and talk. Then we would return to our own home. 
[Age 45 years, East Africa, Gujarati, married, in Canada 1.5 years]

Even though the women were not asked to describe their family structure, women often referred to other family members who were residing within the same household. This would come up during conversations in which they were asked where or from whom they obtained certain knowledge and who guided them. For example, one 37-year old woman said, “My mother lives with us, so I ask her about what to do.” Some family units in this study sample resembled those that would be found in the women’s countries
of origin. For example, some family units included the woman's own husband, her children, and her husband's parents. Sometimes unmarried brothers and sisters of the woman's husband were also included in these family units. This type of family unit was a common occurrence for the younger women who had come as sponsored brides or were newly married and had come to join their husbands.

Although the traditional practice is for women to live with their husbands' family following marriage, there was diversity within this sample. Circumstances surrounding women's immigration (e.g., their age, marital status, and sponsorship status at time of immigration) seemed to influence the structure and composition of family units in Canada. The family unit was different for women who sponsored their elderly parents to immigrate to Canada. In this situation daughters were obligated to help their parents settle in the new country. This included the provision of emotional and economic help. Parents had to live with daughters and their extended families because they had no other means of survival in their new country. In traditional systems in the country of origin, parents are not expected to live with their daughters.

Another unusual form of family unit occurred when older women, sponsored by their sons, lived with their sons' family and the sons' parents-in-law. Traditionally, in India, older women are expected to live with one of their sons, preferably with the eldest son and his family, but that generally would not include the son's in-laws. As a result of these circumstances, both parents and parents-in-law could be living in the same household as their children and grandchildren. Many families were willing to make these kinds of accommodations to accepted norms to support the immigration of family members. One woman in this study discussed the circumstances surrounding her
immigration to Canada and its influence on her family unit. This older woman's immigration to Canada was sponsored by her son. The son accepted a "marriage of convenience" arranged by his family in order to provide an opportunity to immigrate for himself as well as his family. Although the family belonged to one of the highest Hindu castes in India, the family acted against social norms that constrain marrying outside one's own caste (e.g., a farmer cannot marry a carpenter and so on) and agreed to an inter-caste marriage for the son. As she talked about her experience, she was anxious and apprehensive about her future. The reason for her apprehension was likely associated with the way other community members may look down on her family because of her son's inter-caste marriage. She described her feelings related to this situation:

The girl wasn't even his match, but he married her. He came to Canada. All of the family came here and live together in Vancouver, but one son lives in Toronto with his family. We are eight family members, living together. So far it is good. Now one of my son-in-laws is coming from India. My other son, who is not married yet, he is going to get married.

[Age 53 years, Punjabi Hindu, married, in Canada 3 years]

This woman did not mention certain facts that were assumed to be understood. For example, when her son gets married, his wife would be expected to live with the family since the woman's son was living with her. It is a traditional practice that helps to maintain economic security and ensure that the elder women of the family pass on appropriate roles, responsibilities, and family duties to younger newer members of the family. Her son-in-law was also coming from India to join her daughter, and since her daughter lived with her, the son-in-law most likely would be expected to live with the family as well for economic reasons. The expected addition of new members appeared to create some apprehension about future family harmony.
Family Ties

Like women in India, the women in this study sustained connections with their extended families because they wanted their family's support for their well-being and economic security. A 30-year old woman emphasized the importance of maintaining family ties for her mental well-being. She stated, "I have strong family ties and strong ties with my friends and I think these things, you know, help me emotionally." For this woman, having the positive and supportive network of family was essential. As she explained, "A good support structure and all that. That's very important to maintain."

Sometimes the women needed family support for emotional and economic security during difficult times. Family ties became particularly important when a woman's husband was ill or unable to work. By living with her extended family, one woman whose husband was too sick to work was relieved of the responsibility of paying the rent, groceries, and other bills entirely on her own:

When my husband had those [health] problems and the doctor said, "you can't lift anything and you are going to have to give up work." We had some money problems and no one would help us [meaning the welfare system or relatives]. Mummy and Daddy were living with us. They were doing the payment [house mortgage]. Everyone was doing it [helping]. Because they [parents] lived with us, they only had to get groceries. Mummy bought the groceries from the basement rent. Both basements were rented out. They [renters] have to give her rent money. We have to pay bills and house payment...we saw a lot of relatives and nobody helped.
[Age 25 years, Punjabi Sikh, married, in Canada 3 years]

The women in this study not only wanted close relationships with family members, but other family members also encouraged this. An elderly woman who shared a close, caring relationship with her daughter-in-law talked about how she was encouraged to visit:
My younger daughter-in-law she lives far, in Toronto. She often phones me and asks “Mom now when are you going to come here [to Toronto].” I tell her that now that I use a walking stick I am not going to come. Then she says, “What is the big problem? This is your home too. Sit in the plane and you will get here in three hours. What other worries could you possibly have? The way you live there [in Vancouver] you can live here [in Toronto].”

[Age 80 years, Gujarati, widow, in Canada 9 years]

This same woman maintained close contact with her daughters and sisters-in-law by phone:

I have two daughters. My sons-in-law and daughters are very good. They call me a lot. My sisters-in-law they too are very good. One of them lives here in town. One is in London and she often phones. The one who lives here we always phone each other to ask how each one of us is doing. We talk to one another on a regular basis and ask each other about health and other topics, such as work. One of the sisters-in-law lives in Calgary. I stayed with her for three months. She is nice and her kids are very nice. She looks after me really well. We look after each other. There are sayings that if we look after each other then someone will in turn look after us. We have always lived like this in unity and harmony and for this reason we have not had many problems, I think.

[Age 80 years, Gujarati, widow, in Canada 9 years]

There were some situations where family living arrangements were out of the ordinary out of necessity. For example, some women became dependent on their children. A 54-year old participant described her experiences of initially having to live in Fiji without her husband because of his decision to immigrate to Canada. When she finally followed him to Canada, she was still separated from him due to the location of his employment, and she missed the support she had longed for:

My husband came to Canada to work and I was [living in Fiji] with my older brother and his wife for five to six years. There were two kids. My mother used to look after the kids and me. Then I came to Canada. My husband looked after me well for a few days. Now he lives far away. He works there and on holidays he comes home. So, I thought to myself that I’ve come alone to this world and will go away alone as well [laughs]. You come alone and you go alone. That’s how I think and console myself.

[Age 54 years, Fijian Hindu, married, in Canada 20 years]

For women who were used to having their family members with them, the fore-
mentioned arrangement was viewed as particularly undesirable and a potential source of stress due to her isolation from a family support system.

Although patterns of household structure have changed with immigration, other features of the joint family unit have not changed. For example, the family system continues to retain a hierarchical structure of authority and power not unlike the patriarchal joint family system that women experienced in their home countries.

Family Relationships: Patterns of Influence on Women’s Health

The women in this study were very clear about the different relationships they had with various members of their extended family and how that influenced the decisions they made, especially those related to health care. Relationships with family members were important to women and had a major influence on their health. To a great extent, the nature of these relationships and expectations of roles and responsibilities they held for the women were uncontested. Although the women described the benefits they received through these relationships, they also acknowledged some negative consequences. The relationships receiving the most attention included: women as wives/partners; women as mothers-in law and daughters-in law; women as mothers and daughters; and elderly women as dependents.

Relationships with Spouses: Women as Wives and Partners

Given the women’s background in their home countries, it is likely that many of them were involved in arranged marriages, although this was not talked about explicitly in the interviews. Nevertheless, each woman spoke of their notions of a “good husband” as someone who would listen, keep them happy, and not “pressure” them. Some women linked their happiness in marriage to their own health. They saw the first task of
marriage, therefore, as “adjusting” and building a good and happy relationship with their husband to ensure their happiness. A 70-year old woman recalled the time when, as a young woman, she was having a problem with her periods. Her menses stopped after her engagement was announced and then resumed after her marriage. She explained, “When I adjusted to my husband then my menses started again…because the entire system depends on a lady being happy. If you are not happy then it affects the whole body.”

[Punjabi Sikh, married; in Canada 3 years].

The women believed that they could cope with any situation as long as they had a good partner. A good husband was someone who was understanding, encouraging, and did not take “sides” with his own family/parents, or did not fight, and did not drink alcohol. For one Punjabi Hindu woman, having a supportive husband had important implications for her well-being:

We never had fights. Over there, my husband used to say as long as you are okay with me that is all that counts. We had a problem with his family. If there was problem that caused me pain. He used to say just ignore it. Some men would beat up [their wives].

[Age 75 years, Punjabi Hindu, widow, in Canada 23 years]

A traditional practice that is still common in Pakistan is for women to marry their first cousins. These marriages can be potentially stressful because women face the possibility of having children with genetic disorders. Pakistani women grow up knowing the person chosen as their marriage partner. They therefore tend to be much more comfortable with their partners than other South Asian women such as Sikhs and Hindus. Even though they are aware of the potential for genetic problems, these women appear to accept their fate. One Pakistani woman discussed the way her marriage was arranged with her first cousin and described her experience:
In our culture you can marry your first cousins. But you know at that time parents use to decide about marriage. Like both sisters [my mother and her sister] talked to each other that your daughter is my daughter and your son is my son. And when we grew up we got married. He is my mom’s sister’s son. Good thing about these kinds of marriage is that you get better chances to know each other and you don’t face problems to understand the other person.

[Age 45 years, Pakistani, Sunni Muslim, married, in Canada 1 year.]

The women benefited from the support they received from their husbands. For women who grew up in households where all the decisions were made by the male household members, husbands were often viewed as the primary source of assistance with decision making, including health care decisions. Husbands were therefore consulted on a variety of health issues/concerns and ultimately had a say in what was best for the women. Some women were reluctant to share their concerns with anyone other than their husband. For example, one Pakistani woman stated: “I avoid going to friends and relatives if there is something personal. I don’t discuss it too much. I’ll discuss it with my husband.” Another woman stated that the first person she would consult for less serious health concerns would be her husband, “If it was not anything, it does not appear to be anything of the serious nature, then probably I would discuss with my husband.”

Sometimes husbands made decisions for their wives, including decisions related to their health. In part, this happened because newly married young women were expected to assume submissive and acquiescent roles with little or no participation in decision making. Some husbands were very supportive and encouraged their wives to get the health care they needed, especially if the women appeared to be reluctant to take action. Such was the case with a 57-year old Punjabi Hindu woman who had been in Canada for three years. She had consulted a physician because she felt unwell and was
told she had gallstones and that she needed surgery. The woman appeared reluctant to consider the recommended treatment and only agreed to it when the treatment was encouraged and sanctioned by her husband. His explanation of why the surgery was important was not questioned:

If I hadn't gone [to the physician], I wouldn't have known. But she [the doctor] said “You should get it removed.” I said, “if there is no pain why take it out?” When I come home and my husband said that, “If it ever burst inside it could be very harmful for you.”

[Married, Hindu, in Canada 3 years]

Husbands, however, were not always supportive. Some husbands limited their wives’ activities and were not always accepting of their changing roles. One woman who wanted to attend a women’s social gathering felt she could not go. She said, “My husband doesn’t accept it so readily, so maybe I won’t go.” Some husbands were perceived as preventing some women from becoming independent. One woman stated:

I had always hoped that I’d learn to drive a car but what happened is that when I was good [healthy], my husband didn’t let me go to [driving lessons]. Now I probably won’t be able to drive [ due to poor health]. That’s one of my joys that has gone. If I could drive, then I could pick up my son when it would be raining. [But I can’t] because he [husband] wouldn’t let me.

[Age 54 years, Fijian Hindu, married, in Canada 20 years]

Some women recognized how insensitive actions on the part of a husband had the potential to harm their own health. For one woman, her husband’s desire for “greasy” and “overcooked” food, her own need for a diabetic diet, and her desire to provide her sons with healthy food led to an increased workload for her because she cooked three separate meals. She also viewed her husband’s tendency for “bringing things into the house that were not good” as undermining her desire to “live healthy.”

Unsupportive husbands were described by women as being “typical Indian men”
who did not believe in helping with the housework and expected women to fulfill the roles of wives, mothers, housekeepers, and cooks. Women in these situations believed they had no choice but to cope the best way they could:

They [husbands] don’t do nothing. They expect the ladies to do all the work. The wives are there to do cooking, cleaning and they [husbands] have only one job. We do two jobs. We have to go to work as well. I cope. I grumble but I still do it because there is no choice. I still do it.
[Age 53 years, married, Hindu Roman Catholic, in Canada 5 years]

Overall, however, the husbands were perceived as supportive and provided women with important advice and encouragement.

**Relationships between Mothers-in-law and Daughters-in-law**

Another relationship that was particularly influential on the women’s well-being was the relationship between mothers-in-law and daughters-in-law. The women valued and respected their mothers-in-law as matriarchal heads in the extended family units. Mothers-in-law were expected to take an active role in teaching and guiding their daughters-in-law. For example, one woman talked about the role her mother-in-law played during her early marriage when she was not familiar with all her relatives by marriage:

When my mother-in-law was living, after we were free at night [from doing daily activities], then we used to sit on a large swing together and talk. Then my mother-in-law would explain everything to me. These are our relatives. This is how closely we are related to these relatives and to these ones. You should look after them when they get married or have children, or when you have to give [presents] on the sixth day of a baby shower...
[Age 80 years, Gujarati, widow, in Canada 9 years]

Younger women valued the advice they received from their mothers-in-law, especially when they considered their mothers-in-law to be experienced and wise with regard to marital problems, childbirth, and family roles and responsibilities. Even
middle-aged women looked to their mothers-in-law for advice:

But if it is something both of us [husband and wife] can't come to some kind of solution, then yeah, we can consult my mother-in-law and consider her words of wisdom and her years of experience.

[Age 43 year, Hindu Jehovah’s Witness, married, in Canada 21 years]

Some mothers-in-law were caring and nurturing and played an important role in supporting their daughters-in-law, especially after childbirth, when women were breastfeeding. They realized the importance of rest and dietary needs during the post-partum period. For example, one mother-in-law regularly provided her daughter-in-law with specially made drinks of ground almonds and pistachios during the months she breastfed, even though this was a time consuming daily commitment.

A few of the young women who were interviewed talked about how they appreciated the help they received during the post-partum period so that they could observe the traditional practice of the 40-day rest period following childbirth. This rest period, as it was commonly practiced in India after the birth of a baby, included receiving special body massages and foods rich in protein believed to restore the woman’s body and health and to increase breast milk production. For the women in this study, it was possible to observe the rest period by being relieved from household work and consuming special foods when supportive mothers-in-law were present.

South Asian women in this study not only looked to their mothers-in-law for guidance and support regarding traditional practices but also for assistance with household chores and babysitting. One 33-year old participant explained how her mother-in-law helped with babysitting and housework:

I have my mother-in-law with me so we can share [housework]. For those [women] who are alone it is very hard on them. It is okay for people [couples] who do shift work, if they [both parents] do the same shift work then you have to
drop the kids at a different place [baby sitter]. You have to give some money for baby-sitting. Then, it becomes very expensive. Then there are some jobs where we can't change our shifts, then, it becomes very hard. [Punjabi Sikh, married, in Canada 11 years]

Mothers-in-law also turned to their daughters-in-law for assistance and guidance. They sometimes consulted their daughters-in-law about particular health issues because they believed the younger generation had greater knowledge about the health care system. If daughters-in-law were fluent in English, they were often relied upon for translation in health care interactions. It was common for older women to depend on their own children or their daughters-in-law for this kind of assistance because this ensured that confidential information would not extend beyond the family unit and the family “izzat” (honour) remained intact. It was important to many of the women that “family matters” be kept in the family for fear of “losing face” in the community if others were to find out about health issues such as serious illnesses like cancer, domestic abuse, and mental illness.

The relationships between a mother-in-law and her daughters-in-law were important to women. The women hoped for support, acceptance, and respect in these relationships. One middle-aged woman stated:

All my kids are married and settled down except one son. I wish my would-be daughter-in-law should be very nice, and someone with whom I can share my joys and sorrows. She shouldn’t be the one who makes fun of me. She should be the one who can change sad times into happy times. I wish for that kind of life now. [Age 53 years, Punjabi Hindu, married, in Canada 3 years]

Unfortunately, not all relationships between mothers-in-law and daughters-in-law lived up to expectations. Some young women felt unsupported and did not receive assistance from their mothers-in-law. This was particularly evident in one family where the mother-
in-law had a middle or upper class background and had lived a “privileged life.” The daughter-in-law explained, “She [mother-in-law] is not used to doing housework. She has never done it. She was like that from the start.” Her mother-in-law had servants in India to do her housework and cooking.

Some women attributed their health problems to the lack of assistance provided by their family and in particular, from their mothers-in-law. A 25-year old participant felt her health problems were due to not observing the traditional 40-day rest period following the birth of her first baby. She believed this was because her mother-in-law did not assist her with housework:

She [the baby] was born normal but when I had come home and when I started to vacuum because everyone was coming to see her and I wanted the place clean. It would not look good if the place was dirty. My mother-in-law did not help me. I didn’t have anyone to help me and because of that the doctor said my uterus didn’t rest.

[Punjabi Sikh, married, in Canada 3 years]

Older women also felt unsupported when their daughters-in-law were perceived as unkind and uncaring. A Hindu Punjabi woman who visited her son and his family at the son’s invitation told this story:

Like I was in Toronto with my other son and his wife. The doctor told them that I should avoid some foods. My daughter-in-law, most of the time she did not cook anything. If she did and gave me food to eat, she would keep on saying that I eat too much. That made me really upset and I felt I had to eat for my bowels. If I didn’t eat then I had constipation. One time, I could not go to toilet for four days. This could be due to stress or not eating enough. I tried to convince myself that it was okay and they are my children and tried to keep quiet and apologize. They invited me there. I didn’t go there uninvited. I was not supposed to phone anyone. If I had to phone someone then I had to go to my maternal relative’s house and phone from there. It was completely up to them that if they wanted me to talk to somebody then they gave me the phone. My son never said anything. I had that satisfaction.

[Age 52 years old Punjabi Hindu, married, in Canada 3 years]
To keep family harmony, this particular woman did not openly complain, but realized this put her own health at risk.

Relationships between Mothers and Daughters

Another very special relationship that was frequently mentioned by the women was that between mothers and daughters. The women in this study were very clear about the importance of the mother-daughter relationship with respect to the decisions they made, in particular those related to health care. Daughters generally felt comfortable sharing concerns with their mothers. Some women turned to their mothers for advice. When asked whom she turned to about health concerns, one woman answered, “At home I talk to my mom.” Some women referred to their mothers as their “friend.” When one of the women was asked whether she turned to family or to friends for advice about concerns, stated, “No, I don’t have friends except my mom. She is my only friend so I ask her.” Women often preferred and found it more comfortable to talk with their mother rather than any other relative or their mothers-in-law. They felt safe discussing issues with their mother.

Mothers were trusted not to divulge any information to others because mothers were aware of the possible consequences if their daughters’ husbands or husbands’ families found out. There were particular health issues that the women looked to their mothers for assistance. Traditionally, in India women went to their mother’s house when giving birth. There were many reasons for this. It is believed that a pregnant woman needs to rest physically as well as mentally for the sake of the expectant mother’s emotional well-being and for the health of the unborn baby. In the in-laws home she has many responsibilities and family duties and may not receive the desired rest. They
believe their own mother is the best person to care for them. When separated by distance, mothers were available by phone to guide their daughters in terms of family issues or pregnancy-related concerns. A 57-year old woman recalled how she was able to assist and guide her daughter during pregnancy:

My daughter used to phone me during her pregnancy. For her, I am her mother as well as her friend. For everything, whenever something happens she will phone me. If it is good or bad, if she wants to know she has to hear from her mom so I was telling her just don’t believe anything the first time you hear it.  
[Hindu, married, in Canada 30 years]

Older women also talked about the close relationships they had with their daughters and about their reliance on their daughters to assist them with their health care decision-making. The older women acknowledged that their daughters had more knowledge than they had regarding the western health care system. They also had the ability to drive a car and were often fluent in English. An elderly participant, when asked whom she turned to with health concerns, stated:

If I had some problem that I don’t know much about here [in Canada], I say to N...[daughter]. “I have this problem and take me to the doctor”. So she takes me somewhere. I tell my daughter because she knows. She has been here for 5 to 6 years and because she is young.  
[Age 70 years, married, Punjabi Sikh, in Canada 3 years]

In addition to providing transportation, older women often depended on their daughters’ support during medical visits as well as for providing translation during their consultations. Following immigration, some older women became totally dependent on their children due to many reasons.
Elderly Women in Dependent Family Relationships

Elderly women who followed their children to Canada coped with many challenges. Sponsored by their children, they frequently became dependent on them for housing, food, and emotional support. Out of a sense of family responsibility and obligation, the elderly women tried to help their children by trying to do chores around the house such as cooking, cleaning, and babysitting. Elderly women depended on their daughters, especially the unmarried daughters, with whom they lived. Daughters were relied upon for transportation, translation, and emotional support. A 54-year old Hindu woman who depended on her daughter to take her to medical appointments realized that at some point the daughter would not be available to assist her. She stated:

No, I have not had any difficulty because my daughter takes me whenever I need to go, when I am in pain. So I have never really faced any problem. Maybe when she gets married then I’ll find out [laughs]. Then I’ll be alone…
[Fijian, married, in Canada 20 years]

Some elderly women who were totally dependent on their family felt fortunate to have children who were committed enough to take the time that was necessary to provide transportation or other forms of support when assistance was needed. A 65-years old widow talked about her family situation: “My kids are very good, and my daughters-in-law are very good too. They take me to the doctor even without asking their husbands. If I ask for any medicine, they get the medicine right away.” [Punjabi Sikh, widow, in Canada 9 years]. This woman appreciated the support and respect she received from her daughters-in-law.

Some elderly women who were heavily dependent on their children did not want to be perceived as demanding and quietly accepted the assistance that was offered to them by the family members. A 69-year old woman who had lived in Canada for
seventeen years and was still dependent on her daughters for almost all of her needs, including transportation, translation, groceries, and personal shopping, stated:

I do not ask for anything [meaning do not demand] but my children will take me [to doctor]. When a person is in pain then they will say something. Whenever we [husband and her] want to go [to doctor], the girls, all three of them not just one. First they make appointment and tell me that we are going on this day. Sometimes, I don’t even remember that I have to go. They say be ready to go at this time on this day. In this way things go smoothly. I don’t go to the stores. I don’t buy the clothes. I don’t go to get groceries. That’s their job. I say, I am not going to get it. It’s your choice so you get what you want.

[Punjabi Sikh, married, in Canada 17 years]

Elderly women who had been sponsored by their sons or daughters worried about being totally dependent on them. Sponsored immigrants are not entitled to any benefits such as the old age pension and had to rely on their children for their social and economic needs as well as a place to live. This concerned them greatly when they observed that life was hard for their children (e.g., if they were unable to find employment).

Although thankful for being closer to their children, experiences of financial and social dependency in a new and sometimes strange country caused problems for elderly women. These experiences were often referred to as sweet prison or “matti jail.” Although not directly labeled as such by the elderly women, who recounted their experiences, the “matti jail” was implied by several. Isolation was greatest for women whose activities were further restricted by child care responsibilities. A recently immigrated Punjabi woman talked about this:

It is less [like prison] for men because they go outside. They get company and women stay at home. They [women] will keep on baby-sitting children and dusting counters. Some women tell me that they have these kind of problems. Our children don’t take us outside and they keep us inside to look after their children [grandchildren]. That’s why they sponsored us to look after their children. They [women] were better off in India because they had their properties and houses. Some of our people live in rental properties and in that small place, they all live together with their extended families. That’s not the way of living
The experience of "matti jail" is known not only to be limited to the older women, but is also encountered by the younger women as well. However, the younger women in this study did not discuss this topic.

Women in Need: Family Members’ Responses to Women’s Health Concerns

Women in this study with health care issues first turned to their family members. Family members generally responded positively and were supportive. Women were offered emotional support, advice, and instrumental support. This support from family members came in various forms such as transportation, translation, teaching, and the passing on of traditional practices.

Family Members as Providers of Emotional Support and Advice

South Asian women often turned to family members with their health concerns; however, the nature of the health concern influenced to whom the women turned. They tended to make their families aware of health problems if they were of a serious nature that required attention such as when they had chest discomfort, or if they were in pain. Family members either encouraged the women to seek medical attention, or they were taken to see a physician. One young woman discussed how she turned to her family for support and the guidance; "I will tell family first that there is this problem. Then if they all say that the doctor should see it, that it is serious, then I will go to the doctor" [Age 25 years, married, Sikh Punjabi, in Canada 3 years]. Another middle-aged woman was asked to whom she talked first about health concerns. She stated, “Mostly with our parents, or our father, mother, mother-in-law, husband or our children. We talk with
them and they give us advice that we should go to the doctor.” [Age 41 years, Punjabi Sikh, married, in Canada 10 months]

One’s own adult children were preferred confidants over other more distant relatives primarily because of the belief that the information would be kept confidential. Furthermore, women thought that, since one’s children were aware of what was going on, they would know what needed to be done. Most importantly, they could rely on immediate family members to help. One older woman explained why there was no need to go to other relatives when your own children are available, “Whatever I ask, I get that thing in a minute. Even at nighttime. If they know, I have pain, flu, headache or I have any problem, or my hand hurts. Then they will take me to the doctor first thing in the morning without asking me. Why will I ask relatives?” [Age 65 years, Punjabi Sikh, widow, in Canada 9 years]. Children were expected to fulfill their traditional roles and care for their parents. A middle-aged woman voiced this expectation of children, “I think our kids should realize that we have given them birth and they should care about us.” [Age 47 years, Punjabi Sikh, married, in Canada 18 years].

Due to the support women received from their families, they did not feel the need to seek assistance from outside the family when dealing with certain types of health issues that could be managed at home (e.g., common colds, flu or headaches). For these minor health concerns, women preferred to use their traditional home remedies that were passed down by family members. Some women used special teas for cold or flu. One older woman stated, “If I have a cold, I will drink some sonf [tea made with fennel seeds and ginger]. I do these things. If there is no relief, then I go [to the doctor].” [Age 60 years, married, Punjabi Sikh, in Canada 9 years]. Although these women believed in and
used traditional practices, at the same time they recognized the need to seek medical attention if the remedy was not effective.

Younger women who had other obligations and responsibilities such as young children and/or outside employment and older women who looked after grandchildren were likely to ignore their health concerns for as long as possible before making their family members aware of them. One woman described how she managed when feeling unwell, "I used to get up from bed with pain and prepared lunches and went to work. For a short time, I could not walk properly. I managed by limping, but it used to get better later on." Another older woman did not tell her family unless she thought the problem was serious because she did not want to worry them unnecessarily. She said:

So if I have a problem and have to go to hospital, then I tell them. If I have little pain but it gets better, I never let them worry. It is better I do not tell them anything. So I say to my children that I am fine.
[Age 75 year, Punjabi Hindu, widow, in Canada 23 years.]

Health issues related to pregnancy were usually discussed with the family by "birth" rather than the family by "marriage." Talking to mothers or married sisters was the preferred choice for most women. Family members were also one of the main sources of hope and support when the women were going through difficult times. Some families mobilized the women by encouraging them to deal with their health issues and concerns. Discussion of health-related concerns and joint decision making often influenced the women to take action. It was evident that women were confident that advice from family members would be the best for them because family members were expected to be protective and supportive. This belief was reflected in one 33-year old participant’s view:
With my family, probably everything, whether it's as minor a thing as a cold or a major thing like cancer or whatever else. I think I would discuss everything with the family to begin with because that's where I would get the support I would need. I'll go to them for everything.  
[Muslim, married, in Canada 11 years]

Another woman talked about the positive support she received from her family during her illness, and she attributed this support to her recovery:

My family has been very good for me. I feel without my family, I wouldn't be here. Because when I become sick and I had lost about 30 pounds, I was sick and I didn't want to see any friends. I said I don't want to see anybody and because my family was there and they were supporting me so much. Like they used to come to hospital every day to see me and that was the support I got. That made me feel so much better. So I feel my family is major big part of the things that's happened to me. Like they would help me through anything.  
[Age 42 years, East African Ismali, single, in Canada 23 years]

It was during times of illness that many of the women realized how important family support was to them. Family members were an important source of encouragement as one woman described, "I was giving myself for death, but my family were saying no. You have to think positively. You will survive. We are here for you. Just start praying and keep yourself happy."  
[Age 53 years, East African Muslim, married, in Canada 25 years].

It was on the advice and support from family members that women often sought medical attention. Sometimes, it appeared that women were reluctant to see physicians for their problems unless this was sanctioned and encouraged by their family members. A middle-aged woman who was diagnosed with breast cancer recall the discovery of her lump and how her family pressed her to seek medical advice:

Without them [family] I would never have made it because to me, the word cancer meant death. It just came along cancer means death if I had no family support. I had a sister and brother-in-law who are in medical field and you know they did keep on prodding me. At first I found a lump and I wasn't willing to go
to the doctors. Then I talked to my sister about it. Her husband is a doctor and you know they both checked me out and they said yes there's a lump, you better go and check it out. So, this was the family support that pushed me into it. [Age 53 years, East African Muslim, married, in Canada 25 years]

The women sometimes felt overwhelmed by the assistance they received from family members. Although the women appreciated the emotional support they received, they did not want family members to treat them as invalids. Help was welcomed while the women were sick, but once they started to recuperate they needed to be treated as normal:

I really need more emotional support [during illness]. I mean when I was sick I had everybody bringing me food and this and that and I used to tell them don't make me feel too sick. I am not sick. I am able to walk. It's just that I tire out easily. That's all that was affecting me. Don't try and make me an invalid. But they were really kind [to me], and I really appreciated everything they did for me. [Age 53 years, East African Muslim, married, in Canada 25 years]

Some South Asian women were reluctant to seek assistance from friends because they would feel obligated to assist them in return. Women who were busy with household responsibilities as well as outside employment knew it would be very difficult to find the time and energy to reciprocate. One woman stated:

I usually tend not to depend on my close friends. I think if I did turn to friends then I would feel the obligation of having to assist them. You know, when they needed it and I'm not sure how able I would be when they need me. If I would be able to be there for them. That's not something I can guarantee and I feel uncomfortable with that. [Age 33 years, Muslim, married, in Canada 11 years]

Others were concerned about the possibility that their concerns would not be kept confidential by others who were outside the family.
Unspeakable Concerns

Women did not always discuss their health concerns with others. Some of the issues that were not openly discussed were related to gynecological health, family violence, alcoholism, and certain illnesses such as cancer and mental illness. These issues were not disclosed for fear of losing family “izzat” (honour) as well as disturbing family harmony and happiness. In addition, there were feelings of shame and embarrassment surrounding these issues. These issues were therefore often not discussed within the extended family or outside of the family, sometimes resulting in decreased access to needed health services.

It was suggested that some family issues such as domestic abuse were so noticeable that a woman would not see any point in telling the rest of family because they were all aware of it, but the woman could not tell anybody outside the family either. One woman discussed how it would be difficult for women to talk about or admit to being in an abusive relationship. They would suffer in silence because they are not expected to share family issues with outsiders:

If the husbands are abusive, they [women] can’t really go and tell because they [women] are frightened for their life. Their husbands will come and beat them up again or the husbands have hurt them inside. They can’t tell that my husband bruised me. Then the thing will come up, how you were bruised, why were you bruised, why did this happen, and the wives are too frightened because the husbands are ill treating them. Our South Asian women, they bear their crosses, and I find that is sad.
[Age 53 years, Hindu Roman Catholic, married, in Canada 5 years]

Those women who were reluctant to discuss their abusive relationships with family members or outsiders such as health care providers were at increased health risk.

Although the women in this study did not talk about domestic abuse as a problem they
experienced, references like this to the problem suggested it was not an unusual experience for some women.

Another issue that also impacted on women’s health was alcohol abuse by male members of the family. Although women in this study did not explicitly discuss this issue, some indirect references were made to the problem.

Some illnesses such as cancer could not be talked about openly with others due to the stigma associated with it as well as fear and lack of knowledge related to this illness. Some women talked about the community’s response to the word “cancer.” One woman stated:

Like, yeah, I can think of something, like supposing it is cancer, which is such a word. If you tell someone you have cancer though it can be cured what ever, in our community, you are granted, they think you’re dead, finished. You’ll never survive. It’s something of that sort.
[Age 37 years, Muslim, married, in Canada 5 years]

One middle-aged woman who was treated for breast cancer spoke about other people’s responses to her illness. She realized that no one wanted to discuss this because of the social stigma attached to cancer. She stated:

I believe a couple of people told me they had cancer after I had told them about myself. The stigma still exists in our Eastern culture, especially for women. They don’t want to talk about the illness [cancer]. They pretend everything is fine and dandy, and go on and once they find out. Then you find people approaching you, asking you questions, and wanting to know how did you discover your lump.
[Age 53 years, Ismali, married from East Africa, in Canada 25 years]

Social pressures also influenced whether women would accept certain medical procedures such as therapeutic abortion, termination of pregnancy, or ultra sound scan to determine the sex of fetus: “That I may be reluctant or I may be going forward with this procedure [abortion] but I have a lot of guilt feelings that need to be resolved later on. A
lot of stigma I may feel from family or the community” [Age 33 years, Muslim, married, in Canada 11 years]. Whether the procedure was carried out or not, women were in turmoil that sometimes resulted in negative health consequences.

Some women were reluctant to discuss certain health issues even with the extended family for fear of causing the family unnecessary worry, while others were very open with their family members and felt there was no need to hide anything from them. A 33-year old study participant shared her feelings about how she viewed her family: “I don’t see any reason for hiding that information from the family because I see that as a source of support, not as a stigma” [Married, East African Muslim, in Canada 11 years].

**Family Members as Teachers**

One important role that some family members played, particularly the elders of the family, was that of teacher or advisor. Older members of the family were respected and listened to, and they often assumed responsibility for passing on traditional knowledge, values, beliefs, and practices to the younger generation. One woman said, “The words of wisdom from older people, I really respect that, and it really works” [Age 43 years, Hindu Jehovah’s Witness, married, in Canada 21 years]. Some older women passed on a range of traditional practices to younger women including special preparations and home remedies believed to enhance health and well-being. For example, one woman explained that she learned from her grandmother about a herbal medicine called karo, made from fenugreek, anise, dillseeds, allspice, and the bud of a special flower, that prevented stomach pains during childbirth.

Parents were also recognized as important teachers and role models, especially regarding healthy lifestyles. When asked how one woman obtained knowledge about
maintaining good health, a younger woman said she had received it from her parents,

“They used to tell us a lot, that we should eat this food to keep your health, do exercises, you will stay healthy with that. First we learned about what to do from our parents” [Age 25 years, Punjabi Sikh, married, in Canada 3 years]. A middle-aged woman credited her parents, particularly her mother, for teaching her good, healthy habits that she then passed on to her own children:

They always say, parents whatever they teach you, we keep following them and we teach the same things to our children. So, I think it is obvious I am following what she [mother] has been teaching me. That is what I picked up from her actually. Always she used to be after us. You must eat vegetables. You must eat green vegetables. You must eat fruits and, you know, drink a glass of milk and all that. I keep on doing the same thing to my kids.
[Age 55 years, Punjabi Sikh, married, in Canada 8 years]

Family Members as Providers of Instrumental Support

Many women depended on assistance from family members to attend medical appointments or to get other health care services such as physiotherapy, x-rays, mammography, eye examinations, and blood tests. Family members were often relied upon to provide transportation because some of the women were unable to drive themselves or not able to take public transport due to their lack of English language skills.

Family members were often called on to provide translation/interpretation. The family member’s role as interpreter included translating what was being discussed and explaining the meaning of what the health care provider said and prescribed. Generally, when dealing with female issues such as gynecological problems, pregnancy, and breast health, a female member of the family was preferred over the male members due to potential embarrassment and sensitivity regarding these issues. However, at times,
husbands, sons, and sons-in-law accompanied the women to medical appointments depending upon the nature of the health issue and the availability of a female to accompany the woman. There were times some women had little choice about who accompanied them to medical visits.

When translation was required, the women were confident that their husbands, daughters, daughters-in-law, sons-in-law, or sons would explain their problems to the health care provider. This was another perceived advantage to living in an extended family environment and having strong family ties because family members were expected to know about each other’s health concerns. An older Gujarati woman explained how during a medical appointment for an eye problem there was no need for her to talk because her son was with her to explain the problem:

Whenever I go [to the doctors], my son is always with me, so I don't even have the opportunity [or the necessity] to talk. I don't even need to talk. He [my son] tells him [doctor] in English and I talk to my son in Gujarati. If the doctor asks me some things, or shows me some letters or things of the sort then I can reply yes or no. Or if I can see things properly, or if things are not right, I can say this much [to the doctor]. I can understand a lot in English, but I don't have the habit of speaking so I can't speak it.
[Age 80 years, Widow, Gujarati, in Canada 9 years]

There were times when family members accompanied the women to provide emotional support because the women were not used to interacting with health care providers, especially physicians. At other times, family members were required to be present in case the women were unable to take in all the information, especially if it was bad news. Visiting a doctor for the first time could also be extremely stressful, particularly for recently immigrated women. A 45-year old woman who had lived in Canada for a year and a half recalled her first experience with a physician:
When I first went, I was scared. I was scared even at home [before even going to the doctor's office] since I have never ever been to the doctor, even though I had to take my daughter. Like what would they do to her, what wouldn’t they do to her. Since I had never gone before I asked her [sister] to come with me. I wasn’t scared because I thought that my sister was with me. If we were asked anything or had to answer anything then she would be able to reply to it [question]. I felt scared about what I would say to him [the doctor] and what I shouldn’t say. I didn’t really know.

[ Gujarati, married, in Canada 1.5 years]

At times, family members’ other responsibilities made it difficult for women to deal with their health concerns. For example, family members’ commitments to their jobs made it difficult for older women in particular to find transportation for appointments. Nevertheless, family members sometimes made significant sacrifices to help women get the health care they needed. A 65-year old who had a number of health problems discussed the challenges her family faced in order to take her to her appointments:

"I’m happy with it, but that time my son-in-law had to take time off to go with me. He makes $500.00 a day. He make good money, but he had to take days off to go with me. But he gave me more importance than money."

[ Punjabi Sikh, widow, in Canada 9 years]

Some women tried to be independent so that their family members would not have to take time off to accompany them to their appointments. However, for at least one woman, getting to health care providers without the aid of family members by using public transportation was a frightening experience.

There was clear evidence that family members had an enormous impact on the lives of South Asian women and their health behaviours. Mostly, family members were very supportive and a valuable resource to the women. Due to the support they received at home, the women were sometimes a little reluctant to seek assistance from outside. At the same time, family obligations at home took precedence for many of the women.
Fulfilling Family Expectations and Needs: Influences on Women’s Health

Fulfilling family expectations was sometimes difficult and had an influence on women’s health. It was not easy to take care of others. Taking care of others included adherence to the traditional roles of wife, mother, and caregiver, in addition to the modern role of outside employee. Besides taking care of others physically and carrying out the traditionally expected roles, women were also responsible for maintaining family harmony and happiness. Maintaining family harmony and happiness included carrying out the wishes of family members and fulfilling their reproductive responsibilities. The main factor impacting women’s health, in particular for the older women, was their changing role.

Taking Care of Others

Family members’ expectations related to women’s roles often influenced the South Asian women’s physical and mental health. The women in this study were expected to be obedient wives, dutiful daughters-in-law, nurturing mothers, caregivers, and good housekeepers. There were often unspoken pressures or influences that prompted the women to take various actions that increased the stress in their already stressful lives. Even when family members did not expect or ask the women to do extra work, the women felt that this was expected of them:

I'd wake up at 5:30 and no one told me that you have to do it, but I did it because that's just the way. That's just the way I was trained and I won't ask anyone to do it because these are my kids. This is my husband.
[Age 69 years, Punjabi Sikh, married, in Canada 17 years]

In addition, many of the women were expected to have outside employment in order to assist with family finances. The need to carry out family duties and fulfill family
expectations often took precedence over their own needs. Some of the women spoke about their demanding responsibilities and accepted that their workload was much heavier than the men in their families:

A woman’s life is like. You see, men go to work. Women also work and it doesn’t matter if [men] they are highly paid and women are not. There are a lot men that help with the housework. But majority of them don’t help with the housework. They never do [house] work. As well, the responsibility of looking after the children is predominantly on the mother. She has to go to work, look after the kids, and do the housework.

[Age 33 years, Punjabi Sikh, married, in Canada 11 years]

One woman discussed how there are many issues for the South Asian women that have the potential for negative health outcomes. She stated:

The atmosphere that we have grown up in, it’s different. So we are treated in a different way and when we are in India...when you come here, you find that everything is different from day one. You have to think that without me things are not going to work. You have to look after the kids. You have to go outside and work. You have to work right along side men or even more because men, I mean they work 8 hours, they come home and they won’t do anything whereas women they work 8 hours then they come home work another 4 hours. That is very stressful. That is why they become sick.

[Age 57 years, Hindu, Married, in Canada 30 years]

In addition to their domestic chores, some of the women believed it was their duty to pray for the well-being of their family. They would wake up early to pray and then go to work and on return from work they would cook, clean, and again find time to pray. In their country of origin, women were expected to worship their husbands by praying for their well-being and long life. Several women continued this practice. For example, one participant, whose husband had a number of health problems, took time to pray every morning and evening for his well-being.

The role of devoted wife was sometimes difficult to fulfill especially if women had chronic health problems. Some women tried to carry out their role of a devoted wife...
by adhering to the traditional practice of “karvaha chouth da varat”[fasting] for the well-being of their husbands. In India once a year there is a special day when married women are expected to “fast” for the well-being and long life of their husbands. The fast starts before sun rise and ends after sunset. Women only eat after praying in the evening, and with blessing and permission from their husbands. A middle-aged woman with a number of health problems including diabetes, heart problems, and hypertension tried to carry out this practice even though it meant risking her health:

You fast with God’s grace. Last night, I said to myself that this time I am going to fast and not take any medicine. Last time doctor gave me medicine to take on my fast day. Before, I used to think that I should see doctor and check, if everything is okay. He [doctor] could check my sugar level. But he gave me medicine to take. Now I do not believe in the doctor. If I am happy I am healthy I do not need anything. I am okay without medicine. If I am not happy I feel even the medicine does not work that good.  
[Age 53 years, married, Punjabi Hindu, in Canada 3 years]

This woman held strong belief about the importance of fasting to being a good wife. Although by adhering to this traditional practice she put her own health at risk, she was happy because she was able to fulfill her role as a devoted wife.

Due to chronic health issues such as arthritis and heart problems, some women were unable to assist their families by having paid employment. These women felt obligated to do their share of assisting their family members by doing household chores. Yet even simple tasks presented challenges to some. One woman who had a heart condition explained her difficulties with helping with the housework:

I do it slowly, can't work hard. So do it slowly. What happens is that the work that normally takes one hour takes me two hours to complete [laughs]. When you're sick then something that should take you an hour takes two. So, if my health had been good, then I'd have been able to work faster. I have to do the housework, I don't work outside. When I could work outside, my husband didn't let me. Now I am sick so it's hard to go [laughs].
Sometimes, women compromised their own health needs because family members had different preferences, and the women believed they would add to the financial burden if they were to put their own needs first. This was particularly difficult when women required special diets, such as a diabetic diet. One middle-age woman decided to drink only homogenized milk, which was contradictory to her dietary need. Even though she was told to use skim milk because of her diabetes, she believed that buying skim milk was not feasible because her husband was not willing to change his habit of drinking homogenized milk.

Maintaining Family Harmony and Happiness

The women in this study were committed to fulfilling family expectations and trying to maintain harmony within the family unit. In an effort to maintain family harmony, these women often risked their well-being. Women often found themselves caught in the middle when their beliefs about what was best for their health conflicted with the wishes of family members. One woman was torn when her mother wanted her to use traditional medicine for her husband's illness, while the recommended medical treatment was surgical intervention. She felt an obligation to be a dutiful daughter and to not hurt her mother’s feelings, while at the same time she wanted to fulfill her role of wife and do what was best for her husband’s condition:

I've talked a lot about it with my mother, she is from India. Her thinking is that desi [traditional] medicine will provide relief. My mummy didn’t want [husband’s name] to have surgery. In the morning, she prays that he will get well. Without the operation he will get well. They [my parents] are scared of the operation. They [my parents] say that he [my husband] will get better. But we didn’t tell them that he was on the waiting list and that the surgery is in June. [Age 25 years, Punjabi Sikh, married, in Canada 3 years]
Dealing with differences of beliefs between the women and their family was a common problem. Often, it was a case of whom to believe or whose advice to follow. Women were sometimes caught between differing and incongruent points of view. It was “either or,” and impossible to do both at the same time. One woman suffered from chicken pox and wanted to follow a traditional ritual/remedy of praying to the “Mata,” the chicken pox goddess, and to light incense, which her mother encouraged. She believed these actions would help to speed her recovery and decrease her discomfort. Her husband did not believe in these remedies. This situation was very difficult because the woman believed in what her mother told her. She followed her mother’s advice half-heartedly because she was aware of her husband’s feelings.

Among South Asian families, an important role for women was that of reproduction and, particularly, producing a male offspring to carry on the family’s name (Riessman, 2000). Those women who had difficulty becoming pregnant or were unable to conceive felt fortunate when their husbands were understanding and uncomplaining. Even those women who had healthy daughters felt obligated to please their husbands and their families by continuing to attempt to produce a male child to carry on the family’s name. A middle-aged woman with four healthy daughters and a son talked about how she fulfilled her responsibility of producing a male infant, although it meant having more children than planned:

I had in my mind that I am going to have two or three kids. So even now when we are getting old and my husband says this many times that if we had son earlier then we would have only two kids. So then now we would have fulfilled our responsibilities.
[ Age 50 years, Punjabi Sikh, married, in Canada 27 years]

Although women did not perceive themselves as being pressured, nevertheless, it
was implied that they were expected to try every available means to have a child. One younger Punjabi woman tried numerous traditional remedies recommended by family members even though she was not confident they would be effective:

Okay because I never had a pressure from--- [my husband]---[he] has never ever said to me, "You don’t have a kid." [Woman’s voice goes into a whisper]. No never. He always said, “As long as you’re healthy and you’re happy” that’s all. [Researcher: Have you ever tried any alternative therapy?]. It never hurts to try but if you do it with some faith and I always did. I did not take anything that’s 100% because I knew at the back of my mind that these are just alternatives to me. I am doing something to satisfy myself that I can say, “I tried. I did all my level best.” It wasn’t just that I sat back and tried to pity myself. I did it and tried it. It did not work. I tried everything and most of these things my mother-in-law had it fixed up for me when I went to India. She went with me and gave me all the support in the world. She knows that I tried it. I didn’t disappoint her [mother-in-law]. I didn’t disappoint myself that was the most important thing. If it’s not meant to be, it’s not meant to be. What can I do? [Age 34 years, Punjabi Sikh, married, in Canada 16 years]

Family as a Barrier to Women’s Health

There were times when family members acted as barriers to women’s health. Sometimes this was due to changing roles due in part to the immigration process. For example, some women had no choice but to follow their family to Canada, and this dramatically changed their role and position in the family. One of the challenges that women, particularly older women, faced following immigration was losing the respect they had earned due to their age and years of experience and wisdom. Although in India elders of the house were not required to do any household chores, they were expected to supervise younger members of the house and provide advice related to childrearing, traditional practices, and family affairs. This was not always the case for elderly women in this study sample. Elderly women sponsored by their children arrived in Canada to find that this was a different culture where their roles were not as valued. In addition, they faced the challenges of language, transportation, and social isolation. They ended up
cooking, cleaning, and sometimes not having the respect and rest that they had looked forward to in their senior years.

When there was housework that needed to be done, women felt obligated to do their share in order to assist the family. An older woman felt that due to health reasons she should not be performing any housework but had no choice because other family members did not have time to do it:

They [doctors] say that I should not do heavy lifting, and not work too hard. I have to wash dishes and they [children] say don’t wash too many dishes. If I don’t do dishes, I am the only one in the house. Then I have to clean the dishes. So, I wash them. It doesn’t affect me too much. I take a pill. Then I rest. I rest for some time. So after sleeping I feel better and then I do some housework. Because I am alone at home and I have to do everything. Otherwise my daughter is quite helpful. When she is at home she does everything then I just do the cooking. Cooking is not a hard job for me.

[Age 54 years, Fijian Hindu, married, in Canada 22 years]

Some women had left a privileged life with servants to come to Canada with their husbands. However, with immigration their status and their standard of living was significantly altered. This change in their socio-economic level and social isolation resulted in some women having mental health issues. One woman found herself in Canada in a rented basement suite and without servants:

It was a major depression. It is still at times, believe me. Because I was in shock. It is total change and mine was big change. My husband was really doing well there [India]. So you know, for me it was a total change. We were members of US Club. He was army officer, and he was a manager with the particular company. He was corporate manager looking after Bombay, Madras, Delhi, and Calcutta. And you know, we had paid vacations. We used to live in five stars [hotels] at the company’s cost. Then we had a company driver. We had a car, and we had our own car. The driver, he would come and pick him [husband] up everyday and you know he [husband] didn’t even need to drive. So you can imagine for him [husband] how difficult it is. So I really feel for him. I feel depressed even now, when I see myself in a basement suite and you know. Coming back to the same place and you were much better off there.

[Age 42 years, Punjabi Sikh, married, in Canada 1.1 years]
This woman did not have the support of the extended family to help her cope with her depression. She was embarrassed to let her young sons know about her illness, and she did not want her family back in India to know about her illness because it would mean disclosing her lower living standard to them. This isolation further exacerbated her difficulties.

Family members also acted as a barrier to women’s well-being in marital disputes. Women who were experiencing difficulties were encouraged to remain in a marriage because a separation or a divorce would be viewed negatively by the community. A 75-year old woman discussed her daughter’s situation:

> The belief is that for a boy or girl, there should be only one marriage. Not more than one marriage. What’s in one is in the other. One should be satisfied with each other. It is written in stone, so be content. What’s in you is in another woman and those men will only see a different face [women have similar characteristics just the faces are different]. They won’t find difference in anything else. They’ll understand. This is the belief, I said to S—[daughter] that if you divorce then you can’t get remarried. She said mother you are saying this to me. I said look after your child. S—[daughter] sat [had] with two children and I said to her stay with your man no matter what he is like.

[Punjabi Hindu, widow, in Canada 23 years]

In the context of these views of marriage, women were often left with guilt and no real choice but to stay in an unsatisfactory marriages. The women in this study suggested it was not uncommon for women to put up with domestic abuse just to please family members and to save face in their community. These factors impacted on women’s health.

**Summary**

This chapter has described and illustrated the South Asian women’s experiences of the influence of family members on their health decision making and health seeking.
There is clear evidence that the members of the women’s extended family influenced their lives in Canada. Health decisions were not made in isolation but in consultation with other family members. Husbands, mothers-in-law, mothers, daughters-in-law, sisters, sisters-in-law, sons-in-law, and sons all participated in the health seeking and decision-making process for these women. Older women in particular were very influenced by their sons, daughters, and daughters-in-law when seeking help.

Overall, family members were supportive and positive in assisting women with their decision regarding health issues. They provided indirect and direct assistance and often responded positively to women’s needs, although the women were still expected to fulfill their traditional roles and responsibilities as wives, caregivers, housekeepers, dutiful daughters, and daughters-in-law. These roles often affected the decisions they made with regards to their health. This way of living was shown in this study to be both positive and negative for the women in terms of their health.
CHAPTER FIVE

DISCUSSION OF FINDINGS, IMPLICATIONS, AND CONCLUSIONS

Introduction

Chapter four presented the findings of the data analysis for this ethnographic study. In this chapter, the most significant aspects of the findings are discussed in light of the relevant research. Due to the dearth of studies on family members’ influence on South Asian women’s health decision making, references to the literature include references to unpublished and opinion papers and the writer’s own clinical experience and cultural knowledge.

To date, virtually no research has been conducted on the influence of family members on the health decision making and health-seeking practices of South Asian women living in Canada. The purpose of this study was to examine the influence of family members on immigrant South Asian women’s decision making related to their health concerns and their health-seeking behaviours. This study’s findings provide important information on the influence of family on South Asian women’s health and their health decision making.

The most significant aspects of the findings of this study will be discussed. Major findings related to immigrant South Asian women’s commitments to their traditional roles, responsibilities, and family duties are presented. These roles and responsibilities were related to women’s relationships with each member of the family. Findings related to the importance women attribute to their families as providers of emotional and instrumental support will be discussed. This support had both positive and negative
consequences. Of significance is the observation that families sometimes created barriers to women’s health.

The second section of the discussion of the findings will draw on the literature and clinical observations to highlight aspects of women’s experiences that were not openly discussed in the interviews despite their potential importance in influencing women’s health care decision making and health seeking. These aspects of women’s experiences include the impact of arranged marriages, as well as experiences of domestic abuse including emotional, verbal, and physical abuse.

The results cannot be generalized to other groups of immigrant women, but they raise questions for further research on women’s health. The implications of the findings for nursing practice, nursing education, nursing administration, and further nursing research are contained in the next section. Subsequently, the method of the study and its limitations are discussed. A summary of the study concludes this chapter.

The Roles, Responsibilities, and Family Duties

The findings of this study suggest that the strong sense of the responsibility and duty that immigrant South Asian women experience towards their families pervaded the women’s lives and was an important factor influencing their health. In their country of origin South Asian women are socialized very early on in their lives to their expected female roles (Kadetotad, 1979). They are brought up to believe that it is their “Dharm” (religious duty) to carry out these duties and responsibilities to the best of their ability (Kapadia, 1966; Sinha, 1993). Although these roles can vary with generations, education, socio-economic level, and rural or urban environments, there is evidence that non-adherence to prescribed roles has the potential for negative consequences. For
example, lack of adherence to traditional roles has been associated with experiences of
being ostracized by the family, friends, and the community, and with family conflict
(Agnew, 1996; Badyal, 2003; Choudhry, 2002; Dhruvarajan, 1994; Hundial, 2000;
Meadows et al., 2001).

Research indicates that it is not only South Asian immigrant women (Burr, 2002;
Choudhry, 2001) who are highly committed to their traditional family roles, but that this
is also characteristic of other groups including Arab-American (Kridli, 2002; Meleis,
1991), Arab-Canadian (Abu-Laban, 1980), Middle Eastern, and Far Eastern (Meadows et
al., 2001) immigrant women. Yet in attempting to carry out these roles, immigrant
women are often placed at risk for physical and mental health problems (Meleis, 1991).
For example, Kridli (2002) reports that Arab-American women are at increased risk of
health problems for a number of reasons including cultural conflict, trauma associated
with immigration experiences, loss of social support, and lack of knowledge regarding
the Western health system. Women’s invisible and unacknowledged roles also increase
their risk for physical and mental health problems when fulfilling these roles is
complicated by living in two different cultures that have very opposite values (Meleis,

Traditional and Changing Roles Following Immigration

The findings of this study suggest that following immigration, South Asian
women continue to be strongly committed to their roles, responsibilities, and family
duties. Nevertheless, some important changes to these roles associated with immigration
were observed. In addition to their “traditional” family roles and responsibilities, most
women were required to assist family finances by finding outside employment. Some
women in this study linked these role changes to health problems and their ability to take care of their health because of the increased demands for their labour both inside and outside of the home.

Other researchers who focused on the experiences of immigrant South Asian women living in Canada have also observed changes in immigrant women’s roles (Agnew, 1991; Basran, 1993; Burr, 2002; Choudhry, 2001; Choudhry et al., 2002). Choudhry et al., (2002) found that South Asian women acknowledge that role changes were occurring rather quickly and that these changes caused uneasiness and familial conflict between the younger and older generations. However, Meadows et al. (2002) found that immigrant women perceived their role changes positively in that new opportunities were created. For example, for the first time, some women were able to find employment and interact with others (in particular with individuals of the opposite gender). These women also confirmed that role changes associated with immigration were sometimes by choice and at other times motivated by necessity. The impact of role changes on immigrant women’s health, however, has not received a great deal of attention.

The most sacred and essential roles for an Indian woman are that of wife and mother (Ramu, 1977). The immigrant South Asian women, in this study, like the women in India were committed to these roles and reported how their various roles (such as being a wife and mother) directed them to consult with family members on decisions regarding their health and health care. Although the fact that family members occasionally made decisions had negative consequences, for example, delaying seeking medical attention and treatment because the family decision maker was not available,
most of the women in this study described the assistance they received from their families as positive and supportive. Some of the women expected family members to make health care decisions for them, while others were strongly influenced by advice from family members.

Challenges and Conflict Associated with Emerging Roles

Family roles have a special purpose and meaning when they function in a coordinated manner. These roles are important to a family institution because they express familial love and feeling. In India the most important role is that of a wife and the transition from the role of daughter in her natal family to a wife in her husband's family is the most demanding role transition for young women (Jambunathan, 1989; Ramu, 1977; Sinha, 1993). Marriage is considered synonymous with birth and often referred to as a "second birth" for a woman (Choudhry, 2001). It is not just the actual role but the obligation and expectations of the role that present a challenge.

In a study by Derne (1995) in India, it was found that most of the Indian men described the ideal wife as someone who is obedient, accepting of whatever demands the husband has of her, and willing to carry those demands in order to please him. In addition, a wife is expected to dress appropriately to please her husband while ensuring that it will be acceptable to the community and that family "izzat" (honour) is maintained. The newly married girl is expected to take over all household duties to free her mother-in-law from these duties (Choudhry, 2001; Derne, 1995). Therefore, the role of a wife is one of the important roles that women are expected and committed to carry out.
The majority of the women in this study were married. Only five of the forty-seven study participants were unmarried, and five were widowed. Accordingly, one of the most talked about roles was that of a wife. The role of a wife was slightly different from the traditional role that one would typically find in India. Women in the study reported that they often had outside employment and expected their husbands to assist with some of the household chores. In addition, the women shared experiences that reflected their increasing independence, which was perceived as a positive change. The factors that may account for these role changes are increasing awareness of women’s rights, empowerment, and employment opportunities related to immigration to western countries (Agnew, 1991; Basran, 1993).

There is also some evidence from Indian literature dating back to the mid sixties that women’s roles are changing (Kapadia, 1966; Sinha, 1993). Rao and Rao (1982) reported that education is primarily responsible for bringing women out of the confinement of their houses. Rao and Rao describe how employment has resulted in challenges, changes, and conflict for some South Asian women. Some South Asian women with outside employment have enjoyed benefits such as economic independence, participation in decision making about household budgets and family investments, and reduced household responsibilities. Rao and Rao’s study, however, indicated that women’s expectation of help from their husbands with household chores and childcare is consistent with the traditional role, where men are not expected or likely to offer help.

There has been considerable research on American employed mothers in relation to role changes in decision-making power, role conflict, sharing of household chores, assistance with childcare, and in husband-wife relationships. It has been reported that employed
mothers are generally overwhelmed and that full time homemakers are economically vulnerable (Tepperman, & Wilson, 1993).

Agnew (1991) argues that although immigration to western countries such as Canada often creates possibilities for South Asian women to have important choices in their lives (e.g. exercising their individual rights, becoming independent and autonomous). However, immigration also requires women to establish new social support networks, which can result in additional stress in women's lives (Agnew, 1996). The new independent woman's traditional values and beliefs may conflict with new values. Moreover, the family and community often label this independent, self-asserting, autonomous, employed woman as "selfish" and a threat to the traditional norms. Agnew (1991) further states how the working immigrant woman is sometimes compelled to give up some of her traditions in order to fit into the western society, for example having to give up wearing her traditional clothes, "salwar kamaze," or having to cut her hair short. The desire to preserve her own traditional cultural practice and the urge to give in to peer pressure from society result in the South Asian woman experiencing cultural conflict, isolation, and confusion about her own identity (Agnew, 1991).

Similar to other reports in the literature (Agnew, 1991; Choudhry, 2001; Meadows et al., 2001; Melies, 1991; Rao, & Rao, 1982; Tepperman & Wilson, 1993), the women in this study reported that, besides carrying out their traditional roles of wife and mother, they often had additional roles and responsibilities including outside employment to assist household finances. Their employment supported family reunification and often helped them minimize their experiences of social isolation. Outside employment, however, had the potential for family conflict. Women who work for pay outside the
home gain knowledge, independence, and increased potential for more control over their own lives. The working women in this study, like those observed in other studies of South Asian women (Choudhry, 2001), had dual roles and lacked the usual support that would be available in India, such as extended family networks and domestic help. Although men were not interviewed in this study, some women complained about the lack of assistance with household chores from their male partners. The sharing of housework or childcare with their husbands was not referred to by many of the women. One participant stated that if at the end of a workday she complained about how her feet hurt and how she was having difficulty doing the cooking, her husband’s answer was to quit work and live on what he was earning. It appears that despite significant changes in women's and men's roles in Canada, immigrant women who work continue to face challenges that are not unlike those identified by Rao and Rao (1982) over 20 years ago.

Changes in Role and Relationships among Older and Younger Women

The findings of this study parallel the literature that suggests that young women should respect their mothers-in-law (Assanand, 1990; Derne, 1995; Rao, and Rao, 1982). Women in the study demonstrated how they turned to their mothers-in-law to learn about traditional rituals and roles. Women respected their mothers-in-law for their wisdom and knowledge and would seek assistance from them on a variety of issues, including marital concerns. Some women discussed how the older women, in particular the mothers-in-law, helped out with the housework and childcare so that the younger women could continue with the outside employment.

Older South Asian women in the study also benefited from having good relationships with younger women and respected them for their language skills and
experience with the western society. This resulted in their daughters-in-law influencing senior women in their health care decision making. At times, however, senior women were reluctant to tell their daughters-in-law about their health problems because they were aware of the heavy load these young daughters-in-law had with their various roles and responsibilities as well as outside employment. Once again this was a surprising finding that seems to suggest that exposure to the western countries has contributed towards harmony among mothers-in-law and daughters-in-law. Traditionally, the mother-in-law did not show any compassion toward the daughter-in-law.

Changing Role of Daughters

A surprising aspect of the study was the role that daughters, in particular married daughters, played in their parents’ lives, which contradicts traditional norms. In India, once a girl is married, her contact with her parents is very limited, and parents are not expected to live with their married daughters. The study’s findings suggest that this traditional practice may be changing with immigration. Some women mentioned how they had their mothers living with them and spoke positively about how they [mothers] assisted with household chores or with finances. Elderly women living with their daughters also reported benefits of having their daughters assist them with their medical appointments, etc.

Challenges of Role Changes for Older Women Following Immigration

Life for older South Asian women appears to be significantly influenced by immigration. Although the elderly women in this study did not complain openly about the challenges they experienced in their daily lives, there was clear evidence that some were facing difficulties. The older South Asian women were expected and felt obliged to
offer to care for children so that the younger women could work outside the house. Taking care of the children can be demanding work, especially when combined with housework and cooking duties. This was often perceived by the women as too heavy a work load for seniors to handle and too negative an influence on their health.

Clinical observations of the local community suggest that some older women may be compelled to assist family finances by seeking paid employment of any kind. Because these women lack skills and English language ability, the type of work available to them is limited to seasonal farm work, cleaning, or unskilled labour positions. In these jobs individuals are often required to work long hours, for low pay and at times in unhealthy working environments. Role changes associated with immigration appear to be impacting older immigrant South Asian women in a variety of ways.

Women's Health in the Context of Families

The findings of this study suggest that family members were often available for women. They provided support and advice that directly impacted their health. For example, they accompanied women on medical appointments and would often translate, explain procedures, and provide emotional support. Although family support and assistance was perceived positively, there were costs attached to this support.

Family as Provider of Support

Social support is a very complex concept that has been reported to have a favourable role in health (Thompson, 1987). Furthermore, social support has been associated with social networks (Malone, 1988). Immigrant women often lack adequate social networks and this has been linked to negative consequences for “their” health, in particular their mental health (Aroian & Spitzer, 1996; Choudhry, 2001; Jambunathan,
Although social support is usually acquired through social networks, the presence of social relationships does not necessarily guarantee adequate social support.

Although all the women in this study were either living with family members or were in close contact with them, some women reported social isolation and made inferences between the isolation they experienced and their health. For example, a few South Asian women in this study reported that in some situations their relatives were not able to offer the emotional support they needed because they were too busy with their own lives. The women blamed the immigration process for this because everyone was busy with their own settlement issues. They talked about the importance of support from the extended family for their well-being and, if financially dependent on their family, for their survival. Research on other immigrant families supports that, regardless of whether the family is seen as supportive or not, the presence of family is often identified by individuals as important, especially for immigrant families in their adaptation and settlement (Aroian & Spitzer, 1996). Other research has shown that lack of social support networks increases immigrant women's health risks (Aroian & Spitzer, 1996; Choudhry, 2001; Jambunathan, 1989; Kridil, 2002; Steiner & Bansil, 1989). The immigrant South Asian women in this study recognized the importance of social support and worked hard to sponsor their extended family members. Instrumental support provided by the family members who had been in Canada for sometime included material support and resources, such as assistance with housing, food, and basic human needs.
Cost of Family Support

Although there are many benefits and positive outcomes related to family support, nonetheless, for some women, this support had negative consequences for their health. For example, although women appreciated the support of husbands who accompanied them to medical appointments, this practice may have limited their opportunity to discuss health care concerns. There are some “female” issues, such as reproductive health concerns or gynecological issues, that women are not likely to discuss when a male family member is present or with a male physician. At other times, women accompanied women, but again some personal issues such as sexuality or emotional stress due to family conflict may not be shared openly with physicians to protect family honour.

The women in this study did not openly discuss these issues during their interviews. This has also been observed by other researchers who have found that South Asian women are very reluctant to discuss or disclose some sensitive or secretive issues including sexuality and reproductive health to others outside their family, including health care providers (Bottorff et al., 1998; Bottorff, et al., 2001; Chapple, Ling, & May, 1998; Gupta, Kumar, & Stewart, 2002; Johnson et al., 1999). In addition, there are many anecdotal examples from this writer’s own clinical practice to support this observation. The women’s reluctance to share sensitive information during interviews may be related to the unfamiliar context of the research interview. It may also be that the women were worried that disclosures may have negative consequences for their families. Women whose desire to protect the family “izzat” is strong may be at risk for unmet health needs.

Observation of the local community suggest that newly arrived women, when in need of medical attention, are often taken to a physician selected by their husbands or by
a relative. The lack of opportunity to select a medical practitioner of their choice may also be an important factor influencing women's health.

Some older South Asian women reported that their sons accompanied them to their medical appointments because no female member was available. Depending on the nature of the health problem, a son accompanying his mother for a medical appointment may be problematic for women. For example, women who may be experiencing gynecological problems or breast symptoms may be reluctant to fully discuss these concerns in front of their sons. Consequently, their health issues may be neglected until it becomes serious or is obvious to other members of the family.

Most of the older immigrant South Asian women in this study were financially dependent on their children. These women recognized that their children were working very hard and did not want to be an additional burden on them. They shared in interviews that they kept their health concerns to themselves, or waited until the problem became serious. They did this because family members would have to take time off to accompany the women to their medical appointments and because of their concerns about the cost of medication.

Family Pressures and Conflict

Although support from family members was important for immigrant South Asian women in this study, family pressures and conflict also influenced the women. The significance of family pressure and conflict is a potentially important factor influencing women's health that has received little research attention in the South Asian community. While it was notably absent from interviews, there is some evidence to support the importance of these issues, particularly in the context of arranged marriages and domestic
abuse (Agnew, 1991; Badyal, 2003; Hundial, 2000; Thukar, 1992). Although some changes have occurred in the way marriages are arranged, traditional practices remain strong in the local community. Families continue to support arranged marriages, and preference is given to bringing to a spouse from India as a way of maintaining ties and strengthening ethnic identity (Chadney, 1980). Nett (1988) reported that Indo-Canadian parents believe that arranged marriages are far superior to those where the younger people are the sole decision maker. Observations in the local community suggest that some parents are starting to allow their second-generation children to have some say in the selection of a partner; however, this practice does not usually extended to young, newly immigrated women. Often they are under obligation to family members and will marry whoever is selected for them (Jain, 2001). Jain reported on a case where the father attempted to murder his daughter for defying his wish to marry the man chosen for her.

Some of the issues that have been observed within the South Asian community living in Vancouver which were not discussed in the interviews are changes in the way marriages are arranged, the consequent increased stress in women’s lives, because of this change and negative health outcomes. Clinical observations involving young, newly arrived women in Vancouver suggest the impact of the immigration process on the South Asian community’s values and practices especially in relation to arranged marriages should not be ignored. Some young South Asian women have been observed to be forced into inappropriate marriages due to pressures from family members (Harjinder Thind, personal communication March 2003). The extended family members may want someone from India to marry a woman in Canada to facilitate their immigration.

Harjinder Thind, the host of a daily community talk show on Radio Punjab, has hosted
several talk shows on the issues of these “marriages of conveniences.” According to Thind, radio discussions have revealed that such marriages of convenience can lead to psychological health problems and a number of physical health issues. Some women reported encountering family abuse and exposure to sexually transmitted diseases from their male partners. Because the South Asian women are committed to and are influenced by the extended members of their family, they unwillingly accept these marriages. Compounding the problem, when women experience difficulties with these marriages, in order to keep family “izzat”, they are not able to discuss their experiences with anyone outside their home.

Women in arranged marriages with men who are much older than they are face unique challenges because of significant age differences. For example, problems such as a different outlook on life; having to deal with husbands who may already have health problems due to advance age; and different values and beliefs and education levels. Through their marriages, the women not only provide immigration opportunities for the rest of the family, but also are often required to find employment soon after arriving in western countries to financially support family sponsorships. They are often not able to find well-paid employment because of their language skills, unfamiliarity with the western system, and lack of education. Frequently employed as cleaners, or in sewing factories or on farms, they are sometimes exposed to poor working conditions and long hour of work.

Clinical observations and the literature suggest that domestic abuse is a common problem and that women are often unwilling to seek assistance outside their families. Domestic abuse has been linked to several factors, including spousal alcohol abuse
(Agnew, 1991; Badyal, 2003; Raj, & Silverman, 2003; Thakur, 1992). Although domestic violence occurs in every community, in immigrant communities there is less disclosure of this problem (Agnew, 1996; Badyal, 2003; Raj, & Silverman, 2003; Thakur, 1992). Some South Asian women encounter the issue of domestic abuse but are often afraid to take any steps to deal with it. This is in part due to the popular beliefs that family matters should be kept private to protect family izzat (Agnew, 1991; Badyal, 2003; Sihota, 2000). Another reason that restricts women from disclosure of abuse is the fear of disapproval from authorities. These women are in personal turmoil. They cannot leave the abusive situation because they are sponsored immigrants. Canadian law states that the sponsoring individual takes responsibility for providing for the sponsored immigrant for ten years, and subsequently they are not entitled to any government benefits. Any complaints may impact their opportunities to sponsor parents or other close relatives. In order to survive in the strange unfamiliar new country, the women need the support of their family members. Accordingly, women stay quiet and continue to live in abusive relationships and encounter many health issues, both physical and emotional. Fear and shame combined often stop South Asian women from seeking help or admitting that they require the special services, which could account for why this subject did not come up in this study.

Implications of the Findings

The findings of this study have implications for clinical nursing practice, nursing education, nursing administration, and nursing research. Each of the implications will be discussed in separate sections.
Implications for Clinical Practice

A variety of implications for clinical practice have emerged from the findings of this study. The suggestions noted in this section are not new to some nurses but support the urgent need for nurses to address the challenges and difficult issues that arise when providing care to culturally diverse clients.

When providing care to immigrant South Asian women, it is important that nurses not make any assumptions about their understanding of health care issues and the western health care system. It may be necessary to explain to women how the system works and what is expected of them. Since extended family members form an integral part of South Asian women's lives, when planning care or intervening, nurses should seek the support and involvement of key family members but only when the women desire this involvement.

Nurses are in a position to provide education about the health issues not only to families, but also to the South Asian community. Education of community is of the utmost importance, because women often seek the permission of the family as well as the support of the community to deal with health issues. If the community is not aware of women's health issues and what services are available and needed, they are not likely to support and encourage women to access health care services such as preventive and health promotion services.

Nurses need to be aware of sensitive health issues for the South Asian women and to provide a safe and appropriate environment to deal with these issues. Furthermore, nurses should be observant for indications of domestic abuse, family conflict, social isolation, and sexual abuse because women often do not openly share these experiences
with others. Nurses need to be respectful of this and non-judgmental in their interactions with women. At the same time they, need to find ways to provide confidential opportunities for women to share their concerns.

Discriminatory attitudes of health care providers can impact the illness experience of individual under their care (Johnson et al., in press). Nurses need to pay attention to the way they interact with the individual and their use of language when referring to diverse groups of people. Not only should an individual nurse monitor her own attitudes, but he or she should also point out and remind others to recognize their attitudes. Nurses can help each other by having frequent discussions about both passive and active racism.

Finally, it is important that nurses receive ongoing, in-service education on cross-cultural caring. Nurses have a professional responsibility and accountability to provide the best possible care to diverse ethnocultural groups.

Implications for Nursing Education

The findings of this study have several implications for nursing education. Educators are in unique positions that make a difference in the way nurses are educated. Educators have the skills and tools to change attitudes of individuals towards those who may be different from them and are under their care. Cross-cultural caring and communication courses should be mandatory for individuals entering the nursing profession. This education should be introduced early in the program and continued throughout the program at the graduate and postgraduate levels. If nurses are to provide appropriate care to immigrant clients, nursing students need to understand health problems related to culturally diverse clients.
Nursing students working with culturally diverse clients should learn to work with individuals as well as families. At times, it means that the nurse needs to negotiate with families in order to provide appropriate care to their clients.

Ongoing education is not only necessary for students but is also essential for the nursing faculty. The faculty must have knowledge of cross-cultural care and the health issues of immigrant populations. They must have the skills and ability to guide students in learning how to respond sensitively to ethnocultural differences.

Implications for Nursing Administration

This study also has implications for nursing administrators whose job it is to facilitate the effective provision of care to the immigrant South Asian women. To achieve this goal for immigrant South Asian women who seek care, the nursing administrators should seek feedback from the nursing staff about the resources and support that would assist them in providing care to the immigrant communities. This interaction would afford opportunities for the front-line nursing staff to participate in ensuring provision of appropriate care to their clients. This could be achieved through staff meetings. In addition, nurses could provide feedback through verbal or written communication with nursing administrators. Nursing administrators could also enhance the quality of care to culturally diverse clients by employing staff with language and cultural skills. Another means of ensuring provision of appropriate care is by offering specialized programs when necessary.

Nursing administrators need to acknowledge that nurses are challenged in providing care to culturally diverse clients who face many challenges and barriers. Supporting nurses in providing excellent care to culturally diverse clients can be
accomplished through the implementation of appropriate programs, procedures, and policies for intervention and assessment. Important resources for both the nursing staff as well as the client include adequate interpretive services and access to female interpreters when this may be needed. Translated, printed informational material should also be available.

Implications for Nursing Research

The study findings suggest the need for further research. The ways the families influence South Asian women's health in second-generation families should be examined. Research with second-generation South Asian women may reveal a larger variation of responses, resulting in a better understanding of the influence of family members on health decision making and on health seeking.

A study that focuses on examining the immigrant South Asian women's experiences as they receive health care when family members are involved would also be worthwhile and may provide important information. Including both women and their partners in future studies may reveal new insights about how decisions related to health care are made.

Research is also needed to examine the effects of arranged marriages on women's health. This would include both immigrant and second-generation South Asian women. In addition to arranged marriages the effects and impact of the dowry system that pervades immigrant South Asian women's lives would also provide important information.

Finally, studies focusing on the elderly immigrant South Asian women and their family members would be worthwhile. The elderly South Asian women are often
dependent upon their sons or daughters. Therefore, there are several family members that influence their health decisions and health seeking. The result of this research would be useful in identifying appropriate health services for this group.

**Limitation of the Study**

The major limitation of this study relates to the research questions. This was a secondary analysis and the research questions were not included in the original study. This may have affected the quality of the data and the analysis. There is a lot of anecdotal evidence about particular difficulties that South Asian women experience related to their health that was not reflected in these findings. Although the South Asian female research assistants, who were fluent in Punjabi, Hindi, Urdu, and Gujarati, provided women with opportunities to discuss these concerns, women did not openly talk about them. The issues that were not discussed in this study included domestic abuse, arranged marriages, lack of choice in health care decision making, role reversal, mental health concerns, and changing beliefs and values due to immigration to western countries. This may be a reflection of the interview questions, women’s lack of trust and comfort with the interview process, fear of consequences of disclosure, and desire to protect family “izzat”. Conducting more than one interview with each woman to build rapport and trust between the woman and the research assistants and comfort level with interview process may have been beneficial. Using other forms of data collection strategies to compliment the interviews conducted in this study, such as participant observation as well as interviewing clinicians, may have provided important additional sources of information. In addition, it is possible that with more extensive training in interviewing techniques the research assistants may have been able to conduct the interviews in more effective ways.
It should be noted that the research assistants in this study conducted themselves in ways considered appropriate for South Asian woman, including traditional ways of dressing and showing age appropriate respect. This was key to gaining the cooperation of women in this study.

Another limitation of this study was that participants in this study were from the same geographical location. The findings may not be generalizable to what immigrant South Asian women in different parts of Canada are experiencing.

Finally, the influence of the researcher’s personal experience with the phenomenon being studied needs to be acknowledged. Although an attempt was consistently made to identify personal biases throughout the study, there is always the risk of researcher's bias, especially when one has a strong personal attachment to the phenomenon being studied as was the case with this study.

Conclusions

The findings of this study illustrate that the lives of the immigrant South Asian women are complex and often complicated. The women’s commitment to their roles, responsibilities, and family duties influenced their everyday lives in important ways. There was some evidence that traditional roles were starting to change. Although the women did not talk about it, it was implied that roles were changing in order to manage life in two different cultures. In spite of these changes, family influences remain an important factor in women’s health.

There is need for health care providers to ensure that there are adequate resources available and that there is a provision of culturally sensitive, appropriate, and safe care for this special group of women. Health care providers should be equipped to provide
care to South Asian women taking into account the women’s relationships with their family and that the women are not alone in making health care decisions.

Summary

This study was undertaken to examine the influence of family members on the immigrant South Asian women’s decision making related to their health concerns and health-seeking behaviours. This study addressed three major questions: What is the influence of family members on South Asian women's health seeking and decision making? Which family members do South Asian women turn to with their health concerns and problems? How do family members impede and support South Asian women's health?

This qualitative study was part of a larger study, which examined the health-seeking practices of South Asian women. The research method used to conduct this study was ethnographic. This qualitative approach seeks to facilitate understanding of a different culture and make sense of everyday life experiences. Ethnography is a useful method, which allows the researcher to explore any phenomenon from an insider’s point of view.

Using ethnographic methods, data were collected through face-to-face individual interviews with the immigrant South Asian women. A total of 47 women participated in this study. The sample included women, young and old, of Sikh, Hindu, Muslim, and Christian religions. Their years of residence in Canada ranged from 10 months to 31 years. Interviews were conducted in the language of the woman’s choice and at locations chosen by them.
The analysis of the translated and transcribed data revealed that immigrant South Asian women’s health decision making and health seeking were significantly influenced by the members of their families. Relational themes of family relationships: patterns of influence on women’s health; women in need: family members’ responses to women’s health concerns; fulfilling family expectations and needs: influences on women’s health; and family as a barrier to women’s health were identified in the interviews.

There is clear evidence that the members of the women’s extended family influenced their lives. Health decisions were not made in isolation but in consultation with other family members. Husbands, mothers-in-law, mothers, daughters-in-law, daughters, sisters, sisters-in-law, sons-in-law, and sons all participated in the health seeking and decision-making process for these women. Older women in particular were very influenced by their sons, daughters, and daughters-in-law when seeking help.

Overall, family members were supportive and positive in assisting women with their decisions regarding health issues. They provided indirect and direct assistance and often responded positively to women’s needs, although the women were still expected to fulfill their traditional roles and responsibilities as wives, caregivers, housekeepers, dutiful daughters, and daughters-in-law. These roles often affected the decisions the South Asian women made with regards to their health. This way of life was shown in this study to be both positive and negative for the women in terms of their health.

The findings from this study hold implications for clinical practice, nursing education, nursing administration, and nursing research. This study’s findings reveal the importance of culturally sensitive, appropriate, safe, and women centered health care. The practicing nurses should be able to provide care that is culturally sensitive,
appropriate, and acceptable to the immigrant South Asian women. In addition, nurses need to pay attention to their attitudes, because discriminatory attitudes of health care providers can impact the well being of individuals under their care. They also need to be aware that family members are an integral part of South Asian women’s lives and should be involved planning care and treatment.

The implications for nursing education are that cross-cultural care and communication courses should be part of nursing curriculum which should be introduced early on in the program and continued on up to post graduate level. Education is not only necessary for students but is also essential for the faculty. Practicing nurses should receive on-going education related to care of culturally diverse patients. Future nursing research should replicate this study with second generation South Asian women. Research, which examines the effects of arranged marriages on women’s health, should also be conducted and include both immigrant and second-generation South Asian women. In addition, research is needed to examine the effects and impact of the dowry system that pervades some immigrant South Asian women’s lives. Finally, studies focusing on the elderly immigrant South Asian women and their family members would be worthwhile because of the potential for elders post-immigration experiences to place them at risk for health problems.
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