

Transforming possibilities of care: Goan migrant motherhood in New Zealand

ABSTRACT

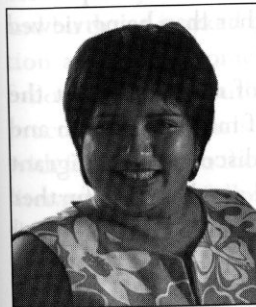
KEY WORDS

maternity;
migration;
Goan women;
discourses;
qualitative
research;
postcolonial
feminist

Little is known about the maternity experiences of migrant mothers in Aotearoa/New Zealand – and in particular the ways in which women adapt and survive when separated from traditional postnatal practices and family support. This paper reports on a study of the maternity care experiences of women from Goa (India) in Auckland, New Zealand. Multiple research strategies were incorporated into the process to prevent reproduction of deficiency discourses. Interviews were carried out with Goan women who had experiences of migration and motherhood. The findings revealed that as a consequence of motherhood and migration, migrant mothers were able to reclaim and re-invent innovative solutions. Nurses and other health professionals can have a significant role in supporting women and their families undergoing the transition to parenthood in a new country and develop their knowledge and understanding of this dual transition.

Received 21 February 2005

Accepted 19 July 2005



RUTH DESOUZA

Senior Research Fellow
Centre for Asian and
Migrant Health Research
Auckland University of
Technology
Auckland, New Zealand

INTRODUCTION AND BACKGROUND

*Simply by sailing in a new direction
You could enlarge the world.*

(Curnow, 1997, p. 226)

Nurses need to develop a knowledge base that helps them meet the health care needs of diverse groups. However, there is a need to

ensure that knowledge developed from research does not merely replicate dominant or hegemonic views of non-dominant groups. For researchers from minority ethnic communities a postcolonial feminist perspective offers a useful theoretical vantage point for further developing knowledge. In particular, using such a perspective seems apt in the context of New Zealand as a former colony and Goan women as former colonial subjects. A key tenet of post colonialism is the desire to 'critique and replace the institutions and practices of colonialism' thereby creating new spaces for the institutions and practices of colonised peoples and ultimately restoring their integrity (Spoonley, 1997: 137). This paper demonstrates how this might be achieved by using the dual transition of migration and motherhood for women from

Goa, India as an exemplar. Goan women were interviewed about their migration history, their adjustment to living in New Zealand and experiences of childbirth and motherhood in a new country using a qualitative approach. Several research strategies were incorporated into the research process to uncover and subvert hegemonic discourses impacting on the health and social experiences of migrant mothers from Goa that have been discussed elsewhere in more depth (DeSouza, 2004). The aim of this paper is twofold: First, to demonstrate the significance of rituals and postnatal practices in Goan women's maternity experiences and, second, to discuss how these are mediated by migration and the separation from sources of knowledge.

LITERATURE REVIEW

Two main issues inspired this research; the dearth of local research to inform practice and; the focus on pathology which renders adaptation efforts invisible and un-legitimated. Research about migrant motherhood in New Zealand has been either limited to women from the Pacific Islands (Butler et al., 2003; Lealaialoto & Bridgman, 1997) or excluded non-dominant populations. In mainstream studies, cultural data has been ignored, under-represented or discarded. Webster, Thompson, Mitchell and Werry (1994) discarded the Edinburgh Postnatal Depression Scale (EPDS) scores of five women of Asian and Pacific Island ethnicity because their scores could not be validated in a clinical interview due to language difficulties. Kearns, Neuwelt, Hitchman and Lennan (1997) explored the social context of well-being for women before and after childbirth but only obtained a sample of four per cent self-identified Maori and Pacific Islanders at a time when these groups made up 18 per cent of the population in the Auckland area.

Internationally, research with migrant mothers has tended to focus on pathology, deficit or risk rather than strengths (Aroian, 2001). This emphasis disregards the resourcefulness and ability of migrant women to care for themselves

perinatally (Sawyer, 1999). Such knowledge of adaptation and resourcefulness that enables survival and wellness remains invisible, unrecognised, unarticulated, even un-legitimated. According to Dossa (1999: 155):

The fact that immigrant women's engagement with the larger society includes creative endeavours that promote well-being has received less emphasis. More importantly these endeavours remain on the margins and in between spaces of the host society in the form of dislocated epistemologies as they form part of the repertoire of knowledge that has not been validated.

One explanation for the focus on problems and lack of acknowledgment of the assets of migrants is proposed by Bottomley (1991) who suggests that Euro-centricity, mono-culturalism and the inability to cope with complexity are prevalent within mainstream organisations. Rather than being seen as achievers and innovators, migrants are seen as problems or weak passive victims who are unskilled and unable to defend themselves against being exploited (Bottomley, 1991; Ip & Lever-Tracy, 1999). Challenges facing migrants in the relocation process become individualised rather than being viewed in their social context.

Consequently, a lack of research about the mothering experiences of migrant women and the need for alternative discourses of migrant mothering was identified as a basis for further investigation. Migrant women from Goa, India¹ were chosen for this research because of the researcher's insider status within that culture.

STUDY CONTEXT

The study took place in Auckland, New Zealand among women of the Catholic Goan community. Ethics approval was obtained from the Massey University Human Ethics Committee. A purposive sampling technique was used and selection criteria limited participation to women who self-identified as Goan and who

had migrated to New Zealand and had a live baby since migrating. Seven Catholic Goan participants agreed to take part in the research, differing in terms of age, length of settlement in New Zealand, modern or traditional identity, education, number of previous migrations, caste, and so forth. None of the participants were born in Goa or came directly from Goa due to the history of Goans as a migratory population.

Data collection involved the use of in-depth semi-structured interviews conducted in English. Data analysis occurred alongside data collection. The interview transcripts were coded line-by-line and analysed within and between interviews to keep me grounded in the data. The codes were clustered according to similarity and reduced. Similar phenomena were grouped into categories and named. In this article, I will discuss the main finding: the loss of rituals. Two other findings were loss of support and the role of health professionals which are not discussed here.

RITUALS IN THE PERINATAL PERIOD

Traditionally in Indian communities, pregnancy and birth are marked by nurturing and celebration and Goan women are no exception. The following section outlines the place of perinatal practices and rituals in Goan/Indian society with findings from the study integrated with the literature. This is followed by a discussion of the three main issues and opportunities that were identified by Goan women in the study, followed by strategies that Goan women used to reclaim and reinvent rituals.

Place of rituals

Most cultures have protective and celebrative practices or rituals that reflect both the new mother's social status and her presumed vulnerability. They are thought to reduce the stress of childbirth and assist in the maintenance of perinatal mental health. The lack of rituals is

thought to make women susceptible to depression in the West (Stern & Kruckman, 1983), and many cultures attempt the continuation of rituals after migration in order to prevent depression occurring. Women from Goa have had rituals modified to some extent through urbanisation, and internal migration prior to migrating to New Zealand. Traditionally in Indian communities, pregnancy and birth are marked by nurturing and celebration of women who are to become mothers. This nurturing is expressed through the giving of special foods and assistance. Rituals can include the restriction of new mothers movements to the home for forty days due to their perceived vulnerability postpartum (Choudry, 1997). During this period, assistance is given with personal care and the physical body is taken care of through massage and ensuring the mother has an opportunity to relax. Grandmothers often play an active part in the preparation of special food and ensuring a nourishing diet that includes foods such as ghee, nuts, milk and *jaggery*² that are given to return the body to balance.

This attentiveness and 'endless care' that is received from the extended family (Shin & Shin, 1999: 611) can be lost in the process of migrating. This celebration of the status of the new mother in 'developing countries' subverts the notion of 'West is best' and that the East is backward, that was taken for granted in my post-colonial upbringing and has been noted by other writers (Khoo, 1996). In a return to tradition, Sarney (1999) suggested that rituals be reinstated to celebrate the status of motherhood. Greta one of the participants found the shift from a social process of pregnancy to an individualised one a painful loss:

Everyone else does things for you and you know in that way you are just pampered. You get all these supposedly nourishing treats and foods and things you know. Like all these pulses and the sweets that you normally have. I'm not very sweet tooth, but I think they do

help in a way you know. The nourishing factors: You know things like that... being here makes you think of all these things that you take for granted back home. (Greta)

Focused individual care is given to new mothers, and family members take on roles in relation to food preparation and hospitality:

You know you get your massages and things. Mum looks after the cooking because that takes away a lot of time and then you don't have to worry about that. Goan things like *moong*, *godshem* and other lentils millet, *tizan*,³ and things like that, you know what that is. I guess you would have had that if you were coming from the traditional villages I'm sure, but we have lost a lot of culture on the way. I guess you also have many more people around you in India so that if you are busy with doing something someone else can entertain make the tea or conversation. (Lorna)

Migrating reminded Lorna of the loss of traditions that began with the move from traditional villages in Goa to urban settings in other parts of India prior to the migration to New Zealand. The drive for upward mobility amongst Goans and the concomitant loss of traditional 'old fashioned' rituals has resulted in loss of forms of nurturance. Also embedded in Lorna's text is the realisation of the loss of culture related to the impact of two colonial masters (the British and Portuguese) on Goans, both in Goa and later in the British colonies that Goans migrated to. Aspects of those colonial cultures already had an impact on participants prior to migration.

Identity and rituals

The word identity originates from the Latin *idem* meaning the same (Bottomley, 1994). Hall (1992) delineates three conceptions of identity, the enlightenment subject, the sociological subject and the post-modern subject. The Enlightenment subject was based on an individualised conception of identity where humans were fully

formed with an inner core that would be built on in the course of a person's life; the sociological subject reflected an interactive conception of identity assuming that the world was more complex and that the supposed inner core of a person was dependent both on others and the culture inhabited by the subject and thirdly, the post-modern subject which has a core but that is developed and modified in 'the interaction between self and society' and bridges the private and public nature of identity (Hall, 1992: 276). Challenges to the notion of identity are occurring, so that increasingly it is viewed as not unified and stable but fragmented and contradictory. The question of identity is complicated for migrants and Parmar (1997: 68) argues 'in these post-modern times the question of identity has taken on colossal weight particularly for those of us who are post-colonial migrants inhabiting histories of diaspora'. Those coming from traditional societies like Goans and wanting to preserve or maintain traditional cultural patterns, need to have 'strong communities and institutions, dense ethnic networks and continued trans-national ties to the sending society' (Foner, 1997: 963).

Giddens (cited in Hall, 1992) argues that the difference between traditional and modern societies is that in the latter, change is rapid and ongoing, resulting in changes in social practises in the light of new information. On the other hand, traditional societies characteristically honour the past and the symbols that go along with cultural maintenance. Thus events are imbued with the continuity of the past, present and future and structured by social practises which are recurrent. This is highlighted in the case of maternity and childbearing. The experience of birth in a new country throws the issues of identity into relief and highlights the significance of tradition. Four patterns of acculturation: integration, assimilation, separation and marginalisation have been identified which each demonstrate a degree of support for either maintenance of ones traditional culture or a

desire to integrate into the host culture (Berry et al., 1987; Berry, Trimble, & Olmeda, 1986). People who are concerned with both maintaining their own cultural identity and extending relations in the host community are considered to have an integrated or bicultural acculturation attitude. On the other hand a person who has little concern in either area is seen to be marginalised. In an assimilated acculturation attitude an individual shows a greater concern for integrating into the host culture than maintaining their home culture (Berry & Kim, 1988; Berry et al., 1987; Berry et al., 1989). The final category, separation or traditional, involves individuals who have a greater focus on maintaining their traditional culture over connecting with the host culture. Goan women in the study had to navigate between these four positions and this is discussed in the following section.

ISSUES AND OPPORTUNITIES: THE BEST OF BOTH WORLDS?

Motherhood in a new country challenged the participants' cultural identity and the birth of a child brought up issues of cultural preservation and maintenance. The participants learned that they had to take an active role in preserving and maintaining their culture, particularly when receiving care from what was essentially a mono-cultural health service. Three main issues and opportunities were identified: separation from sources of knowledge; conflict between traditional and new; and lack of access to cultural resources all of which had an impact on identity and required the participants to navigate between integration, assimilation, separation and marginalisation.

Separation from sources of knowledge

Separation from family and friends or sources of knowledge as a result of migration can lead to social upheaval or significant change (Fitzgerald et al., 1998). This separation results in what Liem (1999: 157) terms a 'vacuum of knowl-

edge' about childrearing, that needs to be 'filled' for women who have migrated without their mothers or extended family. For the participants, migration meant that usual sources of preparation for the transition to parenthood were lost and new ones would have to be found:

My idea of pregnancy or knowing anything about children was someone else's and you just cuddled them and give them back kind of thing so I was totally unprepared. (Rowena)

More choices

However, breaks in knowledge resulting from migration are not necessarily negative and migrant mothers can often be eager to acquire knowledge of the experiences of mothers from the host country, leading to more choices. Migration can mean that migrant mothers no longer feel obliged to take the advice of their community. The influence of midwifery discourses such as the reframing of birth as a positive event and the right to question were empowering for participants. For Lorna and Rowena this meant being able to discard old ways of doing things, particularly advice from well-meaning family friends and 'old wives tales' that seemed to have no logical basis:

They come and see how your baby's progressing and all the advice that you get, God help us all! Yes, all this advice how you should sit and how you should stand, yeah all those things. I'm relieved I didn't have things you know mentioned with no substantial backing. I need a reason for things. You don't tell me how to stand on my head and say that it's good for me in my pregnant state with no real reason for it. (Lorna)

Displacing traditional knowledge

The knowledge of the West displaced and became more valued than that of women elders who traditionally would have been the 'experts'. The new experts were strangers with

no connection and were disembodied objective knowers. The authoritative status of dominant ideologies (for example evidence based practice) had a powerful influence and were privileged over 'traditional' beliefs deemed irrelevant or pathological. This superiority is partly derived from internalised beliefs in the superiority of the West and Western products (Lal, 1999) and partly due to the dominance of science which claims priority over other forms of knowledge (Nicholson, 1993). Marshall and Woollett (2000: 360) note that 'a discourse of rational science serves to legitimate medical/obstetric accounts of pregnancy, to isolate women as mothers-to-be from networks of relationships and render illegitimate other sources of knowledge'. These knowledge claims have not only informed the ideology of mainstream social and health science, but women themselves:

They would say, oh don't eat it but I really didn't pay much attention to it because sometimes I think they are just old wives tales and superstition. (Rowena)

Birth as positive and empowering

Another perceived benefit of being disconnected from rituals was exchanging familiarity and taboo around childbirth for something more positive in New Zealand. In Lorna's case child-bearing was reframed into a much more positive and empowering experience:

You would have been on home ground and had familiar faces and familiar happenings going on. From whatever you hear and grew up with, this child bearing experience is something different and there's a big taboo and things like that. What I experienced here was that child bearing is natural, that natural factor was a great thing. (Lorna)

The reverse of not seeing the peri-natal period as taboo can present women with the burden of carrying on normally with their pregnancy,

which in their new adopted home is no longer imbued with the same sense of the sacred.

Taking control

Along with the framing of childbirth as 'natural' is the notion of women taking control of their birth experience, a view promulgated in most antenatal classes. This discourse, which positions western women as educated, liberated, modern, agents of choice who have control over their own bodies and sexualities (Khoo, 1996) can lead to distress. Given that it creates expectations about the degree of control that women can exercise in childbirth that cannot always be met. It is to be expected that migrant women can decide to view their birth experiences similarly. Rowena decided to be pro-active about her labour and delivery as a way of addressing the gaps in her knowledge. She read and discussed options with her midwife, but wasn't able to enlist support for the kind of birth experience she wanted from her husband before or during the birth:

I read books; I had a lot of spare time by then. I would call up my Midwife, I'd wanted to have a water birth and Pascal said nothing about that. I heard it was a good idea you know, so anyway I went through all the child birth and things like that yeah. Pascal, was sent back with a good friend, then he said no you've got to go back, he couldn't, in fact he collapsed. I was the one who you know had to go through with it. (Rowena)

Rowena's strategy of managing the loss of peers and elders was to replace them with equivalent resources in New Zealand that hide the pain of loss. Her example shows how the disconnection from rituals and the search for replacement ones required spousal support, which was not always available.

Conflict between traditional and new

A second issue encountered by Goan women

who were attempting to perform rituals and postnatal practices was navigating between parallel beliefs (from both their home culture and their host culture). Attempting to holding on to both can be a problem if they want to fit in and are in turn expected to 'assimilate', especially by health providers. Participants resisted and contested the discourse of assimilation but found that they were often forced to choose between home culture and host culture.

Parallel beliefs

A study of South Asian women by Dobson and Homans (cited in Woollett et al., 1995) found that the women held parallel beliefs rather than having beliefs that clashed. They maintained some traditional practices but valued Western medical care. Attempting to carry over traditional rituals into the dominant culture created some challenges for Rowena:

Here they wouldn't believe in massaging baby as such you know. Just bath the baby and change, wrap the baby up. Even in India you'd have baby sleeping with you in your room, whereas here they just say you know, have the separate rooms for the baby. We were flatting by then; we were sharing a big house, so we didn't have the luxury of having the upstairs rooms and all that kind of things. Marita stayed in a cot in our room, it was a big room but yeah and I used to just do things. Like I still remembered massaging her with oil and I used to see women do that all the time in India. They said it was good for them. I just went ahead. (Rowena)

Rowena's example shows how care providers privileged their ways of knowing above Rowena's by universalising dominant group standards or 'appropriate' ways of parenting that included a separate room for the baby. Rowena resisted such 'appropriate' and commonsensical dominant discursive practices by doing what was culturally appropriate for her.

Conflict between rest and mobility

Other clashes identified were the tensions between current practice that encourages women to be independent and mobile as soon as possible and traditional practice that supports the woman to have a period in which to recuperate while being attended to by family. These are acutely articulated in Muriel's story:

It's such a different situation out over here. Mum says oh, it's so cold in this country, don't give a bath here. The midwife says give a bath every day, when hardly a week, the baby is born the midwife says why don't you take her for a walk, it's a sunny day, you know why don't you go out? In India you wouldn't go out for 40 days and things like that. So many conflicting kind of things, which was very difficult and it's really different. (Muriel)

Loss of traditional ways

Muriel's example uncovers how migrant women are challenged between choosing one set of beliefs over another. Furthermore, it is more likely that 'traditional' ways will be lost as the resources and structures that are available to support Muriel in her role as a new mother are geared towards the philosophies and practices of the majority culture. Migrant women can be caught between their new culture that holds their aspirations while working hard to fit into their traditional culture representing their past and the values that have shaped who they are. Muriel's experience resonates with Liem's (1999) findings in a study of Chinese first-time mothers who gave birth in Australia. Liem argues that migration exposes new mothers to other ways of thinking and they then have to decide not only what is best for them and their baby but also who not to offend or embarrass, new or old authority figures.

Exacerbating social exclusion

Bowes and Dar (2000: 311) note that those who are already experiencing 'social exclusion are likely to encounter poorer services in these cir-

cumstances as their diverse needs present particularly complex demands.' They conclude that minorities can then find themselves further excluded by the standardisation and bureaucratisation of services. For participants this exclusion came in the form of being unable to access cultural resources to advise on food or assist with rituals such as massage and having to rely on health services which were geared to the needs of the dominant group.

Lack of access to cultural mediators

The 'vacuum of knowledge' referred to earlier meant that women who attempted to fulfil cultural expectations struggled. Rowena attempted to seek guidance but ultimately was unable to cook any of the things that she thought might be useful because her husband worked long hours and there were no extended family members available to help her enact traditional rituals:

No, in fact I didn't know what to eat, but the hospital kept saying eat a normal diet. Do I have to have spicy food? They said since you've been eating it all your life and during pregnancy, you don't have to drink milk to get milk, just eat well. Because being alone I had to cook my own stuff, so I just continued eating my normal things. (Rowena)

It is possible that access to some kind of ethnic link worker or support worker could have been of assistance.

Needs not met

Flora attempted to maintain tradition by massaging her infant but this was made more difficult without the help she could have had from family or paid help. The naïve request for massage as part of the health care system's service provision was declined. This response exemplifies the hegemonic and narrow possibilities of care open to 'others', who as Wheeler (1994) has observed have little control over resources that are thought to be necessary for their health

by providers, who are in the main white. Importantly, the notion that diverse populations require an equally diverse range of services becomes compromised when resources are limited. A gauge of the power that dominant groups possess is in their capacity to define their values and interests as the norm (Fuller, 1997). Therefore, the universal service that is supposedly provided for everyone, in fact, best gratifies the dominant group.

You know there in India you have a baby, mothers must have a massage. So when I had that back problem and when I had to do the massage it felt so good. I asked the Midwife, she said 'no you have to pay for that' so I said 'just forget it then', you know, and then for baby they said do your own massage but you know having a baby you're all alone and there is no time. I did it and I remembered, but I didn't always do it regularly though they say a massage is good for bonding and all. (Flora)

Lack of practical help

The importance of massage was also emphasised in Muriel's story. She found that attempting to massage her baby was a logistical nightmare, which would have been effortless for the *Malish* ladies or massage women in India:

Back home in India you have the *Malish* ladies, the massage women who come home every day. Every day the massage lady comes with coconut oil bath to give a bath then they bathe the baby for you. Here you are taking the water to the bedroom, heating up the bedroom, mixing, making sure there are no draughts then going down on your knees put the baby into the bath taking the baby out wiping the baby over there. What does the mother do? Windows are all closed, room is completely closed off, baby things are kept all the Johnson products are kept out. The *Malish* woman comes whenever the baby is sleeping she doesn't have time to wait for the baby to

get up. She is doing three or four houses she takes the massage oil, puts the coconut oil on the baby from the head to the toe she is in the bathroom after that with the baby on her legs gives the baby a bath the baby's bawling and crying and everything straight after that the baby is put to the nipple or the bottle and the baby sleeps for about three or four hours. Here give the baby a bath she doesn't want to sleep after her bath. (Muriel)

The narrow possibilities of care available to participants within the context of a hegemonic health system and the lack of family support to carry out traditional practices, led to attempts to reclaim traditional cultural practices or rituals. Simultaneously participants were re-inventing themselves within new social networks and systems, the influence and impact of which were both positive and negative.

STRATEGIES: RECLAIMING AND RE-INVENTING

Goan women in this study used a number of strategies to ensure that they did not become disconnected from their traditional culture. These included: reclaiming rituals; bringing family in to help; assisting fathers to develop new roles and developing new peer networks.

Remembering rituals and sharing knowledge

Reclaiming traditional rituals provided a way of reconnecting with tradition. Sheila managed the isolation and distance from traditional practices and sources of knowledge to inform herself and other generations of Goan women. She recalled how her cousin was able to show her how to do infant massage, and how in turn, Sheila was able to share this with other new families. This knowledge transmission helped to maintain cultural ties and identities:

When I came home, Tanya showed me how in India you massage the baby with oil. Tanya

showed me the traditional thing of oiling the baby, because she said she did it for her babies. She had just observed in India because she had three children in India and in India you have a massager. So she had just observed and then she had done it on her child because she showed me how and I've actually shown Vanessa. I used to go and do it for Vanessa and you know Brian and Sofia? I showed Brian and Sofia how to do it I think it's just something that's traditional that needs to be carried on and if you keep it to yourself nobody knows. (Sheila)

Sheila's example highlights the importance of rituals and 'elders' in transmitting culture. Rowena re-appropriated her culture through remembering what used to be done. Books were inadequate and she needed to reclaim old ways of knowing because the new epistemologies did not meet all her needs:

I remember this massage bit and I would do a bit, like they said don't use soap on a newborn baby and we'd do it with pea flour. You brush them off with you, make a paste like a pea flour paste with a bit of turmeric on it. They say a baby's skin is too soft to use soap on them. I did a massage with coconut oil or baby oil and I would wash her with a pea flour and a turmeric paste. (Rowena)

Bringing family in to support rituals

Several participants brought mothers and mothers-in-law to New Zealand because it was unusual to have a baby 'by yourself', to help with tradition, food preparation, care of the baby and to allow the new mother to rest. Lorna, Greta and Flora chose to bring family members over where possible to provide both support and assistance with rituals. Lorna was fortunate in being able to bring her mother over to help out, and points out the alien notion of the individualising of a major life event like birth:

Then you come to a place with no-one around you, you don't really know if you can make it alone. You know you are not very independent in a way, so it is unfamiliar to have a baby on your own. Yeah, so that's why, so you just sort of have Mum over everybody has Mum over, it's a Goan thing to do, it's an Indian thing to do. (Lorna)

Despite Lorna's early reluctance to engage with 'old wives tales', her cultural beliefs meant that it was still important for her to have cultural support and practical help from her mother. Greta was supported by both her mother and mother-in-law who came to New Zealand to assist with care of the baby and other household tasks which included food preparation and advice. Greta's example illuminates the richness and significance of cultural rituals in the post-partum period:

Fenugreek seeds and jaggery and coconut milk and she kept giving me that and I found that quite nourishing. I don't know whether that would generate just the milk and also a sort of porridge made from semolina. So I would bake that and a drink that would help me clear up my stomach too much of gas so those things helped me a lot. (Greta)

The importance of food to many Goan rituals and special occasions is emphasised in Flora's recount of her child's christening which emphasised the symbolic significance of the Goan connection to the earth through the serving to guests of chickpeas and coconut: Flora's example highlights how she feels she needs to justify the significance or legitimacy of particular types of food to 'Kiwis' or have it legitimated by them. This perhaps represents a sign of her wanting to 'fit in'. This could also be a way of justifying to white New Zealanders the attachment to things Goan:

Even for a normal party you see all Goan tradition, you must make this food you know,

like for an auspicious occasion, like a Christening. Coconut in it, that is a must, you know a christening can't go without that. The Kiwis, you know wonder what are we serving boiled grams (chickpeas) for on an occasion like this. My aunt was going around to all the Kiwi guests saying you know I'm serving coconut. I didn't know what was the meaning behind it, but she was explaining you know chickpeas are the food of the soil, and coconut is also a food of the soil. (Flora)

Developing new social networks

Losing old networks and having to create new ones occurs in the transition to motherhood for many women regardless of whether migration has occurred. Non-migrant mothers often re-create new peer groups in the forms of antenatal groups and coffee groups. With migration, social support networks that were available in the country of origin can be lost (Anderson, 1987). In this research, the loss of support resulted in loneliness and isolation, the changed role of husbands and the need for participants to develop alternative sources of support in order to manage motherhood in a new country. Some of those new supports involved formal structures and informal new supports who were often other mothers.

A review in Victoria, Australia identified the lack of support as an area of concern for NESB mothers (Small, Rice, Yelland, & Lumley, 1999). In modern societies parenting tends to be seen as an individual responsibility rather than a societal one so support systems remain minimal (Woollett & Nicholson, 1998). The shift from a social to individual responsibility can be more acute for women who move from so called 'traditional' societies to 'modern' ones who have grown up with different expectations.

Isolation from the extended family can also mean that friendships become more significant sources of support (Sagrestano et al., 1999), and if these are not available losses can feel even more poignant as in Muriel's example:

Days can go by over here like I've made friends; they are mostly Neville's friends. They are not my friends. I have not made a friend, a friend who I can call a friend of my own. Nobody can replace Shanthi over here, nobody is going to replace my friend Priya back home ... There were many times that I told Neville, oh why did I ever stay here, I should have gone back. If I was back home I would have had this support and I would have had that. (Muriel)

The loss of old friends and extended family, coupled with the validation women might have got from their own culture where they were 'nurtured, valued and supported' (Barclay & Kent, 1998) can result in misery. Barclay and Kent contend that calling the experience of loneliness depression can cause more harm for women from cultures where discussion of mental health problems is stigmatised and taboo. Rowena reflected that:

There was never a time when I really felt very badly depressed, it wasn't you know. I would just get up and go and do stuff, it was just I would feel the isolation more than a depression. (Rowena)

Participants developed new sources of support such as other church members, mothers, The Plunket Society⁴ and Playcentre⁵ which led to exposure to other worldviews and ways of thinking and the development of bicultural mothering practices. Relationships with other mothers can help women to gain confidence in their new role. They also (hopefully) provide affirming feedback that the infant is unable to provide. One of the tasks of a new migrant mother is to take the initiative and access resources (Liem, 1999). Rowena developed a new network of support through her church, which was a lifeline:

I started going to a mothers' group there and I met a lot of other Malaysian and Indonesian and Filipino women and we would go and

have coffee together and that kind of thing and my social life. I got quite involved with the Parish and doing work for the Church because I mean I really didn't know many other people. I think every fortnight or something, we'd meet and have a chat at the Plunket. I did meet a lot of elderly parishioners they were wonderful they would come and give me flowers, chocolates and really spoil me because they knew I was on my own and they were wonderful. (Rowena)

Plunket was beneficial for many women in the transition process, which is significant in view of the funding challenges that face this organisation. Plunket took the place of the network of family or friends that might have advised Rowena, thus replacing old sources of knowledge:

Plunket was great, they'd really give me good advice when I was stuck, come and check up Marita and so they were very supportive but basically I would just go on common sense. (Rowena)

Playcentre played a valuable role in Sheila's life:

I met a very interesting group of women and that was something that I could look forward to every week going to this evening class. Then once a week I had the church and I found the women at Playcentre were so lovely and generous with their time. Getting to know them and getting to know that they had issues like myself. (Sheila)

Evelyn felt that there was no need to feel afraid or alone because New Zealand had so many support structures available and that help was always at hand:

I feel that NZ is a very well organised society, constant care is available, there are lots of avenues for help. There is no need to feel afraid or alone. Even though my mother and sister weren't here, I had regular visits, antenatal classes, play centre, coffee groups.

There was comfort in other women. Plunket nurses coming to home. (Evelyn)

This exposure to a range of providers and women also gave participants new ideas about how they could parent. Balancing old and new models of parenting was also a challenge for participants. Sheila realised that she could not transfer parenting skills that worked in one context to another that was less hierarchical and more liberal and she had to negotiate between two ways of doing things:

If I had my children again I would do a lot of things differently as far as their upbringing goes. We were trying to live like we lived in India, the parents have the ultimate authority, you do as they say and that's it but what I think I would do differently is to listen to what they say. (Sheila)

New roles for fathers

Such changes in peer relationships led to changes in relationships with husbands. Fathers became more active participants in the birth and child rearing process unlike in India where it may have been peripheral. Flora's midwife ensured that Flora's husband could be involved in a way that he hadn't been able to in India:

Yeah, like he never saw the delivery for Cedric and here, the midwife involved him. Chris used to come with me for all my check-ups and she used to explain (Flora).

Lorna's husband's role changed so that he took on roles that he might not have been able to in India where family members would have stepped in:

No, not really because he is by nature caring and a family man so I would have got a shock if he didn't lift a finger. The extent to which he went about was great because as you say the typical Goan male, husband, father is not very involved in child rearing. They don't really take a very active part. (Lorna)

Participants adapted to the loss of support and rituals in diverse ways that ranged from finding new sources of support to coping with isolation and incorporating the old and new ways of knowing. Their active management of their new lives in New Zealand subverts the notion of deficiency.

CONCLUSIONS

There is some positivity associated with the dislocation that occurs in modern societies (Hall, 1992). The fragmentation of formerly stable identities opens up new possibilities and identities as was the case in this research.

The Goan women who participated in this research had been influenced by colonialism and urbanisation prior to migration to New Zealand. Rituals and postnatal practices had already been lost from their own Goan culture. Despite being unfamiliar with New Zealand, they had grown up believing that a 'Westernised' nation would provide them with superior care to that which could be obtained 'at home'. In the process of adjusting to parenthood in a new country, traditional sources of support and knowledge were lost, being replaced with disembodied strangers and the privileging of 'evidence' over 'old wives tales'. It is ironic that the expectation of nurturing and endless care that participants had prior to their arrival in New Zealand positioned them as 'backward' in their new country and that this is one 'tradition' that many Western women are now advocating for.

Not all experiences were negative and many elements of this replacement culture were empowering for participants. The result was that participants were able to reclaim their power in motherhood rather than be inhibited by taboo, although the negative aspect of this empowerment was the loss of protection through dissolution of taboos. At this important life stage, many participants were focused on the task of survival and advocacy. This meant that their ability to be assertive was greatly reduced and this in turn colluded with the

notion of migrant women as passive. The prevailing discourse that positions western women as educated, liberated and with control over their bodies was something that some participants attempted to emulate in the process of acculturation.

Conversely, some participants re-appropriated their cultural rituals as they found that western ways were inadequate in meeting their needs. Participants held parallel beliefs, maintaining some traditional practices whilst also valuing western care. This was not easy and not helped by the attitudes of some health professionals who considered participants had 'over-invested' in their home country as opposed to 'assimilating'.

Participants found themselves positioned within two cultural discourses, one of the pioneer who has to make things work and one of the colonial subject that has to fit in and not complain because they are lucky to have been granted entry into the West. Both discourses required stoicism and a willingness to tolerate present discomfort for future gain. Participants perceived that little support was available for them to maintain traditional practices, such as infant massage, in existing structures that were ethnocentric and hegemonic, catering to the needs of dominant group members. Some participants worked hard to 'fit in' while also attempting to acknowledge past values and traditions that had shaped them. It is these very experiences that highlight how a universal system that provides for everyone fails to cater for the individual needs of minority cultures and how this results in further disadvantage. The outcome for many women in the study was loneliness and silencing, yet there was also resistance to the subjugation of migrant women by the pathologising discourse of the medical model, with a participant choosing to label her experience as 'isolation' rather than pathologise it as 'depression'.

Migration to New Zealand transformed birth and childbearing from a social process to an

individual process. Participants managed the transition by attempting to become bicultural in a sometimes assimilatory system and in the process demonstrated resistance, resilience and creativity.

Endnotes

- 1 Goa is located on the south west Coast of India. It became the 25th state in the Republic of India on May 31, 1987 after almost five hundred years of Portuguese colonisation which was pivotal in Goans becoming a migratory population.
- 2 Jaggery is a coarse brown, unrefined sugar.
- 3 Tizan (a pudding made of coconut juice, jaggery and salt) and godshem (a sweet) are used to cool and strengthen the body.
- 4 Founded by Dr Truby King in 1907 as part of a campaign to improve infant care by educating women about motherhood and to promote breastfeeding (Kedgely, 1996). Plunket operate by running clinics, family centres and visiting women in their own homes.
- 5 Playcentre was a war-time initiative begun by mothers to provide companionship for each other, where mothers took responsibility for each others children and the running of the centre. The goal was also to also enhance the social development of the child and provide time out, Ibid.

References

- Anderson, J. M. (1987) Migration and health: Perspectives on immigrant women. *Sociology of Health and Illness* 9(4) 410-438.
- Aroian, K. J. (2001) Immigrant women and their health, in: D. Taylor and N. F. Woods (eds) *Annual review of nursing research: women's health research* (Vol. 19) New York: Springer.
- Barclay, L. and Kent, D. (1998) Recent immigration and the misery of motherhood: a discussion of pertinent issues. *Midwifery* 14, 4-9.
- Berry, J. W. and Kim, U. (1988) Acculturation and mental health, in: P.R. Dasen, J. W. Berry and N. Sarorius (eds) *Health and Cross-Cultural*

- Psychology: Toward Applications pp 207–236, Newbury Park CA: Sage.
- Berry, J. W., Kim, U., Minde, T. and Mok, D. (1987) Comparative studies of acculturative stress. *International Migration Review* 21, 491–511.
- Berry, J. W., Kim, U., Power, S., Young, M. and Bujaki, M. (1989) Acculturation attitudes in plural societies. *Applied Psychology* 38, 185–206.
- Berry, J. W., Trimble, J. and Olmeda, E. (1986) The assessment of acculturation, in: W. J. L. J. W. Berry (ed.) *Field Methods in cross-cultural research*, pp 82–104, London: Sage.
- Bottomley, G. (1991) Representing the 'second generation': subjects, objects and ways of knowing, in: G. Bottomley, M. D. Lepervanche and J. Martin (eds) *Intersexions; gender, class, culture, ethnicity*. Sydney: Allen & Unwin.
- Bottomley, G. (1994) Living across difference: connecting gender, ethnicity, class and ageing in Australia, in: N. Grieve and A. Burns (eds) *Australian women, contemporary feminist thought*, pp 59–69, Sydney: Allen & Unwin.
- Bowes, A. and Dar, A. S. (2000) Researching social care for minority ethnic older people: Implications of some Scottish research. *British Journal of Social Work* 30, 305–321.
- Butler, S., Williams, M., Tukuitonga, C. and Paterson, J. (2003) Problems with damp and cold housing among Pacific families in New Zealand. *New Zealand Medical Journal*, 11(116) 1177.
- Choudry, U. K. (1997) Traditional practices of women from India: Pregnancy, childbirth and newborn care. *Journal of Gynaecological and Neonatal Nursing*, 26, 533–539.
- Curnow, A. (1997) *Early days yet: New and collected poems 1941 – 1997*. Auckland: AUP.
- DeSouza, R. (2004) Motherhood, migration and methodology: Giving voice to the 'other'. *The Qualitative Report* 9(3) 463–482.
- Dossa, P. (1999) *The narrative representation of mental health: Iranian women in Canada* (Working paper series No. #99-18) Vancouver: Research on immigration and integration in the metropolis.
- Fitzgerald, M., Ing, V., Heang Ya, T., Heang Hay, S., Yang, T., Duong, H. et al. (1998) *Hear our voices: trauma, birthing and mental health among Cambodian women*. Paramatta: Ausmed.
- Foner, N. (1997) The immigrant family; cultural legacies and cultural changes. *The International Migration Review* 31(4) 961–974.
- Fuller, J. (1997) Multicultural health care: reconciling universalism and particularism. *Nursing Inquiry*, 4, 153–159.
- Hall, S. (1992) The question of cultural identity, in: Stuart Hall (ed.) *Modernity and its futures*, pp 274–323, Cambridge: Polity Press.
- Ip, D. and Lever-Tracy, C. (1999) Asian women in business in Australia, in: G. A. Kelson and D. L. De Laet (eds) *Gender and immigration*. London: Macmillan.
- Kearns, R. A., Neuwelt, P. M., Hitchman, B. and Lennan, M. (1997) Social support and psychological distress before and after childbirth. *Health and Social Care in the Community*, 5(5) 296–308.
- Kedgely, S. (1996) *The untold story of motherhood in New Zealand: Mum's the word*. Auckland: Random House.
- Khoo, T. L. (1996) Who are we talking about? Asian-Australian women writers. *Hecate* 22(2) 11–32.
- Lal, J. (1999) Situating locations: the politics of self, identity and 'other' in living and writing the text, in: S. Hesse-Biber, C. Gilmartin and R. Lydenberg (eds) *Feminist approaches to theory and methodology*, pp 100–138, Oxford: OUP.
- Lealaialoto, R. and Bridgman, G. (1997) Pacific Island Postnatal distress. *Mental Health News*.
- Liem, I. I. L. (1999) The challenges of migrant motherhood: the childrearing practises of Chinese first-time mothers in Australia, in: P. L. Rice (ed.) *Asian mothers Western birth*, pp 135–160, Australia: Ausmed.
- Marshall, H. and Woollett, A. (2000) Fit to reproduce? The regulative role of pregnancy texts. *Feminism and Psychology*, 10(3) 351–367.
- Nicholson, P. (1993) Motherhood and women's lives, in: D. Richardson and V. Robinson (eds) *Introducing women's studies* pp 201–223, London: McMillan.
- Parmar, P. (1997) Other kinds of dreams, in: H. S. Mirza (ed.) *Black British Feminism* pp 67–69, London: Routledge.
- Sagrestano, L. M., Feldman, P., Rini, C. K., Woo, G. and Dunkel-Schetter, C. (1999) Ethnicity and social support during pregnancy. *American Journal of Community Psychology*, 27(6) 869–898.
- Sarney, E. (1999) Baby blues: mothers talk candidly about post-natal depression. *NEXT* (95) 18–22.
- Sawyer, L. (1999) Engaged mothering: The transition to motherhood for a group of African American women. *Journal of Transcultural Nursing* 10(1) 14–21.
- Shin, K. R. and Shin, C. (1999) The lived experience of Korean immigrant women acculturating into the United States. *Health Care For Women International* 20(6) 603–617.
- Small, R., Rice, P. L., Yelland, J. and Lumley, J. (1999) Mothers in a new country: The role of culture and communication in Vietnamese, Turkish and Filipino women's experiences of giving birth in Australia. *Women and Health* 28(3) 77–108.
- Spoonley, P. (1997) The challenges of postcolonialism and the academy, in: M. Peters (Ed.) *Cultural politics and the university in Aotearoa/New Zealand*, pp 135–158, Palmerston North: The Dunmore press.
- Stern, G. and Kruckman, L. (1983) Multi-disciplinary perspective's on post-partum depression: An anthropological critique. *Social Science Medicine* (17) 1027–1041.
- Webster, M. L., Thompson, J.M.D, Mitchell, E.A, and Werry, J.S. (1994) Postnatal depression in a community cohort. *Australia and New Zealand Journal of Psychiatry* (28) 42–49.
- Wheeler, E. (1994) Doing black mental health research, in: H. Afshar and M. Maynard (eds) *The dynamics of race and gender, some feminist interventions*, pp 41–63, London: Taylor & Francis.
- Woollett, A., Dosanjh, N., Nicolson, P., Marshall, H., Dihanbakhch, O. and Hadlow, J. (1995) The ideas and experiences of pregnancy and childbirth of Asian and non-Asian women in East London. *British Journal of Medical Psychology*, 1995(68) 65–84.
- Woollett, A. and Nicholson, P. (1998) The social construction of motherhood and fatherhood, in: C. A. Niven and A. Walker (eds) *Current issues in infancy and parenthood*, vol. 3, pp. 1–15, Oxford: Butterworth-Heinemann.

PUBLISHED – December 2004

**ADVANCES IN CONTEMPORARY
CHILD AND FAMILY HEALTH CARE
'Building Health Capacity in Families'**

Guest Edited by Philip Darbyshire and Debra Jackson

ISBN 0-9750436-3-3; iv + 220 pages; softcover; December 2004

This unique collection of readings is an invaluable resource for teachers, researchers, policy makers and practitioners involved in all aspects of paediatric, adolescent, family and public health.

Contents, Abstracts, Editorials, Articles and Order Form at:
www.contemporarynurse.com/vol18_1.php

2005 Course Coordinators are invited to contact the Publisher for an adoption evaluation copy.

eContent Management Pty Ltd, PO Box 1027, Maleny QLD 4552, Australia
Tel.: +61-7-5435-2900; Fax: +61-7-5435-2911; subscriptions@e-contentmanagement.com
www.e-contentmanagement.com