THE CHILDBEARING EXPERIENCE

OF

INDO-CANADIAN IMMIGRANT WOMEN

BY

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ABSTRACT

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This study was designed to elicit Indo-Canadian women immigrants' experience of childbearing. Health care professionals do not know enough about the childbearing experiences of this cultural group. This may lead to conflicts and discrepancies of viewpoints between clients and professionals which may result in nurses providing care that is not perceived as relevant by the individual. This study was directed by the following questions: What are Indo-Canadian women's beliefs about childbearing? What are their perceptions of their traditional practices, in their ethnic community, surrounding childbearing? What are the western health care resources utilized by the women during childbearing? How are these western health care resources perceived by the women?

Phenomenology, a qualitative research methodology, was used in this study. Data were collected through a series of indepth interviews with eight women. The initial audiotaped interviews were guided by the research questions and addressed the women's perceptions of their childbearing experiences. The data were comprised of the accounts given by the women in these interviews. Data collection and analysis occurred simultaneously throughout the study.
Analytic material was thus used to focus and clarify the ongoing construction of accounts.

The women described very different childbearing experiences. Dissimilarities in the phenomena under investigation were more evident than similarities and were attributed to the concept of acculturation. Two themes emerged from the data: the subjects' relationships with their families and the subjects' relationships with health care professionals. Each theme affected and was affected by the concept of acculturation. Influencing factors within the two themes were respect, authority, lack of knowledge and, in the case of the family, shyness. Perceived discrimination was an influencing factor in the subjects' relationships with post-partum hospital nurses.

This study concluded that dissimilarities in the childbearing experiences of Indo-Canadian immigrant women are attributable to the process of acculturation; and that the women's childbearing experiences are located within a broader context of meanings associated with the reproductive cycle. The subjects' relationships with their families and with health care professionals are significant aspects of their childbearing experiences and are influenced by authority, respect, lack of knowledge and shyness. Discrimination is perceived by the women in relation to the post-partum hospital nurses. These conclusions have implications for nursing practice, research and education.
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CHAPTER 1

Introduction

Background to the Study and Conceptualization of the Problem

In the literature one finds many research studies focusing on the experience of childbearing for white, Anglo-Saxon, North American women (Cameron, 1979; Carter-Jessop, 1981; Rubin, 1967). Lay literature has an increasing number of publications on the subject (Arms, 1977; Kitzinger, 1978; Korte & Scaer, 1984). The effect of culture on the childbearing experience in the United States has been researched (Brown, 1976; Clark & Affonso, 1979). However, little information is available about cultural variations among childbearing women in Canada.

The nursing profession values caring for clients in an individualistic manner. Therefore, there is a need to understand and appreciate the health beliefs and practices surrounding childbearing in the different cultural groups that make up nursing's clientele.

Immigration to Canada from non-western countries has generally increased in recent years and the Indo-Pakistani population in British Columbia has grown rapidly. Ames and Inglis (1976) state that the majority of Indo-Pakistani immigrants to British Columbia have been of the Sikh religion
from the Punjab region of India. Prior to 1981, the Canadian census did not separate Punjabi-speaking East Indians from other Indo-Pakistani groups. In 1971, 13,200 Indo-Pakistanis were living in British Columbia (Statistics Canada, 1971). By 1976 that number had risen to 19,850 (Statistics Canada, 1976), and by 1981 the population totalled 43,070 (Statistics Canada, 1981). Punjabi-speaking people in that year numbered 32,725 or 76% of the total Indo-Pakistani immigrant population. As the numbers have grown, East Indian immigrants have made up a greater percentage of nursing's clientele. Nurses should, therefore, have an increasing interest in providing relevant health care to this ethnic group.

There is a paucity of research and writings about the childbearing experiences of Indo-Canadian women immigrants. In order to plan and implement comprehensive, client-centred nursing care, health care professionals should know and understand their clients' experiences from their own perspectives. Literature related to pregnancy of Indo-Canadian women is limited mainly to scientific descriptions of intervention programmes (Bradley, 1978; Vancouver Island Public Health Department, 1981; Vander Ende, 1980).

Studies of the childbearing experiences of East Indian women in their own country have been conducted by anthropologists, who have concluded that childbearing is perceived by these women as a normal life event, with rights
and duties, based on traditions and customs that vary throughout India (Gideon, 1962; Parker & Neumann, 1979). The studies conducted in India, although oriented more to the psycho-social aspects of childbearing, remain limited in number. In addition, one cannot assume that women in the Punjab and women who have emigrated from that country to Canada have the same childbearing experiences.

Health care professionals in Canada acknowledge that the women of the Indo-Canadian community underutilize the prenatal programmes available to them (T. Johnstone, personal communication, May, 1982; Kendall, 1981; W. Meekison, personal communication, October, 1983; P. Pullen, personal communication, May, 1982). This is of particular concern to health professionals as they recognize the Indo-Canadian population as being at risk for delivering low birth weight babies (less than 2500 grams) with concomitant bio-physiological problems (British Columbia Government, 1981; British Columbia Government, 1982; G. Greenstone, personal communication, June, 1984; T. Johnstone, personal communication, May, 1982; F. Simon, personal communication, September, 1984).

As the Indo-Canadian population continues to grow, nurses have a greater responsibility to provide individualistic and relevant care to this ethnic group. Nurses often assume that they understand their clients' experiences of health and illness and that they are providing comprehensive, client-centred care (Henderson, 1967; Luckmann
& Sorensen, 1974; Nightingale, 1969; Sundeen, Stuart, Rankin & Cohen, 1981). However, a nurse's perception of health and illness is frequently drawn from the viewpoint of a health care professional model. The clients often view health and illness from a layperson's perspective, which differs from the professional's. Discrepancies and conflicts may arise between these viewpoints and lead to nursing care that is not client centred. This potential for discordant views increases when the client and the health professional come from different ethnic or cultural backgrounds (Kleinman, 1980; Tripp-Reimer, Brink & Saunders, 1984). Health care professionals must transcend cultural and ethnic barriers to arrive at an understanding of the experience of childbearing for the individual client.

Several researchers have studied the psycho-social aspects of health and illness and many have discussed how these psycho-social aspects are learned within a cultural context. Lipowski (1969) believes that the psycho-social aspects of illness are important factors influencing the course and outcome of every illness. These psychological aspects also determine whether an individual will move from being in a state of health to one of illness. Lipowski discusses four classes of variables that make up the components of psychological reactions "the personality of the patient and his life history, the state of the patient's current interpersonal relationship, characteristics of his non-human environment, and the nature and characteristics of
the pathological process or injury" (p. 1197).

There are three components to the resulting psychological reactions: the intrapsychic, the behavioural, and the social. The intrapsychic "refers to what the patient perceives, feels and thinks—to perceptual, emotional and cognitive components" (p. 1202). Socio-cultural factors have an influence here because beliefs in the client's social situation towards certain conditions, as well as about their cause and prognosis, and the efficacy of treatment, influence clients' response to the illness. The behavioural aspect concerns the client's communications and behaviour: "what the patient communicates, how he does it, to whom and when, is a problem of considerable importance for the delivery of medical care" (p. 1204). Lipowski cautions that client communication is a two-way process that is modified by the responses of the receiver and that patient communication will influence and be influenced by all those who listen. The social aspects pertain to the patient's interaction with others, especially family members and health care professionals. How the individual plays the sick role "influences the course, duration and outcome of any illness .... They are determined by the interplay between the patient, his illness, and his social environment" (p. 1205). Lipowski states that to understand the experience of health and illness for the individual, one has to know what all aspects of the situation mean to the individual and what response he obtains from other persons, including health care professionals.
Fabrega (1975) elaborates on Lipowski's view of the importance of the social and behavioural dimensions of illness, and he agrees and expands on the idea that communication is a two-way process. He points out that until the past two hundred years, social-behavioural changes served as the critical signs of disease. With increased scientific control of health and illness, there has been a shift away from the social-behavioural aspects; and with this shift, problems have arisen between contrasting meanings given to health and illness by the health care professional and the client. He states that "formal attributes of disease may be shared ... but not others related to the individual's equilibrium" (p. 973). Fabrega feels that differences in the orientation of each party in an interaction lead to a false consensus where the same use of language means different things to each person. He argues for a more socially oriented paradigm which would render a more productive professional-client relationship.

Kleinman elaborates on both Lipowski's and Fabrega's emphasis on the social-psychological aspects of health and illness and the difficulties that differing meanings create for the professional-client relationship. He has contributed to the social science literature a "Cultural Systems Model" that views health and illness as socially constructed. This system is an explanatory model in which all aspects of the health care system are conceptualized as cultural systems. These cultural systems are symbolic systems which are
socially and culturally constructed forms of social reality. Social reality is the transactional world in which everyday life is enacted, social roles are defined and performed, and in which people interact with each other in established relationships.

The individual internalizes social reality—as a system of symbolic meanings and norms governing his behaviour, his perception of the world, his communication with others and his understanding of both the external interpersonal environment he is in, and his own internal, intrapsychic space—during the process of acculturation (Kleinman, 1980, p. 36).

Kleinman conceptualizes three distinct, overlapping domains of health care in society: the popular sector, which consists of the individual, family, social network and community; the professional sector, which encompasses the professional health care worker; and the folk sector, that includes non-professional healers (Kleinman, 1977; Kleinman, Eisenberg & Good, 1978). Each sector has its own explanatory systems with social roles, interaction settings and institutions. Explanatory systems are strongly influenced by socio-cultural factors and therefore may vary, not only across the sectors but also amongst and between cultural groups in the same sector. It is Kleinman's contention that in any interaction between the sectors, the explanatory systems, or models, must be understood by all and made
explicit in order to reduce misunderstandings and allow negotiations between models to occur. It is in this way that appropriate and effective health care delivery is ensured.

Chrisman (1977), using Kleinman's early work as a base, suggests the need for a comprehensive approach to the study of the "health seeking process" (p. 351). He suggests several propositions that illustrate relationships among health seeking elements. He believes that clients' explanatory models tend to reflect retrospective views of everyday events as "causal" elements for their sicknesses; and that treatments that recognize the influences of everyday life will lead to a higher degree of compliance. Chrisman also suggests that a higher proportion of the health beliefs found among structurally insular groups will be shared across generational lines than will apply among more open groups. Among insular groups lay consultants are more likely to be consistently consulted for many illness episodes, whereas non-insular groups tend to make only sporadic use of particular persons.

Finally, states Chrisman, the quality of doctor-client transactions, and the degree of compliance are enhanced by specific practitioner attention to explanatory models, role constraints, and the views and influence of lay consultants. Chrisman urges that these propositions be taken into account when caring for individuals in a comprehensive manner.

The literature discussed above accentuates the importance of the individual's socio-cultural backgrounds in
their explanations of health and illness. The need is seen for health care professionals to go beyond mere understanding of these explanations and, when negotiating with clients, the clients explanatory models must be elicited and taken into consideration. It is through these negotiations that interventions are arrived at that are mutually acceptable, and this acceptance increases the probability of successful nursing interventions.

It is Kleinman's view that the intent of clinical research is to understand and describe the client's experience. The explanatory model, with its emphasis on the social and cultural aspects of the experience, allows the health professional to account for and understand the difference between the popular and professional explanatory models.

**Problem Statement**

Health professionals do not know enough about the childbearing experience of Indo-Canadian women immigrants. This may lead to conflicts and discrepancies of viewpoints between clients and professionals, which may result in nurses providing care that is not perceived as relevant by the individual. This study attempts to gain knowledge of the health beliefs and practices of Indo-Canadian women immigrants during the childbearing experience. By using the women as the source of information, the study will begin to
build a knowledge base about the experiences of these women.

This study is directed by the following specific questions:

1. What are Indo-Canadian women's beliefs about childbearing?
2. What are Indo-Canadian women's perceptions of their traditional practices, in their ethnic community, surrounding childbearing?
3. What are the western health care resources utilized by the women during childbearing?
4. How are these western health care resources perceived by the women?

**Purposes of the Study**

To understand the childbearing experience from the Indo-Canadian women immigrants' viewpoints, this study proposed to:

1. elicit the Indo-Canadian women's beliefs about childbearing,
2. determine Indo-Canadian women's perceptions of the traditional practices, in their ethnic communities, surrounding childbearing,
3. identify the western health care resources utilized by the women during childbearing, and
4. determine the women's perceptions of these western
health care resources.

Theoretical and Methodological Perspectives of the Study

Phenomenology, a philosophy, an approach and a type of qualitative research methodology, was chosen for use in this study. The nursing profession's valuing of the individual and the goals of comprehensive, client-centred care, parallels the reverence for the human experience central to this methodology (Anderson, 1981; Oiler, 1982; Omery, 1983).

Phenomenology places importance on understanding behaviour "from the actor's own frame of reference" (Rist, 1979, p. 19) and it "describes experience as it is lived" (Oiler, 1982, p. 178). This methodology "enables a comprehension of human behaviour in greater depth than is possible from the study of surface behaviour" (Rist, 1979, p. 20).

Phenomenology views all phenomena under investigation as socially constructed, and emphasis is placed on "inner or subjective understanding of events, behaviours and surroundings" (Rist, 1979, p. 19) to explain how the world is experienced (Wagner, 1970). "Stress is made on the need for the researcher to 'take the role of the other' and to understand the 'definition of the situation' from within the framework of the participants" (Rist, 1979, p. 20). This methodology accepts the intersubjectivity of researcher and subject and it is this intersubjectivity which takes into
account the social nature of the research act. The researcher as well as the subject bring to the situation background knowledge through which the situation is interpreted.

Data collection and analysis within this methodology is continuous throughout the research process. Subjects are chosen specifically for their ability to answer questions posed by the investigator. This method of purposive sampling means that the exact number of subjects is determined as the researcher moves through data collection and analysis and ascertains the need for further subject interviews.

Constant comparative analysis is the term given to the process by which the data are examined. The analysis serves to generate conceptual categories, and it relies upon continuous analysis of similarities and dissimilarities between the social units under investigation. This process continues until such time as the researcher has developed consistent themes from the conceptual categories and has arrived at an understanding of the phenomena in question.

In this qualitative methodology, ideas and concepts with which the researcher approaches her subject are used to sensitize her initially; they provide a starting point from which she may gain direction but from which she may diverge as the research process continues. The researcher begins with:

grounded events ... the perceptions and understandings of the events in question, and then
seeks to articulate broader patterns and processes that are applicable to other individuals and groups in other circumstances and settings. The task is always one of learning how those involved interpreted and gave meaning to the situation (Rist, 1979, p. 20).

In this methodology, the background knowledge of the investigator is seen as essential to any kind of analysis (Anderson, 1981; Cicourel, 1964). This background knowledge must be made explicit to the reader when study results are reported. Because both researcher and subject in a qualitative methodology can clarify views and socially construct the experience under investigation, data obtained are richer than is the case in quantitative analysis. This closeness to the data results in highly valid research findings (Rist, 1979). Explicating the researcher's own framework, ensures that other investigators analyzing the same data and using the same framework should arrive at similar findings. In this way study reliability is increased.

Kleinman (1978) states that the phenomenological method is appropriate for investigating the lay person's experience of health and illness. Since all phenomena are socially constructed and given meaning by the individual, the popular and professional's explanatory models of health and illness may be explored with the application of this methodology. Phenomenology is also an appropriate methodology for
identifying the health beliefs and practices surrounding childbearing of Indo-Canadian women immigrants as the study objectives focus on explaining the experience of childbearing from the personal perspectives of members of this group. Through eliciting and explaining this experience, health care professionals will have the knowledge required to plan relevant, individual care.

Definition of Terms

1. Indo-Canadian immigrant woman: a woman of the Sikh religion, who was born in the Punjab Region of India.

2. childbearing experience: perceptions, feelings, and practices surrounding pregnancy, labour, delivery, and the first postpartum week.

3. beliefs: the individual's perception, view or outlook.

4. practices: behaviours based on an individual's beliefs.

Assumptions of the Study

1. Although there might be individual differences in the childbearing experience, certain commonalities in the experience do exist for this cultural group.

2. Using the phenomenological method of research, the
investigator can gain an understanding of the health beliefs and practices surrounding childbearing of Indo-Canadian immigrant women.

3. The health beliefs and practices surrounding childbearing of Indo-Canadian immigrant women differ from those of the North American Caucasian population.

Limitations of the Study

1. Because of intra-cultural diversity amongst the Sikh population these findings may not be applicable to all members of this population.

2. Indo-Canadian women who are "verbal in English" may differ from their peers through social class and/or acculturation. This may also limit generalizability of findings.

3. The presence of family members at interviews may have influenced the women's verbalizations in the interview situation.

4. Time constraints and cultural characteristics often precluded the development of a relationship with the Indo-Canadian women in which they would feel comfortable being interviewed in depth.

Organization of the Thesis

The following chapters of this thesis will discuss
relevant aspects of the research process and expand on the study's central questions. Chapter 2 will discuss the process of data collection and analysis, as well as the ethical and human rights issues of the study. Chapter 3 will describe the central structure around which the data were organized. Chapter 4 will describe the subjects' perceptions of their childbearing experiences. By constructing accounts from the women's perspectives, the researcher will be describing what Kleinman has termed the perspective of the popular sector. These popular accounts will serve to answer the study's central questions. In addition, in Chapter 4, these accounts will be compared and contrasted with professional accounts as they appear in relevant professional literature. The thesis will conclude in Chapter 5 with the implications the study has for nursing practice, education and further research.

Summary

This chapter has discussed the background to the study, from which flows the study's problem and purpose. The investigator's conceptualization of the problem has been described and shown to complement the methodological perspective of the study. Material presented in this chapter gives direction to gathering and analyzing data related to the health beliefs and practices of Indo-Canadian women during the childbearing experience. It is only through
understanding the women's perspectives that nurses can negotiate with clients to reduce the conflicts and misunderstandings that occur between the professional and popular explanatory models of childbearing.
CHAPTER 2

Methodology

As described in Chapter 1, the phenomenological method was used to study subjects' perceptions of their childbearing experiences. Because the researcher's task, using the phenomenological method, is to investigate and describe human experience in the way the phenomena appear to the individual (Omery, 1983), and the data obtained should reflect the way in which subjects view their world (Bogdan & Taylor, 1975; Filstead, 1970), data were gathered from Indo-Canadian women immigrants who had had a recent childbearing experience in Canada. Data were collected in the participants' natural home settings. In their own homes, the subjects felt comfortable relating their descriptions in familiar environments in which the major part of their experiences were lived. In this way, the subjects' descriptions of their experiences were enhanced (Oiler, 1982). These descriptions provided the means for the researcher to understand the phenomena of childbearing from the Indo-Canadian women's perspective.

In this chapter, the implementation of the research methodology will be discussed in relation to the selection of participants, data collection and analysis, and the ethical and human rights considerations of this study.
Selection of Participants

The phenomenological approach directs the researcher to collect the data from those who have lived the experience (Giorgi, 1975b; Oiler, 1982; Omery, 1983). Therefore, Indo-Canadian immigrant women who had recently had a child in Canada, were chosen as the source of information.

In order to have a ready source to explore the subjective meaning of the experience, a purposive sampling technique was utilized to select subjects for participation in the study. In this sample, subjects were selected specifically for their ability to answer questions posed by the investigator. The subjects were thus "competent" to answer the study's questions by virtue of their having lived the experience and by having fulfilled four pre-selected criteria.

Criteria for Selection

The following criteria were used to select the Indo-Canadian women immigrants who participated in the study. The subject had to have:

1. lived in the Punjab until the age of 17 years or older
2. been a member of the Sikh religion
3. experienced childbearing in Canada within 12 months of selection for the study
of selection for the study

4. the ability to communicate verbally and read in English.

Some of these criteria were chosen to ensure that the sample of women were competent to describe their experience of childbearing as Indo-Canadian women immigrants in Canada.

Selection Procedure

All subjects included in the study were drawn from a large municipality located 35 kilometres south of Vancouver, British Columbia. Permission to contact potential subjects was obtained from the provincial public health department. The researcher attended in-service meetings in three health unit offices, at which time the study questions, methodology, and criteria for subjects were explained to community health nurses. Because home visits are made by community health nurses to all new mothers in the province, these nurses were ideally suited to assess potential subjects.

In all cases, the local community health nurse made the initial contact with the subject. The study was discussed briefly and the Information and Consent to Contact form (see Appendix A) was reviewed. This letter explained the purpose of the study as well as the request to interview the women. If the potential subject agreed and signed the form, the community health nurse contacted the researcher and passed on the subject's name and telephone number.
The researcher's initial contact with the potential participant was by telephone. At this time, the study was outlined in detail and questions were answered. If the potential subject agreed, a home visit was arranged.

At the first home visit, the investigator re-assessed the prospective subject in terms of meeting the study criteria, explained the study in detail, including the subject's time parameters, and answered questions. If the potential subject agreed to participate, the researcher read the consent form aloud and then had the subject re-read and sign it (see Appendix B). The investigator then proceeded with the first interview, which was recorded on audio-tape.

Although the community health nurses were invaluable in locating and assessing clients, the researcher decided, on her initial home visit, to exclude two women from the study due to their inability to communicate verbally in English at the level required for the investigator to be able to explore the subjective meaning of their childbearing experiences. In addition, one subject, in conflict with her husband over participation, regretfully withdrew following one interview.

Characteristics of the Participants

Ten women consented to participate in this study. Of this number, eight met the criteria and were included in the study. All of the women were married and lived with their spouses at the time of the study. All marriages had been
arranged by the subjects' parents and all weddings had occurred in India. In all cases, at the time of marriage, one partner had lived in Canada and returned to India for the wedding. Then both had returned to Canada. The subjects had been married between three and seven years.

The participants' ages ranged from 23 to 32 years. Six of the women had two children and two had three children. All childbearing experiences, except one, had occurred in Canada. Of the eight subjects, six had grown up in small villages in the Punjab and two in cities. All subjects had lived in extended family situations in the Punjab. Six lived in similar families in Canada. Two subjects lived in nuclear families. All subjects had lived in Canada from five to ten years.

Of the eight participants, seven had earned a B.A. in India—considered in Canada to be a high school diploma. The eighth participant completed high school in Canada. One subject attained a teacher's degree in the Punjab and another was working toward her Master's Degree (considered to be a B.A. equivalent in Canada) at the time of her emigration. In Canada, the women were employed as follows: one woman worked as a part-time keypunch operator; one as a licensed real estate agent; three as seasonal farm workers, and three as part-time unskilled factory workers.

All the participants had infants between two weeks and three months of age. All subjects delivered their babies at the same five hundred bed community hospital. Hospital stays
ranged from three days for vaginal births to five days for caesarean deliveries. Seven of the eight women intended to have another child within the next eighteen months.

**Data Collection**

In-depth interviewing was the process used to collect data regarding the subjects' childbearing experiences. The first semi-structured interviews took place in the subjects' homes at the time of signing the consent form. Subsequent interviews were arranged at intervals of at least one week to allow the researcher time to review the audio-tapes, have them transcribed, and analyze the data. Specific interview times were arranged at the subjects' convenience.

Interviews were audio-taped and lasted from fifteen to ninety minutes. Several interviews were terminated early due to frequent interruptions. For example, one woman arranged to be interviewed at a time when she was caring for seven children aged newborn to three years. When these situations occurred, the subject and researcher agreed to more frequent but shorter interviews. Following each interview, the investigator spent time with the women, social visiting and attempting to create a relationship of trust and rapport. Follow-up interviews clarified and expanded on data obtained in prior interviews. Two women refused second interviews. Subjects were interviewed from one to five times. In all, twenty-five interviews with eight individuals were completed.
over a period of several months.

The semi-structured interviews were guided by a series of open-ended questions which directed the discussion to the central questions of the study. The questions used to elicit the subjects' explanatory models of childbearing originated from Kleinman's discussion of the semi-structured interview (Kleinman, 1980). (See Appendix C for sample questions.) These questions were used to guide the discussion to the subjects' health beliefs and practices surrounding childbearing.

**Interviewer's Role**

In an effort to enter into the "life world" (Giorgi, 1975a) of the subjects and to encourage them to feel comfortable in describing their experiences, the researcher established a relationship of trust and communication. This relationship was developed in ways that were at times unconventional to the research process. For example, during blueberry season, three of the subjects worked in their blueberry fields daily and expressed distress at being short handed. The investigator spent several days in the fields with the women helping to harvest their crops.

Prior to each interview, the study purposes were reclarified and ethical considerations reiterated. Subjects requested frequent reassurances that they were "answering the question correctly", and the stance taken by the interviewer
was that "right and wrong" were not an issue in this situation, but rather that it was important to share information. The attitude taken by the investigator in the interviews was one of genuine interest. All data obtained were accepted as given and a valid part of the individual's experience (Omery, 1983). Subjects were not pressed about issues they appeared hesitant to discuss. As the research relationship developed, the investigator could often successfully return to these previously sensitive areas.

Data Analysis

Constant comparative analysis is the term given to the process by which the data were analyzed. Each audio-taped interview was transcribed and analyzed by the researcher. Every interview was read several times to get a sense of the whole, as well as to determine the natural meaning units of the phenomena as expressed by the subjects (Giorgi, 1975a). All parts of the interview were analyzed.

Redundant natural meaning units were eliminated but all other units were kept as part of the data. Each meaning unit represented a different part of the phenomena under investigation. The natural meaning units were then related to each other and to the phenomena as a whole. The researcher spent time reflecting on each meaning unit and systematically investigated what each unit revealed about the Indo-Canadian immigrant woman's childbearing experience. The
insights that occurred were synthesized and integrated into a consistent description of the phenomena under investigation (Giorgi, 1975b).

Throughout the process of analysis, the researcher was aware of her own perspective and the manner in which her subjective experiences influenced the meaning given to the data. (The researcher's professional perspective will be explicated in Chapter 4 of this thesis.) This involvement of the researcher in attaching meaning to, and making sense of the data, is consistent with the phenomenological method of inquiry (Anderson, 1981; Giorgi, 1975b).

**Ethical Considerations and Human Rights in Research**

Ethical issues surrounding subject selection have been discussed. Prior to signing the consent form, the researcher described the study, explained the purpose of audio-taping, and answered questions. Subjects were encouraged to make their own decisions about giving consent. One subject and her husband requested that the interviews not be taped, but agreed to having the investigator take extensive field notes throughout these interviews. Frequency of contact and time required per interview were also discussed with each subject. Questions about the study purposes or methodology were brought up, not by the women, but by their husbands. These questions were answered by the investigator. Prior to their giving consent, the potential subjects were advised that
participation was voluntary and that they were free to withdraw at any time or refuse to answer any questions, without prejudice to any health care they would receive. Before each interview, subjects were again reminded that they could withdraw at any time or refuse to answer questions.

This ongoing and careful clarification was necessary to reassure the participants' husbands. The men were generally suspicious of the purpose of the study and use of the data and therefore required a continuous reiteration of the ethical considerations and human rights in research. It was the husbands who gave or withheld consent to their wives to participate. Potential subjects were informed that participation did not involve any known risks and that possible benefits, as they contributed to nursing knowledge, would help subjects in future childbearing experiences. The researcher discussed with the potential subjects that privacy and confidentiality would be assured in the following manner:

1. If the use of audio-tapes was agreed to, the researcher and her thesis committee would be the only individuals with access to the recorded data.

2. Each subject would be assigned a code name to replace her own name on the tapes, transcripts, and all written material.

3. The list of subjects' names, codes and consent forms would be kept separate from the data and would be available only to the researcher.

4. Any information which could identify the subject
would not be revealed.

5. The tapes and transcripts would be destroyed upon study completion.

The subjects expressed a strong desire to be apprised of the findings of the study and the researcher agreed to contact them when the study was completed.

The researcher informed potential subjects that, if situations requiring immediate interventions were observed, these would be referred back to the area community health nurse. The subjects were told that these situations would be discussed with them prior to referral.

Summary

This chapter has reviewed the implementation of the phenomenological method in order to elicit the subjects' perception of their childbearing experiences. Methods for subject selection, data collection and analysis have been discussed. The ethical considerations and human rights issues of this research study have also been reviewed.
CHAPTER 3

Analyzing the Data

In this chapter, the data analysis procedure will be elucidated to explicate the investigator's viewpoint and way of interpreting the information obtained from the subjects. This explication is central to this phase of the phenomenological method of inquiry (Anderson, 1981; Oiler, 1982) and is essential to ensure study reliability (Giorgi, 1975; Oiler, 1982). This chapter will also provide a basis on which to present the findings of the study: a description of the childbearing experiences of the women subjects.

Diversity of the Data

The method of data analysis has been discussed in Chapter 2. While analyzing the subjects' accounts of their childbearing experiences, the investigator had expected to find that these experiences would be fairly uniform. The participants had satisfied certain criteria for inclusion in the study, and the researcher had assumed that because the subjects met these criteria, they would be similar, resulting in common childbearing experiences. Dissimilarities in the phenomena under investigation were, however, more evident than similarities. The women described very different
experiences. Data related to their beliefs, practices, and uses and perception of western health care resources, were diverse and difficult to synthesize into a meaningful whole. Reflection on the data, and verification with study subjects, made the investigator aware that one central concept, acculturation, accounted for the individual differences in the experiences.

**Developing the Concept of Acculturation**

During the early stages of interviewing and simultaneous data analysis, the researcher became aware that the concept of acculturation was helping her to make sense of the data. The researcher reviewed the audio-taped interviews, listening for their overall tone. The data reflected differences in the subjects' abilities to understand and speak English. The women described attitudes, beliefs, and practices surrounding childbearing that were similar to those present in either the East Indian or Canadian culture. The subjects were also assessed according to style of dress, house, decor, relationship with spouse and current diet, and, for each woman, these characteristics were found to be either distinctly more East Indian or more Canadian in character.

During the course of interviewing, it became evident that the two women who came from cities, not villages; who lived in nuclear, not extended families, and who had achieved higher education levels, had had childbearing experiences
that more closely resembled those typically found in Canadian culture than had other subjects whose experiences more closely paralleled those typically observed in East Indian culture.

When analyzing the demographic information, the investigator became aware that demographic factors affected the women's degree of acculturation into Canadian society. This enriched data gave direction to the researcher's description of the subjects' experiences in terms of their similarities and dissimilarities to both cultures. The concept of acculturation which emerged from the data accounted for the differences in the subjects' experiences. It was at this time that the researcher consulted the literature on acculturation and returned to reinterview the subjects to validate findings and saturate the conceptual category of acculturation. These two steps are consistent with the phenomenological method of analysis (Knaack, 1984). Both the literature and the subjects' accounts reconfirmed that the process of acculturation was the central concept of the study's findings.

**Acculturation**

The concept of acculturation has its roots in anthropology and later in psychology and sociology. Although the concept is used in the literature as early as 1880, there are two classic definitions currently in use. Redfield,
Linton and Herskovits (1936, p.149) stated:

Acculturation comprehends those phenomena which result when groups of individuals having different cultures come into continuous first hand contact, with subsequent changes in the original culture patterns of either or both groups.

During the process of acculturation, certain cultural traits are selected from the donor culture and integrated into the accepting culture. Redfield et al. (1936) describe three possible results of acculturation:

1. Acceptance: where the process of acculturation results in the taking over of the greater portion of another culture and the loss of most of the older cultural heritage. In this outcome, group members assimilate the behaviour patterns as well as the inner values of the culture with which they have come into contact.

2. Adaptation: where both old and new cultural traits are combined into a different and harmonious cultural whole or where the individuals retain a series of conflicting attitudes and values that are reconciled in everyday life as specific occasions arise, and,

3. Reaction: where because of oppression, or the unforeseen results of the acceptance of new cultural traits, contra-acculturation movements arise and are maintained.

Redfield et al. (1936) drew up a specific outline to facilitate field anthropologists' study of acculturation. Their work remained the most widely accepted until 1954, when
the Social Science Research Council's (SSRC) Summer Seminar reviewed all the work done on acculturation to that date and defined acculturation as follows:

...culture change that is initiated by the conjunction of two or more autonomous cultural systems. Acculturative change may be the consequence of direct cultural transmission; it may be derived from non-cultural causes, such as ecological or demographic modifications, induced by an impinging culture; it may be delayed, as with internal adjustments following upon the acceptance of alien traits or patterns; or it may be a reactive adaptation of traditional modes of life. Its dynamics can be seen as the selective adaptation of value systems, the processes of integration and differentiation, the generation of developmental sequences, and the operation of role determinants and personality factors (p.974).

Berry (1980), expanding on the work of the SSRC, states that although in theory acculturation can occur in either of the two contacting cultures, one group generally dominates the other weaker group and contributes more to the flow of cultural traits. The concept of the domination of one culture by another, "suggests that what happens between contact and change may be difficult, reactive and conflictual rather than a smooth transition" (Berry, 1980, p.10). Relationships between the two cultures therefore are likely
to be fraught with conflict.

Berry proposes a three-phase course to acculturation: contact, conflict and adaptation. For acculturation to occur, contact is necessary, conflict is probable and adaptation is inevitable. Without contact there is no acculturation, therefore this phase is a prerequisite for the other two phases. Conflict takes place only in the case of some degree of resistance; but, as Berry (1980) points out, experience shows that groups do not lightly give up cultural beliefs and values. Conflict at some point during contact has therefore been the rule. Adaptation refers to the three ways in which conflict is reduced or stabilized: adjustment, reation or withdrawal. When one considers Berry's (1980) three-phase course of acculturation, it is apparent that contact, conflict, and adaptation are phases that may be applied at both the group and individual levels. Thus "acculturation may be treated as a two-level phenomenon—that of the group and that of the individual" (Berry, 1980, p.11).

During interviews the subjects, in attaching meaning to their experiences, discussed the phases of their acculturation, often using the term "acculturation." The women differed in their ability to recognize and discuss the process of acculturation, although it was obvious that the process had shaped their perceptions of their childbearing experiences. Women who were in later phases of the process of acculturation were able to understand and explain their childbearing experiences in terms of this process, whereas
women who were in the earlier phases of acculturation alluded to cultural differences but could not directly discuss them. In general, however, the women's accounts of their childbearing experiences spoke eloquently of the process of acculturation.

Themes Related to Acculturation and the Childbearing Experience

With the emergence of acculturation as the central, organizing concept, the researcher returned to the original data and analyzed the women's accounts from a new perspective. It was found that as the women adopted various aspects of Canadian culture, they began to acquire Canadian beliefs and practices. In a cyclical process, as the women took on Canadian beliefs and practices, their process of acculturation into Canadian culture was accelerated. As part of their system of beliefs and practices, their attitudes, views and behaviours pertaining to health, also took on Canadian characteristics.

Although the research questions guiding this study dealt specifically with the women's beliefs about childbearing, their perceptions of their traditional childbearing practices, as well as the women's perceptions of the health care resources they utilized during childbearing, the women could not make sense of their childbearing experiences without placing them within a broader context. Accordingly, as the women spoke of their childbearing experiences they
talked of their health beliefs and practices, sexuality, arranged marriages, a preference for male offspring, the authority and respect due elders, and health care professionals as well as shyness and lack of knowledge in areas of their own sexuality. All of the women in the study spoke of their childbearing experiences in relation to the above topics, and their perceptions of these topics seemed to be affected by the central process of acculturation.

By viewing the childbearing experience within a broader context, the researcher was able to continue analysis and see that two themes emerged from the data and related to the central process of acculturation. These themes existed throughout the childbearing experience, varying in prominence at different times, but always present to some degree. The two themes identified through the data were:

1. The subjects' relationships with their families and,

2. The subjects' relationships with health care professionals.

Throughout the childbearing experience, Indo-Canadian immigrant women are in contact with family members as well as health care professionals. How each woman relates to each group is determined by her degree of acculturation. The women's relationships with each group also played a significant role in shaping their perceptions of their childbearing experiences. Their relationships with their families and with health care professionals served as further
organizing centres around which these women's childbearing experiences could be explained.

The analytic framework which emerged to describe the childbearing experiences of Indo-Canadian women is schematically represented as follows:

![Diagram showing the relationship between childbearing experience and acculturation]

The relationship with family members

ACCULTURATION

The relationship with health care professionals

Figure 1. Acculturation: An analytic framework for the childbearing experience.

Relationship of Analytic Framework to the Explanatory Model

As discussed in Chapter 1, Kleinman's explanatory model suggests that health and illness are socially constructed and that subjects internalize social reality of a new culture through the process of acculturation (Kleinman, 1980). The process of acculturation, in which a subject learns and internalizes a different social reality, is consistent with the explanatory model. Within the popular domain, subjects' explanatory models would alter as they move through the process of acculturation.
The Analytic Framework and the Study Findings

The central concept of acculturation and two themes related to it, provided direction for the researcher to synthesize the subjects' experiences into an organized description. Using the analytic framework described, the researcher was able to understand the subjects' experiences from their viewpoints. Chapter 4 will describe this experience in conjunction with appropriate professional literature.

Summary

This chapter has explained how the data were analyzed according to the phenomenological method of inquiry. The analytic framework was presented and discussed as a way of understanding the phenomena under investigation. The framework was shown to be consistent with Kleinman's (1980) explanatory model.
CHAPTER 4

The Subjects' Perceptions of their Childbearing Experiences

Descriptive accounts of the Indo-Canadian women immigrants' childbearing experiences were elicited using the phenomenological method. These accounts elucidated the explanatory model for the childbearing experience of this particular cultural group.

As discussed in Chapter 3, the women's explanatory models of childbearing were constructed within a broader context. Although the research questions guiding this study dealt with childbearing specifically, the women made sense of their experiences within a larger framework which included sexuality, arranged marriage, birth control, sex preference of their offspring, the authority of, and respect for elders and health care professionals, as well as shyness and lack of knowledge. The concept of acculturation helped the researcher to make sense of the women's experiences. The two themes, related to acculturation, also emerged:

1. The subjects' relationships with their families, and
2. The subjects' relationships with health care professionals.

These two themes served as organizing centres for the women's perceptions of their childbearing experiences in Canada.
In this chapter, the subjects' accounts will be presented according to the umbrella concept of acculturation and the data will be ordered around the two identified themes. This will serve to further organize the data and explicate the experiences under investigation. Relevant literature will be discussed in relation to the data thereby serving as a comparison between the popular and professional views of the childbearing experiences of Indo-Canadian women immigrants.

The Subjects' Relationships with their Families

In this section the women's accounts of their health beliefs and practices during childbearing will be described and discussed in relation to their families. The subjects' accounts indicate that their health beliefs and practices are strongly influenced by their families. The umbrella concept of acculturation will be woven through this section and it will be shown that the process of acculturation both affects and is affected by the subjects' relationships with their families. The process of acculturation therefore impacted on the health beliefs and practices surrounding childbearing.

As the women talked of their childbearing experiences, they explained their health beliefs and practices in relation to sexuality, arranged marriage, sex preference of offspring, pregnancy and the post-partum period. All of these health beliefs and practices were affected by the subjects'
relationships with their families, and were altered by the process of acculturation.

In the women's accounts of their relationships with their families during the childbearing experience, the influencing factors of authority, respect, shyness, and lack of knowledge emerged. These factors pervaded the subjects' relationships with their families, and had an impact on the women's health beliefs and practices related to the childbearing experience. The influence of these factors on the women's health beliefs and practices was also determined by the process of acculturation.

The health beliefs and practices the women spoke of, together with the identified influencing factors in regard to their families, formed a major portion of the women's explanatory models of their childbearing experiences.

Table 1.

<table>
<thead>
<tr>
<th>Theme: The Subjects' Relationships with Their Families</th>
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<tbody>
<tr>
<td>Health Beliefs and Practices</td>
</tr>
<tr>
<td>sexuality</td>
</tr>
<tr>
<td>arranged marriage</td>
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<tr>
<td>sex preference of offspring</td>
</tr>
<tr>
<td>pregnancy</td>
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<tr>
<td>post-partum</td>
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</tbody>
</table>

Influencing Factors

- authority
- respect
- shyness
- lack of knowledge

In this section the subjects' accounts will be presented according to the theme, health beliefs and practices, and influencing factors.
The women described a series of health beliefs and practices related to the childbearing experience that were learned and expressed within the context of everyday family life. The explanatory models that emerged from the data revealed that older, experienced women act as the authorities on childbearing beliefs and practices; furthermore, the accounts described how parental authority and respect for elders contribute to the women's perceptions that shyness is a cultural trait which defines their sexuality from childhood onward. In turn this shyness affects the women's perceptions of their childbearing experiences and contributes to their lack of knowledge in many areas of childbearing. This lack of knowledge may in fact contribute to the family elders' continued authority in certain health beliefs and practices. All the women talked of "listening to the doctor first", but the degree to which the doctors' advice superseded that of the elders on matters such as diet and activity, was directly related to the degree of each woman's acculturation into Canadian society. In their accounts of the onset of menses, the women helped the investigator understand the origins of their present-day perceptions of their childbearing experiences.
Sexuality

The women spoke of shyness in relation to matters of sexuality. They used this term to describe their upbringing in India, explaining that shyness is common to all East Indian women and has a great impact on childbearing because it affects menstruation, sex, and birth control. One woman said of her upbringing:

As I told you, in the old country, people are very shy. Right because we are brought up that way....All people are not same, but mostly you know, I'm talking about the ninety-nine percent, maybe ninety-eight, you're always going to count that much right, nobody counts two persons you know. Ninety-eight percent people, they don't talk to their parents you know...I think I told you that we're brought up like that. You know, when we are in India, we are not talking to our mothers, you know when the menses is coming first time you know, they don't want to talk about that.

Another woman, talking on the topic of sexuality, said:

In our country we are shy from that, we respect parents—we don't talk from those things.

Women often related how they had their first menstruation without having any information of this physiological occurrence. One woman, who had grown up in a city in the Punjab, lived in a nuclear family in Canada, and spoke
English well, said of her first menstruation. Yeah, it was a surprise. I was visiting with one of my other friends. They were having right, and they were telling me—but I never had anything from my mother or anything from my other sisters you know because it's the kind of thing that people are very shy right. They don't want to, you know, ask you know. Even when I got, I was hiding you know, from my mother and from my sister you know, but my sister you know, she found out and she told me what I should do you know.

Another woman, who lived in a large extended farm family in Canada, had been told about menstruation when she approached her sister after she had begun to bleed. Asked if she had been frightened, she replied:

Yeah, that's right. I tell my sister, like it's bleeding blood from my body you know, and she told me "Use pad. It should continue five days it's maybe you have period."

Of the first time she menstruated one subject, who came from a village, lived in an extended family in Canada and spoke very little English, said:

I feel very difficult when I get my period the first time...I didn't know what it was...

Another woman, relating how her mother had not given her any information about puberty, said:

See in our culture, they don't tell anything like
small girls, right, but here they're going to see a movie film in grade five or six right... Yeah, in the school, but in our culture they don't tell anything about this in India.

This woman had emigrated to Canada just prior to graduating from high school. In Canada she had been put back several school years and required to repeat high school. She had socialized into Canadian society and realized and accepted that in Canada her daughter would be a part of this open society.

One participant, spoke English well and had been a school teacher in the Punjab. In dress and manners she appeared acculturated into Canadian society, and told of a different experience:

Well, my sister, my mother and me sat down and said sometimes other ladies said, they talk about that, then I understand.

This direct participation in dialogue about the onset of menstruation encouraged this subject to approach her mother later on.

Yeah, when I start my period, then I go to my mother and she told me about using the pad. And then I used it.

Regardless of who had told the women about what to do and what to use when they menstruated, not one of the subjects had been told the purpose of this normal physiological process. When asked if they were told or knew
why they menstruated, one subject said:

No, I didn't. I did not.

And another:

I don't know because I think that everybody got it.
I got it--my sister. I never had been told (why).

A third said:

I no understand why I get this bleeding, no one tell me.

While at university one subject explained that she had sought out her own information and read an English book in which menstruation was explained. Pursuing her own answers set this woman apart from other study participants and may be partially explained by her background. Living in a city in the Punjab and having good English skills had given her access to the material she wanted.

Another woman could not recall exactly where her information about menstruation had come from.

I think when I came here (age 18), I find that everything is completely different from, you know, from India, especially on T.V. -- I think from there and as well I don't see anyone personally, I don't ask anyone but I knew just from my friends. My friends they got married before me right, and sometimes they are telling me all what's happening and everything.

At this time this woman was receiving information on not only menstruation but also sexual activities and conception. It
should be noted that by occupation (as a real estate agent), living arrangements and ability to speak English, this woman was more acculturated into Canadian society than were the other participants. However, information about sexuality was given to her passively. Despite her acculturation, shyness in this area was still a force in her life.

Three of the above women asked the researcher for information about menstruation and conception. The investigator volunteered to provide the facts after the interviewing was completed. The three women lived on a large extended family farm in Canada. All had grown up in small villages in the Punjab, none of them worked outside the home or farm, and their ability to speak English varied from poor to acceptable. The women all had more than one child, but showed ignorance of menstruation and conception. They asked to talk individually with the investigator while she was giving them information. One of the women told the researcher she was "too shy" to participate in a group discussion on this topic.

Shyness as it influences how or what the women learn about their bodies and menstruation in their younger years, sets up a situation of ignorance in adulthood when the women enter marriage and then experience childbearing. It appears that as women become more acculturated into Canadian society they learn more about their bodies, but even this knowledge is often fragmentary and passively received. Most of the participants learned early in life that it was appropriate to
be shy about all areas of their sexuality and not to ask questions. Their arranged marriages to men they did not know served to put them at a further disadvantage. At this time their accounts spoke of how their respect for their elders led to these arranged marriages and their shyness and lack of knowledge then put them at risk for unwanted pregnancies.

Arranged Marriage

The women made sense of their arranged marriages within a larger context than the marriage itself. Their spouses were chosen by their parents, and they respected and trusted their parents to make the right decisions. However, the women told of being shy and marrying men they did not know. This resulted in the women's continued lack of knowledge of sex, birth control or conception. This ignorance had repercussions therefore on the childbearing experience as it often led to unplanned, unwanted pregnancies.

The women told of how, when they marry, they owe respect to their in-laws. Their in-laws exert a great influence on them from the beginning of their marriage and on through their childbearing years. Again, because the marriage is arranged, they do not know these new relatives before the wedding. It is not unusual for the individual woman to have embarked on a new marriage and a new pregnancy without having prior knowledge of their spouse or in-laws.

All of the women in this study told of having had their
marriages arranged by parents. Several of the women did not meet their future spouses until the wedding arrangements were being made. One woman had not been given the chance to accept or reject the man chosen for her. Once the marriage had been arranged, her future husband had returned from Canada to India for the wedding. The woman then travelled to Canada for the first time. She described her experience.

Every woman after marriage will love their husband. To love is to like too much. After some time, then all the time over there, and their father and mother far away and then she takes her husband and then she likes him too much....It was hard. Too much hard. Yeah, when I came here, I cried too much. All nighttime and I never showed it to anybody. I go in the bathroom and then after that I wash my face--.

This woman described the difficulty and isolation of marrying a stranger and leaving her homeland and the support of her birth family. This woman's experience at marriage substantiates Nichter's (1981) finding that women who marry into their husbands' families and move far away from their birth homes, experience distress at giving up the support of their peers, mothers and sisters after marriage. Despite her feelings, she described her intention to arrange marriages for her daughters in Canada:

In our culture it is our duty as parents to do this.
She told of a strong belief in this East Indian custom although she realized the risks this could entail:

But some is a love marriage. Indian people sometimes they're--some girls love another boys and it's not arranged. They just like them very much. But her father and mother does not want to marry them. And then the daughter lost too much to them.

That's what means love marriage.

In Canada, this woman intended to uphold this East Indian tradition because she saw it as her parental duty. She was aware that in the future this might put her in direct conflict with her daughters' beliefs.

All but one of the women in this study told of being given the final choice after meeting their prospective mates. One woman said:

They are arranged. But they still ask us too, do we like them or not; so is our choice.

And another:

He (her father) might ask me too, not force me to have married him, right. He asked me many times if you like him then you can, otherwise say no.

Although given this choice, not one of the women told of refusing her parents' choice.

Well see--the parents, like, they know us--so see, they know what the mans should be like for us, so we trust them because they is our parents.

The women appear to trust their parents to make the
right choice and this finding is consistent with the literature describing family relationships in India (Gideon, 1962; Siddique, 1977). This is also consistent with the findings of Chance (1965) and Yu (1984), both of whom describe the difficulties an acculturating group has in giving up old values and taking on new ones that often clash. Yu states that, at the time that they are feeling alienated from the ways of their birth country, they are in the process of acculturating to their new country and may for a time feel dislocated, to some extent, from both cultures. This is evident in one woman who had had her marriage arranged and felt it was the right thing for her parents to do. Of her children's marriages in Canada she had this to say:

They'll be probably Canadian typed most of them....Both of us are really broadminded. We just want to see them happy that's all. But still—it strange for us.

This woman was describing a feeling of not belonging to either culture, indicating that she had given up her traditional East Indian culture and was in the process of adapting to Canadian culture. The other participants in this study did not feel dislocated from their own culture but rather continued to believe that arranging marriages was the appropriate method of mate selection.

The fact that the marriages were arranged and the women did not know their new spouses, combined with their shyness about sexuality, resulted in the women coming to the marriage
with very little knowledge of sex, birth control or conception. This in turn influenced their perceptions of their childbearing experiences. They often experienced immediate repercussions in the form of an unplanned pregnancy.

For many of the subjects, sisters or friends were the main sources of information about their sexuality. One woman said:

> Yes, I talk with friends. We tell each other. They tell me and I tell them about this things (sexuality).

And another:

> Yes, my friends told me too—at the marriage right—and some of my friends they come to my house, visiting together. Then they talked about married life. So then they told me.

Still another:

> Through my sisters, they have tell me alot when I had my first time, my period.

And a fourth woman said:

> Yeah, talking, yeah, because remember--maybe I told you, our people are very shy--and if you have very close friends, I think nobody's mind that you're telling them you know, you are telling them about husband, you know, this and that, you know.

This woman's lifestyle and attitudes paralleled Canadian beliefs and attitudes more closely than those of the East
Indian culture. She could intellectually understand the concept of shyness from a Canadian viewpoint, but, in many areas of her life, she continued to define her experiences through shyness.

As the women talked of their more recent experiences, they described how shyness had continued to affect their lives. One woman had no knowledge of her body or sexuality at the time of her marriage. She said:

No. Not--before I married I did not know anything.
And then after we married--I just found out.

The women told of how they married with little, if any, knowledge of their own or their husbands' anatomy and physiology. They related how sexuality is a subject that is hidden in shyness and not discussed openly. Because the marriages of all the subjects were arranged, they spoke of barely knowing their new spouses. They initially did not discuss sex or birth control with their husbands. As a result, they described how they started married life without knowledge, or use, of birth control methods. When asked if they used birth control methods when first married, one woman said:

Not the first time--no nothing.

A second woman said:

I married about 27th February and March I already pregnant--That's why I don't use birth control--no chance, no chance. That's right. That time I were about 15 days after. Then I have no period.
When asked of her husband's reaction:

Yeah, he don't want one yet. He don't want child.
He told me after one year we can get baby, but
already I have baby.

This couple was in India at the time of this first pregnancy. They had investigated the possibility of obtaining an abortion but the woman had decided against it as she felt it was her duty to have the child. At the time of this study this woman had just delivered her third child in five years. Neither partner had ever used any birth control method during their marriage. This woman had grown up in a farming village in the Punjab, where she had lived in an extended family. After emigrating to Canada, she had continued to live in a large extended farming family. She continued to see childbearing as her duty and spoke of how her children would eventually work on the farm.

One subject described the predicament that shyness put her in when she first married:

I shy of husband. No use birth control. After I know him much we talk of this but I be pregnant (already).

One woman had had a serious illness following which her doctor had advised her against conceiving for one year. She continued her practice of not using any method of birth control, despite a prior pregnancy resulting from lack of protection. Following her third pregnancy, she had begun to use a method of birth control as she had decided to wait one
year before her next pregnancy.

Then my husband says I am going to start pills. I don't like pills. It was her husband's decision whether birth control would be used and what form it would take. This woman had had three children but still felt too shy to discuss birth control with her husband. She simply submitted to his decisions.

The woman in the study who talked most openly about her sexuality came from a city and lived a Canadian lifestyle in a nuclear family. She had an interesting story about birth control.

Birth control, you know, oh gosh. I was not using any—That's right, but we were not wanting kids anyways, right away. No, me and my husband decided that we were going to have babies at the time that we want to should do, you know. But I don't know, I asked my sister and she scared me and said that the condoms are not good—Yeah, she said you know, that you can have a problem conceiving the pregnancy right, and I got scared and I was telling my husband I don't want to tell (use) them—and I went to my doctor right.

When asked if she had told her husband why she did not want to use condoms she said:

No. I was shy. She's my older sister right.

Following her first pregnancy, this woman did allow her husband to use condoms:
Oh God. Because then my husband explained to me and my doctor said, it's not you know, just, you know, the right information, you know. Nothin's wrong with it. Everybody was using it, my friends, and I asked them, right and they had a baby. So I thought maybe my sister, you know--she had something wrong, right.

Although having knowledge of birth control and resources for obtaining a method, this woman had initially felt shy about discussing this topic with her husband and doctor and had followed incorrect advice from a family member.

It is apparent from the data that the women's perceptions of their childbearing experiences begin in childhood, when they are taught to attach shyness to matters related to their own bodies. This shyness contributes to a lack of knowledge about their bodies which later is carried over into their arranged marriages and childbearing experiences. This shyness and ignorance seem to hold true regardless of how acculturated the women were into Canadian society. Although, for purposes of this study, the women's childbearing experiences had occurred in Canada, their early years, when their thoughts and feelings about their sexuality had developed, had been in India. One would expect ingrained cultural traits such as shyness to persist for a long time as the process of acculturation continues (Chance, 1965).

Respect for elders is another cultural trait that, from the data, appeared to be ingrained and lasts over time and
despite the process of acculturation. The women spoke of how, because their marriages were arranged, they often did not know their new in-laws. In spite of this, after marrying and leaving their birth families, they owed their primary respect and allegiance to their new in-laws. One woman said:

One must be very good with parents, very nice, take care and listen them.

And a second:

My parents were boss; now I be married is his parents. This is how it is for us.

A third woman described how this respect affected her everyday life:

Like, you know, in India, we respect our— you know, our people, right. And if we were to go out right now then because I'm going I have to tell them, right. I can't even go—you know, you can't walk out without telling them.

One woman in the sample was living in a nuclear family in Canada. At the time of being interviewed she was expecting her in-laws to pay her an extended visit in Canada. She described how and why her life would alter with her in-laws' presence in her home.

Because actually, you know, I used to belong to a big family right. My mom and dad and my brothers and they're all married and live in my family...my relatives are living with my parents and they have it with my parents and I have it with his
(husband's) parents. It's a cultural thing...I won't be able to discuss everything in front of them right. Sometimes if you got any—you know like anything between you and your husband right, I won't discuss certain things because we respect them.

This woman expressed beliefs and values that are characteristic of Canadian society but she nevertheless believed that she owed her in-laws parental respect. She could describe it as a "cultural thing" that she would fulfil, despite its causing changes in her lifestyle:

Oh, it will be a big difference. I won't be able to do that with—you know, friends, you know, in front of them right. Still, I can talk to everyone, but not in front of them.

Several authors (Ames & Inglis, 1976; Siddique, 1977; Wakil, Siddique & Wakil, 1981) have confirmed that in India, Sikhs from the Punjab live in large extended families and, at marriage, the women move into their husbands' family homes. Siddique (1977) and Wakil, Siddique and Wakil (1981) confirm that these family structures are continued in Canada and they point out the difficulties that the value of respect for elders poses as the family members acculturate into a host country such as Canada, where older people are not generally accorded the same measure of respect. Yu (1984), writing of "filial piety" amongst the traditional Chinese, points out that as acculturation progresses, the value of filial piety
declines and this places the elder at a distinct disadvantage. At a time when older family members require increased attention from their children, the children, in an attempt to adopt an American lifestyle, have less time and respect to give their parents. However, amongst this study's sample, respect for elders was still viewed as an important cultural value that, from the women's accounts, did not seem to be affected by the process of acculturation.

The value placed on a continued respect for elders is an important finding for this study as it implies that these unknown elders had authority over the women at the time of their arranged marriage and then during their childbearing experiences. This respect therefore influenced the women's perceptions of their childbearing experiences.

The elders' influence begins early. The women told of being aware of their need to produce sons and the impact their mothers-in-law could have on their lives if they did not fulfil this requirement. The women's perceptions of their childbearing experiences were coloured with the need to give birth to male children.

**Sex Preference of Offspring**

The women gave accounts that indicated their preference for male offspring. They attached great importance to having sons and explained the reasons for this preference. They were also able to explain their desire for boys in terms of
their personal welfare. The women's perceptions of their childbearing experiences were affected by this emphasis on male babies.

One woman had three daughters and no sons. She lived in her husband's extended family and her farming lifestyle closely resembled that of her people still living in the Punjab. She described some of the problems of not having borne a son.

Some first wives—only daughters and then the man goes to another marriage and then some got boys and sometimes it's like that, first lady no baby or no boy and then he goes to the other marriage and other lady has boys....Sometimes I feel very bad because then I think about that I have no boys. So then I feel very bad. Then sometimes I think is okay. My mother-in-law is good and she says nothing as I have only girls but the mother-in-laws, she can make trouble for womans over this. To live with second wife all together would be too much hard....When we get old, God knows where me and husband live if no sons. I don't know. Yeah, yeah, that be a problem, maybe my daughters have room for me...

This woman was expressing her fear that her husband would take a second wife to bear sons. She also pointed out that mothers-in-law can cause problems for their daughters-in-law if no sons are born. This indicates the power the women feel
the female elders in the family hold over them. This woman told the researcher of her desire to wait 18 months before another pregnancy and of her husband's ability to sabotage this decision. She said:

If he wants baby before this I must no say no. If she (her third girl) were boy, then I could say no. This contrasted with two women who had borne sons. When asked if they could refuse to become pregnant again, one said:

I say no because I don't want baby now and I have already two boys.

And the other:

I have boy already so I can stop have baby; boy is important for name.

For these women the number and timing of pregnancies were partially determined by the sex of their offspring. The birth of a male gave them more control to decide when and if another child would be born.

One woman, who held many childbearing beliefs that were consistent with Canadian beliefs and values, had an urban lifestyle that was more in line with Canadian society than East Indian. Despite her being acculturated in Canada, she talked of why it was important to bear a son over a daughter:

That's why even they're thinking too it's a boy, you know, he can handle the family. He can handle their land right. Something like that. But the main thing is the dowry system. So that's why in
India, people, you know, are unhappy when they're having girls....Because when they're getting married it's expensive for the parents....And then they are having troubles...because the in-laws and their husband, they're always telling them you do not bring anything....It's very important to have sons, the girls are going to another house like when they're getting married, they're living with their husband right and the sons are staying with the parents and they're taking care you know, the sons, when they're old. In India they're not sending them to the rest house you know when they're sick and old. They are taking care of the parents right. That's the main reasons. In Canada the same thing because people are not changing here like in our generation. Like our kids, maybe they won't care that much but we do.

Another woman, who held many beliefs and values consistent with those held in Canadian society, such as wanting her daughter to eventually choose her own spouse, gave this account of having a female child:

Oh no, I was so happy. Me and my husband, we just had a--you know we decided that we wanted to have the baby. And no problem, I never thought you know,--I was not sad at all. I wasn't upset at all.
But:

Like my husband is an only son and you know—My husband don't mind but I really feel we should have one boy too. You can keep the name with the boy, family right.

This woman truly preferred a male offspring but welcomed a daughter into the family and felt she needed to justify why she wanted a son. This need to justify her cultural tradition indicated that this woman was rethinking beliefs and values passed on from her native land and that the process of acculturation was occurring.

The impact a mother-in-law has on her son's wife emphasizes the influence that the family, especially elders, have over a woman's daily life (Ames & Inglis, 1976; Wakil, Siddique & Wakil, 1981). The Indo-Canadian preference for male children is consistent with cultures that have an agrarian land base and a value placed on sons looking after their elderly parents (Dinitz, Dynes & Clark, 1954). Many cultures voice a preference for male offspring (Ayres, 1967; Brown, 1976; Williamson, 1979), and, although Canada supports the tenets of feminism, in reality the majority of people still have a sex preference for males (Williamson, 1979).

As the Indo-Canadian women begin to give up their strong preference for male children, they can be expected to adopt the beliefs and values of their host country. If the host country is unsure of these beliefs, an immigrant is left with confusion (Chance, 1965) and a tendency to revert to
established cultural beliefs (Salvendy, 1983). Although through the process of acculturation the women began to feel the need to justify their desires for sons, the women in this study gave accounts that indicated they were realistic in wanting to have male children.

A daughter represented economic hardship; this meant the woman may have to have other pregnancies before she was ready to have another child.; she existed daily at the whim of her mother-in-law's good nature and the possibility that her husband might leave her for a second wife. In addition, it meant that the women had nowhere to live in their old age. For all of these reasons, the issue of the sex of the growing fetus must weigh heavily on these women during their pregnancies. It is while the women were pregnant that the full importance of their female in-laws' authority was apparent. From the time they first suspected they might be pregnant, through the shyness of telling elders and receiving and following the advice of female relatives who had borne children, all the women spoke of the female family members' importance in their childbearing experiences.

Pregnancy

The women said that they relied on the female elders in their households as a source of information and advice about pregnancy. The elders had acquired their knowledge from
their own childbearing experiences and freely passed on their information. Because the women had, through marriage, become part of their husbands' families, the experienced elders were usually their in-laws. They said that information from their own birth families had often been obtained through direct observation during childhood.

The women's accounts of their beliefs and practices surrounding childbearing, embodied a contradiction: although they claimed to follow the doctor's advice they in fact followed the advice given to them by their family elders. Doctors, as will be recounted later, in reality were viewed as having a different, more technological place in their childbearing experience.

The women related how, when they missed their period and suspected a pregnancy, they turned initially to their female in-laws for advice and support. They talked of feeling shy to tell their own mothers of their suspected pregnancy. One woman said:

I no tell my mother. I was shy. If my sister here I tell her, but no mother. Maybe mother-in-law or sister-in-law is okay too.

Another, whose lifestyle in a nuclear family paralleled prevailing lifestyles in Canadian society, said:

I didn't told my mother I'm pregnant right--she just noticed like when I went to sleep and the first--like the beginning, we don't like to do work right. I was ashamed right--like we can't talk that
freely to my parents like we do in the friend. We can't (talk) about that to our parents.

Once her mother noticed the pregnancy symptoms, the two women could talk about what actions were appropriate.

And she told me it's very nice, what to do. I went to the doctor after two weeks.

The study participants whose health beliefs and attitudes most closely resembled those of Canadian society at large said:

No, I did not tell my mother in the beginning right—but I told my mother-in-law—you know because I'm very shy. You don't talk about these things in front of men...with the mother-in-law people are a little frank than the mother.

This woman, who did not want to arrange her own daughter's marriage, who lived in a nuclear family, and who had good English skills, still felt shy when talking with her mother and maintained the East Indian practice of talking more openly with her mother-in-law. The one subject in the study who had been told about menstruation by her mother felt uncomfortable talking with her mother-in-law.

Yeah, because then I came in Canada. When I came, everything is new for me and I never talked about those things with her because I feel ashamed and sometimes I have fear. Because she is my mother-in-law. And I talk about that, you know, what she is thinking, like that, I think--feel
ashamed.

Due to her upbringing and openness with her mother, her story spoke of shyness and fear towards her mother-in-law. This put her at a disadvantage in the East Indian culture where girls marry and leave their birth home to live with their in-laws (Nichter, 1981).

The women's accounts told of seeking information and help from in-laws when they first thought they were pregnant. One woman said:

I talks with my mother-in-law and she tells me "You pregnant, you go to doctor" and then she tells my mother, I no tell her.

A second woman approached her sister-in-law, with whom she lived:

My sister-in-law she tells me. She have baby already so she knows.

A third woman recounted:

I tell my sister-in-law. She told me "you're pregnant" and then I told my husband that not my monthly period coming and then I go to the doctor.

This woman came from a city in the Punjab, lived in a nuclear family in Canada, spoke English fluently and worked as a real estate agent, her parents and in-laws all lived in India. She described her experience when she was first pregnant:

First I tell my husband you know--I don't gots my period. And he said "let's go to the doctor" and when we find out, yes, I'm pregnant, my husband
tell immediately his mother and she tells mine. That's how it is, the husband's family knows first in our culture.

Living at a distance from her in-laws had forced her to confide first in her husband; but following that, she upheld the cultural custom of telling in-laws before parents. Some authors (Gideon, 1962; Nichter, 1981) have described family life amongst East Indians living in India as pointed out previously, a woman, when she marries, leaves her birth home and goes to live in her husband's extended family. In these homes, the female elders wield a great deal of authority and influence over the younger women and receive respect from the younger family members. Most of the women in this study continued to live in the same family constellation as is evidenced in traditional India. It is therefore not surprising to learn that they tell the female elders first of a pregnancy. It is interesting to learn that the women without any parents or in-laws in Canada maintained the custom of telling their in-laws first. It appears that, even at a distance, and despite the process of acculturation, the custom remains firmly entrenched in the women's belief system.

Malinowski (1948) asserts that magic is often incorporated into the belief system in order to alleviate anxiety concerning the outcome of an event, such as childbearing, over which the individual has no control.
Radcliffe-Brown (1952) saw birth ritual, including pregnancy diet and practices, as a means of expressing and emphasizing the social value of an event to the community, and Brown (1976) observed that all reported cultures show some kind of recognition of the childbearing experience. Therefore it appears that all cultures have certain beliefs and practices surrounding the childbearing experience, that are used to help the individual maintain some measure of power and control over the situation and to reaffirm the social significance of the birth.

Gideon (1962), in describing a pregnancy and birth in the Punjab, tells a story of a culture in which traditional birth practices have continued unchanged for centuries. Gideon, Gordon, and Wyon (1964) describe exceptionally high morbidity and mortality rates for mother and child in India; because of these increased death statistics related to childbearing, women from India may be expected to have high anxiety levels concerning the successful outcomes of their childbearing experiences. One would expect many proscriptions and prescriptions for East Indian women to follow during childbearing. Parker and Neumann (1979) confirm a continued high morbidity and mortality in India and they also relate how the childbearing experience in India is largely looked after by female family members. This family involvement seems to be continued in Canada.

Once the pregnancy had been confirmed by the western
physician, the women no longer talked of shyness in relation to elders or sexuality. Their accounts spoke of a shift to discussing practical matters such as dietary and physical practices during pregnancy. Pregnancy practices and knowledge about dietary requirement are passed on from female elders to the pregnant woman either verbally or through observation. One woman said:

I listen from my mother-in-law. She tell me "eat this, do this" and then I knows.

And another:

No one tells me, but when I was in India, so I was watching what they were giving to my sister-in-law and my sister you know.

A third recounted:

My sister-in-law, because she already have two babies and she know everything and she tell me, you do like this, like this, that's why.

This finding apparently contradicted another perception that the women talked of—that of having their doctors as their primary sources of information. It appears that the information received from doctors was generally technological and medical in nature, while the knowledge passed on from family members was often based on common sense and the past childbearing experiences of the elders. One subject, who lived on a farm in a large extended family, said:

My family members tell me "walk alot and don't pick up heavy things and don't walk fast. Just slow you
know." Wear the loose clothes. Not tight. Not tight. And you think—not think too much—it not good—think good things about baby—it not good for baby's health or nature. If you think things, too much fight or...it's not good for baby's nature." I think--I think it's good for me and my babies. I walk alot and mostly I am happy and keep happy.

A second woman, who spoke English well and was a real estate agent in Canada recounted:

But my mother-in-law told me what I should do, you know she was advising me, you know, what you should do and you're going to be in that many months right. Be careful you know. Just take precautions you know...because they told me, you know, don't lift so many heavy things.

One woman told of having edema of the ankles in her last trimester. This was during the time that all the women in the household were harvesting blueberries in the field. Her elder sister-in-law had insisted she stay home and look after the home and children instead of working in the fields. She said:

Look after three, four children. All the time cooking, washing clothes, doing everything. Too much hard, too much hard.

This woman perceived that an overt physical sign had excused her from field work but an elder had judged her still capable of childcare and housework. Despite feeling it was too hard,
the work.

The participant who spoke English well, lived in a nuclear family, and intended to let her daughter choose her own spouse, told of being aware that the warnings issued to her were based on her relatives' past experiences. She said:

But they said you know, these months are very dangerous. You have to be more careful. That's right. When you're in your like ninth month because my mother-in-law she had so many miscarriages on the last month right, because she's got her personal experience so that's why.

Pregnancy customs and practices often appear subjective and are passed on by word of mouth and observation. As the women became more acculturated into Canadian society, they seemed to become aware that some practices were based on personal experience, and, although they continued to conform to many East Indian practices, they told of being more able to look at traditional practices and decide, often with their doctor's help, whether a particular practice was safe for them and their fetus. The woman last quoted said:

You knows, sometimes I'se got to decide--do it the way mother-in-law says--but maybe that be bad for baby because as I told you, is her personal experience right? So then I ask doctor and she tell me what to do.

The women's ability to make decisions using advice from both the popular and professional explanatory models, was also
evident in matters concerning diet in pregnancy.

During pregnancy, women who lived in large extended families and did not speak English well, told of how they did not alter their diets significantly to provide for the growing fetus. Information about diets appears to come from experienced elders, and, as in other practices and beliefs, is quite subjective. When they do occur, dietary changes are based on East Indian notions of "hot" and "cold" foods. One woman said:

No. Somebody who likes to eat, let them eat what they can eat. Different people, yeah, what you would like. I don't like too much tea and like too much meat. I don't like too much red chili. I don't like too much spices.

And another:

Old mother-in-law say what were good to eat. Hot spicy foods no good...because they burn my throat, yeah, and are no good for health. No good for the baby because they are too much hot...I don't know what happens to the baby if I eat but they say is no good.

A third woman told the investigator:

We don't eat hot foods when pregnant. Hurt the baby and too me. Baby and me....It's not good for baby because not good for baby's health. I don't know what it does, something. Some hurt. My sister-in-law tell me.
On examination, the mainstay of cold foods are dairy products, so the taboo on hot foods and stress placed on cold, are really dietary changes to allow for fetal growth, although the women could not tell the researcher why they were making these changes. As women came to hold beliefs and values more similar to those expressed in Canadian society, they talked more about their experience with diet in pregnancy. One woman talked of the reasons for eating specific foods. She said:

During pregnancy, eat what you wants. But be careful you know. Eat eggs for protein, and lentils as I is vegetarian. Eat vegetables and drink much milk. My mother-in-law tells me but mostly the doctor gives me a book.

Information had come from a traditional cultural source but, in addition, because this woman's English reading skills were adequate, she described how she benefited from information gained directly from the health care professional.

One woman had had a pregnancy in India and one in Canada. Her child born in India weighed five pounds and in Canada her newborn weighed over seven pounds. She attributed the difference in weight to a different diet. She recounted:

Maybe in here I already eat better. I don't think so I eat in India. I don't eat very well in India....Then I come here. So others go to McDonald's and I eat milkshake and working in A.&W. So maybe I think it's good.
In India her diet had consisted of rice, vegetables and sweets. In Canada, milk and meat had been added to her diet. She had added these foods when she became interested in and frequented fast food restaurants. Her dietary improvements had not been consciously thought out but rather a result of her acquiring the North American taste for fast foods.

Two women with good English skills, had attended prenatal classes in English at the health unit. They described diets that blended information from both the popular and professional sector. One woman said:

The health unit says, and I do, like maybe I need lots of things for baby's health, like milk, eggs, meat, good foods. Also my older mother like, she told me you eat lots of milk and don't eat hot things--hot stuff, spices, when you are pregnant...because it's not good for babies and me. Yeah, maybe baby hurt this way.

And another woman told the researcher:

My mother-in-law wrote, if someone's having a baby you know, like when somebody's pregnant, all kinds of foods like are good for the mother and the milk is pretty good and then butter is the main thing--I don't know why. Oh yes, she (mother-in-law) told me about meat. Oh, I can eat meat...all kinds of meat I am eating...I don't think that they are saying anything about the spices because in India, in that case, they all eat spicy. But spicey
gives me you know, the heartburn, so I don't eat. This woman stated that she followed the Canadian Food Guide during pregnancy and she did indeed know the essential food groups and recommended amounts. She had some concerns about the information she received from her mother-in-law, and told the investigator how she handled these concerns:

Okay, I just asked about the butter to my doctor because I was not believing so many things you know what my mother (in-law) wrote me, right. So I thought you know, I should ask the doctor. She is the best right.

This woman was seeking information from two health care sectors in society, the popular and the professional, but she placed a greater faith in what the professional sector said in terms of her pregnancy diet.

During pregnancy, female elders appear to play a major role in giving the women information about diet and activity. Initially the women spoke of feeling shy when telling their mothers of the pregnancy, but comfortable in talking with their in-laws. From the time that the elders learn of the pregnancy, the elders guide the women through the traditional personal health beliefs and practices related to pregnancy. The strict proscriptions and prescriptions surrounding childbearing that one would expect to find in cultures with high morbidity and mortality rates (Malinowski, 1948; Parker & Neumann, 1979) were not described by these women participants, perhaps indicating a decrease in anxiety level
related to Canada's low morbidity and mortality rates associated with birth. As the women adopted beliefs and practices that were more Canadian than Indian in nature, they began to question their elders' information and seek out answers from western professional health care workers. The women retained many of their traditional practices as long as they were reassured by physicians, that their babies were not being put at risk. This vivid blending of popular and professional explanatory models was also evident in the women's accounts of their post-partum experiences.

Post-Partum

In the post-partum period, the women's health beliefs and practices continued to be influenced by family elders. The process of acculturation also had a continued effect on the women at this time. The influencing factors of respect for elders and shyness continued to impact the women's perceptions of their childbearing experiences.

During the post-partum period, the women described how dietary restrictions were often based on the same principles applied in pregnancy. This was especially true if the woman was breastfeeding. As before, the women described how they did not know the specific reasons for dietary restrictions. One woman said:

But I eat light foods. Not like hot....Because I was breastfeeding this one. Hot hurts baby.
And another:

Not too hot, like chillies, not too much....Spicey, not spicy. I don't know why—maybe because of the breastfeeding.

Women who had made more dietary changes to provide for their growing fetus and who had consulted their physicians if they had any questions about their family elders advice, told how they did have an idea of why a breastfeeding diet would be restricted. A participant described the reasons:

Oh my God. If the mothers are, you know, breastfeeding, right, then they're supposed to eat you know, things like certain foods you know, which won't hurt the baby's tummy, right. When I eat a very hard food, then he can get into trouble. Because when I eat any large things, it can possible hurt the baby's tummy. I don't know in Canada, but in India they do take light food...when they are nursing, they are saying maybe the baby can have--like diarrhea or this kind of thing.

As the women came to consult western health care professionals in matters such as diet, their understanding of a breastfeeding diet altered slightly but was still fraught with misconceptions. Women talked of altering their diets so that they did not hurt the baby, but they did not speak of dietary modifications in order to ensure growth and development.

However, the study participants discussed punjeeri, a
a mixture of butter, flour and almonds given to the women daily with milk. Punjeeri was thought to speed recovery and the return of strength. When asked why she ate it one woman said:

Well, it's strong for the body. It makes you healthy....My mother-in-law made that for me. I take for two months.

Another woman described how she had first become aware of punjeeri. She said:

You know when I was in India, so I was watching what they were giving to my sister-in-law and my sister you know. So they were telling us, this is the good stuff, you know, after the baby, for the strength.

A friend had made the punjeeri for this woman as her relatives were all in India. This woman's lifestyle was more consistent with Canadian than East Indian society, for example, she dressed in Canadian clothes, ate mainly Canadian food, spoke English to her husband within the home and preferred living in a nuclear rather than extended, family. Following her first pregnancy this woman had not had punjeeri. She had felt weak and tired for a long time.

No I did not eat at all the first time but this time I ate and felt good...you take right after the baby...you can stop maybe after fifteen days, it's good for the body you know. Your muscle can be strong you know....It is like what you take
vitrums... It's not compulsory. It's just it's my
mother she told me.

Berry (1980) discusses the phenomenon this woman was
describing when he talks of immigrants maintaining their
cultural integrity at the same time as they change to become
a part of the new, larger societal framework. This woman had
attempted to abandon an East Indian tradition, but had felt
ill; during her next childbearing experience she had upheld
the custom of eating punjeeri and had felt better.

Knowledge about diet for breastfeeding mothers as well as
punjeeri was gained through observation or direct advice from
elders. As in pregnancy, the influence of the family members
in the post-partum period, is great, although diminished
slightly by the process of acculturation as the women began
to consult with health care professionals in matters such as
diet. The effects of acculturation could be heard more
clearly when the women talked of breastfeeding in hospital.
Shyness at this time was a major influencing factor. One
woman said:

I breastfeed in hospital under blankets. It
private and I shy from the people.

When asked why some women did not want to nurse in hospital
but did so eagerly at home, one woman, who felt comfortable
nursing in the hospital replied:

Now okay, maybe they're shy. That could have been
the reason otherwise there are no other reason.

Another said:
Lots of people are doing like that. Yeah, it is hard because the baby, he's not getting used to it. One woman, who came from a village and lived in a small extended family, said:

I don't know, maybe they want to, they stay for four days in hospital, they feel they want to rest, then I think they come to home and they want to nurse them—Yes, I think so (that it is related to shyness), but I don't shy. It's not good—shyness is not good.

The subject who had been told about menstruation by her mother, enjoyed breastfeeding her infants and felt no shyness:

I am not feeling not bad—I like to breastfeed.

This woman was an exception amongst the study subjects and this is consistent with her being raised with less cultural shyness evident amongst her adult role models. The majority of the women in this study appeared reluctant to expose their private body parts in a semi-public setting. This too is consistent with their upbringing and experience with cultural shyness. However, as the process of acculturation occurred the women appeared to understand that shyness in terms of breastfeeding was a negative trait that delayed their success in feeding their newborns. An interesting finding is that, although the women talked of breastfeeding in the hospital, they discussed shyness in relation to people in general and not in relation to health
care professionals in particular.

Women in this study were also able to observe and discuss the limitation their culture placed on physical activity in the post-partum period. The same pattern of slow movement from one belief system to another during the process of acculturation was again evident.

Women talked of restricting their physical activity for six weeks after a baby is born. Gideon (1962) confirms that this is done in the Punjab in an attempt to isolate mother and baby from possible disease, and reduce the woman's heavy workload. This six-week period of rest is consistent with western obstetrical practice, which does not consider women physically recovered until six weeks post-partum (Lytle, 1977; McKinlay, 1972). The women in this sample described how they varied in the amount of rest they received post-partum and they gave different explanations for this rest period. One woman said:

I spent like 20, or more than 20 days in my mom's home after his birth and she helped me there.

And another:

My aunt was there. She came at my house for two weeks and she do my work.

These women described the help given them in the post-partum period, but did not explain why their elders gave such help. As the women increased their English skills and began to consult their physicians for advice on activity and nutrition, they could explain the reasons why they needed
help. A study participant said:

Mostly one month from hospital I rest. I stay in house. Because some think that weakness. That's right...health reasons mostly. If I do feel well, so's I can go out, it's okay, but I stay home--rest.

And another:

When I come home I rest. Family members look after everything. Because it's hard for the stitches. Maybe I twist the stitches and maybe it's hard when I pick up, overlift. So I rest maybe six weeks.

One woman, living in a nuclear family said:

M...hm. After a week or so, then you feel better, you like to or you can walk. In India they spend I think six weeks at home, but I don't able to.

This woman's experience was, out of necessity, different from the other women's. Not having relatives here to care for herself or her family, she had not spent the customary time recovering. Chance (1965) points out that old cultural practices are discarded more quickly and new ones taken on when it is beneficial to do so or such changes are required of the acculturating group or individual.

The woman who had not had punjeeri following her first baby but found that it helped her recovery after her second, had this to say:

Yeah, we're keeping same customs most often, but that's changing too. In India, ... forty days the
women are not going out of the house, six weeks they are staying in, you know and lots of people are not coming to visit them because they're thinking the baby's going to get germs you know. But here nobody minds and I think the women are going out after two, three days. I think in India, oh God, there are so many superstitions right, that people still believe that right but I don't think they should stay in bed for forty days you know....No I did not go myself. I did not feel good that time, I thought I should stay in because my baby was, you know, small and I thought even if I'm going to stay in, he will be much better. Also, because when you are going to go out, that people come and hold your baby, right because in our culture you can't stop and sometimes the people, they've got dirty hands and they put them in the mouth after and I did not want my baby to get anything right. So, I did not go.

This woman verbalized her belief that the old custom of staying in for six weeks post-partum was not necessary and was a mere superstition. However, she did stay in and she rationalized her decision in terms of "germs"—a modern, western health care concept. Integration (Berry, 1980) of the two cultures was occurring for this woman at this time.

It appears from the data that the process of acculturation affects the women's diet and behaviour in
pregnancy and post-partum. The experienced elders in traditional societies are influential sources of information during the childbearing experience, and, in Canada, these elders appear to continue to be influential during this time. As the women in the study became more acculturated into Canadian society, they began to seek out the advice of the professional sector more often. But they remained committed to many practices they learned from the popular sector of health care. MacClain (1982) confirms that cultural change rarely eclipses traditional practices but rather provides an additional alternative and source of control over the childbearing experience. This appears to be true for the women in this study.

The popular explanatory models of the women in this study in relation to their childbearing experiences differ from both the popular and the professional models of Canadian society at large. A growing number of Canada's popular explanatory models perceive that the "pregnant couple" must take control of their childbearing experiences (Arms, 1977; Korte & Scaer, 1984), while many couples yield control completely to health care professionals. In giving up control over their own experiences these couples' health beliefs and practices in areas such as diet are dictated by health care professionals and client compliance is high (Lytle, 1977). Regardless of which popular Canadian explanatory model is adhered to, pregnancy and breastfeeding are celebrated (Kitzinger, 1978), and shyness in relation to
these subjects is not an issue. Family elders are seldom consulted for information and advice on health beliefs and practices and respect for the elderly is declining (MacClain, 1982).

Similarly, the professional health care explanatory models often perceive that knowledge of the childbearing experience is their exclusive domain (Arms, 1977; Cameron, 1979; Kitzinger, 1978). Although this is changing slowly to allow for more client control over their own experiences (Lytle, 1977; MacClain, 1982; Mercer, Hackley & Bostrom, 1983), health care professionals still feel they are the authorities on matters such as pregnancy diets. The difference between the professional and East Indian popular explanatory models has implications for the East Indian women's health care as conflict may arise between the advice given by the health care professional and the family elders. As the women in this study became acculturated into Canadian society, it is interesting that their accounts revealed that they continued their old practices but explained them differently. In addition, they began to adopt childbearing practices characteristic of Canadian society.

Summary of the Subjects' Relationships with their Families

Regardless of the degree of acculturation that had occurred for the women in this study, they all said that shyness had had a negative impact on their lives. The women
clearly expressed distress at their lack of knowledge of their own anatomy and physiology in the areas of sexuality, sex and pregnancy; and indeed they had plans to alter this experience for their own daughters. One woman said:

I am going to tell her of these things. It be important. Some things are too scary, too scary if no know.

And another:

Some girls do that (talk) about lots of these things. Some maybe shy, that's why not. Yeah, I like that (to talk). It's knowledge that's why.

And a third:

Well, I'm going to tell her (daughter) everything...It's better right--I feel very difficult when I get my period the first time.

Asked how she would feel telling her daughter, one woman observed:

I think not bad because now, in Canada, you know, we know this country is completely different from India. Even you can kiss and so many things, even on the street, but in India, nobody is doing that there....Even my husband's friends, like male, they're talking about things in front of everyone but we don't. We are very open right. We are just like--you know, when I'm having some guests, they're Canadian, I will be like them. If they're East Indian, I will be like them, right. So, when
they are coming at our place, it's very open. Even they're discussing sex, everything, in front of everyone, right. But in our culture, like when I was having a baby, you know, the men they were asking me to see how the baby's doing, but Canadian, they were saying, can I see your tummy. Can I do this? They were doing like that. So that's the difference.

This woman perceived that her new life in another country would entail changes in behaviour and adaptations that she had already begun to make in an effort to be a part of her chosen society. In addition, she could see the benefits that this new openness would have for her child.

Yu (1984) points out that values from different cultures often clash, and the immigrant, in order to live peacefully in the new culture, must give up some old values. Chance (1965) points out that in the process of acculturation, old values are given up more readily if the new values are clearly perceived and capable of being integrated into existing social and cultural patterns. All of the women made sense of their world through shyness. This cultural trait was an important and major part of their explanatory model and as shyness influenced their childbearing experiences, they could see the value of helping their daughters to alter their explanatory models.

Regardless of the level of shyness the women recounted when they told of their childbearing experiences in Canada,
they had all had contact with and received care from the professional health care sector. The degree of their contact, as well as the benefits they received from this contact were affected by the process of acculturation.

The Subjects' Relationships with Health Care Professionals and Influencing Factors

In this section the women's perceptions of the western health care resources they utilized during their childbearing experiences will be described and discussed.

On the subject of their relationships with health care professionals during their childbearing experiences, the subjects' discussions were fraught with contradictions. Although they claimed that the physician was their primary source of information, their actual practices were based on information obtained from family members; and although they experienced discrimination by the hospital nursing staff, they preferred delivering their babies and spending their post-partum time in Canadian hospitals. Throughout the childbearing experience they seemed to perceive the health care professionals as absolute health authorities and placed their trust and respect in them.

The women described their relationships with their physicians, the community health nurses, the hospital staff nurses in the post-partum period, and, in a general way, their perceptions of the western hospitals where their babies
were born.

In the women's descriptions of their relationships with health care professionals, the influencing factors of authority, respect and lack of knowledge, were once again prominent in their explanatory models. They were also influenced by the discrimination they felt was directed at them by hospital nurses. Despite this, they spoke of the safety factor that a hospital delivery offered both mother and baby. The women's relationships with health care professionals, together with the identified influencing factors in these relationships, affected and were affected by the process of acculturation. These relationships, in turn, formed a second major portion of the women's explanatory models of their childbearing experiences.

Table 2.

<p>| Theme: The Subjects' Relationships with Health Care Professionals |</p>
<table>
<thead>
<tr>
<th>Relationships/Preferences</th>
<th>Influencing Factors</th>
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<tr>
<td>Physician</td>
<td>Authority</td>
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<tr>
<td>Community Health Nurse</td>
<td>Respect</td>
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<tr>
<td>Post-Partum Hospital Nurse</td>
<td>Lack of knowledge</td>
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<td>Hospital</td>
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In this section the subjects' accounts will be presented according to the theme: relationships, and influencing factors.
The Relationship with the Physician

All the subjects claimed that the doctor was their primary source of information about their pregnancy, labour and delivery and about appropriate actions to take during this time. One woman said:

The doctor—she gave me a book. There is a lot of things about pregnancy and baby's birth.

And another:

I think just my doctor gave information. Not even friends.

A third woman said:

Well, the doctor gave me some books.

And a fourth described how she perceived her doctor:

I thought of him (the doctor) as my good friend.

All but one of the women in the study did not actively question the doctors about childbearing but rather accepted information given to them. However, when asked about their actual practices, most alterations were based not on accepted western medical practice but on information received from family members. This contrasted with the trust placed in the doctors by women, but is consistent with the writings of MacClain (1982) and Oakley (1977) which describe the ease with which a traditional culture picks up the technological aspects of western medical care as opposed to a Western belief system.

The women described situations in which they placed
obvious trust in their doctors. Several of the women said that they trusted their doctor as they considered the physician as the authority. These women held beliefs and values similar to those found in East Indian culture. Women who held beliefs and values associated with Canadian culture, such as consulting their doctor about diet in pregnancy, placed their trust in their doctors according to their knowledge of what was happening to them. Acculturation appeared to affect the reasons behind their trust in their physician. One woman had had labour induced and had felt comfortable giving control over to the doctor unquestioningly.

I did not start pain. The doctor—yeah, I had to go to the doctor...he moved something. Yeah, then he told me that "you start pain otherwise you phone me." I did not start pain. I phoned to the doctor and he said "You go in the hospital." I go in the hospital that day...the doctor came over there...then they start paining with the machine. Give some medicine and I start pain.

This woman had no idea of what was done in the process of inducing labour nor did she feel a need to question the doctor as she trusted and respected his judgment and authority.

Another subject talked of being in the delivery room without any relatives present. She said:

It doesn't matter. If doctor is good, I know
because my brother's wife already got two babies with that doctor so I know the doctor.

Two women had had births by emergency caesarian section. The first woman had not attended prenatal classes and had never heard of a caesarian birth prior to her own operation. So, that's when she (the doctor) told me, you might have a caesarian section. So, I didn't know there was a caesarian section.

Asked if she was scared or had asked for more information, she replied "No" and that she trusted her doctor to do what was best for her.

The second woman had good English skills, lived in a nuclear family, and had attended prenatal classes.

Then I was in labour yeah. When I was in hospital, you know, I went for my normal delivery. But in the morning time, just after 13 hours, they said, the doctor, you know, she was very scared and she told me that I got some problem. My baby was not breathing properly and I was having contractions. I was cutting oxygen from my baby....And then they said, we want to operate you right. So that time I was very glad you know so I says yes. It means my baby was fine and I was fine.

This woman had asked for and been given the information she needed to persuade her that the surgical procedure was necessary. She too trusted her doctor, but she also had the knowledge to make a judicious decision.
The women in this sample all perceived that their physicians were the authorities in health care that had a western technological base. Women in the sample who had become more acculturated, seemed to have total trust in their physician but their trust was based not only on "blind faith" but also on their ability to understand various practices in their new culture. This finding is consistent with the works of Berry (1980) and Chance (1965) who both point out that, as the process of acculturation occurs, the individual is better able to question and understand new cultural practices.

The women in this sample appeared to trust their doctors on physiological and technological matters, but it was with community health nurses that they felt more comfortable discussing beliefs and practices.

The Relationship with Community Health Nurses

Two of the eight study subjects and their husbands had attended prenatal classes at the local health unit. Both of these women lived in nuclear families in Canada and their close relatives lived in India and were thus unavailable as dispensers of information and advice. One of the women had grown up in a city and not a village in the Punjab; both spoke English fluently and had beliefs and attitudes commonly held in Canadian culture. For example, both had consulted their physicians about a nutritious pregnancy diet and one had asked her doctor's advice before she had undertaken a
traditional practice told to her by a family elder. When asked where they had learned of the classes, one replied:

Doctor told me. I went cause I want to.

The second replied:

Oh, I went to my doctor and she told me about the health unit and so I go there.

A third woman had also been told about prenatal classes by her doctor. She said:

No, I didn't went there because I didn't have the time. I was working.

In fact, she worked four hours per day three days a week and her husband worked day shift. This woman's mother lived with her during her pregnancy and the woman described how her mother had provided the information she felt she required about childbearing.

The five other women in this sample had not heard about prenatal classes and seemed genuinely surprised to learn of their existence. This finding is surprising when one realizes that three of these women had the same physician as the two who had attended classes on the recommendation of their doctors. It is difficult to assess what actually happened between this group of clients and their practitioners, however, it seems obvious that a misunderstanding occurred on one or both sides of the relationship. One of the women who, because of this miscommunication, had not attended prenatal classes, wished she had been able to attend:
To learn from these things would be nice.

And another:

Oh yes, I would go. Is important. I don't think for husband to go though—he no go as is for women this--I be shy with men at that place.

The public health unit from which this study's participants were drawn, has been offering Punjabi-language prenatal classes for approximately two years. Despite extensive advertising, these classes are poorly attended (G. Greenstone, personal communication, July 21, 1985; P. Pullen, personal communication, March 1985). This is inconsistent with the findings gained from the women in this study, who either attended or said they would have liked to attend classes. The prenatal classes are, however, co-ed, and as has been shown in this study's findings, the women's explanatory models perceive childbearing as a purely female experience.

The women who did attend classes felt that they were helpful. They talked of how they perceived the community health nurses. The first woman said:

They tell me things--they help me to know.

And the second:

They are very nice. You know even when I started prenatal classes, I was having lots of help from them and I really admired, you know, and I'm telling everyone--you know. Like some people they don't know anything about pregnancy or anything.
They should go to the health unit. And they are very friendly, they're explaining it and behaving very nice.

The prenatal classes benefited this woman greatly when, after a long labour, her baby went into fetal distress and she underwent an emergency caesarian section.

It is encouraging to learn that the community health nurses are perceived as having both the knowledge and the interpersonal skills to provide relevant care for this group of women. This is particularly important in view of the work of Johnson, Snow and Mayhew (1978), who state that women from a low income multi-ethnic background are at risk as childbearers due to their limited knowledge. The community health nurse may be in a privileged position to work effectively with Indo-Canadian women. The challenge now for the community health nurse should be to work with childbearing women who are less acculturated into Canadian society and who have explanatory models that prevent them from approaching the community health nurses for physical care and emotional support (G. Greenstone, personal communication, July 21, 1985; B. Meekison, personal communication, November, 1984; P. Pullen, personal communication, March, 1985).

Following contact with community health nurses, the women talked freely of their relationships with the nurses on the post-partum ward of the hospital. Their relationships with this segment of the professional health care sector contrasted sharply with any other accounts they gave.
The Relationship with Nurses in the Post-Partum Period

During their post-partum time in hospital the women were in close contact with the hospital nurses. The women explained how their hospital stay was characterized by feelings of being discriminated against by the nursing staff. All of the women talked of feelings of unhappiness and/or anger at this discrimination.

The women spoke freely about the reasons they felt their ethnic group was being discriminated against. The women did not uniformly use the term "discrimination" to describe the nurses' attitudes and behaviours. Women who were less educated with poor English skills did not describe the phenomena of discrimination in the same way as the more educated women with better English verbal ability and with attitudes more similar to Canadian culture, although all of the subjects related that lack of English skills was a significant cause of this discrimination. Again, however, women with higher education and good English skills, could identify broader underpinnings for the felt discrimination.

In their accounts, all the subjects related that this felt discrimination by the hospital nurses, affected the nursing care they received. They related a range of coping behaviours to deal with discrimination. The coping behaviours varied from ignoring the nurses, to yelling at them, to contacting the hospital administration. Again, the
women who coped in an appropriate, effective manner by speaking to the administrators, by speech, background and education, were more similar to the Canadian than East-Indian culture.

Regardless of the felt discrimination, all of the subjects saw the hospital nurse as the health care authority and respected her in certain areas of their care and the women uniformly preferred a Canadian hospital delivery to home birth in India.

The women were clearly able to say that they perceived that hospital nurses did not like the Indo-Canadian community. One woman said:

Is problem if nurses no like as I am East Indian--is not nice for me.

And another:

They (the nurses) no like us...they be different with us. It is hard for me.

A third woman described her preference for a hospital delivery and post partum stay because:

Then I can rest all the time...if I need something, ring for the nurse. Nurse comes to me slowly, but she come. To other peoples she come quick.

When asked why she felt this difference in response time occurred she said:

They (the nurses) do same to all East Indian. They no like us.

As the women moved through the process of acculturation
and became more consistent in dress, attitude, and behaviour with Canadian society, they were able to identify the nurses' dislike for their cultural group as discrimination. At the same time, they became aware that discrimination levelled at them was decreasing.

One subject did not feel discriminated against personally but observed it directed at others and had feelings about it:

I do not feel it because I know how to be in hospital, but others do not and it brings much sadness.

When asked to explain "how to be in hospital" she continued:

Be more like Canadian you see, do more like they say to do and listen what they say you to do. This woman was clearly successfully trying to become like the larger society in an attempt to decrease discrimination directed at her.

One woman had two babies in the same hospital ward at an interval of two years. When asked about her hospital stays she replied:

Shall I tell you truth? See, the first time, I don't know, I did not like the nurses behaviour very well. When I went the first time, I don't know. They were really rude. The second time, oh my god, they were nice to me, but still to other East Indian womans they were rude. This is discrimination you know. I get so mad at this.
In the two years since her first childbearing experience, this woman had moved forward in the process of acculturation and now carried out many more Canadian than East Indian practices related to childbearing. She was an educated woman who described and gave a name to the nurses' behaviour. In addition, she could take actions in hospital to reduce or eliminate discrimination.

All of the women spoke freely about why their cultural group was discriminated against. One woman said:

The (nurses) just no like (us). I know no, maybe as no speak English.

And a second:

No like East Indian people, I don't know why. Is hard to speak one to another.

A third tried to explain:

Maybe...maybe it is hard for us yes? We don't understand the English language and so not understand everything very well. We don't--we just don't feel comfortable after baby. And for this maybe the nurses don't like us, so is hard to be in hospital sometimes after baby.

One woman who came from a city in the Punjab and lived in a nuclear family in Canada, talked of discrimination as a broader issue than language. She said:

Mostly in Canada nurses treat you same. If don't speak English it is problem--then they ignore you.

But is bigger problem than language, it is about
how they feel from us—they afraid from us and we be afraid from them. Is silly yes?

A second woman who also came from a large city and lived in a nuclear family described the problem of discrimination more fully:

Really it is because of a language problem...it's not their (the nurses) fault they are like that with us...they don't understand and so they don't care...Oh my god, it really is more than language right? Me, I never feel discrimination from anyone, but my friends tell me and I see. Canadians you know they don't understand; they afraid from their jobs and their children, and then maybe we do things different, some little things maybe, but they see and then oh my god they discriminate. At this time you know, so much to think and feel, it is more difficult for them (the women) to speak English. And then it's hard you know, the ladies are very tender, emotional you know.

All the women could identify a language problem as a contributing factor to their discrimination. When the women were more educated and more consistent with Canadian beliefs and practices, they were able to deflect discrimination from themselves and to describe other core reasons for the existence of discrimination.

Berry & Tischler (1978) view discrimination as the
unequal treatment of equals, either by bestowing of favours or imposing of burdens. Discrimination touches every aspect of life. Aboud and Skerry (1984, p. 3) define ethnic attitudes as a "predisposition to respond in a favourable or unfavourable manner toward people of different ethnic groups" and in a critical review of the literature, they suggest that ethnic attitudes emerge at about the age of four and, as time passes, different groups begin to show more own group preference and other group rejection.

All of the women in the study delivered their babies at the same large community hospital. On the post-partum ward the nursing staff consisted predominantly of Caucasian Canadians. The Indo-Canadian immigrants delivering babies in this ward were an ethnic minority with childbearing beliefs and values that differed markedly from those of White Canadians. The situation on his ward existed for potential discrimination and the study participants confirmed that they did indeed feel discrimination on the part of the hospital nursing staff.

Knowledge of a language has consistently been mentioned as a factor facilitating assimilation; the final step in acculturation (Eisenstadt, 1970; Simpson & Yinger, 1972; Warner & Srole, 1945.) When assimilation occurs, the individual is a fully functioning member of the group into which he/she is acculturating, and therefore discrimination decreases. The subjects' perceptions that their inability to speak English contributes to discrimination by the larger
society, is therefore consistent with the literature. Consistent too, is the more acculturated women's view that language is only one factor; race and education are also mentioned in the literature (Friedman, 1973; Handlin, 1941; Hannan, 1979). The so-called "visible minorities" are constantly at the risk of being discriminated against by the predominant race in the society. Education is often mentioned as a powerful force because educated immigrants are generally more acceptable to members of the larger group and because education helps immigrants to overcome language and cultural barriers which obstruct access into broader social circles (Heiss, 1969; Portes, 1984; Ragin, 1979). Women in this study who perceived a broader reason than language for the felt discrimination, had better English language skills, attained higher levels of education than other study participants and had become more similar in beliefs and values to Canadian than East Indian culture. The woman who spoke of Canadians being afraid of losing their jobs and of cultural differences, was reflecting on discrimination resulting from Indo-Canadians being a visible race minority.

Regardless of their reasons for the felt discrimination the women's accounts showed that the discrimination by hospital nurses became part of their explanatory models of the childbearing experience. All the subjects described the effect this felt discrimination had on the hospital nursing care they received. The women could look back and clearly see that they were negatively affected. One woman said:
They (the nurses) leave me alone; I leave them. Is better for me but too hard for taking care of first baby. I no know how to take care of baby.

One woman explained that, although being ignored was not the nurses' "fault", it still affected her and her baby.

Is no one's fault. I no understand, others no understand, so they (the nurses) no bother--is hard for them too--but then for first baby, is hard to understand what to do--and the nurses no bother to help.

A second woman described her experience:

Is difficult in hospital see, because I have caesarian but still the nurses say "do this, do that" all by myself; and I can't because is hard after baby. And I see they help other women with the same thing and this is no good--but mostly you know they were very nice to me.

This same subject later said:

They make me go to washroom by myself and they make me care for baby by myself. This is really too hard right, I can't do this right, take care of baby by myself right, 'cause I have section, and then it is not fair to baby, so really it not fair to all my people.

This woman was not aware that accepted western obstetric practices required women to be up and self-sufficient in the post-operative period. She attributed the nurses'
instructions to discrimination when the situation did not warrant it. She believed in the East Indian practice of post-partum bedrest for the mother (Gideon, 1962) and this provides a good example of the conflict phase in the process of acculturation (Berry, 1980), where the beliefs, values and practices of the acculturating group clash with those of the dominant group. This conflict between nurses and clients, increases when nurses do not explain the rationale for their actions or procedures.

One subject, having had her first baby in a hospital in India, was in a unique position to view her nursing care during her post-partum hospital stay in a Canadian hospital. She said:

Is no different, same from Canada, same from India. The nurses treat us same as Canadians; maybe if they don't understand English is a problem. Maybe that's why the East Indian womans don't like nurses in Canada. For me is no problem, but see, this time I gets my second baby so I know to take-care. If nurses and womans don't like (each other) and don't speak language the same, for sure is problem with first baby especially.

This woman was adapting to life in Canada. She had not felt discrimination directly but saw it aimed at others. She could understand that lack of communication with nurses was involved in discrimination and was a problem for women having their first babies.
The women felt that the effect discrimination had on their nursing care was a particular problem for the first-time mother. Health care professionals consistently recognize the importance of providing support and education for the woman having her first child (Lytle, 1977; Reeder, Mastroianni & Martin, 1980). It is noted that women having their first baby need emotional and practical support to make the transition from pregnant woman to comfortable parent (Carter-Jessop, 1981; Cameron, 1979; Kitzinger, 1977; Reeder et al, 1980). Anthropologists (MacClain, 1982; Newman, 1972) have also noted that in many cultures the birth of a first child is an important rite of passage as the woman takes on the formal role of mother. It is evident that women in this study felt that birth is a phenomenon in which special care and education of the mother were required and for this reason the women who were first-time mothers suffered most from the effects of discrimination by hospital nurses. This finding is not surprising when one considers that the women's perceptions of their upbringing were shrouded in shyness and that they arrived at their childbearing experiences lacking adequate knowledge of what was happening to them or their infants. It appears that this ethnic group requires a great amount of extra nursing care whereas in fact their perceptions were that they received nursing care that included discriminatory practices.

In the study sample, the woman who appeared to have beliefs and values most consistent with Canadian values,
talked eloquently of discrimination in the hospital.

One of the East Indian women, she had a daughter, you know, she was crying so much, maybe she was having cramps or anything, right? And she called the nurse and she (the nurse) did not care, you know. She did not comfort her and then the woman came in my room and she said "Can you help me, you know, my baby is crying and they're not telling me anything right." And then I called the nurse. I said "what's going on, right? Why are you not going in her room?" And she said "She's not feeding her enough, right." And the East Indian woman was having a second baby, so she knew, and they were just accusing her, you know and that's not nice. It is a problem from the language, sure, but it is also a problem from how they think we are and, oh my god, everyone suffers, the baby, the women--maybe even the nurses right?

This woman perceived that members of her cultural group were being given different care from other groups, that this care was based on the nursing staffs' feelings about Indo-Canadian women and that all the individuals concerned suffered negative physical or emotional repercussions from these feelings.

The women spoke of dealing with discrimination in various ways. Generally their coping behaviours appeared to the Canadian-born investigator, as constructive or
non-constructive. Many of the women, however, saw their coping behaviours as a way of living through their hospital experience with the least amount of overt conflict. Speaking of coping with discrimination one woman said:

I ignore pretty good yes. Spend four, five days in hospital and no listen—is no use because they (the nurses) treat like this and I no change (them).

After my time I go home and it be finished.

This woman is the youngest daughter-in-law in a large extended family dominated by the mother-in-law. She acknowledges her lack of authority and respect within the family structure.

Another subject discussed how difficult it was to deal with discrimination.

What good to say anything? They (the nurses) no listen, they just be worse after and they no understand when I speak—so I just leave alone. Is no long time in hospital so is better to leave.

One subject tried to deal with discrimination by direct confrontation:

One time I yell at them for doing like that—then they yell worse at me "Do this, do that," so is no use. It get worse yes. How come it be like this?

This woman had English language skills that allowed her to respond to the nurses. She realized that this method of dealing with discrimination was not effective but she was unable to find a more suitable coping behaviour.
One woman did not experience discrimination personally but observed it directed at others and reiterated how she took steps to prevent her own experience of it.

They (the nurses) not be like that with me because I try to be like the others (White Canadians) in hospital. Also see, like I go to prenatal classes yes, because then I know how to be so they no act like that to me. But I see them act that way with other East Indians that's for sure.

This woman clearly felt that she dealt with discrimination effectively by consciously assuming Canadian beliefs and practices such as attending prenatal class. This subject lived alone with her husband and two small children. All their relatives lived in India, she lived in a nuclear family and, by necessity, made many decisions she would not be permitted to make in an extended family.

In her first post-partum hospital stay the real estate agent with good English language skills, and a higher level of education than other study participants, did experience discrimination. She took steps to alter this for her next hospital stay. She explained:

With my first baby, there were four ladies in the room, and two were Canadian and two were East Indian, and they (the nurses) were mostly giving more attention it seemed, to other people. I was crying most of time and I was telling my husband you know, how they be like that, my husband felt
bad. He said "I wish you'd complain you know, to the head nurse. You should tell them because they are doing like that." And this time my husband told them you know. We did it very nicely you know. "First time we were treated like this and this time we don't want it like that." Yeah, we told them you know. And I think maybe this time I was very friendly you know and talking to them and they were very nice to me. And this time we ask for private room right? And this helps to not have Canadians to get their attention, you know. So then they aren't rude to me.

This woman had characteristics that the literature states facilitate assimilation (Eitzen, 1973; Hannan, 1979; Simpson and Yinger, 1972) and indeed, she took positive, effective steps to ensure she did not experience discrimination.

As described by Portes (1984), individuals with less education do not always label their experiences as discrimination, while those with higher educational levels do label their experiences as discrimination. Portes' writings are consistent with the findings of this study. Although all the study subjects felt discrimination by the nursing staff directed at their cultural group during their post-partum hospital stay, women who used the term "discrimination" to describe their experiences had attained higher education levels. Furthermore, the reasons given for the existence of discrimination, the effect it had on their hospital stay, as
well as their strategies for coping with discrimination, differed according to each woman's degree of acculturation into Canadian society.

Several authors have written about clients' perception and approaches to childbirth (Kitzinger, 1977; Snow, Johnson & Mayhew, 1978) and how divergences from professionals' views are responsible for non-compliance with staff recommendations. Shaw (1974) points out that patients' access to alternative sources and methods of obstetric care is significantly related to the nursing staff's perceptions of their social worth, with the result that, poor, minority women have less control over their hospital experience than do other women. Women in this sample, having little access to the traditional home births that they are familiar with in their country, and being members of a poor minority group, experienced little control over their hospital experience.

Professional nursing literature has addressed itself to the need for assessing clients' cultural beliefs and values in order to provide relevant, client-centred care (Brown, 1976; Davis & Yoshida, 1981; Tripp-Reimer, Brink & Saunders, 1984). However, the literature has not described the problem of clients' explanatory models including discrimination directed at them by the nursing staff. This lack in the literature may indicate that nurses do not see themselves as discriminating against certain groups of people, while the popular sector attaches the meaning of discrimination to their interaction with some health care professionals.
Despite this felt discrimination, the study subjects' accounts indicated that they trusted and believed in what the hospital nurses told them. This is especially evident in the area of breastfeeding.

It is interesting that, despite the felt discrimination, the women described the hospital nurses as their main source of information about the care of their new babies. In discussing discrimination and communication problems with the nurses, the women realized the negative effect this had on helping them to care for their infants. Their confidence in the nurses' knowledge as health care professionals remained intact, however, despite the felt discrimination. This belief in the nurses' knowledge was evident in the area of breastfeeding and the value of colostrum for the newborn. One woman said:

There is just water is coming, but I know how—that the water is good for babies. The nurses tell me this.

And another:

In hospital they (the nurses) tell you it's very good for the baby so I give it.

One woman, who had the ability to read English, had done her own reading on colostrum and had later had her facts confirmed by the nurses.

First I read that it is good—then in hospital the nurses tell me so I give it to baby.

The participant who spoke English fluently and had
attended prenatal classes did not have an explanation of what colostrum was, but she trusted the nurses' advice. When asked why she gave her baby colostrum, she said:

I don't know. Just they told me to—you know, you should nurse like this, the nurses told me. Oh, even they are telling the prenatal classes too. Yeah, in the beginning—watery like—it was yellow....Yeah, that when it's coming in, sort of feed the baby with that and then...I did the nursing maybe one day after that.

In hospital this woman had confirmation of information given in prenatal classes. She acted willingly on this information as did the other women, in the belief that the health care professional was the authority.

The women in this sample had explanatory models which conferred the status of "authority" on the hospital nurses. This remained true despite conflict and felt discrimination between the nurses and women. If the barriers to communication were reduced and the conflict negotiated, hospital nurses would be in an excellent position to provide more effective and meaningful care to these Indo-Canadian women.

The Preference for Hospital Births

All of the women spoke of preferring to have delivered their babies in Canada and not in India. Their explanations
for their preferences arose from their knowledge of the dangers attached to delivery in India and their appreciation of the post-partum time in hospital.

One woman said she preferred a Canadian hospital delivery:

Because over there, there's too many so sick.

Some women appreciated both the safe hospital environment and the luxury of being looked after. One woman said:

Is good, is safe for me and baby. All the time that was crib, bottles and towels and anything...everything.

And another:

Having nurses there to help is good. Yeah, in the house helping...yeah, but sometimes they are busy and the work, it's too hard.

The two women who had had caesarian births were most convinced of the desirability of a hospital delivery in Canada. The first said:

Because certain--they deliver at home right?...If there's a problem like me. That's why I'm scared there. If there's no like hospital near, what are you going to do right...Like most of the people in India, they are not in the city, so there's no hospital here.

And the second:

And I was very glad because in India there are not too many, you know, that you can say--nice
hospital. Because in India, especially the ladies, most of the ladies are having kids at home and my case, you know, when I got my baby, my case was completely different because they never told me that I was going to have a section, you know... One of us could have died, my baby or me. Yeah, so I'm very glad that I got my baby in Canada.

This woman, who held beliefs and practices more similar to Canadian than East Indian culture, was able to use her own experience as an example to point out her reasons for preferring western health care practices.

All of the women had seen, first hand, the dangers inherent in childbearing in India, and they were grateful to be in a country where medical facilities decrease the morbidity and mortality rates. The women also said that their experience in Canada was improved by their being cared for in hospital. Both these reasons provide examples of a people giving up their old practices to take on new cultural practices when they can see the advantages the new practices have for them (Chance, 1965). The women's preferences for hospital deliveries, regardless of their degree of acculturation, also illustrate how individuals' explanatory models may alter as they see the benefit of taking on new beliefs and practices.

It is obvious from the data, that health care professionals have explanatory models about childbearing that differ from the explanatory models of the Indo-Canadian women
immigrants in this study. The professional health care workers have an impact on the childbearing experiences of these Indo-Canadian women immigrants. This impact is not always positive, as in the case of felt discrimination. At times the women stated the professional did have an influence when only a minimal influence existed, as in the case of verbalizing following doctors dietary advice while really listening to elders advice.

As the women came to hold beliefs and attitudes more prevalent in Canadian society, their practices came more into alignment with those of the health care professionals and their ability to deflect or cope with discrimination increased. Regardless of their acculturation, these women's perceptions of health care professionals during their childbearing experience was based on trust in technological areas, and, for reasons of safety and comfort they preferred delivery in a Canadian hospital.

Summary

In this chapter, the subjects' experiences of childbearing in Canada have been presented in relation to the process of acculturation. The subjects' accounts have contained their explanatory models and these explanatory models have been compared to pertinent literature. Similarities and dissimilarities amongst and between the accounts have been explained in relation to acculturation.
CHAPTER 5

SUMMARY, CONCLUSIONS AND IMPLICATIONS FOR NURSING

Summary

The purpose of this study was to gain knowledge of the health beliefs and practices of Indo-Canadian women immigrants during the childbearing experience. The study was directed by the following questions: What are the Indo-Canadian women's beliefs about childbearing? What are the Indo-Canadian women's perceptions of their traditional practices, in their ethnic community, surrounding childbearing? and finally, how are these western health care resources perceived by the women?

As outlined in Chapter 1, the Indo-Pakistani population in Canada has increased in recent years, from 13,200 in 1971 (Statistics Canada, 1971) to 43,070 in 1981 (Statistics Canada, 1981). Punjabi-speaking people in that year numbered 76% of the Indo-Pakistani population (Statistics Canada, 1981). As their numbers have grown, this immigrant group have made up a greater percentage of nursing's clientele. There is, however, a paucity of research and writings about the childbearing experiences of Indo-Canadian women immigrants, despite the health care professionals' acknowledgement that Indo-Canadian women underutilize the
prenatal programmes available to them (T. Johnstone, personal communication, May, 1982; P. Pullen, personal communication, May, 1982) and that these women are at risk for delivering low birth weight babies with concomitant bio-physiological problems (British Columbia Government, 1982; G. Greenstone, personal communication, June, 1984). Health professionals do not know enough about the childbearing experience for this cultural group. This may lead to conflicts and discrepancies of viewpoints between clients and professionals, resulting in nursing care that is not acceptable to the individual.

In this study the stance was taken that notions of health and illness are socio-culturally constructed and that people interpret and explain health and illness in different ways. Many authors (Chrisman, 1977; Fabrega, 1975; Kleinman, 1978; Lipowski, 1969) have discussed the problem of discrepancies and conflicts between the views of health care professionals and clients. Kleinman (1978), in his cultural system or explanatory model, states that individuals interpret health and illness according to the social positions they occupy and the system of meanings they employ. The client, in the popular sector of health care, explains health and illness in a different way from the professionals.

The potential for discordance increases when the health care professionals and clients are from different ethnic and/or cultural groups. In order to plan and implement effective client-centred care, professionals must elicit and understand the clients' viewpoints of their situations. It
is only after making explicit both the professional and the popular explanations of health and illness, that negotiation can take place to reduce or remove conflict. This provides direction for effective nursing care.

In order to elicit the subjects' explanatory model of their childbearing experience, the phenomenological method of research was used. This qualitative approach to the research problem enabled the researcher to collect data by entering into the "life world" of Indo-Canadian women immigrants. This methodology assumes that together, the investigator and the participants construct accounts of the phenomena under study.

Data were collected through indepth, audio-taped interviews with eight Indo-Canadian women immigrants who had had recent childbearing experiences in Canada. All of the women were drawn from one provincial health unit located 35 miles from Vancouver, British Columbia. Audio-taped interviews were transcribed verbatim and served as the main source of data. All parts of the data were included for analysis. Data collection and analysis occurred simultaneously through the process of constant comparative analysis. Interviewing and data analysis continued until such time as the researcher felt that the conceptual categories arising from the ongoing analyses had been saturated and the research questions answered.

The women's accounts were analyzed so as to make explicit their explanatory models of their childbearing
experiences. The investigator had expected to find that these experiences would be fairly uniform. The participants had satisfied certain criteria for inclusion in the study, and the researcher had assumed that because the subjects met these criteria, they would be similar, resulting in common childbearing experiences. Dissimilarities in the phenomena under investigation were, however, more evident than similarities. During the early stages of interviewing and simultaneous data analysis, the researcher became aware that the concept of acculturation was helping her to make sense of the data. Reflection on the data and verification with study subjects made the investigator aware that the concept of acculturation accounted for the individual differences in the women's accounts of their childbearing experiences.

As the women talked of their childbearing experiences, it became evident that, as they adopted various aspects of Canadian culture, they began to acquire Canadian beliefs and practices. In a cyclical process, as their beliefs and practices became more Canadian in character, their acculturation into Canadian society accelerated.

Although the research questions guiding this study dealt with childbearing specifically, the women talked of their experiences in a broader context which included sexuality, arranged marriage, authority, respect, shyness, and lack of knowledge. Two themes emerged from the data and related to this larger context as well as to the process of acculturation. These themes existed throughout the
experience, varying in prominence at different times. The two themes were, the subjects' relationships with their families, and the subjects' relationships with health care professionals.

The women's accounts made it clear that their health beliefs and practices surrounding childbearing were located within a broader context of meanings related to the reproductive cycle and were learned and expressed within the context of the family. In turn, the process of acculturation both affected and was affected by the subjects' relationships with their families. The concept of acculturation therefore impacted on the health beliefs and practices related to the childbearing experience.

Women in the study experienced menstruation for the first time without having been told of this physiological event. The women all explained this lack of knowledge in relation to shyness, which was described as a cultural phenomenon. Out of respect for elders, they did not ask for information. The concept of acculturation appeared to affect this shyness, as one study participant with views and beliefs similar to those found in Canadian culture, had been forewarned about the onset of menstruation. None of the women in the study had been told why they would menstruate and three of the study participants remained ignorant of basic anatomy and physiology.

Shyness and respect, as they influence how or what the women learned about their bodies and menstruation, set up a
situation of ignorance when the women subsequently married. It appears that, as women became more acculturated into Canadian society, they learned more about their bodies, but this knowledge was often fragmentary and passively received. Most of the participants learned early in life that it was appropriate to be shy about all areas of their sexuality and not to ask questions.

All of the women in the study spoke of the continued respect they had for their parents and how they trusted their parents to choose the right spouses for them. All of the women had had their marriages arranged and all owed their primary respect to their in-laws. The women's arranged marriages had an influence on their childbearing experiences. Because the women did not know their new spouses, and because of their shyness about sexuality, the women came to marriage with very little knowledge of sex or birth control. This often led to unplanned pregnancies which affected their perceptions of their childbearing experiences. Women who held beliefs that were more consistent with Canadian beliefs soon learned about birth control; other women either felt it was their duty to produce children or else looked to their husbands to dictate their birth control decisions. Regardless of their degree of acculturation into Canadian society, all of the women still discussed shyness in relation to their own sexuality.

The women's explanatory models all included the need to produce male offspring. They attached great importance to
having sons and were able to make sense of their desire for sons in terms of their own personal welfare. The women described how, if they did not bear sons, their husbands might take second wives; their mothers-in-law might cause problems; their husbands would control the number and timing of future pregnancies, and they would have nowhere to live in their old age. The need for male offspring clearly influenced the women's perceptions of their childbearing experiences. The process of acculturation was evident here when one of the study participants justified wanting a son in an acceptable Canadian manner—to keep the family name.

During pregnancy and the post-partum period, the women learned about diet and activity from their female in-laws. Health beliefs and practices surrounding diet and activity appeared to be passed on in an individual and fragmentary manner with very little modification made for pregnancy. Few of the women in the study could give the reasons behind the modifications they made. Women who had beliefs and attitudes more consistent with Canadian ones tended to seek out the reasons behind the practices, were more aware that the advice passed on was individually based and sought out professional health care advice to be used in conjunction with their elders' information. It was during the post-partum period that women who were more Canadianized reverted to their East Indian practices. Although they justified the practices in terms consistent with a western health care concept, their popular explanatory models remained different from the
professional explanatory model.

In this study, the women talked of utilizing four western health care resources: the physician, the community health nurse, the post-partum hospital nurse, and the hospital itself. The women's relationships with health care resources during childbearing were fraught with contradictions.

Although all the women stated that their physicians were their primary source of information, their actual practices were based on information obtained from family members. Women who were less acculturated into Canadian society and practices, received information passively from their physicians and trusted the doctors' decisions. Women who had beliefs and practices more Canadian in character also trusted their doctors but, in addition, sought out their own information.

Two women had attended prenatal classes at the local health unit on the advice of their doctors. These women both lived in nuclear families in Canada and did not have in-laws to dispense information. Although three of the other participants shared the same doctor, they stated that they had not been told of the classes. They said they would have attended if they had known of the classes. Women who did attend the classes perceived that the community health nurses had both the knowledge and the interpersonal skills to provide care for this group.

All of the women described the feeling of being
discriminated against by the post-partum nursing staff. Women in the study who had beliefs and practices more similar to Canadian culture used the term "discrimination" to describe the phenomenon they were experiencing and they could give many core reasons for the existence of discrimination. These women could also act to deflect discrimination from themselves or decrease it. All of the women felt that this phenomenon negatively affected the nursing care they received and saw this as a problem for the first-time mother learning baby care. Despite this felt discrimination, however, the women maintained their trust in the nurses' knowledge as health care professionals and followed the nursing advice given.

Finally, all of the women preferred having delivered their babies in a Canadian hospital. Their explanations for their preference arose from their knowledge of the dangers attached to delivery in India and their appreciation of the post-partum resting period in hospital.

**Conclusions**

The following conclusions were drawn from this study:

1. Dissimilarities in the explanatory models of the Indo-Canadian immigrant women's childbearing experiences are attributable to the process of acculturation.

2. The Indo-Canadian immigrant women's perceptions of their childbearing experiences are located within a broader
context of meanings associated with the reproductive cycle.

3. The Indo-Canadian immigrant women's relationships with their families, and with health care professionals, are significant aspects of their childbearing experiences and are influenced by authority, respect, lack of knowledge, and shyness.

4. The health care resources utilized by the Indo-Canadian immigrant women during their childbearing experiences were the physician, the community health nurse, the hospital nurse, and the hospital itself. The women perceived these resources as the authority in areas related to western technological medicine but not in areas such as diet in pregnancy. Health care professionals were not utilized as resources for psycho-social support.

5. Within their childbearing experiences, the Indo-Canadian immigrant women perceived discrimination directed at them by the post-partum hospital nurses.

**Implications for Nursing Practice**

The conclusions of this study suggest a number of implications for nursing practice:

1. The knowledge of acculturation should guide the nurses' practice throughout by contributing to nursing's knowledge base. Within her practice, the nurse is guided in her assessment. The need is seen to assess for differences and not assume that the Indo-Canadian population is a
homogenous group. Individual care must be planned and implemented with the understanding that each woman is a unique individual. Within the assessment phase of the nursing process important data to collect would be related to acculturation. Examples of specific information the nurse would want to collect are: highest level of education attained; living in a nuclear versus extended family; coming from a city or village in the Punjab and, occupation in Canada. This information would serve as a guide in delivering nursing care but the nurse must be aware of the potential for developing stereotypes from the data that would result in uniform care to all women with the same characteristics. The assessment phase must include information related to the individual woman's beliefs and values surrounding childbearing and these views must be taken into consideration in the planning and implementation of care.

2. The knowledge that the Indo-Canadian women immigrants' perceptions of their childbearing experiences are located within a broader context of meanings associated with the reproductive cycle, gives the nurse guidance to assess what the larger context consists of for this cultural group and what the meanings are for the specific individual. Care should be planned within the context of the broader meanings both for the group and the individual.

3. The importance of the family and health care professionals at this time, and the influencing factors of
authority, respect, lack of knowledge and shyness have implications for the nurse to provide family focused nursing care with emphasis on the women and the female elders. The family must be assessed for the appropriateness of including female elders and, where appropriate, this should be planned. An example of this would be female elders and the women attending prenatal classes together.

The women must be assessed as to whether they actually listen to their elders or doctors in matters such as diet and activity in pregnancy as this has implications for appropriate interventions. The women's prior childbearing experiences should be assessed and, if emphasis is still placed on producing a son, care should be planned to provide support. Support should be maintained in the post-partum period while the woman is adjusting to the birth of a daughter and the probability of another pregnancy in the near future.

The nurse is given direction to assess the women for their base line knowledge of reproduction and plan to fill in any information gaps in a culturally acceptable manner. It is important to assess the women (and female elders) for their knowledge and understanding of health care professionals' roles and functions so that they become aware, for example, of prenatal classes.

Direction is given for the nurse to respect the women's beliefs and values when providing care. The nurse must be aware that in this cultural group shyness persists despite
the process of acculturation. If the woman's shyness is overlooked by the nurse, she may misinterpret the woman's behaviour and lose her rapport to this client. Privacy and confidentiality within this particular group should be given a high priority when planning and implementing care.

4. Direction is given for health care professionals to set up special programmes using nurses from different cultural backgrounds. Health care professionals with similar backgrounds to their clients would be in an excellent position to provide the women with the psycho-social and practical support that is now missing from most of their relationships with health care professionals.

5. In order to reduce perceived discrimination, the nursing profession must act on many levels. Nursing administrators must be made aware of the perceived discrimination by clients. Nursing policy must make explicit that discrimination towards any individual, or groups of individuals, is unacceptable. To this end, in-service education programmes should be set up to help nurses develop self-knowledge. Through an awareness of self the nurse will come to know her own beliefs and values, and in so doing, may feel more comfortable negotiating with individuals holding different beliefs and values.

Implications for Nursing Research

The conclusions of this study suggest a number of
implications for nursing research:

1. The participants varied in their ability to speak English. The researcher related these variations to the process of acculturation. This relationship has implications for repeating this study with a Punjabi speaking researcher. More research must be done to determine if acculturation in fact accounts for the women's differences in their childbearing experiences, the need is seen therefore for a comparative analysis between two groups of women, with one group being further along in the process of acculturation than the other group. The two groups would then be studied to see similarities or dissimilarities of their childbearing experiences.

2. The factors related to the childbearing experience was not the focus of this study. The need is seen for a more indepth examination of all the factors in the study which seem to affect the childbearing experience.

3. Several questions arise from the subjects' relationships with their families and with health care professionals; as the women consult the health care professionals more often, do they consult their elders less? If they consult them less does this cause friction? What is the women's knowledge of their own reproductive cycle? What information about reproduction do they actually impart to their children and how do they provide it? As the women did not talk about shyness in relation to health care professionals, it would be important to investigate this area
4. It is important to understand in greater depth the relationship between health care professionals and Indo-Canadian immigrant women. Studies should be undertaken to determine why health care professionals are usually not seen as sources of psycho-social support. It is important to ascertain if and how nurses can alter their nursing care in order to provide the support directly or to foster its provision by family members.

5. This study was carried out in one hospital; further studies must be done in several hospital post-partum wards to determine if discrimination exists elsewhere. It would be important to determine if discrimination is perceived by the women at any other time in their childbearing experiences. If discriminatory practices by nurses is more visible in the post-partum time in hospital, more research is necessary to determine why it occurs then.

Implications for Nursing Education

In order to foster self-awareness and acceptance of different belief and value systems, nursing curricula must include a broad knowledge of the social sciences. By integrating social science concepts into the curriculum the nurse is provided with the information necessary to move her nursing care beyond that of a technically skilled individual to a professional practitioner.
Nursing curricula should be developed that help students understand the explanatory model of Indo-Canadian women immigrants during the childbearing experience. The students should be encouraged to explore their own explanatory models and given the opportunity to compare and contrast models so that they are aware of the differences and similarities. It is important that the curricula build in opportunities for students to care for people from cultures different from their own during the childbearing experience so that they may integrate their knowledge and learn to negotiate between their own and their clients' explanatory models.

Direction is also provided for the design and implementation of ongoing staff development programmes in the area of trans-cultural nursing.

Summary of Chapter

The findings of this study have implications for nursing practice, research and education. Although providing a beginning, further study into the Indo-Canadian immigrants' perceptions of their childbearing experiences is needed in order to plan more effective, relevant care. This distinct cultural group explains their childbearing experiences in a manner that is different from the professionals' explanatory model. As health care professionals we must understand and take the Indo-Canadian women's explanatory model into account when providing nursing care. As one study participant said:
My Gods, we be human beings too right. We be the same right mostly. It not be fair right that they think we no goods just as we be different in some little things like. Womens really have babies the same everywhere rights and we need the same care for our tender emotions then right? You understand?
REFERENCE LIST


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APPENDICES
Appendix A

Information and Consent to Contact Form

My name is Halina Struser. I am a registered nurse involved in graduate work at the School of Nursing, University of British Columbia. I am interested in the experience of pregnancy, labour and delivery for East Indian women in Canada.

The purpose of my study is to learn how you view your pregnancy, labour and delivery and what is important to you at this time. I am inviting you to participate in this study and, if you agree, I would like to interview you in your home to share your views with me. Each interview will last approximately one hour. I will ask to interview you more than once, to allow both of us to discuss your views in greater detail, but you will decide if more than one interview is to take place.

The only people I will discuss the interviews with will be my teachers at the university. Your name will not be identified in any conversation or written reports.

Your decision to participate or not in this study, WILL NOT AFFECT ANY CARE YOU RECEIVE FROM THE PUBLIC HEALTH UNIT. If you decide to participate in this study, YOU MAY WITHDRAW AT ANY TIME WITHOUT ANY CONSEQUENCES TO YOUR FUTURE CARE.

Information gathered in this study will help me learn more about pregnancy, labour and delivery for East Indian women in Canada. This knowledge will be given to other
health care workers caring for East Indian families.

If you have any questions about this study, if you would like any more information, or if you agree to participate, please allow your community health nurse to give me your name and phone number and I will contact you by phone.

Yours truly,

Halina Struser

I agree to allow the community health nurse to give my name and phone number to Halina Struser.

Date: __________ Signature: ________________

I acknowledge receipt of a copy of this information and consent to contact form.

Signature: ___________________
Appendix B

Consent Form

I have talked with Halina Struser about her research study and I agree to participate in it. I understand that Halina Struser will discuss the interviews only with her teachers at the university and that my name will not be identified in any conversation or written report. I further understand that my decision to participate or not in this study, WILL NOT AFFECT ANY CARE I RECEIVE FROM THE PUBLIC HEALTH UNIT and I MAY WITHDRAW from this study at any time WITHOUT ANY CONSEQUENCE TO MY FUTURE CARE.

Date: ___________   Signature:__________________

I acknowledge receipt of a copy of this consent form.

Signature:__________________
Sample Questions for Initial Interview

1. Please describe your pregnancy (labour, delivery). What special things did you do at this time? What special things were you not allowed to do? (e.g. What foods did you eat? What did these foods do for you?)

2. How was your experience different from what you may have experienced in India? How was it the same?

3. Would you have preferred to have had your baby in India or in Canada? Why?

4. Who gave you information on pregnancy (labour, delivery)?

5. Did this information come from members of your community? From outside your community?

6. Who was with you during labour and delivery?

7. Who would you like to have been with you?

8. After the baby was born, can you tell me about your hospital stay? (e.g. hospital routines, time spent with baby; time with family; perceived attitudes of hospital staff; hospital food). How was this different from what you would have experienced in India?

9. What suggestions would you have for other East Indian immigrant women having their babies in Canada?
Appendix D

Demographic Information

Code: Husband_________________________Wife:__________________________

Date of Birth (Year)_____________Place of Birth____________________

Year of Immigration to Canada____Year of leaving India____

Has subject returned to Indian since emigration?____________

If yes, when?________________________For how long?____________

If subject has lived in other countries or provinces prior to B.C., please list with dates and length of stay:________

Number of years of schooling in India__________________________

Number of years and place of any other schooling________________

Highest level of education attained in India___________________

Highest level attained in any other country_____________________

Occupational Preparation_____________________________________

Present Occupation_________________Hours of Work_______________

Number of years of marriage______Marriage arranged?_______

Number of children_____Birth dates and places of birth__________

Number of people living in household and relationship to subject____________________

Interview number: 1__________2_________3_________4________

Interview dates: ____________________________

Who was present at each interview? Please list ________________