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Pregnancy and Childbirth Practices Among Immigrant Women from India: "Have a Healthy Baby"

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Pregnancy and Childbirth Practices among Immigrant Women from India: “Have a Healthy Baby”

Abstract

In India, practices relating to pregnancy, childbirth and child development have been rooted in cultural beliefs and traditions that are based on knowledge contained in ancient Indian texts. Many Indians residing across the globe continue to observe these practices. Some may find it challenging to do so when they are residing abroad, away from familiar surroundings and separated from their extended families. A small body of research exists that shows that migrant Indian women do observe traditional maternal practices based on cultural beliefs, but there is a need to learn more about how this knowledge is acquired, disseminated and preserved. This qualitative case study examines how immigrant women from India in the United States (US) acquire knowledge about and observe traditional maternal practices. Interviews and participant observation indicate that the women in this study adroitly mixed many traditional practices with the medical model of care provided in the US, and importantly, most of them followed these practices more as a deference to the norms laid out by their elders. The goal of traditional practices appeared to be to ensure birth of healthy infants.

Keywords

Cultural Beliefs, Immigrant, Indian Women, Pregnancy, Child Birth, Traditional, Maternity Practices, Case Study

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Pregnancy and Childbirth Practices among Immigrant Women from India: Have a Healthy Baby

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In India, practices relating to pregnancy, childbirth and child development have been rooted in cultural beliefs and traditions that are based on knowledge contained in ancient Indian texts. Many Indians residing across the globe continue to observe these practices. Some may find it challenging to do so when they are residing abroad, away from familiar surroundings and separated from their extended families. A small body of research exists that shows that migrant Indian women do observe traditional maternal practices based on cultural beliefs, but there is a need to learn more about how this knowledge is acquired, disseminated and preserved. This qualitative case study examines how immigrant women from India in the United States (US) acquire knowledge about and observe traditional maternal practices. Interviews and participant observation indicate that the women in this study adroitly mixed many traditional practices with the medical model of care provided in the US, and importantly, most of them followed these practices more as a deference to the norms laid out by their elders. The goal of traditional practices appeared to be to ensure birth of healthy infants. Keywords: Cultural Beliefs, Immigrant, Indian Women, Pregnancy, Child Birth, Traditional, Maternity Practices, Case Study

The life history of the individual is first and foremost an accommodation to the patterns and standards traditionally handed down in his community. From the moment of his birth the customs into which he is born shape his experience and behavior (Benedict, 1934, pp. 2-3).

US Indian migrants represent a highly educated group. Sixty-one percent hold a college degree. Sixty percent of all employed Indians in the U.S. work in professional or managerial fields (US Census Bureau, 2010). Indian immigrants (i.e., post-1965 Immigration and Naturalization Act migrants from the Indian subcontinent) originate from across the Indian subcontinent, rather than from a single region. They are less likely than European migrants to settle in ethnic enclaves, choosing instead to take up residence throughout urban and suburban areas. As reflected in the participants in this study, geographic dispersion stems largely from the generally high socioeconomic status of immigrants arriving in the 1960's and 1970's, many of whom came to the United States to pursue post-graduate education and/or professional opportunities in the fields of medicine, engineering, and science. Most of these immigrants chose to live alongside upwardly mobile colleagues in suburban areas, rather than in ethnic neighborhoods (Helweg, 2002).

This paper describes and analyses a case study involving eight US immigrant women in a Midwestern state. Women who participated in this study were from different parts of India, but mostly from the South. The aim of the study was to explore US Indian women's perspectives and beliefs about pregnancy and childbearing, describe related practices, and consider the possible implications these may have on child development and health.

Many women in India follow specific practices during their pregnancy, childbirth and postnatal period. These practices are largely based on their cultural beliefs, religion, customs

and upbringing. These specific practices are important because of the deference to elders that is widely observed by Indian families and the value attached to orally disseminated knowledge by elders. It is well documented that the source of knowledge for many regarding healthcare is rooted in Ayurveda, the Indian system of medicine (Jain & Tiwari, 2012; Kala, 2006). It is also well known that traditional knowledge about the use of plants and herbs as food and medicine has been passed down orally (Katewa, Chaudhary, Jain, & Galav, 2003; Natarajan, Paulsen, & Korneliussen, 2000). Even those women who are distanced from their homeland continue to follow traditional practices and simultaneously use the medical model of care (Posmontier & Teitelbaum, 2009). Thus, it is important that practitioners value their life stories and narratives.

Ayurvedic texts described and prescribed maternal practices and behaviors that aimed to promote the health of the mother and developing infant. As a corollary, they aimed to prevent birth of children with disabilities (Dhiman, Kumar, & Dhiman, 2010). Given that the detailed study of the human body and its healthy development can be traced to its hoary history in the Vedas, it is pertinent to ponder over the belief in and continuity of these practices. Such an endeavor is especially valuable for Indians living in their home country or abroad, and for medical practitioners across the globe because it is critical to develop a broader understanding of prevention measures utilized across cultures. Armed with such knowledge, medical practitioners as well as migrant Indian women can find ways to effectively integrate those practices. This is especially true given that women's post-migration acculturative experiences result in differential access to informal knowledge networks such as pregnancy and childbirth practices (Levitt & Waters, 2002; Plüss, 2005; Raj, 2003). As Levitt (2007) notes in her study of second-generation migrant acculturation, middle-class migrants employed in the professional sector "selectively assimilate elements of where they come from the where they settle" (p. 1229).

Maternal Care in the Ayurveda

Ayurveda, the Indian system of medicine, has guidelines for pregnancy and childbirth, use of a wet nurse and treatment for common childhood illnesses (Lakshmi & Srivastav, 2013; Tullu & Kamat, 2000). Scholars estimate that the Vedic texts date back to ancient times perhaps as early as 1000 B.C. (Kishore, Padhi, & Nanda, 1990; Mukherjee, Nema, Venkatesh, & Debnath, 2012; Patwardhan, 2012; Wujastyk, 2003). A number of scholars have reviewed ancient texts with an eye toward examining the texts' treatment of maternal care and preventative childbirth practices such as birth rituals and breast-feeding (Laroia & Sharma, 2006), pregnant woman's emotional well-being (Manohar, 2013), prevention of birth defects (Dhiman et al., 2010), dietary guidelines (Dwivedi, 1995), and use of herbal remedies for physical, physiological and psychological needs during the post-partum period (Posmontier & Teitelbaum, 2009; Shukla, Dwivedi, & Kumar, 2010). Some of the practices, therapies and remedies outlined by Ayurveda have been validated by modern research (Basri & Fan, 2005; Jigna, Rathish, & Sumitra, 2005; Pan et al., 2014; Pande et al., 2008; Weinberger, 2005).

Maternity Practices of Migrant Indian Women

A few researchers have examined the maternity practices of women from the Indian diaspora living in the Western Hemisphere. For example Kannan, Carruth, and Skinner (2004) studied breastfeeding practices among Indian women in the US. Similarly, other researchers have compared the practices of Indian women during pre-lacteal and lacteal periods with women from other countries such as the US, Europe and Australia (Choté et al., 2011; Chakrabarti, 2010; Jani Mehta, Mallan, Mihrshahi, Mandalika, & Daniels, 2014; Kannan et al., 2004; Laroia & Sharma, 2006; Maharaj & Bandyopadhyay, 2013). Few studies have explored

South Asian immigrant women's experiences and perspectives about maternity care through their own words, as does this study.

Other studies illuminate South Asian immigrant women's personal preferences about Western health care and maternity practices. Small et al. (2014), compared studies from Australia, Canada, Sweden, the United Kingdom and the US. This study found immigrant women prefer care that focuses on respectful attention to their individual needs as perceived through a cultural lens. Mitu's (2009) study of Bangladeshi immigrant women sheds light on the importance of extended family support during maternity care – a finding also supported by other studies (See, for example, Castañeda, 2008; Harley & Eskenazi, 2006; Reitmanova & Gustafson, 2008; Sargent, 2006). In their study of immigrant and non-immigrant women's experiences of maternity care, Small et al. (2014) found immigrant women preferred care that focused on respectful attention to their individual needs as perceived through a cultural or ethnic lens. Small's immigrant participants also preferred health providers who took care to deal effectively with communication or language difficulties, and who disseminated information about how maternity care is provided in the host country. Medical staff “cannot possibly *know* every culture.... Moreover, cultural beliefs and practices [related to maternity care] are not static phenomena” (Small et al., 2014, p. 152).

In summary, ancient Indian literature such as the Ayurvedic texts show evidence about rituals and behaviors aimed at promoting maternal health and ensuring infants develop healthily. Many of these practices continue to be preserved and observed by Indians—even those distanced from their homeland. A review of literature demonstrates the existence of established theories in Ayurveda regarding these practices and recently, researchers have also conducted clinical trials to check the curative properties of many of the recommended herbal remedies.

Purpose of the Study

This case study examines how immigrant women from India in the US observe traditional maternal practices and specifically investigates: (1) The extent of knowledge and use of traditional practices during pregnancy and childbirth by U.S. Indian immigrant women; (2) The means for acquiring this knowledge; (3) Whether they continue to observe traditional, maternal practices; (4) Participants' awareness about the protective factors involved in traditional, maternal practices.

Researchers' Familiarity with Traditional Maternity Practices: Situating the Researchers in the Research

The authors represent both in-group and out-group perspectives regarding US South Asian migrant women's maternity practices. The first author was born and raised in India. The contributing author is of Cherokee ethnicity. Both authors are employed in the same academic unit in a mid-sized US Midwestern university. Here are our stories.

First Author

I was born and raised in India, in a South Indian Brahmin family, and thus I am very familiar with traditional beliefs and practices and expected behaviors associated with women in my community. My close relatives were trained in and professionally practiced the Ayurvedic system of medicine. Thus, I am easily able to identify closely with the subject which equips me with the necessary cultural sensitivity and competency essential to my interactions with my participants. As I began to acculturate myself to gaining knowledge through course

work and text books in an American university where I studied later on, I realized I was beginning to intellectualize the ideas and ideologies that I had either inherited or that had influenced my upbringing. My knowledge of multiple Indian languages facilitated participants' use of terminology from their mother tongue.

Second Author

I was born to a Native American family of the Cherokee Eastern Band and raised in the Southeastern United States. My research tells the stories of "the Other" via oral history interviews with a focus on South and Southeast Asian immigrants and refugees. Still, I realized there were nuances and unspoken understandings among my interviewees that I, as an "outsider", may never comprehend. The collaborative research relationship I have with the first author has, I believe, resulted in truer analyses than could be possible through single authorship.

Silverman (2007) believes, "Things being seen afresh are hallmarks of good ethnographic description" (p. 18). Thus, we hope our collaborative approach will provide a fresh perspective to previously established knowledge. Moreover, the background each of us brings to our research, and the first author's familiarity with the traditional beliefs and behaviors of our participants acts synergistically to facilitate a more in-depth sharing by participants of their own beliefs.

Methodology

Ethical Issues in Qualitative Research

In this study we paid close attention to ethical issues such as obtaining approval from the Institutional Review Board (IRB) from the authors' university, participants' informed consent, ensuring each participant's anonymity, allowing interviewees participants autonomy over where and how the interview was conducted and the extent of information to be shared. Informed consent was obtained from participants. Real names of participants were removed from transcripts of the interviews and pseudonyms assigned. Participants were able to choose telephone interviews, Internet interviews (Skype), or face-to-face interviews in a location they selected. During the interview process, each participant had the freedom to share as much information as she desired. Participants also were permitted to take breaks, pause, or even terminate the interview at any time.

Another critical ethical issue that most qualitative researchers encounter pertains to the nature of relationship between the researcher and the researched, particularly if one is conducting research in one's own community. Because the first author belongs to the same culture and the community to which the participants belonged, the boundaries of relationship between them and the first author were rather blurry. Keeping in mind the suggestion put forth by DiCicco-Bloom and Crabtree (2006, p. 94) that "the personal interaction between researchers and participants is crucial in data gathering by keeping in mind the research focus and being clear about the role of researchers", the first author made a conscious effort to make her role as a researcher clear to the participants at the beginning and during each interview. At the same time, the first author engaged in active listening when and if participants began to share more personal accounts of their lives in which the topic of research was situated. In reciprocation, the first author shared some of her own traditional beliefs while gently veering the conversation back to the research questions when needed. In this manner, our research methodology can be most specifically described as feminist interviewing technique (see, for example, Minister, 1991): both interviewee and interviewer engage in a conversational (semi-structured) interview format and, upon occasion, the normal give-and-take of an informal

conversation between two women both occurs and is a welcome part of the interviewing process.

Because of the first author's close association with people who were knowledgeable about the origins and basis of maternity practices and behaviors, it was invariable that she enter the research arena with inherent biases. Furthermore, her connection with the university provided access to extant literature about the nature of the practices. Lastly, as the first author herself was — at the time of the interviews — at a great distance from her home country, looking back at her own cultural beliefs created a pronounced awareness that she frequently looked for positive meanings about the maternity practices rather than viewing the practices as negative. Being acutely conscious of the above-mentioned biases, the first author was careful during the interviews to avoid leading or misleading participants to take one position or the other, instead merely posing questions that invited them to share their own viewpoints and experiences. She also avoided making value judgments about participants' practices and behaviors.

Ensuring Rigor and Trustworthiness of Data

We employed Guba's (1981) model for ensuring trustworthiness of research. Guba's model is based on the identification of four aspects of trustworthiness that are relevant to both quantitative and qualitative studies: (a) truth value, (b) applicability, (c) consistency, and (d) neutrality. Based on the philosophical differences between qualitative and quantitative approaches, the model defines different strategies of assessing these criteria in each type of research. These strategies are important to researchers in designing ways of increasing the rigor of their qualitative studies and also for readers to use as a means of assessing the value of the findings of qualitative research. For example, according to Krefting (1991), "...truth value is usually obtained from the discovery of human experiences as they are lived and perceived by informants" (p. 215). The lived experiences that our participants shared served to support this. Furthermore, the findings can be generalized to Indian migrant women in other parts of the world as well. This ensures applicability and consistency. Finally, we strove towards neutrality by allowing the data to speak rather than elaborately explain the data through the researchers' lens.

Using Grounded Theory Approach

Qualitative Research Methodology

This case study uses Minister's (1991) feminist interviewing technique to explore U.S. Indian immigrant women's knowledge about and use of traditional Indian practices during pregnancy and childbirth. The authors utilized multiple qualitative data collection techniques consisting of semi-structured tape recorded interviews with eight participants and subsequent transcripts, participant-observation in local Asian Indian cultural events, informal conversations with key informants, and social interactions with participants following the interview process to develop this case study and to analyze findings. Four research questions guided our study:

1. What is the extent of U.S. Indian immigrant women's knowledge of and use of traditional practices during pregnancy and childbirth?
2. How do U.S. Indian immigrant women acquire knowledge about traditional maternal beliefs and practices?

3. Do U.S. Indian immigrant women who know about and use traditional maternal practices during pregnancy continue to observe traditional practices following the birth of their child?
4. What is the extent of U.S. Indian immigrant women's awareness about possible protective factors involved in traditional maternal practices?

This article is based on a qualitative, instrumental case study wherein the authors employ a feminist interviewing technique. Minister's (1991) feminist interviewing technique recommends women use a conversational format to interview women immigrants in their own homes and, when requested, in participant's native language (Gluck & Patai, 1991). A questionnaire was used to guide semi-structured interviews in participants' homes, and interviews were conducted in an informal conversational format by the first author in an effort to put participants more at ease while discussing a sensitive and often taboo subjects such as pregnancy and childbirth (Farver et al., 2002).

According to Stake (1994) an *instrumental case study* is one in which "...a particular case is examined to provide insight into an issue..." (p. 237). The value of the case study approach, according to Schram (2006) "lies in facilitating appreciation of the uniqueness, complexity, and contextual embeddedness of individual events and phenomena" (p. 108).

As Stake (2000) points out, a case study is "not a methodological choice but a choice of *what* is to be studied" (p. 435, emphasis added). Case study research involves the in-depth study of "one of more phenomenon ... in its real-life context that ... reflects the perspectives of the participants involved in the phenomenon" (Gall, Gall, & Borg, 2007, p. 447). The case study sheds light on the "particular instance of the phenomenon" (Gall et al., 2007, p. 447). In this study, the phenomenon being studied is maternal practices. The "unit of analysis" in a case study is the "aspect of the phenomenon" that will be studied across cases (Gall et al., 2007, p. 447). For this study, the unit of analysis of the phenomenon maternal practices is the U.S. Indian immigrant population in Midwestern US cities. Each phenomenon has multiple aspects; thus, researchers must identify both the unit of analysis and the *focus* of the phenomenon being studied across cases (Gall et al., 2007, p. 448). In this study, the focus is knowledge and observation of traditional Indian maternal beliefs and practices among U.S. Indian women living in a Midwestern state.

Finally, in-depth study of the focus identified in a case study involves collecting "a substantial amount of data ... over an extended time period ... [using] several methods of data collection" (Gall et al., 2007, p. 448). Data for this study were collected over a period of several months and included semi-structured interviews with eight participants, participant-observation by the first author during Asian Indian socio-cultural events, informal conversations with key informants and social interactions with participants following interviews such as lunches.

Case study research also involves studying the phenomenon in its real-life context. Kirk and Miller (1986) visualize qualitative research as a form of social science investigation involving "watching people in their own territory and interacting with them in their own language, on their own terms" and, wherever possible, interacting with participants in their everyday settings (p. 9). The first author's Asian Indian ethnic identity permitted her to engage with study participants in their everyday settings and as all participants were fluent in English, the interactions were mainly in English. Some of the participants referred to a few remedies or traditional rituals in Sanskrit or their mother tongue and they have been translated here.

Minister's (1991) feminist interviewing technique, as has been mentioned, was employed for this study. Minister's technique uses a conversational format to interview

immigrants in their own homes and, when requested, in immigrants' native language (Gluck & Patai, 1991). Multiple qualitative data collection techniques, including semi-structured interview questions and transcripts, first author's participation in South Asian cultural and community events, informal conversations with key informants, and examination of related media sources, were used to develop this study and to analyze our findings.

The first author developed a questionnaire that sought to examine participants' knowledge about practices during pregnancy and after childbirth in these 11 areas: food, hygiene, diet, traditional medicine/herbs, beliefs, rituals, physical activity/exercise, spiritual/religious activities, source of knowledge about practices, support systems and western/medical practices that they followed. See Appendix A for a sample questionnaire.

Participants

Participants were recruited from the membership of local cultural/religious groups belonging to the Indian diaspora. Recruitment was initiated with an email list and snowball technique added to the initial, available participants. As this was a convenience sample, it is possible that these women may have been more prone to adhere to ethnic customs than Indian women that are not. To be eligible to participate in the study, participants needed to be mothers of Indian origin who had migrated to the US. Participants were contacted individually via email and interviews were scheduled with those who consented to participate. Participation in the study was voluntary. Interviews were scheduled at a time and place chosen by each participant. All interviews were audiotaped and transcribed. All confidential and personal information about participants were removed and codes given in place. Real names were replaced by pseudonyms and care taken to ensure that the pseudonyms were totally dissimilar in structure and spellings of the original names.

Eight women ultimately agreed to participate in the study. The length of their stay in the US spanned between 2-10 years. Most of the participants were originally from South India. The age range of participants was 25 to 35 years. Four participants had two children each and four had one child each, with all children aged below 10 years. Each participant was interviewed at least once. Three participants agreed to be interviewed twice. Interviews were held in their residences or over the phone and each interview lasted from half an hour to two hours. In addition to formal interviews, the first author engaged in informal conversations on the topic of this study with participants. This provided an opportunity for member checking and verifying what they had shared during the interviews.

All participants had migrated to the US for economic, occupational and educational reasons. During the course of the interviews, it became apparent that because they came to the US when they were adults, some after marriage, traditional maternity practices and beliefs had already been ingrained in them prior to their arrival in the U.S.

Analysis

Based on content analysis methods outlined by Graneheim and Lundman (2004) each interview was scanned and data coded using the following steps:

Step 1: Initial Coding

- 1.) Scan the entire interview transcript and look for words and phrases that represent the above constructs in the questionnaire
- 2.) Highlight each word/phrase that seems to represent the constructs and write the corresponding number next to them from 1-11.

For example- What foods did the expectant mother consume during pregnancy and what did she avoid or was asked to avoid? 1

- 3.) A research assistant and the co-author read the coding and verified the accuracy of the coding until a 100% agreement was reached.

Step 2: Collapsing Data

The data were then collapsed until all overlapping constructs were organized into more comprehensive categories. Some of the constructs were merged as they seemed to elicit overlapping responses. Beliefs, rituals and religious activities, diet and physical activity were combined together under Behavior, as this served as an overarching theme for various behaviors that the women engaged in during pregnancy and childbirth. Through this process, the categories that emerged were: source of knowledge, behavior, medication, Ayurvedic and folk remedies and support systems.

Step 3: Analyze and explain each category using information shared by participants.

Findings

Source of Knowledge

Women in this study reported that the main sources of traditional knowledge, practices and behaviors during pregnancy and childbirth were elderly women in the family — mothers, mothers-in-law and a grandmother. All participants continued to consult/defer to parents and/or in-laws who lived in India through phone or other distant communication modes such as Skype.

Some mothers and mothers-in-law traveled to the US in order to be present at the birth of their grandchild just before the birthing. Those that were unable to travel were still an integral part of the process by purchasing and sending gifts from India for their pregnant daughters on the occasion of a rite of passage called *Seemantham*¹. Gifts included traditional clothes, jewelry, money, fruits, flowers and sweets.

Megha shared that her mother was knowledgeable about Ayurvedic system of medicine and sent her herbal remedies such as *Shatavari*² and *Brahmi*³ and a popular book on pregnancy care from India. Her mother had advised her to read well, eat well and listen to “good music” during pregnancy. Megha’s mother-in-law advised her to avoid eating papayas. Rupa’s mother joined her during the 9th month of pregnancy and brought with her jewelry, herbal remedies and sweets.

Pregnancy and delivery can be a stressful experience for Indian women living in the U.S. especially if they do not have their mother and/or other female relatives with them to serve as the traditional support system. The modern American practice of husbands accompanying their wives in the hospital delivery room is also new to many migrant women, who prefer to have close female relatives present during childbirth and postpartum care (Fisher, Bowman, & Thomas, 2003).

Behavior

All participants were well educated with either a Bachelor (B.S.) or Master’s (M.S.) degree (M.S.=7, B.S.=1) or higher but they continued to unquestioningly follow their mothers’

¹ A traditional ceremony performed during the 7th month of pregnancy, akin to a baby-shower.

² Shatavari: *Asparagus racemosus*, an Ayurvedic herb used in maintaining uterine health.

³ Brahmi: *Bacopa monnieri*, an Ayurvedic herb used to treat stress related disorders.

dictates regarding rules imposed on the female child. They did not question parents when they declined to discuss matters pertaining to sexuality such as puberty, marital relationships, pregnancy and childbirth. Sexuality and related constructs such as childbirth, often are considered by Indian parents to be taboo topics (Aggarwal, Sharma, & Chhabra, 2000; Fisher et al., 2003)

Separation and cleansing.

The women in this study recalled that when they were growing up, the elder women in their families had specific practices and rules that women were expected to follow during women's menstrual cycle, pregnancy and childbirth. Some rules included being housed in a separate room for a specific period of time during menstruation and after childbirth. Jaya said that the cleansing period after childbirth lasted between 11-21 days. Jaya felt that the elders were divided in their reasoning behind the practice of separation. She said:

It's a question of purity, yes...They had mixed beliefs...the traditional (and) the technical...There are two schools of thoughts: one is, people considered this rest time...on the other hand some...think women are not pure during that time so they need to be outside the house and they are (not allowed) to (bathe) or perform (household chores).

Megha said that her parents were not "so strict" about separation when she was in India, but "...After coming to the US, she was just like forget about it."

Spiritual beliefs and guidance.

Other behaviors during pregnancy included listening to devotional music and chanting hymns. According to Megha, a mother's actions had a direct effect on the developing infant. Megha listened to an audio book that her mother had given her and followed the given guidelines. She said there was an emphasis on 3 behaviors including:

...the way you talk, everything you say is being absorbed by the growing infant. Whatever you listen (to)...and what you eat also is absorbed by the fetus...if I study (the scriptures), these create emotional impact (on the pregnant mother). I mean if I see a violent movie, then that will (have an) impact (on) my pregnancy because my emotions are going through (to) him...

Similarly, Gita and Rupa chanted devotional hymns every day because they believed that their developing infants were listening to sounds outside the womb. When Meena's labor seemed to last beyond the auspicious time, her husband played devotional songs in the delivery room.

Pallavi's *Seemantham* was performed later than usual but her mother carried all the necessary material required to perform the ceremony such as jewelry, clothes, idols, sweets and herbs. After delivery, Pallavi's mother performed a traditional ritual called *arti*⁴ for her and her child when they reached home.

⁴ A traditional ritual where a plate of few grains of rice in turmeric water is gently waved in front of the recipient to welcome him/her home from a life event such as child birth in this case.

Diet.

There were rules on what foods to avoid what special foods to incorporate into the regular diet during pregnancy and lactation. Foods were avoided that posed danger to the developing infant including pineapple, papaya, sour pickles, strong and hot spices, potatoes and cauliflower and certain types of lentils. For example, Jaya said:

...the mother is given specific dietary restrictions. She's not (allowed) to eat yogurt, lemon juice or any lemon based items and sour things...and there is lot of butter and ghee in the food. And the food is not hot (spicy)...This is practiced for almost three months after the baby's birth and then slowly you get back to your old routine of eating all kinds of foods. This is done basically (because) they believe that whatever that you eat will also affect lactation.

Gita said the emphasis was on eating freshly cooked, vegetarian food that included a balanced diet of proteins, carbohydrates and fats. Pallavi said that her mother fed her a diet that included Dill leaves, gourds and lentils. She reduced hot spice in the food and also avoided vegetables that were believed to cause flatulence such as potatoes. Gita, Meena and Jaya avoided eating papaya, hot spices and sesame as these were believed to harm the fetus. Roopa said "I made sure I took a lot of ghee and turmeric." Sneha's mother had told her to add plenty of ghee to her food because it helped absorb the effect of hot spices in the food and also helped the baby's digestion.

Sudha's mother told her to avoid eating Sago during pregnancy and immediately after child birth, her mother put her on a strict diet of hot, lentil broth, which she believed helping in cleansing the uterus after delivery. Sudha's mother also supervised her diet for the first two months of childbirth, where she gradually progressed from lentil broth to flat bread and lentil soup and a paste made of coconut, edible gum and ghee. She was also told to avoid eating "sour things" such as some fruits.

Medication, Ayurvedic, and Folk Remedies

Participants reported taking both vitamins and supplements prescribed by the medical practitioner and Ayurvedic and/or folk remedies suggested by the elder women. Roopa and Jaya said that their mothers gave them an herbal paste to be taken daily with unrefined sugar or honey and ghee, which were aimed at improving digestion. Meena and Jaya said chewing lemon and cloves helped control morning sickness and nausea and Megha recalled cutting down spicy foods. Sneha's mother asked her to eat pickled gooseberries to control nausea.

Megha's mother sent her a powder called *Shatavari* and instructed her to take it with ghee, milk and honey. Megha also mentioned having had "...one spoon of *Brahmi*...And that actually relieved stress. *Brahmi* is good for the brain health...and fenugreek helps in lactation" she said. Megha learned about the herbs from her mother who had followed practices outlined in Ayurveda during her own pregnancy.

Pallavi travelled to the US during her 3rd trimester of pregnancy and experienced severe nausea. "My mom used to pack me a big bottle with buttermilk, *jeera* (cumin) and coriander leaves." The spicy drink was refreshing and helped her through the long journey by flight. After delivery, Pallavi's mother prepared home remedies for her with ingredients that she had brought from India. There were 2 types of herbal remedies-a sweet made of ground dry fruits, edible gum and herbs and an herbal paste. Her mother believed that these preparations helped in promoting uterine and spinal health and enabled the new mother to assume her normal routine work.

Support Systems

The women in this study reported that they had a strong circle of support consisting of other families of Indian origin who resided within the same area, fellow community members, visiting parents and/or parents-in-law and spouses. Participants also shared that mothers or mothers-in-law traveled to US to offer support for the mother and the newborn during the first few months after birthing and guidance, support and care for the mother and the newborn.

One participant, Megha, also initiated a support group on a social networking website, where she facilitated sharing of tips, knowledge, beliefs and guidance. All participants shared that their spouses were very supportive during pregnancy and they were also present in the delivery room during birth. Pallavi's husband accompanied her on long walks in the evenings and during regular visits to the doctor. In addition, he helped calm their baby down when she was colicky or irritable and stayed awake with the baby on occasions so Pallavi could get a respite. The presence of parents and in-laws during birth was important to Meena and was happy that they were able to travel to be with her. In addition, Meena was glad that the hospitals in the US allowed her husband to be with her during delivery.

Sneha was new to the US when she learned about her pregnancy but was fortunate to have her fellow community members living in the same locality who were very supportive. The group members helped her with things she valued such as availability of Indian groceries, participation in weekly worship, sharing meals together and preparation of certain foods that she craved.

Discussion

Social Capital

South Asian immigrant women have been learning about maternity practices from their female relatives—mothers, grandmothers, aunts or older sisters—who transmit this knowledge orally and/or by serving as role models of these practices. This knowledge cycle fits well into Lin's (1999) model of social capital in which individuals are constantly utilizing and returning it. Lin (1999) states, "The premise behind the notion of social capital is rather simple and straightforward: investment in social relations with expected returns" (p. 4). Lin further proposes that there are 4 key elements that constitute social capital- "*information, influence, social credentials and reinforcement*" (p. 4).

Applying Lin's model to this study, the following figure illustrates how traditional knowledge is created and passed on to future generations in a cyclical manner:

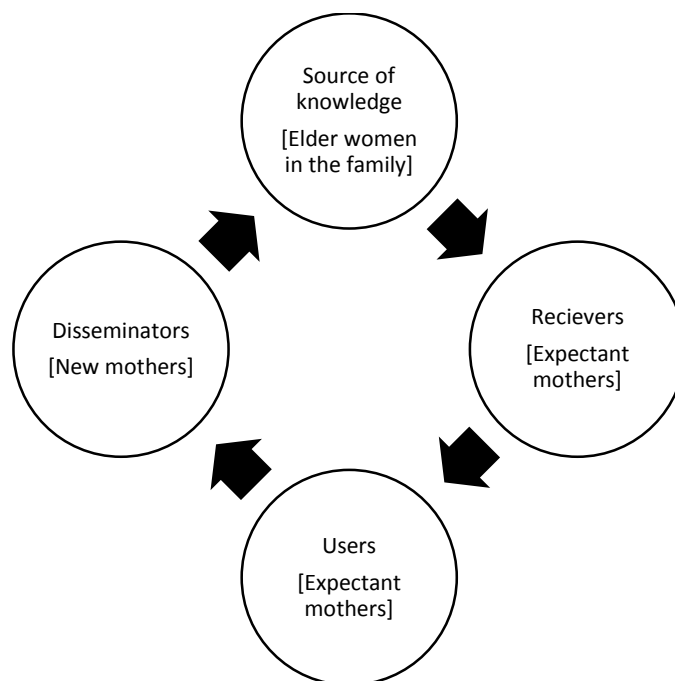


Figure 1: Traditional Knowledge Transmission Cycle

The main sources of knowledge for the women in this study were the elder women in the family and by following traditional practices themselves, they served as models to their daughters or daughters-in-law. The expectant mothers received the knowledge and made efforts to use it even when they were physically separated from the extended family. Using the knowledge and sharing it with other new mothers within their own community helped reinforce their in-group identity, and compensated for the fact that elders could not be present during the entire period of the pregnancy. Finally, the new mothers' experiences with the traditional practices seemed to empower them to become empathetic disseminators of knowledge for their fellow community members. This is exemplified by the fact that one participant who seemed to have absorbed and used the knowledge very extensively, perceived its value and felt the need to share it by creating an online support group for new mothers.

This study analyzed the knowledge and use of traditional maternity practices by a small sample of U.S. Indian immigrant women in a Midwestern state. This study aimed to understand traditional maternity care among members of a specific group, recruited through the first author's affiliation with local, cultural groups in which these women were members. As all except one participant belonged to the Hindu community, some but not all the findings may be generalizable to Indian immigrant women in other countries in the Western Hemisphere and also to Indian immigrant women belonging to other religions.

The Indian immigrant women in this study appeared to benefit from the receipt of a multi-pronged system of maternity care. Rather than maternity care being confined either to the U.S. medical system standard of care model or to the traditional Ayurvedic care model, the women in this study embraced maternity care that included female Indian immigrant community members, parents and parents-in-law (particularly mothers and mothers-in-law), spouses, and local medical professionals. This comprehensive system of prenatal and postnatal care comprised traditional dietary recommendations; expected behaviors by pregnant women; traditional, folk and medical guidelines; and a strong circle of support which aimed at promoting the emotional, physical, spiritual, and psychological health of both mother and infant.

As was the case with Small's (2014) study, the women in our study preferred maternal care that focused on individual needs through a cultural or ethnic lens. Likewise, some of our participants believe certain ethnic maternity practices should change based upon individual circumstances such as whether one's close female friends are available to relieve one from household chores during the postpartum period or whether one would be well served to accept the well-meaning efforts of one's spouse to clean house and cook meals.

Like Mitu's (2009) participants, some women in this study were dismayed and often frustrated by a lack of extended family support and support provided by a close circle of female friends before and after the birth of their child. Also like Mitu's participants, some our participants found this lack of family and/or close friend support to be most negatively perceived during the days and weeks immediately following their baby's birth. For example, after delivery, Pallavi's doctor expected her to go about her daily routine as usual, unlike in India, where she would have someone to take care of her, help her bathe, do household chores and attend to the baby when she needed some rest.

Jaya's said neither her mother nor her mother-in-law could travel to the US for her child's delivery and she missed their support, particularly during winter time when she found it challenging to attend to her older child and her newborn.

The point at which our study departs from the professional literature is its emphasis on immigrant Indian women's deference to elders in matters related to maternity care and child rearing practices. For example, all participants were highly educated and most held masters' degrees or professional degrees from India except one who had a college degree from the US. However, college education did not prevent them from accepting and incorporating the traditional system of maternity care outlined by their elders along with the medical model of care in the US. Two of them hypothesized the scientific basis for some of the traditional practices but all of them shared that their elders were willing to concede that some practices such as separation after childbirth may not be practical in the US. Thus, new mothers and their elders were willing to let go of some of the beliefs to adapt to the demands of modern lifestyle in the US. For example, Meena believed that the baby should be delivered at an auspicious time as indicated in the Hindu calendar, but because of complications during delivery, she let go of her belief and followed the attending doctor's guidelines. Pallavi's mother expressed anxiety at having to put the newborn in a car seat, separated from the mother. Being unfamiliar with snow and other severe weather conditions during winter, her mother feared that the baby would fall sick and preferred to ensconce her in protective clothing, and placed preferably close to the mother's body.

Furthermore, all participants indicated that the traditional practices were aimed at ensuring the birth of a healthy baby and promoted protective factors through diet, behavior, emotional and psychological health of the mother.

In summary, the views and experiences of the women in this study indicated that they gained knowledge about traditional maternity practices from elderly women in their families, used the knowledge in combination with US medical care and had faith in the protective factors in traditional care. However, the women indicated that they did not follow the practice of no contact for a certain period (11 days - 40 days). It was also evident that they placed a great emphasis on following dietary guidelines, traditional remedies, clothing and jewelry and presence of extended family members. The purpose behind traditional practices appeared threefold: (1) to promote the overall health and well-being of the mother; (2) to help prevent disabilities in the newborn; and (3) to assist in their delivery of a healthy infant.

Understanding the rationale behind such faith-based beliefs can inform health care practice in the US and enhance practitioners' cultural sensitivity to the population they serve. Future researchers could examine and compare traditional maternity practices from immigrant women across diaspora to strengthen their cross-cultural knowledge. It would be interesting to

see the extent of and faith in traditional practices among immigrant Indian women who may not necessarily belong to religious/cultural groups.

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