CULTURE, IDENTITY AND EXPERIENCES OF EARLY MOTHERHOOD

OF

ETHNIC INDIAN IMMIGRANT WOMEN IN MELBOURNE, AUSTRALIA:

AN ETHNOGRAPHIC STUDY

Submitted by

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SUMMARY

This study brought together the interplay of migration, identity and motherhood for ethnic Indian women living in Melbourne. It examined their lived experiences of early motherhood through their migration trajectories, the impact that this had on their identities and how this shaped their approach to mothering. A broad critical paradigm encompassing a medical anthropological framework guided this research. This facilitated investigation of the historical, political-economic and socio-cultural factors that determine the extent of the acculturative process and what it means for mothering across cultures. Women displayed varying levels of acculturation through their replication or reconstruction of traditional customs surrounding mother and infant care and feeding, as well as through their acceptance of or resistance to Australian norms of childrearing. This research suggests that, although women may identify as Indian, ethnically, their approaches to mothering can differ depending on their identity, communally and personally. Regardless of length of residency in Australia, the desire to embody traditional ideologies of maternity created a prioritisation of motherhood and a resistance to outsourcing childcare for some women. Constructing new gender roles within the family and society created personal identities other than 'mother' and facilitated the adoption of Australian models of mothering for others. Embracing biculturalism to some degree brought about a cross-cultural approach to parenting, and an overall sense of belonging and wellbeing in their adopted home. Accordingly, it is recommended that health practitioners expand the clinical view to encompass the social and cultural dimensions of immigrant motherhood. In order for health service provision to be most effective, women's acculturation should be taken into account so as to target

services at levels that are sensitive to and appropriate for the degree of cross-cultural competence of immigrants, to promote confident and healthy mothers and children.

STATEMENT OF AUTHORSHIP

Except where reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis submitted for the award of any other degree or diploma.

No other person's work has been used without due acknowledgment in the main text of the thesis.

This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

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CHAPTER 1: INTRODUCTION AND BACKGROUND

The population landscape of Australia has changed dramatically in the last four decades, with large numbers of non-European people migrating to the country. Traditionally, immigrants to Australia have been from Western countries such as the United Kingdom, Europe, and New Zealand. Since the demise of the 'White Australia Policy' and adoption of multiculturalism as government policy in the early 1970s, non-Western immigrants from Asia, the Middle East and Africa have been moving to Australia in increasingly large numbers. These migrants are visibly and culturally different to that of the majority of the population. The recent demographic change in Australia necessitates knowledge and understanding about these new population groups. This has become urgent to effect successful settlement of these groups.

There are currently knowledge and information gaps relating to these various population groups with regard to acculturation and health-seeking behaviour. Another major gap is information pertaining to the way immigrants adapt to parenting in Australia. It is important to know how these different communities raise their children in Australia's Western environment so that steps can be taken where necessary to ensure that the second generation of immigrant children in Australia settles successfully.

One of the larger new population groups is the Indian community, which comprises peoples from India, Britain, Fiji, South Africa, Malaysia, Singapore, and Mauritius among other diasporic groups. Very little is known about them, their culture and their

needs in Australia, including the impact of culture and identity on their experiences of mothering in Australia.

To gain an in-depth understanding of this community, brief background information on Indian immigrants in Australia is provided here.

Indian immigration in Australia

Indians first came to Australia in 1837 as part of the 'coolie' (labour) trade from India. However, this came to an abrupt end in 1839 with the enacting of legislation in India prohibiting coolie immigration outside India. However, small shipments of Indian labourers continued to arrive in the 1840s and 1850s (Rajendra, 1994). In the late 19th century, Queensland and South Australia attempted to reintroduce coolie emigration, but were unsuccessful due to Indian Government legislation. Some still arrived; however, under some form of unofficial or disguised indenture system, mainly from Punjab. In the late 1890s, the introduction of legislation excluding Asians, Africans and Pacific Islanders from Australia, prevented the immigration of large numbers of Indian immigrants, but those Indians already in Australia were allowed to bring their wives and minor children as permanent residents (Rajendra, 1994).

The Immigration Restriction Act of 1901 (the foundation of the 'White Australia Policy') prohibited Indian immigration to Australia for many years until 1948 when Indians were declared British subjects. However, Indians could not apply for residential status until 1966 when a small number of non-European skilled migrants were allowed into Australia (Lahiri, 1992). Numbers began to increase after the abolition of the 'White Australia Policy' in 1973 and the subsequent implementation

of the ‘points system’ in Australia’s immigration policy (Ip, 1993). Since that time, there has been an influx of educated, professional Asian immigrants in Australia, mainly from China and India. There has also been immigration of Indians from other places such as Fiji and South Africa (Ip, 1993; Rangaswamy, 2005).

In the last few decades, there has been a significant increase in the number of ethnic Indians migrating to Australia partly as a result of globalisation. According to the 2011 census, 390,894 people (2% of the Australian population) stated they had Indian ancestry. Australia’s largest source of new immigrants comes from India, and the largest group of ethnic Indian residents in Australia live in Victoria (Australian Bureau of Statistics, 2011). In Victoria, most Indians live in metropolitan regions, specifically the areas of Monash, Greater Dandenong and Casey. Melbourne has the second largest Indian population in Australia, whose presence can be felt through the workforce and the growing number of Indian restaurants and stores (Lakha & Stevenson, 2001).

Indians in Australia are generally middle-class, educated and skilled, highly paid immigrants from white-collar professional backgrounds (Bilimoria & Ganguly-Scrase, 1988; Rangaswamy, 2005). Indians in Melbourne, who constitute the recent wave of immigrants, are heterogeneous with regard to religion, language, and place of origin. The number of Indians from India, Mauritius, Sri Lanka, Malaysia, South Africa and Fiji has increased considerably since the 1960s. There are now a large number of Indian cultural organisations and associations in Melbourne, many of which fall under the umbrella of The Federation of Indian Associations of Victoria (FIAV). Cultural identity is very important to Indian immigrants, who are concerned about the lack of knowledge of their culture in Australia (Ip, 1993).

Indian immigrants mothering in Australia

Indian immigrants to Australia have brought their own beliefs and customs into the existing cultural environment, which are foreign to 'mainstream' Australians. They are actively engaged in expressing these beliefs and customs through infant care and childrearing practices, and are asserting their cultural or ethnic identities through gender role differentiation and extended family structure, which is distinguishably different from the majority Anglo-Australian population. Parenting practices are an avenue through which immigrants can articulate their culture. Cross-cultural mothering provides a lens through which immigrant experiences can be viewed, and a means by which Australia, as a host society, can better assist in the acculturation of immigrants.

Mothering can be affected by social and psychological problems because of isolation and cultural conflicts that immigrant women face (Tummala-Narra, 2004). As with all women, bearing children is a very significant time in life. This is especially so for immigrant women, where issues such as support become even more important to facilitate a smooth transition into motherhood. The host society's response to this need can impact on the wellbeing of new mothers and infants, in turn impacting the acculturation and settlement experience of immigrant women. Therefore, knowledge and understanding of these cultural belief systems and how they translate to infant care and childrearing amongst this large immigrant group is necessary in order to competently cater for immigrants as individuals, families and a community.

A significant problem for immigrant people is health care professionals' misunderstanding and stereotyping of the traditions and beliefs surrounding pregnancy, birth and the postpartum (Betancourt et al., 2005). This is often

exacerbated by differing views of health care professionals from the host society with regard to mothering. Studies about other immigrant groups in Australia show that there is a need for understanding the cultural and societal aspects of motherhood in order to promote culturally appropriate healthcare for immigrant groups (e.g. Homer et al., 2002; Li et al., 2004; Liamputtong & Naksook, 2003; Liamputtong Rice, 1999; Rossiter & Yam, 2000; Small et al., 1999).

A key issue in medical care has become the relationship of culture to the care of patients (Weidman, 1983). This was evident in cross-cultural health education seminars that I attended at hospitals in Brisbane. During these seminars, health workers showed concern at not being able to relate to ethnically Indian immigrant mothers and their concerns about breastfeeding. The health workers reported a lack of understanding of the cultural context of their healthcare. They also expressed a keen interest in acquiring knowledge about the cultural context of breastfeeding, in order to provide a better health care service to this group of mothers.

In a prior study done by myself on Fiji-Indian mothers in Auckland, New Zealand, health workers were perceived by these migrant mothers as being unable to cater to their needs, and the mothers were perceived by the health workers as too demanding of assistance with breastfeeding and not willing to take post-natal advice on good breastfeeding practice. These mothers had trouble initiating breastfeeding and continuing in accordance with health workers' recommendations, because health workers were unable to deliver their service in a way that showed an understanding and knowledge of traditional methods and values. On the other hand, the health workers were unsure of how they could better cater to the needs of these women who

had particular cultural beliefs and traditions that were foreign to the healthcare providers (Maharaj, 1999).

Significance of the study

Lack of understanding between health professionals and women from Asian backgrounds who have migrated into a new cultural environment is challenging and is not a new phenomenon. Clearly, knowledge is required on the cultural and social context influencing infant care and childrearing behaviour and how this influences identity construction and cross-cultural parenting amongst Indian immigrants in Australia. The broad spectrum of experiences that various individuals encounter during mothering as an immigrant demonstrates the variability of practice amongst members of a community. This understanding is likely to assist in the breaking of stereotypes of Indian immigrants amongst health service providers and in improving communication and interaction between Indian immigrant women and health professionals, providing more effective health service delivery and better health outcomes for mothers and infants. Furthermore, the provision of more effective health services will ensure its most appropriate use. Moreover, it will have a positive impact on settlement outcomes for Indian immigrants to Australia.

The influence of culture and identity on the experience of mothering amongst Indians in Australia will fill existing knowledge gaps, and provide an understanding of the cultural and social context for current infant care and childrearing practices of this immigrant group and of the impact of cultural affiliation and identity on the process of mothering in an adopted home.

Aim and objectives

This study aims to investigate the influence of culture and identity on the immigrant experience of mothering among ethnic Indian women living in Melbourne.

The specific objectives of the study are:

- To investigate the processes of acculturation and identity construction for Indian immigrant women in Melbourne.

- To describe the cultural context of mother and infant care among Indian immigrant women in Melbourne.

- To explore the role of cultural identifications on cross-cultural parenting for Indian immigrants in Melbourne.

Research question:

The main research question that has guided this study is: How does culture and identity influence the construction of motherhood for Indian immigrant women in Melbourne?

In order to answer this question, the following sub-questions had to be answered:

1. What differences in culture do Indian immigrant women perceive in Melbourne?

2. Have Indians acculturated to the new cultural context in Melbourne? If so, what factors contribute to this acculturation?

3. Has the process of migration impacted on their cultural identities? If so, to what extent?

4. To what extent do traditional aspects of mother and infant care continue to be practised in the new cultural context?

5. To what extent do traditional approaches to childrearing continue to be practiced in Melbourne?

Scope of research

This study is about the personal lived experiences of immigrant ethnic Indian women living in Australia, and how they encountered migration and early motherhood. It examines the influence of the migration and acculturation experience on their cultural identifications and their construction of motherhood. It is limited to women who identify, ethnically, as Indian, regardless of where they were born. The term South Asian is also used in this thesis to refer to this group, as Indians are often referred to as South Asians in many other research contexts. In this thesis, however, the term does not refer to women from the rest of the sub-continent. Therefore, the literature review encompasses research involving the Indian diaspora worldwide, and their experiences of migrating, acculturating, identifying and parenting. It does not include the copious amounts of literature available on other immigrant populations around the world as the focus of this research is on the Indian/South Asian diaspora. It is also limited to first generation Indian immigrants to Australia, in order to capture the immigrant and acculturative experiences of those who moved to this country from another.

Researcher's narrative

I am ethnically Indian, an immigrant and a mother. Born in South Africa, my family immigrated to New Zealand when I was 13. I migrated to Australia at the age of 26 to undertake my doctorate. As an immigrant and a woman, migrant issues surrounding motherhood were of special interest to me, and the impetus for embarking on this research. During my candidature, I had two children and became placed in a parallel position as those whom I had begun researching. As a mother, this research became even more personally significant and relevant.

My positioning in this work is therefore not only as a researcher, but also as an active member of the diaspora (having many friends within the Indian community in Melbourne and participating in cultural gatherings and festivals), and as a mother, and, hence, literally a participant-observer (Dasgupta, 1998). The perspectives I present are personal as well as researched. I am an 'insider' endeavouring to take a critical look at my own position in society, and the 'instrument' through which the subjective experiences and understandings of my participants are interpreted and analysed. Although I am Indian, ethnically and culturally, and I had rapport with my participants because of our shared cultural background, they knew that my life experiences were vastly different from theirs as I was not born in India and had grown up in two other countries before migrating here. I was seen as enough of an insider in order for women to talk freely with me and for me to understand the cultural nuances of our discussions, but also enough of an outsider who did not have the community networks that could make them feel vulnerable when sharing their life stories with me (Bandyopadhyay, 2011). It is through this distance that I

maintained objectivity as well as the rigour and integrity of data collection and analysis.

Definition of terms used:

Culture refers to the cumulative deposit of knowledge, experience, beliefs, values, attitudes, meanings, hierarchies, religion, notions of time, roles, spatial relations, concepts of the universe, and material objects and possessions acquired by a group of people in the course of generations through individual and group striving (Hofstede, 1997).

Diaspora refers to people dispersed to more than one location, who may not completely acculturate to their host countries, and may continue connections with other communities within the diaspora (Ember et al., 2005).

Ethnicity, as described by Robbins et al. (1998, p. 122), refers to "shared values, behaviours and customs as well as patterns of thinking and feeling that distinguish one cultural group from another". Ethnic identity, refers to "one's sense of belonging to an ethnic group and the part of one's thinking, perceptions, feelings, ethnic knowledge and commitment, as well as behaviour and practices that is due to ethnic group membership" (Phinney & Rotheram, 1987, p. 13). The women in this study are referred to as 'ethnic Indians' as they share a sense of belonging and membership to this ethnic group despite being born in various countries.

Identity consists of personal identity and social identity, both of which are aspects of the self gained from a person's membership in salient groups (Tajfel & Turner,

1986). Individuals define themselves or are defined by others in terms of social and cultural group membership (Byron, 2002).

South Asian usually refers to people from the Indian subcontinent, namely countries including India, Pakistan, Bangladesh, and Sri Lanka. This includes diasporic people of Indian ethnicity who have migrated to Australia from another country such as South Africa, Britain, and Fiji. Indians are often referred to in the literature as South Asian. In this study, the women who presented were all of Indian origin, that is, they came directly or indirectly from India, as opposed to the other South Asian countries. Therefore, in this thesis, women are referred to as Indian and South Asian interchangeably.

Western countries or countries marked strongly by European immigration (including the Americas and Australia) are generally defined or labelled as Western, and the cultural ethos that they espouse is known as Western culture. In this thesis Western culture is delineated by the measures set by the Organisation for Economic Co-operation and Development (OECD). The OECD membership countries are defined by their commitment to democracy and the free-market economy. They are high income countries with a very high Human Development Index (HDI) and are regarded as developed countries. Open economy, pluralist democracy and respect for human rights comprise key criteria for OECD membership.

Organisation of the thesis

The following briefly outlines the chapters in this thesis:

Chapter 1 provides background to the Indian community in Australia, and more particularly in Melbourne, and an introduction to the study including its significance, aim and objectives.

Chapter 2 is a detailed review of the literature on the differing philosophies that guide Indian and Australian culture and the differing ideologies surrounding Indian and Australian motherhood, as well as acculturation and identity construction amongst the Indian diaspora. The cultural practices of mother and infant care and feeding amongst Indians and the influence of culture and identity on cross-cultural parenting amongst the Indian diaspora overseas is then examined, specifically describing the cultural practices of mother and infant care, infant feeding and childrearing that impact cross-cultural parenting in a Western context.

Chapter 3 overviews the methodology and design of the study, particularly, the ethnographic approach and the case study design as well as the procedures, limitations and ethical considerations of this research.

Chapter 4 discusses acculturation and identity construction amongst Indian immigrant women in Melbourne, and demonstrates this with case studies.

Chapter 5 describes the cultural context of mother and infant care and infant feeding amongst Indian immigrants in Melbourne, illustrating with case studies.

Chapter 6 examines identity and its impact on cross-cultural parenting amongst Indian immigrants in Melbourne, using case studies examples.

Chapter 7 provides discussion and conclusions drawn from the findings, and makes recommendations for future research and improved health service provision.

CHAPTER 2: LITERATURE REVIEW

This literature review will first describe both the cultural philosophies and gender and motherhood ideologies amongst South Asians in comparison to those of the Anglo-Australian majority population of Australia. It will then consider the acculturative process for Indian immigrants, and how this impacts on identity construction and cross-cultural parenting for the Indian diaspora in other countries.

A substantial amount of international literature is available on Indian immigrant mothering practice (e.g. Price, 1988; Brookes, 1991; Kannan et al., 1999, 2004; Laroia & Sharma, 2006; Choudhry & Wallace, 2012). However, there is little information on the impact of cultural identity on cross-cultural parenting amongst Indian immigrants worldwide. Clearly absent from the literature is the influence of cultural identity on cross-cultural parenting amongst Indian immigrants in Australia. This section presents a critical review of the significant literature in these areas; specifically discussing the differing philosophies that guide South Asian and Western culture, i.e., collectivism and individualism, as well as the ideologies surrounding gender and motherhood in Indian and Australian culture. It examines acculturation and identity reconstruction amongst the Indian diaspora, and significant cultural practices that impact on Indians parenting in a Western context, in particular, mother and infant care and feeding and childrearing. Of literature on Indian immigrant acculturation, identity construction and mothering practice, much emerges from the latter part of the 20th century and has mostly been conducted by immigrant and South Asian researchers; this is reflected in the literature review.

Indian collectivism and Western individualism as cultural philosophies

Collectivism is a term used to describe any moral, political, or social outlook that stresses human interdependence and the importance of a collective rather than of separate individuals. Collectivists focus on community and society and give priority to group goals over individual goals. The philosophical underpinnings of collectivism are often related to holism or organicism – the view that the whole is greater than the sum of its parts. Specifically, a society as a whole can be seen as having more meaning or value than the separate individuals that make up that society. This group orientation stems from and results in close personal ties with family, including the extended family (Triandis, 1995). People in collectivist cultures, compared with people in individualist cultures, are likely to define themselves as part of a group, to give priority to in-group goals, to focus on context more than the content in making attributions and in communicating. Collectivist cultures pay less attention to internal than to external processes as determinants of social behaviour, to define most relationships with in-group members as communal, to make more situational attributions, and tend to be self-effacing (Triandis, 2001). Collectivist cultures are characterised by interdependence and sociability and are correlated with perceived social support and low levels of alienation (Triandis et al., 1986). Studies show that Indian peoples are generally collectivist exhibiting the attributes described above (Sobrun-Maharaj & Wong, 2010; Tse et al., 2007).

Individualism, on the other hand, stresses the moral worth of the individual and promotes the exercise of personal goals and desires through independence and self-reliance, while opposing most external interference upon personal interests, whether by society, family or any other group or institution. Individualism is characterised by

separation from in-groups and correlated with emphasis on achievement and perceived loneliness (Triandis et al., 1986). Generally, Western peoples are considered to be individualistic (Brown, 1993; Lukes, 1973).

However, Individualism-Collectivism (I-C) as a cultural dimension (Hofstede, 1980) is a continuous rather than a dichotomous measure allowing cross-country comparisons of cultural variation (Triandis et al., 1986). This explains the value of 'relativity' of the I-C dimension, for example, Australians are relatively more individualistic than the Germans even though they are both individualistic cultures. Therefore, Australian individualism and South Asian collectivism could be seen to be on reverse ends of the continuum.

These two worldviews are clearly in opposition, and when one encounters the other, there is potential for conflict at various levels, as is often seen when people from collectivist societies migrate to countries which are predominantly individualistic (Sobrun-Maharaj & Wong, 2010; Tse et al., 2007).

Against this backdrop of individualism and collectivism, I explore the Indian immigrant experience and its impact on acculturation, identity construction and cross-cultural parenting.

The migration experience and its impact on acculturation and identity construction amongst Indian immigrants in Western countries

Migration is said to be the most life changing transition (Greeff & Holtzkamp, 2007). It can be an alienating experience for Indians as they cross territorial, cultural and social boundaries and experience disconnections in their worldview and identity. Theories of cultural displacement, acculturation, resilience, identity conflict and

identity reconstruction assist in interpreting immigration patterns, family dynamics and cultural issues for Indian immigrants (Tewary, 2005).

Cultural displacement

A common theme in studies of migration is that of a sense of displacement amongst immigrants who can feel physical displacement as well as a sense of being socially or culturally 'out of place'. Bhugra (2004) hypothesises that migration from a country that has a sociocentric or collectivist culture, such as Indian communities in India and diaspora communities from Fiji, South Africa and Britain, to one that is egocentric or individualistic, as are most Western societies like Australia, calls for a huge shift in values and norms. This can make immigrants who are culturally different feel alienated compared to those who come from similar cultures. For women who are accustomed to having networks of family and community to rely on for all sorts of support, this shift from a community-based society to one which places emphasis on individual responsibility can cause problems in acculturating.

Displacement from one's home country, and the loss of location, heritage and culture that diasporic communities experience, can promote the persistence of gender power structures and patriarchal ideologies, despite the new environment allowing change in this regard (Moghissi, 1999). Gender roles in traditional, patriarchal cultures such as Indian communities worldwide, are such that men hold power and can control and dominate women through the social systems of organisation (Bhopal, 1997). This means women have a secondary status to men and have to defer important decisions to their husbands or other senior members of the household (Tewary, 2005). The self is constructed through a healthy marital and family life, respectful children, and

support from the extended family, with self-satisfaction being gained through fulfilling family roles. This can be in conflict with the Western idea of the individualised self (Tewary, 2005).

When women are displaced from their natal cultures, their experience can be more positive than men's due to their efforts to create a new home, but the pressure to resist cultural change can counterbalance this positive experience (Moghissi, 1999). It is due to this 'cultural resistance' that patriarchal values and norms are perpetuated and reignited through the role of family and community (Moghissi, 1999). Therefore, maintaining patriarchal gender roles and family structure, which represent the native culture and identity, become more important for diaspora peoples, to the detriment of women. Challenges to these values and norms are discouraged as 'outside' influences, and the native culture becomes the standard for a 'higher culture', and a source of pride (Moghissi, 1999).

Bhopal (1997, p. 151) states that the dominant norms and values of South Asian culture disadvantage these women as they are "expected to be homemakers, participate in arranged marriages and engage in dowry practice" and "traditional" women want to continue with arranged marriages and dowries as markers of their South Asian identity. South Asian women in Britain experience two forms of patriarchy, namely, private (arranged marriages, dowries, domestic labour and domestic finance) and public (the labour market). The position that South Asian women have within the household, which includes the family, affects what they do with their lives (Bhopal, 1997). As indicated in the above-mentioned study, younger women are experiencing a change from private to public patriarchy. Education and employment has an influence on their position in the household and on the forms of

patriarchy experienced by them, as well as the degree to which they are traditional or independent (Bhopal, 1997).

Buijs (1993) also proposes that women can accrue increasing importance within the family due to new economic and social responsibilities. Women can also gain power through their culture and communities as they recreate their cultural systems, choosing to retain certain traditions in their cultures. Westerners might view these traditions as oppressive for women, while the women themselves do not, and can use them to their advantage. For example, East African Sikh British women are able to move around freely in London due to their employment and expanded contacts, hence contributing financially to their own dowries and deciding how the money is spent. This paid employment and resulting independence influences the negotiation of power domestically (Bhachu, 1985).

In the past, Indian immigrant women in Australia have generally been well educated, professionals engaged in paid employment (Joshi, 1995), in contrast to the stereotypical Indian woman, and are likely to seek self-satisfaction not only through marriage and motherhood, but through personal goals and self-development as well. However, education does not prevent a woman from feeling strong social pressures to conform to the traditional image of a woman (Whelehan, 1988). This could cause conflict between what is culturally prescribed for women and what is seen as fulfilling in a Western, individualistic sense. Women could feel pressure to adhere to traditional roles in order to maintain their culture whilst also conforming to Western notions of gender equality. Moreover, since 2004, the demographic profile of Indian women in Melbourne has changed as there has been a new wave of immigration, with more women arriving under the family reunion programme, who are not

necessarily tertiary educated or professional women. This sets up a different set of dynamics with regard to roles and identity. These women clearly fall into traditional roles prescribed for women, with these either being perpetuated in this environment or requiring change because of economic circumstances.

Acculturation and identity construction

Acculturation is the process whereby cultural identity is transformed after migration. This transformation occurs to varying degrees and takes place at the intersection of different groups in a society. Acculturation can be broken down into two stages, namely, a stage of material acculturation in the first generation of migrants, and a stage of formal acculturation or the reinterpretation of the original culture by the second generation (Abou, 1997, p. 8).

For minority groups in Western society, keeping distance from the foreign beliefs and practices of the dominant culture requires maintenance of or reconnecting with some aspects of traditional culture which allows the formation of a stable ethnic identity (Uba, 1994). Individuals attain a strong ethnic identity and traditional orientation in coping and adapting when they separate themselves from the norms and values of the majority society and identify with those of the minority group (Robbins et al., 1998). When settling into a new country, most new immigrants adhere to critical traditional values and behaviours while excluding the dominant culture's traits (Nicassio, 1985; Phinney, 1990; Sue & Sue, 1971).

The resentment that can build towards the dominant culture and its beliefs and customs generates the ensuing cultural resistance, which can operate as a safe haven from class and ethnic prejudice. Hence, uncritical acceptance of patriarchal systems

can be encouraged by the solidarity that can be characteristic of diasporic communities due to their marginalisation (Moghissi, 1999). Therefore, the loyalty that Asian Indian immigrants show to their natal culture is an important aspect of the psychology of the minority in society, as it affirms their ethnic identity (Kibria, 1987, 1993; Sue & Sue, 1999; Tajfel, 1981; Uba, 1994).

Continuity of culture is seen through cultural traditions, which are stabilising for migrants and needed for continuity of identity (Lakha & Stevenson, 2001). Some researchers believe that ethnic identity is the most important aspect of a person's social identity because of the shared cultural components of an ethnic group, such as common history, traditions and language, which offers an essential and firm foundation from which the personal identity can be conveyed (Taylor et al., 2003).

Identity has many facets, including, gender, ethnic, religious and national identities (Tajfel & Turner, 1986). Usually, cultural identity is equated with ethnicity. However, cultural identification can occur on different levels, namely, the ethnic group, the national culture, and a cultural affiliation that transcends national boundaries. Because of a shared historical heritage, ethnicity can give rise to the feeling of a common cultural identity in groups of diverse nations (Abou, 1997). This is the case with the Indian diaspora across the world, irrespective of country of birth. Hence, Indians born in various countries around the world, such as Fiji, South Africa and Britain, share a common cultural identity with each other as well as with Indians born in India.

Migration impacts on a person's sense of self, calling for a reinvention of one's identity (Ward & Styles, 2003). Individuals differ in the intensity of their

commitment to an ethnic identity depending on their loyalty to different aspects of the natal culture and the degree to which they identify with the dominant culture (Hutnik, 1986; Sue & Sue, 1999; Uba, 1994). This determines the degree of identity reconstruction in which immigrants engage. Dasgupta (1998) identifies three categories of immigrant identity based on a dimension of internalisation of the dominant cultural norms: (a) assimilationists, who adopt critical behavioural norms of the dominant group to the exclusion of ethnic characteristics; (b) biculturalists, who amalgamate both ethnic and dominant group features; and (c) marginalists, who feel alienated from both cultures. Phinney (1990) offers a three-step model for the process of cultural identity development, calling the first stage, uninspected ethnic identity, where the minority group unquestioningly conforms to its own values and norms. The second stage, exploration, is when the group begins exploring its relationship with the dominant culture. The last stage, consolidation, involves incorporation of identity that may merge both cultures. A person may return to a previous stage from a higher level, as the stages are not hierarchical. Also this development may take a couple of generations to complete. Hutnik (1986) also categorises ethnic identification in a similar fashion: (a) dissociative (traditionalist), (b) assimilative (assimilationist), (c) acculturative (bicultural), and (d) marginal.

Dasgupta (1998) describes a multi-layered trajectory of acculturation to a new culture. This trajectory is not linear nor is it static, and external as well as internal pressures which are all part and parcel of the immigrant experience, help immigrants acculturate and gain a sense of belonging in the new country. This is a common expression of ethnic identity among Indians in America; Sue and Sue (1971) label such behaviour as traditionalism, whilst Robbins et al. (1998) call it traditional adaption. Dasgupta (1998, p. 953) states that “ethnic identity is part of a positive self-

concept that consciously anchors an individual to a particular ethnic group". She refers to the control of the course of acculturation by the immigrant through the conscious effort to maintain critical attitudes, values and behaviours, as "judicious biculturalism". Indian immigrants in the United States continue to keep ties with their cultural heritage by regular visits to India, while psychological closeness is maintained by reinventing Indian culture in the United States (Bhattacharjee, 1992). Also, these migrants reinforce their closeness to their culture by forming a network of businesses, religious institutions, cultural associations, and social gatherings (Mehra, 1992). Investment in property and exchange of visits are some other ways that British Gujaratis maintain ties with India. Efforts of this nature are part of ethnic identity making, which take place alongside their reconstruction of India (Kalka, 1990). This is important because as Hyers (2001) has noted, ethnic identity has a positive association with self-esteem and psychological wellbeing.

Bicultural socialisation refers to adapting to elements of both cultures and possibly mastering both (Robbins et al., 1998, p. 128). People learn coping skills to function in the majority/sustaining/mainstream system and the minority/nurturing/family system, integrating "positive qualities of his/her culture of origin and the dominant society's culture" (Lum, 1995, p. 60). Those who cannot may experience bicultural tension, as their coping skills are only based on that of the family or society of origin. Bicultural adaptation refers to retaining traditional cultural values and identity whilst learning, adopting and integrating norms of the mainstream society. These people become culturally integrated as they are able to accept both and attain "bicultural adaptation skills, bicultural competency and a bicultural identity" (Robbins et al., 1998, p. 134).

Negotiating identity and incorporating degrees of biculturalism allow women to feel a sense of belonging in the new country (Bhugra, 2004). Also, as ethnic minorities become bicultural, traditional values (which are usually different from those of the mainstream society) will alter (Robbins et al., 1998). This process of acculturation and ensuing metamorphosis of identity can only be harmonious if the integration of cultures takes place within favourable sociological conditions (Abou, 1997).

These theories of biculturalism have value in identifying the stages of acculturation for Indian immigrant women in this study for whom incorporation of Australian cultural traits will be a necessary mechanism for a sense of belonging in their new home.

Resilience

Not all people experience the trajectory of acculturation in the same way, although it may seem that people face the same challenges. This difference in the way people experience the settlement process in a new country can be interpreted through resilience theory (Dixon et al., 2010).

Resilience has been described as "a dynamic process of encompassing positive adaptation within the context of significant adversity" (Luthar et al., 2000, p. 543). Personality traits and coping styles are said to contribute to an individual's success under the stressful conditions of migration (Werner, 1993). The social and cultural context of resiliency also needs to be taken into consideration when examining resilience cross-culturally. This requires investigation of many aspects including individual development, community impact and cultural systems of thought (Tummala-Narra, 2007). Family and ethnic communities can provide individuals

with resources and support, thereby, serving as a source of resilience; this is termed collective resilience (Hernandez, 2002). Their cultural values and beliefs promote and further resilience. The ways individuals express resilience depend on one's cultural identifications, involvement with family and interactions with mainstream culture (Tummala-Narra, 2007).

Factors associated with resilience include internal factors such as a sense of cultural heritage and the existence of religious or spiritual beliefs (Walsh, 2002) and shared values and continuance of family rituals (Silberberg, 2001). External factors are informal and formal social support systems (Silberberg, 2001). This includes a supportive family and a sense of community and of belonging (Mandleco & Peery, 2000; Nayar, 2005).

Resilience theory has significance for understanding why some women have positive experiences of acculturation and settlement, while others, less so.

Multiple identities

Researchers state that ethnic identity is context-specific and is produced or achieved instead of being issued (Phinney, 1990), where feelings of ethnicity can depend on the circumstances at the time (Williiams, 1992). Mankekar (1994, p. 363) states that identities are not stable and unified, rather, conjunctural. Hall's (1996, p. 4) assertion that in contemporary societies, identities are "increasingly fragmented and fractured" are similar to that of Brah (1996, p. 183) who writes that identities are shaped by material circumstances of daily life and narratives that people articulate, and are not constant. The construction, negotiation and reproduction of identities are also affected by transnational settings and dynamics. The identities of groups of

people are negotiated within social worlds across many places, just as many people's transnational networks are based on a perception of common identity (Vertovec, 2001, p. 573).

Helweg (1992) described new Indian immigrants to Australia as being comfortable in both Western and Indian surroundings. Naidoo (2007) observed that Indian immigrants in Australia display hybridisation of their Indian heritage and their Australian citizenship whereby they reconstruct personal and communal identities. Under transnational movements, it is more common to see competing and multiple identities (Smith, 1998); the identity is in constant flux and comes in heterogeneous forms due to the fluid and varied contexts of contemporary South Asian diasporic communities. This cultural heterogeneity amongst Indian diasporic communities is seen alongside unity of national identity (Lakha & Stevenson, 2001). Transculturality means that a person can adapt to various cultures, and embrace commonalities and differences among different cultures. Cultural pluralism is based on the process of acculturation where diverse groups stay together and share their cultures (Robbins et al., 1998, p. 121). This effect is illustrated in a study of Indo-Caribbeans (Warikoo, 2005) which found that this group had little or no conflict between the various parts of their identity.

This context-specific and transcultural view of ethnic identity provides a useful lens for examining the Indian women in this study whose transnational movements and affiliations can, as they acculturate, create various representations of the self depending on the circumstances they find themselves in.

Immigrants can experience isolation, cultural displacement and identity crisis which can lead to either rejecting or accepting the dominant culture or adopting and maintaining both cultures simultaneously, which is necessary for the development of self-esteem and a positive identity (Tewary, 2005). Immigration and acculturation can create transitional marginality for adults as they encounter social role and ethnic identity conflicts. The status that comes with certain traditional family roles can be eroded, offering women more opportunity for independence whilst causing upheaval in the traditional family structure (Robbins et al., 1998). Identity and personality development in traditional cultures is generally not an individual responsibility, but a collective one. Absence of or reduced traditional support structures impacts on identity formation and potentially causes identity conflict in a new hybrid social and cultural environment.

This appears to be the case more with first generation immigrants than second generation. South Asian first generation immigrants can encounter confused identities resulting in an identity crisis because of their feelings for their homeland as well as the hostland (Visweswaran, 1994). Difference in expectations and cultural values of both societies can also create mixed up identities (Archer, 2001) and culture value conflicts for South Asians as seen in a North American study (Inman, 2006). Here, immigrants find themselves conflicted by the values of their natal culture and that of the prevailing culture, whereby they are unsure as to which of their cultural identifications to prioritise in a given situation.

Researchers have shown that people who are visible ethnic minority groups might be seen as outsiders, regardless of the time they have spent in a particular country (Moghaddam & Taylor, 1987). However, a study on South Asians in North America

shows that individuals who are able to resolve prejudices and messages of inferiority from the mainstream/majority society and develop a positive ethnic identity are successful at dealing with the conflict and tension that arise from dual cultural influences (Robbins et al., 1998).

South Asian women are known to have developed positive personal and communal identities in their new spaces (Ralston, 1998). They are their own agents in the social spaces that they enter, and can reconstruct their culture and redefine their identities and self-representation to the other, through the practical aspects of their everyday lives (Ralston, 2006).

Culture and motherhood

When examining Indian immigrants mothering in the Australian context, transmission of cultural prescriptions surrounding motherhood becomes particularly pertinent as the articulation of culture provides familiarity and security as well as a sense of pride in cultural identity. There is a vast amount of literature on motherhood; however, research on Indian immigrants mothering in Australia is lacking; hence, the need for studies such as this one.

The following review is confined to comparisons between two different cultural approaches to motherhood, namely, the Australian and the Indian. These cultures have different approaches to mother and infant care. In this section, the cultural ideologies of gender and motherhood are overviewed, followed by a comparison of cultural conceptions of mothering, including traditional mother and infant care among Indians, as well as infant feeding for both groups.

Since motherhood takes its meanings from the family and the wider community (Woodward, 1997), the culture of mothering needs to be reviewed in order to shed light on the conflict that results for immigrants attempting to mother across different cultural environments. The major themes that appear in this literature on motherhood include contrasting conceptions of motherhood, which encompasses traditional aspects of mother and infant care practiced by Indian communities globally, as well as infant feeding practices within both cultures.

Indian and Western ideologies of gender and motherhood

The traditional ideology of womanhood in India defines women as homemakers and nurturers who should be devoted and selfless (Donner, 2008). This places marriage centrally in Indian women's identities. In most parts of India, marriage is socially mandated, usually arranged, and is seen as necessary to ensure the chastity of women. In India, marriage is seen as a union between two families, and is firmly rooted in religion and culture. Intimacy develops in marriage as an outcome of parenthood (Puri, 1999). A study conducted amongst 54 middle and upper class women in Chennai, India (Puri, 1999) explores their understandings of gender and sexuality including class, nationhood and identity. The study reveals the underlying structural tensions and dominance of hegemonic discourses of sexuality that are encouraged by the Indian state. Women's expectations of marriage are not based on companionship (Puri, 1999). The accounts of women are not rooted in assumptions of subordination, but in their agency. None of the marriageable-aged unmarried women indicated that they would not want to marry, and none of the married women suggested that they would prefer not to be married (Puri, 1999). Also, women's accounts on aspects of marriage show how the premise of womanhood is sustained in

women's lives, and the social mandate of marriage are sustained by the discourse of compassionate marriage. Women deploy this framework of marriage strategically to both negotiate and secure their positions within the marital relationship and in the larger conjugal family. In this way they are able to partially gain from their compliance to wifehood (Puri, 1999).

In Indian society motherhood is still considered a necessary aspect of womanhood and marriage. It is recognised as a socially powerful role, and serves an important role in the fashioning of hierarchy within the society. Motherhood enhances a woman's integration into the husband's family and acts as a vehicle for negotiating and securing roles (Puri, 1999). The meaning of being a mother is conditioned by the fact that motherhood is not a personal thing, but instead is shaped by family and the rest of society. The experience of motherhood is hence a process of control of the mother, often under the guise of religion and familial love. The reproduction of womanhood through marriage is hence both limiting and enabling. However, although this tells us about middle class Indian women, the findings may not be true for lower class women or women from the North East of India or from other matriarchal Indian societies.

Amongst Indian immigrants in Australia where the extended family is absent for the most part, a woman's place in the nuclear family could potentially become more influential, securing more autonomy and power within the marriage and the family as a whole.

In contrast to Indian notions of motherhood, in the West feminism has steered the culture of mothering in recent times (Power, 2005). It began with the task of

separating the definition of ‘woman’ from that of ‘mother’. Since then, motherhood has been entangled in the radical individualism of the 1980s, and has now returned to a need for a restructuring of the workplace to create more balanced opportunities for both men and women, especially with regard to raising children. This debate has partly been in reaction to the idea that women can have it all (Power, 2005). For Western women, motherhood is no longer a precondition to being a woman, and when it is chosen/occurs, women are encouraged to retain their individual identities and seek personal fulfilment separate from motherhood. This culture of individualism views children as counterproductive to the right to self-development, with motherhood being seen as counteractive to self-fulfilment. Parents are generally concerned with keeping their lives unchanged after having children (Manne, 2005). According to Cannold (2005), motherhood is at a crisis point in contemporary Australian culture. It is proposed that circumstantial childlessness grows as a result of women’s over-employment, as full-time employed women are still doing two thirds of household work and are statistically less happy than in previous times (Maushart, 2005). In this society, due to the market economy, stay-at-home mothers are not looked upon as economically valuable as they are seen to not be contributing to the household income (Manne, 2005).

A study in Australia, by Davies and Welch (1986) examined the conflicting moral imperatives: that mothers are the best people equipped to raise their own children; and that women are people and have the right to their own lives. Interviews with 10 women with young children showed that being a mother and being a person can be mutually exclusive to these women, especially when they idealise motherhood. Motherhood under the conditions of being isolated from the extended family and thinking of motherhood and womanhood with a particular set of beliefs, can lead to

loss of identity and self. In another Australian study by McVeigh (1997) in Melbourne, a six week postpartum survey data of 79 women was drawn upon to discover the experiences of first-time mothers. Mothers felt that medical staff had deliberately not told them about how difficult caring for their infant would be, including loss of personal space and time. It was suggested that education programmes directed at mothers long before they give birth are potentially more effective (McVeigh, 1997). Yet another study (Wearing, 1990) conducted on 60 mothers who attended baby health centres in Sydney revealed how the sense of being a good, selfless mother, affects women's health. The study showed relationships between leisure time and personal space and aspects of general and mental health. Wearing (1990) suggested that women who are able to develop strategies to negotiate motherhood benefit in regard to their control of their situation within the family and have greater emotional wellbeing.

In Australian culture, the idealised view of a good mother stemming from the 19th century has been mostly defined by middle class Western standards (Ladd-Taylor & Umansky, 1998). Women's experiences are evaluated by this measure, thereby undermining women who do not conform (especially, adolescent, lesbian, single and working mothers) (Hunt et al., 2005). There are also conflicting Western images of motherhood (Kirkley, 2000). Mothering has been referred to as the essence of womanliness and femininity and ultimate fulfilment (Abbott & Wallace, 1997), while has also been described as onerous responsibility rendering a woman virtually powerless over the direction of her life, and the ultimate example of oppression (Lovenduski & Randall, 1993). When people from a collectivist culture migrate to a country with an individualistic culture, traditional ideologies and conceptualisations

of motherhood may be challenged as women try to negotiate the norms and values surrounding mothering in a cross-cultural sense.

Western women choose to have a child rather than to start a family, and have the option of being single mothers (Dowrick, 1986). In South Asian culture, marriage is seen as mandatory for motherhood, and due to the patriarchal nature of Indian society, negative attitudes to widow remarriage, and social stigma attached to divorce, all contribute to the taboo of single motherhood (Bharat, 1986). Amongst traditional Indians, a fatalistic view prevails about life, hence most women believe that they do not have control over whether or not they fall pregnant (Choudry, 1997).

In Western society, from the 1980s, the culture of mothering has centred within feminist discussion about female qualities and fostering an awareness of a woman's natural self and potential. The feminist critique of the biomedical model of birth developed around the notion of colonisation of women's bodies by the medical profession (Crouch & Manderson, 1993). Womanhood was traditionally a precondition for motherhood; now motherhood has become an expression of it, symbolically represented by labour. Although the number of women in Australia delivering at home is small, there is increasing public interest in home and alternative birthing. This has involved a shift from the foetus to the mother, a shift in locus of control from the activities of the practitioner to the experiences of the mother during labour, and a shift in focus from outcome to process, involving clients and practitioners (Dowrick, 1986).

Amongst Indians, most middle and upper class women seek medical intervention and have a doctor attend their childbirth in a hospital, due to the influence of Western

medical practices, urbanisation and education. Childbirth in India is still very much women's business, with midwives and female relatives providing support, and male participation in the birth process is still uncommon (Kuruvilla, 1987; Leininger, 1988). Traditional families generally resist change; however, equality is on the rise among affluent, educated and urban families, with joint responsibility and decision making (Choudry, 1997). Amongst British Indians, traditional practices are being reconstructed. A study by Woollett et al. (1995) found that as women no longer saw childbirth as women's business, they wanted their husbands present at the birth, and most had their partners present at delivery. Acculturation was associated with variability in Indian immigrant women's beliefs and narratives, but religion was not associated with this variability (Woollett et al., 1995).

In Australia, since community support is not emphasised for new mothers, partner support is more relied upon and seen as important (McVeigh, 1997). A study by Terry et al. (1995) addressing stress during motherhood drew on questionnaire data from 137 employees of a large retail organisation and 197 expectant mothers in Queensland. The results showed that support for the employees from colleagues on levels of adjustment were mediated through coping mechanisms, whereas support received from supervisors was direct. Support for the mothers from partners, on their adjustment to motherhood, was mediated through coping mechanisms, whereas support from family members was direct. The suggestion was that social support can benefit adjustment to stress by aiding the development of coping mechanisms (Terry et al., 1995).

In Indian culture, mothering comes with the expectation of support and knowledge from senior women in the community throughout the course of this experience. The

social order calls for extended family, friends, neighbours, and traditional midwives (*dais*) to lend assistance and care to a new mother. When they are no longer part of the picture, as with many immigrants, women are deprived of essential physical and emotional support, during a time of need (Choudry, 1997).

The cultural context of mother and infant care amongst Indians worldwide

Not all women experience motherhood in the same way. Women bring to the role of mother skills and abilities that are shaped by various factors that are drawn over a lifetime (Logsdon & Gennaro, 2005; Misra et al., 2003), with their knowledge, attitudes and practices towards mothering growing out of the interplay between biological and environmental factors in their lives (Evans & Stoddart, 1990).

Mothering experience and perception of motherhood is influenced by images in Western society, ethnicity, cultural background and employment status (Koniak-Griffin et al., 2006). Motherhood is impacted by cultural displacement, with immigrant women's ideas of themselves as mothers being greatly defined by their culture of origin (Tummala-Narra, 2004). The mothering role is learned and the cultural environment hugely shapes mothering behaviours and experiences (Koniak-Griffin et al., 2006).

Mother and infant care in Indian culture

Specific beliefs and practices surrounding pregnancy, delivery and the postpartum are culturally created (Brettell & Sargent, 1997). Mead and Newton (1967) found during a literature review of 222 cultures, that all have understandings about appropriate conduct, making childbirth and infant rearing virtually universally

situated in culturally specific customs regarding such things as activities to avoid, foods to eat, and care of mother and child, with such traditions becoming especially important when practiced amidst a different cultural milieu.

Traditional ideas often contrast with Western medicine with regard to care during the antenatal to postnatal period (Kim-Godwin, 2003). Western hospital care stresses the value of bonding and establishing early mother-child relations. However, there is little reference to such practices in anthropological studies of childbirth nor are they referred to often by Indian women (Dobson, 1988; Henley, 1979; Homans, 1982) suggesting that concern about early mother-child relations is a feature of the hospitalised maternity systems of the United Kingdom and United States (Lozoff et al., 1988). However, lack of concern with early mother-child relations may also reflect the cultural context in which Indian women traditionally bring up children. In extended family networks in which female relatives share responsibility for childcare, the establishment of a one-to-one relationship between mother and child is less of an issue (Dobson, 1988).

As women mother across cultures they encounter questions and challenges concerning identity reconstruction for first generation mothers as well as their children (Tummala-Narra 2004). The reproduction of customs and rituals by the women's female familial support network allows for a reiteration of identity for immigrants, as they are constantly reminded of their culture through the various traditions surrounding pregnancy, birth and early motherhood (Dasgupta, 1998). The Indian community, a minority distinguishable from the Anglo-Australian majority, has the opportunity to perpetuate their traditions through visiting mothers or mothers-

in-law and articulate their ethnic and cultural identity through this process of mothering.

Women, traditionally the keepers of culture, continue Indian customs upon immigration, designating senior women in the family most significant in the transfer of culture (Mani, 1992; Tummala-Narra, 2004). Cultural transmission is where successive generations learn survival techniques from previous generations whereby an information system, namely, material objects, ideas and beliefs and ways of doing things are transmitted from one generation to another through non-genetic mechanisms. In this transmission, imperfect replication of culture takes place as younger generations reinterpret rules they have learned from elders taking into account their own experiences and challenges. New ideas are often gained from neighbouring groups; namely, the host population, in the case of immigrants. Selective retention of new ideas and techniques also occur in response to their effectiveness in coping with challenges, including situations that threaten the incorporation of the individual and the group (McElroy & Townsend, 1996).

Other Indian traditions relating to mother and infant care which are formal, culturally defined practices, part of a broader, collectivist system include:

Support and confinement

Usually Indian pregnant women are not expected to do heavy work as the resulting build-up of heat is believed to lead to abortion (Pool, 1987). However, only affluent and high caste women are able to rest and be pampered by their families, while working class and poor women have to continue work, and those on farms fetch

water and carry heavy loads until labour begins, with the risk of miscarriages (Choudry, 1997; Pool, 1987).

Traditionally, women often return to their natal homes during pregnancy, especially for first babies, anytime from their seventh month onward, to be nurtured by their family. Mothers cook and clean for expectant daughters during this time and mothers-in-law take over women's household duties in their husband's homes while they are away (Raheja & Gold, 1994).

A postpartum rest period or confinement is common in most non-Western cultures, with only its length varying across cultures (Lauderdale, 1999; Nahas et al., 1999). This usually extends for 40 days after birth during which time female family members and midwives provide help and support for the new mother who requires time to recuperate (Holroyd et al., 1997; Nahas & Amashen, 1999). This is typical in India, where women and newborns are seen to be vulnerable during the first 21 days for Hindus and 40 days for Muslims and their seclusion protects the new mother and her infant from exposure to evil spirits as well as illness (Assanand, et al., 1990; Kolanad, 2000). During this time, Indian women, in common with women in many cultures, are viewed as impure or unclean. They are encouraged to stay at home and not to engage in activities such as praying or cooking which may put themselves in contact with others and also place themselves at risk of catching infections. At the end of this period of impurity, women begin to take up their usual activities (Lozoff et al., 1988). This approach is clearly articulated by women from a variety of religious and cultural backgrounds in contrast to Anglo women for whom the last vestiges of such practices are to be found in the churching of women after childbirth (Dobson, 1988; Homans, 1982).

British Indian women show knowledge of their traditions whilst not being negative towards Western biomedicine, even though hospital and biomedical practice often do not complement cultural practices. Indian women showed greater concern toward restrictions on certain activities and a need to rest and recover in the postpartum, than their British counterparts. Traditionally mothers and children are often looked after by other women, and mothers are given special foods to build up their strength in anticipation of the time when they return to their duties (Henley, 1979; Homans, 1982). This is subject to women's circumstances, such as whether they have other children and how much support they receive at home (Woollett et al., 1995). This approach is seen by Indian women to contrast with that of hospitals which encourage mothers to take responsibility for themselves and their infants on the postnatal wards (Woollett et al., 1995).

With South African Indian women, activity during pregnancy is advocated to loosen the muscles and help keep the baby small so that delivery will be easy (Chalmers, 1993). They return to their mother's home about one month before delivery. As most births are now at hospitals, the traditional midwife will generally be called to attend the mother in the post-partum period. The new mother is confined to an isolated part of the house during the postpartum period as she is regarded as unclean (Chalmers, 1993).

Ayurvedic medicine and food

Hot-cold concepts of healthcare (also called humoral theories) are centuries old in the traditional cultures of Latin America, Africa and Asia (Manderson, 1987; Spector, 2009). Within the Indian subcontinent there is a rich tradition of lay

medicine based on foods and herbs as well as yoga, magic and religion. Humoral views of food, illness and health including the 'hot/cold' concept are widely held, and are central to *Ayurveda*, the principle traditional medical system. It lays a heavy emphasis on the disturbance and rectification of the 'hot/cold' equilibrium. The *materia medica* is based on herbs, minerals and dietary manipulation, but also borrows freely from the drugs and techniques of Western medicine (Bhopal, 1986). 'Hot' and 'cold' do not refer to actual temperature states, but to abstract qualities. Foods, bodily states and diseases are classified as being hot or cold and diseases are thought to be caused by excess heat or cold in the body (Pool, 1987).

Hot diseases are generally seen as being caused by too much heat in the body. The symptoms of this are caused by the externalisation of excess heat from the centre of the body to its outer surface and are externally visible and cause redness of the skin, swelling, boils, rashes and other maladies, liquid flowing out of the body (diarrhoea, vomiting, bleeding, and emissions of semen) and abortion. Hot diseases are not generally painful but are often characterised by irritation and treatment is by cold remedies (Pool, 1987).

Cold diseases, on the other hand, are generally seen as being caused by too much cold entering the body. The symptoms of this are the result of the internalisation of the excess cold deep in the body and are less visible but are often painful and disabling, These include bodily pains, rheumatism, paralysis, congestion (of the lungs, respiratory tract, intestines and womb) and treatment is with hot remedies (Pool, 1987).

Everyday illnesses are also understood in terms of the hot/cold balance. Mustard oil is said to be effective for coughs and colds as it is said to have heating qualities (Reissland & Burghart, 1987). Other agents are added to enhance the heating properties of the oil. Each household has its own recipes, but of common use are: mustard oil mixed with ground nutmeg and cumin; mustard oil mixed with ground *asafoetida*; and mustard oil steeped in garlic. These preparations are then rubbed on the infant's body. A further recipe, used in the treatment of coughs, entails mixing camphor with ghee and rubbing that on the chest and throat of the infant. The aroma is rather like that of Vicks Vaporub (it should be added that this popular remedy for coughs and colds is marketed by the Indian subsidiary firm as an *Ayurvedic* medicine (Reissland & Burghart, 1987). Although a cooling massage can be given, cooling substances are not generally used in infant massage. In northern parts of India, coconut oil is considered a cooling substance, but is not used as a daily oil or to dress the hair until the infant is two years old. Equilibrium is restored from fevers by loosening or removing the child's clothes until body temperature returns to normal (Reissland & Burghart, 1987). Oils, such as almond and mustard are used for massage to cure fatigue, muscular pain and abdominal pain (Bhopal, 1986).

In *Ayurveda* there are many methods that promote the health of the pregnant woman and the mother and baby following childbirth (Sharma et al., 2007). *Ayurvedic* medicines help the mother's womb heal and allow her to regain energy, facilitate a good breastmilk supply, and help with digestion for mother and baby. *Ayurvedic* medicines are added as spices to food, or taken as tablets or syrup, and herbs are added to baths.

Ginger, turmeric and garlic (condiments of the everyday diet) are also used for their medicinal value. Turmeric (*haldi*) is ingested as an internal antiseptic, being recommended as such in the post-partum period. It is also used externally as an antiseptic and applied as poultices to cuts, bruises and infections. Asafoetida (a spice noted for its carminative properties) is sometimes used as a remedy or as a condiment. Fennel seed (*sonf*) prepared in water, milk or tea is said to be effective for gastrointestinal problems and for respiratory infection (Bhopal, 1986). The *Ayurvedic* system also recommends other herbs to promote lactation and the growth of the baby (Sharma et al., 2007).

In many non-Western cultures, blood is considered hot. Therefore, after giving birth, when a woman has lost blood she is considered to be in a cold state. Hence, in order to restore the new mother's humoral balance, postpartum care includes keeping the new mother warm (Kim-Godwin, 2003). Therefore, after birth warm baths are taken with cold baths or showers being avoided (Choudry, 1997).

Amongst South African Indians, the woman is not given food until the day after the delivery as she is believed to be too exhausted. She is first given pepper water, a strongly spiced chilli and garlic broth believed to warm the body. A distilled alcoholic drink like brandy may be given on medicinal grounds as a tonic with healing properties (Chalmers, 1993).

With Fiji Indians, while still at hospital, the mother is brought a hot ginger spice drink, *sont*, by her family, which she has to drink three times daily to help initiate lactation (Morse, 1984).

In India, there are certain customs and taboos surrounding pregnancy and the postnatal period. One area that is greatly bound by these is food. There are various foods that are to be consumed or avoided during pregnancy and the postpartum illustrating the diversity of practices across regions in India. Food is either classified as hot or cold according to the ancient *Ayurvedic* system of medical science (Choudry, 1997).

During pregnancy, the general rule is that hot foods are harmful and cold foods are beneficial. Pregnancy generates a state of hotness which means that the person concerned is particularly hot, vulnerable to hot food, weather, etc., and particularly prone to hot diseases. Therefore, adjustments have to be made to the amount of heat a person is exposed to during the various stages of pregnancy. In this process, different factors have to be taken into account, namely, the sources of heat (the pregnancy itself, bodily constitution, diet, weather, etc.) and the dangers inherent in pregnancy (abortion, difficult delivery, still-birth, illness in the infant, and so on). Hence, in early pregnancy, excess heat can lead to spontaneous abortion (Pool, 1987). Therefore, it is thought to be desirable to attain balance by eating cold food (Nag, 1994).

Hot foods are encouraged during the third trimester (Choudry, 1997). Women are advised to eat hot food in order to encourage labour and to build up the heat necessary for delivery, especially important for women with a cold constitution because they are said to be more likely to have difficult deliveries. Women who have a hot constitution do not need to eat extra hot food as they should have sufficient bodily heat to ensure an easy delivery (Pool, 1987).

There is less information about foods that are beneficial during pregnancy, but more about those said to be harmful (Nag, 1994). In India, restrictions during pregnancy seem to be greater for fruits than for any other food. The most widely believed harmful fruit is papaya, with banana, jackfruit and pineapple being next in order. Papaya is mostly avoided during pregnancy because of its hot quality and its ability to induce abortion. Symptoms associated with its hotness, include the instigation of uterine haemorrhage, white discharge from the vagina and diarrhoea. The following spices are seen as harmful during pregnancy because of their hotness: amaranth, chillies, fenugreek, garlic, ginger, onion, salt, sour spices and tamarind (Nag, 1994).

Advice usually given by mothers-in-law and traditional birth attendants from rural areas include: eat in moderation during pregnancy to avoid having a large baby and difficulty in childbirth (Chatterjee, 1991) and to avoid indigestion (Nag, 1994). It is quite the opposite in urban middle and upper class populations, where women are encouraged to consume a lot of food (Nag, 1994).

Hot and cold are not the only qualities ascribed to food; they can also be described as strengthening, difficult to digest (heavy), easy to digest (light) and flatulent (windy). Strengthening foods are usually hot. They are strengthening because they generate energy. Heavy foods seem to be mainly cold and they tend to cause weakness from lack of energy, and this weakness can be manifested as difficult digestion. Hot foods are identified as being difficult to digest (Pool, 1987).

It is believed that although pregnancy generates a state of hotness, the delivery upsets the balance achieved during pregnancy and brings about weakness. In non-Western countries, there is a general strong emphasis on heating food during the postpartum

period, and cooling food is prohibited (Kim-Godwin, 2003). It is good to include milk, ghee, nuts and *jaggery* (a course brown sugar made from palm sap) in the diet of the new mother to return her to a state of balance, and to avoid cold food and water. Dried ginger is eaten in the belief that it helps control postpartum bleeding and acts as a uterine cleansing agent (Choudry, 1997).

Jesudason and Shirur (1980) surveyed 1,106 pregnant, lactating, and weaning women in Andhra Pradesh concerning their beliefs about harmful foods. Foods considered hot, and therefore bad for the mother and fetus or newborn were: papaya (70%), pumpkin (55%) buffalo milk (20%), chicken (11%), and eggs (6%). The women surveyed believed that these foods could cause boils or diarrhea. Twenty percent of the women also said that banana could cause maternal fever and coughing and was bad for the foetus. Fish, meat, eggs, spices, and salt are generally believed to induce abortion (Ferro-Luzzi, 1980; Jeffery et al., 1989; Khanum & Umpathy, 1976; Sewa-Rural Research Team (SRRT), 1992, cited in Nag, 1994). Meats were also considered impure and believed to cause maternal vomiting and skin disease and fetal deformity (Nag, 1994). Papaya was frequently reported to be harmful; it is believed that papaya can cause abortion (Nag, 1994). Eggplant is considered to be among the most harmful of all vegetables (Mathews & Benjamin, 1979; Pool, 1987; Rao, 1985).

Village women of Gujarat who were surveyed (SSRT, 1992, cited in Nag, 1994) considered yoghurt, milk, banana and leftovers as cold foods that could lead to the formation of a sticky layer of fat around the fetus, making it stick to the womb and causing great pain during labour. Pool (1987) found that cold foods were considered beneficial, particularly during the first trimester. Milk was considered good during

pregnancy (Jeffery et al., 1989; Khanum & Umpathy, 1976; Rao, 1985). These beliefs are consistent with *Ayurvedic* medicine.

Indian immigrants in Britain also tended to be influenced by traditional concepts of diet during pregnancy and post natal care, as well as utilising Western care, as demonstrated by a study by Woollett et al. (1995) amongst Indian and non-Indian women in East London. Dobson (1988) and Homans (1982) both state that many immigrant Indian women do not hold one set of views rather than another, but operate with parallel sets of ideas and beliefs about pregnancy and childbirth, maintaining some aspects of traditional practice but at the same time valuing Western medical care. Such parallel sets of beliefs can also be seen to be operating in women's approach to diet in pregnancy (Dobson, 1988; Homans, 1982). Women report dietary practices based on the *Ayurvedic* system of medicine, with pregnancy considered to be a 'hot' state, and women advised to eat 'cool' foods to counter balance the heat of pregnancy.

With South African Indian women, dietary restriction, both in terms of quality and quantity is practiced. Too much food is believed to be harmful to the baby. Nourishing food is recommended. Although quantity is restricted, women are advised to satisfy their craving for specific types of food lest the child be affected; birth marks on the child are thought to reflect the mother's unsatisfied craving for some food (Chalmers, 1993). Cravings for sour or bitter foods as well as for sweet foods have been noted. Women are advised to avoid cooling foods as well as eruptive or windy foods, all of which are believed to threaten the foetus. After childbirth, milk and yoghurt in particular are prohibited as they are believed to inhibit the healing of wounds and to cause wind and indigestion. Because the woman

is believed to have wounds in her womb after birth, these foods are contraindicated. As it is feared that the new mother may suffer from ‘cool illness’, she must be given hot nourishment, such as coffee or hot water, rather than cooling substances like tea. Women are believed to be susceptible to ‘cool illness’ after birth because of the abrupt loss of the mother’s blood and body heat after the baby is born (Chalmers, 1993).

Since some ‘hot foods’ such as meat, fish, eggs and pulses are recommended to pregnant women in Australia, antenatal clinics need to be aware of cultural proscriptions and should to take them into account in the advice they give to South Asian women (Woollett et al., 1995).

Traditional massage

Massaging refers to “rubbing the body with oil or some ointment, and to warming one’s hands over a fire and then pressing them, palms open, to the body, so that the warmth is transferred to the other person” (Reissland & Burghart, 1987). In India, massage and breastfeeding are considered the two most significant practices of motherhood, and are the two most important ways a mother can nurture her child. Daily massage is expected to increase an infant’s strength and invulnerability and is thought to instill fearlessness, harden bone structure, enhance movement and limb coordination, and increase weight (Reissland & Burghart, 1987).

As the infant is considered to be highly impressionable during birth and weaning, it is also believed that its identity and physical, mental, and moral character can be shaped by the women who nurture the baby, in particular, through the mother’s milk (Reissland & Burghart, 1987).

Much of massage in the immediate post-partum is to ‘unfold’, clean and beautify the baby since it is seen to be born cramped, soft, vulnerable and dirty. The massage then takes the form of a series of stretching movements similar to yogic exercises. Mustard oil is used as it is said to harden the bone structure rendering the baby invulnerable to external danger (Reissland & Burghart, 1987).

The midwife is the first person to hold the newborn and also the first to massage the baby. Generally the midwife massages or cleans the baby with a cloth and some mustard oil by rubbing all traces of vernix from the skin, and at the same time “pulling each arm out full-length from the shoulders and then straightening the legs by pressing on the knees until thigh and leg form one line” (Reissland & Burghart, 1987).

Initially women present at birth try to correct certain physical defects while the neonate remains malleable, such that if the baby’s head has become elongated in squeezing through the birth passage, the women reshape it by pressing their palms against the cranium. Women such as the child’s father’s brothers’ wives and the father’s mother may take on the duty of massaging the baby. For people who trace descent patrilineally, this is important as it is these values that are being literally rubbed into the baby, as much as those of the mother (Reissland & Burghart, 1987).

Massage is also believed to help the baby put on fat and make him/her look healthy. Plumpness conveys a healthy appetite and a beneficent household. This healthy look is thought to be gained mainly through regular breastfeeding, but also by massage. Therefore, if a baby is thin, massage becomes more important since oil is seen as a

fatty substance which increases the fatty tissue as it is absorbed into the body (Reissland & Burghart, 1987).

These practices are also evident amongst South African Indians (Chalmers, 1993), and among diasporic Indians worldwide.

Bed-sharing

Bed-sharing is a form of co-sleeping that incorporates an infant and a caregiver sleeping side by side on a shared surface; co-sleeping is where mothers and infants sleep within proximity of each other (McKenna, 2000; McKenna & Volpe, 2007). In many Asian countries, co-sleeping along with breastfeeding approaches 100%, with Sudden Infant Death Syndrome (SIDS) deaths being amongst the lowest in the world (Nelson & Taylor, 2001). SIDS is the "sudden death of an infant under one year of age, which remains unexplained after thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history" (Willinger et al., 1991, p. 681).

Mother-infant co-sleeping "evolved specifically to maximise maternal well-being and infant survival" and is therefore possibly the most advantageous sleep environment for parents and babies, biologically and emotionally (McKenna & Volpe, 2007), and reduces infant death from SIDS by half (Carpenter et al., 2004). Western health professionals recommend against bed-sharing, a form of co-sleeping. In traditional societies night-time sleeping arrangements are usually indicative of "the nature of family values and the quality of social relationships at any given time" and are a cultural manifestation (McKenna & Volpe, 2007, p. 360). The resurgence of breastfeeding and bed-sharing in Western societies is being accompanied by a

great reduction in SIDS rates, especially with middle and upper class families (Nelson & Taylor, 2001).

Infants are usually placed in more than one sleeping arrangement during the course of the night. Ball et al. (1999) showed that although some parents report that their babies are crib sleepers, after their first night feed they often move them into the parental bed. It is probable that many parents feel unsupported by health professionals in their decision to bed share, causing them to hide the fact that they are doing this (McKenna, 2000).

Traditionally, Indians bed-share with their infants, although this is a generalisation and there may be some variability in infant sleeping practice across India due to various sub-cultures and traditions across the sub-continent. These practices are constantly changing and in a state of flux in the 21st century, and it is likely that traditional practices have been replaced by Western values because of the influence of modernisation and urbanisation.

Indians in Britain are reported to bed share with their infants more than the rest of the population and are less likely to die from SIDS (Petersen & Wailoo, 1994). Amongst South African Indians, the baby customarily sleeps in the mother's bed as it is believed that the first person one sees on awakening will influence the remainder of the day, it is important that the mother is smiling when the baby awakes (Chalmers, 1993).

Culturally competent health service provision concerning traditional infant care amongst the Indian diaspora

Most immigrants do not talk about the traditional aspects of care when dealing with Western health professionals because of fear of disapproval and a belief that doctors are neither knowledgeable nor interested in Indian medicine and culture. When British Indian immigrants use traditional remedies, they usually do so without mention to Western medical practitioners as they see this as a separate aspect of care, as shown in a study conducted by Bhopal (1986), in Glasgow. It found that Indian remedies were used before, with and after Western medicine, but this did not affect attendance to Western medical practices. As other studies show, there is little evidence that Indian women make less use of maternity services (Rocherson, 1988; Woollett et al., 1995). Traditional remedies were used as alternatives to 'over the counter' drugs for acute self-limiting illnesses and supplementary to professional consultation for chronic problems (Bhopal, 1986).

Although many customs are changing even in the immigrant's country of origin, the cultural practices of Indian immigrant women differ from those of women born or brought up in North America, for example. A study conducted by Choudhry (1997) amongst Indian immigrant women to Canada and the United States found that Indian women migrated from an authoritarian, restrictive socioeconomic environment to the liberalism and individualism of North American society. They brought with them beliefs surrounding what facilitates a good pregnancy and its outcome, as well as negative sanctions that may be difficult to ignore. Once these women encountered people who were not familiar with their customs and beliefs, they may begin to doubt those beliefs and themselves. An appreciation of cultural meanings sensitises health service providers and helps ensure provision of appropriate care, particularly when

the care depends on what the client thinks is important and that to which she will agree (Choudry, 1997).

Phoenix (1990) argues that it is important, from a theoretical and practical perspective, to consider parents' general patterns of adjustment as well as the diversity and variability in Indian women's attitudes and experiences. Indian women operate with parallel sets of beliefs and practices, illustrating how familiarity with and commitment to a Western healthcare system does not necessarily replace women's beliefs in or their commitment to some aspects of traditional practices around pregnancy, childbirth and infant care. An understanding of the ways in which these systems interact with one another, together with the part played by the context in which women live, provides the basis for culturally appropriate maternity care (Woollett et al., 1995).

Infant feeding in Indian culture

In India, breastfeeding is almost universal, however, initiation of breastfeeding is generally after three days and colostrum is discarded (Bandyopadhyay, 2009). There are cultural practices that surround the initiation of breastfeeding because of the fact that it is viewed as good. A common and widespread reason for delaying breastfeeding is attributable to the beliefs surrounding colostrum (Rogers et al., 1997). It is understood as indigestible and pus-like, deeming it a taboo substance (Walia, 1982, cited in Choudhry, 1997). The practice of withholding colostrum does not mean that a woman does not intend to breastfeed, however (Laroia & Sharma, 2006). Gururaj et al. (1990) found that only a small number of the women they surveyed fed colostrum to their newborns. Eighty percent of the women in one study

(Parihar, 1984) and 56% in another (Mukhopadhya & Achar, 1992) manually expressed and discarded colostrum. In the Indian state of Bihar, it is believed that in the *Sushruta* (ancient Indian scriptures), breastfeeding should begin on the 5th day, otherwise it is initiated on the 6th day after a celebration called *chatti* (Choudry, 1997). Breastfeeding is usually done on demand, once established, and continues as long as the mother feels that she has sufficient milk. Discontinuation occurs if the mother becomes pregnant, falls ill or decides to wean (Choudry, 1997). Although breastfeeding is prolonged, in certain population segments, such as the urban and the educated, the duration of breastfeeding is decreasing (Kalra et al., 1982; Khan, 1990).

Prelactation foods for the baby include boiled water, tea, sugar, honey, *jaggery*, or glucose with plain water and diluted animal milk (Khan, 1990). When infants are very young (0-3 months) they are usually fed on demand. For those aged three to six months, the frequency of suckling episodes does not go down significantly among non-working women; however, it drops considerably among those working women who do not take their children to work (Khan, 1990). In India, breastfeeding commonly continues until the infant is a year old, and even beyond, but is usually supplemented by cows', buffaloes' or goats' milk, depending on availability. Sometimes, animal milk is given to the infant, from a spoon or bottle, at a few weeks of age. The milk, however, is usually modified by adding sugar and diluting it, until the infant is a few months old. This preparation is recommended by several groups of health workers (Arora et al., 1985).

Breastfeeding duration amongst Indians in Britain is shorter and occurs less than in the Indian sub-continent (Price, 1988). This could be as a result of the accessibility of

formulae in Britain. Indian migrants take to using formulae in Britain rather eagerly, because in the sub-continent it is seen as a progressive practice of the wealthy. Indian immigrants to Britain use manufactured baby foods to a much greater extent than do Indians in the sub-continent, and they make more use of infant formulae and milk when the child is a year or older. Weaning is also brought forward. Since these migrant women prefer not to feed their babies colostrum, this is misread as a desire not to breastfeed and therefore bottle-feeding is introduced at the hospital (Price, 1988). However, a national United Kingdom study showed that Indian immigrant mothers were more likely to initiate breastfeeding and be continuing at three months compared with the Anglo population, and that acculturation may be reducing breastfeeding rates in ethnic minority groups (Kelly et al., 2006). Also, in a study conducted by Ingram et al. (2003) amongst Indian women in the United Kingdom, grandmothers and other female extended family members were seen to influence breastfeeding practice by their involvement in infants' care. Choudhry and Wallace (2012) suggest that acculturation has been shown to have a negative impact on breastfeeding practices of South Asian women in Britain. Less acculturated women fed their infants formula in response to their perceived increased demands for milk and because of conflicting information about feeding method from health professionals. More acculturated women also fed infants formula more than women do in India due to influences of the formula-feeding culture in Britain, therefore, migration impacts on traditional breastfeeding practices.

Amongst Indians in the United Sates exclusive breastfeeding for the recommended duration in not common either. Laroia and Sharma (2006) suggest that the cultural practice of grandmothers feeding babies limits breastfeeding. Kannan et al. (2004)

note that amongst South Asians in America, women lack guidance on breastfeeding, unlike their counterparts in India who are assisted by female relatives.

Similarly, amongst Indians in Fiji, once the baby is brought home, the infant is cared for primarily by the mother-in-law, who is the key decision-maker regarding the infant. Consequently, the nurse's advice to the mother at the hospital is usually in vain as only the mother gets to hear this, and since the mother-in-law takes over at home, she dismisses what has been said to the mother by the nurse. Also, the mother-in-law prefers to bottle feed the infant, as this facilitates her feeding the child (Morse, 1984). Mixed feeding takes place within weeks of birth. Breastfeeding is encouraged by the hospital, even though mothers often insist that they are not producing any milk, due to soreness of nipples during breastfeeding (Morse, 1984). Also hindering lactation may be perceived Insufficient Milk Syndrome (IMS). This is experienced by these mothers who believe that their breasts are empty due to them being softer after lactogenesis (Kannan et al., 1999). Morse (1984) concludes by stating that in the Ba area, in Fiji, cultural factors optimise a combination of breast and bottlefeeding (mixed feeding), which results in the infant being minimally breastfed twice a day (morning and evening). The ideal total breastfeeding regime is not feasible, as the maternal work role demands a contribution to the household that separates the mother from the infant for long periods of time.

In a study conducted by Lakhani and Jansen (1984), amongst Indian and African women in Nairobi, Kenya, mothers were uncertain about the advantages of breastfeeding and had an impartial or negative attitude towards breastfeeding. Amongst the Indian mothers, 87 percent were giving milks other than breastmilk or had stopped breastfeeding completely before they had been discharged from hospital.

The hospital also provided bottles at feed times, and infants were fed with bottles in the nursery at night. Of the Indian mothers, only few were aware that complementary feeding was unnecessary up to 4-6 months of age. The perception of 63 percent of the Indian mothers was that formula was (equally) as good as breastmilk for a baby of 3-6 months of age. Attitudes such as the thought that it was a sacrifice to breastfeed came from 66 percent of Indian mothers. Also, two thirds of the Indian mothers said that they would only feed in the privacy of their bedrooms. In a later study conducted by the same authors on the same sample in 1987, breastfeeding ceased at earlier ages than 4-6 months and 28 percent of Indian mothers were feeding their babies cereals at six weeks. Most Indian mothers in Kenya discontinued breastfeeding completely before leaving the hospital (Lakhani & Jansen, 1987).

In India, infants are weaned onto family foods at various ages. Since younger children are not believed to be able to digest foods other than milk, solids are infrequently given before six months of age, and usually not until nine to twelve months, or even later (Price, 1988). Adults in India have a generally nutritious diet, which is in many ways healthier that those of many Western countries. Still, it is not calorie dense in lower socioeconomic families, and can therefore lead to poor nutrition, especially in infants (Price, 1988). The growing infant is usually weaned on foods being eaten by the rest of the family that are seen as suitable for the infant. These family foods are generally not specially modified for weaning, and manufactured baby foods are almost never used as they are limited in supply and very expensive. Initially, the water in which the pulses (*dhal*) or rice or millet is cooked is fed to the child. Gradually, the child is then fed the cooked *dhal*, cereal and vegetables. Food cooked with chilli is not introduced until the child is two years

or older, however, salt and other spices are used. The foods most frequently eaten are savoury, and sweet foods are mostly eaten on special occasions (Reddy, 1987).

For Indian immigrants in Britain, weaning was brought forward and manufactured baby foods were used to a much greater extent than in the Indian sub-continent (Price, 1988). Due to health professionals' uncertainty about the suitability of Indian family foods, they actively promoted the use of manufactured baby foods, even though modified family foods would have been a nutritious alternative (Jones, 1987).

Culturally competent health service provision concerning breastfeeding amongst the Indian diaspora

Choudhry and Wallace (2012) recommend that health service providers in Britain be aware of and meet the needs of immigrant South Asian women at varying levels of acculturation. They suggest that factors influencing infant feeding choice need to be understood in the context of acculturation pathways that may have an impact on such decisions. Ingram et al. (2003) noted that antenatal educational intervention programmes, to promote good breastfeeding practice, that include extended family members are influencing behaviour, including giving colostrum. Kannan et al. (2004) suggest that health providers in the United Sates need to understand the cultural reasons behind Indian immigrants withholding colostrum and deliver messages concerning breastfeeding that take these customs into account.

Morse (1984) notes that rooming-in by a female relative who instructs the mother on how to breastfeed; and demand feeding generally establishes successful lactation for Indians in Fiji. However, the lack of privacy available in the open ward may be a stress-inducing factor for the mother, possibly hindering lactation (Morse, 1984).

Lakhani and Jansen (1984) also found that women felt they could not initiate breastfeeding at hospital due to lack of privacy. Hospital practices and attitudes of medical staff were also important in deciding the method of infant feeding amongst Indian women in Nairobi, Kenya.

The approach and care provided by health professionals dealing with childbearing women from various cultures can affect the quality of the experiences of these women. Differing socioeconomic and educational backgrounds, as well as the degree of acculturation of women from India and other diasporic communities may lead to varied and sometimes contrary impressions. Cultural patterns are selectively expressed. Expecting all women of Indian origin to behave and act in a similar fashion leads to misinterpretation and stereotyping (Choudhry, 1997).

Parenting amongst Indian immigrants in other Western countries

International studies (e.g. Akhtar, 1999; Sonderegger et al., 2004) state that there are various psychosocial factors involved in the settlement experiences of immigrants. Some of the most significant are changes to family structure and gender roles upon immigration from a collectivist society to an individualistic one, which has implications for rearing second generation immigrant children. Retaining some aspects of traditional family structure and gender roles assists in the continuance of cultural or ethnic identity and pride. Hence, immigrants attempt to perpetuate cultural structures, values and customs seen as important in order to inculcate them in their children as a marker of identity. However, it is changing family structure and gender roles that facilitate new maternities for immigrant women (De Souza, 2006). These

aspects of immigration and their influence on attitudes to parenting amongst the Indian diaspora are discussed below.

Changing family structure

Upon immigration, women can face disruption to varying degrees within their family units as family dynamics change. These dynamics can be dependent on the relationship with the spouse, pre-immigration history, extended family living in the new country, political and interpersonal trauma, and economic circumstances (Tummala-Narra, 2004).

Research shows that immigrant women find themselves bearing the burden of caring for husbands and children, where they might otherwise have had assistance from others in their extended family in their country of origin (Tummala-Narra, 2004) as family structures change from extended to nuclear upon migration, from a collectivist to an individualistic society. Many immigrant mothers receive some support from visiting family members in the new country, but family members' own cultural conflicts can sometimes taint this support (Akhtar, 1999), hindering the process of cross-cultural mothering. Immigrant mothering means relying on an interdependent system of support, such as husbands, friends, and health professionals (Tummala-Narra, 2004). This provides immigrant women opportunity to strengthen spousal relationship as women's reliance on husbands become greater. Mothers also tend to rely more on friends within their ethnic communities (Akhtar, 1999); hence the creation of women's social groups within ethnic communities become a way in which some immigrant women combat isolation in the new country (Tummala-Narra, 2004).

Changing gender roles

Although changing family structure and dynamics can mean a lack of familial support in raising children, this also allows women the prospect of breaking out of the socially and culturally defined roles of a collectivist society. Hereby, mothers have the opportunity to reproduce their cultural connections as well as reinvent their roles in the family and social context (Tummala-Narra, 2004). Besides reinvention of one's cultural identifications, mothering across cultures also requires reinvention of one's gender identifications. Renegotiation of gender roles is necessary for immigrant mothers to form their own personal identity in the new culture as gender roles are intimately linked with altering cultural identifications (Meyers, 2001).

Research shows that some women fantasise about being able to leave their natal families to start a new life that will allow increased personal freedom and choice (Tummala-Narra, 2004). However, Indian immigrants tend to continue traditional, differentiated gender roles wherever they migrate to (Agarwal, 1991; Kar et al., 1995/1996; Kurian, 1989; Sodowsky & Carey, 1987, 1988).

Sometimes, immigration can emphasise the division in gender roles in order to maintain a sense of familiarity or psychological safety (Espin, 1999). At other times, immigration encourages redefining parenting by the increasing involvement of fathers in raising children in a new country (Williams & Carmichael, 1985). For women, this can mean a decrease in full-time parenting and an increased presence in paid employment. As Tummala-Narra (2004) suggests, the advantage for women who were already in the workforce in their homeland, is that they can re-enter paid employment quite easily, thereby follow their interests, and integrate into mainstream society this way. Furthermore, immigrant mothers require access to

emotional refuelling for support on their journeys to becoming bicultural mothers through contact with members of their ethnic group and with friends and colleagues outside their ethnic group (Akhtar, 1999), which they can receive at work.

The impact of identity on the cultural context of childrearing amongst the Indian diaspora

Indian immigrant women articulate their culture and identity through motherhood (Tummala-Narra, 2004). When moving from a collectivist to an individualistic culture, immigrant mothers are faced with and have to adapt to several cultural changes with regard to parenting. These include a "shift in emphasis on the child's exposure to multiple adult models with greater infant indulgence and the child's conformity to a traditional family hierarchy, to an emphasis on a more permissive socialisation and the child's autonomy and separation" (D'Cruz & Bharat, 2001, p. 174).

The immigrant mother's sense of identity and confidence in bringing up children that are bicultural is formed by her pre-immigration fantasies, the actual migration to a new country, and post-immigration experiences. Immigrant women's adaptation involves the images and fantasies of the new country prior to leaving their home countries. These images of the West held by immigrant women are dependent on factors such as their current socioeconomic circumstances and family relationships (Tummala-Narra, 2004). The difference in pre-immigration fantasies and the actual adjustment to the new country is reflective of the process of mourning the loss of the mother country. Immigrants grapple with mixed emotions of sadness, guilt, and anxiety in coping with different cultures. This activates shifts in cultural identifications (Grinberg & Grinberg, 1989).

Separation from maternal figures and homelands also bear on the process of adjustment to the role of mothering in a new land (Tummala-Narra, 2004). Bicultural mothering calls for the resurgence of memories of maternal figures and of one's cultural parenting values. For example, first generation mothers can desire to reconnect with cultural traditions in the hope of reliving the nurturing, idealised images of their parental figures and cultural heritage (Chodorow, 2000). Immigrant and second generation women experience intensified physical and psychological separation from their mothers with regard to their own formation of maternal identity, especially when there is a lack of regular communication with maternal figures. Hence, immigrant women have to draw on the memories of their pre- and post-immigration maternal figures, which include mothers, aunts, grandmothers, and other relatives, while they develop their own maternal identity (Chodorow, 2000; Espin, 1999).

Women are expected to be carriers of cultural traditions for their children in the new country, and are responsible for raising their children to adapt to two cultures. Women can often be surprised by their attempts to retain cultural values and traditions during motherhood, as a need to reconnect with their cultural heritage is often suppressed before migration. Religion and/or language classes for children are not uncommon as well as wanting to mix with other children and families of the same ethnic background. This refuelling is an adaptive function, whereby attempts to reconnect with the culture of origin help cope with the losses of immigration (Akhtar, 1999).

However, this attempt to reconnect with the country of origin can interrupt the mother's and child's involvement with the new culture. Attempts to raise children

biculturally strongly depend on the immigrant mother's ability to negotiate her identity in the two cultures. Immigrant mothers need to be able to come to terms with their own losses, in order to facilitate biculturalism in their children (Tummala-Narra, 2004). They can gain a bicultural identity by refuelling through their ethnic community and/or maintaining some connection to their homeland, as well as accepting their child's mixed loyalties to both cultures (Akhtar, 1999).

The formation of new cultural identifications is related to the process of mourning distance from one's native culture. Immigrants can fantasise about returning to their countries of origin, as a result of their anxiety of having gone "too far" (Akhtar, 1999, p. 85). When this is not possible, often because of economic strain, mothers sometimes leave children in their native countries to be raised by grandparents and other family members. At other times, those with more financial resources, choose to sponsor their relatives to live with them and help with child care. With both scenarios, parents hope to be better placed to assist their children retain their cultural values, traditions and language (Tummala-Narra, 2004).

Dasgupta (1998) asserts that the maintenance of culture and identity is constantly threatened from within by the next generation. She found that first generation Indians in the United States see their biggest challenge as the transfer of culturally significant behaviours and identity to a generation of young adults who were brought up in the States. Since the continuation of the Indian community as a distinct ethnic group is dependent on the next generation's loyalty to their culture, great effort is made to raise children with traditional values and customs (Dasgupta, 1998). An important aspect of ethnic identity is to replicate significant customs and traditions with children by socialising them to adhere to them (De Santis & Ugarizza, 1995; Kar et

al., 1995/1996; Phinney & Rotheram, 1987; Spencer, 1987). Language and religious groups have been created to promote cultural practice to inculcate values in the second generation, and festivals are now taking on an additional role of acquainting the new generation with their Indian heritage. Many communities are founding youth forums to specifically familiarise their children with the parent's culture and values (Dasgupta, 1998), besides incidental learning.

Historically, South Asian women are the bearers of culture and identity. It is the duty of daughters (second generation) to perpetuate traditions and customs (Mani, 1992). Women have to balance group and personal expectations. Even though mothers hold more liberal gender values than fathers and sons, they are responsible for maintaining traditional gender roles for their children, especially daughters, in keeping with Indian women's roles as keepers of culture (Dasgupta, 1998). Dasgupta terms this active and empowered effort by immigrants as judicious biculturalism, a course of adaptation used to optimise adaptation by organising one's own experiences and controlling, negotiating and directing the rate, level and progress of acculturation to the new culture. Hence, more expectations are placed on daughters as they will be the conveyers of culture to the next generation of Indian immigrants.

Even though Indian immigrants in the United States and Canada have adapted well to their new homes, they have kept their traditional values regarding home, family, children, religion and marriage (Kar et al., 1995/1996; Kaul, 1983; Kurian, 1989; Moghaddam & Taylor, 1987; Wakil et al., 1991; Saran, 1985; Segal, 1991; Sodowsky & Carey, 1987, 1988). Despite Indians' unequivocal financial and social achievements, there is great difference in gender roles, with first and second generation women facing gender role restrictions from their ethnic community

(Dasgupta, 1998). The second generation daughters are restricted more than sons because of fear of cultural disintegration by "Americanisation" and cross-cultural marriage (Dasgupta, 1998). However, gender equality and feminism in the United States is supported by first generation Indian women, but second generation women are unhappy about the restrictions placed on them (Dasgupta, 1998; Siddiqui & Reeves, 1986).

Some studies have shown that Indian parents can prevent their children from dating and socialising with other non-Indian children so as to continue intra-cultural marriage (Kar et al., 1995/1996; Kurian, 1986, 1989; Sharma, 1984; Stopes-Roe & Chochrane, 1987). This is encouraged more aggressively for girls as "…the popular definition of a 'good Indian girl' is one who does not date, is shy and delicate, and marries an Indian man of her parents' choosing" (Agarwal, 1991, p. 52). Similarly, Agarwal (1991, p. 52), reported that in the United States, "several women [first generation] said that their immigration to the United States brought them independence and liberation from the institutional repression of women in India…the second generation Indian woman feels that old-world gender roles are still rigidly being upheld for her".

Indian immigrant women conceptualise the roles of women by images of Indian women during their time in their homeland. This cultural lag can cause even greater intergenerational conflicts (Espin, 1999). Despite conflict between parents and children, the second generation usually upheld the values of their parents. Parental guidance was sought on important decisions, especially marriage, amongst Indians in the United States (Espin, 1999). Girls seem to remain less separated from their mothers than boys do of either parent (Meyers, 2001). Adaptation to a new country

involves bidirectional influence of parents and children. Mothers and daughters exert mutual influence in each other's gender and cultural adaptation and identity.

Summary

Indians in Victoria, Australia, are a heterogeneous population, however, many are educated, highly skilled professionals, who have migrated on those grounds for a higher standard of living. Migration for Indian immigrants generally involves a cultural shift from societies or diasporic communities of collectivist, patriarchal philosophy to countries such as Australia where individualism and gender equality are valued. Cultural displacement results in the articulation of ethnic/cultural identity as an important aspect of the settlement process for Indian immigrants. Cultural conflict poses challenges to the dynamics of families as a whole as well as to personal identity. Dynamics that change within the family include family structure and gender roles. Acculturation is seen on various levels through time, but is also dependent on women's pre-immigration history, their involvement in paid employment, their social acceptance and their resilience to adapting to their new environment. Identity is also reconstructed through time, but can also be seen in multiple dimensions dependent on the prevailing circumstances. The roles of Indian women, in particular, are challenged when migrating from India or diasporic communities where the cultural values and norms are different to those of a Western nation such as Australia. This results in different approaches to mothering where Indians generally rely on the cultural expectation of support from extended family as well as a host of traditional aspects to mother and infant care. Conversely, Australians place more emphasis on tackling motherhood single-handedly with both women and men having a hand in childrearing. Acculturating and reconstructing

identity to incorporate aspects of natal as well as host culture is the challenge for Indian immigrants as they attempt to parent across cultures. Acknowledgement of these differences and difficulties by health service providers can promote positive experiences of cross-cultural parenting for mothers and children and can facilitate settlement for Indian immigrants in Australia.

The next chapter discusses the methodology and methods applied in this study.

CHAPTER 3: METHODOLOGY AND METHODS

This chapter describes the methodological approach adopted for this study and outlines the research design of the project. This includes a detailed description of the sample of participants and recruitment procedures, and the instruments and methods of data collection. Attention is also given to ethical considerations.

Conceptual framework

The key concepts in this research are migration, culture, identity and motherhood. They are interrelated due to their influences on each other. Culture and identity is situated in migration and the experience of motherhood is shaped by that of being a migrant. These concepts are further situated within the wider social context. Hence, migration, culture, identity and motherhood are deeply contextual, with a myriad of factors that constitute the broader social context of these women's lives. To capture the complex interrelationships between these factors, a critical approach have been utilised which acknowledges the contextual framework in which individuals live and operate. Individuals are members of families who are situated within communities, and these in turn are part of the wider society. It is through this critical gaze that this research is approached. Since this study is ethnographic in nature, due to understanding that people's behaviour is driven by their cultural prescriptions (Ellen, 1984), and with the emphasis being on 'thick description', its purpose is to explore the context within which these key concepts are seated (Geertz, 1973) and how these influence the interplay between immigration, identity and the cultural aspects of motherhood.

The methodological approach

Overall, this research is guided by a broad critical paradigm encompassing a medical anthropological framework in order to facilitate a holistic approach to data collection. It is driven by the theoretical proposition that knowledge about health is fixed in culture and constantly modified by the changing environment.

As a medical anthropologist, I am particularly interested in using a critical approach in analysing the acculturative process that is central to life as an immigrant, taking into account the historical, political-economic and socio-cultural factors that come together to determine the extent to which this takes place and what it means for mothering across cultures. A holistic perspective is employed to explore the influence of culture and identity on the experience of motherhood for Indian immigrants in Melbourne. The overall approach to culturally competent care should value alternative realities, expanding the clinical view to encompass much of the social environment, and be willing to negotiate other approaches to healthcare (Chrisman & Johnson, 1996). A method of study has been adopted that utilises experiences of the community as expressed in its various conferences, media, and anecdotes in addition to formal assessment tools.

It is commonly accepted by anthropologists that health and illness are social and cultural constructions. Social constructions are those concerning political and economic relations that are directed by the system that one's activities are governed by, and cultural constructions are those concerning traditions, beliefs and values that are influenced by the community that one affiliates one's self with. The influence of the social and cultural environment, that within and outside of the home, is of central importance to the immigrant experience of infant care and rearing and its impact on

the wellbeing of mother and infant health. The perceptions of individual women and their families can be of great value in determining this and must therefore be taken into account in such research.

There is the assumption that for any particular outcome or phenomenon to be explained, there are a great many inter-related factors at work. The scope of variables interacting in this process extends past the limits of a purely social and cultural examination. Existing literature demonstrates that an holistic approach has not been extensively utilised in examining acculturation and identity amongst Indian immigrants mothering. The gap that this research is hoping to fill identifies the interplay of acculturation and identity reconstruction amongst Indian immigrants mothering in Melbourne, Australia, as a phenomenon that cannot be understood without including an analysis of the individual, household, community and institutions (Van Esterik, 1995). Therefore, this study uses a critical approach within the framework of medical anthropology.

Medical anthropology is concerned with the way in which all knowledge relating to the body and health is culturally constructed, negotiated, and renegotiated through time and space (Lock & Scheper-Hughes, 1996). In practice, this means that medical anthropologists are likely to collect a great deal of data about economic features, social relationships, cultural belief systems, political processes, and other aspects of a community, even if the research intention is focused on a specific health question.

Explicit discussions of culture as an approach to healthcare and its variability across members of the same culture should consequently be important for health workers (Isaacs, 1983) in the Australian context where there is a constant influx of ethnic

Indian immigrants from various diasporic communities around the globe. Hence, this framework is relevant to a discussion on the mothering practices of a group of women who share a traditional culture, but who have migrated to Australia from different places in the world, either directly from India or through successive migrations, over generations, originating in India.

Contemporary debates within medical anthropology that bear on the topic of multiculturalism are likely to have important implications for the development of a political-economic biological anthropology and for the wider project of developing a critical biocultural synthesis. Of particular concern in this regard is the effort to create a critical, political-economically informed medical anthropology (Singer, 1998). Hence, this study will be approached critically as a result of perceived limitations in conventional medical anthropology.

Critical medical anthropology (CMA) philosophy revolves around class and related race and gender antagonisms as pivotal to a capitalist society and the reigning world system. Feminist critiques of medicine state that women lack power in the health system, with no influence on medical priorities and the allocation of resources, as well as impacting their individual experiences and disallows them having an active part in their treatment which leaves them feeling uncared for. Their own experiences are devalued in comparison with that of the doctor's expert knowledge and the doctors are often unwilling to admit ignorance or uncertainty (Graham & Oakley, 1981).

The development of CMA reflects a turn towards political economic approaches in anthropology generally, and an effort to engage and extend the political economy of

health approach by uniting it with the cultural sensitivity and in-depth local study of anthropology (Singer, 1998). Critical medical anthropology defines itself in terms of a concern with the macro-level of political and economic forces that shape medicine and determine the nature and extent of its interventions. It pays attention to macro-structural questions and the role of power in social life, and the way in which biomedicine is culturally constructed. Biomedical theory and practice is problematic not simply when it fails to address cultural and social issues involved in individual patient care but because of its sustaining role in dominant political economic systems (Singer, 1998).

Hence, antagonisms, such as class and race differences between patients and health professionals, as well as gender relations between husbands and wives need to be addressed in light of decisions made concerning mothering amongst Indian immigrants in Melbourne.

Firstly, the impact of migration on acculturation and identity construction amongst Indian immigrants is examined, followed by an examination of the influence of this on cross-cultural mothering amongst Indian immigrants. These objectives will be achieved by utilising historical, political-economic and socio-cultural levels of analysis. Hence, this research will take into account aspects of the migration experience, political dynamics, economic circumstances, as well as the societal and cultural aspects of immigrant's homeland as well as their adopted land to utilise an holistic approach to explain the current context of Indian immigrant mothering in Melbourne, Australia.

Research design and rationale

This study is exploratory, descriptive and explanatory in nature; and hence, requires a qualitative inquiry to provide in-depth and detailed data in context (de Laine, 1997). To achieve this, the study was designed utilising an ethnographic approach to data gathering. This method, although "time-consuming and demanding", has "real value" and "much to offer"....."when more structured research methods fail to deliver the information required" (Bandyopadhyay, 2011, p. 6). Within this general approach, a case study method was adopted to capture the personal lived experiences of individual women. It involves 12 case studies and many variables, as suggested by Ragin (1987) and Creswell (2012), in order to illustrate the complex narratives and holistic nature of the experiences of cross-cultural parenting of this group of women.

The study is illuminative and iterative in nature; therefore, an emergent and inductive approach to data gathering and analytical explanations was adopted (Thomas, 2003). Although theoretical ideas formed a starting point, key concepts and theoretical perspectives were identified as the study progressed. This inductive approach to theory development through observation resulted in theoretical propositions.

The collective case study

The collective case design is of relevance to this study as the emphasis is on inquiring into how the newly introduced cultural context of motherhood influences the perceptions and experiences of parenting of these migrants. The event takes place within the intersection of two cultures, two ways of understanding health and illness, and two ways of dealing with it. The unit of analysis is the group of mothers and their families.

With a collective case study, individual cases are selected with the objective being that these cases will provide better understanding of wider experience, and in theorising about a larger collection of cases (Stake, 1994, p. 237). The collective case study also allows clear comparison between different groups of people, namely, newly arrived immigrants and more established immigrants.

Case studies can also be useful in understanding the everyday circumstances and contexts that influence culturally relevant experiences and practices (de Laine, 1997), such as those pertaining to motherhood. Within a medical anthropological approach case studies can increase sensitivity towards health care delivery to ethnic and cultural minorities such as Indian immigrants in Australia. They facilitate an understanding of definitions of health and illness that are outside the realm of the biomedical model, as is the case with Indian customs and traditions. Furthermore, the case study can illustrate how the 'problem' is not solely for an individual, but applies to relations of the individual with others in his or her immediate and wider social networks, as is true of parenting cross-culturally.

Moreover, cases that illustrate traditional beliefs about health practices provide a conceptual framework with potential for providing culturally-competent healthcare (de Laine, 1997, p. 3).

Study site

This ethnographic study was conducted in an urban setting. The study site is metropolitan Melbourne, specifically areas in north-western, north-eastern, and south-eastern suburbs of the city as this is where the Indian population is concentrated. The interviewing and observation of primary participants was

conducted in women's homes in these areas. Conversations with health professionals (mother's obstetricians and gynaecologists) took place at their places of work in the study locations. Participation and observation of community activities occurred at various venues such as temples and school facilities where communal Indian festivals were celebrated to gain insight into the diversity of the Indian community in Melbourne and facilitate understanding of the communal aspects of the culture.

Immersion and rapport building

In order to gain people's trust, I immersed myself in the Indian community in Melbourne (to the extent that one can in a large city with a scattered and varied Indian population). I attended community gatherings and festivals. The Indian community here is diverse, comprising sub-groups from various regions in India and diasporic groups worldwide. I engaged in as many activities as I could across these various groups during my year of fieldwork. I spoke with elders and told them of my proposed research, which they seemed to find interesting and worthy. I also spoke with six Indian obstetricians and gynaecologists in the suburban areas of Melbourne where the Indian community is concentrated, to build rapport and to recruit participants from their practices. Women who decided to participate called me to arrange our first meeting. At this time, I spoke of my background and further explained the purpose of my study and that it had no direct benefit for them, but might for future immigrant women settling into motherhood in Australia. Women were very keen to participate and talk with a fellow Indian immigrant, whom they felt could empathise with their experiences here as immigrants. Having not been a mother myself at the time, seemed to be advantageous, as women felt that they needed to educate me on what I would experience in the future. They were thus very

forthcoming in divulging their intimate stories with me. I talked about my own life, migration history and cross-cultural marriage, which allowed women to feel comfortable disclosing the personal details of their lives, knowing that I was not ensconced in the Indian community here and would not jeopardise the privacy of the information they shared with me. I spent hours at each visit involving myself in their lives as much as I could, assisting with caring for baby, while women talked and got on with their household chores. Once they were comfortable with me (which was evident when women started confiding in me), I began formally gathering data. Methods of data collection changed from time to time, as is possible with ethnographic research, depending on the type of data being collected. This flexibility of method facilitated rigour as it allowed "the most appropriate and rich data" to be collected (Bandyopadhyay, 2011, p. 4). I used case studies, in-depth interviews, informal conversation and observation to collect various kinds of information which ensured data triangulation.

Participants

The participants include primary and secondary participants. The primary participants are ethnically Indian women born in India, Fiji, Britain and South Africa. They are all first generation immigrants to Australia. Some were established immigrants having migrated as children with their natal families or some years ago as adults for economic reasons, while others were recently arrived women who migrated with their husbands or to marry Indian residents here. Women who met the following criteria chose to take part: they were in their third trimester of pregnancy at the time of recruitment and identified as an ethnic Indian immigrant to this country. Women were expecting a child, gave birth and weaned during the course of this

study. All were from middle-class backgrounds; the majority had a tertiary qualification and about half were in paid employment. Secondary participants were members of the women's family who were present in the home during my visits and who wanted to participate in discussions and gave consent to be tape-recorded.

Sampling and recruitment

Opportunistic sampling occurred with the assistance of six Indian obstetricians and gynaecologists practicing in metropolitan Melbourne. Due to their specialisation and ethnicity, they were more likely than other doctors to see a significant number of pregnant Indian women. Collaborating with these doctors reduced the time taken to recruit participants. Recruitment from antenatal clinics at hospitals was considered, but proved difficult as hospital statistics at the time did not reveal country of birth and ethnicity of women concurrently, making it impossible to ascertain probable numbers from which to recruit participants.

The collective case study consists of as many individual cases as are required to reach data saturation (de Laine, 1997), namely, recruitment continues until there are no new themes emerging from discussions with participants. Twelve women were recruited from six Indian obstetricians and gynaecologists during the provision of antenatal care, and all gave birth in either public or private hospitals. I sourced the obstetricians from the Melbourne business directory and identified them as Indian by their names. I then called them and talked to them about my study and then visited them and talked about the research in more detail. At this point, with their permission, I left information sheets with their receptionists to be given to women

who identified as ethnically Indian. Recruitment and data collection occurred during 2004 and 2005.

Sampling was thematic in nature, whereby representativeness of concepts, and not people, was important. This is a process whereby data collection induces theory. Data were collected, coded and analysed concurrently, thereby deciding what is collected next and where it can be found (Glaser & Strauss, 1967). This continued until no further themes new emerged. Themes included acculturation, cultural identity and cultural aspects of motherhood and parenting.

Women who presented to these obstetricians and gynaecologists were presented with the information sheet (Appendix 1) by the receptionists at the rooms, explaining this study. Upon them giving consent to the receptionists to be contacted by myself, potential participants were called and I further explained the research to them. Participants were given verbal and written information about the study before their informed and voluntary consent (Appendix 2) was obtained to participate in the project. The information provided included their right to withdraw and/or refuse to answer questions without any reason or negative repercussions. Further explanation was given at the first visit, arranged at the participant's convenience. The researcher emphasised that participation was purely voluntary and that each persons' decision to participate, or not, would not influence them adversely in any way. They then had the opportunity to accept or reject participation in this project. It was made clear to them that lack of participation in the study would not compromise their care with their doctor.

Procedures

The study was conducted with 12 case studies, through participant observation and in-depth interviews with women and their families, in their homes, over a period of one year.

For each individual case study, a series of in-depth, semi-structured interviews and unstructured/informal conversations with the woman were conducted. The purpose of these instruments was to glean in-depth and descriptive information on their perspectives on the immigration experience, acculturation, cultural identity, cross-cultural mothering and cultural practices and attitudes surrounding mother and infant care and childrearing. Interviews were conducted in English as all women were fluent in English. I am not fluent in any of the Indian languages and did not wish to compromise the interviews with issues of privacy and reliability of information that may have arisen if an interpreter was used. All interviews were audio-taped with the participant's consent and later transcribed by me for accuracy of information. Observations were also noted immediately after visits with the women.

Mothers were followed for approximately 12 months, from before they gave birth to when they began weaning their infant onto solid foods, and beyond, in order to gain information on their intentions to breastfeed and take care of their baby before birth and then on their practices after birth. Due to the explorative and iterative nature of qualitative research, new themes continued to emerge throughout the interview process, and each successive interview was initiated with these themes in a semi-structured manner to facilitate open-ended discussion. These themes were also validated by the participants at the beginning of each visit. A semi-structured

interview guideline (Appendix 3) was developed which was adapted after each interview to accommodate the emerging themes from previous interviews.

Approximately one interview was conducted every three months with each of the women during the duration of their participation. During this time there were unstructured and focused observations of the mother in the home setting, and, as opportunity arose in some cases, at initial home visits from the maternal and child health nurse. Results were shared with participants as the opportunity arose. These procedures were repeated for each of the cases.

More than one source of evidence was used so that there were converging lines of inquiry which allowed triangulation of data. These included semi-structured interviews, unstructured or informal conversations and observations. In this way, construct validity was addressed where data was validated by more than one source of information. This included tape recordings, observation field notes and narratives of answers to the objectives in the case study protocol.

Data collection

The broad themes of immigration, acculturation, identity, and the cultural context of infant care and child rearing, are explored in this study. This was achieved through:

Observations

Observation results in first-hand experience where reported practice can be verified, hence is useful when investigating breastfeeding and other cultural practices. Also, unusual and unknown aspects of behaviour can be noted. The purpose of observation is to note interactions in the participant's natural social settings as this behaviour is

purposeful and expressive of deeper values and beliefs. The limitations of observations are that the researcher may be seen as obtrusive, considering the private nature of breastfeeding. Furthermore, unstructured observations are unrepeatable making data organisation difficult (Marshall & Rossman, 2006).

Observations occurred at regular intervals in participants' homes. Interactions were observed between mothers and other members of the household, as well as, opportunistically, between some mothers and maternal and child health nurses during initial home visits. The body language observed during these interactions was noted. This was important in noting the actual behaviour and power dynamics occurring during these interactions, for example, between mothers and health professionals.

In-depth interviewing

Interviews are useful to discover subjective meanings and interpretations surrounding the experience of motherhood. Semi-structured interviews are systematic and comprehensive, yet conversational, so as to collect data in an organized yet natural manner. Unstructured interviews allow exploration of new topics that would not initially be expected to arise (Marshall & Rossman, 2006). The purpose of interviewing, combined with observation, is to allow understanding of meanings people hold for their everyday experiences and to highlight the nuances of a culture (Marshall & Rossman, 2006). The limitations of semi-structured interviews are difficulty comparing data due to the less structured way of collecting data, and those of unstructured interviews are difficulties presented in organisation and analysis of data (Marshall & Rossman, 2006).

The interviewees were everyone involved in the study, namely the women as well as members of their household who were present and wished to participate in interviews.

A range of interviewing techniques were used, namely, informal, unstructured/casual conversational to the formal semi-structured/general interview guide (Patton, 2002), at different times according to the formality of the situation. Informal conversational interviews were recursive (Minichiello et al., 1990), whereby a normal conversation was followed allowing the flow to direct the research enquiry. The semi-structured and unstructured interviews consisted of a series of face-to-face encounters in order to understand the participants' perspectives on their lives and experiences, as expressed in their own words. For the semi-structured interviews, an interview guide was used which consisted of a list of topics to be discussed that emerged from previous interviews (Minichiello et al., 1990, p. 103).

Life histories/narrative inquiry

Life histories examine and analyse the subjective experience of individuals and their constructions of the social world (Jones, 1983, p. 147). Life histories and narrative inquiries are valuable for studying cultural changes that occur over time, capturing the evolution of cultural patterns and how those patterns are linked to the lives of individuals (Edgerton & Langness, 1974) and are appropriate in discovering migration experiences and how they affect cultural and identity construction (Marshall & Rossman, 2006). Limitations may lie in the minimal comparability of information gathered from each respondent due to the unstructured nature of data collection (Marshall & Rossman, 2006), singularity of experience and recall biases.

In using narrative inquiry the researcher assumes that people's realities are constructed through narrating their stories (Edgerton & Langness, 1974). These stories provide an insider's view of the participants' lives through their migration experiences and document the cultural traditions of their heritage and how they have changed over time. Participants' stories were recorded and thematic analyses were applied.

Data analysis

Data analysis was conducted using a general inductive approach (Thomas, 2003). The interview transcripts were analysed through multiple readings developing themes or categories. Upper level themes were derived from the study aim and the lower level themes from multiple readings of the data objectives. These resulted in summary categories that enabled the identification of themes which were most relevant to the research objectives. Finally, common or recurring themes were identified in all of the case studies. Divergent experiences were also noted and accounted for. A detailed list of themes and sub-themes that arose during analysis is presented in Appendix 4 (page numbers 221-224)

Summary of the case studies

Case study 1: Ria

Ria was born in Fiji and immigrated to Australia in 1996, when she was 21, to marry. She did not complete the tertiary course that she had started in Fiji and began work in customer service here. When first interviewed she was 29 years old, living here for eight years, and about to have her first child. She took maternity leave for six

months, and continued to work full-time thereafter. I also spoke with her sister who lived with her whilst a student. She stated her religion as Hinduism.

Case study 2: Julie

Julie was born in South India and came to Australia in 1997, when she was 23 years old, as a student. She then qualified as a nurse, met her husband here, and had a daughter. She continued to study for a Master degree in Nursing and Management. When first interviewed, she was 30 years old, living here for seven years, and about to have her second child, a son. She continued to work after taking maternity leave for about four months. She stated her religion as Christian.

Case study 3: Nikita

Nikita was born in North India and immigrated to Australia in 1999, when she was 24, to marry. At the time of the first interview she was 29 years old and living here for 5 years. She had completed a Master degree in Mass Communication and worked in India before migrating, upon which time she resumed work. When first interviewed, she was 29 years old, she had a son, and was about to have her second child. She took maternity leave and went back to part-time work after having her daughter, her last child. I also spoke to her mother who came from India to help care for her and her baby. She stated her religion as Hindu.

Case study 4: Sharmila

Sharmila was born in North India and immigrated to Australia in 2003, at the age of 25. At the time of the first interview, she had been living here for a year. She did a Bachelor of Commerce degree and worked as an Information Technology consultant

in India before migrating with her husband. Here, she worked in a factory. When first interviewed, she was 26 years old and about to have her first child. After having her daughter, she returned to work.

I also spoke to her husband, as well as her mother-in-law who came from India to help before the baby was born. She stated her religion as Hindu.

Case study 5: Nandita

Nandita was born in Fiji and immigrated to Australia in 1996, when she was 24, to marry. She had received a certificate in accounting at a technical institute in Fiji and began working here. When first interviewed, she was 32 years old and living here for eight years, she had a son and was having her second child. She resumed work after a long break to have her children, and decided that she was not going to have any more. I also spoke to her mother who came from Fiji to help care for her and her baby. She stated her religion as Hindu.

Case study 6: Nina

Nina was born in South India and immigrated here in 1990, with her husband, when she was 28 years old. She did tertiary education in India and worked there in Information Technology (IT). When first interviewed, she was 42 years old and living here for 14 years. She had a daughter and was having her second and last child. After a year's maternity leave for her second daughter, she returned to work part-time. She stated her religion as Christian.

Case study 7: Mary

Mary was born in South India and immigrated here in 2003, with her husband and two children, when she was 37 years old. At the time of the first interview she had been living here for a year. She was educated in India as a nurse and continued nursing here. When first interviewed, she was 38 years old and about to have her third and last child. After a year's maternity leave for her son, she decided to return to work part-time. I also spoke to her mother who was visiting from India to help care for her and her baby. She stated her religion as Christian.

Case study 8: Patricia

Patricia was born in Britain, and immigrated here with her family in 1991 when she was 14 years old. She did her secondary schooling here and had begun a nursing course, but did not complete it. She worked as an air steward, married, then resigned from work to have children. At the time of her first interview she was 27 years old, living here for 13 years, and was having her second child. She now has three daughters and is undecided as to whether she will have a fourth child. I also spoke with her husband who worked from home, and her father who was helping her during the day with her baby. She stated her religion as Christian.

Case study 9: Victoria

Victoria was born in South India and immigrated to Australia with her husband and daughter in 2003. At the time of the first interview, she had been here for less than six months. She went to university and worked in India and did not resume work upon migration. When first interviewed, she was 29 years of age and having her second child, a boy. She has since had her third and last child, another girl. I also

spoke with her mother when she came to visit from India to help with her baby. She stated her religion as Christian.

Case study 10: Amani

Amani was born in South Africa and immigrated to Australia with her family in 1988, when she was 12 years old. She went to secondary school and university here, and became a teacher. When first interviewed, she was 28 years old, had been living here for 16 years, and was having her first child. She went back to work, part-time, within a year of having her daughter. I also spoke with her cousin who was helping her one day after her baby was born. She stated her religion as Hindu.

Case study 11: Preeti

Preeti was born in North India and immigrated to Australia in 2004, to be married. At the time of the first interview she had been living her for less than six months. She was schooled and had worked in Punjab. She did not continue working when she came here. When first interviewed, she was 27 years old and was having her first child. She had a son and wanted to have more children. She stated her religion as Sikh

Case study 12: Rohini

Rohini was born in South India and immigrated to Australia in 2002 when she was 25 years old, to be married. She had completed a degree in Commerce in India before getting married, but did not work after coming here. When first interviewed, she was 27 years old and about to have a daughter. Thereafter, she had her second and last child, a son. She stated her religion as Hindu.

Ethical considerations

Written consent was arranged with an explanation on the importance of protecting the identity of the participants. The written consent form with participant's signature and name is stored separately from the data in a locked file cabinet at the university and only accessed by myself and my supervisors. Data and research findings have codings with pseudonyms only (i.e. no identifying details are recorded in the data set or findings). Data will be kept for five years after the completion of the study, after which paper copies will be shredded and electronic copies deleted.

Approval of the study, the recruitment methods, and the data collection procedures outlined in this report was granted by The University of Melbourne Human Participants Ethics Committee (Reference 43/2003).

After data collection was complete, I took leave from my studies to raise two children. Following the departure of my original supervisors from The University of Melbourne, I transferred my PhD candidature to La Trobe University, where I completed the writing of this thesis.

Publications

Some findings from this study have been published in an edited book:

Maharaj, N. (2007). Maternity and identity among ethnically Indian immigrant women in Melbourne, Australia. In P. Liamputtong, (Ed.), *Childrearing and infant care issues: A cross-cultural perspective* (pp. 185-198). New York: Nova Science Publishers, Inc.

Further publications in academic journals are anticipated.

Conferences

Findings have also been presented at several conferences:

Culture and identity: Mothering experiences of Indian immigrant women in Melbourne, Australia. Fifth International Asian and Ethnic Minority Health and Wellbeing Conference, Auckland, New Zealand 27-29 June, 2012.

The social and cultural context of early motherhood with migrant ethnic Indian Women in Melbourne, Australia. Third Australian International Conference on Motherhood: Theorising and Representing Maternal Subjectivities, Brisbane, 29 September-1 October, 2005.

The social and cultural construction of pre- and post-natal care amongst migrant ethnic Indian women in Melbourne. Psychosocial Obstetrics and Gynaecology: Current Controversies, Melbourne, 5-6 August, 2005.

The cultural context of motherhood amongst migrant ethnic Indian women in Melbourne. Fifth Annual Australian Women's Health Conference, Melbourne, 20-22 April, 2005.

Breastfeeding and mothering amongst migrant ethnic Indian women in Melbourne. Asia-Pacific Week 2005, The Australian National University, Canberra, 31 January-4 February, 2005.

The following three chapters present the results and analysis of this study by attempting to answer the main question asked, which is: How does culture and identity influence the construction of motherhood among ethnic Indian women living

in Melbourne, Australia? In order to answer the main question, differences in culture in Australia, as perceived by Indian immigrant women, were explored. The process of acculturation and extent of identity reconstruction for Indian immigrant women in Melbourne was investigated. The practice of the cultural aspects of mother and infant care for this group of immigrant women was described. The role of cultural identifications on child-rearing was examined. The themes that emerged from the sub-question are presented in chapters 4, 5, and 6.

The next chapter, chapter 4, is about acculturation and identity construction amongst ethnic Indian immigrants in Melbourne, Australia. It examines the themes of changing family structure and lifestyle, sense of belonging and renegotiation of gender roles within the context of acculturation and identity construction.

CHAPTER 4: CULTURE AND IDENTITY FOR INDIAN IMMIGRANT WOMEN IN MELBOURNE

Ganguly (1997) states that categorising 'real Australians' as a single physical and cultural type with no affiliations outside the country needs to be challenged. I agree with this as the narratives of some of the immigrant women in my study speak of Australian identities despite these women being visibly and culturally different to the Anglo-Australian majority. In this chapter, I demonstrate that immigrants can take on an Australian identity whilst maintaining other cultural/communal identities through transnational ties. Using Ria's story, I discuss the process of adopting an Australian identity through acculturation. This brings into focus shifting traditional gender roles and developing a sense of belonging to facilitate the formation of other cultural/communal identities for immigrants. Narratives from Nandita, Preeti and Victoria's case studies, among others, will also be used to illustrate the variation in lived experiences of my participants including the resistance to Australian culture and identity by some. These stories are told from the women's perspectives. I begin with a summary of Ria's story:

Ria's story

Ria was born in Fiji and brought up in a town there with her natal family and other members of her extended family. They lived in one of many Indian communities, where Indian culture had been largely preserved since the first Indian settlers of the 1860s. She grew up with many of the values and norms that are seen as typical of an Indian upbringing. Risk management is considered an important aspect of good parenting in Indian culture as children are thought to be vulnerable and as such are

protected to keep them from harm. Hence, she was restricted from engaging in childhood experiences that are considered 'dangerous' by Indian parents, for example, swimming in the ocean, or going out with friends unaccompanied, but are seen as part and parcel of a well-rounded and liberal upbringing by Australian parents. As a result, her childhood was very sheltered. As she grew older, she could not be seen to have boyfriends and so had to go out with friends on the quiet, away from the gaze of the close-knit community that would be keeping a watchful eye on an adolescent girl. When she was of marriageable age, she was introduced, through people in their community, to a suitable man – from a 'good family'. Kamal was also an Indian from Fiji, but he was living in Australia. Kamal had migrated here with his family when he was in high school. He had gone to university, began working in the area of property finance and eventually obtained a Master's degree.

During Kamal's visit to Fiji, he met Ria, once, in the company of family members. Kamal then returned to Melbourne, they began corresponding, and decided they liked each other. They got engaged, and shortly after, got married in Fiji. Ria then moved to Melbourne in 1996 to live with Kamal and his family. She was 21, and had not lived outside her natal home. She did not have any family here and did not know anyone else. Ria now had to live with her husband, mother-in-law and husband's brother and his wife, in a place that that was unfamiliar to her.

In Fiji, Ria did not complete the tertiary course she had begun, but had started working in customer service. After a few months in Australia, she got a job also in customer service. Kamal and Ria then bought a comfortable, three bedroom home of their own in the northern suburbs of Melbourne. Sometime thereafter, her sister came to live with them while studying at a Tertiary And Further Education (TAFE)

institute in Melbourne. Ria and Kamal had decided to wait several years before having a child, so that they could establish their relationship as well as their finances. They had conceived previously but had had a miscarriage. When I first met Ria in 2004, she had been married and living in Melbourne for eight years. She was in her last trimester of her first pregnancy.

Independence and reliance

Ria's migration story has much in common with the other participants in this study. The commonalities between Ria and the other women are that they were all from Indian communities either in India or the diasporic communities worldwide, and had been instilled with similar values and attitudes to life. They were all from middle class families. They came to Australia through skilled migration, theirs, their spouses, or parent's skills, as in Patricia's and Amani's cases, who migrated as children. They wanted a better quality of life. Mostly, however, they all encountered change to their traditional family structures and ways of living, that required a level of acculturation for each of them in order to gain a sense of wellbeing and belonging in this country.

The distinction between Australians and Indians appears stereotypical: Australians minding their own business and Indians minding everyone else's. However, it highlights the incongruence of worldviews and cultural attitudes, emphasising ethnic or cultural differences (Dasgupta, 1998). In considering the main difference between Indian and Australian culture, participants focused on differences in cultural philosophy, namely, that of collectivism and individualism, which determines how society is organised and the views and attitudes espoused by members of that society

(see explanation of these philosophies in chapter 2: Literature Review). As Indians, my participants were all raised in collectivistic societies (Sobrun-Maharaj & Wong, 2010; Tse et al., 2007), either in India or in well-established Indian communities in Britain, South Africa or Fiji where there was sharing of similar values and norms, and community involvement was customary. They had either lived in extended families or had their family living close by, and also had a network of friends whom they could depend on for support. The move from a collectivist society, to an individualistic one, and from extended family structures to nuclear families, created a huge shift in approach to living. Migration to Australia impacted on the traditional family structure and on support systems. Many women in this study found that they went from living in close-knit communities and extended families to only having the nuclear family to rely on in Melbourne.

However, unlike most of the women in the study, Ria welcomed the change in lifestyle upon migration. She came from a home with a domineering and authoritarian father who controlled where she went and with whom she associated, and accompanied her on all her outings. She also displayed a tenacious and independent character, which set her apart from the other women in the study. Because of these character traits and her cloistered upbringing, her desire for autonomy was felt since childhood. This desire and these attributes provided her with the right tools for acculturating in Australia:

> Like you couldn't do anything without asking and you had to have permission to do things and I wouldn't want to go back to that. Like, it was a big change when I came here and my husband, and if I said that I was going somewhere, he wouldn't say "why?" or "how long will it be?" it was like "yup". Yes, it was

> independence. Very strict the way Dad brought us up, like you could do anything at home but you weren't allowed to go out... And my mother-in-law would never ask me, I would say that I was going somewhere with friends and she knew that my husband knew where I was going. It was funny when I came over I would tell my husband that I was going to be home at this time, and once I was a bit late, I came home and he opened the door and asked me how my day was and I said "sorry I am late" and he said "yeah, and?" and I was like, "why didn't he ask me why I was late?" So that was also independence. (Ria)

Tummala-Narra (2004) reports that some women fantasise about increased personal freedom and autonomy within the family, upon migration. Ria felt liberated by the change in lifestyle, as she found living here freed her from what she viewed as the limitations of a communal lifestyle and gave her the independence to live life as she wanted, without the censure and scrutiny that were part and parcel of living in a community-based society as in her natal home of Fiji. My observations reflected this sense of liberation that she felt here, as she presented herself in fashionable, Western clothing that might not be suitable for a woman in traditional society. Also her body language and conduct displayed the self-assuredness and confidence gained through making personal choices and decisions.

Ria seemed to also have an adaptable personality. She displayed strength of character in coping with the challenging circumstances of migration. Her positive attitude to change, for the betterment of their lives, seemed to expedite her acculturation.

> Yes, it is my home, I have to make it home. There is nowhere I would rather go…it is the best place. I have lived in Fiji, so, with the health system and everything else, it is not as close or anywhere near to what we have here, the

> privileges and everything…and I love it…But as I said, maybe I just adjusted to the change, I just made sure that everything I did had to be that I was happy with and that was going to count in what I do in the future. So I was, like I had to do it and there was no going back, I wasn't going to go back home, no way…that's the risk I took leaving my family and coming over, not knowing my husband well, not knowing anything and taking that risk with my family and thinking what if something goes wrong, I have to make things happen for us and that's what I did. (Ria)

However, for most women who are accustomed to having networks of family and community to rely on for all sorts of support, this shift from a community-based society to one which is predominantly individualistic, and altered family structure from extended to nuclear, can cause problems with acculturation. Immigrants find themselves living between two cultures and attempting to negotiate the values and norms of their culture with those of the host society (Meleis, 1991). The women in this study came from an Indian cultural expectation of support and reliance, on family and community, to a culture that values autonomy and independence, thereby, placing emphasis on individual responsibility. They realised the expectation to face challenges on their own in this culture, but most found support lacking in Australia. This came through discussions on family and community.

Nandita, Preeti and Victoria, whose stories are each a little different, like Ria had to adjust to differences in cultural values and philosophical approach to life in Australia. However, unlike Ria, the nuclear family structure and an independent approach to life here, left them feeling displaced and pining for the familiarity and support of their families and their communities in their natal homes. They had come from collectivist societies (in Fiji and northern and southern India) where people live

in extended families and have a communal lifestyle. Hence, initially, these women had difficulties acculturating. Briefly, here are their stories:

Nandita

Nandita, like Ria, was born in Fiji. When I first met Nandita in 2004, she had a three year old son and she was in her last trimester of pregnancy with her second child. She was 32 years old and had been living in Melbourne for eight years. She had migrated here in 1996 from Fiji at the age of 24, after being married. Her husband had already been living here for ten years and went back to Fiji to marry her. He was working as a computer engineer. She had received a certificate in accounting at a technical institute in Fiji and had been working as a personal assistant there. They live in a large home in a new subdivision in the northern suburbs of Melbourne. Nandita had not visited Melbourne prior to migrating here, and did not know anyone here. She came to Australia because it was the country that her husband had chosen to emigrate to from Fiji before marrying her. When she arrived here, she was unable to get a job immediately so she stayed at home while her husband went to work every day. She felt lonely and missed not having a large family and a closely knit community around her:

> When I came to live here, the first year was so difficult. …we used to be eight people living in the house, my parents, my grandparents, my brother, my sister-in-law and my younger brother. And when I came here to Australia, all of a sudden, from eight there is only two of us, and in Melbourne, I didn't have any friends…And back at home, if you want to go shopping you have your mother to look after the baby for a couple of hours...Of course over there, elderly

> people we call them Aunty and Uncle and people you don't know, you smile at. That is a bit different here. (Nandita)

After several months here, Nandita found employment and began to engage in the wider society. Joining mother's groups and playgroups once she had her children, also provided avenues for building friendships. When I met her, my observations of her were of someone who seemed well settled in her daily life and comfortable in her surroundings.

Preeti

Preeti, a newly arrived woman, who migrated here from India after an arranged marriage, felt an even more pronounced change in lifestyle to Nandita. Preeti migrated to Australia six months prior to me first meeting her and was pregnant with her first child. She and her husband lived in a new home in the south-eastern suburbs of Melbourne. She was born in north India and immigrated to Australia in 2004. She had completed high school and worked in Punjab, however, she did not continue working when she came here. Her husband is an engineer and Preeti was left alone at home every day as he went to work. She was unable to drive and could not leave the house during the day. Although she seemed grateful to have some company and someone to relate to during my visits, I observed her demeanour to be one of displacement and loneliness. Like Nandita, she was accustomed to a communal way of living in India, and did not know anyone here before migrating. Her husband, however, was already accustomed to life in Australia as he had been living here for six years already and had returned to India to marry. Unlike Nandita, Preeti seemed less willing to form friendships outside her ethnic community in Melbourne. She felt less keen to do things outside the home as she felt the cultural differences, between

her own upbringing and that of Australians, were too great. This left her with fewer options for meeting people and making her own friendships, thus, she relied on her husband's friends for company. Not having her family around and a social network that she could rely on, meant a huge shift in lifestyle for Preeti. This disjuncture between her old way of life and her new one in Australia made her feel out of place and isolated. She was pining for family and friends, and the communal lifestyle that she was accustomed to in India. She felt displaced and missed her parents and other extended family, and the sense of community one gets from knowing neighbours and other people:

> My life has changed because I miss my family and all that. But it is different because of culture and all that…in India there is a lot of socializing. But here I think it is not. In India if you are at home, you know each and every neighbour in your place. Even I know my mother's side [neighbours], my in-laws [neighbours] also. But over here nobody knows who the neighbours are. It is different. (Preeti)

I observed Preeti to be pining for her home and cultural connections. She seemed retreating and uncomfortable with the idea of interacting with her neighbours.

Victoria

Victoria was born in south India and immigrated to Australia with her husband and daughter in 2003. They live in a modest home in the south-eastern suburbs of Melbourne. Her husband is working as a tradesperson. She had a university education and had worked as a business manager in India. Like Preeti, Victoria was newly arrived. She had been here for about six months, and had decided not to

resume work upon migration. Unlike Preeti, she had family in Australia – her sister had also migrated here. Having each other and each other's families gave them company and a support system that was lacking for Preeti. This allowed Victoria to develop a sense of community here soon after arriving in Melbourne. I visited Victoria at times when she had her extended family around and observed the way they shared the responsibilities of caring for the children and running the household, and the level of contentment that Victoria seemed to have during those times. Victoria's sister and family and her ethnic community in Melbourne compensated for the lack of pre-existing networks and allowed her to replace the lifestyle she enjoyed in India with one that was comparable, in a communal sense, negating the feeling of disjuncture or difference in culture felt by Nandita and Preeti.

> Oh, we've got plenty of family and friends, you know, where we are from. (Victoria)

Victoria also showed resilience in her positive attitude and coping style that made her determined to succeed in her new country, despite the challenges and adversities of migration (Werner, 1993). This was the case for all the women in this study, to some degree.

> Mainly we were taught to adjust to any environment; that is the main thing. My mother often used to tell me, you have to adjust, once you set up, it is all there in your mind. If you feel it is too difficult, it will be difficult. If you feel you can do it, you can do it. It is all your mindset. (Victoria)

However, Victoria still missed living with her extended family and spoke of her desire to continue that family structure here:

> We will have our own house, she [mother-in-law] will come and stay with us. She is good, I don't have to worry about my mother-in-law. She is like my Mum and friend. You know my Mum, sometimes she used to get jealous about me and my mother-in-law, we used to talk like friends. She never treated me like a daughter-in-law, she was very good, just casual talking. (Victoria)

Bhugra (2004) hypothesises that migration from a country that has a sociocentric or collectivist culture, as are most traditional societies such as Indian communities in India and diaspora communities such as those in Fiji, South Africa and Britain, to one that is egocentric or individualistic, as are Western societies like Australia, calls for a huge shift in values and norms that can make such immigrants feel alienated, compared to those who come from similar cultures. Hence, for women such as Nandita, Preeti, Victoria, Rohini, and Nikita who were accustomed to having large networks of family and community to rely on for all sorts of support, this shift from a community-based society to one which places emphasis on individual responsibility, created a sense of displacement, isolation and a need for a sense of community in their new home, that had to be addressed for them to begin to acculturate and gain a sense of belonging in Australia. Ria, on the other hand, saw the change in lifestyle as a positive one, due in part, to her personality and life experiences. Although she had her in-laws in Melbourne, she was happy living in her nuclear family and was enjoying the freedom of having more control over her life.

Tradition breakers and homemakers – gendered identity

Traditionally, Indian women are defined by their roles within the home, as wives, mothers, sisters, daughters and daughters-in-law, and a woman's value comes from her potential for a good marriage, her marriage status and her motherhood (Donner,

2008). Women's roles are governed by the patrilineal and patriarchal structures of the communities they are members of. Traditionally, women's identities within the family and community arise from their relationships with their fathers before marriage and from their husbands after marriage. The extended family system plays an important part in constructing the hierarchy of roles for the familial members within it (Donner, 2008). It is through the everyday activities between mother and daughter that a girl is socialised for her roles as wife and mother in later years and familial males and elder familial females monitor the prescribed roles for younger women in the family. It is this socialisation of gendered identity that allows for an area of conduct within the domestic sphere for women (Katyal & Chanda, 1998). These ideologies of domesticity facilitate the construction of female identity within South Asian communities and these gendered definitions are pivotal to the collective identity of Indian culture even beyond the sub-continent (Raman, 1995).

With migration out of India and diasporic communities around the world, and the ensuing change in family structure, women are able to redefine their roles. With mothers-in-law present in the extended family structure, younger women do not have autonomy or the power to make their own decisions. When family structure changes, and mothers-in-law are absent, wives bear more responsibilities in the home (De Souza, 2006), resulting in elevated status within the family. Women are then able to have autonomy within the home, facilitating greater control over their lives. Tummala-Narra (2004) and Ganguly (1997) suggest that migrant women are able to minimise the private patriarchy they experience and empower themselves within the home, thereby modifying traditional gender roles.

As Nandita began to acculturate, she used this change in family structure and approach to life to modify her roles as wife and mother, change that empowered her and elevated her status in her nuclear family. Traditionally, for a woman, living in an extended family means living with in-laws; and a new daughter-in-law has a low status in the household. Nandita spoke of her role and status in the family as a young daughter-in-law and said that she was glad not to be living in this way as it would not be a favourable situation for her:

> Their [the husbands] mothers are their mothers and their family is always first, when they come and live with you, so to some extent you have to understand that if you are married to an Indian....With the extended family, the mothers [daughters-in-law] miss out a lot. It's the grandmothers who take over and the mothers are always in the kitchen or washing and other things rather than spending time with their children. Someone else gets to spend more time with your kids than I do...You know how daughter-in-laws are expected more of all the time, like now I live on my own and if my daughter gets up for two or three feeds and I am tired, I can still stay back in bed till eight o'clock or 8:30, I don't have to worry about the second person and what they might think. I have got all the freedom and I don't have anyone watching me. Whereas if you live with your in-laws, they always expect the daughter-in-law to be the first one to get up, the daughter-in-law is the one who has to do everything. You are the person who is less appreciated at the end of the day. You do more, but you are less appreciated…And plus I think I am very close to my kids as well. I have brought up my kids myself and I really know what my kids want, what they don't want, what they like and what they don't like. (Nandita)

This change in family structure and empowerment that results for women impacts on the marital relationship. It facilitates a more intimate bond between husband and wife, as there are no competing loyalties for husbands – towards their mothers and their wives – and spouses have only each other to depend on. During my many visits to their home, I observed an affectionate and mutually respectful relationship between Ria and her husband, that was clearly nurturing as well as empowering for Ria. She said that once she and her husband moved into their own home, they began to develop a closer relationship because they had more time together as a couple without interruptions or interferences from other family members:

> …And when it was only the two of us, we did grow closer. And we started to talk more to each other and learn about each other more because it was only the two of us…obviously it does bring you closer. (Ria)

The nuclear family structure also impacts the mother-child relationship, as extended family usually plays an important part in childcare and rearing in a traditional living arrangement. With the absence of mothers-in-law, mothers are able to take a primary care-giving role with their children and have autonomy over their upbringing. The change in family structure and ensuing change in role for Nandita in the family meant a positive change with regard to her relationship with her children. She felt she had more time with them and a closer bond with her children, which she might not have had, had they lived within the extended family structure.

While migration and changing family structure meant positive role shifts for Ria and Nandita, for other women, such as Victoria, this was not the case. Other research shows that Indian immigrants tend to continue traditional, differentiated gender roles

where they migrate (Agarwal, 1991; Buchignani, 1983; Kar et al., 1995/1996; Kurian, 1989; LaBrack, 1988; Ralston, 1998; Sodowsky & Carey, 1987, 1988). Upon migration, Victoria's husband, who was newly arrived, believed that his wife should be at home to fulfil roles as wife and mother. Even though Victoria worked in India, she too believed that, in Australia, it was important for her to stay at home with the children. She and her husband made a decision that she should not work here. Perhaps the desire to maintain cultural identity in a country where it seemed in danger of being diluted, made her husband fear that if Victoria went to work here, her exposure to Western, liberal culture might result in the breakdown of the familiar, traditional patriarchal system within the home. For Victoria, spending most of her time at work and having her children grow up without her undivided attention and cultural instruction made her fear that they may acculturate to the values and norms of this society at a pace that they were not comfortable with. As newly arrived immigrants, the differences in culture seemed vast, negative and confronting to them, thus, Victoria conformed to the traditional gendered roles of wife and mother in Australia to maintain the family's cultural identity. My observations of Victoria and her husband together reiterated the submissive and subservient role that Victoria had fallen into – one that is common within the patriarchal dynamic of traditional Indian marital relationships, but was probably heightened due to her domesticity in Australia. Espin (1999) noted that immigration can emphasise the division in sex roles in order to maintain a sense of familiarity or psychological safety. Uncritical acceptance of patriarchal systems can be encouraged by the solidarity that is characteristic of diasporic communities due to their marginalisation (Moghissi, 1999). Hence, Victoria reverted to a traditional role of domesticity upon migration to Australia:

> My husband as soon as he comes home, he should not find me in the kitchen, he should not find me doing anything. So the moment he comes home I have to be around him talking to him, listening to him and doing what he says. He says "all this work you must finish before I come". He is very strict on that. When he comes inside he expects the daughter and wife, everyone to be with him. (Victoria)

For women, remaining in the home provides a sense of familiarity and comfort that limits exposure to that which is different and potentially confronting. It also means that it quells the fear of losing one's culture, thus, one's identity through the effects of acculturation. Hence, newly arrived women in the study chose to stay at home and/or had husbands who insisted on them being domestic, so as not to be exposed to other cultural influences that could topple their sense of a positive and stable cultural identity.

Breaking out of the traditional sphere of domesticity for women and getting out in society at large, through employment or other community activities, means becoming part of mainstream society. Women's access to employment plays a significant part in gender role shifts as it brings women into the public domain and exposes them to influences outside of the home that can alter their sense of self. In a Western environment, women have the ability to embrace any role they so desire, as such, women from patriarchal cultures can aspire to new gender roles upon acculturation. However, altering feminine roles can only be achieved through support from men and shifts in masculine roles as well. If women are to work outside the home, they require help from their husbands at home to manage both these sets of responsibilities. With changes to family structure in the new country, an important

aspect of redefining mothering, thus, is the increasing involvement of men in the home (Tummala-Narra, 2004; Williams & Carmichael, 1985). Once Ria set up her nuclear family here, she did not have the support of her extended family as she would have traditionally, instead, she felt that her husband took their place and was her greatest source of support. Tewary (2005) suggests that relying on husbands becomes more important after immigration as they are often the only source of support. Ria's husband shared in the housework and in raising their child, even though, traditionally, those duties fall solely under a woman's role.

> Like anything to do with Rishaan, I don't have to ask him. Like when I have to work on weekends I know that Rishaan will be fed, and supporting me all throughout with everything that I do...Like the thing is that every little decision that I make he will say 'okay, if that is what you want, if that is what you think'. If he hadn't been the husband he was, or the father he was at that time, I would have probably lost it at that time. Because it was getting used to a lot more different to what I thought it would be. He gave me time to sleep and if Rishaan cried at night he would get up and look after Rishaan and feed Rishaan as well at night obviously because I wasn't breastfeeding. Until today, the first kiss Rishaan gets in the morning is from Dad. He has supported me all the way through. (Ria)

Despite the fact that Ria's and Preeti's stories are different (Ria had been living here for a longer time and was working in paid employment, Preeti moved here recently and was not employed) they had the commonality of having husbands who had been living in Melbourne for many years. Preeti also spoke of how her husband took an active role in the running of the household and in caring for their child, contrary to tradition:

> If I need something, even in the hospital, I don't want that hospital food, but my husband used to come here and used to cook very nice Indian food and used to bring to the hospital for me after having the baby…he used to make some Indian traditional food after having a baby, 'you will eat this and eat that', my mother-in-law told me, and he had made all of that stuff. Even in that you can see that having a lot of herbs that I have to eat, and it was made by my husband, having a full recipe from my mother-in-law and even from my mother. (Preeti)

Even though there are women in the study who are involved in paid employment, they still are enmeshed in their cultural traditions of being good wives and mothers, daughters and daughters-in-law, gender identities that carry certain expectations. Without these identities, women themselves feel devalued, as well as being devalued within their cultural communities. Here, society allows for a woman's role outside the home being just as important as the one in the home, and it is often the former which women are defined by (Manne, 2005). In this environment, sometimes the role of wife and mother is that which is undervalued. For immigrant women, this flip in priorities is confronting and liberating at once. Some women felt constant competing expectations of family/culture and work/society. Working within and outside the home means conflicting pressures of domestic harmony and personal fulfilment. They are left with balancing these various roles and identities and deciding which to prioritise. These external structures that dictate the roles which women should fulfil, and one's commitment to these social structures, is what will determine which roles are played out. Stryker (1968, 1980) suggests that identities are many internalised sets of role expectations as reflective of roles in different social relationships, and suggests the commitment of an individual to specific roles is dependent on its place in the hierarchy of identities of the self. Hence, immigrant women can occupy

multiple roles, within and outside of the family, and their varying degrees of commitment to these multiple role identities at various time points depend on their importance at any particular point in time.

Feeling at home and wanting to go back home

Women's access to paid employment (Mehra, 1992) and social acceptance by Anglo-Australians are beneficial for immigrants to come to terms with the difference in culture and in establishing themselves in Australia (Ganguly, 1997). Tummala-Narra (2004) suggests this too, and states that the advantage for women, who were already in the workforce in their homeland, is that they can enter into paid employment more easily, thereby follow their interests, and integrate into mainstream society this way. This is of significance when looking at Nandita's and Ria's cases as they were already in paid employment in Fiji, which enabled them to transition into working here quite easily.

For Ria, becoming employed shortly after migrating assisted in the acculturation process. Getting involved in something that she had interest in helped her to engage with the new way of life in Australia, to forge friendships here and to feel in some way part of Melbourne society. Through work, she began to develop a sense of familiarity and community in her new home:

> When you get a job then you make new friends as well. And you learn from them as well. Because obviously here everyone has to be independent and doing things on their own. And it does give you a sense of independence and because you don't spend a lot of time at home, you get into a routine of going to work

> and you have got other things to do, you sort of forget about being lonely or needing someone or wanting someone to be there. (Ria)

Employment assisted in integrating her into this society and gave her a sense of belonging in this country. It made her feel more than just a member of her nuclear family at home, but a member of something larger, a member of the wider society. As a visible ethnic minority, the need to be part of mainstream society in some way is paramount in feeling a sense of belonging. Hence, employment or mother's groups and other such community activities, provided a sense of acceptance by society, that one is a legitimate member of the community.

Nandita too began to develop a sense of belonging here after getting involved in paid employment. Pursuing her interests through employment and becoming familiar with the people and the place here made her feel incorporated into Australian society.

> The first three months were really hard because I wasn't working…And I just knew nobody, it was so hard. But after six months I went for holidays and when I came back, then I got a job, and as soon as I started working, then I started liking it here, because I started going out and knowing the place, and slowly I learnt my way about how to get around the city and I started knowing where to go shopping. But now, this is home... But in the beginning it was hard, it took me one whole year to get used to it. (Nandita)

Once Ria and Nandita began to develop friendships here, they began to feel a sense of belonging in this country. The sense of community that they gained from these friendships was important as they came from a collectivist society in Fiji. However, unlike Ria, Nandita did not continue working after she had her first child. Because

she no longer had access to friends through work, she required another avenue for community involvement, so she joined a mother's group. Participation in the mother's group, playgroup and other such activities, continued to facilitate the development of friendships, and a sense of community and belonging in Melbourne.

> It feels very much like home. I was so surprised, it was Maya's birthday, I didn't expect anything from anybody, and then I had calls from my other friends, like my Australian friends, they came with a present, they visited Maya. Even they came when Maya was born. They are like my family as well, they are always there when there is an occasion, when there is festive season, they have been in touch, I don't have problems mixing around. (Nandita)

Women in the study such as Ria, Nandita, Nikita and Julie felt that in order to feel at home and gain a sense of belonging in Australia, they needed to be incorporated into mainstream society, and employment gave them this avenue:

> I think mainly when I arrived, as I said, the transition wasn't that easy because you don't know the people, you don't know anybody, you don't know what's going on, and then, as I said, when I started working I started meeting all different kinds of people, different nationalities, different cultures… And then all my friends were Australian from my work place, and I had one or two Polish people, but the rest were all Australian. And then I started getting along with their culture, their movements and I just followed them, what they were doing, then it was easy for me. (Julie)

However, as newly arrived immigrants, many women such as Victoria, Rohini and Mary initially gained a sense of community, and belonging therein, from membership in cultural organisations:

> We have Malaylam Association here and we have a prayer meeting every month in our own language, and we have mass services every month. So we meet people there. Yes, lots of them. There are about 15 families around this Endeavour Hills area that we meet every month for the prayer. (Mary)

For established women such as Nandita, Julie, Nina, Patricia and Amani, this membership continued to give them a sense of communal cohesion that they could only gain from their own ethnic communities, as visible ethnic minorities.

Accessing employment assisted Ria, Nandita and others such as Julie in learning the norms and values of this society which helped them understand and appreciate mainstream culture. The social acceptance women felt they gained from their friendships through work or other community activities such as mother's groups assisted them in reaching a level of acculturation in Melbourne.

By contrast, because Victoria and Preeti were not involved in paid employment and did not join a mother's group after having babies here, they had very little exposure to mainstream culture and society. They were unable to gain familiarity with this culture or make friends outside their ethnic communities. Their lack of community involvement in Melbourne hampered the acculturation process as they were unable to feel social acceptance and a sense of belonging in Australia. They did not feel acculturated here and could not identify with aspects of Australian culture, hence, were keen to maintain their Indian identity entirely:

> No, [I am] an Indian, living in Australia, holding onto the Indian culture and tradition, bringing up my children in the very same way. (Victoria)

> I don't know, I think I can't even make myself at home over here, even after 10 years or so because maybe I was born in India and having an education over there, it is very difficult because over here it is different religion, different way of living, different society, in India it is totally different. (Preeti)

Remaining at home and having no avenue through which to enter their local communities, made it difficult for them to feel part of the wider society. As a result, they felt they could not bridge the gap between the two cultures. For Victoria, becoming enmeshed in her extended family and ethnic society, gave her a sense of community, but one that was marginal and exclusive of other Australians, not mainstream or inclusive of society at large. So although it gave her a sense of belonging in the 'community' of family and Indian friends they had established in Melbourne, she did not have a sense of belonging in mainstream Australian society. Preeti had neither family nor friends. She only associated with her husband's friends and felt that she had no friends of her own. She also felt reluctant about mixing with Australians as she found the cultural differences too confronting. She did not have a sense of community or belonging at all at this stage.

Australians and aliens – cultural identity

Immigrants can experience isolation and identity crises which can lead to either rejecting or accepting the dominant culture, or maintaining both cultures simultaneously, which is often necessary for the development of self-esteem and a positive identity in one's new home (Tewary, 2005). However, depending on each woman's alignment with various parts of their culture of origin and their ability to accept Australian culture, the women in this study showed varying degrees of adherence to their Indian identity (Hutnik, 1986; Sue & Sue, 1999; Uba, 1994).

The process of acculturation, for Ria, was apparent through the changing gender roles within her family. Accessing paid employment and gaining social acceptance here, gave her a sense of belonging in Melbourne. Her establishment here then translated into the development of an Australian identity amidst her other cultural/communal identities.

> I am an Australian...but I still say that I am from Fiji. People do ask me where I come from or what is my background, then I say I am an Indian from Fiji. But no, I live here so I have dual citizenship, but I live here and I have made this my home, and that's what I am. (Ria)

Both Ria and Nandita demonstrate, through their explanation of their identity, that identity can be multilayered and context and time specific for immigrants (Phinney, 1990). It can shift according to the situation that one find's one's self in at any particular point in time.

> It is my home, it is my home…but when I have met Australians, they have never asked me where I am from. But when I meet people of my own ethnicity, the first question they ask is 'where are you from?', 'are you from India or are you from Sri Lanka?', then I tell them I am from Fiji. Because I was born in Fiji, I always tell them that I am a Fiji Indian, whereas my son, he tells everyone that he is Australian, because he doesn't know, he was born here, and he will say 'my background, my parents were from Fiji'. But I basically cast myself as, I live in Australia, I vote, I am an Australian citizen, I am an Australian just like any other people. (Nandita)

The construction, negotiation and reproduction of identities are also affected by transnational settings and dynamics. The identities of groups of people are negotiated

within social worlds across many places, just as many people's transnational networks are based on a perception of common identity (Vertovec, 2001, p. 573). This is certainly the case with Indian immigrants, who can be found across the world in diasporic communities, yet share a common identity, even if alongside other cultural/national identities. Continuity of culture is seen through cultural traditions, which are stabilizing for migrants and needed for continuity of identity (Lakha & Stevenson, 2001). Under transnational movements, it is more common to see competing and multiple identities (Smith, 1998); hence, their identity is in constant flux and comes in heterogeneous forms due to the fluid and varied contexts of contemporary South Asian diasporic communities. This cultural heterogeneity amongst Indian diasporic communities is seen alongside unity of national identity (Lakha & Stevenson, 2001). Hybridised forms of identity are also seen amongst established Indian immigrants in Australia, stemming from their attachment to their cultural heritage and their lived experiences in their adopted home (Naidoo, 2007).

Deliberate resistance to Australian culture helps maintain a positive identity for immigrants like Victoria, Preeti, Rohini and Mary. This is in accordance with Uba's (1994) suggestion that maintaining some aspects of the traditional culture allows people to have a stable and positive ethnic identity. According to Helweg (1992) new migrants to Australia are comfortable in Western and Indian surroundings. This, however, was not the case for Victoria and Preeti, newly arrived immigrants, who were holding onto their Indian culture and resisting Australian culture. They displayed traditionalism along with judicious biculturalism whereby they were in control of the course of their acculturation (Dasgupta, 1998, p. 953). This has implications for the immigrant women in this study who still identify with their natal

culture and yet have to adapt to the new cultural environment whilst always being viewed as the 'other' by mainstream society.

Nandita was eager to identify with certain aspects of her cultural heritage in order to display a positive, stable ethnic identity. As visible ethnic minorities, the women in the study were keen to express their difference as Indians, apart from the Anglo-Australian majority, through identifying as such. This was regardless of where they were born or how long they had been living here.

> See we are brought up in the Western world, and we try to be more Indianised and we try to learn about our culture and stuff. (Nandita)

Therefore, the loyalty that Indian immigrants show to their natal culture is an important aspect of the psychology of the minority in a society, as it affirms their ethnic identity (Kibria, 1987, 1993; Sue & Sue, 1999; Tajfel, 1981; Uba, 1994) and justifies their visible difference. Researchers have shown that people from visible ethnic minority groups might be seen as outsiders, regardless of the time they have spent in a particular country (Moghaddam & Taylor, 1987). Individuals who can resolve prejudices and messages of inferiority from the sustaining system/mainstream/majority society, and develop a positive ethnic identity, are successful at dealing with the conflict and tension that arise from dual/multiple cultural influences (Robbins et al., 1998). Women who were living here for a longer time, such as Ria, Nandita, Patricia and Amani, and were established here, identified bi/multiculturally as they considered themselves to be both Australian – by length of residency or citizenship, and Indian – by appearance, family or community (Malhi et al., 2009).

This process of acculturation and ensuing reconstruction of identity can only be harmonious if the integration of cultures takes place within favourable sociological conditions (Abou, 1997), which can be achieved through social acceptance by mainstream society as well as through maintenance of ties with their ethnic communities. Hence, aspects of the settlement process that assist the Indian immigrant women in this study to acculturate to their new environment, such as involvement in cultural groups, for example, need to be understood in terms of tools for renewing their commitment to their ethnic culture and maintaining psychological wellbeing (Mehra, 1992; Hyers, 2001).

Summary

The above mentioned models for the process of cultural identity reconstruction are useful when examining Indian immigrants who have been in Australia for various lengths of time as it offers an explanation for the resistance to Australian cultural norms and values by some as well as the varying degrees of identity reconstruction by others. The more exposure women had in Australia, or within a Western culture, the more acculturated they felt, the more likely they were to embrace an Australian identity. Similarly, the less exposure women had to Australian cultural or any other Western culture, the less acculturated they felt, the more likely they were to resist an Australian identity. Therefore, the women who identified biculturally or even occupied multiple, shifting identities such as Ria and Nandita, seemed to acculturate faster and develop a sense of belonging in Australia. The women who identified solely as Indian, such as Preeti and Victoria, seemed resistant to any cultural adaptation and could not yet think of Australia as home. Length of residence in Australia, accessing employment, and gaining social acceptance all played a part in

the ongoing process of acculturation and identity reconstruction amongst the Indian immigrant women in this study. Clearly, resilience, individual personalities and life experiences as well as those of partners also play a role in women's migration experience and acculturation process. Identities can be dynamic, multi-layered and in constant flux, and as such, Nandita and Ria's stories are two amongst others that challenge the notion that 'real Australians' are a single physical and cultural type without ties outside the country.

The next chapter describes mother and infant care and infant feeding amongst Indian immigrant women in Melbourne and the varying degrees of reconstruction of these traditional practices, along with aspects of traditional care impacted by health service provision.

CHAPTER 5: IDENTITY AND THE CULTURAL CONTEXT OF MOTHER AND INFANT CARE FOR INDIAN IMMIGRANTS IN MELBOURNE

Discussions of culture as an approach to healthcare and its variability across members of the same culture should be important for health providers (Isaacs, 1983) In this chapter, I demonstrate that due to their common Indian identity, the women in my study could depend on a level of support from family that is part of the cultural heritage that is evoked when expressing their identity. The collectivist philosophy that situates this culture draws on the priority of children and inclusiveness of extended family as core values; this is also the common thread with which the narratives of my participants are weaved. Using Sharmila's and Patricia's stories, I show that despite their varying levels of acculturation in Australia, the centrality of children and the extended family is indicative of the South Asian value system that is common to all the women in my study. The spectrum of traditional postnatal care delivered to mothers and infants brings into focus their levels of acculturation as well as the political, economic and socio-cultural environment in which the women live. Narratives from the other case studies are also used to illustrate the variance of lived experiences of my participants, including the desire to acculturate and embrace an Australian identity which brings about the reconstruction of customs surrounding mother and infant care. I begin by introducing Sharmila and Patricia's stories:

Sharmila's story

When I first met Sharmila, she was six months pregnant with her first child, 26 years old, and had come from India eight months previously. Sharmila and Anil met each other at work, fell in love and married two and a half years earlier in their home town

in northern India. Anil had entered Australia as a student – they said it was an easier way to come to Australia – and planned to later apply for permanent residence. Sharmila came to Melbourne in late 2003, to be reunited with Anil, who had already been living here for six months. They said they came to Australia for a better quality of life, and to Melbourne, specifically, because they knew other people from India who had chosen Melbourne.

Unfortunately, neither Sharmila nor Anil was able to gain employment in their field of Information Technology (IT), despite Anil later attaining a Masters degree in IT from an Australian university. Sharmila got a job in a factory and Anil as a security guard while he was studying; later he gained employment as a manager of a car wash business.

When Sharmila fell pregnant with their first child a couple of months after coming to Melbourne, Anil and Sharmila were surprised, as they had hoped to be more settled before having a baby. Nonetheless, they were very happy, and Sharmila continued to work until her last trimester of pregnancy. She then took maternity leave about a month before her baby was due.

Sharmilia's mother-in-law, Kamala, came from India during Shamila's eighth month of pregnancy to support her and Anil in bringing their first child into this world. Baby Anjini was born in a private hospital in the northern suburbs of Melbourne, by natural birth. Anil and Kamala attended the birth; they also had midwives and their obstetrician present. I visited Sharmila and Anil again about a week after Sharmila and baby Anjini returned home. They were thrilled by the arrival of their daughter;

they felt she had changed their lives in such a positive way and had brought them unimaginable joy and fulfilment.

> The whole world is new for me, you can say, it is totally different... New feelings, new excitement. (Anil)

Sharmila and Anil embraced the traditional aspects of care for mother and baby, as this was their cultural expectation during this time, as well as an expression of their cultural identity as Indians. They said it was very important to them that their children grasp the cultural values and norms of their Indian heritage and identify as Indian. They were both keen to express that their identity would not change here:

> Indian, always Indian, maybe after 25 years too, Indian. (Anil)

> Yes, I think so (this is home now), but we are national Indians. (Sharmila)

Patricia's story

When I first met Patricia in mid 2004, she was in her last trimester of pregnancy with her second child, 27 years of age, and had come to Australia as a child. She was born in England after her parents had migrated there from southern India. They then immigrated to Australia in 1981, when she was four years old, for a better quality of life. They also had extended family living here with whom they wanted to reunite. They spent three years in Melbourne, and then moved to Papua New Guinea, with her father's work, for seven years, before returning to Melbourne. Her grandparents on both sides of her family lived in Melbourne.

Patricia is married to Andrew who was born in Sri Lanka and came here with his family when he was two years old. Andrew is a builder and has his own business which he runs from home. Patricia helps him with the administration side of the business. She used to be a flight attendant but did not return to work after Poppy was born. Patricia, Andrew and Poppy live in a large, modern home in a new development in the south-east of Melbourne. Andrew designed and built their home. Patricia and Andrew have a large extended family in Melbourne, and many Indian and Sri Lankan friends.

Patricia and Andrew had known each other for two years before they married. They did not wait to begin planning a family. Patricia fell pregnant soon after marriage, but had two miscarriages before having their first child. When I met them, they had been married for four years, and had a daughter, Poppy, who was then 18 months of age. A couple of months after we met, Lily was born.

The birth of Patricia and Andrew's first child, Poppy, took place at a public hospital in a south-eastern suburb in Melbourne. Both her mother and her husband were present at the birth, with her grandmother, her father, two younger brothers and some friends waiting outside. For her second child, Lily, Patricia also gave birth at a public hospital. The birth was attended by midwives, Andrew and his niece, who was staying with them at the time. Her parents stayed at home to look after Poppy. Because her mother could not be at the birth, they videotaped it for her. Patricia stayed just one night in hospital as she wanted to come home to Poppy.

Patricia identifies ethnically as Indian and Andrew identifies as Sri Lankan and they believe that they share a South Asian culture. Patricia and Andrew are proud of their

respective identities as Indian and Sri Lankan and the South Asian culture and value system that their identities encompass. At the same time, they both call themselves Australian – they came to Australia as children, have a love for this country and see it as their home. In terms of raising their children, Patricia and Andrew have an appreciation for their traditions, but also for Australian culture, and want to pass this biculturalism onto their children. They expect that their children will acknowledge their South Asian cultural heritage in time to come, as well as identify as Australian. To this end they were keen to continue the traditional customs and norms that go along with instilling certain aspects of a South Asian values system, whilst adopting what they see as the cultural benefits of Australian society:

> I always want our kids to know where they are from, but I don't want them to be too hooked up with it, as in I don't want them to be blind to other cultures or have a lack of appreciation for other cultures or even for the country that we live in. (Andrew)

> Most people ask me, 'what is your cultural background?', because they can tell that I am not Australian, so that is the question. I live here, I mean they [her children] are Australian, they were born here, but I am sure when they are older they are not going to say that they are Australian either, because they know that their mother is Indian and their father is Sri Lankan...I feel right at home here, I wouldn't want to be anywhere else. I love Australia. (Patricia)

Patricia realised that people did not view her as 'Australian' because of her difference in appearance to the Anglo-Australian majority. Despite Patricia feeling at home here, the fact that others did not see her as belonging here, made her aware of her physical difference. As a visible ethnic minority, it was important to her to assert

her identity as an Indian and to have pride in this as it gave her a sense of group membership that was unquestioned by the wider society.

'It takes a village to raise a child'

Traditionally, the raising of children is a communal endeavour, with the family as well as the community playing a role. Whilst women in this study shared some Western understandings of parenthood, they also espoused traditional South Asian understandings which impacted on their attitudes toward mother and infant care. These understandings fit into the philosophy of collectivism that South Asian culture is situated within (Sobrun-Maharaj & Wong, 2010), where the community's well-being is important rather than individuals' (Triandis, 1995). This involves extended family participation in the process of preparing a mother for motherhood and bringing a baby into this world, rather than assuming individual responsibility. This understanding of parenting perpetuates a sense of community, and facilitates a sharing of workload as well as resources of as many people as possible for the betterment of the child. Communal involvement is seen as an expected part of parenting, rather than the expectation of coping without the assistance of community, as in Western societies such as Australia (McVeigh, 1997). Instead, Australian women mention receiving support from husbands, rather than extended family, after childbirth (Bandyopadhyay et al., 2010). Social networks are seen as important to facilitate the sharing of knowledge, advice and support that is considered integral in the raising of children in South Asian culture. Other Australian studies have also shown that immigrant women want more support after having a baby and are vulnerable to experiencing feelings of isolation and loneliness (Bandyopadhyay et al., 2010).

Support from family

The raising of children is seen as a key and powerful role for women; especially, it is an important role for elder women (Puri, 1999). Traditionally, mothers and mothers-in-law play important roles in their daughters' and daughters-in-law's mothering. It is seen as their cultural responsibility at this time, to pass on traditional knowledge about the customs surrounding mother and infant care and childrearing. For Indian women, support from extended family and community at the time of the birth of a child is a cultural expectation. Motherhood is seen as rendering a woman a fully-fledged adult and allowing one access to knowledge which propels one's status further up the social hierarchy (Puri, 1999).

This perception was shared by the women in this study and they maintained this important position through the practice of their traditional mother and infant care customs. Although women did not make overt comments about this, I observed that those who were newly arrived, like Sharmila, assumed greater responsibility for parenting and saw their role as mother as one that was separate from their husbands' role as parent and one that privileged them to knowledge that was 'women's business'. This gave them a sense of importance that was not afforded to men; this was especially so for elder women, such as Kamala, her mother-in-law. For the women in this study, mothers, mothers-in-law and other female family members offered support and education concerning whatever they considered relevant for their journeys through motherhood. During this time, women were given advice and taken care of in any way necessary for the baby and mother's safety, good health and comfort. Elder familial women's assistance was seen as a critical and necessary part of the experience of motherhood. In India, Sharmila and Anil would have had their

extended family as well as friends and neighbours to support them during their transition into parenthood.

Despite Sharmila and Anil's excitement at the birth of their daughter, they were overwhelmed at the unanticipated sense of responsibility and care that their new role, as parents, required; here Kamala took the lead and guided them through their transition into parenthood. They both felt indebted to her, as they did not feel that they would have been able to cope as well without her. They said that they felt unsure and afraid every time the baby coughed or sneezed, and would have been visiting the doctor regularly had it not been for Kamala's assurances. The baby had some indigestion and reflux, which worried them:

> Sometimes she cries too much, she's upset, she does not sleep, she does not feed, I'm upset and I went to doctor, but my mother-in-law she comes to know immediately what's wrong with her, that is what she is like, she is experienced. This is my first time, (mothering) it will come easily, but I come to know much from my mother-in-law in this period in time. Even, I don't know how to put on the nappies, how to give bath to baby, she helped me a lot with everything. Without her it would have been difficult because she knows much, much, much more than us. (Sharmila)

Being new immigrants to Australia, this was a time of uncertainty for Sharmila and Anil, so they depended heavily on the involvement of their extended family, namely Kamala, Anil's mother. Relying on their identity and cultural expectation of support afforded them comfort and security in an environment that was doubly unfamiliar to them as new immigrants and new parents.

Even though Patricia felt that she belonged in Australia, she also retained her Indian identity, which meant that she acknowledged the importance of the core values of extended family involvement and prioritising children and wished to retain these values in her life. Because Patricia's parents lived in Melbourne, she had easy access to her family and cherished regular involvement with them. She also embraced motherhood and chose to devote herself entirely to her children, so gave up her job when she fell pregnant.

Her parents took care of Poppy and Lily daily, with her retired father coming to Patricia's house four days a week, during the day, while her mother was working, and both parents looking after the girls on the remaining three days of the week that they were at home together. This allowed Patricia to run errands without the children and have a break from the routine. Retaining the Indian way of raising her children afforded her the cultural expectation of support from her parents.

Other women such as Amani, who also had her extended family in Melbourne, knew that they could depend on parents for care and nurturance, not only with regard to grandchildren, but for themselves as well, in keeping with their collectivist approach to life:

> Yes, she [Mum] has been helpful. Like really good. I always go over there and she is always cooking food for me, or she will run a bath for me and give me a massage, so she is great. When we go shopping she will buy lots of things for me here and there. (Amani)

This outlook underpinned the experience of early motherhood where extended family played an integral role in supporting women through the customs and traditions surrounding mother and infant care during the postpartum.

Postnatal care

Rest period

Sharmila's mother-in-law was here to take care of the housework, look after Sharmila and show the new parents how to take care of their baby. I observed Kamala taking over the running of the household – cooking and cleaning and looking after the baby. Kamala waited on Sharmila during this period to allow her to rest and recuperate as fully as possible in accordance with custom:

> After delivery, for at least 11 days, you can't leave her alone, even if she is here, somebody has to be here…it is in our tradition, when a girl gives birth to a baby, she is reborn. The girl itself is reborn and she is so delicate and fragile that you can't leave her alone...That's why my Mum is here all the time. (Anil)

According to tradition, once a new mother returns home after the delivery of her baby, she should observe a period of confinement where she gets taken care of for a period of time by her mother (upon return to her natal home in the case of her first child) or by her mother-in-law (Raheja & Gold, 1994). This period is dependent on parity, the region of India that women come from, their religion as well as other aspects of their backgrounds, as customs and traditions in India vary according to these factors (Bandyopadhyay, 2009). Because most of the women in this study did not have their parents living in Australia, they could not follow their traditional practice of confinement. For them, going back to their natal home overseas was not

practical since this meant that their husbands, who generally did not have family here either, would be alone here without support. Also, some women mentioned that they could not go to India due to the financial cost. However, most overseas-based parents or parents-in-law came to Australia to lend support during this time, and tried to observe this confinement period as much as they could for their daughters or daughters-in-law.

Sharmila and Anil commented that these traditional customs are both part of everyday life and an important aspect of their identity. Fully embracing their customs and traditions was their assertion of identity in an environment in which they did not feel a sense of belonging:

> Either your grandma will be talking about those things, your neighbour will be talking about those things, you are travelling in a bus and two ladies are talking about the same things, you get all of these things from your society…few of them we are aware because they are normal talks at home, these are not extraordinary that we are hearing for the first time. We are a bit consumed by all these things…most of them are heard because they are part of our tradition, because you are born and brought up in that tradition, at some stage of life you get all these things as part of your life. (Anil)

Even though Patricia and Andrew were well acculturated in Australia, as they had both lived here since childhood, when they had their first child, Andrew's parents gave them the level of support expected at this time, within a South Asian family. They flew down from Brisbane to allow Patricia rest and recuperation and to guide them through their transition into parenthood:

> So it is, it's really helpful, I don't know what I would do without them actually…and actually when she [Poppy] was born, we had Andrew's parents, they live in Brisbane but they were here for about a month before she was born they came. And his Mum is like a champion, she was just cooking everyday so I didn't have to do anything. So even when we came home when she was born, they were with us for another month, so it was so helpful. Because I didn't have to do anything, just look after the baby, all our meals were cooked. (Patricia)

Other established immigrants, such as Ria, Nandita, Julie, Nikita, Nina and Amani who had been living here for more than five years and who felt acculturated, said that they found it difficult to be confined to bed in their own homes and waited on by their aged mothers, and so insisted on resuming as many household duties as soon as possible. Ria accepted the support given by family at this time and saw their involvement as important, but also decided to be as capable in the process as she could be. I observed Ria as an immigrant determined to embrace her life in Australia, and to this end, she had realised that in order to fulfil the role expected of mothers here, she needed to get on with life as independently as possible. I saw this attitude later too, as she chose not to rely on help offered by her mother-in-law here, by making her own arrangements for childcare.

> Probably things would have been different if I was in Fiji, I would probably go, "yup, let's do it", but I think with time I have changed too. I don't want too many people hassling over me, it's like, you don't need to, I probably can take care of myself, I don't know. (Ria)

Being here from childhood and not having the need to acculturate to a new environment meant that Patricia had a stable identity, Australian in nationality, and

Indian in culture. This also meant that she did not have to prove that she belonged here, which placed less pressure on her to cope on her own during her transition to motherhood. Whereas Ria needed to prove her belonging and her ability to do things on her own, so she aligned herself with a more independent approach to mothering.

For the women in my study, this period was less of a confinement and more a time of support, as women continued with their household duties in some capacity and had some time to rest and recuperate, with the assistance of their mother, mother-in-law and/or husband.

Ayurvedic medicine and food

Kamala prepared Sharmila special food and *Ayurvedic* remedies to aid in her breastmilk production and her healing after the delivery – on my visit after Anjini was born, I observed Kamala serving Sharmila special meals as she recuperated in bed – this was seen as an integral part of postnatal care, and an important role of an elder familial woman:

> After a woman has given birth, they have different kind of meal, especially those which give them strength. Like they have raw egg in milk, and ghee, heavy fatty stuff, that gives you strength. At least for forty days, you have to be on this diet of *pinjeeree*. It is basically like flour, pure ghee, 16 different types of *Ayurvedic* medicines and almonds...It is warming to the body...In India, most of the shops have those *Ayurvedic* medicines. (Kamala)

Ayurvedic medicine is traditionally used to help the mother's womb to heal and allow her to regain strength; they facilitate good breastmilk supply, and help with digestion for both mother and baby (Bhopal, 1986). Most women in this study chose to use

traditional *Ayurvedic* medicines for themselves and their babies after the birth for both theirs and their baby's healthcare. The women spoke of the value of these *Ayurvedic* medicines in terms of their benefits to their health, and they took them as spices in food, or as tablets or syrups, or added to baths. The medicines were brought from India or bought here from Indian grocery shops and were mixed together by elder female family members with knowledge of which spices to include and the quantities required. It was seen as an important duty for these women to pass on their knowledge of postnatal care, consistent with their role as senior women in the family.

The hot/cold classification of food, whereby foods are consumed at certain periods during one's life depending on your body type and requirements at the time, was known to the women in the study. Foods were either prescribed or prohibited during pregnancy and after birth, for the mothers and baby's good health (Nag, 1994). Those foods that women reported as discouraged included lentils, potatoes and fruits such as pineapples and mangoes, as well as "too much" chilli, as these are seen to cause gas or wind for the baby when the mother breastfeeds. Foods encouraged included fish, green vegetables and traditional breads cooked with extra *ghee* (clarified butter) (Nag, 1994).

Sharmila felt that the traditional medicines that her mother-in-law used for Anjini and herself were better than being treated with Western medicine. Since Kamala had more confidence in her own remedies, so did Sharmila. Her pride in her cultural identity translated to pride in the cultural knowledge surrounding motherhood. Also, the cultural value of respect toward elder familial women, meant that Kamala's advice was looked upon highly:

> She [baby] wasn't going well, I knew that, because if she had a cold or something we went to doctor immediately, but with my mother-in-law, she knows everything, how to deal with things. I don't know much but she guides me. The time she stayed here for four months, we never went to the doctor for special treatment, never ever. She grew all the remedies at home. (Sharmila)

Preeti, who was also from the northern part of India mentioned the same dish that had to be eaten after birth and Victoria's mother, from the southern part of India, (who came to lend support after her delivery), mentioned a similar mix of ingredients for recuperation after birth, but called it by a different name:

> I make it into a powder and when I prepare her curry I put it in. Dried ginger powder, asafoetida powder, and then *jeera* [cumin] and *methi* [fenugreek], roasted and powdered. Pepper, *jeera*, asafoetida, dried ginger, and coriander powder, all mixed up, without chilli...we use a lot of garlic. Garlic helps in the production of breastmilk. And it helps to stop the gas problem. And we use a lot of small onions...whatever I make, I put that *masala* only, nothing else, and onions and garlic and *gingerlee* oil [sesame oil], not other oil. It is good for health and no fat. It will cool the body and everything, it's good for health. (Victoria's mother)

Newly arrived women such as Sharmila, Preeti, Victoria, Rohini and Mary were aware of the postnatal care delivered in India, hence, following the diet dictated to them by their mothers and mothers-in-law was what they believed to be good for their recuperation after birth as well as their babies' nutrition via their breastmilk:

> They don't allow us to eat or drink certain types of foods, gas forming foods. I think when you have the *Ayurvedic* medicines, you have to not eat some types of food, like meat, potatoes, because the baby's stomach will be upset when you breastfeed. (Mary)

Reproducing this diet here gave them a sense of familiarity and comfort at a time of vulnerability and insecurity as new immigrants in a different cultural environment.

Ria's and Nandita's mothers, both from Fiji, had a similar recipe for their daughter's diets after birth, to help with breastmilk production, however, the name they called it was different from the name used by those from India (probably as result of dialect differences):

> Yes, that tea masala that they made, the *saut* that Mum said to drink. (Ria)

> She was telling me that when I am breastfeeding I should eat certain foods to produce more milk and she gave me a herbal mixture from home which you mix and cook it in milk and have it and that will give good supply of milk. It's got things like ginger in it and other herbs and spices... They call it *saut*. That is what I am having now. (Nandita)

Even though Ria and Nandita were keen to embrace an Australian identity and an Australian way of mothering, the idea of respect for their elders, and mothers, in particular, made them adhere to their directions to take the *Ayurvedic* remedies. Also, their desire to do what they thought of as best for their babies, as they were now the priority, encouraged them to follow their mothers' advice.

Patricia and Andrew felt that both sets of parents delivered advice on postnatal care that seemed more modern or convenient rather than traditional or cultural:

> ‘Drink Sustagen or a glass of milk or Milo or something like that’ (her mother said), which I did do and still do. They both (her mother and mother-in-law) sort of agreed that I should take her out as little as possible for the first two months while she was really small, in terms of ‘don’t go out and expose her to the cold or to people’, because she might catch a cold or germs and stuff like that, so they were both particular about things like that. (Patricia)

They both thought that since their parents had been living in Australia for a long time, they had not maintained some traditions, but the fact that, as a family, they are supportive and nurturing, and “eat curries”, makes them Indian. Patricia and Andrew were secure in their South Asian identity so did not feel that they needed to follow all traditions to justify this; they felt they had the important markers of South Asian culture.

Traditional massage

Kamala also massaged Sharmila and the baby as part of their daily postnatal care routine:

> Baby and mother both need massage, baby needs some oil massage when the sun is out...For the mother, the best oil is mustard oil. For the baby I put Johnson’s baby oil or olive oil. (Kamala)

Traditionally new mothers and babies are massaged daily for recuperation after birth (Reissland & Burghart, 1987). The newly arrived women in this study did not have

access to a traditional midwife or housemaids who would have performed this duty in their homelands, but some visiting mothers and mothers-in-law assumed this duty for them. All women acknowledged massaging their babies and I observed many babies being massaged with oils before their baths, as part of the daily rituals of care.

Sharmila was happy to receive massages from Kamala as this would have affirmed her commitment to her traditions and her pride in her culture. The bond that this act would have created between Sharmila and Kamala would also have solidified their relationship and provided Sharmila with the support that she required during this vulnerable time; this would also have affirmed Kamala's role in the postnatal care of her daughter-in-law and grandchild.

Patricia's mother also said that they should massage Poppy as it would relax her, so after her bath Andrew would massage her with baby oil. Her mother would massage Patricia's back, shoulders and feet when she felt sore, and she also went to a professional masseur. Their use of commercial baby oils and more Western interpretations of the use of massage is probably due to their level of acculturation. They still saw the importance of this traditional practice showing their commitment to their Indian identity.

Ria and Nandita embraced an Australian identity too, and because of their desire to acculturate and adopt some Australian approaches to mothering, did not conform to all the traditional Indian aspects of postnatal care. They made a compromise with regard to massage and opted for a more Western approach to this therapy. They felt reluctant to bare themselves to an elder female family member, especially an in-law, or to burden their old mothers or mothers-in-law with this or be fussed over. Instead

they chose to make a couple of visits to a Western masseur when they felt ready. Their babies, however, were massaged by their visiting mothers with special oils, and Ria and Nandita continued with this after their mothers had returned to their homes in Fiji:

> No, I think it was more me who didn't want a lot of things done, like I didn't want to have my Mum, you know, I didn't think it was necessary because I had had two massages while I was in the hospital with a professional masseur...No, I just was in pain, like my body was aching and my husband said, 'I've seen this flyer around, do you want to have it done?', and I said, 'okay, fine'. So I had a half hour massage for two days... And I didn't think it was the great deal coming home and having things done to me, so no, and my Mum is about 56 years old, so. (Ria)

> Mum used to do it, back at home we had a special lady coming and massaging, but over here, we don't have that option. And with me, I am a bit uncomfortable with my Mum massaging me...And because we have special masseurs here, I am having an appointment to have a massage done by a professional masseur. So back at home we have this option that we have the ladies in the village who are traditional masseurs but over here we have to pay money and go to a professional masseur, so I am doing that. (Nandita)

Although Nandita had a Western approach to some aspects of motherhood, she thought some customs, such as traditional massages for babies, should be continued here as they have value:

> I think we should follow [Indian aspects of childcare] because I have noticed some of the things that our grandmothers have done when we were born, they

> are emphasizing that now, the midwives are telling us to do those things now. One good example is massaging, massaging comes from Asia, and now they have a booklet on how to massage a baby, in the hospital, they are telling them…so I feel some of the things are important, we should follow them. (Nandita)

Continuing the traditional massages in some form, particularly, on their babies, was also a way of keeping their mothers included and retaining their role in the postnatal care of their babies. This allowed them the freedom to reconstruct their own postnatal care in order to express their acculturation and embrace aspects of Australian models of mothering, while maintaining traditional Indian aspects through their babies.

Nikita, who was living here for many years, did not have massages while she was in Melbourne, but did so when she went to visit her family in India:

> I know it would be a big deal if we were in India, so when I went back to India when he was about 2 months, then I did have a lady come in on a regular basis to give me a massage. But not while I was here, nothing. (Nikita)

Nikita felt that she could reconstruct certain traditions while she was here, but conformed to custom under the cultural expectations of her homeland. In this way she adapted her approach to mothering depending on her environment and the beliefs of that particular society. Women such as Ria, Nandita and Nikita, who were established here but maintained transnational networks, were flexible in their attitudes and practices, demonstrating fluid loyalties to their homelands and their adopted land.

Bed-sharing

Kamala cared for Anjini, as her duty as the elder female relative in the house, and slept with her at times to let Sharmila have a restful night's sleep. The collectivist Indian approach to motherhood meant that caring for a baby was a communal responsibility, and those firmly embracing an Indian identity were keen to draw on the assistance provided by extended family:

> We can't put her in the cot, we are not going to put her in the cot, we are going to put her in our bed...she is sleeping with her [Sharmila] or my Mum or with me sometimes and she feels the warmth of our body, so she feels comfortable and she sleeps well. (Anil)

Traditionally, babies should be kept close to their caregivers, including sleeping with them at night (McKenna, 2000). Sharmila or Kamala slept in the same bed with Anjini. Kamala thought of this practice as an important traditional aspect of childcare. This afforded her status as one of Anjini's primary care-givers which meant that decision-making for all aspects of childcare was also her responsibility.

Victoria, who was also recently arrived from India, felt the same way about bed-sharing with her baby, and her visiting mother also assumed the responsibility of caring for the baby sometimes at night:

> First of all we don't put the child in a separate room, and we are awake the whole night when the baby cries, I am awake. Taking personal attention and things like that. Yes, for us it is more time consuming when it comes to newborn kids. And the child should feel secure, at least for the first three months they have a very insecure feeling...but here they keep the monitor near

> the baby, only when the baby really cries then they come and see. All that concept I really don't like. They have the cradle and baby cot or whatever all in a different room. That is really unappealing, I don't like it. (Victoria)

> And you know here they say you have to buy a cot, and put the baby in that. We are used to putting it near to us. Usually the elder people will be always with the mother and keep an eye on the baby because the mother herself will turn. (Victoria's mother)

Sharmila's mother-in-law and Victoria's mother regarded bed-sharing with the baby a fundamental aspect of their role in the care of their grandchildren. This was a culturally expected part of caring for their infants, and so Sharmila and Victoria relinquished some time with their babies at night, with the benefit of having some uninterrupted sleep.

During my visit to Sharmila and Anil after baby Anjini was born, the maternal and child health nurse also made a home visit. She saw that Anjini was sleeping next to Sharmila in the bed and advised her to sleep baby in the cot instead. From my observations, Sharmila and Anil seemed perplexed and concerned as to why the nurse said that this is a dangerous practice. They later said to me that bed-sharing is done traditionally, and to their knowledge, without risk.

I was also present when Mary (a nurse from India who had just had her third child) had her home visit from the maternal and child nurse. She was questioned by the nurse as to how she was sleeping her baby and when she disclosed that they were bed-sharing, she was told that although it is a cultural practice, it is wrong and should not be done. Despite the fact that Mary was a health professional as well, the power

differential between the Australian nurse and Mary, a newly arrived Indian immigrant, left Mary in a vulnerable and undermined position.

Patricia slept with her children in her bed. Patricia and Andrew felt that people in Australia thought bed-sharing was strange and so they generally didn't tell friends. The other mothers at her mother's group knew that Patricia slept with her daughters; all their babies slept in cots. On the other hand, they said that all their Indian friends slept with their children and did not make use of the cots they bought. The maternal and child health nurse recommended that the baby be put in the cot to sleep and Patricia said that she did not disclose that she slept with her at night. Once again, because she was secure in her identity, as both Indian and Australian, Patricia did not feel that she had anything to prove by following the Australian model of infant sleeping, and was not influenced by the nurse to abandon her custom. Instead, she knew that bed-sharing is done traditionally and can be a very safe way of sleeping, and felt that having her children close to her at night would make them feel nurtured and loved. She thought that this would inculcate in them the traditional values of close-knit families and devotion to children, which she saw as important aspects of her Indian identity.

> If they want to sleep with us until they are five or six years old until they are ready to go to their bed, then we will just build a bigger bed. Until they are ready to have their own space, well they can be with us, it doesn't really bother us…Because when you go to bed at night, and you see this little life lying next to you, and you get up in the morning and you see that they are so cute and gorgeous, I just couldn't see how you would want it to be any other way. (Patricia's husband)

Nandita and Ria slept their babies in cots as they felt it was more convenient to have the baby in its own bed. They said they felt more comfortable knowing that they would not roll onto the baby, and they also did not want the baby to form the habit of sleeping with them as they wanted to have some independence from their children:

> What Indians do, they try and keep the baby in the bed. But I thought I don't have help here, I am basically by myself. And I thought if from day one, I tuck the baby in the cot, the baby will get used to idea, and the baby will always sleep in the cot, and I will sleep comfortably...they did say at night when you are sleeping, it is better to keep your child away from you, just in case there is an accident, like you are sleeping and all of sudden you get on the baby and the baby can die or something like that. But I was very comfortable putting the baby in the cot. (Nandita)

> Since Saturday he has moved into his room as well so he is not sleeping with us anymore. He is too big for his cradle now and we were sleeping him in our bed and I thought that was not a good idea because he was getting used to the warmth and all that. So in the day I was putting him in his cot in his room, because the cot is a bit too big for my room so in the night he sleeps in his room. It wasn't hard. (Ria)

Their desire to embrace an Australian identity translated into embracing a Western attitude to mothering, whereby, inculcating independence in their children from the start was seen as a beneficial aspect in their development, and it would result in more independence for Ria and Nandita. They felt that they should not lose all independence as a result of having a baby. They thought they should have some time

to themselves and quality of sleep, as well as more opportunity to fulfil their other roles as wives, thus, slept their babies in their own beds in their own rooms.

On the other hand, Sharmila, Preeti, and Victoria, who were newly arrived and identified firmly as Indian, had strong opinions on how babies should sleep and felt that their babies should have a high level of dependence on them, including at night, as this was a culturally expected part of early motherhood.

Research has shown that integrating two cultures can be difficult and leave women open to miscommunication and discrimination (Tummala-Narra, 2004). Since there is no evidence to suggest that bed sharing is harmful to babies where adults are behaving responsibly, there is no reason why women should be told not to practice this custom. The censure of this practice belittles women's traditions and culture and leaves them lacking in confidence about their ability as parents, and unable to approach and communicate with health professionals who might be helpful in other circumstances.

Infant feeding

Before giving birth, Sharmila had expressed a desire to breastfeed her baby for as long as possible, as she knew that it is what is done traditionally, as well as what is best for babies, and is what her mother and mother-in-law had advised. However, she began supplementing her baby's feeds with formula at the hospital soon after giving birth:

> Yes, in the hospital they used to give formula. Just topping the breastmilk just 20 ml or 30 ml. I think now I am getting enough milk to feed her. Just topping

> up. But sometimes in the night time, one time, just formula. Because maybe I didn't have enough milk. I feel as if I didn't have enough milk (Sharmila).

The main reason Sharmila began supplementing her baby's breastfeeds was because she believed that her milk supply was insufficient. This seemed to result from the misconception that her milk flow should be immediate after birth. It was common for the women in my study to be uninformed that it is natural for one's milk not to 'come in' for at least the first few days after birth. In these cases it led them to believe that they were unable to breastfeed or had insufficient milk. This caused many to give up breastfeeding or begin supplementary feeding before leaving hospital. Usually formula was offered by the midwives at hospital when women felt distressed about their milk supply, as was the case with Sharmila. For her, the midwives knew best. Having been recently arrived from India where health professionals are highly looked upon because of their knowledge and position, she relied heavily on their advice in this regard. Hence, she did not question her midwife's offer of formula as she assumed that they would present the best option for herself and her baby. In India, hospitals allow the practice of 'rooming-in' where a female family member is allowed to stay overnight with the new mother to assist her with initiating breastfeeding. Since this is not practice in Australia, women depended on the assistance of midwives.

Some maternal and child health nurses also advised some women to give their babies formula if they seemed uncertain about the amount of breastmilk their babies were receiving. This seemed to result in the belief that they had an insufficient milk supply. For Preeti, newly arrived from India and unfamiliar with this culture, and

believing ‘doctors know best’, taking advice from her maternal and child health nurse, a health professional, was unquestioned:

> She [her mother] told me that it is very good to have the breastmilk; according to the advice of the doctors here, start formula, otherwise it is good to have breastmilk. Yes, I think sometimes he is not satisfied with my milk because he needs something more. I am not saying that my breastmilk is not coming, maybe his capacity is more. She [maternal and child health midwife] told me to have one or two bottles a day, but continue with my breastmilk also. (Preeti)

Preeti knew that breastfeeding is the traditional way of feeding and is best for her baby, but like Sharmila, was influenced by her health professionals to start supplementary feeding. Some women were easily swayed by health providers as they felt that they knew best.

Ria gave up breastfeeding soon after she came home from hospital as she could not get her baby, Rishaan, to attach to the breast. Even though she did not express an attitude of ‘doctors know best’ as did the newly arrived women such as Sharmila and Preeti, the covert power dynamics that are present between health professionals and patients made their advice weigh heavily:

> When Rishaan was in hospital, I think it was the second or third day at night, he got really hungry obviously. They were saying to me that the first milk that comes out, the 5 ml or 1 ml or whatever should be okay for him. But he was growing and he started to get hungry and I couldn’t get anymore milk than what was coming out. And this night I started crying because Kiran [husband] was not there at that time, and I didn’t know what to do and there was no milk coming out. And because I was stressed out, that stops milk from coming out as

> well, and the nurses just said to me, 'look, it is up to you if you want to give him formula', and I just said 'yup, that is it, do it'. (Ria)

Ria also needed the encouragement of her husband to persist in her efforts to breastfeed during her stay in hospital (McVeigh, 1997). Women in my study who had their husband's support to breastfeed, showed greater success with initiating and continuing breastfeeding as they relied on their husband's support when there was no elder familial woman around.

Sharmila started weaning her baby off the breast from one month of age as she said that she had to go back to work two months after Anjini was born. Kamala, her mother-in-law, fed the baby formula during the day when Sharmila was at work and Sharmila breastfed her when she got home. Sharmila eventually ceased breastfeeding at four months. Sharmila, like the other women in this study who were involved in paid employment, did not breastfeed for the recommended duration, due to their need to return to work. They had all stated that they knew that exclusive breastfeeding for six months and continuing beyond that is highly recommended by health professionals as well as what is done traditionally; however, the economics of their daily lives disallowed them from doing what they knew to be best for their babies:

> Breastfeeding, in India it is a must. If you don't' you are sort of looked down upon like you are not doing the right thing as a mother. Because I fed Leila till she was about 10 months, and we went to India when she was about a year and two months, and back there people are still breastfeeding their babies till they are past a year old, so you had to answer to them. 'Why aren't you feeding her? You should still be feeding her!', and I said, 'No, I can't feed her because I am back to work now'. So those sorts of things come up. (Nina)

Nerlove (1974) and Gussler (1987) stress the importance of the concept of discretionary versus non-discretionary activities for understanding how infant feeding and economic roles interact. Activities are classified according to prevailing values and beliefs. If breastfeeding is considered non-discretionary, it will be accommodated even if extra household work, or work outside the home, is also considered nondiscretionary. Conversely, if breastfeeding is considered discretionary, it will give way to the changing demands of nondiscretionary work activities. The women in the study were under the influence of cultural change (as a result of a lack of extended family involvement at hospital deliveries and a reduced confinement for women after birth), as well as change in their economics and values (women being involved in work outside the home and having to prioritise this), that acted together to erode traditional breastfeeding practices and impacted on optimal breastfeeding as advised by the World Health Organisation (WHO) and hospitals and maternal and child health centres in Australia.

Patricia also knew that she wanted to breastfeed her first child, but unlike Sharmila, was not influenced by outside forces such as health professionals or economics. She said it was something her mother did, and that she was going to do too. I observed her breastfeeding on demand on many occasions, as this is the traditional way of breastfeeding, without regard for scheduling feeds as often advised by health professionals. After Poppy was born, she found breastfeeding difficult with regard to attachment and soreness of nipples. She persisted as she knew its benefits and was aware of the recommendations of the WHO. She never fed Poppy formula, breastfed on demand and continued breastfeeding until she was 17 months old, when she had to stop due to her second pregnancy. Patricia breastfed her second daughter, Lily, as well, and did so until 13 months of age, when she fell pregnant with her third child.

> I will do it [breastfeed] anywhere, I have never had any issues…all the time, wherever they needed it, I just did it...she [her mother] was exactly the same, Mum never worried about breastfeeding anywhere.

Her confidence in what she knew to be best for her babies seemed to be fuelled by her self-education on breastfeeding and her establishment in this country. She did not feel that she had to defer to what others were advising, as she was informed and confident in her own beliefs. She also strongly identified as Indian and wanted to mimic the Indian way of mothering that she received from her mother, which included breastfeeding. Patricia had strong opinions on what she saw as being the positives of Indian motherhood and was proud of asserting these practices and values. She also had the daily support of her family (husband, mother and father) who believed that breastfeeding was the norm, and she was able to stay at home to care for her children without the pressure to return to paid employment.

Midwives and maternal and child health nurses are trained to support breastfeeding in Australia (Fletcher, 1997), through the Baby Friendly Hospital Initiative, an outcome of the The Innocenti Declaration (WHO/UNICEF, 1990). According to this Declaration women should be encouraged to breastfeed exclusively for the first four to six months, and to continue partial breastfeeding up to two years of age and beyond (WHO/UNICEF, 1992). Unfortunately, responses from women in the study revealed that where support from health professionals was received, it inadvertently resulted in reduced breastfeeding rates compared to what is recommended. Women either began supplemental feeding or ceased breastfeeding altogether under the care of health professionals. Some support was viewed as confusing for women, especially when there are various positions for breastfeeding offered by hospital

midwives and maternal and child health nurses. Women such as Ria, Preeti, Amani and Rohini reported that they were given conflicting information about which positions to breastfeed in by different midwives at the hospital, making the process of initiating breastfeeding difficult to adjust to. Women were advised to breastfeed on demand by their mothers and mothers-in-law. Demand feeding is traditional practice and the way women expected to breastfeed. However, women such as Ria, Nandita, Victoria, Preeti, Amani and Rohini were told to follow some sort of feeding schedule by their midwives and maternal and child health nurses, which undermined their traditional approach to breastfeeding and their confidence in their ability to care for their baby:

> Sometimes I feed her on demand, or every three hours now… The other day I called my Mum because she is not sleeping well and she was not taking milk properly. She was a bit concerned and she said to try to give her a feed whenever she feels like it, then I was doing the same thing. Now she is okay. But these people [hospital midwives], they didn't tell me anything like that you know. They said 'three hours, after that, five hours', that's it. They didn't mention anything like, 'sometimes the baby feels like breastfeeding', they didn't tell me anything about that, but my Mum told me 'If she feels like taking breastmilk, just give her, don't hesitate to give her whenever she feels like it'… In the hospital they [midwives] used to give formula, because maybe I didn't have enough milk. (Rohini)

Hence, uncertainty and misunderstanding about what position to breastfeed in and how often, and supplementing breastfeeding with formula, could have contributed to an inability to attach baby to the breast successfully and/or a reduction in milk supply

for women in this study who stated insufficient milk as a reason for ceasing breastfeeding before recommended durations.

Hospital midwives and maternal and child health nurses seemed to play an important role in most women's decisions to start formula feeding or cease breastfeeding, thereby having the ability to influence the breastfeeding practices of many of the immigrant women in my study. This was more apparent amongst the recently arrived women where health professionals were looked to for appropriate practice medically, and for what is 'right' in Australia. The unequal power dynamic present within this relationship, between health professionals and immigrant women, was clearly apparent as some women uttered sentiments of 'they know best'. This is a common phenomenon in a medical professional-patient relationship (Lakhani & Jansen, 1984), and can be pronounced where women are in a culture that is unfamiliar to them, and come from a culture that is even more hegemonic in this regard, due to the caste/class system in India. Women looked to their health professionals for advice and guidance relating to good practice, medically and culturally, in Australia.

Due to the migration experience and the influences of healthcare providers, family and employment in Australia, traditional extended breastfeeding practice was eroded for many of the women in this study.

All women in the study introduced solid foods to their infants between four and six months – depending on when they felt their babies were ready to begin eating – despite generally delayed introduction in India. They also knew this to be the recommended period for weaning in Australia and were keen to comply with what their maternal and child health nurse advised. As discussed earlier, the information

provided by health professionals weighed heavily for some women as they felt they knew best. Women began feeding their infants cereals and pureed fruit and vegetables, which they generally prepared at home, before bringing family foods of rice, pulses and a range of other mildly spiced Indian dishes into their diet:

> It is understood that it is four to six months [when you introduce solid food], that is what everyone says. The maternal and child health nurse told me that you have got to look to see whether the kid is interested in food and you can start introducing solids at four months as well. She [baby] was very keen, she was very interested in food and looking… Both my kids eat curries, I started them as soon as possible on regular [family] food, so what we did was we tone down our food, as in we didn't put in so much chili We stopped eating too much spicy food ourselves, not that we eat too much spicy food anyway. Both of them eat regular food, nothing really specific for them. (Nikita)

Women saw it as important and necessary to get their children accustomed to the family diet as it constitutes part of the family's daily lived experience, thus, is non-discretionary (Gussler, 1987; Nerlove, 1974):

> She is eating everything, curries, everything… Because if she doesn't develop the taste for Indian food, what we are eating, it is going to be a problem after later stage. (Sharmila)

Traditional food is an integral and entrenched aspect of women's everyday lives, their culture and their identity (as mentioned by Patricia earlier in this chapter). Since Indian food is generally nutritious and modified family food suitable for weaning (Jones, 1987) their use is supported by health professionals in Australia and this traditional aspect of infant feeding was continued for women in this study.

Cross-cultural – a two-way street

It was important to all the women in the study, to be able to practice some aspects of their culture surrounding early motherhood. Sharmila and Anil keenly adhered to the Indian customs and traditions surrounding the birth of their baby, including the integral role of their extended family and their collectivist culture. Dasgupta (1998) explains that traditionalism, or the firm retention of culture, is the first stage of acculturation, as was the case for the newly arrived women such as Sharmila, Preeti and Victoria. The maintenance of various aspects of Indian traditions by the women in this study facilitated the retention of their cultural/ethnic identity (Kibria, 1987, 1993; Sue & Sue, 1999; Tajfel, 1981; Uba, 1994). Sharmila and Anil needed to assert their culture, as newly arrived immigrants, as it was a positive statement about their identity as visible ethnic minorities.

Even though most of the women in this study welcomed support from extended family, when some decided to embrace an Australian identity and adopt a bicultural approach to parenting, they realised that family members' own cultural conflicts tainted this support (Tewary, 2005). The differing expectations from family and mainstream society caused a degree of culture conflict for these women. When Ria began to parent cross-culturally, she felt that she was enriching her original cultural identity by the cultural traits acquired from Australian society, as is the case when immigrants are engaged in the process of material acculturation (Abou, 1997). Since she saw this form of acculturation as a positive step in the migration experience, the differing opinions of elder female familial members were set aside so as not to interfere with this process:

> Um, she [mother-in-law] did, once he was born, she taught me how to properly massage him a little and do bits and pieces. But I think times have changed since they had babies, and I don't think they are, I sometimes don't feel very confident doing things that she tells me to do, I think because, as I said, we do read a lot. Yes I would follow, probably bits and pieces here and there. I would listen to her, but I always try what I think is right. (Ria)

Therefore, many of the women in this study found that they depended, especially, on the advice of health professionals, whether as a result of a lack of family here, or because they were ready to embrace a bicultural approach to parenting. Immigrant mothering means relying on an interdependent system of support, such as husbands, friends and health professionals (Tummala-Narra, 2004).

As a result, women needed to feel that the cultural aspects of care were acknowledged by healthcare providers as they adopt a bicultural approach to parenting. However, for the women in this study, health professionals were not usually equipped with the cultural knowledge or sensitivity required to bridge the gap between the two approaches to parenting. As a result, some women found their cultural expectations and preferences in regard to bed-sharing and breastfeeding were neglected or undermined due to health providers' lack of cultural competence (Lauderdale, 1999).

Sharmila was not supposed to eat certain foods after delivery and while breastfeeding, according to cultural proscription. However, she could not observe these food restrictions during her stay at the hospital, and this caused Sharmila and Anil distress as they both felt that they had no choice or control at that time, as Anil explained:

> She should not be eating too much spicy [food] because according to the old ladies, they say whatever you eat, if you breastfeed the baby, it can affect her [baby]. If you eat something bitter, your milk is going to be bitter. If you are going to eat spicy, the baby is going to have spicy milk. One day at the hospital, early morning, at breakfast, there was tomatoes in the sandwich, Sharmila had a bit of a sore throat, the child, too, had a sore throat for two days. They are both fine when they are home, because now she [Kamala and mother-in-law] is cooking very light food…she said we shouldn't be giving green chillies or red chillies to the mother because it can cause digestion problems in the child as well as some problems with the urine, because you can have a burning feeling when you pass urine or go to the toilet. (Anil)

Victoria's mother wanted to make food with *Ayurvedic* [medicinal] spices for her daughter after the birth of her baby, but said she felt hesitant on the day of the maternal and child health nurse's home visit, due to fear of censure. The power dynamics between health professionals and patients, especially in the case of the immigrant women from India, placed them in a vulnerable position and feeling insecure and uncertain about practicing their customs:

> I didn't bring anything this time because I don't know, here everything is different...So I am not going to prepare that *masala* also here. Whatever the doctors guide her, I am going to give her...They are very strict here with mother and baby. (Victoria's mother)

> I told her that they said at the hospital that after you deliver, the maternal and child health nurse will be here to visit you. She is scared that they might say something if she gives me all that. (Victoria)

> After you come home, I can prepare that dish for you. (Victoria's mother)
>
> But in the hospital you cannot bring me any special food. (Victoria)

Victoria, who had experienced having her first child in India, mentioned that she would have preferred her mother to have had more involvement in her care during her stay in hospital. In India there is the practice of allowing extended family, such as a mother or mother-in-law, to stay overnight at the hospital to assist a woman with all her needs after the birth of her baby. Since rooming-in is not allowed here, she had concerns about her stay at hospital during the birth of her second baby:

> Here I am comfortable now because I am now going to a gynaecologist who is from Sri Lanka. And now since I have had the frequent visits to the hospital and meeting the midwife, slowly I am getting used to it. The only thing that is worrying me is that they don't allow attendants to stay overnight, so that is a bit worrying, because at night if I need help, then every time I have to keep calling them [midwives]. It is the only thing that is worrying me, otherwise I am fine...The first day of the caesarian and one week at the hospital all alone throughout the night with the baby. That one experience I didn't like. (Victoria)

These, and other newly arrived women such as Preeti and Rohini, felt that they required an obstetrician of the same ethnic or cultural background, so that they understood the cultural traditions surrounding motherhood:

> The GP referred us to North Park hospital, and we found Dr Pahuja there. We preferred her so we can talk freely with her. (Sharmila)

It is important that where health providers cannot be chosen from similar cultural backgrounds, women can be assured of a professional environment where their cultural traditions are respected and understood. For women in this study, practicing some aspects of traditional care was important as this facilitated a level of familiarity as well as pride in their culture and their identity. This is important for immigrants who are visible ethnic minorities, and who need to feel some sense of group membership, even if it is not within mainstream society. To this end, cultural competence is necessary on the part of health professionals, so as to assist women settling into Australia as well as motherhood.

Summary

For the women in this study, maintaining customs surrounding motherhood was important, as it was part of their cultural heritage. It is the continuity of these traditions that created a sense of familiarity and empowerment amongst the immigrant women which provided a stable and positive ethnic identity. All the women in my study received a high level of familial support and practiced some traditional aspects of mother and infant care. The most important aspects of traditional care that were practiced were: a rest period; *Ayurvedic* medicine and food; traditional massage; bed-sharing and breastfeeding. The newly arrived women strongly maintained their Indian identity and closely adhered to traditions surrounding the care of mothers and infants. The women who were established immigrants embraced an Australian identity and adopted a cross-cultural approach towards mothering. Levels of acculturation draw attention to variability of experiences across members of the same cultural group.

The next chapter discusses the influence of cultural identifications on childrearing amongst Indian immigrant women in Melbourne.

CHAPTER 6: IDENTITY AND THE CULTURAL CONTEXT OF CHILDREARING FOR INDIAN IMMIGRANTS IN MELBOURNE

Immigrant mothers have the opportunity to reproduce their cultural connections as well as reinvent their roles in the family and society (Tummala-Narra, 2004). In this study, parenting was contextualised by the South Asian value system of collectivism and the centrality of motherhood and raising children in Indian culture. This chapter discusses women's approaches to motherhood and childrearing, from those who were newly arrived and firmly identified as Indian, such as Sharmila, Preeti and Victoria, to those who were established in Australia and adopted multiple cultural identities, such as Nandita and Ria, and those who grew up here, yet were confidently asserting their South Asian heritage, such as Patricia. This demonstrates the varied lived experiences of the women in my study, whereby childrearing was influenced by levels of acculturation and gender and cultural identifications.

A question of identity: Retaining Indian values for the second generation

Once Sharmila's mother-in-law, Kamala, had to return to India, there was no one to care for Anjini, as Sharmila had returned to work. Anjini was four months old, and Sharmila and Anil were not keen to put her into childcare as they believed in family playing an integral role in childcare and rearing. Hence, they decided that it would be best for Kamala to take Anjini back to India with her, to be taken care of by her and the rest of their extended family there.

Sharmila and Anil said that they missed Anjini terribly and had cried every day since she had gone. However, they phoned her in India daily and were comforted by hearing her voice and knowing that she was well cared for. The family in India said

that she was happy and growing well and not suffering from any of the ailments she had endured in her first four months of life in Melbourne. Sharmila and Anil put this down to the climate and the care that she was getting in India:

> She is good with my mother-in-law because from the time she was born, she is with her, and she takes care of her more than me, because most of the day she is with her. And over there [in India] she is comfortable and lucky. Because she had a problem at the time of the birth, acidity and heartburn, it is all gone there [in India]. It is too hard, but it is okay. This is a good thing because she is okay there and she is doing well there, everything is suited there, atmosphere, climate and everything goes right…I do miss her, but the thing is, when you come to know that she is doing well there and more people are there to take care of her, I am happy. (Sharmila)

According to Sharmila and Anil, being surrounded by her extended family also meant that Anjini would learn about their customs and traditions. My observations were that their decision to send their baby to India was very difficult on both Sharmila and Anil, however, their desire for her to be immersed in their culture was strong enough to warrant this action. For first generation Indian immigrants the biggest challenge is the transfer of culturally significant behaviours to the second generation growing up away from their homeland (Tummala-Narra, 2004). Sometimes, the idea of returning to their country of origin or sending their children there is related to their anxiety of having moved too far from their home country and wanting to hold onto those things that are familiar to them (Akhtar, 1999). For Sharmila and Anil, the retention of their values and norms meant having a sense of pride in their culture and their identity as Indians:

> I feel when she is going to stay with my parents, her ethical values are going to grow, her social values are going to grow. Somebody is always going to be with her…For me, children are like blank paper, whatever you write, they just grab. If something is written on her paper at school, at least we can correct it at home if we have time, but if we don't have time, the thing is finalised...Whereas if she comes home and my parents have got enough time to correct it, because they can spend 20 hours with her, at least she'll be having a hand. (Anil)

Sharmila and Anil said that they worried very much about sending Anjini to school here as she might learn what they called the 'wrong values', such as liberal sexual mores and not respecting elders, and might grow up not knowing Indian values such as the importance of knowing their place within the social hierarchy and the importance of education in achieving success in life. I observed the shock with which they spoke of these differences between the two cultures, and the anxiety that this created for them. They wanted to ensure that their daughter grew up in the way they did, so would wait and see how things progressed here:

> Until fours years (of age) she is going to stay with us, but after that we will see, she studies here for primary school and then will go back to India because I don't think the culture over here for youngsters is good...that is why we are scared to live in Australia, they [children] shouldn't adopt this Australian culture, that is why we are worried. (Anil)

From our conversations and my observations, it was clear that Sharmila and Anil were afraid of being confronted later in life with a child who had embraced a value system that was different to that which they held dear. As newly arrived immigrants, the customs and traditions of their homeland were precious as it gave them a sense of

familiarity and stability in an otherwise foreign environment. Presently, their sense of pride and wellbeing in this country depended on their identity as Indians and the cultural values that this entailed.

Other newly arrived women such as Preeti, Victoria, Rohini and Mary mentioned similar concerns. Preeti and Victoria were worried about their children losing cultural values such as conforming to the traditional social hierarchy (respecting and obeying parents and other elders), maintaining conservative sexual ideology (not dating before marriage) and striving for academic success (prioritising school-work over play). My observations of them, too, were of women culturally displaced and suffering culture shock. They were also fearful of their children being exposed to a different set of values and norms here and one day being confronted by teenagers who did not share the same mindset and outlook on life:

> I think it is very hard [to bring up children with your values here] compared to India. Because in India it is not like culture over here, it is very a different type of culture and family atmosphere...I want him [her son] to know our culture as well. Like respect, we do respect the elder people in India. (Preeti)

> We are trying to build the faith and values right from day one…that is why we will ensure that we take them to India, every year, we have to take them and make them know their cousins, they should know their relations…I am still not able to accept this country's culture, the values of life, the family values, the lack of commitment in the husband and wife relationship...Here the constant shock is there for me, culture shock...When you go to common places and things like that, you will see them doing all sorts of things in public places. We are not exposed to all of that when we were brought up in India...And of now

> it's no problem because she is a kid, but as the days go by and she reaches 13, 14, teenage years, the confusing years, maybe that time. Maybe whatever she does and says, maybe I will not be in a position, my mindset is not in a position to accept that. (Victoria)

Victoria said that she would wait to see how her children were growing up here before deciding whether to send them to school in India, and Preeti said that, in time, she might return to India to raise her child there. In the meantime, both women said that they would try to minimise or counterbalance the influence of Australian culture on their children, by schooling them at home with their culture and traditions, and by sending them to extra-curricular language and religious schools. The maintenance of culture and identity is constantly threatened from within, by the next generation, thus, Indian parents in the United States are constantly making efforts to transmit their culture to their children through youth forums and language and religious groups to inculcate values in the second generation (Dasgupta, 1998; Tummala-Narra, 2004). Likewise, the women in my study were keen to teach these cultural norms through raising children with these values at home as well as having children mix with members of their own ethnic group at extra-curricular activities. As a result, again I challenge Helweg's (1992) categorisation of 'new' migrants to Australia as comfortable in Western and Indian environments, as these newly arrived immigrants were not comfortable with their children developing Western values and norms, fearing this would destabilise their positive ethnic identities. For these women, continuing cultural values and norms was seen as necessary for maintaining cultural identity (Lakha & Stevenson, 2001).

At eight months of age Anjini returned to Melbourne with her grandmother Kamala, who then went back to India. At this point, Sharmila decided to stay at home and care for Anjini. Sharmila and Anil planned to keep Anjini with them until she was to go to school, when they intended to return her to the extended family in India for her education. In the meantime, they said they would make regular trips to India so that Anjini could know her family and her heritage:

> Yeah, now used to it. It is okay for us because we are now grown up and we know what we have to do. There is no other choice, we are here, and we have to adopt this life and this culture. But for our baby there are more options... Because we are here, we know what is good and what is bad for them [the children]. For us we have to stay here because we are here for jobs. There are bad points here too in Australia, but we have to adopt it. But for baby it is okay because we have to choose the life for her at a later stage. (Anil)

Other newly arrived women such as Preeti, Victoria, Rohini and Mary also mentioned the desire to take children to India regularly to know their relatives and learn their culture. Immigrants fantasise about returning to their countries of origin, as a result of their anxiety of having gone "too far" (Akhtar, 1999, p. 85). This refuelling is an adaptive function whereby attempts to reconnect with the culture of origin help cope with the losses of immigration (Akhtar, 1999). Yet others, who could afford to bring their parents out here to live with them to assist with rearing their children, did this for short periods at a time, depending on visas and grandparents' other familial commitments back home. In the above situations, the hope is that children will retain their parents' culture (Tummala-Narra, 2004) as well as receive the love and nurturing that only family is seen to be able to give.

All women, regardless of their length of stay in Australia and heterogeneous cultural identifications, displayed unity in their Indian ethnic/cultural identity (Lakha & Stevenson, 2001). Women such as Ria, who were well established here and identified as Indian, Fijian and Australian, as well as others such as Patricia, who had been here since childhood and identified as Indian and Australian, all expressed a desire to impart at least some aspects of the value system that their shared Indian identity conveyed:

> I can always teach my son, regardless of where I am... I will explain my culture to him as much as I can. (Ria)

> I always want our kids to know where they are from [their heritage]. (Patricia)

Hence, regardless of their ability to accept the prevailing culture, or to balance Indian and Australian culture, all women wished to retain some Indian values in the raising of their children, as a marker of their ethnic/cultural identity and an indicator of their pride in their heritage.

Being 'a good Indian mother'

Immigrant women experience intensified physical and psychological separation from their mothers with regards to formation of maternal identity, especially when there is a lack of regular communication with maternal figures (Chodorow, 2000). Mothering in different culture calls for the resurgence of memories of maternal figures and women can often be surprised by their attempts to reconnect with their heritage. For example, first generation immigrant mothers can desire to re-engage with their

cultural traditions and values in the hope of reliving the nurturing, idealised images of their mothers, grandmothers and others carers (Chodorow, 2000).

For the women in my study, being raised within a South Asian collectivist approach to life meant prioritising the raising of their children, as their mothers did before them. Thereby, their most significant understanding of motherhood appeared to encompass the idea of being a selfless parent (Donner, 2008). Both Patricia and Andrew had a sacrificial attitude towards caring for their children and placed great emphasis on parenting, which they felt is a South Asian cultural trait:

> Patricia is what I would describe as being a very 'mother's mother'. Patricia is like my Mum and her Mum, she would sacrifice a hundred percent...I think a lot of Western attitudes are quite bizarre in terms of upbringing of children…I think a lot of Western or Australian Mums and Dads feel like they have got to retain their current lifestyle without much change when a baby comes into their life…And I think that it is unrealistic and I think that is where a lot of kids go off the rails. In a way if you analyse what that means, it means that they are too selfish to actually sacrifice their own time…I think that it is because we don't feel that it is a sacrifice, I actually feel, and I think we both feel, that it is a privilege much more than a sacrifice. (Andrew)

Even though Patricia and Andrew had lived here since childhood and had bi-cultural identities, they saw merit in the South Asian way of raising children, as it evoked fond memories of their own childhoods. This sense of pride in their upbringing and the cultural values attached to it meant that they viewed this approach as a positive one. Hence, they were keen to continue this way of life with their children as an important aspect of their South Asian identity:

> I mean they are Australian, they were born here, but I am sure when they are older they too are not only going to say that they are Australian, because they know that their mother is Indian and their father is Sri Lankan. (Patricia)

They also valued many aspects of Australian culture, but realised that these would be instilled in their Australian-born children as a matter of course. They felt that it was important to assert their South Asian culture in the way they parented, so that their children would not lose positives aspects of their cultural heritage. To this end, Patricia prioritised motherhood and the raising of her children as 'a good Indian mother' should, so as to conform to what she saw as the positive aspects of her cultural heritage and to give her children the foundations of an identity that she did not wish them to lose. Hence, placing her children's needs ahead of her own was part of her cultural understanding of what it meant to be a good mother. She did not see this sacrifice of her personal space and time as negative, rather, as a necessary part of her role as mother.

Many women in this study, such as Preeti, Victoria, Rohini, Mary, Ria, Nandita, Patricia, Nikita and Nina believed that the selfless attitude that Indian parents have towards parenting makes the difference between successful and unsuccessful lives for their children. From a South Asian perspective, the most important goals for parents is having your children gain a good education and marry suitably:

> Now you start thinking about his future. Firstly I was thinking about having a baby, now I am worried about his future, his studies and all that. (Preeti)

> You are planning for her future, her education, her marriage. Whatever it is, it concerns, it is very important in our house. (Rohini)

Imparting the necessary values and skills to children so that they may reach these goals, is an essential aspect of being a good parent; children's success in life is evidence of this. Their investment in their children's upbringing meant that they would ensure their children have successful futures, hence, fulfilling their role as parents. The focus shifts from adult to child, and the goal shifts from one of personal success to that of the family's success:

> For me, if you had to talk to me before Leila was born, my career was everything, I always wanted to move up, do things, achieve what I could achieve, but now that is not important enough, what is more important is spending time with them [children]… Everything changes after you have a baby. (Nina)

These women recognised and chose to retain this traditional South Asian value of being a selfless parent; they also saw parenthood as a "privilege" rather than an encumbrance. As such, they were happy to prioritise motherhood and devote themselves to raising their children instead of seeing it as a hindrance to their personal ambitions. This selfless attitude toward parenting was evident in discussions with many women and some husbands who no longer saw their own needs or wants as important and placed their children's above their own. I observed the passion with which they spoke of this devotion to parenting as well as the constant attention that they indulged on their children:

> There is less time [for me] but I am happy, I don't need more time for myself. I am more interested in my baby, not me now. It is time for my baby to get attention, not me. If you know, you should expect this, then you won't be concerned about those things. (Mary)

They felt that since they had become parents, their efforts should go into raising their children at the expense of themselves, their career or life outside the home. This meant giving up one's individualistic goals and desires and devoting one's self completely to motherhood for the time being, as this encompassed the traditional gendered notion of being a woman and a 'good Indian mother'.

Postponing employment and saying 'no' to childcare

Immigrant parents have to cope with a cultural shift, in raising children in Australia. Traditionally a child must conform to a family hierarchy where there are multiple adult role models who indulge the infant. In Western culture, the emphasis is on a more permissive socialisation and the child's autonomy and separation from family (D'Cruz & Bharat, 2001). Most women in this study thought that having family care for their children was necessary to pass on their culture to their children. They also mentioned that they felt that only family could give their children the love and nurturing that they felt was necessary for their children's care.

Some women, such as Patricia, Nandita, Victoria and Rohini gave up employment in favour of raising their children, themselves, at home. Also, since children would traditionally be cared for by the extended family, these women found it difficult to think of having their children cared for by people outside the family. Therefore, their selfless attitude to parenting coupled with their belief that children should be cared for by people who love and nurture them, meant that placing their children in a childcare facility was not looked upon favourably.

Sharmila and Anil felt that the constant attention and devotion that Anjini got from her extended family in India, meant that she was always cared for in the 'right way'.

> The problem here is, what I feel, we can't spend time with our children, most of the time they are in day care centres, and most of them feel alone, and if we are working, and we need rest, even then they don't have time...There she is very happy. Somebody is always going to be with her. (Anil)

When the extended family was no longer able to care for her child and Anjini was returned to Melbourne, Sharmila gave up her job to stay at home to look after her. She felt that she had to postpone working until she was able to find appropriate care for Anjini. Sharmila said that she wanted to return to work but would only do so once she was satisfied with a childcare facility. Sharmila said that it was important to her to work again as this is what she was used to doing, but was very happy to dedicate herself to Anjini's care while she was little, as this was her duty. Her desire for their daughter to be cared for by family who would love her, and raise her in 'the Indian way', was more important to her than fulfilling her personal ambition.

The same was true for other newly arrived women, such as Victoria and Preeti, who did not want to work outside the home until they had their family here to care for their children. Preeti felt that childcare was not the appropriate place for her child to be cared for:

> Yes, otherwise, I don't want him to go into childcare. I think that time my mother-in-law may be here so maybe that time [I may go to work], but I am not sure at this time. Otherwise I don't want him to go and be alone in the crèche if I am working, I don't want that, even my husband doesn't want that. (Preeti)

Victoria worked outside the home in India, but had her family to look after her first child there; she did not have her family here, so stayed at home to care for her

subsequent children, as she and her husband did not want their children to be cared for outside of the home:

> I want the children with me, they should get the warmth and love of the parents...So the child must either grow with you or with the family. (Victoria)

These newly arrived women could not reconcile working in paid employment when there was no family at home to look after their children. The idea of outsourcing childcare is contrary to the traditional notion of caring for children within the home by family, as well as contrary to the traditional notion of being 'a good Indian mother'. My observations reflected their distaste for outsourcing childcare as they spoke of this prospect in a disapproving manner. Personal ambition was put on hold while they were fulfilling their role as mothers, which, traditionally, required them to be selfless for the sake of their children. They saw their identity as 'mother' as their priority, and one that embodied their Indian cultural identification as 'woman'. Their middle-class socioeconomic status would have facilitated them taking time to raise their children without the pressure of returning to employment. Also, because of their need for psychological safety in their new home, some may have reverted to pronounced division in gender roles (Espin, 1999), as in the case of Victoria who had been involved in paid employment in India, but in the absence of family in Australia, she and her husband decided that she should concentrate on bringing up their children. As newly arrived immigrants, keeping to their traditional gender roles in Australia meant that Victoria and her husband felt secure in that which is familiar in an otherwise unfamiliar environment. Maintaining their culture for their children was also important, as previously mentioned. Victoria staying at home to take care of

their children might also have been seen as a chance to instill traditional values in them.

Nandita, even though established here, gave up her job when she fell pregnant with her first child and returned to work after her second child began school. She had kept her children at home, and did so until they went to kindergarten. This was because she believed that motherhood was her priority and that being raised by people who loved and nurtured them was best for her children, therefore, she had decided to devote all of her attention to them in their early years:

> To have kids in Australia, it's a big commitment, I used to work full time and now I am home full time, until I have my Mum or my Dad or somebody who can be with my kids when they are home from school...So two parents with full time jobs, I think kids are neglected, that's what I feel. So it's hard. Say for instance, if I had to work, then I would have no choice, put them in child care and go to work. And I have seen the difference with kids who are brought up with Mum and kids who are brought up in childcare. I have seen it...I am thinking once they start school I will go back and study. (Nandita)

Patricia resigned from her job when she fell pregnant and did not have plans to return to work while her children were young, as she too felt that she could not put them into childcare:

> I stopped flying before she was born, and I haven't gone back, I resigned last year in September because my maternity leave had run out and I just wasn't willing to go back to being away…I mean, there were other options for me, I could have done ground work and all that sort of thing, but I just wasn't

> prepared to leave her. And I'm still not…Yeah there is no need (to put them into child care), and I love having them with me. (Patricia)

Patricia lived in Australia since childhood, was acculturated here, and embraced an Australian identity. As a result, she felt a sense of belonging here and did not feel a need to always embrace a cross-cultural approach to parenting. She felt confident in her bicultural identity and her ability to choose the model of parenting that she thought best at a particular point in time. She cherished the traditional belief that children should be cared for by the family, as she saw this as a positive of the Indian way of parenting. She was very proud of her Indian identity and the cultural values that this identity entails. Hence, being a selfless parent was an assertion of her cultural identity.

Childcare presented a model of care in juxtaposition to that which is traditional, where children are cared for on a one-to-one basis by family in the home environment. Staying at home to care for children facilitated the continuance of traditional values for children as well as traditional gender roles for women – both creating a sense of familiarity and safety in the new cultural environment. Hence, women in the study who wished to hold onto their Indian identity and the cultural values of raising children that accompany this identity felt that they needed to be at home to bring up their children (Katyal & Chanda, 1998), even if this meant giving up their career for the time being. This included women who were newly arrived, those who were established here and those who had been living here since childhood. Even though some of the women were well acculturated and had adopted Australian identities, because of their collectivist upbringing, they saw this selfless behaviour as a positive aspect of their South Asian culture, thus, crucial for being 'a good Indian

mother'. Resisting the outsourcing of childcare among these women is a novel finding of this study, and to my knowledge this has not been found in any of the relevant literature on this topic.

Embracing identities other than 'mother'

For women who adopted an Australian identity, acculturating meant incorporating influences of Australian culture and its primarily individualistic structure in order to meet expectations of women in a Western, liberal culture. This meant altering gender roles to comprise goals apart from those centred on motherhood, including a career for personal fulfilment.

Even though Patricia was not currently involved in paid employment, and had decided to devote herself to raising her children while they were under school age, as this was her notion of being a good mother, she nevertheless wanted to return to other work once they went to school. She thought she would play an active role in their business, or even learn another skill:

> As for when they are both in school, I will have more time then [for working in their business], so I think I will get a bit more involved in the day to day running of stuff, but I think I would also like to perhaps go back and do some study. In what I am not exactly sure, but just to keep the brain ticking and keep up with things, I would like to. (Patricia)

Patricia and Andrew grew up in Australia and identified biculturally. Patricia wanted to mother in a South Asian way, but also wanted to do something for her personal growth as is a common expectation in this culture. Andrew, too, was keen to have

Patricia see value in embracing a life outside caring for children, as women generally do in Australia:

> And that is where I am trying to get her or trying to convince her [Patricia], or trying to influence her, to say 'okay look, it's great that you are that devoted to your kids, but one day your kids are going to get up and move away, and then what are you left with?'...Sri Lankan and Indian parents are typical of the type of parents who generally end up sacrificing themselves during the nurturing years of parenting, and end up leaving themselves behind. (Andrew)

To Patricia, this desire to have an identity apart from 'mother' meant that she could pursue something that fulfilled her beyond motherhood, something that would occupy and fulfil her once she had raised her children. In this way, she thought that she would be a good role model for her daughters, in a bicultural sense, embracing multiple personal identities through her lifetime.

Working women and children in childcare

For Ria, who was established here, acculturating in Australia meant adopting Western, liberal values surrounding gender roles, family, and childrearing. She did this by being involved in work outside the home (Mehra, 1992) and gaining social acceptance in this society (Ganguly, 1997). Employment made her feel connected to mainstream society and gave her a sense of belonging in this country, which assisted her in constructing Australian gender and cultural identifications. Retaining aspects of her cultural heritage as well as embracing parts of this culture was necessary for maintaining multiple cultural/communal identities and for the construction of positive identities in Australia (Tewary, 2005).

Ria had not resigned from her job when she had her child as she felt that it gave her a sense of independence and achievement. Tummala-Narra, (2004) has suggested that immigrant women can desire increased personal freedom and autonomy after coming from collectivist societies where their roles are defined by patriarchal systems. Ria's ambition towards her career also meant that she did not want to give up her personal goals while raising her child:

> At that time there were other positions going at work and you felt that you were going to miss out on it and if you were there you would know better, and obviously my team was growing and there were new people, and I was a bit like, they will probably know more than I do and I wouldn't feel as senior as I am supposed to...I could have taken 12 months off, but because I wanted to go back to work because I couldn't just do the whole [housewife] thing everyday, it just became a routine...So there were two reasons, I wanted to go back to work, and financially, but I just wanted to go back to work. (Ria)

Ria and other employed women such as Julie, Nikita, Nina and Amani who did not give up their jobs, but who took maternity leave to return to paid employment after having their babies, felt that their jobs afforded them a role and an identity other than 'mother' and gave them a sense of worthiness outside the home and beyond that they gained from motherhood. Going out into the workforce offered them a degree of empowerment and autonomy within the home too. It was clear from my observations that Ria and other employed women had a level of independence and autonomy within the home, in the decision-making influence they had and in the way they related to their husbands, that was not apparent in households where women stayed at home. Thus, by modifying traditional gender roles, these women were minimising the private patriarchy they experienced (Tummala-Narra, 2004; Ganguly, 1997). This

modification of personal identities, made allowances for the way they were encountering motherhood, facilitating caring for children outside the traditional models of parenting.

Economic pressures and changing values were giving rise to the erosion of traditional gender roles, family dynamics and childrearing for women who were adopting an Australian way of life. Thereby, some women desired change in traditional gender roles in order to begin to embrace Australian gendered and cultural identity. These women were, therefore, able to reconcile being involved in paid employment after giving birth and felt comfortable outsourcing childcare. Thus, having a career and having children in childcare is reflective of length of residency in Australia and acculturating to a more Western, liberal approach to life. Balancing motherhood and personal goals meant women were simultaneously constructing multiple communal as well as personal identities.

Bridging the gap: Cross-cultural parenting

Attempts to raise children cross-culturally, strongly depends on the immigrant mother's ability to negotiate her identity in the two cultures (Tummala-Narra, 2004). This can be achieved by refuelling through one's ethnic community and/or maintaining some connection to one's homeland, as well as accepting their child's mixed loyalties to both cultures (Akhtar, 1999). Reconnecting with the country of origin, however, can interrupt the mother's and child's involvement with the new culture. Immigrant mothers need to be able to come to terms with their own losses, in order to facilitate biculturalism in their children (Tummala-Narra, 2004) as the

formation of a new cultural identification is related to the process of mourning distance from one's native culture (Chodorow, 2000).

For women in this study, cross-cultural parenting required connecting with people within their ethnic group as well as with those outside their ethnic community in order to negotiate their various cultural values and identifications. With a lack of family in Australia, connections within and outside the ethnic community became especially important as a source of support. These were established via cultural organisations, mother's groups and/or playgroups as well as through maternity healthcare.

All women in this study – newly arrived, established and those who were here since childhood – required a sense of cultural connectedness or emotional refuelling from their ethnic networks (Akhtar, 1999). This they received from family and friends within the South Asian community here:

> And neighbours here, this one is Sri Lankan, that side is an Indian, she is from Kerala, it is the same environment, like at home. (Victoria)

> I started to make friends with Mums who are Indian. One was born here but her background was Fiji Indian, another lady was from Pakistan and another lady is from Fiji as well...And it is good too, mothers socialize at the same time, you have coffee and meet other mothers. (Nandita)

> We have lots of Indian and Sri Lankan friends actually. We see my family a lot. My parents' friends, we see them, but also our own friends, like our own age, we have a few and they have just started to have children as well, which is nice. (Patricia)

For the newly arrived, like Victoria and Sharmila, the established women like Nandita and Nina, as well as the women who had been here since childhood, like Patricia and Amani, intra-ethnic networks were important as they gave these women companionship and support that entailed a level of understanding of their lives which they could not receive from outside their ethnic communities. This was especially important for women such as Victoria, as it alleviated their sense of cultural displacement as newly arrived immigrants. All women, however, found that they could talk more freely about the cultural aspects of motherhood and parenting with other women from their ethnic group. These contacts provided them with a sense of community and belonging, which in turn made them feel more at home in Australia and more open to embracing Australian approaches to parenting.

Messages of Australian ways of parenting

Preeti, Rohini and other newly arrived women who believed that they would regularly go back to India for holidays or eventually move back there, had not yet come to terms with the losses of immigration (Tummala-Narra, 2004) as they had not yet mourned distance from their homeland (Chodorow, 2000). They strongly identified as Indian which meant that they preferred the traditions of their cultural heritage. They spent the postnatal period confined to the home, then travelled to India to spend time with their extended families there, following custom. As a result, they did not join mother's groups (as they were in India during the postpartum period when the groups had formed), or involve themselves in the rest of the society much.

Instead, they socialised within their cultural networks, rather than befriending outside of their ethnic communities. They sought support and emotional refuelling from

friends within their ethnic group as part of the settlement process, in order to renew their commitment to their homeland and preserve psychological wellbeing (Mehra, 1992).

Newly arrived women were as yet unable to accept many cultural differences however, they acknowledged the benefits of receiving maternity care in a system that is based on equality for all patients regardless of their background. In the caste/class driven society of India, healthcare is no exception to the inequalities in care and service that this kind of system facilitates:

> No, in India they just have assistance during the birth, they just have the delivery and then go back, maybe after 24hours nobody cares, especially in the hospital… And I am talking about the nurses and doctors in a private hospital, a big hospital, even then they don't know how to speak, they are very rude… The system over here is very good Natasha, in India it is not good. Over here it is very nice, like every two, three months it is time for him [baby] to go to the maternal and child health centre, but in India, nobody bothers, nobody bothers. Lots of telephone numbers you can ring over here and they have a 24 hour help line. Like if your baby is not okay or not having his proper feed, you can call them and get them chatting over here. It is very helpful over here. (Preeti)

In this regard, the maternity healthcare system proved to be a good resource for exposure to Australians and Australian culture for these women. Antenatal classes at hospitals brought them into contact with people outside of their ethnic community, with whom they otherwise might not have had much prior contact. Midwives and maternal and child health nurses provided them with advice and support and introduction to Australian models of parenting during a time when they did not have

a wider social network to draw on. Many women reported their midwives being very informative and attentive during their pregnancies, deliveries and postnatal periods at hospital, despite them sometimes receiving mixed messages regarding breastfeeding positions:

> People were very nice, after every couple of hours the midwife would come, the bell was there, buzzer was there. Even if I didn't ring the bell, she would come automatically after 15/20 minutes asking if I have any problems. They are very caring. The thing is how they care for baby, how they care for mother, and how they train me. (Sharmila)

> A lot of people are contacting me, talking to me, and the hospitals, the way they take you through the pregnancy is beautiful. The people from the hospital they will call you and fix up the antenatal classes and things like that, and we went to the hospital and I went through a counselling session and they told me what labour could be, how long I need to be in the hospital. The doctors are very nice here. (Victoria)

> Fantastic! Even after shifting to the ward the midwives and nurses are very helpful, they are very helpful. Always they are asking, 'Have you any pain, have you any pain?', 'Is everything okay, is everything okay?' All are very nice, all are. (Rohini)

The care offered by hospital midwives surrounding the birth of their babies, as well as the continuity of care provided by maternal and child health nurses during the postpartum and beyond was a welcome change for those coming from India. This level of advice and support better enabled these newly arrived women to understand and appreciate this culture. It was seen as a positive of this country, which made

warming to this culture easier. These constructive interactions with other Australians facilitated the settlement and acculturative process for these women (Abou, 1997).

Newly arrived women such as Sharmila, Preeti and Rohini mentioned a desire to have been involved in a mother's group for support during the postpartum, demonstrating willingness to network outside their ethnic groups. Once they had babies who became Australians by birth, they began to feel some sense of belonging in Australia. These were steps towards acculturating, adopting an Australian identity and embracing a cross-cultural approach to mothering over the course of time.

Established women like Nandita and Ria, who had embraced many facets of Australian culture, were open to embracing aspects of Australian ways of parenting as well. They had been involved in paid employment here and made Australian friends which had facilitated their acculturation and sense of belonging in Australia. They tended to rely on these friends from the wider society, including those they met through mother's and/or play groups, as a source of support during motherhood and as a means of coming to terms with new ways of parenting (De Souza, 2006). These networks helped women develop skills as bicultural mothers (Akhtar, 1999).

> No, see I came to Australia and my husband and I both were working, I never had any friends, I actually made friends through kids…and of course I started knowing Australian culture when I had my son because then he made friends who were Australians and I would go to their place and learn their culture, their way of doing things, and when they come to my house, they know about my culture, my traditions, the way we do things. (Nandita)

For women like Nandita and Ria, the maternity healthcare system provided an avenue through which their husbands could be informed about childbearing and rearing. Ria thought that the antenatal classes were especially helpful for her husband, who otherwise would not have known much about the process of birth and caring for babies. She thought he should be informed so that he could actively parent their child as men generally do here, hence, assisting with the shift in traditional gender roles:

> I think it was more for my husband probably than for me. Like I said I had looked after babies and I sort of knew. I just wanted my husband to go through it, because he had never held a little baby. I think Rishaan was the first one that he had held. (Ria)

Exposure to Australian society through paid employment, the maternity health care system and mother's and/or play groups, meant that women, as well as men, were able to begin to embrace Australian values and norms. Women participating in paid employment and husbands helping with household chores and childcare assisted with the alteration of traditional gender roles and the reconstruction of parenting (Tummala-Narra, 2004; Williams & Carmichael, 1985). Forging friendships within their ethnic communities as well as within mainstream society nourished their multicultural identities. They were thus able to begin to resolve conflicts and tensions from their various cultural influences (Indian, Fijian and Australian) and develop positive, multicultural identities (Robbins et al., 1998). Established women who had adopted Australian cultural and gendered identities, therefore, were able to embrace many aspects of Australian life, including parenting models such as outsourcing childcare.

However, even those parents, like Patricia and Andrew, who were living here since childhood and embraced both cultures were still in the process of adjusting to the expectations of both cultures. They had developed Australian identities through the course of growing up here, however, they also maintained their South Asian identities as this culture dominated at home. Patricia and Andrew realised that their children were born here and would see themselves as Australians and adopt Australian culture. Therefore, even though they wanted to parent in a traditional way in some respect, they realised that they also needed to be the kind of parents whom their children could identify with and look up to, growing up in this culture. Thus, they felt that embracing a cross-cultural approach to parenting would help their children adjust to both cultures (Tummala-Narra, 2004). Also, they thought that both Australian and South Asian culture had positives, and utilising both approaches in raising their children would mean giving them the best of both worlds (Lum, 1995):

> From our point of view we want to create role models for our kids, without being obsessed with any particular area, we are trying to maintain some sort of balance. (Andrew)

Women who had lived here since childhood, such as Patricia and Amani, and had grown up with South Asian values, carried bi/multicultural identities. They felt secure in their various identities, and did not feel the need to demonstrate their loyalty to either cultural identification through embracing one approach and/or abandoning the other. Just as they were constantly balancing their dynamic and fluid communal identities, so were they constantly negotiating their personal identities and ways of parenting.

Summary

Childrearing was influenced by women's gender and cultural identifications. The forces of migration and globalisation compelled women to modify their attitudes and behavior and propelled them in embracing aspects of Australian norms and values as they acculturated. However, the centrality of motherhood and core collectivist South Asian values relating to childrearing persisted, despite the influence of liberalism in Australian culture. All women in this study identified as Indian and had positive feelings towards their ethnic group and cultural heritage despite the heterogeneous origins of this group of women. Those who were here from childhood or established here and identified bi/multiculturally, however, were more likely to incorporate Australian culture and had more confidence and security mothering across cultures. Those who were newly arrived and strongly identified as Indian, resisted Australian culture which brought about the firm retention of Indian values and norms for second generation immigrant children, including a desire to have children cared for by family. This included a dislike for outsourcing childcare; the first study to my knowledge to refer to this. Women with some level of acculturation were open to the idea of embracing a cross-cultural approach to childrearing including, a level of compromise between traditional parenting models and women's engagement outside the home, thereby, reinventing their roles within the family and society. Indian immigrant women's experiences of childrearing in Melbourne generally varied according to the theoretical proposition that embracing aspects of cross-culturalism within parenting, including outsourcing childcare, required a level of acculturation as well as embracing Australian communal and personal identities.

The next chapter concludes the thesis with a discussion on the findings from this research, including limitations and recommendations for future research and for health service provision.

CHAPTER 7: DISCUSSION AND CONCLUSIONS

Introduction

The study findings support a broad range of earlier observations relating to experiences of immigrant mothers. These include the various psychosocial factors involved in the experience of the immigrant, such as the birth of children, that have significance in the lives of women who migrate as mothers or who become mothers in a new country. This study explored the influence of culture and identity on the experiences of early motherhood amongst Indian immigrant women living in Melbourne. Key findings elucidate the pathways which women traverse over the course of time in reconstructing their culture and redefining their identity through their experiences of mothering in Australia.

A broad critical medical anthropological framework was applied in this study to understand the impact of historical, political-economic, socio-cultural and environmental factors on people's everyday lives. The historical factors refer to the migration experience of the women, including where they came from, why they came here, how long they have been here and how they are acculturating here. Within the political-economic sphere are ethnic, class and gender antagonisms, such as the dynamics between the majority Anglo-Australian population and the Indian immigrants, who are visibly different and perceived as the 'other' (Moghaddam & Taylor, 1987), despite the fact that they may see themselves as Australian. There are also the obvious power differentials in the health sector within health professional-patient relationships (Lakhani & Jansen, 1984), especially in the case of Indian immigrants from a class/caste based society where educated, knowledgeable people

are valued more. There are gender antagonisms between husbands and wives and the patriarchal and fiscal influences that shape women's roles and power within and outside of the home. Socio-cultural refers to aspects of the immigrant women's cultural heritage (the influences they bring with them to Australia from other countries) as well as the culture of Australia (the influences this society has on them) and its impact on their lived experiences. This includes the philosophical underpinnings of the traditional societies that they lived in, namely, collectivism, and those of other Western countries that they may have lived in, including those of Australia, such as, individualism and liberalism. Ideals of womanhood and motherhood within South Asian and Australian culture are also variables under the sphere of socio-cultural factors. All these factors also included personal, household, community as well as macro-levels of analysis, such as institutional influences. It is within this framework that I constructed my study and analysed the data.

Acculturation and reconstruction of identity among Indian immigrant women in Australia

Migration from a collectivist society, such as the South Asian communities (in India and in other Indian diasporas worldwide) that women had come from (Sobrun-Maharaj & Wong, 2010; Tse et al., 2007), to a primarily individualistic one, as are Western countries such as Australia, can leave people feeling alienated (Bhugra, 2004). Acculturating to the differences in world views (Dasgupta, 1998; Meleis, 1991) between Indian and Australian society, means constructing new cultural/communal identities (Abou, 1997).

Migration can emphasise differentiated gender roles (Agarwal, 1991; Buchignani, 1983; Kar et al., 1995/1996; Kurian, 1989; LaBrack, 1988; Ralston, 1998; Sodowsky

& Carey, 1987, 1988) in order to retain cultural familiarity (Espin, 1999) in an otherwise unfamiliar environment, and solidarity as visible ethnic minorities (Moghissi, 1999). This was the case for the newly arrived immigrants, as they continued their traditional gender roles. Observations of these women validated their differentiated roles and their domesticity. For them, holding onto patriarchal definitions of womanhood represented tradition, which brought about a sense of stability and pride in their Indian identity (Uba, 1994) and maintained their commitment to their ethnic community (McElroy & Townsend, 1996; Moghissi, 1999). Some of them clung to their Indian values and norms and resisted Australian cultural ideals and attitudes (Nicassio, 1985; Phinney, 1990; Sue & Sue, 1971); this stage on the trajectory of acculturation being identified as traditionalism (Dasgupta, 1998; Sue & Sue, 1971).

Changes to family structure from extended to nuclear in Australia, for the most part, and the absence of elder familial women in the household (mothers and mothers-in-law were only present as visitors during the postpartum period), left women with more responsibility in the home, but also more decision-making power. Women felt elevated to a higher status with greater influence over the household. Even the few who had extended family here chose to live in nuclear families for this reason. Women were mothers and wives, and in many cases, income earners. They were becoming empowered, autonomous and in control of their lives, minimizing private patriarchy and redefining gender identifications (Ganguly, 1997; Tummala-Narra, 2004). Observations confirmed women's sense of confidence, independence and decision-making influence within their homes, especially amongst those who were involved in paid employment. They still, however, retained many aspects of their

natal culture and adopted new cultural traits at their own pace, with this stage of acculturation being referred to as judicious biculturalism (Dasgupta, 1998).

The process of acculturation to a new country is a multi-layered trajectory influenced by many internal as well as external factors (Dasgupta, 1998). Whilst acknowledging that each woman's experience is individual and that there was some deviation from the pattern, generally, Indian immigrant women's experiences of mothering in Melbourne fell into a continuum based on levels of acculturation: those on one end could be seen as accepting Australian culture and exhibiting many Western or 'Australian' traits, and those on the opposite end could be viewed as resisting the new culture and clinging on to their traditional or Indian culture in their knowledge, attitudes and practices. However, most women had acculturated to some degree, and the degree of acculturation was largely dependent on exposure to Western culture in other countries through successive migration over the generations, and length of residence in Australia. Accessing employment and social acceptance also influenced women's level of acculturation. For women in this study, acculturation was reflected in renegotiation of gender roles and a sense of belonging in Australia. Observations of women's circumstances, environment and conduct corroborated their level of acculturation.

Newly arrived immigrants felt that in order to feel at home or gain a sense of belonging in Australia, they needed to come to terms with the cultural displacement and feel incorporated into mainstream society. Social acceptance (Ganguly, 1997) by Anglo-Australians and access to paid employment (Mehra, 1992; Tummala-Narra, 2004) were instrumental in allowing established women to feel acculturated here. Getting a job and joining a mother's group were turning points for these women, as

making new friends and getting out into the wider society helped ease the sense of alienation in Australia, and increase familiarity with Australian culture.

This study shows women's resilience in their attitude to change upon migration to be an important factor as well. It is associated with women's sense of belonging and community (Mandleco & Peery, 2000; Nayar, 2005), thus, acculturation and settlement in Australia. Though some women acknowledged feeling out of place to begin with, but with an attitude to adapt to their new environment, they soon began to feel at home here. Some newly arrived immigrants displayed a great deal of resilience which facilitated and expedited their acculturation enabling them to come to terms with their new circumstances. Maintenance of their culture through traditional customs and values (Silberberg, 2001; Walsh, 2002) and support from family and ethnic community were mechanisms of resilience (Silberberg, 2001) and assisted them in maintaining communal identity and social cohesion in Australia. Observations of women getting on with their daily lives in this country verified their will to succeed in Australia. This resilience was evident in their positive attitudes, strength of character and determination to succeed in their adopted country despite any adversities they encountered (Werner, 1993).

Due to their shared historical heritage, women felt a common ethnic/cultural/communal identity, despite their origins in different countries (Abou, 1997; Naidoo, 2007). The newly arrived women felt a great gap between their culture and that of Australian society and were in culture shock (Dasgupta, 1998). Due to the vast changes in lifestyle upon migration, including the changes in family structure and loss of extended family, a few women felt the need to go back to India regularly to visit their families, as they could not yet see Australia as their home. This

refuelling with their natal culture provided an avenue to deal with the losses of immigration (Akhtar, 1999). Consequently, they were unable to gain a sense of belonging here, driving their need to assert their cultural heritage as a means of maintaining a positive and stable ethnic/cultural identity (Uba, 1994), self-esteem and psychological wellbeing (Hyers, 2001).

Women who had been here for a longer period of time had acculturated to some degree and embraced an integrated or hybridised culture, due to favourable sociological conditions (Abou, 1997; Naidoo, 2007), such as attaining social acceptance or gaining employment. They welcomed an Australian identity alongside their other cultural/communal identities (Tewary, 2005) whilst maintaining their Indian identity as visible ethnic minorities (Kibria, 1987, 1993; Sue & Sue, 1999; Tajfel, 1981; Uba, 1994) and a cohesive diasporic group transnationally (Lakha & Stevenson, 2001; Vertovec, 2001). They saw themselves as Australian because of the length of time they had spent here and Indian due to their appearance and connection to their family/community (Malhi et al., 2009) while others retained their identification with the nations they were born in, other than India. Some identities illustrated their pride in the values of their Indian cultural heritage, others their loyalty to the nations they were born in, yet others showed their sense of belonging in their new home, Australia (Naidoo, 2007). Brah (1996) says that identities are not constant, and are created by the narratives that people articulate. These identities shifted in accordance with the prevailing circumstances (Williams, 1992), thus, were context specific (Phinney, 1990). Women carried dynamic, multi-layered identities (Smith, 1998) and illustrated the notion that ‘real Australians’ are not a single physical and cultural type without ties outside the country (Ganguly, 1997).

Migration had varied impacts on the social/cultural/communal identities for the women in this study. They acknowledged their Indian heritage and still thought of at least some parts of their identity as Indian, thus identifying as ethnic Indian irrespective of their duration of residence in Australia. Women who were newly arrived were more likely to resist the new culture and identify solely as Indian. Women who were established and felt at home, were more likely to accept aspects of Australian culture and embrace an Australian identity alongside other cultural/communal identities, becoming bi/multicultural. The women who adopted an Australian identity with ease were born in a country other than India, namely South Africa, Britain or Fiji, and were also bearing those identities. They identified as ethnic Indian, acknowledging their cultural heritage, but were also carrying the identities of the nations they were born in, as well as now embracing an Australian identity. As such, they embodied multiple cultural/communal identities. They inhabit multiple spaces, living within and outside their communities, identifying themselves with, and also distinguishing themselves from, these communities (Askland, 2005, p. 161). The women in this study have diverse and heterogeneous identities, due to the effects of globalisation (Hall, 1996), whilst maintaining a common ethnic identity for a sense of cohesion and community in Australia.

Indian immigrant women having babies in Australia

No matter where their place of birth, Indian women contextualise the birth of their children with the traditions and customs surrounding the arrival of the newborn. Hence, beliefs and practices surrounding pregnancy, delivery and the postpartum are culturally defined (Brettell & Sargent, 1997). It is a period that is entrenched in cultural expectation whilst challenged by the erasing effects of time and distance.

Women's experiences of motherhood are constructed by their cultural heritage as well as the cultural displacement that women experience upon migration (Tummala-Narra, 2004). Traditional ideas often clash with Western biomedicine (Kim-Godwin, 2003) and Western models of mothering. Thus, as women mother across cultures, they question and reconstruct their identity and their culture (Tummala-Narra 2004). Conversely, mothering is also an important process in reaffirming Indian culture and identity (Dasgupta, 1998).

Support

Support during early motherhood is a cultural expectation amongst South Asians due to the collectivist nature of their culture (Triandis, 1995). Bringing a child into the world means the involvement of extended family as well as the community. It is seen as a critical and necessary part of the experience of motherhood (Dobson, 1988). Women in this study were visited by parents and parents-in-law during the postpartum, to assist with their rest and recuperation by caring for the mother and her new baby and managing the household (Puri, 1999). Their visits to the expectant mother's home were in lieu of the confinement and saved women travelling great distances and leaving their husbands for an extended period of time. Since senior women in the family are most important in the transfer of culture (Mani, 1992; Tummala-Narra, 2004) elder familial women saw it as their duty to reiterate customs and rituals in order to continue Indian traditions upon migration (Maharaj, 2007). This was substantiated through my observations of mothers and mothers-in-law carrying out various traditions of mother and infant care during their visits to their family in Melbourne.

An important aspect of redefining mothering is the increasing involvement of men in the home (Tummala-Narra, 2004; Williams & Carmichael, 1985). Relying on husbands becomes more important for immigrant women as they are often the only source of support (Bandyopadhyay et al., 2010; Tewary, 2005). Most women in this study came to this country not knowing anyone apart from their husbands. They did not have a social network to draw on for emotional or practical support. Therefore, husbands took the place of the extended family. Husbands had begun to share in the household duties, including taking a more active role in caring for children. I observed husbands participating in the daily activities of the home, authenticating these claims. Those husbands, who had been living outside of the Indian social order for longer periods of time and were established here, had adopted more egalitarian ideas towards gender roles, aligning them with the culture of their adopted country. Husbands were the most important source of support for immigrant women in the postpartum period and in the long-term in their new home. This parallels Australian women's experiences of early motherhood, where women rely on partners for support due to the lack of community involvement (Bandyopadhyay et al., 2010; McVeigh, 1997).

However, newly arrived women felt isolated and lonely in the postpartum period, and would have liked to have had more support, as was evidenced in this study and reported in a study conducted in Melbourne on other immigrant women (Bandyopadhyay et al., 2010). Choudry (1997) suggests that women are deprived of essential support at a time of need when the social order is altered, as is the case for Indian immigrants here. As such, they found the postpartum period trying as they were in an environment where social networks were either non-existent or still developing. Those who were unemployed had feelings of displacement and

alienation as they were generally housebound as they did not drive or leave the house without their husbands. They were unable to familiarise themselves with their surroundings or develop friendships.

The advice and support that women received from health providers was crucial during this time. Having a baby here propelled women into the public arena of maternity hospitals and maternal and child health centres, where, during this prolonged exposure within the healthcare system, they began to familiarise themselves with the new society and negotiate their way through a different cultural milieu. In the Western liberal society of Australia, women had access to more information as this culture encourages women being informed and empowered about their own health. Here, knowledge is not simply the domain of health professionals and speaking openly of pregnancy and birth is not frowned upon. Information from health professionals was well received and highly depended upon by women. Moreover, women were able to gain support from their midwives and maternal and child health nurses that was greatly valued when there was no family or other social networks to rely on. Women's overall positive interactions with Australians (Abou, 1997) through the health sector helped women gain understanding and appreciation for Australian culture. These were steps towards acculturating and developing a sense of belonging in this country. However, some women received conflicting advice from health professionals regarding traditional aspects of care such as bed-sharing and breastfeeding which could potentially hinder the settlement and acculturative process. Misunderstanding and miscommunication by health professionals could cause women to lose confidence in their ability to mother as well as to withdraw from participation in the wider society, leaving them with no support at this critical time.

Postnatal care

Generally, motherhood and its associated customs and traditions provides opportunity to bring women's cultural heritage to the fore. In a society where Indian culture is different to that of the majority culture, it is in the privacy of their homes that women had the power to assert their identity. In this way, women maintained some customs relating to postnatal care. This was important for the settlement process too as it brought about a sense of familiarity, pride, and emotional wellbeing as visible ethnic minorities in this society (Hyers, 2001; Mehra, 1992).

All women participated in some aspect of traditional mother and infant care surrounding the postpartum period (Maharaj, 2007). Aspects of traditional care that were mostly practiced were: a rest period; *Ayurvedic* medicine and food; traditional massage; bed-sharing; and breastfeeding. Bed-sharing and extended breastfeeding are significant features of traditional Indian infant care, and sometimes conflicted with the advice women received from midwives and maternal and child health nurses.

Newly arrived women followed traditions closely after birth maintaining their traditionalism (Dasgupta, 1998). Observations of women participating in many of these customs (rest period, massage and *Ayurvedic* food prescriptions) during my visits with them corroborated their practice. Women reported feelings of censure by their healthcare professionals, hence, did not mention the traditional aspects of care during consultations. This was also the case amongst Indians from India and British Indians who saw their traditional care as separate to the care received from Western medical practitioners. Bhopal (1986) found that traditional remedies were used instead of Western medicines for acute illnesses, and as supplementary to Western

medicine for chronic problems. Other researchers have shown that British Indians and sub-continental Indians utilise 'medical pluralism' (Bandyopadhyay & MacPherson, 1998) and use traditional remedies before, with and after Western medicine, without this affecting their attendance to maternity medical practices (Bhopal, 1986; Rocherson, 1988; Woollett et al., 1995).

The established immigrants took a cross-cultural approach towards care surrounding the postpartum reiterating some Indian traditions. As such, women displayed varying degrees of conformity to various aspects of their Indian customs depending on the degree to which they retained an Indian identity and the extent to which they identified with Australian culture (Hutnik, 1986; Sue & Sue, 1999; Uba, 1994). Women participated in some aspects of their customs as a way of asserting their ethnic/cultural identity (Kibria, 1987, 1993; Sue & Sue, 1999; Tajfel, 1981; Uba, 1994) whilst adopting aspects of Australian ways of mothering through judicious biculturalism (Dasgupta, 1998).

Bed-sharing

Bed-sharing is a traditional aspect of childcare, which is advised against in Australia by midwives and maternal and child health nurses due to its association with Sudden Infant Death Syndrome (SIDS). This practice is done safely in many Asian countries, with SIDS deaths being amongst the lowest in the world (Nelson & Taylor, 2001). It enhances a strong maternal bond with the newborn and facilitates breastfeeding ease at night-time, thus, promoting breastfeeding (McKenna, 2000). Women chose to ignore the advice they received from their health professionals (although their conflicting position on bed-sharing did concern some women) and shared their bed

with their infants, thus, ensuring that they kept this significant Indian tradition and custom alive. Since some women were aware that it is not cultural practice here, they omitted the fact that they were bed-sharing with their infants during consultations with their maternal and child health nurses. This was also found in an earlier study with an immigrant group in the United States (McKenna, 2000). Health professionals' lack of cultural competence as well as broad generalisations about negative outcomes from bed-sharing strip away women's confidence and security as immigrant mothers (Lauderdale, 1999). They are left questioning their competence as mothers and their traditions as immigrants.

Breastfeeding

Prolonged breastfeeding is traditional practice and all women wanted to continue this practice upon having their babies as they knew that it is nutritional as well as what is professionally recommended. All women initiated breastfeeding, but many started supplementary feeding before six months of age, and most ceased breastfeeding before their baby was a year old, not meeting the recommendations of the WHO (1992). Husbands played a part in supporting women and encouraging them to continue breastfeeding. Paid employment, however, was a reason why many women ceased breastfeeding before they intended to. This was observed among Indians in the sub-continent, where breastfeeding duration dropped by almost half when women returned to work (Khan, 1990). Hospital midwives and maternal and child health nurses as well, seemed to play an important role in women's decisions to start formula feeding or cease breastfeeding prematurely. Demand feeding is traditional practice (I observed many women putting their infant to the breast on demand, without regard for timing intervals between feeds), however, scheduling feeds, as

advised by many midwives and maternal and child health nurses, conflicted with what women were told by their mothers and mothers-in-law. Advice on various breastfeeding positions also caused confusion. Some midwives reportedly introduced babies to formula at the hospital before women had begun lactating. This fuelled the misconception that women had insufficient milk supply. This was also the case among Indian women in Nairobi, Kenya, where health professionals were found to be influential in women's decisions around infant feeding choice (Lakhani & Jansen, 1984).

Unfortunately, the well-meaning advice of hospital midwives and maternal and child health nurses seemed to inadvertently make women feel that they had to supplement feeds or give up breastfeeding. This is a missed opportunity for all women, especially for the newly arrived and still acculturating, for whom the advice of health professionals would have weighed most heavily, and could instead have led them to continuing breastfeeding towards the optimal levels for the good health of mothers and babies. These women were keen to be spoken to about reproductive health, as the open and empowering attitude to these issues in this culture was a welcome change for women coming from India where these topics are taboo and the culture of access to knowledge is quite different. Women already felt warmly towards their midwives for guiding them through their deliveries, and saw their supportive attitude towards them as a positive of this culture, thus, midwives could have drawn on women's receptiveness to educate them on breastfeeding.

Indian immigrant women raising second generation children in Australia

Women were keen to maintain significant aspects of South Asian childrearing traditions as defining features of their South Asian identity. All women wanted their children to uphold some core South Asian values, such as respect for elders and the value of education. Some newly arrived parents, who had not acculturated and did not have a sense of belonging here, felt that they should return to India at some point or send their infants there to be cared for by extended family, others thought of sending their children back to India once they were of school age, to be educated. Since, traditionally, childcare is a communal endeavour and fostering a one-to-one relationship between mother and child is not emphasised (Dobson, 1988) as it is in Western hospital contexts (Lozoff et al., 1988), having children raised by extended family is not an unfamiliar concept. Women who were still experiencing culture shock, could not imagine their children growing up here. Others, who could afford to, sponsored their parents to come to live here with them and assist with childcare and rearing. Yet others thought they would send their children to extra-curricular cultural activities. These actions were due to feeling too far removed from the values and norms of their South Asian culture (Akhtar, 1999). Therefore, I do not agree with Helweg's (1992) categorisation of 'new' migrants to Australia being comfortable in Indian as well as Western environments, as the newly arrived women were clearly not comfortable with their children growing up with Western values and norms. Their feelings of displacement in Australian society was evident in their desire to do whatever it took to immerse their children in their culture and minimise the influence of Australian culture. Continuing their culture in the second generation meant maintaining their cultural identity (Lakha & Stevenson, 2001).

Established women, who had been living here for a longer period of time and felt at home here, did not feel the need to return to their natal home, but thought that they could raise their children here, at home, with appropriate South Asian values. In the above scenarios, parents hope that their children will be socialised to maintain some of their cultural values and traditions (Tummala-Narra, 2004) to preserve cohesiveness as a visible ethnic minority group (Moghissi, 1999).

Women's sense of identity, communal as well as personal, influenced the way they wanted to raise their children. Thus, the following discussion focuses on women's identities, cultural and gendered, communal and personal, in terms of raising children and the impact of these on their attitudes to parenting in Australia.

In South Asian culture, women are traditionally defined by and valued for their roles as wives and mothers. The domestic sphere is the centre of female conduct, within which the hierarchy of roles are established (Donner, 2008) and where women's sense of self and satisfaction are gained (Tewary, 2005). These gendered identities of domesticity create a collective/communal identity for Indian women throughout the diaspora (Raman, 1995). Childrearing in the Indian sub-continent is traditionally a community initiative, with the extended family playing a significant role in the upbringing of children in accordance with South Asian collectivist approach to life (Sobrun-Maharaj & Wong, 2010). Children are, therefore, nurtured and indulged by many adults in the household and community.

In Western society, women are valued for roles within as well as outside of the home and gain a sense of self and accomplishment apart from that attained through motherhood (Manne, 2005). Childrearing includes fostering independence and

autonomy in children, with children spending time away from the family in outsourced childcare (D'Cruz & Bharat, 2001).

This move from a collectivist and traditional society to one that is individualistic and liberal in values and norms, therefore, has implications for raising second generation children. Women are left balancing communal and personal expectations (Dasgupta, 1998), raising children on their own without familial support amidst other roles that they may take on in their new home. This brings about new constructions of womanhood and motherhood that women have to negotiate in order to help their children adjust to being bicultural (Tummala-Narra, 2004).

Retaining Indian models of motherhood and resisting outsourcing childcare

The immigrant mother's sense of security and confidence in bringing up her second generation children is formed by her pre-immigration fantasies, the actual migration to a new country, and post-immigration experiences. The difference in pre-immigration fantasies and the actual adjustment to the new country are reflective of the process of mourning the loss of the mother country. Immigrants grapple with mixed emotions of sadness, guilt, and anxiety in coping with a different culture (Grinberg & Grinberg, 1989). Separation from maternal figures and homeland also impact on the adjustment to mothering in a new country (Tummala-Narra, 2004). This separation creates sentiments of nurturing, idealised images of their mothers which facilitate the formation of their own maternal identity creating a need to reconnect with their natal culture (Chodorow, 2000; Espin, 1999) and reinvigorate communal identity (Raman, 1995).

In general, women felt that staying at home to care for their children would perpetuate the notion of the 'good Indian mother' – nurturing, devoted and selfless – the way they remember their own mothers. They saw prioritising the raising of children as a defining feature of Indian motherhood (Donner, 2008; Raman, 1995), and a positive aspect of the South Asian culture of mothering that they wished to retain. In order to maintain this central aspect of motherhood, women felt they needed to give up their jobs for the time being and dedicate themselves to their children. Observations of these women caring for their children verified the doting and indulgent manner in which they parented, despite their own needs. Their full commitment to their families as wives and mothers, gave them a sense of communal and personal identity that was contrary to that of the Western, individualised self (Tewary, 2005). Also, families raising children at home in a nurturing and indulgent environment defines South Asian childrearing practice (Katyal & Chanda, 1998). Thus, women did not want to put their children in childcare services as this was contrary to their notion of motherhood and childrearing in South Asian culture. This rejection of outsourcing childcare was a novel finding of this study; to my knowledge this has not been referred to in any relevant literature on this topic.

Embracing a new motherhood and parenting cross-culturally

Women are expected to be keepers of culture for their children in the new country, as well as mediators between the two cultures. Thus, women themselves needed to reconcile the differences between their various cultural influences in order to raise children to adapt to both cultures (Tummala-Narra, 2004). Women looked to their ethnic communities to renew their commitment to their cultural heritage and to maintain a sense of emotional wellbeing (Mehra, 1992) and cohesiveness as visible

ethnic minorities (Moghissi, 1999) and retain a stable and positive cultural identity (Uba, 1994). They also relied on various sources of support, such as health professionals, husbands and friends outside of their ethnic communities (Tummala-Narra, 2004), reinventing and reconstructing models of early motherhood in order to come to terms with a cross-cultural approach to parenting.

Women have to negotiate differences in communal and personal expectations as they are expected to manage the household, engage in paid employment and socialise their children into Indian culture despite their changing family structure and gender roles (Dasgupta, 1998). The natural trajectory of acculturation upon migration means a questioning of traditional values and norms. Women felt that in order to feel at home and have a sense of belonging here, they needed to adopt certain ideals of this society. This put into place a process of reconstruction of culture and identity. All women still thought of themselves as Indian, but those who had been here for many years, now also thought of themselves as Australians. These women wanted to reconstruct their maternal identities while mothering cross-culturally by reconnecting with their culture as well as reformulating their role in the family and society, a form of material acculturation (Tummala-Nara, 2004). In order to do this, they needed to embrace altered personal identities. An egalitarian approach to gender roles, upon migration, was a welcome change for women who had looked forward to independence and liberation from their traditionally prescribed female roles. They wanted to align themselves with Australian culture and Western women, embodying identities independent of motherhood (Manne, 2005), thereby, reconstructing their personal gendered identities.

Women who were embracing Australian gender roles and models of motherhood, which included returning to work after having their babies, were the ones who had desired an identity other than 'mother'. They mentioned that working gave them independence and autonomy and a role apart from mothering that enriched their personal identities (Abou, 1997). This fit into Western ideology of motherhood where women should retain personal goals and identities after becoming mothers (Manne, 2005). They realised that in Australia, women need to be seen as contributing to the household's economy in order to be valued, thus, have to occupy roles other than 'mother' (Manne, 2005). My observations of women's conduct within the home corroborated this sense of empowerment that women said they received from working outside the home. They also felt they needed to set an example for their daughters, especially, by occupying multiple personal roles during the course of their lives. The public and private domains provided platforms for women to settle and come to terms with the differences between their various personal and communal identifications and helped in creating positive reconstructed gendered and cultural identities. This level of acculturation facilitated the reconciliation of working outside the home and having children in childcare, in accordance with Western models of parenting. The ideology of childrearing was shifting from infant indulgence and exposure to many adult role models to one of autonomy and separation from family (D'Cruz & Bharat, 2001) for some women in this study.

Women who had acculturated and embraced an Australian identity tended to rely on various social networks outside of their ethnic communities which assisted them in developing skills as cross-cultural mothers (Akhtar, 1999). They made friends within the wider society mostly through employment, mothers' groups and playgroups. This

helped them overcome feelings of isolation, especially when having children in this country, as it meant they did not feel alone during a time when support was paramount. Sharing anecdotes on parenting with their Australian friends assisted in familiarising women with the culture of mothering here (Tummala-Narra, 2004) and made them feel better equipped to mother cross-culturally. Embracing new gender roles and new social networks created new maternities (De Souza, 2006) and a cross-cultural approach to parenting.

Cross-cultural marriage for second generation immigrant children

Even though the topic of cross-cultural marriage was beyond the scope of my study, conversations on arranged marriage emerged during discussions on continuing values and traditions through the second generation. This shed light on women's level of acculturation. Newly arrived immigrants were concerned about retaining traditional values relating to sexual conduct and marriage for their children. They were eager for them not to adopt the liberal sexual mores of Western society and to participate in arranged marriages. Women living here for a longer period of time approached the topic of dating and cross-cultural marriage open-mindedly. These women had participated in arranged marriages in their natal homes, but were altering their own gender roles and empowering themselves and wanted the same for their children. This required a level of acculturation and a sense of belonging in this country. Established women who had embraced an Australian identity were prepared for their children to be Australian, not only by citizenship, but by culture as well.

Limitations

A possible limitation of this study is the relative homogeneity of the study sample as all women were middle class and educated who came to Australia through skilled migration or as a result of marrying someone who came here through skilled migration; although the study sample includes women who were born in India, Fiji, Britain and South Africa, and women who were newly arrived, established and here since childhood. All segments of the Indian community could not be included, therefore, findings may not be generalisable to other socio-economic sub-groups of migrants from South Asia. However, it is the depth of information gathered, and not the breadth or statistical representation that is important in an ethnographic study; hence, this has not compromised the credibility of findings from this research.

Future research

It would be beneficial to study a larger sample of Indian immigrants to gather statistically relevant data for development of optimal public health messages. Quantitative research involving similar themes of inquiry would generate data that could be valuable in the development of migrant settlement and health policy. Also, involving a more representative sample, including Indian women who have migrated from other countries in the world and who are from varied socio-economic groups, as well as taking into account religion, would add relevance to any generalisations that can be drawn regarding Indian immigrants in Australia, as well as to variations in experiences that can be noted amongst individuals or sub-groups within this ethnic/cultural group.

Implications for health service provision

Health professionals' approach when caring for immigrant women can have a significant influence on the quality of the experiences as well as health outcomes for immigrant women and their children. Immigrant women who are recently arrived and less acculturated can feel great stress when confronted with cultural beliefs and models of healthcare that are foreign to them (Balcazar et al., 2007). Improving women's understanding of cultural models can increase compliance. Also, continuity of healthcare provider, where women are able to see the same midwife at each visit, can assist in this (Thomas et al., 2010).

Health professionals need to be sensitive to cultural meanings in health service delivery to immigrant women, especially when care depends on women being discretionary toward what they think is important (Choudry, 1997). For example, some women were apprehensive about disclosing cultural practices, such as food proscriptions, as well as participating in some aspects of Western maternity healthcare, such as consuming food offered at hospital. Some researchers have recommended that women's choices should be respected, and hospitals could include dietary preferences as long as women's choices do not interrupt health-related food restrictions (Lauderdale, 1999). Cooling foods, tea, coffee or broth are suggested to be served at hospital instead of cold drinks during the postpartum (Kim-Godwin, 2003).

Bed-sharing is another custom that is open to censure by healthcare providers. The negative messages towards this practice in Australian society, creates insecurity and confusion, especially among newly arrived women, about a custom that has traditionally been done safely. This criticism of a practice that is an important aspect

of motherhood to women curbs the ease with which they can communicate with health professionals and limits the opportunity for dialogue on issues of cross-cultural parenting which women could be educated on.

Extended breastfeeding as a traditional practice can also be impacted due to misunderstanding and miscommunication by healthcare providers. Various positions for breastfeeding and messages of timing intervals between feeds alongside those of 'demand feeding' are confusing and strip women's confidence in their ability to know how to care for their baby. Not clearly understanding the physiology of breastfeeding and believing that they have insufficient milk supply creates a feeling of failure among women who are traditionally well supported during this time. Cultural awareness and acceptance would assist health professionals support this traditional practice in a manner that is empowering for women. Breastfeeding support groups would be a helpful tool for women upon discharge from hospital. Mothers' groups are offered to first time mothers in Australia, although they are not specifically organized to promote breastfeeding. The format of an informal mothers' group, regardless of parity, where women have the support of their peers and have access to lactation consultants could be beneficial and less confronting than in the clinical setting of hospital when women feel vulnerable.

South Asians are able to have a pluralistic approach to health and wellbeing, showing that their acculturation to Western approaches to healthcare does not negate their participation in traditional aspects of care and vice versa. Culturally competent maternity care should include familiarity on the part of healthcare professionals of how these two systems work together (Woollett et al., 1995). Cultural sensitivity should thus include collating information about a person's values, health beliefs and

practices to inform health professionals' approach to health service delivery (Mays et al., 2003). Establishing basic dimensions of social variation and determinants of health including culture and ethnicity, as variables for possible disadvantage (Blane, 1995; Smith, 2000; Karlsen et al., 2011) in maternal and child health should not, however, diminish immigrant women's empowerment and autonomy within a pluralistic approach to health and wellbeing. After all, women who are not Caucasian and not Australian-born have been shown to have less adverse obstetric and neonatal outcomes (Thomas et al., 2010), although fear of discrimination and misunderstanding from healthcare providers creates a reluctance to use health services (Henderson and Kendall, 20011).

To avoid misinterpretation and stereotyping, women's exposure to Western culture should be taken into account in assessing their level of acculturation. The degree of acculturation of women from India against other diasporic Indian communities can be very different. Patterns of adjustment as well as diversity and variability in Indian women's attitudes and practices should also be taken into consideration (Phoenix, 1990). Bilingual community-based navigators could be considered to attend to women's concerns and their unfamiliarity with the health system and its services (Henderson and Kendall, 2011). If health professionals are able to assess a mother's degree of acculturation, linguistic ability, and education level when providing service to immigrant mothers (Balcazar et al, 1997) the dialogue between healthcare provider and woman would be more effective and meaningful, creating better outcomes for mother and child.

Conclusions

As a mother, immigrant and ethnic Indian myself, I was able to identify with my participants as closely as possible despite the wide differences in our experiences. I used my unique positioning and situational ethnicity to build rapport and to understand the myriad cultural complexities to glean rich and meaningful narratives of the lived experiences of the women in this research (Lee et al., 2001). I could connect with the newly arrived immigrants and share in some of their experiences, despite not being born in India and raised in South Africa and New Zealand. I have myself encountered some of the dilemmas women narrated, relating to acculturating, reconstructing identity and mothering as an immigrant in Australia. Maintaining multiple communal identities as an immigrant, my Indian ethnic identity alongside other cultural and national identities, as well as multiple personal identities, that of a PhD candidate and mother, amongst others, provided insight into the intricacies of self-identification for myself and my participants. Making the transition into motherhood as an immigrant, trying to balance my cultural beliefs and practices with an Australian approach to mothering, especially relating to childbirth, breastfeeding and bed-sharing, gave me an appreciation of the difficulties encountered by other immigrant women. These commonalities created an environment of empathy and sensitivity that added to the authenticity of exchange between us strengthening the data collection process and the data collected.

Newly arrived immigrants held onto their South Asian culture whilst resisting Australian values and norms – a manifestation of traditionalism (Dasgupta, 1998). The disparity between their traditional, collectivist worldview and that of the primarily individualistic Australian approach to life left them feeling culturally

displaced and alien in this new environment. Since they had no sense of belonging in Australia, they identified ethnically and culturally as Indian. Women who had lived here for a longer period of time had adopted aspects of Australian culture, which they maintained alongside their Indian culture – a form of judicious biculturalism (Dasgupta, 1998). They had reached a level of acculturation in Australia, and saw this country as their new home. With this sense of belonging here they embraced an Australian identity together with their other cultural/communal identities. This created, in some cases, multiple identities (Smith, 1998), which were fluid and contextual.

All women retained some aspects of traditional mother and infant care. Newly arrived women strictly adhered to their traditions and customs in accordance with their stage on the acculturation trajectory. Bed-sharing and breastfeeding were aspects of care that were most impacted by health service provision. Established women displayed varying degrees of adherence to Indian mothering traditions in keeping with their level of acculturation. All women also approached childrearing with the core traditional values that construct parenting in South Asian culture, despite the liberal influences of Australian culture. Women who were newly arrived and firmly identified as Indian, resisted adopting Australian culture, including gender identifications, and saw their role as 'mother' as self-defining. For established women who had adopted an Australian identity, embracing aspects of Australian culture facilitated the incorporation of other personal identities through altered gendered roles. Many women, including some who were established here, prioritised their role as mother, as a marker of their Indian identity, putting paid employment on hold until their children were of school age. Embodying the traditional idea of 'a good Indian mother' gave them a sense of enacting a 'higher culture' (Moghissi,

1999). This pride in their cultural heritage brought about a stable, positive ethnic/cultural identity (Uba, 1994), psychological wellbeing (Hyers, 2001) and cohesion as a visible ethnic minority group (Moghissi, 1999). This included a rejection of outsourcing childcare, with women caring for children at home.

Cultural and gendered identity can be said to underpin the experience of mothering for Indian immigrant women in Melbourne, Australia. While reconstructing their culture and redefining their identities, through the practical aspects of their daily lives, women have developed positive communal and personal identities in their adopted home (Ralston, 2006). Acculturation is a key factor in assessing a mother's ability to navigate a cross-cultural approach to parenting. Due to the clear retention of many traditional aspects of parenting amongst the women in this study, healthcare providers should show cultural competence in delivering services to this group of first generation immigrants. This would facilitate positive experiences and good health outcomes for mothers and their children. Indian immigrant women's experiences of childcare and rearing in Melbourne generally varied according to the theoretical proposition that, in order to embrace aspects of cross-culturalism within parenting, including, outsourcing childcare, women required a degree of acculturation and adoption of Australian gender and cultural identities.

APPENDIX 1

Information Sheet

My name is Natasha Maharaj. I am a PhD student in the Department of Public Health at The University of Melbourne. I am conducting research on: The Experiences of Mothering Amongst Ethnic Indian Immigrant Women in Melbourne.

The purpose of this research is to explore the experiences of motherhood among Indian immigrant women in Melbourne, and to determine how culture, society and identity influence mothering practice. Any benefits that may arise from this study are indirect and may apply to future Indian migrant women by creating awareness among health professionals of potential cultural issues facing immigrant women, through dissemination of findings in published material.

I am hoping to work with a group of 12 to 15 Indian breastfeeding mothers who were born in India or Indian diasporic communities worldwide. I would like to stay in contact with you for approximately a 12 month period from before you give birth until you start weaning your baby so that I can ask you about your intentions, decisions and experiences during pregnancy, breastfeeding and taking care of your baby. Also, I would like to tape-record the interviews that I have with you.

Your participation is voluntary and you may decline to answer any question with which you feel uncomfortable, and you may withdraw your consent at any stage along with any unprocessed data/information supplied without giving a reason or having any negative effects. You are not obligated to participate, and if you do not wish to, this decision will not affect your ongoing treatment with your doctor.

All information you share with me is confidential and confidentiality of information provided is subject to legal limitations. I will store information under lock and key at the university and it will only be accessed by myself and my supervisors. Your name will not be attached to any data that will be collected, stored and reproduced. The data will be kept for five years after the completion of the study, after which time it will be destroyed. I will discuss a summary of the findings individually with you at the conclusion of the study.

This study has been cleared by the Human Research Ethics Committee of The University of Melbourne in accordance with the university's ethical guidelines and the National Statement on Ethical Conduct in Research Involving Humans. You are of course free to discuss your participation in this study with me (ph: [researcher's home telephone number] or [researcher's mobile telephone number]). If you have any concerns about the conduct of this research project you can contact the Executive Officer, Human Research Ethics, The University of Melbourne, ph: 8344 2073; fax: 9347 6739.

You are invited to participate in my research and I look forward to any help you can offer me. If you wish to participate please contact me on [researcher's home telephone number] or [researcher's mobile telephone number] for an interview at your convenience. Thank you very much for your time. Your involvement in this research will be greatly appreciated.

APPENDIX 2

Participant Consent Form

The Experiences of Motherhood Amongst Ethnic Indian Immigrant Women in Melbourne

Principal researcher: Ms Natasha Maharaj (PhD candidate), Department of Public Health, The University of Melbourne.

I have been given and have understood an explanation of this research project. I have had an opportunity to ask questions and have them answered. I understand that I may withdraw my participation at any time during the course of the study along with any unprocessed data previously supplied, without giving a reason and without any negative repercussions. The information shared during the course of this project will be completely confidential and this confidentiality will be subject to legal limitations. I also consent for interviews being tape-recorded and all such information will also be confidential and de-identified.

Signed:

Name:

Date:

APPENDIX 3

Interview Guide for Initial Interview with Participant

Participant's pseudonym:

Date:

Place:

(1) Where did you migrate from?

(2) Tell me about how you came to Australia

Probes: reasons for leaving; when; age; country of birth

Prompts: educational reasons; economic reasons; political reasons

(3) How do you find living in Melbourne?

Probes: likes/dislikes

(4) Tell me about your household

Probes: members of household; ages; country of origin

(5) Tell me about your husband?

Probes: occupation; involvement in home

(6) How has your pregnancy gone?

Probes: why/why not

Prompts: difficulties/illness; family/health service issues

(7) When do you expect to give birth?

Probes: anticipation; where; attendants (family/professionals); support

(8) What are your intentions about breastfeeding?

Probes: why/why not; duration

(9) I am interested to know why people choose to breastfeed. What influenced your decision?

Probes: information from advisors; information read

Prompts: health information; family members/social contacts; health professionals

APPENDIX 4

Themes Used in Data Analysis

Themes	Sub-themes
CHAPTER 4: CULTURE AND INDENTITY FOR INDIAN IMMIGRANT WOMEN IN MELBOURNE	
Independence and reliance	Communal living Displacement Isolation Coping alone Autonomy Resilience
Tradition breakers and homemakers – gendered identity	Nuclear families Changing relationships with husband and children Shifting roles for women Women's access to employment Men's involvement in the home Empowerment in the public sphere Private patriarchy
Feeling at home and wanting to go back home	Access to employment Social acceptance Sense of community / belonging Communal cohesion / intra-ethnic membership Visible ethnic minorities

Themes	Sub-themes
Australians and aliens – cultural identity	Identity crises Resistance to Australian culture and identity Stable and positive identities Psychological wellbeing Acculturation and reconstruction of ethnic identity Integrating cultures under favourable sociological conditions Social acceptance by mainstream society and maintenance of ties with ethnic communities Multi-layered, context-specific identities
CHAPTER 5: IDENTITY AND THE CULTURAL CONTEXT OF MOTHER AND INFANT CARE FOR INDIAN IMMIGRANTS IN MELBOURNE	
'It takes a village to raise a child'	Support from family Knowledge transmission by elder familial females Motherhood has value Traditions emphasised
Post-natal care	Rest period *Ayurvedic* medicine and food Traditional massage Bed-sharing Infant feeding

Themes	Sub-themes
Cross-cultural: a two-way street	Cultural familiarity and group belonging Cultural expectations neglected or undermined, e.g. bed-sharing and breastfeeding practices Cultural competence by health professionals Cross-cultural approach relies on inter-dependent system of support (i.e. husbands, friends and health professionals)
CHAPTER 6: IDENTITY AND THE CULURAL CONTEXT OF CHILDREARING FOR INDIAN IMMIGRANTS IN MELBOURNE	
A question of identity: retaining Indian values for the second generation	Pride in culture Traditional values seen as 'good' Marker of ethnic identity
Being 'a good Indian mother'	Idealised images of their mothers Prioritising motherhood Being a selfless parent Postponing employment Resisting outsourcing childcare Family caring for children Pronounced gender division Psychological safety Intra-ethnic group belonging

Themes	Sub-themes
Embracing identities other than ‘mother’	Economic pressures, changing values Altering gender roles, personal identities Multiple identities (communal and personal) Embracing personal goals Working women Children in childcare Empowerment and autonomy within the home
Bridging the gap: cross-cultural parenting	Negotiating identity in two cultures Cultural refueling from ethnic communities Acculturation through friendships and maternity health services Wider society as introduction to Australian ways of parenting Positive interactions with Australians resulting in cross-cultural approaches Balancing parenting models with personal and communal identities Cross-cultural approach assisting children to adjust to both cultures

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