

## Cultural Practices of Pakistani Immigrant Women During Pregnancy and Childbirth

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### Abstract

#### Background

Life events as pregnancy and childbirth reflect important cultural traditions of families and society. They provide a rich context for understanding cultural dynamics and adaptive responses of immigrants in the new culture.

#### Purpose

Compare cultural values and practices in pregnancy and childbirth of Pakistani immigrant women in the US with their cultural traditions in Pakistan.

#### Method

Data for this article were drawn from the literature on Pakistani cultural values and practices and findings from the authors' previously published ethnographic study of Pakistani immigrant women in the US.

#### Results

Salient Islamic traditions observed particularly in the care of the newborn and preference for gender-congruent care. Cultural adaptation was evident in transnational gendered social networks,

negotiated gender roles, and decisions regarding timing of pregnancy, location of residence in the US and place for childrearing.

#### Relevance to Clinical Practice

Assessment and accommodation of major religious and gendered care traditions, transnational social network and emerging adaptive roles of spouses should be planned with the women, their husbands and religious leaders.

### Keywords

Pakistani culture, Pakistani immigrant women, Pakistani immigrant birthing practices, transnationalism, cultural adaptation, transcultural nursing and midwifery.

Culturally competent care is the cornerstone of culturally responsive and effective health-care practice. As early as the 1950s, Madeleine Leininger identified the need for culturally congruent care in order to provide supportive, beneficial and meaningful care. Beneficial, healthy and satisfying culturally-based nursing care enhances the well-being of clients which can only

occur when cultural care values, expressions, or patterns are known and used appropriately in nursing care (Leininger, 1998; McFarland & Wehbe-Alamah, 2012). In 1989, Cross, Bazron, Dennis & Isaac defined cultural competence as a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations. This definition was adopted and expanded by the Office of Minority Health (2013) to include linguistic competence as the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities (OMH, 2013).

Understanding cultural values and practices is significant to building therapeutic relationships between patients and healthcare providers. This is especially relevant today with increasing globalization and greater movement of populations worldwide. Cultural values and beliefs not only influence health and utilization of healthcare services but also underline rituals and role expectations during pregnancy, childbirth and postpartum. Cultural traditions and the family play a central role during pregnancy and childbirth in South Asian countries such as Pakistan and India (Grewal, Bhagat, & Balneaves, 2008). Despite a growing Pakistani immigrant population in western countries, very few publications have reported on the cultural aspects of childbirth in this population.

Immigration brings new challenges to pregnant women and their families. Immigrant women may not have family members who can provide assistance with pregnancy and childcare (Grewal, et al., 2008). Traditional practices observed in their home country may not be possible in a new environment (Messias & Rubio, 2004). The pregnant woman and her family are likely to encounter formal and informal healthcare systems that are substantially different from those in their country of origin (Kaushal

& Kaestner, 2013). Lack of information and understanding of the new culture by immigrants and of Pakistani culture by healthcare providers may contribute to insensitive and ineffective care for these women (Grewal, et al., 2008). This can lead to miscommunication and misunderstanding between the care provider and recipient (Grewal, et al., 2008).

### **Purpose**

This article addresses a gap in the literature regarding core cultural practices of Pakistani immigrants during pregnancy and childbirth. The purpose of this article is to provide culturally relevant information for healthcare professionals caring for Pakistani women immigrants and their families during childbirth by comparing cultural practices during pregnancy and childbirth of Pakistani immigrant women in the US with their cultural traditions in Pakistan.

### **Conceptual Framework**

Acculturation has been used extensively in immigrant health research. Leininger (1995) defined acculturation as a process by which immigrants adopt behaviors and values of the host culture. The earlier definition of acculturation has been criticized for assuming that change in behaviors was unidirectional. Acculturation is now recognized as a dynamic continuum and multifactorial process of cultural learning which assumes that with longer interaction between groups change can occur in either group (McDermott-Levy, 2009; Sam & Berry, 2010). Berry (1980) proposed a model that incorporated both psychological and behavioral changes in migrating individuals. Acculturation is adaptation that occurs at multiple levels inclusive of psychological, sociocultural, health and communication values and behaviors (Sam & Berry, 2010). Berry posited that sustained contact between members of various cultural groups may result in assimilation, integration, separation, or marginalization. Assimilation occurs when an individual decides not to maintain his/her

cultural identity by seeking contact and daily interaction with the dominant group. Separation occurs when an individual values holding on to his/her original culture. Integration occurs when individuals maintain ties both with their own ethnic group and with the dominant group. Marginalization occurs when individuals lose cultural and psychological contact with both their traditional culture and the larger society.

### Ethnohistory

#### Migration of Pakistani Immigrants to the US

Pakistan exports manpower to other countries extensively with a net international migration rate of -2.4 indicating that more people emigrate than settle in the country (U.N., 2013). Between 7 and 10 million people of Pakistani origin reside in developed countries (Syed, 2013). Migrants to countries such as the U.S., Australia and Canada consist of well-educated and technically trained professionals who generally settle permanently in these countries (Syed, 2013). In most cases, Pakistani men immigrate first followed by their families. In 2011, an estimated 400,000 people of Pakistani origin resided in the United States, 62% of whom were foreign born. The median age was 29 years. Seventy percent held associate or higher degrees and 60% were engaged in the labor force with a median income of \$60,000 and a poverty rate of 17% (Census, 2014). The largest concentrations settled in New York, New Jersey, Illinois, California and Texas (Census, 2014).

#### Healthcare System in Pakistan

The healthcare system in Pakistan consists of public or private, and formal or informal systems. The public system is composed of hospitals, basic health units, rural health centers, maternal child health centers and dispensaries (Khowaja, 2009). The private sector picks up where the public system leaves, but most pri-

vate facilities are located in urban areas and are quite expensive (Khowaja, 2009). Nearly 76% of the money spent on healthcare represents out-of-pocket expenses by consumers. Hospitals offer obstetric services but many maternity hospitals provide birthing services exclusively. A great number of Pakistanis prefer and practice alternative medical therapy (Khowaja, 2009). Birthing practitioners in the informal healthcare system include traditional birth attendants (*Dais*), homeopaths, traditional/spiritual healers (*pir*, *faqeer*), *Unani* (Greco-Arab philosophy) practitioners (*hakeems*), bone setters (*pehelwans*) and quacks (Khowaja, 2009). Other conditions for which informal providers may be sought include infertility and depression.

#### Maternal and Child Outcomes in Pakistan

In 2011, the United Nations reported that 32% of total births in Pakistan comprised of low birth weight babies, neonatal mortality of 36 per 1,000 births and infant mortality of 59/1,000 births, maternal mortality ratio of 260 per 100,000 live births (UN, 2011). The prevalence rate of gestational diabetes was 4.2 (Rahman, Jafri, Raza, & Sattar, 2007). High prenatal and postpartum depression rates were found by some researchers in Pakistan (Gulamani, Shaikh, & Chagani, 2013).

#### Maternal and Child Outcomes Among Pakistani Immigrants

Higher prevalence of low birth weight infants was found among Pakistani immigrants in the Europe (Pedersen, Mortensen, Gerster, Rich-Edwards, & Andersen, 2012; Seaton, Yadav, Field, Khunti, & Manktelow, 2011). Pakistani pregnant women in Norway also had higher prevalence rate of gestational diabetes (9/1000) compared to Norwegian women (3.6/1000) (Vangen et al., 2003). In addition, Pakistani immigrant women had low rates of postpartum depression compared to Norwegian women (7.6% vs. 8.9% respectively) (Yap & Stray-Pedersen, 2011). The rate was much high-

er (16%) in the UK (Husain et al., 2012).

### Cultural Systems in Pakistan

Pakistan is one of the oldest continuously populated regions of the world with roots that can be traced back to the Indus Valley civilization some 5000 years ago (U. N., 2013). While Islam plays a unifying role among Pakistanis, it is secondary to ethnicity and kinship (*biradari*) in defining cultural identities. *Biradari* is comprised of a vast network of extended family. There are four major ethnic groups that are distinct from each other in such areas as language and food practices but share common traditions and practices rooted in Islam such as the *nikah*, marriage ceremony. In addition to ethnicity, social class plays an important role in Pakistani society and people are stratified by occupation, education as well as kinship (Critelli, 2010).

Further social stratification is based on religious affiliation of Shia or Sunni Muslim (Critelli, 2010). Although nearly 98% of the country's population is Muslim, religious affiliation is multilayered. The two major sects, Sunnis and Shia are unique and branch out to include groups having different interpretations of the code of conduct based on the *sharia* or jurisprudence prescribed by the *Quran* (Critelli, 2010).

**Family.** Pakistan has a patriarchal society evident in its patrilineal descent, patrilocal residence and inheritance laws (Critelli, 2010). For example, all official identification cards include the father's name. Sons and brothers may live together in the family home after marriage. Men have much greater autonomy than women and considered the providers, protectors and breadwinners of their families. However, women's level of autonomy is also a reflection of the local culture and variation can be observed based on the ethnic group, region and social class status (Critelli, 2010). While culture defines gender roles, these roles may vary because of life circumstances. Some women may have to support their family if challenged financially. Generally women are home makers. There is

gender-based segregation and contact between males and females is limited in accordance with the *pardah* (literal translated as 'curtain') rooted in the Islamic prescription and protection of women (Critelli, 2010).

The family plays a central role in all aspects of Pakistani life. Family collective decision making is evident in matters such as education, marriage, living arrangements, financial and emotional support (Zaman, 2014). Although men play a central role in all decision making, it is women, especially older female members (mothers, mothers-in-law) who take charge on issues related to the social, cultural and medical aspects of reproduction (Ali, Ali, Waheed, & Memon, 2006). Women from both households (parents and in-laws) provide support once the woman is pregnant. Support can be in the form of physical help, household chores, and pampering or accompanying the pregnant woman for prenatal checkups (Qureshi, 2012).

**Marriage and procreation.** Marriage and childbearing are considered important milestones and motherhood elevates the social status of women. According to Choudhry (1997) a common blessing bestowed on newly married women is, "May you bathe in milk and bloom among sons." Milk represents motherhood and sons symbolize prosperity (p. 534). Although motherhood is cherished, sons are preferred over daughters. Sons ensure the continuation of the family line and are expected to provide economic help and support for parents in old age (Zaman, 2014). Girls on the other hand may be perceived as an economic burden by some because they need dowries for marriage (Zaman, 2014).

In a patriarchal society where a woman's role is based on her reproductive ability, infertility causes distress among women (Husain, et al., 2012). Family pressure, especially from mothers-in-law, can be intense and drive women to seek help. Women feel responsible for not conceiving and may submit to a battery of tests, while men are not tested even for simple sperm



counts. A childless marriage is a legitimate reason for divorce or second marriage and the family plays an important role in care decisions relevant to fertility (Fisher, Bowman, & Thomas, 2003).

In general, Pakistani women and men do not receive any formal education on sexual health, contraception, sex or pregnancy. They are assumed to learn when the time comes and ignorance is equated with chastity and purity among girls (Ali, et al., 2006). Marriage is considered a religious obligation and being a mother is considered an honor (a higher honor than being a father) as depicted by the saying, 'heaven lies under a mother's feet' (Zaman, 2014). Abortion is not permitted in Islam except under special circumstances such as danger to the mother (Alamri, 2011) and is illegal in Pakistan. Contraception is not forbidden but not encouraged (Alamri, 2011). By contrast, a study of immigrant Pakistani women in the UK found that while they considered religious teachings, decisions about abortion were based on medical needs (Bjerke et al., 2008). Furthermore, female relatives accompany women in labor as men are not allowed in delivery rooms in Pakistan. Generally women prefer female obstetricians and giving birth in a specialized maternity hospital.

Pregnancy is highly valued and celebrated. Early announcement of pregnancy is avoided and often kept a secret to protect the woman from envy and protect the mother and her baby from *nazar* (evil eye) (Husain, et al., 2012). Pregnancy is considered a delicate condition requiring special care.

### **Cultural Beliefs and Practices in Pregnancy and Childbirth**

**Diet.** Special foods are provided for pregnant women that are rich in proteins, dairy, fruits and nuts. It is customary for pregnant women to consume *panjeeri* /*panjir*—a mixture of dried nuts, lotus and melon seeds, edible gum and other traditional herbs, clarified butter, semolina or whole wheat flour and sugar (Qureshi,

2012). It is widely recognized as fortifying and provides extra energy during pregnancy. Two or more tablespoons of *panjeeri* is taken with milk each night (Qureshi, 2012). Women tend to consume high protein foods, milk, fruits, nuts, and fats as well as observe other traditional dietary regimens (Shahid, Ahmed, Rashid, & Khan, 2011).

Traditional dietary practices, during pregnancy and postpartum, are based on the specific effects (*taseer*) of foods on the body (Shahid, et al., 2011). *Taseer* can be either hot or cold. Hot and cold refer to the innate properties of food when ingested rather than its temperature (Shahid, et al., 2011). In many South Asian cultures pregnancy is considered a hot condition and foods with cooling properties are advised in the early phases of pregnancy to avoid the risk of an abortion, while foods with hot properties are encouraged towards the end to help with labor and promote a successful delivery (Shahid, et al., 2011). Hot foods include beef, mutton, chicken, organ meat, eggs, dried fruits (almonds, dates, walnuts etc.), garlic, butter, and spicy foods. Cold foods include squashes and other vegetables, bananas, oranges, ice, cold water and ice cream (Shahid, et al., 2011). Cold foods may also cause coughs, colds and congestion. Some 'inert' foods that do not exhibit hot or cold properties include melons, watermelons, papaya, spinach, pumpkin, etc. Gas forming foods (*badi*) such as cabbage, cauliflower, rice, fried foods, potatoes, chick peas, lentils (*daal*) and spinach are avoided during postpartum and during the entire period of breastfeeding because they can cause colic in the baby (Shahid, et al., 2011).

**Religious practices.** Pregnant women may fast during the month of *Ramadan*. Although pregnancy is considered a delicate condition, fasting has religious and spiritual value, and considered not harmful to the unborn child (Mubeen, Mansoor, Hussain, & Qadir, 2012). The alternative practice of *kuffara* allows pregnant women to provide food for the needy in

lieu of fasting (Shah, Bowen, Afridi, Nowshad, & Muhajarine, 2011) or may fast at an alternate period (Mubeen, et al., 2012).

**Postpartum.** After the baby is delivered the women may remain in the hospital for a few days and observe a forty day period of rest called *chilla* (Qureshi, 2012). Many superstitions surround this period. Most parturient women do not leave the house for fear of having the 'evil eye' or *nazar* cast on them (Husain, et al., 2012). Women may refrain from doing anything strenuous. They eat fortified foods rich in proteins and fats (Qureshi, 2012).

**Newborn care.** A highly esteemed family member usually an older male, other than the father, recites the *azan*, the Muslim call to prayer, into the ear of the baby soon after birth. The *azan* represents the first words heard by the newborn (Chaudhry, Husain, Tomenson, & Creed, 2012). Another common practice is feeding the baby *ghutti* (first taste of food) soon after birth. An elderly pious person gives the baby *ghutti*, often sucked from his/her finger. It is believed that giving the *ghutti* allows transfer of the person's positive qualities to the baby (Chaudhry, et al., 2012). *Ghutti* may consist of honey or a small, softened piece of date rubbed in the baby's palate (Imam, 2012). *Ghutti* is believed to have a laxative effect, reduce colic and strengthen the baby (Chaudhry, et al., 2012). In other Islamic groups this practice is known as *Tahneek* or *Tasmia* (Imam, 2012). Other commonly used remedies for calming babies include the use of Gripe Water, a commercial product to reduce colic (Fikree, Ali, Durocher, & Rahbar, 2005). Baby massage is also commonly practiced to relax the baby and build stronger bones (Fikree, et al., 2005).

Both male and female newborns' heads are shaved usually around seven days after birth, which is celebrated by the extended family in the ritual of *Aqeeqa*, where a lamb is sacrificed and shared with the family and the poor (Ayyoush, 2012). Male babies may be circumcised at this time although circumcision may be done at any

time after birth (Ayyoush, 2012). Parents may bring the baby to the hospital or invite the local barber to the house to perform circumcision and shaving of the head (Khadduri, 2008).

### Methodology

Data for this article were drawn from the authors' ethnographic study of Pakistani immigrant women in the northeastern region of the US (Qureshi & Pacquiao, 2013) and information drawn from the literature. The ethnographic study comprised of twenty six women as key informants who originated from various regions in Pakistan and settled in three largest Pakistani enclaves in northern New Jersey. The informants experienced giving birth in the US and some had experienced birthing in Pakistan. The study was approved by the Institutional Review Board of the University of Medicine and Dentistry of New Jersey.

### Findings and Discussion

**Cultural stress.** Participants in the ethnographic study (Qureshi & Pacquiao, 2013) provided evidence of similar and variant cultural experiences secondary to adaptation with migration. Migration to the US brought changes in their family structure and support network. Many of their spouses in the US were self-employed and had no access to employer-sponsored health insurance. These women were unfamiliar with health insurance programs in the US because health care services and payment structures are very different in Pakistan and health insurance is uncommon. Medical expenses are generally affordable and in most cases paid for by their families. Participants experienced enormous stress economically and psychologically because of lack of health insurance. The initial excitement about the pregnancy was superimposed by worries about lack of information about the healthcare system and the financial burden of birthing.

### Cultural Adaptation

**Residential location.** Participants generally joined other Pakistani families (family or friends) in the initial relocation and moved to their own place once established. Decisions regarding residential location were based on where their husbands were able to work and availability of other co-ethnics in the area.

**Timing of pregnancy and location of early childrearing.** Other adaptive strategies included postponement and timing of pregnancy to allow travel of female family members to support the mother during birthing and postpartum. Back in Pakistan couples are expected to have children soon after marriage. In some cases, the wife traveled back to Pakistan to deliver the child. Other couples sent their young children to be cared for by their kin and brought them back when they were older. Some couples who decided to keep their infants with them learned to share caretaking and household roles with their husbands, blurring traditional gender-based role boundaries.

**Social networks.** Survival in the new society especially during childbearing was conditioned by how successful they were in navigating and accessing information about the healthcare system, developing local networks with Pakistanis and non-Pakistani acquaintances, and maintaining connections with social networks in Pakistan. Because of distance from their families and absence of female kin-based social networks in the US, these women had to adapt by modifying the composition of their network. Some relied on co-ethnics within their enclaves while others befriended non-Pakistani women in their neighborhoods to gather information to navigate the healthcare system. Any knowledge they gained from experience and others was shared with other Pakistani women.

Women in urban enclaves developed networks through acquaintances from the neighborhood facilitated by face-to-face contact. These women were mostly homemakers and unable to drive. They preferred the urban en-

vironment because they were able to meet with other women without relying on their working husbands to drive them. By contrast, women living in the suburbs were isolated from other Pakistanis by distances but maintained contact by phone and occasional visits. Many of them were gainfully employed and able to drive.

**Role negotiation between husbands and wives.** Women living in the suburbs relied more on their husbands for assistance after birth. Some of them reported increased participation by their husbands in childcare and household chores which were traditionally performed by women in Pakistan. Expanded roles of husbands in traditional women roles were generally kept private and not shared with families back home. In contrast, women in urban environments had easy access to gendered social support because of proximity with each other and easy access to public transportation.

**Religious and cultural practices needing accommodation.** Performance of religious rituals was especially a concern. Their ethnic network informed them of availability of a religious leader within the hospital setting to perform the *Azan*. Feeding the newborn the *ghutti* was another ritual most women wanted but hesitated because of possible objection from the hospital staff. Celebration of the baby's birth was generally postponed until relatives and friends can join the couple several days or weeks after discharge. Some did not have a big celebration because of absence of extended family members which caused women much nostalgia since the birth of a child especially a boy is widely celebrated right after birth.

Pregnancy, birthing and newborn care are considered realms of activities that are exclusively for females. As such preference for female obstetrical practitioners and staff was universally valued by women immigrants. Although exceptions were observed, this tradition was valued if circumstances allowed. Women felt more comfortable in the presence of gender-congruent caregivers. If this was not possible, presence

of female kin or friends was preferred while in the hospital. Culture-specific meals for mothers during pregnancy and postpartum were not always available because of lack of access to food ingredients, lack of time and energy to prepare them or lack of knowledge about their preparation. These roles are traditionally done by female relatives back in Pakistan.

### Conclusion

Pakistani immigrants are transnationals who maintain close ties with kin in Pakistan. Transnationalism (Glick-Schiller, 1992) is an adaptation of Pakistani women immigrants during pregnancy and childbirth to maintain gender-congruent support. Access to affordable communication network facilitated maintenance of this support system across the globe and women immigrants maintained gender-based support systems transnationally by constant communication with female kin seeking their advice on cultural and religious practices relevant to pregnancy and childbirth.

While it is important to learn cultural traditions that may guide the care of immigrant populations, it is equally important to study the dynamic nature of culture and adaptation of immigrant groups in the host country. The ethnographic study of Pakistani immigrants in the US did find significant processes that help facilitate their adjustment to the host culture. Adaptation is evident in transnationalistic composition of their social support network that transcends neighborhood and national boundaries. The cultural expectation of pregnancy soon after marriage is modified and delayed to maximize survival of the nuclear family in the host culture. Practical realities in the host culture create differential observance of rituals during pregnancy and childbirth as seen in the limited practices on nourishing food for pregnant women and big family celebrations of the birth of a child, especially males. Immigrants prioritize observance of cultural practices.

For Pakistani women and their families, the

Islamic tradition of whispering the *Azan* to the newborn's ear and the feeding of the *ghutti* to the newborn remained important rituals. Accommodating these practices was identified as important by women necessitating the need for religious brokers to inform care protocols. Cultural accommodation of the type of food safe to give a newborn can be arranged between Islamic religious leaders and birthing centers.

Childbearing and newborn care is an exclusively female domain. Gender-congruent care is important when a female's privacy is most vulnerable such as during antepartum, birthing and postpartum. Lack of familiarity with the healthcare system predisposes lack of access to female practitioners which requires organizational accommodation. Partnership with local Pakistani and Islamic communities can help address these issues and develop policies and practices that promote privacy and dignity of Pakistani women immigrants.

### Relevance to Clinical Practice

When caring for Pakistani women immigrants during childbirth it is imperative to determine their knowledge of the healthcare system and birthing practices in the new culture. While women may be separated by distance from their families in Pakistan, they maintain close transnational ties that influence their expectations and desired practices during pregnancy, birthing and postpartum. They also rely on social networks comprised of Pakistani immigrants and other groups to help navigate the healthcare system. Transnational ties and social networks should be included in the assessment of pregnant women as well as their expectations about their care and cultural traditions that are important to them. Collaborative planning with a local religious leader in accommodating important Islamic traditions such as the *Azan* and the feeding of *ghutti* to the newborn would ease some cultural concerns.

Gender-separation may be expected during birthing but husbands should be integrated in



teaching about newborn care and care of their wives. Healthcare providers should not assume that every Pakistani immigrant couple has the same degree of observance of their traditional gender roles. Couples should be asked about their comfort and willingness to share caring responsibilities for their child and each other. Men may need support to perform non-traditional female roles much needed for survival in a nuclear household. Gender-specific support groups can be developed to encourage cultural role adaptation.

Bridging strategies with immigrant communities to create mutual understanding of cultural and health care system differences should be initiated. Local community leaders, particularly religious leaders and women, should be sought to inform healthcare providers of their needs and expectations. Healthcare organizations should facilitate engagement of immigrant populations nested in their environments in developing policies and infrastructure responsive to their unique needs. Immigrant communities especially in enclaves can provide much needed support for women during pregnancy and childbirth in the absence of their extended family. Community volunteers can guide accommodation of Pakistani traditional practices in healthcare organizations and participate in providing culturally competent care for birthing couples.

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