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**South Asian Women's Perspectives about Pregnancy Needs  
and Utilization of Canadian Prenatal Health Services**

**Rishma Ladha, R.N., B.N.**

**Thesis submitted to the  
Faculty of Graduate and Postdoctoral Studies  
in partial fulfillment of the requirements for the  
Master of Science Degree in Nursing**

**School of Nursing  
Faculty of Health Sciences  
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*Mothers, the newborn and children represent the well-being of a society and its potential for the future. Their health needs cannot be left unmet without harming the whole of society.*

Lee Jong-wook, Director-General  
World Health Organization, 2005

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## **Dedication**

*I dedicate my thesis to  
Abbas and Aliana*

## Abstract

- Context:** South Asians are the largest immigrant group in Ontario, Canada. They may express perceptions of pregnancy that differ from the dominant cultures influencing mainstream health care. Prenatal services are underutilized by immigrant women in part due to language barriers and issues of racism.
- Purpose:** To explore and understand South Asian Canadian women's pregnancy needs and experiences in utilizing prenatal health services in Ottawa, Canada.
- Method:** Ten women were recruited to participate in semi-structured interviews. Data were analyzed using content and thematic analysis following a descriptive exploratory qualitative approach. An anti-racist approach was used to gain insights about these women's perspectives on the use of prenatal health services.
- Results:** All women expressed that their husbands provided support and nurturance. Female elders including mothers, South Asian neighbours, and friends played an important role in providing pregnancy information and support. Almost all participants were not aware of available community-based resources, including prenatal programs. Almost all women expressed that they were given different treatment, ignored by administrative staff and/or perceived that health care providers spent less time with them compared to other Canadians. Some health care providers did not understand and respect cultural and religious rituals.
- Conclusions:** Providing information about the availability of community resources is a vital step. Exploring South Asian husband's perspectives, the potential use of internet resources and creating interpreter networks through Indo-Canadian organizations are recommended. The Canadian health care system needs to address barriers and racism encountered by South Asian women to provide culturally sensitive health care.

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## Glossary of Terms

**Immigrants:** Term used to refer to permanent residents who have voluntarily migrated to Canada as business, economic or family class immigrants (Citizenship and Immigration Canada, 2008).

**South Asians:** People who trace their origins to South Asia, encompassing India, Pakistan, Bangladesh, Sri Lanka, Bhutan, Nepal, and Afghanistan. Also referred to as Indo-Canadians or East Indians.

**Prenatal Support:** Informal support including prenatal education provided to pregnant women to enhance their understanding of pregnancy. Resources include family and friends, books, internet, and previous pregnancy experiences.

**Primary Prenatal Health Services (PPHS):** Health professionals, including obstetricians/gynecologists, family physicians, midwives, nurses, and nurse practitioners providing health services, professional support and prenatal education programs to pregnant women. They monitor pregnancy, identify and reduce associated risks, and help women to understand factors that contribute to poor maternal and infant outcomes. The Society of Obstetricians and Gynecologists of Canada (SOGC) recommends that women receive these services every 4 to 6 weeks in early pregnancy, every 2 to 3 weeks after 30 weeks gestation, and every 1 to 2 weeks after 36 weeks gestation (SOGC, 1998).

## **Chapter One – Introduction**

### **Organization of Thesis**

This thesis explores South Asian women's prenatal experiences and utilization of prenatal health care services. The thesis is organized into five chapters. Chapter One introduces the background, demographics and role of immigration, background of South Asian cultures, prenatal health challenges for South Asians, study purpose, objectives, and relevance of the study for nursing. Chapter Two provides an overview of the relevant empirical and theoretical literature. Chapter Three describes the philosophical underpinnings of the research that guides the study as well as methodology, recruitment and sample selection, procedures for data collection, data management and analysis, a self-reflection with ethical considerations. The results of the study are presented in Chapter Four. Finally, in Chapter Five a discussion of study findings and implications and recommendations for nursing education, primary health care and public health, clinical nurse specialists and advanced practice nurses is presented. The chapter will end with study limitations, study strengths, and future topics for research.

### **Background**

One of the Millennium Development Goals is to have universal access to reproductive health by 2015 (Edouard & Bernstein, 2009). Globally much has been achieved, but there are certain geographical areas and subpopulations where progress is lacking and can be improved (Edouard & Bernstein). There is evidence that access to and use of health care and other community services is limited in immigrant populations. Underutilization of health care services can have a significant impact on new immigrant women's health, particularly during pregnancy (Grewal, Bhagat, & Balneaves, 2008). To better understand how and whether underutilization of health care services can have a

negative impact on pregnant immigrant women it is necessary to provide some background information on the complexities involved in the use of prenatal health care services by immigrants living in Canada. This section will begin with a brief description of immigration and its pivotal role in Canadian society. Particular attention will be drawn to South Asian Canadian women and their experiences using prenatal health services in Canada. This will be followed by an explanation of how multiple factors such as gender, ethnicity, and racism can have an impact on the use of the health care system causing health inequalities for pregnant South Asian immigrant women.

### **Demographics and Role of Immigration**

Immigration has been integral to Canada's social, cultural, and economic development. Each year a significant number of immigrants enter Canada and begin to settle in their new homeland. Immigration to Canada has created a culturally and ethnically diverse society. Both the character of immigration and its role in Canadian society have changed with time to reflect new domestic and global realities (Statistics Canada, 2008). Between 2001 and 2006 over one million immigrants entered Canada and the 2006 Census found that close to 20% of the population (over six million) were foreign-born (Statistics Canada, 2007). Approximately 60% of newcomers are from Asia (compared to 12% in 1971), 16% from Europe (62% in 1971), 11% from Central and South America, and 11% from Africa (Statistics Canada). Approximately 70% of recent immigrants settled in Census Metropolitan areas, such as Toronto, Montreal and Vancouver (Statistics Canada).

In Ontario, between 2001 and 2006, the foreign-born population increased by 12.2%, nearly three times faster than the Canadian-born population (Ontario Ministry of Finance, 2008). In the past few decades major source countries for new immigrants to

Canada have changed from European countries to Asian countries. South Asians represent the largest single immigrant group in Ontario, accounting for 28.9% of the immigrant population compared to Chinese at 21% and Blacks at 17.3% (Ontario Ministry of Finance). Cultural, economic, social, and political differences combine to make immigrants' experiences challenging in their first few years in Canada (Ratna & Richmond, 2003). Depending on the circumstances, migration can have a positive or negative impact on the health and well-being of immigrants, for example women's experience of migration is different from that of men (Bierman, Ahmad, & Mawani, 2009).

### **South Asian Cultures**

South Asia is a Southern region of the Asian continent with diverse racial groups and a mix of cultures, religions, traditions, and languages (Assanand, Dias, Richardson, Chambers, & Waxler-Morrison, 2005). The Indian-sub-continent, which is part of South Asia, is comprised of India, Pakistan, Sri Lanka, Bangladesh, Nepal, Bhutan, and Afghanistan. Of the many languages spoken by South Asians, Hindi and Urdu are among the most common, especially in India and Pakistan, respectively. South Asians value highly their ethnic customs and traditions, such as holidays and celebrations, food, clothing, and art (Tran, Kaddatz, & Allard, 2005). This group of nations has overall cultural and ethnic similarities, including customs, traditions, beliefs, food habits, and styles of dress. Many religions are practiced by South Asians, including Hinduism, Islam, Christianity, and Buddhism. Despite the different languages and religions, there are cultural similarities shared among groups of South Asians that connect them together. Some of the shared values, beliefs, and rituals include: strong ties within family, including taking care of the elderly; ethnic holidays, food, clothing, and art; being happy

during pregnancy; wearing a religious thread around their wrists; giving honey to a newborn baby, and many others.

South Asian cultures<sup>1</sup> are patriarchal, male privilege reinforced through gender roles (Hoskins, 2004). Most South Asian cultures promote male domination by giving power and privilege to men in the society. Men are the sole decision makers and breadwinners in the family and do not participate in household chores (Guruge, Khanlou, & Gastaldo, 2009). Gendered responsibilities vary over time, among families, and across socioeconomic groups, but women are primarily responsible for cooking, cleaning, and childrearing. Lacking support from their husbands, their female family support becomes more important. Traditionally, South Asian women live in an extended family structure which provides the support they need from other family members, especially women (Assanand et al., 2005).

During the nine months of pregnancy South Asian women are treated with great care and attention (Assanand et al., 2005; The Cross Cultural Health Care Program (CCHCP), 1996). Women in the family or community provide support to those who are pregnant. A woman may return to her parents' home for delivery. After giving birth, the new mother anticipates a forty-day postpartum rest in a comfortable environment in which to take care of the baby (CCHCP). Female elders take care of older children in the family and prepare meals. There are specific foods, which are high in calories, that are prepared for the new mother to promote strength after giving birth (CCHCP).

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<sup>1</sup> Culture is defined as a "shared set of beliefs, norms, and values. It is the totality of what people develop to enable them adapt to their world, which includes language, gestures, tools, customs, and traditions that define their values and organize social interactions" (McGibbon & Etowa, 2009, p. 209).

## **Prenatal Health Challenges for South Asian Women**

Pregnancy is a stage of life during which major physical and psychological changes occur in women. Such changes can cause happiness as well as anxiety and stress as women and their families adjust the activities of daily living and prepare to accept new parenthood (Polomeno, 2000). During pregnancy, women need social support, timely expertise, and ongoing prenatal health education (Ricci, 2007). Information regarding prenatal care can be obtained in many ways including: attending prenatal classes and pregnancy-g geared community programs; reading public health agency pamphlets, books, and internet; and by communicating with a network of female family and friends.

Several studies done both internationally and locally in Canada have identified that pregnant immigrant women have low attendance rates at prenatal classes, irregular visits to the family doctors, and other difficulties, such as lack of social support during pregnancy, labour, delivery, and the postpartum period (Ny, Dykes, Molin, & Dejin-Karlson, 2007; Grewal et al., 2008). Women who do not receive adequate prenatal care are less likely to receive early diagnosis, effective intervention, or preventive care during pregnancy (Ny et al., 2007). Pregnant immigrant women who do not utilize prenatal services have been observed to have increased rates of low birth weight (LBW) babies, preterm babies, and malnutrition (Sword, Watt, & Krueger, 2006; Grewal et al., 2008.). Health Canada and the Public Health Agency of Canada have worked together to emphasize the importance of being healthy before, during, and after pregnancy to decrease the incidence of maternal and prenatal morbidity and mortality rates (Health Canada, 2010a).

Health literature has acknowledged that issues of racism and lack of understanding of pregnancy needs and cultural practices are playing an important role in

immigrant women's use of health care services and their decision whether to use health services again (Reitmanova & Gustafson, 2008; Wheatley, Kelley, Peacock, & Delgado, 2008). There remains a pressing need to understand how multiple factors, such as gender, ethnicity, and racism are related to inadequate utilization of health services by immigrant women. The social conditions, such as racism and discrimination, that shape access to health care are the same factors that shape inequities in health (Bierman et al., 2009). To understand how different factors contribute to health disparities, it is important to unfold the factors of gender, ethnicity, and racism.

Gender has a significant influence on health status. According to Vissandjee, Hyman, Spitzer, Apale, & Kamrun (2007) gender refers "to the social norms, perceptions, and meanings associated with being a woman or a man" (p. 35). The inequities arising from gender roles and relations are important contributors to women's health (Bierman et al., 2009). International research has focused on gender inequities operating at interpersonal, community, and societal levels that have an impact on women's health. Often women immigrate to a new country as dependents of their spouses, and their health needs are not adequately addressed resulting in lack of access to health care services (Guruge & Collins, 2008; Mawani, 2008).

Ethnicity, referring to "members of a social group with traits originating from a common racial, regional, linguistic, or religious source" (Bierman et al., 2009, p. 101), is another factor that shapes health inequity for South Asian women. Fleras and Elliot (1999) argue that ethnic inequities are reflected by cultural norms and beliefs that portray ethnic groups of women as inferior and having cultural values different from those of the dominant group. Issues of ethnicity, gender and racism relate to pathways of utilization

and barriers encountered by immigrant women when accessing and using health care services (Spitzer, 2004; Bierman et al.; Vissandjee et al., 2007).

Racism is yet another factor that causes health disparities among immigrant women. Briefly stated, racism refers to individual and systematic practices that involve dominant groups “thinking and acting based on the belief that one’s own racial group has superior values, customs, and norms” (McGibbon & Etowa, 2009, p. 115). Basically, racism is an unequal distribution of power that hinders racialized groups of women from accessing health care. The inequities in health care services associated with gender, ethnicity, and racism are the result of multiple factors, such as socioeconomic status, discrimination, and differential treatment encountered when accessing and using care (Vissandjee et al., 2007; Bierman et al., 2009; Hyman, 2009). The social determinants of health<sup>2</sup> illustrate how social and economic status strongly affect the health of women, men, families, and communities (Etowa & McGibbon; Vissandjee et al.). Raphael (2004) agrees, “Social determinants of health are the economic and social conditions that influence the health of individuals, communities, and jurisdictions as a whole,” (p. 1), which play a role in health outcomes. Differences in accessing quality health care demonstrate social factors as influences that can have an impact on the use of health care services.

Being ethnically different with limited knowledge about the health care system has the potential to determine the quality of and access to health services. Immigrant women can experience racism when accessing health services due to their limited or

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<sup>2</sup> Social determinants of health include “income and social status, social support networks; education and literacy; employment and working conditions; social environments, physical environments; personal health practices and coping skills; healthy child development; biology and genetic endowment; health services; gender, and culture” (Public Health Agency of Canada, 2010, p. 1).

complete lack of knowledge about the health system, making them feel alienated and inadequately cared for. There is strong evidence that ethnicity and racism should be added to the list of social determinants of health (Etowa & McGibbon, 2009; Vissandjee et al., 2007).

The process of migration experienced by immigrants can also have a significant influence on their health. Migration can occur within the country or across countries and continents (Vissandjee, Thurston, Apale, & Nahar, 2007). The experience of migration can have positive as well as negative effects on immigrants. Families migrating to a new country often deal with separation from other family members as part of their migration process. Such an experience can cause stress and anxiety that can make immigrant women vulnerable to health risks during pregnancy (Kongnetiman & Okafor, 2006). Anxiety and stress are health risk factors that also can affect women's health after pregnancy. A study that was recently conducted in Canada indicated that immigrants, refugees, and women seeking asylum in Canada are four to five times more likely to suffer from postpartum depression symptoms than Canadian born women (Stewart, Gagnon, Saucier, Wahoush, & Dougherty, 2008). Family separation caused by the immigration process causes lack of social support for newcomers. Service providers should make support available by providing information and referrals to appropriate services (Stewart et al., 2008).

The experience of migration and racism has been found as a stress generator that has a mounting effect on mental health (McKenzie, 2006) and subsequent health service utilization (Whitley, Kirmayer, & Groleau, 2006). In Canada, the findings of a study conducted on South Asian women revealed that those ethnic groups with strong ethnic

identification are at a higher risk of experiencing psychological distress if discrimination is perceived (Beiser & Hou, 2006).

For pregnant immigrant women to understand and utilize prenatal health care services, it is important that they be informed about resources available in the community. Some of the prominent factors that have been identified in underutilization of prenatal health care services by immigrant women are: differences in prenatal approach between Canada and their home countries, low socio-economic status, language barriers, lack of understanding of the Canadian health care system, acculturation stress, social isolation, limited educational background, racism, and lack of community health services in the geographic location (Champlain Immigration Health Network, 2007; Edwards, 1994; McLafferty & Grady, 2005; Sword, 1999; Hoskins, 2004; Spitzer, 2004; Visandjee et al., 2007).

Pregnant immigrant women, such as South Asian women, have a different perception about pregnancy and their needs may not be the same as other pregnant Canadian women (Hoskins, 2004; Assanand et al., 2005). As a result, these women underutilize formal health services that could have provided them with more support and knowledge about prenatal health. Since these women have difficulty understanding and accessing formal health services, they tend to seek knowledge from other sources, such as women from the same background, friends, and family to substitute for the information received from health care providers. Culturally, it is acceptable for these women to seek help from other women.

In an American study done in 1996, researchers reanalyzed transcripts to examine narratives about pregnancy from low-income primiparous visible minority and white

women who participated in focus groups. They found that minority women including immigrants experienced disparities in the quality of prenatal care received during pregnancy (Wheatley et al., 2008). The quality of communication including the attentiveness of the health care providers in explaining and providing information to pregnant women was not as effective as the women had desired (Wheatley et al.). The results confirmed that health care providers did not show respect. Their behavior was interpreted as rude and the women felt that they did not receive adequate attention during routine prenatal check-ups (Wheatley et al.). This study finding was congruent with some of the studies conducted in Canada (Spitzer, 2004; Reitmanova & Gustafson, 2008; Grewel et al., 2008). Certainly, there is a need to explore this issue further using different theoretical lenses to contribute to the knowledge available and to find strategies to address immigrant women's health concerns.

Three Canadian studies done in three different provinces explicitly show barriers that hinder South Asian women from using prenatal services. Spitzer (2004) examined hospital childbirth experiences of visible minority women, including their interactions with nursing staff. She documented that nurses felt that visible minority women, including South Asian women, were too time-intensive and therefore spent less time with them. Racist comments from nursing staff labeled South Asian women as "lazy or behaving like princess when refused to walk" (p. 499). This study provides evidence that at least some nurses treat South Asian women differently. Language barriers added frustrations for women, especially those foreign-born women who did not speak English and who experienced difficulties expressing their needs (Spitzer).

A qualitative Canadian study explored factors that affect access to maternity health services for immigrant Muslim women living in St. John's, Newfoundland. Discrimination, insensitivity, and lack of knowledge about immigrant Muslim women's religious and cultural practices created prenatal barriers to the use of health services. Significant gaps existed between prenatal health services and women's needs for emotional support including culturally and linguistically appropriate information pertaining to pregnancy (Reitmanova & Gustafson, 2008).

The third qualitative study conducted in Vancouver, British Columbia explored the prenatal experiences of newly-arrived South Asian women, particularly Punjabi immigrant women. The importance of health beliefs and practices in the prenatal period, role of family members in supporting women during pregnancy, and communication issues encountered with health care providers are interwoven dynamics that shape the quality of prenatal care given to Punjabi immigrant women. The findings suggest that a change is required in the health care system, particularly among health care providers and the community. There is a crucial need to better understand immigrant women's beliefs, values, and practices within their family unit in order to accommodate and acknowledge their cultures (Grewel et al., 2008).

In summary, the results of these three studies do not necessarily transfer to South Asian immigrants living in other Canadian cities as the findings might not accurately portray the prenatal experiences of women with different immigration histories. Hence, there is a need for further research that focuses on prenatal experiences of South Asian women living in Ottawa, Canada. To obtain a better understanding of pregnant South Asian women's utilization of prenatal health care services, it is important to identify their

pregnancy needs from their own perspectives. Such a research initiative, focused specifically on this unique population, may lead to the development of evidence based and culturally appropriate primary prenatal health services.

### **Research Purpose and Objectives**

The purpose of this research is to explore and understand South Asian women's pregnancy needs and their experiences in utilizing prenatal health services in Ottawa, Canada.

#### **Research objectives.**

1. To increase understanding of South Asian women's pregnancy needs in order to develop strategies and resources that will provide support and resources to promote an optimal level of prenatal health.
2. To increase understanding of South Asian women's prenatal health issues for health care providers, including nurses, in order to enhance their knowledge of culturally appropriate care for women in a diverse society.
3. To increase understanding of South Asian Canadian women's access to and use of prenatal health care services in Ontario, including challenges they experience and strategies to overcome these barriers.
4. To generate recommendations for nursing education, nursing practice, primary health care, public health, clinical nurse specialist and advanced practice nurses that potentially would provide useful information for nurses providing care to South Asian women.
5. To generate increased knowledge for further health services research with respect to South Asian women living in Canada.

### **Relevance of the Study**

The Registered Nurses' Association of Ontario (RNAO) (2007) Best Practice Guidelines, *Embracing Cultural Diversity in Health Care: Developing Cultural Competence* recommends that health care providers reflect on their own beliefs, practices, and value systems in order to understand individuals from diverse ethnic backgrounds. Therefore, health providers can better serve their clients by increasing their understanding and awareness of the cultures they serve. An increase in understanding of South Asian women's culture will provide guidance to health care providers to offer services that are conducive to these women's needs and increase the probability of these women using these services. The study may provide scientific information to enhance cultural competence in providing prenatal health care services to South Asian women.

The knowledge generated from the participation of South Asian Canadian women in sharing their experiences may create new avenues and ideas to provide culturally supportive, sensitive care. This study has the potential to provide some guidance to health care professionals, especially nurses, for the health care of South Asian women. By increasing nurses' understanding of South Asian women nurses may be able to provide culturally competent care which is important in the delivery of quality health care. As Dugas and Knor (1995) state, "cultural competence does not mean knowing everything there is to know about another culture. It is instead, respect for the difference, eagerness to learn and a willingness to accept that there are many ways of viewing the world" (p. 298).

As health professionals, it is important to understand that cultural competence is a process that requires on-going learning, reflection, and self-assessment (Etowa & Adongo, 2007). The process of acquiring cultural competence is vital when working

across cultural boundaries (Etowa & Adongo). The cultural competence of a nurse is important because it addresses the problem at the individual level and also at a larger systemic level which reflects on the health care profession's depth of education and delivery of health care services.

### **Acting beyond cultural competence.**

In our efforts as health professionals to work towards health equity, we need to look beyond cultural competence strategies. Miranda et al. (2003) argues that despite having some cultural competence strategies that may have the potential to improve the quality of the delivery of health services, there is limited evidence of the reduction of health disparities. There is a need to search beyond the factors that contribute to health inequities, and to reflect on how nurses can enhance their knowledge to understand these factors to reduce their impact on the quality of health care.

Henry (2002) argues that “multiculturalism has in fact failed to control racism against ethno-racial minorities” (p. 231) because even though cultural diversity programs are being promoted some populations, such as Aboriginal peoples, immigrants, refugees, and other marginalized groups, continue to experience inequities in health care. Henry argues that Canada, being a diverse country, needs a more critical approach to diversity – one that understands the power relations among different cultural and racialized groups. Inattention to the existing power dynamics masks the dominance of whiteness. Therefore, addressing the root causes of racism and other factors that hinder marginalized populations' access to and use of health services is critical (Henry).

To understand better the dynamics of racism and other social factors that impact health, an anti-racism approach is used in this study. Anti-racism is a model that explores the dynamics of discriminatory traditions that play a role in the lives of ethno-racial

people (McGibbon & Etowa, 2009). Racism is consistently reported to impact both the health status and the utilization of health services by diverse populations, including South Asian women (Whitley et al., 2006). Therefore, this study will provide nurses with information on how different facets, such as gender, ethnicity, and racism, contribute to underutilization of prenatal health services by South Asian women. With this enhanced knowledge, nurses will be able to advocate for both an individual client as well as for an anti-institutional racism approach which promotes equitable access to and use of Canadian health services.

## **Chapter Two – Literature Review**

The main purpose of the literature review was to: understand pregnancy needs of South Asian women and explore some of the barriers that hinder their utilization of prenatal health services. Nursing and social science databases that were used that included: CINAHL, Pubmed, PsychINFO, Genderwatch, and Anthrosource. A search strategy used the following terms: South Asian women, immigrant women, prenatal care, pregnancy, prenatal education, use of health services, prenatal health care services, facilitators and barriers in using health services, social support, anti-racist approach, racism, discrimination, ethnicity, qualitative study, cultural competence, health care providers, and nurses.

In this chapter, both qualitative and quantitative studies are reviewed. All the studies provide empirical evidence regarding facilitators and barriers that hinder immigrant women's utilization of prenatal care including health services. Three major concepts identified as central elements include: accessible prenatal education and resources, social support, and cultural and linguistic differences.

### **Accessible Prenatal Education and Resources**

One of the strategies to ensure that essential information and support is given to pregnant women in a timely manner to promote maternal health is through prenatal education. As defined by Best Start (n.d), prenatal education is “a series of classes, either online or in person, provided for groups of pregnant women and their partners or support people” (p. 5). The three main goals of providing prenatal education are to: provide pregnant women with information they need to improve pregnancy and birth outcomes; help pregnant women to have a positive birthing experience; and lastly, prepare pregnant women for parenting roles (Best Start). The tradition of transmitting information from

one woman to another is still common at this time (Sword, 2003). In addition, there is a range of cultural beliefs practiced during pregnancy, birthing, and the postpartum period. For example, in South Asian cultures mothers, mothers-in-law, or married sisters, may continue to have a significant role in sharing their experiences about pregnancy and after birth, as well as in providing support (Assanand et al., 2005).

In Ontario, prenatal education programs are offered by a variety of agencies: public health units, hospitals, Community Health Centres, non-profit organizations, and some private businesses (Best Start, n.d). These programs are offered to pregnant women and their support people, including partners or a relative or a friend. Topics covered in prenatal class may include: prenatal care, healthy lifestyles, labour and delivery, role of support person, breastfeeding, newborn care, postpartum care, adjustment to parenting, and community resources. Refresher prenatal programs are available for those parents who may need to review information for subsequent pregnancies. Most women attend prenatal education classes during their first pregnancy to learn about pregnancy and birth (Best Start).

Prenatal education programs often are designed by health care professionals. The expectations of health care providers and the receivers of health care services are different when both of them do not share the same culture, and the difference in expectations may be more pronounced than expected (Berman, 2006; Bhagat, Johnson, Grewal, Quong, & Triolet, 2002). The health beliefs and practices associated with child bearing vary among cultural groups, and prenatal programs offered often reflect dominant North American cultural beliefs and practices. Therefore, when designing prenatal

education for immigrant populations, there is a need to emphasize relevant cultural and belief practices (Berman).

Some agencies offer prenatal education in both official languages of Canada. Courses are also offered in other languages for those pregnant women who have limited understanding of English or French. For example, in Ottawa, Ontario the Public Health Department offers prenatal education programs in various languages to meet some immigrant mothers' needs including English, French, Chinese, Vietnamese, and Arabic (City of Ottawa, 2007). Since the number of South Asian immigrants is growing in Canada, it is imperative to acknowledge that South Asian women comprise an important immigrant group. There is a need for research to determine the prenatal education needs of South Asian women to provide guidance in designing culturally sensitive community-based prenatal programs for them.

Apart from prenatal education classes, there are many types of prenatal programs to accommodate pregnant women's needs, such as online prenatal programs, blended prenatal programs, one-to-one prenatal programs, drop-in prenatal programs, and others (Best Start, n.d). There are some organizations that offer online prenatal education programs for people who cannot access services easily, such as people living in rural areas. Blended prenatal programs offer information online as well as face-to-face meetings. One-to-one programs are offered for pregnant women who may wish to take a session with a prenatal educator. A variety of factors can influence pregnant women to take one-to-one programs, such as geographical location, financial reasons, language barriers, or complex work schedules (Best Start). Drop-in prenatal programs are offered to provide education in the context of the Canadian Prenatal Nutrition Program (CPNP)

and to focus on reaching women living in isolation, poverty, or those lacking social support or education. These programs are very common in the Community Health Centres.

Interestingly, in the United States a new model called ‘Centering Pregnancy’ has been developed to combine both prenatal care and education components for pregnant women who receive their regular obstetric care in a clinic. After meeting with the health care provider, the women join other pregnant women or couples with similar due dates for an education session. Such an innovative model not only provides both the health services and education components together, but also offers an opportunity for pregnant women to meet other women who share similar experiences. Increasing the social networks of pregnant women may provide support for pregnant immigrant women who lack social networks in a new country. In Canada, this model has been used in British Columbia (Best Start, n.d).

Prenatal education programs are advertised by the agencies offering the programs, such as the Public Health Department, Community Health Centres, hospitals and private businesses. Health care professionals, including obstetricians, family doctors, midwives, and nurses, are expected to promote use of prenatal education programs that enhance pregnant women’s knowledge of pregnancy. In addition, programs are promoted through family resource centres, Ontario Early Years Centre, and community groups, using posters, pamphlets, online publishing, and other means (Best Start, n.d). While many Canadian women are aware of prenatal education programs, there is no data presenting a multi-cultural perspective. Differences continue to exist in how pregnant immigrant women receive information on prenatal education programs.

In a Canadian study conducted in Calgary, Alberta the use of prenatal care services by South Asian women was compared with that of Canadian-born women (Brar et al., 2009). The results revealed that there was a significant difference in the amount of information received by women about prenatal education. Fewer South Asian women (33%) were told by their health care providers to attend prenatal classes compared to Canadian-born women (57%). As a result, only 13% of South Asian women attended the classes compared to 23% Canadian-born women. Reasons cited by South Asian women for not attending prenatal classes were lack of husband's willingness to attend and a preference to acquire prenatal knowledge from female relatives and friends. South Asian women may not see a need to attend prenatal classes since they might not be accustomed to do so in their countries of origin. However, since they lack female support in their host countries, prenatal classes can be beneficial for them. Therefore, culturally sensitive and appropriate classes geared towards South Asian women can be useful to provide information about pregnancy, labour and delivery, and the postpartum period (Brar et al.).

Prenatal classes have a potential to improve women's self-esteem and self-confidence, enhance family relationships, promote breastfeeding and improve communication between women and health care providers (Chalmers, Mangiaterra, & Porter, 2001). Enkin et al. (2000) add that prenatal classes can increase women's satisfaction with birth and reduce the need for analgesic medication in labour. The *Canadian Family-Centred Maternity and Newborn Care: National Guidelines* and the World Health Organization recommend providing prenatal education to women and their families (Health Canada, 2000; Chalmers et al., 2001).

Beliefs, practices, and perceptions of women regarding pregnancy and childbirth vary depending on their experiences, educational background, and culture. Attending prenatal education classes might not be appropriate for some pregnant immigrant women, especially those such as South Asians who acquire knowledge from other women in the family. South Asian women are encouraged to attend prenatal classes but decide not to pursue them for a variety of reasons, such as language barriers (Assanand et al., 2005). It is not common in South Asian cultures to discuss sex openly with strangers, and childbirth movies shown in prenatal classes might make women uncomfortable (Assanand et al.).

A qualitative study done in Minnesota, U.S exploring eight South Asian Muslim immigrant women's experiences of accessing prenatal care reported that women's prenatal health education needs were unmet (Gulzar, 2008). Most women did not attend prenatal education classes, because they were told by friends within their community circles that prenatal classes were not very useful as they did not provide information on how to care for their newborns. Women preferred more personalized and individualized education offered in informal, interactive environments rather than in formal, English language only, "one-size fits all" classes (Gulzar, p. 2). The study clearly indicated that the need for prenatal education exists, but the formal class format is not culturally-appropriate and the content and language may not address specific needs of South Asian women (Gulzar).

### **Social Support**

People who migrate to new countries experience a change in their life circumstances that can have negative implications on their health (Ali, McDermott, & Gravel, 2004). One of the ways to integrate and adapt in the host country is by having

adequate social support. For immigrant women, lack of social support can cause feelings of lack of belonging or isolation. Support from extended family is likely to be limited for those immigrant women who migrated only with their spouses. Immigrants' perceptions of social support depend on their past experiences in their countries of origin (Stewart et al., 2008). Both informal and formal social support are important and can impact positively the health of immigrants in enhancing integration, reducing stress and loneliness, improving mental health, and building networks (Stewart et al.). "Formal" refers to support from the government, including the health care system, whereas "informal" refers to support from family and friends. When immigrants arrive in their new host country, they may not be aware of the kind of support services available to them. Lack of awareness of health and community resources available for immigrants makes it difficult for them to access or use the services. Culturally, these women might not see the need to seek formal services from government or public sources since they are accustomed to seek support from family and friends.

There is evidence that migrants<sup>3</sup> experience challenges in obtaining social support in their new host countries (Stewart et al., 2008). Adapting to a new country's way of life can be difficult and challenging for many immigrant families, resulting in acculturative stress and increasing their vulnerability to health problems (Kongnetiman & Okafor, 2006). The presence of family or friends in the adopted country provides companionship and enables immigrants to overcome challenges associated with acculturation. Pregnant immigrant women may experience social isolation in Canada after leaving their countries of origin, families, and friends. Hence, loneliness increases their stress levels. High stress levels have been found to have negative effects, including anxiety or depression during

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<sup>3</sup> The term "migrant" refers to anyone who has moved from one country to another.

pregnancy, influencing the health of pregnant mothers as well as the unborn baby (Kongnetiman & Okafor).

Schaffer and Lia-Hoagberg (1997) studied the effects of social support on prenatal care and health behaviours of pregnant low-income ethnic women. Results of the study documented that mothers, sisters, women friends, and extended family provided pregnancy support, information, and sharing of pregnancy experiences. Professional support provided by nurses, counselors, and caseworkers was inadequate due to the limited time that health providers spend with pregnant women. Health care professionals, including nurses, should be able to identify pregnant women with inadequate social support as soon as the pregnancy is confirmed in order to refer women to specific community programs to increase their social networks. Lack of social support in the pregnant immigrant woman's environment contributes to delay in seeking prenatal health care (Schaffer & Lia-Hoagberg).

Female family support is indeed very important especially in those cultures where other women provide care during pregnancy and birth. For example, within the South Asian cultures, female relatives are the main source of support and husbands are not involved in any part of the pregnancy, childbirth, or postpartum period (Assanand et al., 2005; Hoskins, 2004). These pregnant women living in Canada will experience lack of support if they must rely solely on their husbands. Social isolation may increase for these mothers if they are lacking other forms of social support since their husbands are not accustomed to providing support to their pregnant wives (Hoskins).

Traditional South Asian rituals performed during pregnancy play an important role in the pregnant woman's life. For example, a special feast for the mother-to-be in

which she receives gifts and choices of food, and in which prayers are recited, might not be possible for women living in North America and can increase social exclusion (Hoskins, 2004). Other prenatal rituals might not be feasible to perform due to lack of family support and presence in the host country. For example, the nurturing ritual of bidah, in which a woman in her seventh to eighth month of pregnancy moves into her mother's home in preparation for the upcoming delivery (Grewal et al., 2008), may be lost to her experience.

### **Cultural and Linguistic Differences**

Cultural difference is a barrier that discourages pregnant immigrant women from using the services offered to them. Pregnant immigrant women experience difficulty in finding culturally appropriate services that respect their culture and value system without prejudice (Sherraden & Barrera, 1996; Herrel et al., 2004; Stewart et al., 2008). The value and importance of prenatal care is dependent upon pregnant immigrant women's perception of health needs, which in turn determines their interest in seeking pregnancy information. In many studies, it has been reported that pregnant immigrant women's perception of prenatal health care has been linked with their late introduction to participation in prenatal health services (Sherraden & Barrera; Herrel et al., Ny et al., 2007). In most North American societies, prenatal care is emphasized pre-conceptionally to prevent congenital abnormalities, but this might not be the norm for all ethnic populations including South Asians.

In South Asian cultures, pregnancy is viewed as a normal process of life, not an illness requiring medical attention (Hoskins, 2004; Assanand et al., 2005). In Canada, some South Asian women believe regular check-ups during pregnancy are not important (Assanand et al.). Therefore, participation in prenatal health services might not be

perceived as a good health strategy by some South Asian women, and they tend not to seek health services until late in the pregnancy (Hoskins, 2004). Women's tendency not to seek health care support at the beginning of the pregnancy is explained by their cultural beliefs emphasizing the idea that women will receive help primarily from their female relatives.

A Canadian descriptive study found that some South Asian Canadian women did not participate in community prenatal classes due to linguistic barriers and beliefs that certain body and childbirth processes should not be discussed with others until the appropriate time (Spitzer, 2007). Attending prenatal classes is an idea so influenced by biomedical culture that the women who do not participate in these classes are often labeled as "disinterested and uncaring mothers" by health care providers (Spitzer, p. 165). Such behaviours emphasize a negative attitude towards women from different cultural backgrounds. Prenatal care is not only obtained by attending classes; some women choose to acquire knowledge about prenatal care and healthy pregnancy by reading pamphlets and learning from friends and family (Spitzer).

In addition to the cultural differences, language has been identified as a barrier that hinders immigrant women from using health services. Studies have consistently identified language and cultural factors as the two most important reasons that limit pregnant immigrant women's ability to utilize prenatal care and health services (Herrel et al., 2004). In a longitudinal study Edwards (1994) examined factors that predict prenatal class attendance among immigrants living in the Ottawa area. In her analysis, it was pointed out that the inability to speak one of the official languages of Canada (English or French) was a barrier to attending prenatal class (Edwards). Of the different ethnic groups

that participated in the study, women from Somali and Lebanon had the lowest rates of prenatal class attendance: 7.1% and 9.7% respectively (Edwards).

Being foreign-born and having language difficulties have been found to be related to the inadequate use of prenatal health services by pregnant immigrant mothers in other studies as well. In 2007, a retrospective study done on immigrant pregnant women living in Malmö, Sweden showed that 33.7% of 519 South Asian women attended their first prenatal visit at more than 15 gestational weeks in comparison to 17.4% of 2925 Swedish women (Ny et al.), a statistically significant difference. The study results indicate different patterns of utilization of prenatal health care services among groups of foreign-born pregnant women and Swedish-born pregnant women. Foreign-born pregnant women were not satisfied with the services received for various reasons including a language barrier, which caused health care providers to spend less time with them. Immigrant pregnant women expected the same kind of services, such as professional support from health care providers, that they were accustomed to in their home countries. Lack of language skills and professional support from health care providers resulted in women under-utilizing routine prenatal health care services.

The fact of late initiation to prenatal care being linked to language barriers has been of concern for many years. Sherraden and Barrera (1996) conducted an in-depth ethnographic study with 41 Mexican immigrant women living in Chicago to examine women's experiences in seeking prenatal care. Almost half of the women (44%) had communication problems with health care providers and felt they were ignored by the clinic receptionist, because they did not speak English. Further, language issues limited their access to social assistance programs during and after pregnancy. Lack of

communication between health care providers and women led to 73% of the women waiting three to five hours for their appointments, more than the benchmark wait of 20-30 minutes. About 32% of women said that a lack of emotional and physical energy kept them from going to prenatal appointments. Such feelings were related to language barriers and long waiting times (Sherraden & Barrera). There is a strong inverse link between the use of health services and language barriers. There is evidence that immigrants with language barriers experience perceived institutional racism when accessing and using formal support, including the health care system (Stewart et al., 2008; Hyman, 2009). Institutional racism defined as “institutional structures that have the power to provide space for individuals in society to discriminate against one another” (McGibbon & Etowa, 2009, pg. 214).

Both language and cultural barriers can play significant roles in the confidence levels of women from different ethnic backgrounds. Mantha et al. (2008), in a Canadian quantitative study, compared women who reported either a high or a low confidence level during the postpartum period about breastfeeding and infant care. Women who reported that their first language was neither English nor French were found to have significantly decreased confidence about breastfeeding. There was a possibility that these women may have experienced language and cultural barriers during their prenatal care, which increased anxiety and decreased confidence postnatally. These factors place women at risk of early weaning or of not breastfeeding at all. Therefore, it was recommended that nursing care must support cultural beliefs and practices, and bridge language barriers when educating diverse mothers (Mantha et al.).

In summary, promoting accessible prenatal care is important for South Asian Canadian women. Therefore, understanding South Asian women's cultural perspectives is an essential first step that can inform and guide health care professionals, including nurses, to provide equitable health care. South Asian women continue to experience barriers that hinder them from using prenatal health services. Therefore, this study was designed to provide additional information on pregnancy needs and the use of prenatal health services, both formal and informal support, for South Asian Canadian women living in Ottawa, Ontario. Obtaining South Asian women's perspectives will expand the body of knowledge in this area.

### **Chapter Three – Methodology**

The following section describes the philosophical underpinnings that guide the study. Specifically, the design, recruitment and sample selection, procedures for data collection, and data management and analysis are outlined. In addition, self-reflection of the fieldwork is included, in which I examine the experiences of South Asian women from a personal lens of a researcher as an instrument. The chapter concludes with an overview of ethical considerations.

#### **Philosophical Underpinnings of Study: Incorporating an Anti-Racism Lens**

Access to health care is an important Canadian value. The differences in utilization of health services by immigrant women and resulting outcomes have roots in the history of racism (McGibbon & Etowa, 2009). In addition to Aboriginal and Black Canadians, Roy (2008) identified South Asian Canadians as a group that has endured a history of racism. South Asian Canadians were subject to legalized racism, whereby they were denied entry into professional occupations, denied the right to vote, and subjected to discrimination in housing (Roy; Bolaria & Li, 1985). Legalized racism means “racist practices that are enshrined in the laws and policies of a country” (McGibbon & Etowa, p. 211). History can shape the challenges encountered when accessing formal institutions, such as academic institutions, the health care system, and other venues (McGibbon & Etowa). Racism in the health care system, as a significant barrier to accessing and using health care services, is well documented by many researchers (McGibbon & Etowa; Spitzer, 2004; Spitzer, 2007; Stewart et al., 2008; Visandjee et al., 2007).

Health inequities have their origins in systematic power imbalances that continue to marginalize immigrant women. Understanding the power structures that exist in the health care system is important to be able to address issues of racism. Racism in the

health care system indirectly jeopardizes the enforcement of the principles of the Canada Health Act (CHA) (McGibbon & Etowa, 2009). As per Health Canada, the Act's objective is "to protect, promote, and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" (Health Canada, 2010b, p. 1).

The use of an anti-racism lens in this research will uncover women's pregnancy needs and experiences in using prenatal health services. An antiracism lens examines "systematic power structures that create and maintain racism" (McGibbon & Etowa, 2009, p. 213). The objective of this lens is to achieve social justice for racialized peoples. This critical lens provides guidance for looking beyond the biomedical framework, and traditional health and social perspectives that have an impact on utilization of health services. This study is based on women's perspectives about women and for women and focuses on the South Asian women's strengths while recognizing their challenges. The research question originated from my own experience of being a South Asian living in a host country (Canada); therefore, my experience is part of this research process. To a certain extent by using this approach, I was able to understand the hierarchical relations and power dynamics experienced by South Asian women. This study highlights lived experiences of South Asian women and explores how gender, ethnicity, and racism intersect to cause health disparities in utilization of prenatal health services.

### **Design**

A descriptive exploratory qualitative design was used for this study to understand South Asian pregnant women's use of prenatal care and health services. Qualitative research methods are holistic and inductive, providing the tools for examining experiences of study participants (Field & Morse, 1985). Reinharz suggests that to

increase understanding of women's experiences and knowledge we must listen to the voices of women (1992). Researchers using qualitative methods can examine research problems using emic perspective, that is, from the perspective of the participants (Field & Morse; Creswell, 2007).

Qualitative methods are best suited to understand immigrant women's experiences from their own perspectives (Field & Morse, 1985). Through the understanding and creation of knowledge particular to women, the status quo can be challenged and patterns of care reconstructed (Duffy, 1985). Therefore, knowledge developed from women's experiences and perspectives marks an important contribution to the provision of equitable health care.

Health related inquiry explores women's lives to understand the underlying factors that impact their health, acknowledging that interrelated and complex variables, such as gender, ethnicity, and racism, continue to contribute to the multidimensionality of women's experiences causing health disparities (Johnson-Odin, 1991; Vissandjee et al., 2007). Women's perception of pregnancy differs from one individual to another and these differences are related to biological, cultural, geographic, social, economic, and psychological factors (Liamputtong, 2007).

To develop critical awareness of injustice associated with health provision and to expose racial discrimination experienced when using health care services (McGibbon & Etowa, 2009), it is important to listen to women's experiences. Health care providers need to hear immigrant women's stories to increase their awareness of women's experiences (McGibbon & Etowa). By recognizing that different influences come together in distinct ways and lead to various health outcomes for individuals and groups,

such a perspective provides context to health experiences and draws attention to the dynamic interplay between the individual, family, community, health organizations and the larger social structures and systems (Guruge & Khanlou, 2004).

### **Research Context**

Prior to the recruitment process, assessment of the available prenatal resources for South Asian women in Ottawa was sought to develop a plan for feasible recruitment. A public health nurse recommended by the reproductive department at the Ottawa Public Health unit was contacted to discuss available programs. During the discussion with the public health nurse it was discovered that there were no specific prenatal programs designed for South Asian women nor information offered in languages spoken by the women. In examining the services available at the community level it was noted that there was a prenatal class designed and offered by a South Asian woman. To seek information about the South Asian prenatal class, the prenatal facilitator was contacted and study information was given. The prenatal facilitator was willing to help with the recruitment, but it became obvious that most of the South Asian women attending the prenatal classes were Canadian born which did not fit with the selection guidelines of this study. As a result, none of the women were recruited for the study. Regarding other prenatal programs available for South Asian women in the community, I learned that there were no programs designed specifically for this cultural group.

Regarding the context of recruitment, some key agencies played a significant role in assisting to provide possible networks for the fieldwork. First, the Indo-Canadian agency was approached to discuss the possibility of facilitating access to interested participants. The key stakeholders of this agency were asked to offer assistance in locating various South Asian women's networks. Their contacts provided helpful

suggestions for increasing the diversity of sites from which to recruit potential participants. Prayer places, such as a temple and a mosque, were significant venues for the recruitment of South Asian women, since many of them congregate there.

Approaching participants in these two prayer places was feasible because the researcher's cultural and religious heritage facilitated access, and was an asset in the establishment of a trustworthy relationship. The women recruited from these prayer places played a vital role in arranging for and referring other potential participants to this study through a snowballing process.

### **Recruitment and Sample Selection**

Women were recruited using five different access points including the placement of posters in grocery stores, a temple, a mosque, Tejaswini: An Indo Canadian Women's Organization, the Catholic Immigration Centre, and Community Health and Resource Centres (CHRCs). A snowball sampling method was also used to recruit, whereby women who participated in the study were requested to refer other potential participants (Creswell, 2007). The Coalition of Community Health and Resource Centres (CCHRC) provided a letter of support (see Appendix C) to grant permission to access all 14 CHRC's to recruit women. The importance of volunteer participation was emphasized in the advertising poster inviting women to participate in the study (See Appendix D). Staff at CHRC's were contacted with an explanation of the study and to have any pertinent questions answered. During recruitment discussions with CHRC's it was revealed that South Asian women were not accessing their services much with the exception of two centres offering Early Year's programs. These CHRCs agreed to advertise the poster in their community rooms. A study information letter (Appendix E) was also available for the staff to distribute to potential participants.

The logic of sample size rests on the notion of data saturation, that is, the point at which no new insights are likely to be obtained (Field & Morse, 1985; Creswell, 2007). The number of participants needed to reach saturation depends on the quality of data collected (Field & Morse). If study participants can share and articulate their experiences, then saturation can be reached with a small sample size (Field & Morse). No further issues emerged after reviewing the data provided by ten participants. Therefore, the sample size of ten women was sufficient to reach data saturation on the major concepts under study, so no further recruitment took place.

Creating a list of inclusion and exclusion criteria is important to decrease study bias (Polit & Beck, 2008). Initially, the inclusion criteria included women from India, Pakistan, and Somali: between the ages of 20 and 40 years; who had given birth in Canada to a healthy baby; aged three months to three years at the time of the study; and who had immigrated to Canada within the past five years. Women from other ethnic backgrounds were excluded. During the recruitment phase, it was noted that most of the South Asian women living in the Ottawa area had immigrated to Canada more than five years ago. As well, it was found that a number of South Asian women were born and brought up in countries apart from India and Pakistan. Thus, to complete this Master's thesis in a reasonable time frame, the inclusion criteria were expanded to accommodate diverse South Asian women. A modification form was completed for the University of Ottawa Research and Ethics Board requesting minor changes to the inclusion criteria. The modified inclusion criteria included: South Asians regardless of country of origin and those who had immigrated to Canada within the past ten years. The study documents were modified to reflect the changes.

Focusing solely on South Asian women was intended from the beginning of the study. The graduate student researcher was not sure if there would be enough South Asian women for recruitment; therefore, Somali women were included in the inclusion criteria for ethics review. During recruitment, it was discovered that there were enough South Asian women living in Ottawa, Ontario that would agree to participate voluntarily in the study. Based on this observation, it was decided that Somali women would not be recruited for the study.

### **Procedures for Data Collection**

Qualitative interviews allow the researcher an opportunity to pay attention to the understanding, knowledge, and insights of the participants (Rubin & Rubin, 1995; Creswell, 2007). Semi-structured interviews were used to provide in-depth understanding of women's attitudes and experiences (Rubin & Rubin; Creswell). An interview guide (Appendix G) was created to direct the semi-structured interview process using open-ended questions. The interview guide consists of fifteen semi-structured and open-ended questions about prenatal experiences and utilization of prenatal health care services. Face-to-face interviews were conducted at a time of the women's convenience and in a location where they felt most comfortable, to encourage a relaxed atmosphere. Together with the interview, a one page demographic questionnaire (Appendix H) was completed by each woman. The interview method offers participants an opportunity to share their thoughts and ideas using their own words rather than using the researcher's terminology and bias (Reinharz, 1992). Giving women an opportunity to take the initiative to share their stories can provide valuable insight into the phenomenon under study (Reinharz).

All the participants chose to be interviewed in their homes, in their living rooms or around their kitchen tables. Verbal consent was obtained and recorded from the

women prior to the interview sessions which lasted from 30 to 90 minutes. All interviews except one were audiotaped using a standard portable digital tape recorder. One participant refused to audio tape as she did not feel comfortable recording her voice so handwritten notes were taken. Two interviews were conducted in Urdu and translated into English by the graduate student researcher. All recorded interviews were transcribed. A study number was assigned to all participants' names and important information to ensure anonymity. As a token of appreciation, a \$20 grocery gift certificate was given to all women for their dedication, time, and sharing of their experiences.

### **Data Management and Analysis**

Several factors were involved in managing the quality and integrity of the data. During the interviews, notes were written when applicable to provide insight into a particular statement or comment. After interviewing the participants, field notes were written to provide a description of the physical setting and non-verbal communication. Field notes helped the researcher to deal with perceived privilege and increased reflexive awareness. As well, a diary of impressions was kept to record subjective information (Denzin & Lincoln, 2000). The reflexive diary helped the researcher trace the development of the research in terms of the reflections written during the process. Throughout this exercise, the written notes provided inspiring thoughts and ideas that have contributed to strengthening and developing a thorough understanding of the context of this thesis. An identity file with the list of participants' information for tracking purposes was kept in a separate folder from the audio tapes and original transcripts. The three data sources were kept in a secure locked cabinet in the Nursing Best Practice Research Unit (NBPRU) at the Faculty of Health Sciences. The identity file consists of participants' real names and pseudonyms, phone numbers, address, and

relevant information. According to the University of Ottawa Research and Ethics Board protocols, audio files will be destroyed within two years and any files pertaining to the research will be stored for a period of five years until 31<sup>st</sup> December, 2014 and then destroyed.

Organizing and handling of data was done manually. The interviews were transcribed verbatim and four copies were made of each transcript. One copy remained intact, the other one was used for coding, and the third was used to cut up significant passages from common themes in different interviews placed together in appropriate folders. For overlapping categories, the fourth copy served to allow filing in several folders. All transcripts were reread to obtain a thorough sense of the participants' views as a whole (O'Connor & Gibson, 2003; Miles & Huberman, 1994). To understand women's perspectives, a content analysis was used to treat a transcript as a whole or to analyze its parts to explore metaphors concerning women (Hsieh & Shannon, 2005).

An anti-racism approach was used in the data analysis in order to better uncover concepts that hinder South Asian women's access and use of prenatal health services. This approach was helpful in the sense that it illuminated the key barriers that the women had acknowledged as difficulties towards use of health services considering equity. The women revealed that the challenges encountered in accessing and using prenatal health care services is related to factors, such as ethnicity, gender, racism, and cultural and language barriers. Therefore, the anti-racism approach was suitable in understanding and interpreting women's experiences and their alienation when accessing and using prenatal health services.

Using an inductive approach, words coming directly from the data captured the key thoughts to interpret, which then became the coding scheme (Field & Morse, 1985; Hsieh & Shannon, 2005). Such an approach allows the researcher to acquire direct understanding from the study participants without imposing preconceived categories; as well, themes emerge from the bottom-up method (Hsieh & Shannon; Creswell, 2007). Emerging codes were sorted into categories to organize and then regrouped into meaningful clusters of categories (Field & Morse; Hsieh & Shannon; O'Connor & Gibson, 2003).

The data categories provided the fundamental features in which a group of data shared a commonality (Graneheim & Lundman, 2004). Each category contained clusters of sub-categories illuminating different aspects within it. A category helped to clarify what the participants were saying (Graneheim & Lundman). Wide margins helped for coding, categorizing, and comments. Different coloured highlights were used according to the categories created. After every interview was analyzed, a summary of interpretations, memos, analysis of participants' responses, emerging themes, and clustering of codes were documented (Miles & Huberman, 1994). Themes emerged from the clusters of categories to provide multiple meanings (Graneheim & Lundman). A theme is defined as a "thread of an underlying meaning through, condensed meaning units, codes or categories on an interpretative level" (Graneheim & Lundman, p. 107). Creating themes helped to connect data in different categories (Graneheim & Lundman). Morse and Field (1985) discussed the notion that all themes will not be common to all participants and these differences provide richness in data.

Unlike in quantitative studies, whereby instruments are administered to seek answers, in a qualitative study, the researcher herself is an instrument. Four main criteria constitute the trustworthiness of qualitative data and interpretations: credibility, dependability, confirmability, and transferability (Polit & Beck, 2008). The credibility of qualitative studies depends on the researcher's method of data collection and analysis of the data (Polit & Beck). Credibility depends also on the integrity, validity, and rigor of the researcher doing the fieldwork (Polit & Beck). Credibility was established through prolonged engagement with the data that provided direction from participants' meaning.

Dependability is the second important criteria in developing trustworthiness. Similar to reliability in quantitative studies, the notion of dependability emphasizes that the researcher must account for the ever-changing context within which research occurs (Polit & Beck, 2008). The process of analysis was discussed thoroughly with the thesis supervisor and decisions were made over time to reflect the true meaning of the data. Therefore, the aspect of dependability was verified. Emerging themes and subthemes were identified to enhance the interpretation of the data. Finally, the entire thesis committee met to discuss the themes and subthemes and helped to reduce their number by regrouping them.

Confirmability as another criteria to ensure trustworthiness refers to the degree to which the results could be confirmed by others (Polit & Beck, 2008). Descriptive and interpretative processes were employed to derive meaning from the data collected. The interpretations collected through interviews were reviewed by the thesis supervisor to maintain neutrality so that the interpretations reflected participants' voices and not researcher's bias, therefore ensuring confirmability of the study (Davies & Logan, 2008).

The researcher did not verify the accuracy of the interpretation of the data collected due to the following reasons: coming from the same cultural background, speaking the same common languages spoken by the South Asian women as well as having lived the experience of an immigrant. There was thus limited room for ambiguity or mis-interpretation of the data.

Lastly, to develop trustworthiness by ensuring transferability of the data, sufficient descriptive data describes the context and assumptions central to the study (Polit & Beck, 2008). Transferability in a qualitative study is the responsibility of the person using the study results; therefore, it is important for that person to judge whether the results can be transferred to another context (Polit & Beck). A good qualitative researcher provides adequate information about the study so findings can be transferred to improve quality of care in other settings (Polit & Beck).

The themes include women's words highlighting their experiences. Selected quotes are used in the text to provide context for women's experiences. Quotes have been edited slightly for grammar, participants' names are omitted from the text and pseudonyms are used to protect their anonymity and respect their privacy. Some identifying factors have been removed or altered to protect the anonymity of the study participants. The altered facts do not change the overall meaning implied by participants. The methodology and ethical considerations applied respected and prioritized the participants' needs to avoid marginalizing and stigmatizing these women. The results will be revealed in Chapter 4 and the interpretation of the results will be provided in Chapter 5.

Reflecting on the data collection and analysis process, the researcher decided to self situate in the women's scenario. This process is vital in qualitative research whereby the researcher is an instrument in the process of the data analysis and interpretation.

### **Self-Reflection: Situating Myself in the Study**

Throughout this journey of research, I have learned considerable amount from the South Asian women who agreed to participate in the study. I offer the information shared with me and my personal experience in the hope that someone else will appreciate its significance and learn from it. In the following two sections, I provide my personal experience of situating myself in the study before initiating the research with the women; the second section highlights reflections during the writing of this thesis.

#### **As a woman and a health professional.**

I decided to explore and envision the realities experienced by pregnant immigrant women, especially South Asian. Being a South Asian myself who had immigrated to Canada, I felt confident that I would relate to some of the experiences encountered by these women. I decided to focus on this immigrant group to understand and contribute to the knowledge of challenges encountered by South Asian women when accessing and using prenatal health services in Canada. Using my expertise of speaking some of the same languages as these women, I decided to voice their experiences and opinions about the realities of using the Canadian health care system.

Being in the field and having the privilege of hearing their stories without language barriers, I situated myself in the woman's position of having language difficulties and lack of information about the Canadian health care system. That inspired me to use the results of this project to provide recommendations to organizations that offer prenatal services to South Asian women and to policy makers to promote a change

in health care delivery and social justice. Equitable health for all Canadians will be achieved by helping organizations and policy makers reflect on the quality and efficiency of health care services.

**As a pregnant woman.**

During the writing of my thesis, I was blessed in becoming pregnant which granted me with a great opportunity to understand and experience the feelings of the women participants in this study. As a nurse, knowledgeable about the Canadian health care system, I decided to use this privilege as a unique opportunity to test my own results of the study as a service seeker. I chose to try out the experience of being a pregnant South Asian woman seeking prenatal services without using my professional expertise to live the same challenges as a pregnant woman from the same background. From the lens of a South Asian woman, I could relate to what the participants shared during the interviews. As a health professional, I started to question the legitimacy and quality of the Canadian health care system. Despite my fluency in one of the official languages, I was not given all the necessary information pertaining to my pregnancy or a list of available community resources. Desperately seeking for more information, I asked the health care provider questions pertaining to pregnancy, such as availability of prenatal classes in the community. I was astonished by the lack of information and support given by the health care provider.

**Ethical Considerations**

Before collecting any data, approval from the University of Ottawa Research and Ethics Board was received (Appendix A). Women were reminded that participation in the study was voluntary and they had a right to withdraw at any time or to choose not to answer any questions. Explanation was given of the benefits and risks involved in the

study. The process of data collection, storage, and dissemination of results in any publication or report was explained to ensure participants that maximum measures would be taken to ensure confidentiality and anonymity. After explaining the study to the women, the researcher reviewed a copy of the consent form (Appendix F) in the language of their choice. A brief explanation of the research process was discussed as well as mutual expectations. Participating women were given a choice to sign the consent form or to give a recorded verbal consent. All participants signed the consent form prior to the interview.

Measures were taken to protect the women's confidentiality. The researcher is the only person with access to the names of the participants and their interview tapes. The names are listed on a separate document and stored in a locked cabinet in the Nursing Best Practice Research Unit (NBPRU) at the Faculty of Health Sciences. No identifying information was entered into the computer files when reporting the participants' comments and no identifying information has been included in the description. At all times, women's names are omitted from the text to protect the anonymity of the women.

## **Chapter Four – Results**

This chapter provides the results of data analysis. It is organized as follows: first, the characteristics of the sample and access to prenatal services are presented. Then, the content and thematic analysis of women's experiences is presented in the form of themes and sub-themes.

### **Characteristics of the Sample**

Participants were recruited from different agencies as follows: two women from Tejaswini: An Indo Canadian Women's Organization, two women from a temple and a mosque, three women from the Catholic Immigration Centre, and lastly, three women from the snowballing method. All ten (n=10) women immigrated to Canada within the past three to ten years. Four out of ten women were from India, four were from Pakistan, one from Afghanistan and one from Nepal. All women spoke little or fluent English as well as their own other languages. Some of the languages spoken by the women were: Hindi, Urdu, Gujarati, Bengali, Punjabi, Persian, Nepali, Sindhi, and Hindko. The sample size was composed of three primiparous women and seven multiparous women. All the women were married and living with their spouses. Half (n=5) had a bachelor's or postgraduate degree and all others had some high school or post secondary education, or a college degree. The majority of women (n=6) were housewives, and the rest (n=4) were employed.

### **Access to Prenatal Services**

To understand South Asian women's utilization of prenatal health services, women were asked about the usage of prenatal health and community resources. The resources under inquiry were the Community Health and Resource Centres (CHRCs), prenatal classes, obstetrical services, family doctors, midwifery services, doula services,

drop-in centres, community houses, and prenatal groups and workshops. Interestingly, it was observed that all women used obstetrical services. A few used their family doctors before their care was transferred to obstetrician services. Only one woman took prenatal classes with her husband. One woman had used a drop-in centre after her first child was born. None of the women used midwives, doulas, Community Health and Resource Centres, community houses, or prenatal groups and workshops. In fact, it was noticed that the majority of women were not aware of these prenatal services. All of the women were unfamiliar with the role of doulas and the purpose of the Community Health and Resource Centres, except one woman who had used one of the Community Health and Resource Centre's Early Years programs after the baby was born. Women felt that they were not informed about the different health services that existed in the area, which they could have used if they had known.

### **Thematic Analysis**

Five major themes arose out of an analysis of the interviews: 'MY' body, feelings, and baby; support systems; learning about pregnancy and community resources; barriers related to use of prenatal care services; and use of the Canadian health care system. Each of these themes encompasses several subthemes. Table 1 below illustrates themes and subthemes.

Table 1  
*Thematic Analysis*

Themes	Sub-themes
'MY' body, feelings, and baby	<ul style="list-style-type: none"> <li>• Meaning of pregnancy</li> <li>• Women's identity and roles</li> </ul>
Support systems	<ul style="list-style-type: none"> <li>• Help from husbands</li> <li>• Help from family, friends, and others</li> </ul>
Learning about pregnancy and community resources	<ul style="list-style-type: none"> <li>• Health care providers</li> <li>• Family, friends, and others</li> <li>• Using internet and books</li> </ul>
Barriers related to use of prenatal care services	<ul style="list-style-type: none"> <li>• Limited basic access to Primary Prenatal Health Services (PPHS)</li> <li>• Language</li> <li>• Cultural and religious beliefs</li> </ul>
Use of Canadian health care system	<ul style="list-style-type: none"> <li>• Appreciation of Canadian health care services</li> <li>• Relationship with providers</li> <li>• Valuing and respecting women's time</li> <li>• Racism</li> </ul>

**'MY' body, feelings, and baby.**

“ 'MY' body, feelings, and baby” is the first theme that emerged from the data. In essence, the theme encompasses South Asian women's meaning of pregnancy and the needs associated with it. The theme is comprised of two sub-themes, meaning of pregnancy and women's identity and roles.

***Meaning of pregnancy.***

Healthy pregnancy as a concept was defined by almost all the women as the state of being physically well and not experiencing any signs or symptoms pertaining to pregnancy itself or any kind of illness, such as hypertension and diabetes that may have a negative impact on their health as well as the unborn baby's health. Women expressed

their desire to be physically healthy in relation to their ability to perform everyday chores. The majority of the participants in the study experienced morning sickness during pregnancy which caused them not to enjoy their pregnancy in the beginning. As well the majority of women reported 'getting tired' causing them to refrain from doing work including household chores. Women expressed the importance of becoming aware that the baby's growth and development was progressing without any difficulties. As identified and stated by Gita, the meaning of healthy pregnancy is explained:

Healthy pregnancy means that the baby is healthy, weight gain and everything is going well including the tests etc. But then it also means being in an easy frame of mind knowing that once the baby is here, things are going to be fine.

Physical wellbeing was not the only concern for the women, the importance of being psychologically fit was also very important. The women knew the importance of being happy during pregnancy, but it became difficult during the early trimester of pregnancy since the women were experiencing a lot of changes in their bodies. Women described their feelings as "sentimental", "depressed", or "insecure" when probed about their emotional feelings. Their expressions of feelings were caused by some kind of stress and anxiety in their lives, such as not knowing what to expect. Faiza said, "Emotionally you are stressed out, especially for me a couple of months when I was debating whether do I want it (pregnancy) or not, because it's a big responsibility".

Women perceived their emotional feelings as normal in pregnancy. Some women were very careful about their emotional well-being during pregnancy believing that the baby would absorb emotions and reflect maternal thoughts and actions. Women were cognizant of the need to maintain a peaceful attitude throughout their pregnancies. As

Reena describes in her statement, “Whatever I am, my baby will be like that. So if I eat healthy, she will eat healthy food and if I have mental shanti (peace), so my baby will be well too”.

***Women’s identity and roles.***

Women shared their experiences of fulfilling their roles as mothers, wives, and professionals. As mothers, they wanted to make sure the pregnancy went smoothly without any complications. They felt that as women, they had responsibilities towards providing care and nurturing their unborn baby or other children. Women who were professionals also felt that they were accountable to balance taking care of their immediate family, including children and their homes, and their work lives. Women had difficulty fulfilling all their responsibilities including taking care of the house and ensuring their household chores were done. A mother describes her experience:

Sophie: Here you have to do everything from A to Z. I mean cleaning, washing, housework, cooking, and everything else. There (home country) you have maids or people around who can help you, such as mother and sisters. Especially when someone is pregnant they (mother and sisters) take extra care of you and here you only have your husband who is not home all day with you. Definitely you need someone.

**Support systems.**

Support systems are the second theme. Informal social support was viewed as being particularly important for the women. Almost all women felt that there was a constant need for someone to look after them especially those who were experiencing some physical symptoms of pregnancy and finding it difficult to cope with other responsibilities. The two main sources of informal support systems that emerged from the

data and are elaborated as subthemes: help from husbands and help from friends, family, and others.

***Help from husbands.***

All women expressed their need to receive care and support from their husbands since there were no female family members present to provide the care. Everyone commented that their husbands provided support and nurturance so that they would not have a difficult pregnancy. Despite husbands working full-time, they would return home from work and help women with household chores when necessary.

Sarika: Yeah my husband, like when he was here (Ottawa) he would come from work or on the weekends, he would help with what he could do. He doesn't know much about cooking so he would take care of my daughter and that was a big help too; because the first three months I don't feel like going out or walking or doing anything, just lying down on the bed. So he took care of my daughter by taking her out and helping with household chores.

Some husbands provided support by accompanying their wives to prenatal visits to their doctors. Women who had limited English language skills relied on their husbands for interpretation during their medical appointments.

***Help from family, friends, and others.***

Apart from receiving support from husbands, almost all women talked about the importance of getting help or advice from others, especially women. Female elders, including mothers and mothers-in-law, played an important role in advising women about their diet and lifestyle, encouraging women to be healthy and stress free during their pregnancy. The majority of women's (n=8) families were living in their countries of birth. Only two women were fortunate to have their parents, especially mothers, visit

them in Canada either during the last months of pregnancy or after delivery of the baby. Support from families was very important as women felt they could seek help in doing household chores or receive advice from them.

Women who were housewives found it very difficult being alone at home without any social networks. The feelings of being alone were worst for those who did not have any family in the country causing the women to be isolated. The feeling of being lonely was making these women yearn for their dear ones, such as mother or sister(s). As Leena describes in her statement,

Like here we don't have any family, so like the first three months was very hard. I definitely felt like if I had my family that would be good. And again sometimes you feel very tired and you don't want to do anything and just think if my mother or maybe my sister were here then they could help . . . this is important. At this time, some mothers were lucky who found some support from family, friends, or neighbours for others.

For some women, the first trimester of pregnancy was very difficult due to morning sickness. As a result, the women were in a constant need of someone to visit and help them out. During that time, women were feeling more tired and were wishing for others to pamper and nurture them by cooking their favorite South Asian food.

Nazia: And you are not able to go walking. You are living alone with your husband who goes to work, and you are alone at home. That's when you need someone to come, share, sit, and help out . . . Especially in first trimester, I was not able to cook because of the cooking smell, so my need was that somebody who can cook and feed me what I wanted to eat.

For those women (n=2) whose parents (especially mothers) were available, the parents made a difference by providing extra help when needed. Women felt that having family around helped reduce their loneliness. Some families residing in their home countries continued to provide support to the women over the phone. The majority of women noted that friends, coworkers, and neighbours, especially South Asians, provided physical, emotional, and moral support during pregnancy. As Tina describes, her friends helped her cope and nurtured her with homemade South Asian food when she got tired from working and doing household chores.

Well I have a few friends who at least in the last two months or so, they started providing me with food on a rotational basis. They would cook something and drop it for me because I was working which was making me really tired by the end of the day. Every three or four days, they would drop off a couple of things for me. So that really helped a lot . . . so that's the support I got from friends, basically.

For some women, coworkers were helpful in providing support by reducing workload for the pregnant women in order to avoid stress. Neighbours, especially South Asians were another source of support for women. Women who lacked family support made strong connections with them. Having neighbours from the same cultural background made it easy for the pregnant women to associate with them and share their concerns.

Salma: Yes, when I came to live in this apartment, there was nobody but then afterwards I had neighbours who were from India. The woman had a baby girl and she helped me a lot. Because I was alone at home having morning sickness,

nausea, and not feeling good, she used to ask me to lie down while she would clean my apartment floor. She helped me a lot. Then I had another neighbour who was also from India . . . she is still helping me a lot. During my pregnancy, I was not in the mood of doing anything, but only going out and my husband was busy. These people were around me to take me out.

### **Learning about pregnancy and community resources.**

In this third theme, women expressed how they learned about pregnancy and other community resources that helped them to understand the benefits of healthy pregnancy. This theme is comprised of three sub-themes: health care providers, family, friends, and others and using internet and books.

#### ***Health care providers.***

All women felt that learning about healthy pregnancy was important in order to attain balance through healthy diet and exercise to make sure that the baby was developing and growing as recommended. Women reported that they did not receive enough information about pregnancy issues, such as physical and mental changes, nutrition, or exercise from their health care providers. In order to learn more about the pregnancy, the women had to be proactive and ask questions appropriately to learn from their health providers. As Reena commented on her encounter with her provider, “he never told me what I should eat, but if we have questions, like we asked can I eat this . . . so he answers. And exercise, he said that you should walk and that’s it. He didn’t tell me anything”.

Mariam felt that her provider was focused more on her basic assessment whereas providing information on pregnancy was not of any interest to her provider. She pointed out, “my first gynecologist did not tell me much about pregnancy . . . she just checked my

blood pressure, my weight, and how my uterus was growing with my pregnancy”. Almost all women confirmed that their health practitioners did not provide information about different prenatal care services, such as prenatal classes, midwifery services, doula services, and Community Health and Resource Centre programs for pregnant women, available to them in the community. Instead, they were informed of some of these services by their friends or other women in the community. As Mariam continues to comment, “After my son was born, I took him to Community Health Centre because they have certain drop-in programs . . . my friend told me that there are certain Centres where you can go and ask questions if you need something”.

Only one woman participated in prenatal classes. One woman had taken prenatal classes in her previous pregnancy so did not find it necessary to take them again. She found the classes were very useful in helping her to understand the process of pregnancy. The one woman who took a one day prenatal class with her husband found it to be helpful. Madhu shares how her husband felt after taking the class, “It was helpful; my husband says it helped him more as he didn’t have any idea, like I knew little but it was definitely helpful”. The majority of women were not aware of prenatal classes offered in the community and a few women who were aware decided not to attend. Their reasons for non-attendance included not being able to afford to pay for the classes, unwillingness to attend the classes on their own when their partners could not attend, and in one case receiving inaccurate information from a health provider. This woman assumed that prenatal classes were intended only for women planning a vaginal birth after she was told by her health provider not to worry about attending prenatal classes. As Gita explains, “You just told me that I will be having a cesarean section, she (doctor) was like, oh yeah!

So you don't worry about it (prenatal classes) . . . That's why I had no clue of what is covered in these classes".

Those women who were not aware of prenatal classes showed that they would have considered the classes if they were informed but they felt that they had adequate prenatal care. Furthermore, they provided some thoughts of how prenatal education could be beneficial for pregnant woman. As Meena said, "Good . . . because I would have a chance to meet many expecting mothers, and they would share their experiences with me and I would share mine with them . . . this would help the nervousness to go away". The one woman who attended the class shared how the prenatal classes benefitted her during the previous pregnancy. As Kareena comments, "In class they taught us how to cope with pain. Especially when you are in labour, you cannot listen carefully what the nurse is telling you to do, but when you are in class you can practice, for example breathing exercise. I found it (breathing exercise) to be helpful to cope with pain".

Women also shared their thoughts on what could be included in the prenatal classes. Women were more interested in learning about the changes that occurred in each trimester including hormone imbalances, nutrition, exercise, and mood swings including education on depression and understanding complications of pregnancy. Further, they wanted to understand how normal pregnancy differed from abnormal. First-time mothers felt that this information would have been helpful since they were not aware of it.

Information was not routinely offered to them; instead they had to ask for it. At times when the women expressed their concerns, they were told that it was normal to experience and further explanation was not provided. First-time mothers lack the understanding of what to expect in pregnancy so it was difficult for them to be aware of

what normal means in pregnancy. As Mariam shares her experience, “I was not satisfied and I didn’t know much about, except . . . I had some questions that I asked my doctor. . . And then she would say, ‘Yeah that’s okay, it happens during pregnancy, that’s normal for you . . . she didn’t explain further’”. This was a problem for some who were not aware of what information they needed. As a result, women had to rely on other sources for information.

*Family, friends, and others.*

Family, friends, and neighbors not only offered support for these women, but also provided information about pregnancy. Asking questions and talking with others was viewed as a means to learn more about pregnancy and validate experiences for multiparous women. Support from family, friends, and others was useful in understanding community services available for women especially those who were new to Canada and pregnant for the first time. Family members, especially women, provided support and information to the pregnant women to ensure the mother and baby’s health was good.

As Meena expressed,

My mother and mother- in-law back home used to tell me that I need to do some exercise, i.e. go for walk. Like during the time of delivery, I might have difficulty if I don’t exercise. If you just sleep, just lie down then that might not be helpful for you.

Experiential knowledge gained through sharing experiences with other women including their mothers and friends was valued. Women felt that other women with children would understand what they were experiencing. Almost all women felt comfortable asking and learning from their own mothers and friends. Women who had

their first child in their home country learned from their mothers and other women who helped them during pregnancy. The experience learned during the first pregnancy helped them with their subsequent pregnancies in the new country, but some apprehensiveness was noted as the services offered are not the same. One of the women shared her desire for a community network consisting of a circle of women of all ages who could share their experiences and learn from each other.

Rani: Like in India it's not just people your own age compared to here we make friends with whom we go university but here is not so much of a community friendship. But in India there is that so when others have their babies you have some exposure to it and you get some knowledge . . . you learn from their experiences, and you can ask others what they did and what they didn't do.

***Using internet and books.***

The internet and books were some of the sources used by women to enhance their understanding of healthy pregnancy. The wealth of pregnancy information offered online has led women to use different online resources for answers to their questions and concerns. Since limited pregnancy related information was provided by health care providers, women actively browsed the internet to find information to meet their needs. Women were interested in understanding the changes that occur week by week including the growth and development of the baby. An online pregnancy resource, such as [www.babycenter.ca](http://www.babycenter.ca), was mentioned by a few women who used this website frequently to find information. Women signed up to these websites to receive week by week information pertaining to their baby's growth and development. These websites also kept women up to date with current information not only pertaining to their baby, but also the care that would be provided by the health care provider, such as the blood tests to be

ordered. One of the women also used additional websites of companies with baby products, such as Nestle, Similac, and Enfalac.

Kareena: I did lots of 'googling'. Two websites, baby centre and another I forgot in which I registered in order to receive information every week like what will be happening this week. So I used to read and how the baby will be, how I will feel . . . I like to read . . . I like internet because it's always up to date. It says this week your doctor will order this kind of tests, so I knew before that this will be done.

The internet also provided a source of reassurance for those women who knew about healthy diet during pregnancy, but wanted to verify information from other sources.

Mariam: Yeah, I knew about so many things, but I was browsing on the internet to find out what kind of food should I eat, what is healthy food, and which food is not good for me during pregnancy. Like tuna, they have research that the pregnant women should not eat tuna. Yeah and the milk – how important is milk and meat.

The internet was not the only source of information for women as some women preferred books more than using computers. For other women, books were valuable in providing advice and support on pregnancy. For one woman, her sister-in-law gave her a pregnancy book recommended by her co-worker, which provided her with valuable information. The book, *'What to Expect When You're Expecting'*, really helped her during pregnancy. Some first time pregnant women were enthusiastic about checking out what was available in the local library in terms of books and audio cassettes in order to acquire knowledge on pregnancy.

Roshni: During my daughter's time, I read a book. I still have that book . . . . I don't remember the title of the book, but I read that book and I got audio cassettes from the library because that was my first time, and I didn't know anything.

**Barriers related to use of prenatal care services.**

In this fourth theme, women described challenges they encountered when accessing and using prenatal care services. Access to services is not limited only to availability of required services but also how the services are delivered. Women spoke about inequalities in the provision of services that created barriers in the further use of services. Three main barriers emerged from the data which are discussed as subthemes: limited basic access to Primary Prenatal Health Services (PPHS); language; and, cultural and religious beliefs.

***Limited basic access to PPHS.***

The first barrier to prenatal care was basic access to health services. Women who had immigrated to Canada had to wait for at least two to three months before they could have access to health care. They had to wait in order for them to receive their Ontario Health Insurance Plan (OHIP), which is a requirement when using health services. One new immigrant woman found out that she was pregnant two months after arriving to Canada, but had to wait for another two months before she could start her prenatal checkups. Finding an obstetrician was another challenge, because the husband did not have a regular family doctor where he could take his wife. Her husband's friend helped them locate a family doctor, but without the OHIP card the woman could not access health services unless the couple was ready to pay for the services. As a result, her prenatal care was delayed.

Masuma: My husband didn't have a family doctor. He used to go to walk-in clinics when in need. One of his friends showed him a family doctor who would agree to see me. We went there, but they said after you get your health card come back and we will search an obstetrician for you . . . For the first two months we didn't know that we have to find a family doctor who will refer us to the obstetrician. By the time we came to know and found a family doctor, I had then received my health card and I was already four months pregnant.

The shortage of doctors was another issue addressed by a few women that caused stress for them. Women expressed their concern at not being able to find a family doctor who accepted new clients so that they could be followed up for regular prenatal check-ups. Not having a family doctor was a big challenge especially for one woman who had recently moved to Ottawa. As she could not find a doctor, she continued to use her family doctor who was residing in Toronto traveling back and forth every month for her monthly prenatal checks.

Pari: When we moved here, literally within a week we realized I was pregnant and my doctors were located in another city. I had a really tough time getting a doctor here for the first three months. I used to go back and forth each time for every test, because there was no doctor here.

### ***Language.***

Almost all women cited linguistic barriers as major challenges when using prenatal services. They experienced difficulty expressing their health concerns and voicing their pregnancy needs. Women experienced two issues with language barriers: the use of medical terminology and the English language itself. The use of medical

terminologies by the doctors increased the difficulty for the women to understand and/or ask questions.

Heena: I had difficulty understanding her (doctor) because she used high level of medical terminology when explaining me. I had to ask her to repeat what she was trying to tell me.

Women struggled with language and communication difficulties that caused them to experience anxiety and to remain silent as a means to avoid embarrassment of making further mistakes. During the prenatal appointments, the women tried to translate their concerns in English, but in doing so the meaning of the sentence changed. As a result, the health care providers failed to understand the real concerns of these women, hence making the women feel frustrated.

Morin: I was new (in Canada) and had some language problems. My accent was not good and I did not understand them properly because they spoke fast. So first I insisted that please speak slowly so that I can understand what they were trying to tell me. We don't speak English in our country. We do understand, but as a language we don't use it. So for me whatever I need to ask, I first translate the sentence in English, but it was not a proper language. So I feel that the other person who is listening to me, for example my health care provider took a different meaning of that sentence.

Women's husbands who were helping translate for their wives also experienced language barriers when translating information for them. Women with language barriers required more time when communicating as they needed clarification or explanation for information using simple terms that were understandable. Staff working at the doctor's

office showed some negative attitude towards women and their families who had language issues. These experiences generated feelings of not being respected and frustration for the women and their families.

Khadija: The main problem I faced was my language as I couldn't understand her (doctor) and my husband would help me, but they said in order to save their time from being wasted as we didn't know anything, let's quickly go through the question and answers, and call in the next patient. That's why I used to get frustrated, because my husband would happen to ask them some questions, but they would reply something else to him. Even he would get frustrated, I could tell from his facial expressions, and he felt confused whether he should ask more questions fearing their cold responses. He would get scared and say let's not ask further questions, because they will get angry. My concern was why would they behave like that with us?.

***Cultural and religious beliefs.***

Some women's needs related to their cultural and religious background. These needs were not met by health care providers, especially nurses working in the hospital. Women did not feel that their cultural and religious beliefs were respected. As a result, they were forced to abide by the hospital rules.

Meena: I don't think the nurses understood my cultural and religious beliefs. They are very cut and dry about certain things. For example, we wear this religious thread around our wrist . . . and before they were taking me into the operation room, they were like 'no you have to cut it off'. It's a religious thread . . . In our religion, like whenever you go for something big you go to the temple and they tie this thread to protect you . . . but they (nurses) were like 'no you can't' and they

made me cut it off. So it's such a big moment for me – like stepping into something that is little scary and maybe scientifically it makes no sense but it does provide emotional comfort and assurance.

### **Use of Canadian health care system.**

In this final theme, women compared the Canadian health care system to that of their home countries to assess their pregnancy experiences. In essence, four sub-themes comprised from the data are: appreciation of Canadian health care services; relationship with health care providers; valuing and respecting my time; and racism.

#### *Appreciation of Canadian health care services.*

The majority of women were satisfied with some services offered by the Canadian health care system. Women's satisfaction was based on the comparison of services available in their home countries. Most women spoke about the importance of having access to basic health services when needed. Some women voiced concerns regarding the importance of being able to have access to facilities that offer help in emergency situations, such as calling 911, regardless of their ability to pay for the health services. In most developing countries health care is private. Therefore, the advantage of using a health card, such as OHIP when accessing medical services is considered equitable for the women.

Maya: I come from a poor country and we do have facilities there, but if something happens to me in pregnancy here I can call 911 and I will be rushed to the hospital. But it's not the same in our country. Yeah there are people around you, your own people, your parents, family, but other things such as these kinds of facilities you don't have it there.

One of the women did not have regular prenatal check-ups in her home country during her first pregnancy because the country was at war. Neglect of women's reproductive health was perpetuated by the country's law of focusing on the political needs of the population rather than the health of its citizens. The woman and her family could only access health services on a needs basis, such as during the delivery of the baby. She experienced intimidation and public humiliation by soldiers when the woman was forced to provide proof of marriage when seen with her husband. Such unlawful acts continued to victimize women by compromising their pregnancy needs in terms of accessing health services. As a result, she sought knowledge about pregnancy from her mother and sisters during pregnancy.

Zulfa: In our country, we go to hospital when there is a problem and when the baby is going to be born. Otherwise, it's not normal to go every month and get your prenatal check-up done especially if the baby is healthy. And over here they check the mother's health, her blood pressure, and everything. It's not the same in our country . . . Unless you are feeling ill then you have to go but even then it was difficult during the war. If we were to go to doctors, it would double our chances of losing our lives . . . because the soldiers used to ask when husbands were with us, they (soldiers) wouldn't know and they needed proof to make sure they were our husbands or some other people we are going out with . . . It was very difficult to leave the house.

***Relationship with health care providers.***

Some women (n=4) who did establish a positive working relationship with their health care provider commented favorably about their providers who readily offered information and answered their questions pertaining to pregnancy. Women perceived

their relationship with their health care provider to be satisfactory if the provider answered women's questions. Women who were satisfied with their health care providers, such as obstetricians during their previous pregnancies preferred to have the same provider during consecutive pregnancies. The bond of trust was built and women felt comfortable to be treated with the same provider. One woman, in recalling said,

Oh I'm very satisfied with my gynecologist ... she is wonderful, I really like her . . . During my first pregnancy I had her and I wanted the same doctor again, . . . there is a hospital near to us . . . . But I wanted the same doctor and she is in . . . another hospital so we didn't mind driving, because I wanted to have the same doctor . . . .

Some women who did not have a good experience with their providers during their first pregnancy preferred to look for another provider. Others describe the qualities in health care providers that were conducive to establishing a supportive and working relationship. These qualities include listening and respecting the woman's needs. Women felt obliged to attend their prenatal visits despite providers' lack of respect and time to let women voice their concerns. Women felt that it was important to attend regular prenatal visits except for one woman who had four children and decided not to access prenatal service until she was six months pregnant. She did not feel a need since her past experience with the doctors had influenced her not to use the service during the present pregnancy.

Attending prenatal visits every month helps women build trust in health care providers that during labour and delivery the doctors will be present to care for them. Yet, women expressed that it was not the case since it is not guaranteed that they will

have the same provider in the hospital. Women felt that there was lack of compassion and doctors did not show any supportive care by being there for the women. As described by Amal in her statement

I . . . insisted saying I could give birth normally, but the doctors here would deny it due to my first child being born via a c-section. But I'm saddened by the fact that the doctor who used to perform check ups on me, always said "have faith, be confident, I will operate on you", . . . but on the day of the operation she would call saying "I cannot make it" and got me operated by someone else. This happened during the birth of both my daughters. They would call me saying "were sorry, we cannot make it". It was difficult considering I had the same doctor for nine months during my checkups, but they couldn't care less, such that they would send someone else on the day of my operation.

Nurses' providing the care to the women in the doctor's office were limited and focused on the task at hand rather than on the women as recipients of care. Women felt that nurses were not approachable to ask questions.

No, the nurse . . . walks in . . . does the stuff runs out . . . that's all . . . the nurse didn't seem very approachable - at my obstetrician's clinic, . . . , but then whatever questions I had I would save it and just talk to my doctor . . . .

Women felt that nurses were capable of doing more than just the basic tasks, such as taking vital signs, weight, and checking urine samples for the doctor. Rani stated, "she (nurse) just weighs, takes urine sample, checks blood pressure and that's it". Women reported that nurses lack the ability to make decisions when consulted for explanation as they would always have to first consult doctors as Faiza stated ". . . nurses' will always

say, oh we can't answer you, we have to ask the doctor. So they (nurses) should have more power to answer and take decisions". One woman spoke favourably of the nurse's role,

Mariam: nurses, they can help a lot. Yeah if they explain things, like see, this is . . . your first time and in this first three months you can experience nausea, vomiting, or . . . you can have a pain in your lower abdomen. So if you feel these kinds of things, these are normal with your pregnancy, these are hormonal changes . . . I think they can help a lot. If I am feeling . . . uncomfortable with all these things, she would know why these things are happening to me . . . instead of going to the doctor for small things, if a nurse explains then I would know.

Respecting health-related cultural and religious beliefs and practices by health care providers was reported by women as essential. Almost all women preferred a female health provider throughout their pregnancy and delivery as they felt more comfortable and also the provider would be able to relate to the changes happening during pregnancy compared to male providers who would not be able to understand what the women were feeling.

Gita: well you just feel more comfortable, and you feel that the person can answer some of your questions better . . . like towards the end of my pregnancy is where I get really bad pain in my ribs, . . . you just feel that the female doctor can maybe relate to it and she understands what you mean, whereas the male doctor cannot, . . . I mean he has heard about it but he just doesn't know what I mean by it.

Some women (n=5) reported that they were told that female provider might not be available during delivery time as the doctor on call would attend to their needs. One

woman in particular commented how health systems in two provinces can be different as one is more flexible to meet the diverse needs of all women compared to the other where there are rigid policies. Heena's comments,

In Winnipeg, it was clearly identified in my chart that no male doctors are to deliver me. When I was in labour my doctor was called and she came to conduct my delivery. In Ottawa, the services are not good, because I was not given the option. They clearly told me that whoever is on call will deliver the baby. I prefer a lady doctor, but didn't get one.

As Heena went on to say, it was important that the system was respectful and sensitive of diverse women's wishes. "In Winnipeg, staff in the hospital was so sensitive about my needs that even a male cleaner would not enter my room for cleaning, because I preferred only females". Respecting and listening to women's preferences as well as positive experiences contribute to a sense that the health care system was there for them as South Asian women.

***Valuing and respecting my time.***

The notion of 'time' was mentioned on many occasions by all women. Women reported that they were frustrated at the amount of time they had to wait for a consultation during a prenatal visit and the amount of time a health care provider would spend with the women. Frequently, they had to wait one to two hours before they were able to see their health providers. Finally, when the women were called upon to see the doctor, they were asked again to wait in the examination room for another fifteen to twenty minutes. Women felt that the health care providers did not value and respect the difficulties they encountered during prenatal checkups. Despite the constraints, such as

chaotic lifestyles of managing other children, the health care providers failed to recognize women's efforts in utilizing prenatal health services.

One of the most troubling findings was that one of the women did not seek prenatal health services early during her pregnancy, because she perceived the services to be more of a burden than a benefit. In the past, she had faced a practitioner who did not demonstrate interest of taking the time to listen. As a result, the trusting relationship was not built between the health care provider and herself. Her experience had a detrimental effect that hindered subsequent use of health services. As a result, she was not willing to consult medical advice early during pregnancy.

I didn't go to see the doctor until I was seven months pregnant, because my experience with the doctor in the past had been not good. I hate to wait to see a doctor for prenatal appointment. Doctor says everything is normal. I wait for my appointment for one to two hours and finally when I am called inside I have to wait again in the exam room for at least fifteen to thirty minutes. Meanwhile, my other three children are home waiting for me.

Women expressed their frustrations not only about long waiting times, but also about the quality of service they received from doctors. After waiting for two or three hours, women expected to spend enough time with the doctors so that all their concerns could be voiced. Instead, women commented negatively about the limited time spent with the doctor and other health care providers, such as nurses. South Asian women felt that the health providers focused more on getting the basic task done rather than providing individual care, such as education.

Heena: She (doctor) would spend five-ten minutes – checking baby’s heart beat, movement, and if I have any questions . . . then she would say everything is fine - the position of the baby in the uterus, heartbeat, and movement of the baby. The doctor did not educate me about the process of baby’s growth happening every month.

Most women assumed that their health providers were too busy to spend time with them. A few women perceived that since there were so many pregnant women waiting to be seen, the women should not ask too many questions and felt guilty for consuming too much of the doctor’s time. As a result, the women’s pregnancy needs were jeopardized as they could not advocate for themselves. Sophie, one of the women, felt that it was important for the health care providers to spend time with them to understand their pregnancy needs as new immigrants to build a supportive working relationship between the health care provider and them;

Because they have limited time, so many patients waiting outside and I can see and imagine their jobs, but if a new mother comes to the doctor and she is new to the country who doesn’t know anything . . . then I think it is important for the doctor to educate her.

### ***Racism.***

Almost all women strongly expressed that as South Asian women they were given different treatment compared to other Canadian women during different encounters with health care providers and administrative staff at the clinic. Perceived rudeness was experienced in interactions with doctors. As Nazia shared her experience, “She was quite rude. I don’t know why, maybe she was racist . . . But this was my experience with her.

She didn't explain anything to me and . . . when you come to a new country where there are new people around you, you feel shy a bit".

Women not only had issues with their health providers, but they were also ignored by clinic administrative staff because they did not speak English well. Negative attitudes from the staff got worse when a language barrier was encountered, resulting in women feeling too anxious to ask more questions. As one participant shared her negative experience with the clinic staff,

Zumi: Generally everyone is good here, but some of them are rude. Like once, I went to the clinic and handed my ultrasound paper to the lady at the counter, who kept it on her desk, and didn't put it forward. The patients that came in after me were being attended first and I asked her that I gave you my paper for ultrasound you didn't forward the paper and she didn't reply . . . . Another lady who was there waiting asked me as to why I was still waiting considering four to six clients who came after me had already left and I was still waiting. I told her that she (receptionist) didn't forward my paper and wasted my time. This is what had happened one day and . . . she shouldn't have done like this . . . She has to be nice to everyone . . . the second time I had gone to the same place, the receptionist was behaving in the same manner with someone else . . . I don't know maybe she (the person) was a South Asian or another race . . . Maybe it's her habit . . . but she needs to be nice.

Women perceived that their providers spent less time with them compared to other women in the clinics as the physicians always appeared to be in a hurry. There was a perceived lack of attention and difference in care received by the South Asian women

compared to the mainstream Canadian women. South Asian women observed that Canadian women would spend more time with providers when called in the examination rooms. As Masuma addressed,

I felt that there was a difference of care provided to immigrants and Canadians. I don't like to say this, but there was discrimination as Canadian pregnant women spent more time in the room. Perhaps the doctor gives them more information and with me the doctor would only spend two to three minutes. That's why I hate to go to the doctor.

### **Conclusion**

In this chapter, five themes with related sub-themes were presented. South Asian women shared both positive and negative experiences encountered during pregnancy. All the themes and sub-themes highlight pregnancy needs and experiences of utilizing prenatal services. These findings are discussed further in the following chapter. They will be contrasted and compared with the available literature. In addition, the connection between nursing and the promotion of health equity is explored with respect to the factors, such as gender, ethnicity, and racism that hinders South Asian women to access and use prenatal health services.

## **Chapter Five – Discussion and Recommendations**

The chapter compares the study results to the currently available literature. Both the similarities and the differences between what was discovered in this study and the currently available literature are explored. South Asian women's experiences were similar to those of other immigrant women although some variation was noted. The chapter ends with implications and recommendations for: nursing education; nursing practice, primary health care, public health; and clinical nurse specialist and advanced practice nurses. Finally, the study's limitations, strengths, and topics for future research are stated.

The study discussion is presented below using three main arguments: a need for health equity (equality and fairness) in the delivery of PPHS, the importance of social support, and nurses' roles in reality versus vision.

### **A Need for Health Equity (Equality and Fairness) in the Delivery of PPHS**

Health equity refers to fairness in accessing health care regardless of one's race, gender, nationality, ethnicity, language skills, socioeconomic status, age, religion, immigration status, and health status (Whitehead & Dahlgren, 2006; Graham, 2004). Access to health care is considered a basic value in the Canadian society as highlighted in the Canada Health Act. However, health services are sometimes inappropriate, unacceptable, and thus inaccessible to immigrant women. Despite the attention drawn by social scientists, challenging interactions continue to exist between bio-medically informed health care institutions, staff, and ethnic minorities (Spitzer, 2004). To ensure that health care is offered with equitable access, policy-makers and health professionals must accommodate the needs of immigrants.

Prenatal care is essential in facilitating a safe pregnancy. “Women of colour are less likely to go into pregnancy in good health because of lack of access to primary health care services” (Amnesty International, 2010, p. 19). Insufficient access to quality health care services increases women’s chances of entering pregnancy with untreated health conditions, risking both mother and unborn child. South Asian women in this study lacked knowledge of how to acquire access to primary prenatal health services early in their pregnancy and had to wait until their second trimesters. Women received insufficient prenatal care that could have repercussions for their health considering that early access to prenatal care has the potential to prevent maternal morbidity. Maternal health is a human rights issue regardless of women’s background (Amnesty International).

Studies have found several pragmatic issues that constrain immigrants from accessing and continuing to use health services. These constraints include, but are not limited to, language barriers, cultural and religious barriers, poor patient-provider communication, negative attitudes of providers, lack of client-centredness, and systemic barriers, such as racism and discrimination (Reitmanova & Gustafson, 2008 ; Spitzer, 2004; Sword, 2003). These issues are consistent with the difficulties described by the South Asian women in this study. The findings in this study indicate that racism and discrimination act not only as barriers to access but also as obstacles to establishing supportive relationships with health providers. Further, the study findings suggest, from the perception of participants, that racism and discrimination impact one’s mental health by leading to further isolation, stress, anger, and depression.

The findings of this study indicate that South Asian women lack professional support from health care providers. Health care providers have the potential to serve, in many ways, as part of South Asian women's system of support. Establishing a working and supportive relationship between the health care provider and the individual South Asian woman was found to be a process that required trust and cultural competence. This finding resonates with Wheatley et al.'s (2008) study reporting that effective communication between provider and client is essential for a good working relationship. They suggested that explaining information, showing respect, and spending enough time are vital patient-centredness markers to delivery of quality health care. Failure to provide these can cause distrust in health providers and emotional distress for clients. Trust in the provider relationship, as indicated by effective communication and continuity of care, has been shown to influence adherence among minorities (Armstrong, Ravenell, McMurphy, & Putt, 2007). Not establishing a working and supportive relationship with health providers leads to experiences of alienation within the health care system that hinders health care access and continuity of care. On the other hand, establishing a supportive working relationship with a health provider facilitates maintaining health as it increases acceptability and accessibility of the services offered. Experiences such as racism and discrimination decrease the relative accessibility of health care services. Several researchers have found health care services to be inaccessible to immigrants within Canada (Grewal et al., 2008; Reitmanova & Gustafson, 2008; Marmot, 2003; Spitzer, 2004; Sutherns & Bourgeault, 2008; Sword, 2003;).

To examine one of the findings in this study we must define discrimination in the context of health care. Discrimination occurs indirectly and systemically. Indirect

discrimination occurs when “exactly the same services are provided to everybody (so that they appear fair) but when for cultural, religious, linguistic or other reasons it is not possible for members of one or more black and minority ethnic groups to benefit equally from them” (Henley & Schott, 1999, p. 47). As mentioned in the results section, one of the women reported that she felt that she was treated differently by the health care providers than Canadian pregnant women.

Racism, on the other hand, indicates the use of power that denies people access based on gender, age, or racial category (McGibbon & Etowa, 2009). Both systemic and individual racism were experienced by the South Asian women when accessing and using prenatal health services. One of the women shared her experience of individual racism when she felt that the health care provider was rude and did not provide information nor address her pregnancy related concerns.

Addressing discrimination and racism in the health system is vital so that health services are accessible to everyone regardless of their ethnicity, culture, gender, or socio-economic status (Drevdahl, Canales, & Dorcy, 2008). The authors argue that cultural competence is helpful, but it may not eliminate the actual problems experienced by individuals, families, or communities. To understand the actual problem, health care providers need to understand the family structure of South Asian women and social barriers that impact health outcomes. Nurses, as health care providers, have the potential to address some of these issues since they are the first point of contact for immigrants trying to access Canadian health care services. Nurses and health care providers need to understand how racism interrelates with other social determinants of health and this requires an anti-racist approach (McGibbon & Etowa, 2009).

Discrimination strongly influences a woman's chances of being healthy; immigrant women experiencing discrimination are less likely to have access to adequate prenatal health services (Amnesty International, 2010). South Asian women in the study perceived discrimination and racism from the health care providers and staff when there was a language barrier, such as lack of fluency in English. Women found it difficult to express their health concerns or ask questions pertaining to their pregnancy. Although some of the women's husbands were supportive in interpreting for health care providers when necessary, it was difficult for those husbands who also had difficulty with the English language. Access to language services raises the question of whether the client has equal access to health care; language access becomes a matter of equity. Negative attitudes, ethnicity, language, racism, and discrimination all contribute to denial of equitable access to services (Weerasinghe & Williams, 2002). Despite Canada's emphasis on multiculturalism, which focuses on equity across ethnic, linguistic, religious, and racial categories, there is a need to identify systemic racism in the health care system.

Health care providers, including nurses, must reflect critically on the assumptions they make about clients and consider how their actions might contribute to marginalizing discourses and practices that contribute to health inequalities (Pauly, MacKinnon, & Varcoe, 2009). As Canam (2008) suggests, nurses need to acknowledge and articulate their clients' situations and resources to make services accessible to them. Lack of services in minority languages has been found repeatedly to be a barrier to access to health and social services. For example, language, cultural, and religious factors were identified by Muslim women as barriers to accessing necessary information (Reitmanova & Gustafson, 2008). In addition, Punjabi women identified a lack of prenatal classes

offered in their language and a lack of interpreters as their main difficulties in their use of prenatal health care services (Grewal et al., 2008). Reitmanova and Gustafson have argued that diversity responsive health care services potentially addresses immigrant women's needs and decreases health risks associated with inadequate care. Availability of language interpreters at the site of health care, such as the obstetrician's office, was one of the suggestions provided by a few South Asian women in this study.

Health care services could collaborate with community-based Indo-Canadian organizations to provide interpreters. For example, a network or group of South Asian women might volunteer or be paid as lay helpers to provide cost-effective interpretation services. This would positively contribute to these women's understanding of the health care system, because the interpreters understand the women's cultural and religious beliefs.

To ensure equity of health services, culturally sensitive delivery of prenatal health care is a necessity. As health care providers, nurses need to evaluate whether prenatal health services currently are delivered appropriately and according to the standards of practice. In general, women in this study were provided with insufficient information about pregnancy, having to seek out information on their own.

The women perceived a lack of communication relating to the provision of information from health providers. In this study, and consistent with other studies, women had to proactively ask questions that partially answered their concerns, but some health providers demonstrated communicating styles that left women feeling rushed (Raine, Cartwright, Richens, Mahamed, & Smith, 2009; Sword, 2003).

Since the majority of South Asian women accessed obstetricians' services, health care providers should take responsibility for ensuring that women are well-informed about community services and their benefits, including prenatal care resources.

Arrangement for health-related information pamphlets at clinics in the language spoken by the locally-served population is important. Innovative approaches, such as online resources designed by public health nurses and an inter-professional team, could be helpful in ensuring that South Asian women receive timely information. In addition, providing information via different media, such as advertising in South Asian newspapers or on multicultural television channels designed specifically for South Asian audiences potentially could increase awareness of prenatal services.

Prenatal classes are a resource that provide both pregnancy and health related information and networking opportunities. However, greater awareness of the classes is needed by health care providers and community agencies, including public health. Since language is one of the barriers to accessing services, offering classes in the language of choice would be beneficial. Involvement of ethnic women in developing prenatal classes is important to ensure that cultural and religious beliefs are incorporated. Involving South Asian women in the process will allow women to share their suggestions and be part of the community. The women expressed that prenatal classes need to be less structured and should include time for sharing ideas and experiences. Pregnancy circle is a program offered by Ottawa Public Health Department for women who are thinking of pregnancy and for pregnant women and their partners. The objective of the pregnancy circle is to meet other pregnant women and find information pertaining to pregnancy, birth, and postpartum including breastfeeding (Carlington Community Health and Resource Centre,

2010). Since South Asian women are accustomed to learn from other women's experiences, perhaps public health could design a pregnancy circle class specifically for South Asian women.

Immigrants have not only different pregnancy needs, expectations, and resources but also different residential locations that may affect their geographic access to prenatal care. McLafferty and Grady's (2005) study found that South Asian women had a high need for prenatal care services, but poor geographic access. The study demonstrated that not having resources available in the neighbourhood can have a negative impact on the use of prenatal services by South Asian women. Geographic access includes distance, transportation, and mobility factors that influence women's ability to use services when and where they need them. Some of the women who participated in the study lived in areas where no community health centres were located; thus, they could not take advantage of prenatal services.

### **Importance of Social Support**

The most significant finding in this study was husbands' participation in providing physical and emotional support to women during the prenatal period. All husbands were willing to take on active roles in performing domestic household chores and providing care even though South Asian men are not accustomed to supporting their pregnant wives this way. The support provided by husbands was important since some women had no extended family living in the country or in the same city. As a result, the social network zone for these women in Canada changed to reflect husbands' new role of taking interest in their wives' pregnancy. A social network zone depicts layers of relationships that women can mobilize for support. Similar findings have been reported in a previous study done on pregnant Punjabi South Asian women (Grewal et. al., 2008).

According to Gottlieb (1983), there are different levels of social network zones depending on the individuals and their family structure. South Asian women's social relationships in their home countries and thus their social zone networks might differ compared to when they immigrate to a foreign country. As previously discussed, pregnant South Asian women when in their home countries tend to rely more on other women in the community for support than on their husbands.

Husbands can play a role in ensuring that ethnic women's needs are voiced appropriately and care is accessible to them. Husbands can no longer be an observer to care, particularly for South Asian women who lack other social support in a foreign country. Therefore, emphasizing the inclusion of husbands in development of prenatal care services may have many benefits, such as delivery of family-centred health care. These findings support previous research recommending that husbands should be included in prenatal care plans and in the delivery of health care services (Milligan et al., 2002).

Regardless of the number of years they had been living in Canada, all the women expressed the need to have family, friends, or women from the same background provide support and help during pregnancy. The experience of separation during migration can have an indirect impact on immigrant women's health. The majority of women's families and social support networks were not available causing women to experience stress and anxiety and loneliness since they were not aware of what to expect or the changes that were happening during pregnancy. This is extremely difficult for South Asian women since their main source of support is other women (Assanand et al., 2005).

The stress of the challenges experienced by immigrants in a foreign country can also have a negative effect on the mother's and unborn child's health. Some of the challenges are "language, navigating the system, social isolation, emotional loneliness, and communication" (Stewart, 2005, p. 1). These findings support previous research revealing that lack of social support can increase stress in pregnant women especially their perceptions about self which can have a negative impact on their self-esteem (Morrow, Smith, Lai, & Jaswal, 2008; Sword, 2003). Lack of social support can also increase women's chances of having depressive symptoms which can result in post partum depression (Whitley et al., 2006). Immigrant women can be at higher risk of developing depression, because they are culturally and physically separated from their support networks (Grace, Wallington, Stewart & Robertson, 2006).

The findings further highlighted the importance of family, friends, and others in supporting South Asian women's perceptions of the importance of physical and emotional health. Women from the same background provided support and assistance to the pregnant women, because they understood pregnant South Asian women's cultural and religious beliefs. Women were able to understand pregnant South Asian women's lack of family support; therefore, they were willing to offer help in doing household chores and at times prepare traditional meals that the pregnant women desired. Families and friends are useful resources in providing moral support as well as provide pregnancy information to pregnant women.

### **Nurses' Roles in Reality Versus Vision**

Women's health during pregnancy and after delivery can have a marked effect on the child's healthy development and on the woman's health and experience of motherhood (Heaman, 2009). Therefore, health care providers play an important role in

making sure pregnant women are receiving the care they need. In the study, most of the women were not satisfied with the care received from the health care providers, including nurses. Primary care nurses failed to establish a therapeutic bond with the pregnant South Asian women. As a result, the women did not feel the nurses could help them with their needs. Nurses were limited in fulfilling their roles as they focused on routine tasks, such as taking vital signs, height, weight, and checking urine samples, more than on providing educational and professional support. In reality, nurses' job expectations are limited to providing brief episodic meetings with pregnant women lasting from 5-10 minutes. One woman in the study shared her vision of how nurses could provide support and information to pregnant women on changes occurring during pregnancy so that they do not need to consult the doctor unnecessarily.

Current health care and nursing services direct nurses to focus on treatments and to adhere to institutional hierarchal policies and procedures rather than spend time to develop a relational bond with clients (Pauly et al., 2009). The rigid hierarchical structures of organizations, including the health care system limits nurses' roles (Timmermans, Bowker, & Star, 1998). Spending time with clients to develop a relational bond is controversial; the existing biomedical approach does not agree that "laying hands on patients is nursing" (Timmermans et al., p. 215). The notion rests on the fact that time is important and that nurses need to focus on required clinical tasks. Nurses have to budget their time with clients carefully to reduce stress that can engender difficulties completing their interventions.

Immigrant women with language barriers and cultural challenges are often regarded as time-consuming clients (Spitzer, 2004). Despite the institutional influences

that shape nurses' practices, nurses need to resist them and advocate for health promotion and recognition of social inequalities of groups experiencing institutional racism in the health care system. The practice of hierarchical structures disempowering nurses has been recognized by nursing organizations, some of which are politically advocating for change in nursing practice. Certainly, nurses have been advocating for their profession, but there is a need to increase awareness and collaboration between and within different organizations to achieve this goal. Nurses are in a better position to, and have the potential to, advocate for their clients, as well as their professional roles, to ensure health equity (Pauly et al., 2009).

Good (1994) argues that biomedical thinking separates medical conditions and social issues. He adds that health professionals learn to incorporate the values of biomedicine through professional training in which they separate the human body from its social context. The structures of power are implanted in health professionals through the transmission of values, beliefs, and ideas that promote authority and control over those seeking health care. To provide holistic care to South Asian pregnant women, it is important to identify the social conditions of these women that hinder their access to and use of prenatal services. By doing so, we will be able to address health inequalities. It is imperative for nurses to recognize that a person's social location may affect their ability to follow health care advice. Nurses are in a good position to understand and explore health resources available to women in the community. Nurses need to be aware that they have the responsibility and capacity to advocate with and for their clients who are vulnerable in order for them to access and use services. Nurses can help their clients to

discover and use their strengths to improve their quality of life, instead of, as Canam (2008) argues, only delivering routine tasks, indirectly increasing health inequalities.

The study findings revealed that South Asian women were not aware of community resources, such as Community Health Centres, doula services, prenatal classes, prenatal groups or workshops, and drop-in centres. These services could help ethnic women to engage in preventive services and to network with other women for social support, a goal encouraged by *Family-Centred Maternity and Newborn Care: National Guidelines* (Health Canada, 2000).

Health care professionals are knowledgeable and experienced, but there is much about women's circumstances of which health professionals are not aware that can have a considerable impact on women's health (Carver, Ward, & Talbot, 2008). Primary care nurses are the first point of contact with women using health care services and should use this key opportunity to enhance women's health to provide resources and information. The majority of women in the study were not aware of midwifery services available when planning for childbirth. A few learned of it through friends after delivery of their children. Both primary care nurses and public health nurses have a responsibility to provide information to women about choices of care providers including midwives, family doctors, and obstetricians and about community resources.

Furthermore, some South Asian women proclaimed that nurses lacked awareness and respect of their cultural and religious beliefs, having an impact on the client-nurse relationship. For example, one of the South Asian women in the study was forced to remove a religious thread worn on her wrist prior to her caesarean section. Despite the woman's effort to explain that it was worn to protect her and the baby during surgery, the

nurse did not make an exception for her and cut the religious thread. In addition, the nurses refused to allow the woman's family to give honey to the baby when it was born. Giving honey to newborns is a cultural ritual practised by South Asian women. During the data collection of this study, the woman suggested that nurses need to be respectful of client's wishes and to increase their understanding of different cultural and religious practices for prenatal and newborn health.

To address the cultural dimensions of health care at the organizational level organizations could incorporate new literature and find strategies to increase staff's awareness of diverse women's cultural and religious beliefs. For example, The Best Start: Ontario's Maternal Newborn and Early Child Development (2009) agency has developed a practical guide for service providers working with diverse women, *Giving birth in a new land: Strategies for service providers working with newcomers*. Organizations can provide professional support by offering workshops and in-services at work places for staff to become familiar with this guide to aid in implementing successful strategies for improved service delivery.

Unequal power relationships between health professionals and women may hinder communication of a woman's needs (Stapleton, Kirkham, Curtis, & Thomas, 2002). In addressing women's pregnancy needs, it is important that health professionals be aware of the social circumstances that contribute to poor usage of health services. From the study findings, South Asian women did not use community resources that would have been beneficial for them due to lack of awareness of services. In addition, social circumstances, such as language, culture, religion, and family support were barriers to accessing and using services. Addressing health needs of clients is an important

responsibility; finding ways to articulate inequalities in the conditions that affect health is an important part of nurses' work (Pauly et al., 2009). It is important for nurses to understand that the process of integrating into a new country takes time and to be mindful that recent immigrants may experience language difficulties that hinder their ability to interact socially and to develop and build social networks (Vissandjee et al., 2007).

Understanding of cultures and diversity is vital and an important practice of maintaining cultural humility (Racher & Annis, 2007). Minkler (2005) pointed out that cultural humility is a commitment to address power imbalances to develop respect and understanding of others. Although health care providers can never become truly competent in another's culture, making an effort to recognize the differences, openness to learning, and demonstrating humility to others can be effective ways to work with ethnic populations. Language is a key tool used to express personal perceptions and helps to shape interactions with the other; hence, use of this tool can be beneficial to help new immigrants integrate and use services which are designed for them. Ignoring barriers to accessing and using maternity services has a negative impact on women's health (Reitmanova & Gustafson, 2008).

In summary, an anti-racism approach was used to explore South Asian women's pregnancy needs and experiences using prenatal health services. The goal was to understand and analyze through the lens of the women how the social factors of gender, ethnicity, and racism influence prenatal health care experiences. An anti-racist framework was a suitable theoretical approach that helped in examining how women of colour experience racism in the current Canadian health care system, revealing the challenges that they have experienced. Gender and ethnicity were fixed criteria for inclusion in this

study which included only South Asian women as participants. The difficulties consistently encountered by most of these women support that there exists a pre-conceived assumption, at the institutional level, that treats non-white clients differently from the dominant cultures. An anti-racist model has the potential to increase our knowledge about what is meaningful from these pregnant women's perspectives and thus inform and lead to improvements in nursing practice. Organizational policies and procedures need to be informed by client's experiences and further attention is clearly needed in order to provide culturally attuned care. In addition, consistently using an anti-racism approach across many health care organizations and services will ultimately contribute to the improvement of health equity for many Canadians.

### **Conclusion**

The study findings have been discussed with respect to currently available literature in the context of the study of South Asian women's pregnancy needs and utilization of prenatal health services. The three main issues are: a need for health equity; the importance of social support; and the nurses' role. In voicing the challenges of pregnant South Asian women in accessing and using prenatal health services, this study has the potential to contribute to improving health equity in accessing and using prenatal health services.

The most important lesson learned from this research study is that the utilization of prenatal health services must be viewed in the cultural context of women's lives. Prenatal care is an aspect of pregnancy that South Asian women valorise, which is embedded in their cultural norms. According to the constructive view, culture is not perceived as static, fixed, or homogeneous. In other words, the meaning of culture was constructed by the women in the study based on their specific context which is neither

necessarily applicable nor generalizable to other immigrant women. Difficulties in communication dynamics continue to exist between South Asian women and their health care providers reflecting a need to enhance mutual understanding, respect, and humanistic care.

### **Implications and Recommendations**

#### **Nursing education.**

This section explores the implications of this research for nursing education by examining curriculum content for students in the university baccalaureate program. The results of this study provide an empirical example of South Asian women's pregnancy needs and utilization of prenatal care services. The study further outlines barriers that exist between the South Asian women and health care providers. This section will explore how nursing education can help student nurses become aware of issues encountered by ethnic women and how these issues can be acknowledged within nursing programs.

Future nurses need to be able to practice competently and compassionately with an understanding of their role in alleviating health and social inequalities. The increasing number of South Asian immigrants settling in Canada adds a professional responsibility for nurses to acquire the knowledge needed to understand their cultures, beliefs, and practices. Such understanding potentially will strengthen relationships between South Asian women and nurses which play a vital role in access to health services and reduction in health inequity. One of the strategies to improve quality of service delivery of prenatal health care to ethnic women is to develop cultural competence skills (Etowa & Adongo, 2007).

The Registered Nurses Association of Ontario's (RNAO) (2007) *Embracing Cultural Diversity in Health Care: Developing Cultural Competence Best Practice Guidelines* recommend including and supporting cultural competence in curriculum so that nursing students can understand their professional responsibilities towards their colleagues and clients. There is a need for nursing programs to instil in students an understanding of the value of diverse cultures, a potentially large work force to build a stronger society. It is also vital to include sensitive topics, such as discrimination and racism, in the nursing curriculum to build nurses' capacity and knowledge of health equity in the hope of minimizing behaviours and attitudes that lead to racist acts. The use of cultural competence skills taught in the nursing program would enable future nurses to work effectively across cultures and to address health disparities among racial and cultural categories (Etowa & Adongo, 2007).

Another strategy that needs to be instilled in nursing education is cultural safety. Cultural safety is a framework that may guide nursing in addressing power dynamics that exist between health care providers and clients (College of Registered Nurses of Nova Scotia, 2006). Cultural safety goes beyond the skills and attitudes of health care professionals on which cultural competence focuses. Rather, cultural safety invites nurses to self-reflect on their own cultural identity and its impact in their everyday practice (College of Registered Nurses of Nova Scotia). Cultural safety enables nurses to address inequities by acknowledging issues of racism and discrimination, social contexts of care, and to understand what is considered to be culturally safe care as determined by the one receiving care (McGibbon & Etowa, 2009). Nursing students who are taught the concept

of culturally safe care would be in a position to reduce barriers to active participation in achieving health equity for ethnic populations.

A teaching methodology that might work well is the use of in-depth case studies. The students will be assisted to see pregnancy, health care needs and experiences accessing services through the eyes of a South Asian woman and her family. Most importantly, including case scenarios in program curriculum will help students become acquainted with material that will broaden their knowledge to provide culturally sensitive care to ethnic women seeking prenatal services.

### **Nursing practice, primary health care, and public health.**

The study findings encourage nurses and health care providers to involve South Asian pregnant women's husbands in a prenatal care plan. In other cultures, it might be typical for husbands to be involved in their wives' prenatal care, but it is unusual in South Asian cultures. However, the South Asian husbands are taking an interest in their wives' pregnancy by supporting them in a foreign country. It is important for nurses to ensure that husbands are included in the care plan since this is a fairly new role for them. Hence, nurses need to provide pregnant women, as well as husbands, information pertaining to pregnancy. For example, primary care nurses can make resources available for the couple, such as location of the closest prenatal classes in the community, information about pregnancy-related programs, and community networks, particularly South Asian, to help the couple connect to people of the same background.

In addition, the results of the present study support the idea that nurses need to apply a holistic approach in their practice, to expand further the boundaries of health and the factors that determine it. By implementing a holistic approach, a provider will be able to move beyond the biomedical approach and understand the whole human being. A

holistic health approach supports the idea that mind and body are not separate entities. Nurses will acquire the knowledge that will provide them with the best and adequate strategies to deal with South Asian women. Primary care nurses have the potential to take on the key role of providing education for pregnant women, moving beyond their everyday practices of providing technical care, to offer more comprehensive prenatal education, including educating women about nutrition, exercise, and mental health. For a nurse to assess the health needs of the women early in pregnancy and make appropriate referrals to community resources, including diverse ethnic organizations, would be one way to utilize nurses' time more effectively. Referral information should be available in different languages and include potential services and opportunities available in the community.

One of the nurse's key roles is to provide health education for clients and families. If a nurse perceives that language is a barrier for clients to receive health services then the nurse could intervene and provide information about interpreter services available to them in the community for future primary health care visits. Nurses advocate for their clients and families, and they have a professional responsibility to engage clients in self-advocacy, leading to women's empowerment.

Nurses working in public health need to increase their awareness of other services in the community and publicize them. Public health nurses could, for example, make sure that program pamphlets are distributed to health care providers, such as obstetricians, family physicians, and midwives so that the providers can promote public health services personally to their clients. For example, if the provider assesses a pregnant woman and finds out that she is a new immigrant with a language barrier and a lack of social support

then the provider could give specific agency program pamphlets to the mother and advise her of the benefits of the services described. In doing so, the pregnant woman's sense of belonging will increase as she will feel that the provider cares and wants her to use the service increasing the possibility that the woman will do so. Therefore, it is extremely important for providers to personally advertise the program rather than having the pamphlets in the waiting area expecting the woman to take them. It is also important to ensure that information is available in different languages, especially those most commonly spoken by South Asian women.

Another promising strategy that public health nurses can lead is to create an online resource site, whereby both Canadian and ethnic women can access information on pregnancy. The online resource may include information on prenatal classes, midwifery services, doula services, and community network groups. The website should also be accessible in different languages and include information brochures, so that women with language barriers do not feel isolated. Chat forums specific to ethnic women, such as South Asian, may be included so that women can network with other women and create their own community network circle. Information documents should also be available for South Asian husbands so that they can learn how to best help their pregnant wives. Perhaps a chat forum dedicated entirely for husbands could be useful to connect to other South Asian men in the community and also identify credible sites for the men to access.

Furthermore, government departments and agencies, such as Health Canada and Public Health Agency of Canada, could make their information websites more accessible, by advertising them either through television, newspapers, doctors' offices, hospitals, and

non-government organizations, including community associations, to promote healthy pregnancy as well as familiarize pregnancy health seekers with available services. The women in the study used other websites, such as babycenter.ca to keep informed of the progress of their pregnancy. Instead, if they were aware of the Canadian government health related websites then they could have become familiar with pregnancy guidelines recommended in Canada. Women received weekly updates on their baby's development and growth from babycenter.ca when they signed up in the website. Perhaps, the government websites, including public health can include such special features so that pregnant women in general can receive the information weekly as they desire.

#### **Clinical nurse specialist and advanced practice nurse.**

Nurses in clinical nurse specialist and advanced practice roles can use the findings of this study to better understand the pregnancy needs of South Asian women. Further, the study results encourage nurses to consider the context in which a client lives; taking time to find out what is important, and including husbands in the care plan. Nurses can facilitate the provision of decision support within the roles of educator and consultant. Through the leadership and research role, advanced practice nurses can facilitate and advocate for future research that can improve delivery of health services and decrease health inequity gaps for diverse groups of women. The study holds implications for advanced practice nurses in their roles as collaborators to increase cooperation and communication across community organizations. Given the study findings, the advanced practice nurse can serve as an advocate and a leader in bringing changes that can improve access to and use of health care services. Nurses can work intersectorially with government to promote policies and programs for diverse populations depending on their needs.

### **Study Limitations**

The study had several limitations. The findings from this study reflect the views of South Asian women most of whom have lived in Canada for more than five years. Only a few women were considered new immigrants. The experiences encountered by new immigrants may be different from those who have lived in the country for many years. Despite the fact that nearly all the women were well-educated, had high income levels, and used obstetricians' services, they had no information about other community resources including options of care. Women with language barriers experienced more challenges accessing and using prenatal health services. Women's experience of services provided by other providers, such as family doctors, nurse practitioners, and midwives may differ. Therefore, these experiences can not be transferred to how women would have used other services. Coming from the same cultural background there may be bias in my reflections as a researcher that may have had an impact on the interpretation of the data.

### **Study Strengths**

The interviews were tape recorded and transcribed verbatim, then verified for accuracy to ensure rigor. The use of multiple languages in the interviews provided women with the opportunity to participate without feeling embarrassed. Since many of the participants had lived in Canada for more than five years, a strength for this study was that these women could look back to reflect upon and evaluate their experiences in accessing and using prenatal health services in the host country. With nursing knowledge, midwifery expertise, and South Asian cultural heritage, the study researcher was able to facilitate a healthy dialogue and discussion about the paradigm of South Asian cultures within the Canadian health care context with the thesis supervisor, who is a Canadian.

Women recruited to the study were comfortable in relating both positive and negative experiences in their home settings. The study's findings reveal the vision of active nursing roles rather than simply continuing the bio-medical approach of performing routine tasks.

### **Future Topics for Research**

Included in the findings of this study are some areas that lead to a need for further explication. This section will provide some ideas for future research. One, there is a need to explore further South Asian husbands' perspectives on the use of prenatal health services. This potential study can investigate how nurses can provide support to South Asian husbands, what resources they require for prenatal care, and what kind of information they are interested to find in an online resource website. The other area of investigation would be to design an intervention study to test the relevance and feasibility of interpreter services available for ethnic women when accessing and using services. Finally, since the South Asians were not aware of most community-based prenatal health services, a study is proposed to evaluate different media and social network campaigns through organizations, including Indo-Canadian, and women's groups, to promote the use of public health and community health and resource centres.

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## Appendix A: Ethics Approval Letter

File Number: 10-0235

Date (mm/dd/yyyy): 04/11/09

Université d'Ottawa / University of Ottawa  
 Services communautaires et de soutien / Community Support Services

### Ethics Approval Notice Health Sciences and Science REB

#### Principal Investigator / Supervisor / Co-Investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Bethia	Davies	Health Sciences - Nursing	Supervisor
Arshia	India	Health Sciences - Others	Student/Researcher

File Number: 10-0235

Type of Project: Masters thesis

Title: Prenatal Health Care: Exploring South Asian and Somali Women's Experiences

<u>Approval Date (mm dd/yyyy)</u>	<u>Expiry Date (mm dd/yyyy)</u>	<u>Approval Type</u>
04/11/09	04/30/2010	Ia

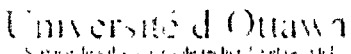
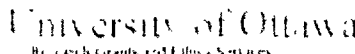
(Ia - Approval, Ib - Approval for initial stage only)

**Special Conditions / Comments**  
 N/A

1  
 Université d'Ottawa / University of Ottawa  
 Ottawa, K1N 6N5 / 45, rue des Sciences, Ottawa, Ontario K1N 6N5  
 (613) 563-5100 / (613) 563-5100 ext. 5100  
 http://www.uottawa.ca / http://www.uottawa.ca

File Number: 01-0135

Date (mm/dd/yyyy): 01/11/2009


  
 Université d'Ottawa / University of Ottawa  
 Service de la recherche / Office of Research Grants and Ethics Services

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed in the section above entitled "Special Conditions/Comments".

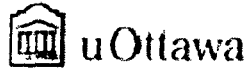
During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove subjects from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must promptly alert the REB of any change which increases the risk to participants, any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at <http://www.ices.uottawa.ca/ethics/application/dwn.asp>.

Please submit an annual status report to the Protocol Officer 4 weeks before the above referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at <http://www.ices.uottawa.ca/ethics/application/dwn.asp>.

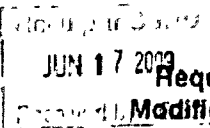
If you have any questions, please do not hesitate to contact the Ethics Office at extension 5831 or by e-mail at [ethics@uottawa.ca](mailto:ethics@uottawa.ca).

Pierre Ndoundou  
 Protocol Officer for Ethics in Research  
 For Dr Daniel Lagace, Chair of the Health Sciences and Sciences REB

## Appendix B: Modified Ethics Approval Letter



University of Ottawa Research Ethics Board

Request for REB Approval of  
Modification to Research Project

This form is to be submitted to seek approval of modifications to previously approved protocols. Revised procedures should not be used until approval has been received. Take note that certain changes may have to undergo minimal risk or full REB review.

REB File # **H02-09-13** Initial date of approval (mm dd yy) **04-21-09**

Title of the research project **Prenatal Health Care: Exploring South Asian and and Small women's experiences.**

NOTE: Advise the Protocol Officer of any changes to the study form letter by filling out section 2.

Name of Principal Investigator (or Supervisor) **Dr. Barbara Davies**

Faculty **Health Sciences**

Department/School **Nursing**

Phone 2: ext.

Fax

Name of Co-Investigator (or Student) **Rishma Latha**

Faculty **Health Sciences**

Department/School **Nursing**

Phone 2: ext.

Fax

Other Investigators: (Please state the names of all other co-investigators, students and or supervisors - If there are none)

Preferred language of correspondence:  French  English

NOTE: Answer all of the following questions.

1. Check the modifications you wish to make to the research project.

- |   |   |
|---|---|
| <input checked="" type="checkbox"/> Participant recruitment process       | <input type="checkbox"/> Data confidentiality / Security arrangements |
| <input type="checkbox"/> Participant sample / Subject population          | <input type="checkbox"/> Study and date                               |
| <input checked="" type="checkbox"/> Consent forms / Information sheets    | <input type="checkbox"/> Location of study                            |
| <input type="checkbox"/> Research instruments (e.g. questionnaires, etc.) | <input type="checkbox"/> Changes to research team                     |
| <input type="checkbox"/> Research design or methodology                   | <input type="checkbox"/> Other (Please specify)                       |

( ) If you checked any of the above, describe the nature of each modification requested and explain why the modification is necessary.

There are three minor modifications made in the REB application form. First, instead of South Asian (India and Pakistan) it will only indicate South Asian without specifying "from India and Pakistan". The reason being that any South Asian women can be included in the study regardless of their country of origin.

Following are the sections of REB application form which will reflect the changes.

Section B - Summary of the research protocol 6a, 6b, 6c, 7a, 7b, and 8a.

Section C - Risks and benefits of the proposed research 10e

Section D - The informed consent process 11e.

Second, the inclusion criteria which initially stated women "immigrated to Canada within the past five (5) years" is now changed to "immigrated to Canada within the past 10 (ten) years". The reason for increasing the number of years South Asian mothers have been living in Canada is that it was observed in the recruitment process that majority of the South Asian mothers have been residing in Canada for more than five years. Therefore by increasing the number of years I will be able to recruit mothers who are willing and interested to participate in the study.

Following is the section of REB application which reflect the changes.

Section B - Summary of the research proposal 8a.

Third, University of Ottawa's logo is added to the advertising poster because one of the Community Health and Resource Centers (CHRCs) requested to add the logo in the poster before advertising to reflect the study is

Revised in September 2005

study is supported and approved by the REB of University of Ottawa.  
 Please refer to the attached documents: advertisement poster, study information letter, and interview consent form with highlighted areas that indicate new changes.  
 Please submit in two copies all modified documents (e.g. questionnaire, consent form, etc.) and highlight the sections that are revised or added.

2. Have there been any unexpected problems or adverse events related to the participation of human beings in your project?  
 Yes  No  
 If you answered YES to this question, provide a description of the problems.

3. Modification to contact information. Changes are made in the following documents: 1. Advertisement poster - Three (3) changes have been made in the poster. First, one of the Community Health and Resource Centers requested to add University of Ottawa logo in the poster before advertising to reflect the study is supported and approved by the REB of University of Ottawa. Second, the poster states South Asian without specifying from India and Pakistan. Third, the statement "immigrated to Canada within the past five (5) years" is now changed to "immigrated to Canada within the past 10 (ten) years".  
 2. Study information letter for the women - Only one (1) change made to the letter - The purpose of the study indicates South Asian without specifying from India and Pakistan.  
 3. Interview consent form for the women - Two (2) changes made in the consent form. 1) The purpose of the study and inclusion criteria indicates South Asian without specifying from India and Pakistan. 2) The inclusion criteria is changed to "immigrated to Canada within the past 10 (ten) years".  
 Please refer to the attached documents with highlighted areas to reflect new changes.

I request ethics approval of the modifications / revisions described above. All modified documents and procedures are appended hereto for REB review and approval.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
 (Principal Investigator or Supervisor)

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
 (Student, if applicable)

**Print and mail to:**  
 Humanities and Social Sciences REB  
 Catherine Paquet  
 Protocol Officer for Ethics in Research  
 Research Grants and Ethics  
 Tabaret Hall  
 550 Cumberland, room 159  
 University of Ottawa  
 Ottawa, Ontario  
 K1N 6N5, Canada

Health Sciences and Science REB  
 Rita D'Alessandro  
 Protocol Officer for Ethics in Research  
 Research Grants and Ethics  
 Tabaret Hall  
 550 Cumberland, room 159  
 University of Ottawa  
 Ottawa, Ontario  
 K1N 6N5, Canada

**IMPORTANT:** Please submit your modified documents to me before the expiry of the modification below.

**For administrative use only** REB:  HSS  SSH

The modification(s) requested have been reviewed and approved.  
 This approval extends to \_\_\_\_\_ (expiry date).  
 Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
 (REB Chair or Protocol Officer)

SquirrelMail

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**Subject:** Ethics File No. H02-09-03 - "Prenatal Health Care: Exploration of South Asian and Somali women's experiences"

**From:** Gilles B. Morier"

**Date:** Tue, 29 July, 2009 4:47 pm

**To:** ...

**Priority:** Normal

**Options:** [View Full Header](#) | [View Printable Version](#) | [Download this as a file](#) | [Add to Addressbook](#)

Dear Dr. Devles and Ms. Latha,

Thank you for submitting the attached request for modification of the above-referenced ethics file. The following modifications have been approved by the Chair of the Research Ethics Board:

1. Participant recruitment process:
  - i) Change from 'India and Pakistan' to 'South Asia'
  - ii) Change inclusion criterion to 'immigrated to Canada within past 10 years'
  - iii) Add University of Ottawa logo to recruitment poster

These modifications are approved and covered by the extension of certification of ethics approval granted from April 21, 2009 to April 20, 2010.

Should you have any questions or comments, please do not hesitate to contact me.

Best regards,

Gilles Morier

-----

Gilles Morier

Director, Research Grants and Ethics

University of Ottawa

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https://webmail1.utorawa.ca/webmail/utorawa/sr/read\_body.php?m...

590 Cumberland Street, Room 159  
Ottawa, Ontario  
K1N 6A5

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**Attachments:**

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HG02-09-13 - Request for modif cas.07.10. 1.pdf	204 kb	[application/octet-stream]	Download

4

## Appendix C: Letter of Support from Coalition of Community Health and Resource Centres

COALITION DES CENTRES  
DE RESSOURCES ET DE SANTE  
COMMUNAUTAIRES D'OTTAWA



COALITION OF  
COMMUNITY HEALTH AND  
RESOURCE CENTRES OF OTTAWA

[www.coalitionottawa.ca](http://www.coalitionottawa.ca)

Carleton

March 24, 2009

Centre for Health

Research Grants and Ethics Board  
University of Ottawa  
550 Cumberland Street  
Ottawa, ON  
K1N 6N5

Carleton

Chaboussier

Dear Protocol Officer,

Centre for Health

On behalf of the Coalition of Community Health and Resource Centres of Ottawa, we are pleased to extend this letter of support for Rishma Ladha's master thesis titled "Prenatal Health Care: Exploring South Asian and Somali Women's Experiences." We have reviewed the research proposal and feel that Rishma's project will contribute our knowledge and understanding of diverse women's prenatal needs in order to provide culturally safe and responsive care.

University of Ottawa

Nepean, Rideau & Ottawa

We are willing to support Rishma's project by advertising study poster in community health and resources centres across Ottawa and by identifying selected staff who will inform women about the study and volunteer participation.

Ottawa, Ontario

Proctor, Ottawa

Subject to ethical clearance by the University of Ottawa, the Coalition will support the study design. We are confident that this study will produce tangible results that will be useful to health care in Canada.

St. Mary's Hospital

Please do not hesitate to contact us if further information is required.

St. Mary's Hospital

Sincerely,

South East Ottawa

Cathy Jordan, Co-Chair  
Coalition of Community Health  
Resource Centres of Ottawa

Copy to

cc: Rishma Ladha

Western Ottawa



## Appendix E: Study Information Letter For Women



# Université d'Ottawa - University of Ottawa

Faulté des sciences de la santé  
École des sciences Infirmières

Faculty of Health Sciences  
School of Nursing

### **Prenatal Health Care: Exploring South Asian and Somali Women's Experiences.**

You are being invited to participate in one-on-one interview directed by Rishma Ladha, RN from the University of Ottawa

#### **What the Study is about**

The purpose of this study is to explore South Asian and Somali postnatal mothers' experience of utilization of prenatal health care services during pregnancy. Mothers' experiences related to pregnancy and prenatal health care services will provide valuable information that will offer understanding of prenatal health needs of diverse women.

If you agree to take part in this study, you will participate in a 45 to 60 minutes interview and complete a demographic form.

#### **Your Rights Related to Participation in the Study**

There are no known risks to participation in this study. There are no direct benefits to you participating in this study. However, the information provided by you and other mothers may help agencies, such as public health and Community Health and Resource Centers to understand your prenatal health needs in order to provide culturally supportive care.

There is no obligation to participate in this study. You may choose to withdraw at any time, or choose not to answer any specific questions.

Your name will not be recorded with any information collected. A number will be assigned to all information collected.

Any tape-recording of conversations will be destroyed within 2 years. Written transcripts and documents related to the study will be kept in a locked cabinet in the research office of Dr. Barbara Davies at the Nursing Best Practice Research Unit (NBPRU) for a period of five years and then destroyed to protect your privacy.

For more information regarding this study, please contact Rishma Ladha. You may also reach my thesis supervisor Dr. Barbara Davies at the University of Ottawa, if you have any questions regarding rights of participation, you may contact the protocol officer for Ethics in Research

Thank you for cooperation

Rishma Ladha, Masters Candidate, University of Ottawa, School of Nursing

## Appendix F: Interview Consent Form for Women



# Université d'Ottawa - University of Ottawa

Faculté des sciences de la santé  
École des sciences infirmières

Faculty of Health Sciences  
School of Nursing

### **Prenatal Health Care: Exploring South Asian and Somali Women's Experiences.**

You are being invited to participate in one-on-one interview directed by Rishma Ladha, RN and a Masters Candidate from the University of Ottawa

#### **What the Study is about**

The purpose of this study is to explore South Asian and Somali postnatal mothers' experience of utilization of prenatal health care services during pregnancy. Mothers' experiences related to pregnancy and prenatal health care services will provide valuable information that will offer understanding of prenatal health needs of ethnic women.

#### **I am being invited to participate in this study because:**

- I am a woman from South Asia or Somali between the age of 20 and 40 years
- I speak English.
- I have given birth to a healthy baby between three (3) months to three (3) years in Canada
- I have immigrated to Canada within the past ten (10) years

Your participation in the study will take about 45 to 60 minutes in an individual interview. The interview will be held at your convenience. You can choose to conduct the interview in your home or in a private interview room located in the Nursing Best Practice Research Unit (NBPRU) at the University of Ottawa. I will ask you to answer a few questions about your age and background. It is important to remember that we are not evaluating you, so there is no right or wrong answer. We will not judge your responses and all the information that you give us will be confidential. The interview will be recorded and the researcher may take some notes.

#### **Benefits of this study:**

- Your answers will contribute to a better understanding of the prenatal health care needs of women of different cultures and how health care providers can best meet your prenatal needs.

#### **Potential Risks Involved:**

- The risks for this study are not higher than those lived in everyday life.
- I understand that by participating in this study I will be asked to give some personal information. I may feel uncomfortable answering some questions. I have a right to refuse to answer question(s).

**Confidentiality and Anonymity:**

- I understand that the information that I share will be used only for this study and it will be kept confidential.
- My name will not be written on any documents. A code will be used to track the documents.
- The list of names for tracking purposes will be kept in a separate file and in a secure locked cabinet in Room 1480 at the Nursing Best Practice Research Unit (NBPRU) at the University of Ottawa.
- The interview recording and transcripts will be saved in a locked filing cabinet in Room 1480 at the Nursing Best Practice Research Unit (NBPRU) for a period of five years and then destroyed to protect my privacy.
- The interview and transcript file will only be accessed by the researchers.
- I have a choice to either sign the consent form or give a verbal consent. Verbal consent will be recorded.
- Reports of this study will include quotes of what I said. However, the researchers will use a fake name instead of my real name and may change some details of my life so that I will not be personally recognized in any reports or public presentations about this study.

**Conservation of data:**

Completed demographic form, interview audio files, and transcripts will be stored in the Nursing Best Practice Research Unit (NBPRU) at the University of Ottawa. Only Dr. Barbara Davies and Rishma Ladha will have access to this information. These files will be kept for five years and then destroyed to protect my privacy.

**Compensation:**

I will be given a grocery gift card of \$20.00 (twenty dollars) as a token of appreciation for my time. Bus tickets and parking costs will be compensated if I decide to travel to the Nursing Best Practice Research Unit (NBPRU) private room for an interview. In any case if I do not wish to sign or give verbal consent, I will be given \$20.00 grocery gift card as a token of appreciation for my time and I will not proceed with the study. Any bus tickets and parking costs will be compensated.

**Voluntary Participation:**

- I do not have to participate in this study
- I can refuse to answer questions and stop the interview at any point
- I can withdraw from the study at any time; in this case the researchers will only use the information that I have given with my permission. If I do not wish the researchers to use this information, they will destroy or give it to me.
- I can ask questions regarding the study at any time.

**If you have further questions or concerns please contact:**

Rishma Ladha

Dr. Barbara Davies  
Nursing Best Practice Research Unit (NBPRU) Room 1480  
Faculty of Health Sciences, University of Ottawa  
451 Smyth Road

**If you have any questions about the ethical conduct of this study, please contact:**

Protocol Officer for Ethics in Research,  
550 Cumberland Street

I consent to the interview being audio taped: Yes  No

There are two copies of the consent form, one of which is mine to keep.

I, \_\_\_\_\_, voluntarily agree to participate  
in this study,  
(Print Participant's Name)

-----  
(Participant's Signature)

(Date)

\_\_\_\_\_  
(Researcher's Signature)

(Date)

### Appendix G: Interview Guide for Women

1. What does healthy pregnancy mean to you?
2. What are some of your pregnancy needs?
3. How did you take care of yourself during pregnancy?
4. What did others do to help you take care of yourself during pregnancy?
5. How did you learn about preparing for and taking care of yourself during pregnancy and childbirth?
6. If you had a baby in your home country, how did you prepare for that birth?
7. How did being pregnant here in Canada differ?
8. Thinking of your most recent pregnancy, did you use any community resources?

For example: Please reply yes or no

- a) Community Health and Resource Center
- b) Prenatal Classes
- c) Obstetrician services
- d) Family Doctors
- e) Midwife services
- f) Doula services
- g) Drop-in center
- h) Community houses
- i) Prenatal groups
- j) Prenatal workshops
- k) Other \_\_\_\_\_

9. How did you feel about using the above services?
10. Do you feel that the programs were helpful in giving you a better understanding of your pregnancy?
11. When using the prenatal health care services were there any challenges you experienced?
12. Do you feel that the health care providers, including nurses understood your cultural and/or religious practices?

13. How do you think health care providers, including nurses could help women like you from different cultures understand their pregnancy needs?
14. If we were to develop a prenatal class for you, what would you like to learn in that class?
15. Would you prefer the prenatal class to be a structured class or an open discussion class?
16. Do you have anything you would like to add?

**Appendix H: Demographic Questionnaire for Women**

Participant # \_\_\_\_\_

Questions about your age and background

1. What year were you born?

\_\_\_\_\_

2. What country were you born in?

\_\_\_\_\_

3. How long have you lived in Canada?

\_\_\_\_\_

4. How many languages do you speak? Please select all that applies

 English Hindi Urdu Gujarati Swahili Other \_\_\_\_\_

4. What is your marital status?

 Married Common-Law Living with a partner Single (never married) Widowed Divorced

4. Was this your first pregnancy?

 Yes No

5. If no, how many children do you have?

 1 2 3 4+

6. What is your highest level of education?

- < high school
- high school diploma
- some post secondary college or university
- college degree
- undergraduate degree
- graduate degree (master's and PhD)

7. In the past 12 months, what is your total household income from all sources?

- No income
- Under \$10,000
- \$10,000 – 19,999
- \$20,000 – 39,999
- \$40,000 – 59,999
- \$60,000 – 79,999
- Over \$80,000