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ABSTRACT

EXPERIENCES OF PREGNANCY, CHILDBIRTH AND POST-PARTUM PERIOD IN URBAN AND SUBURBAN IMMIGRANT PAKISTANI WOMEN

**By
Rubab Itrat Qureshi**

A body of research suggests that immigrants arrive in the U.S. in good health, a healthy immigrant effect. As immigrants acculturate and absorb dominant cultural norms (measured by proxy variables such as language preference, employment, smoking and alcohol consumption), their health status deteriorates. There is a need to understand how immigrants adapt to a changed social and cultural environment and how this may influence health.

A study of pregnancy, childbirth and the postpartum period in immigrant Pakistani women living in New Jersey explored the interface of culture, immigration and health. The study employed a three pronged approach. Census data were analyzed to identify areas with the largest Pakistani immigrant populations in New Jersey. A sample of 26 women from urban (Jersey City) and suburban (Parsippany and Edison) towns were then interviewed, and tours of their neighborhoods were undertaken to describe their environments.

The in-depth interview data revealed that the pregnancy experience of these women was influenced by the timing of their pregnancy, the quality of their social networks, socio-economic status, and knowledge and ease of negotiation of the U.S. healthcare system. Initially, these women experienced a weakening of social networks and a fall in socio-economic status. Moreover, women who experienced a pregnancy soon after immigrating to the U.S. also encountered a healthcare system that was difficult

to navigate. These women adapted by building new networks (friends and neighbors), strengthening kinship ties (in-laws), investing in relationships (exchange of favors) and consequently deepening embeddedness in these new networks. These new networks also functioned as conduits of information that facilitated the obtaining of healthcare. Social networks in Pakistan were linked via a range of transnational mechanisms.

Differences in socio-cultural adaptation occurred based on urban and suburban location, and these influenced the women's pregnancy experience. Urban and suburban networks differed in composition (e.g. urban networks were comprised of other Pakistani immigrants vs. suburban networks that were more diverse) and collective social capital, and these women used their social capital to address different needs and to achieve different goals. Urban women tended to be more conservative in their adaptations and maintained old social patterns, while suburban women were comparatively more flexible. Additionally, these individual adaptations have collectively shaped urban and suburban Pakistani immigrant communities.

**EXPERIENCES OF PREGNANCY, CHILDBIRTH AND POST-PARTUM
PERIOD IN URBAN AND SUBURBAN IMMIGRANT PAKISTANI WOMEN**

**By
Rubab Itrat Qureshi**

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May 2010

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APPROVAL PAGE

EXPERIENCES OF PREGNANCY, CHILDBIRTH AND POST-PARTUM
PERIOD IN URBAN AND SUBURBAN IMMIGRANT PAKISTANI WOMEN

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I would like to dedicate this dissertation to my parents Itrat and Mubarik Qureshi.

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TABLE OF CONTENTS

Chapter		Page
1	RESEARCH PROBLEM.....	1
1.1	Introduction.....	1
1.2	Problem Statement.....	3
1.3	Research Questions.....	4
1.4	Significance of Research.....	4
1.4.1	Scarcity of Literature.....	4
1.4.2	Birth Outcomes.....	5
1.4.3	The Immigrant Pregnancy, Childbirth and Post-partum Experience.....	6
1.4.4	Social and Cultural Context.....	6
1.4.5	Place of Residence: Urban vs. Suburban.....	7
2	REVIEW OF LITERATURE- PART 1.....	8
2.1	Immigration and the U.S.....	8
2.2	Health and Immigration.....	9
2.2.1	Changing Immigrant Health Status.....	9
2.2.2	Birth Outcomes.....	9
2.2.3	Biomedical Factors.....	10
2.2.4	Human Ecology.....	12
2.3	Toward a Theory of Immigrant Health.....	15
2.3.1	Definitions.....	15

TABLE OF CONTENTS
(Continued)

Chapter		Page
	2.3.2 Complementary Theories.....	16
	2.4 Framework.....	28
3	REVIEW OF LITERATURE-PART 2 PAKISTAN AN OVERVIEW...	30
	3.1 Demography.....	30
	3.2 Push Factors Favoring Emigration from Pakistan.....	33
	3.2.1 Labor Force Participation.....	34
	3.2.2 Employment.....	34
	3.2.3 Trends in Migration.....	35
	3.2.4 Government Policy: Export of Manpower.....	35
	3.2.5 Remittances and the Economy.....	36
	3.3 Pakistani Immigration to the U.S.....	37
	3.3.1 Who Migrates.....	38
	3.4 Pakistani Society.....	40
	3.4.1 Culture.....	40
	3.4.2 Gender and Society.....	42
	3.5 Healthcare System and Utilization.....	46
	3.6 Pakistanis and Issues Related to Reproduction.....	47
	3.6.1 Marriage.....	47
	3.6.2 Role of Family.....	48
	3.6.3 Sex, Contraception and Conception.....	49
	3.6.4 Infertility.....	50

TABLE OF CONTENTS
(Continued)

Chapter		Page
	3.6.5 Gender Preference.....	51
	3.6.6 Diet in Pregnancy.....	51
	3.6.7 Childbirth.....	53
	3.6.8 Post-partum Period.....	54
	3.6.9 Newborn Care.....	55
	3.6.10 Religious Beliefs.....	55
	3.6.11 Pregnancy Related Complications.....	56
	3.7 Pakistani Immigrants in the United States.....	59
4	RESEARCH DESIGN.....	61
	4.1 A Qualitative Paradigm.....	61
	4.1.1 Pilot Study.....	62
	4.1.2 Method.....	63
	4.2 Informed Consent and Ethical Considerations.....	70
	4.2.1 Informed Consent.....	70
	4.2.2 Confidentiality.....	71
	4.2.3 Audio Tapes.....	71
	4.3 Validity.....	71
	4.4 Reliability.....	73
	4.5 Limitations.....	74
5	THE PAKISTANI POPULATION IN NEW JERSEY.....	76
	Demographics.....	76

TABLE OF CONTENTS
(Continued)

Chapter		Page
5.1	Pakistani Immigrants in New Jersey.....	78
5.1.1	Family.....	79
5.1.2	Education.....	80
5.1.3	Language.....	80
5.1.4	Employment Status.....	81
5.1.5	Occupation.....	82
5.1.6	Household Income.....	84
5.1.7	Immigration Status.....	85
5.2	Pakistani Immigrants in New Jersey Counties.....	87
5.3	Urban and Suburban Pakistani Immigrants Populations.....	88
5.3.1	Family Type.....	90
5.3.2	Age.....	91
5.3.3	Marital Status.....	91
5.3.4	Educational Attainment.....	91
5.3.5	Employment Status.....	92
5.3.6	Language Proficiency.....	94
5.3.7	Place of Residence.....	95
5.3.8	Enrollment in College or Graduate Schools.....	96
5.3.9	Industry.....	97
5.3.10	Occupation.....	98

TABLE OF CONTENTS
(Continued)

Chapter		Page
6	JERSEY CITY AND SUBURBAN NEW JERSEY.....	101
6.1	Jersey City.....	101
6.2	New Jersey Suburbs.....	113
6.2.1	Edison/Iselin Area.....	114
6.2.2	Parsippany Area.....	118
7	MAKING A HOME IN NEW JERSEY.....	122
7.1	The Study Participants.....	122
7.2	Family and Gender in Pakistani Society.....	124
7.3	Immigration to the U.S.....	128
7.3.1	American <i>Rishta</i> (marriage proposal).....	128
7.3.2	A New Beginning and Role of Networks.....	131
7.4	Settling in Urban and Suburban New Jersey.....	139
7.4.1	Pakistani Immigrant Women in Jersey City.....	140
7.4.2	Pakistani Immigrant Women in Suburban New Jersey....	146
7.5	Different Physical Environment.....	149
7.5.1	Weather.....	151
7.5.2	Mobility Issues.....	152
7.5.3	Changed Lifestyle.....	155
7.5.4	Housing.....	156
7.6	Loss of Social and Cultural Capital.....	158
7.7	Negotiating Marriage in America.....	167

TABLE OF CONTENTS
(Continued)

Chapter		Page
7.8	Social Environment	168
	7.8.1 Social Support in the U.S.....	168
	7.8.2 New Norms, Expectations and Obligations.....	170
7.9	Maintaining Old Networks.....	180
7.10	Reprise: Urban-Suburban New Jersey.....	187
8	PREGNANCY, CHILDBIRTH AND POST-PARTUM PERIOD.....	193
8.1	Pregnant in Pakistan.....	193
	8.1.1 Pakistani Cultural Norms.....	193
	8.1.2 Summing Up.....	215
8.2	Pregnant in the U.S.....	215
	8.2.1 New Environment, Uncertainties, Loss of Supporting Networks.....	216
	8.2.2 Pregnancy Experience in the U.S.....	217
	8.2.3 Timing their Pregnancy.....	231
	8.2.4 Childbirth Experience.....	232
	8.2.5 Post-partum Period in the U.S.....	240
	8.2.6 Creating New Networks.....	246
9	CONCLUSIONS.....	252
9.1	The Sample of Urban and Suburban Pakistani Immigrant Women	253
9.2	Research Limitations.....	255
9.3	Research Questions.....	258

TABLE OF CONTENTS
(Continued)

Chapter		Page
9.4	How do you Transplant a Pakistani <i>habitus</i> in an American <i>field</i> ?	268
9.4.1	The New Jersey Pakistani Community.....	268
9.4.2	First Pregnancy in the U.S.....	269
9.4.3	Subsequent Pregnancy in the U.S.....	272
9.4.4	Place and Social Networks.....	275
9.5	Social Capital, Culture and Health.....	277
9.5.1	Social Capital and Health Research.....	279
9.5.2	Culture, Acculturation, and Social Capital.....	282
9.5.3	Gender, Social Controls, and Immigration.....	286
9.6	Policy Implications.....	287
9.7	Future Research.....	287
APPENDIX	RESEARCH PARTICIPANTS; DATA FROM THE INTERVIEWS.....	288
REFERENCES.....		292

LIST OF TABLES

Table		Page
3.1	Population of Pakistan.....	33
3.2	Women's Participation in Pakistan.....	43
5.1	Urban and Suburban Immigrant Pakistanis-General Demographic Features.....	90
5.2	Pakistani Immigrants Enrolled in College or Graduate School.....	97
7.1	Urban and Suburban Women Comparison.....	124
7.2a	Existing Networks in the U.S.....	133
7.2b	People Immigrating Women Stayed with in the U.S.....	133
9.1	Functions of Pakistani Immigrant Women's Networks.....	279

LIST OF FIGURES

Figure		Page
2.1	Stock of social capital.....	28
3.1	Map of Pakistan.....	32
5.1	Population pyramid for Pakistani immigrants living in New Jersey in 2000 by age and sex.....	79
5.2	Language proficiency of the Pakistani immigrants in New Jersey in 2000.....	81
5.3	Labor participation of Pakistani immigrants in New Jersey in 2000.....	82
5.4	Occupations of the Pakistani immigrant population in New Jersey in 2000.....	83
5.5	Gender differences in types of employment.....	84
5.6	Household income of Pakistani immigrants in New Jersey in 1999.....	85
5.7	Citizenship by year of entry.....	86
5.8	Pakistani population in New Jersey counties in 2000.....	87
5.9	Population density of Pakistani immigrants in northern New Jersey.....	89
5.10	Labor force participation of immigrant Pakistani men.....	93
5.11	Labor force participation of immigrant Pakistani women...	94
5.12	Pakistani immigrants' ability to speak English.....	95
6.1	Districts in Jersey City.....	102

CHAPTER 1

THE RESEARCH PROBLEM

1.1 Introduction

The United States has one of the largest and most culturally diverse immigrant populations in the world. Immigrants are also the fastest growing segment of the U.S. population. Between 1990 and 2000, the U.S. immigrant population increased by 57%. By 2050, the immigrant population is expected to triple (Malone, 2003).

Asians represent a large proportion of the U.S. immigrant population. The U.S. Census Bureau estimates that Asians comprise 26% of the foreign-born and nearly 5% of the total U.S. population (Census, 2005; Jayasankar, 2005; Yan, 2004). This population is in itself quite diverse with the largest numbers of immigrants coming from China, the Philippines and India.

A majority of Asian immigrants reside in proximity to urban, gateway cities such as Los Angeles, New York and Chicago (Batalova, 2008; Foner, 2000). New Jersey is one center of Asian settlement, due in large part to the state's proximity to New York City and Philadelphia, and also because of the state's many fine universities. In 2000, New Jersey had the third-largest Asian population among the 50 states (Census, 2005). From 1990 to 2000, New Jersey's Asian population nearly doubled. In contrast, the nationwide Asian growth rate was just 13% (Census, 2005).

South Asians (individuals from India, Pakistan, Bangladesh and Sri Lanka) comprise an important and growing segment of the U.S. immigrant population (Kandhar, 2005). Sizable ethnic enclaves of South Asians reside in the urban environs of Queens and Brooklyn in New York City, and in Jersey City, New Jersey. Additionally, a

significant number of South Asians reside in suburban areas such as Edison and Iselin Middlesex County in New Jersey (Kandhar, 2005).

Immigration requires substantial adaptations to a new environment and a new culture (Hattar-Pollara & Meleis, 1995; Hertz, 1993; Uppaluri, Schumm, & Lauderdale, 2001). Numerous problems must be solved, ranging from housing and employment issues to the establishment of new social networks and the maintenance of old relationships (Hertz, 1993; Messias & Rubio, 2004). Additionally, the migrant encounters a new culture and new set of social structures, and must learn in varying degrees how to navigate under these new conditions (Messias & Rubio, 2004).

Pregnancy, particularly the first pregnancy, also requires substantial adjustments in social status, provision for the health of the fetus and mother, and preparations for the new child. In all societies, pregnancy is a major event. Tradition, culture and the family play a vital role during pregnancy, childbirth and the post-partum period in South Asian countries such as Pakistan and India (N. Ali, Azam, S. Noor, R., 2004; Faruqi, 2004; Mead, 1967b). Therefore, immigration places pregnant women in a unique situation- a new environment where they may not have any family member present and their traditional practices of pregnancy may not be observed (Hattar-Pollara & Meleis, 1995; Messias & Rubio, 2004; Tsianakas & Liamputtong, 2002). Additionally, the pregnant woman and her family are likely to encounter formal and informal healthcare systems that are substantially different from those in their country of origin (Stephen, Foote, Hendershot, & Schoenborn, 1994). The combination of pregnancy and immigration, therefore, require multiple adaptations to a new environment and within a relatively short space of time (Hertz, 1993). As a culturally important event, pregnancy provides

occasion for a focused encounter between the immigrant and the host culture and social system.

1.2 Problem Statement

Immigrant health declines as time spent in the U.S. increases. Researchers have tried to explain this problem using different theories, models and concepts. Increasingly culture has been used as a variable (L. M. Hunt, Comer, B., 2004). It is theorized that as immigrants absorb native cultural norms their health outcomes deteriorate (L. M. Hunt, Comer, B., 2004). These health outcomes include, but are not limited to, low birth weight babies and increasing incidence of early onset of diseases like diabetes and hypertension. The cultural norms are usually measured by proxy variables such as preferred language, entering the job market and other social markers such as smoking and alcohol consumption. Although, these variables may play a significant role in predicting health outcomes, they fall short in examining the core cultural practices and what happens when an individual migrates to a new environment. Change is not limited to the acquisition of dominant cultural practices of the new environment, but also comprised of a loss of social, cultural and physical native environments. The question arises as to how do new immigrants adapt to their new surroundings? What changes take place and how do they cope?

1.3 Research Questions

This was a descriptive, exploratory study of Pakistani immigrant women's experiences during pregnancy, childbirth and post-partum periods. It addressed the following questions:

- What are the cultural practices of immigrant Pakistani women pre and post-migration with respect to pregnancy, childbirth and post-partum?
- How do socio-cultural changes influence their childbearing experience?
- What factors influence Pakistani immigrant women's experience with the U.S. healthcare system?
- How do Pakistani immigrant women adapt to their new social environment?
- What is the importance of transnational ties in the pregnancy process?
- Do socio-economic status and place of residence (suburban vs. urban) influence adjustment to the U.S. and childbearing experience?

1.4 Significance of the Research

1.4.1 Scarcity of Literature

Although there has been immense interest in immigrant health, very little research has been conducted on South Asians of Pakistani descent. Most of the available data is population based with little detail with respect to different ethnicities. It should be noted that a majority of studies (Antecol, 2006; Biddle, 2003; McDonald & Kennedy, 2004; Stephen, et al., 1994; Williams, 2005) use population-based surveys that employ self-reported or self-rated data. One of the limitations of these studies is the lack of individual

or group histories. Another criticism concerns the application of western based models to explain behaviors of people of eastern origins (Katalanos, 1994). Katalanos (1994) argues that recent South East Asian immigrants hold health beliefs that are different from those of healthcare professionals in the U.S. and this leads to miscommunication and misunderstanding of information. These differences can have important effects on health processes, especially in health related situations such as patient-physician or patient – nurse encounters.

1.4.2 Birth Outcomes

A nation's health can be assessed using multiple indicators. One of the indicators used by The World Health Organization is the birth weight of babies born in a country. The U.S. has a relatively high low birth weight rate and ranks low among developed nations on this indicator. Minority populations have a disproportionate burden of disease in the U.S. (DHHS, 2005b). U.S. born blacks and Hispanics are twice as likely, to have a low birth weight baby than U.S. born whites (J. W. Collins & David, 2004; J. W. Collins & Shay, 1994; Crump, Lipsky, & Mueller, 1999; Guendelman & English, 1995). Immigrant blacks, Hispanics and Asians fare better and have rates of low birth weight that are more comparable to the white population (J. W. Collins, Wu, & David, 2002; Crump, et al., 1999; Doucet, Baumgarten, & Infante-Rivard, 1992; Fuentes-Afflick, Hessol, & Perez-Stable, 1998). Unlike other immigrant groups, first generation South Asian women tend to have a higher incidence of low birth weight and this tends to increase with subsequent generations (Gould, Madan, Qin, & Chavez, 2003; Margetts, Mohd Yusof, Al Dallal, & Jackson, 2002). Unfortunately little is known about this segment of the immigrant population. The United Kingdom, home to a large South Asian community, does offer

some population based studies that corroborate the high incidence of low birth weight, but very little detailed, in-depth information is available.

1.4.3 The Immigrant Pregnancy, Childbirth and Post-partum Experience

In all societies, pregnancy is a major event. Culture and family play a central role during pregnancy, childbirth and the post-partum periods (Mead, 1967b). Immigration brings new challenges to pregnant women and their families. In a new environment these women may not have family members, who can provide assistance with their pregnancy and childcare. Traditional practices observed in their country of origin may not be possible in a new environment (Hattar-Pollara & Meleis, 1995; Messias & Rubio, 2004; Tsianakas & Liamputtong, 2002). The pregnant woman and her family are likely to encounter formal and informal healthcare systems that are substantially different from those in their country of origin (Stephen, et al., 1994).

Pregnancy also provides the occasion for focused encounters among immigrant women and their families and the host culture and its healthcare system. The study of pregnancy, childbirth and post-partum periods provided an opportunity to explore the interface of culture, immigration and health. It also provided insights into the role of cultural, social, economic and physical environmental change in relation to health.

1.4.4 Social and Cultural Context

A literature search also highlighted the need for research on the social and cultural environment and practices of Pakistani immigrant women in Pakistan and in the U.S. This research provided context to their lives and experiences in Pakistan and the U.S. It also helped in understanding how Pakistani immigrant women adapted to their new social and cultural context after immigration to the U.S., what was the influence of urban or

suburban environments, if there was any, and how this adaptation influenced their experience of pregnancy, childbirth and the post-partum period here in the United States. This research identified the social and cultural needs of pregnant Pakistani immigrant women and provided a basis for better understanding and development of culturally sensitive and holistic healthcare for them (DHHS, 2005b; Jayasankar, 2005).

1.4.5 Place of Residence: Urban vs. Suburban

The largest numbers of immigrants live in gateway cities such as New York, Los Angeles, Miami and Chicago (Foner, 2000). New York has the highest numbers (2.9 million), followed by Los Angeles with 1.5 million. Although some of the 'new' immigrants reside in these urban neighborhoods that were home to immigrants from the first wave of migration in the early twentieth century, most immigrants today are better integrated and live wherever they can afford. Asian immigrants have moved into more affluent neighborhoods with the greatest ease (Foner, 2000).

Since residential choice is not limited for many new immigrants ethnic enclaves exist which may house more than one ethnic minority group or poly-ethnic in nature (Foner, 2000). Some enclaves are more a concentration of businesses than residences representing enclaves of networks rather than actual space. Although there are large numbers of Asian Indian businesses in Jackson Heights, New York, many business owners do not live there, but in suburban Long Island (Foner, 2000). Nearly half of all Pakistani immigrants in the U.S. live in the urban centers of New York City, Houston, Chicago and Los Angeles (ACS, 2006).

CHAPTER 2

REVIEW OF LITERATURE- PART 1

2.1 Immigration and the U.S.

The immigrant population is the fastest growing segment of the U.S. population. Between 1990 and 2000 the U.S. population grew 13% and nearly 40% of this population growth was attributable to migration of foreign-born individuals. In this period the foreign born population increased 57% from 19.8 to 31.1 million (Malone, 2003; Walker, 2007). The Census Bureau estimates that the Hispanic and Asian populations will triple by 2050 (Bergman, 2004).

In 2000, the U.S. population consisted of 70% Whites, 12.3% Blacks and 12.5% belonged to a 'race' other than white or black (Hobbs, 2002). The Census and the Office of Management and Budget categorizes population groups by using 'race' as a proxy for common geographic origins, family ancestry, language and traditions. Hence, the 12.5% belonging to the race "other than white or black" included people of Hispanic, Spanish or Latino, Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Native Hawaiian, other Pacific Islander and other Indian descents (Census, 2005; Williams, 2005). Of the foreign-born individuals, those of Hispanic, Latino or Spanish origin comprised 52%, while 25% came from Asia (Larsen, 2004; Malone, 2003).

2.2 Health and Immigration

2.2.1 Changing Immigrant Health Status

Generally recent immigrants are in better health than those who have been in the U.S. for longer periods of time (Antecol, 2006; McDonald & Kennedy, 2004; Stephen, et al., 1994; Williams, 2005). Recent immigrants are healthier than immigrants who have lived in the U.S. for ten years or more years (Antecol, 2006; Guendelman & English, 1995; Stephen, et al., 1994; Williams, 2005). Similar findings have been reported in other countries with large immigrant populations such as Canada (McDonald & Kennedy, 2004) and Australia (Biddle, 2003).

Another important finding is that instead of converging towards the mean of the general population, immigrant health tends to deteriorate with time (Antecol, 2006). This health phenomenon is contributing to rising health disparities between the majority white and the numerical minorities (African Americans and immigrants) (Fennelly, 2005).

2.2.2 Birth Outcomes

Birth weights of babies born to foreign-born mothers are generally greater than their U.S.-born counterparts and in some cases higher than those of whites (Forna, Jamieson, Sanders, & Lindsay, 2003; Fuentes-Afflick, et al., 1998; Guendelman, et al., 1999). Babies of Mexican-born Hispanic women in California have higher birth weights than those of white mothers (Guendelman, English, & Chavez, 1995). Babies of foreign-born blacks are consistently larger than those of U.S.-born blacks (J. W. Collins, et al., 2002).

Incidence of low birth weight increases as length of residence in the U.S. increases (Crump, et al., 1999; Guendelman & English, 1995). Guendelman and English (1995) found a 51% increase in low birth weight rates among immigrants who had lived

in California more than 5 years (Guendelman & English, 1995). Rates of low birth weight increase with each subsequent generation among blacks of Caribbean origin (J. W. Collins, et al., 2002)

Rao et al. (2006) found that Pakistani/Indian women had the highest incidence of low birth weight (11.5%) among Asian Americans with full term deliveries. In the United Kingdom, Margetts and Yusof (2002) found a similar situation among women of Southeast Asian origin. Low birth weight was higher among babies born to immigrant parents than the white population. Higher rates of low birth weight and infant mortality persisted through subsequent generations of immigrants (Margetts, et al., 2002).

2.2.3 Biomedical Factors

2.2.3.1 Risk Factors. To assess immigrant health, Kandula, Kersey & Lurie (2004) examined ten indicators of health included in the public health objectives of Healthy People 2010. These health indicators include: physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence and environmental quality. The researchers found that:

- Although immigrants are involved in more manual labor, if physical activity is conceptualized as exercise then, immigrants reported less physical activity than the general population (Kandula, Kersey, & Lurie, 2004). However higher socio-economic status is associated with higher rates of exercise (Jonnalagadda & Diwan, 2005).
- Although tobacco and substance abuse is less common among recent immigrants it tends to increase with longer residence time in the U.S. (Guendelman & English, 1995).
- Obesity increased over time with more women than men affected (Antecol, 2006). Recent immigrants have lower Body Mass Index than those who had been U.S. residents more than 10 years. South Asian women are more likely to become obese after several years in the U.S. (Jonnalagadda & Diwan, 2005).

2.2.3.2 Health Care. Access to care is the gateway to better health and depends on a range of factors. The most significant variable is affordability of both medical care and health insurance both of which depend upon the socioeconomic status of an immigrant. Immigrants are less likely to have health insurance than the rest of the population (Kandula, et al., 2004). Non-citizens cannot apply for Medicaid for five years after entering the country. Individual states offer health insurance for children, but many immigrant families do not apply even though they may be eligible because of linguistic and cultural barriers and lack of familiarity with the U.S. healthcare system. Cultural barriers include stigma associated with receiving government aid, fear of disclosing use of traditional medicines and practices, and procuring medications from their countries of origin to healthcare providers (Kandula, et al., 2004)

Some facts about immigrant healthcare include the following

- Immigrants are less likely to have health insurance than the general population because of legal status, ineligibility for Medicaid and existence of cultural barriers (Kandula, et al., 2004).
- Approximately 45% of immigrant children have not completed recommended immunizations (Kandula, et al., 2004).

2.2.3.3 Mortality Rates. Immigrants have lower mortality rates than their native born counterparts. Using mortality rates as an indicator of immigrant health, Williams (2005) found that immigrant mortality rates were lower than the white population. Age adjusted mortality rates for Hispanics 14 years and younger are comparable to those of whites, but higher for the 14- 35 year olds. After age 35 the mortality rate for Hispanics falls below that of whites. However, Williams (2005) identifies three limitations in calculating mortality rates including, undercounting of undocumented aliens, younger age

of immigrants and preference by older immigrants to return to their countries of birth to die.

Infant mortality rates are generally lower among babies born to foreign born mothers than among their U.S. born counterparts (Singh & Yu, 1996). However, there is no information existing on South Asians.

2.2.4 Human Ecology

2.2.4.1 Culture. The interest in using culture as a variable in immigrant health research has risen over the last decade (Hunt et al. 2004, found more than 2000 articles indexed on acculturation since 1996 on Medline) (L. M. Hunt, Comer, B., 2004). Increasingly culture is being used as a 'default' variable in health related research on immigrants to explain health outcomes (L. M. Hunt, 2005).

Although culture plays a role in health outcomes, measures of acculturation (levels of acculturation) alone only partially explore the immigrant experience and its' influence on health. These measures are simplistic and use proxy variables such as preferred language (native tongue or English) and residential preference (ethnic neighborhood or more integrated neighborhoods) and ignore the complexity and diversity of cultures. Culture is multidimensional and includes the social, economic and physical environment of individuals in a society.

Understanding the role of culture in health requires a broader inquiry with an emphasis on immigrant voice. It also requires that cultural inquiry to be situated within a social, economic, physical environmental context in the case of immigrants and this research provided that opportunity.

2.2.4.2 Environment. There is growing empirical evidence of neighborhood effects on health (Diez Roux, et al., 2001) Higher incidence of heart diseases, allergic conditions, adverse birth outcomes, infectious diseases (Tuberculosis, AIDS), diabetes and obesity prevail in urban populations (DHHS, 2005a). Impoverished neighborhoods have long been linked with morbid health outcomes (J. W. Collins, Jr. & Shay, 1994; Diez Roux, 2004; Diez Roux, et al., 2001) Among blacks, the incidence of low birth weight increases as median income declines (J. W. Collins & David, 1990). Unlike blacks, Hispanics rarely reside in hypersegregated neighborhoods and poverty per se is not directly associated with low birth weight as was residence in impoverished communities. Hispanics in impoverished neighborhoods have low birth weight rates similar to blacks (J. W. Collins, Jr. & Shay, 1994).

2.2.4.3 Social Structure. Social structure cannot remain unchanged upon immigration (Foner, 1997). Although immigrants may try to shape their social structure in the context of their pre-migration social culture, some changes are inevitable. Immigrants adapt to their new social environment by reconstructing and redefining their social structure. Where extended families played a central role in their home countries, the immigrant may not have many family members in their new environment. Vietnamese immigrants create 'fictive' kinship within their social circle when there are no siblings or kin in their host country (Kibria, 1993). There may be compromises and gender roles may be reconstructed in order to survive. Women may participate more actively in public life and gain access to social and economic resources as a result of economic need (Kibria, 1993). Marriage patterns undergo reconstruction. Sometimes the demographic composition of an immigrant group (e.g. disproportionate male to female

ratio) reshapes these patterns (Foner, 1997). In some cases adaptation to a new environment is met with resistance, Pakistani immigrants to the United Kingdom go to great lengths to ensure that their children marry within their extended family or kin even though the rate of such marriages is much lower in Pakistan. Another arena for change and adaptation are family dependencies. As immigrants retire they may be financially independent and their cultural preference of living with their children (so that they are taken care of in old age) may change for a more independent retirement (Foner, 1997).

2.2.5 Immigrant Health and Socio-economic Status

Socioeconomic status is comprised of various factors. These include (but are not limited to) immigration status, level of education, language skills and type of employment. This has translated into immigrants being employed in a variety of jobs and as a result their incomes vary widely. From elected officials to taxi cab drivers and day laborers, immigrants make up a sizeable chunk of the United States' labor force. This stratification has several implications. It not only indicates a wide range of incomes, but also other factors that are related to employment such as type of health insurance (if any) and the place of residence.

Socioeconomic circumstances play an important role in health outcomes. Both health insurance status and place of residence greatly influence the immigrant health experience. However research indicates that there are some health problems that are more prevalent in immigrants in general regardless of their socioeconomic status. Among these is a higher risk of early onset type II diabetes and increased incidence of low birth weight as time of residence in the U.S. increases. Research does indicate that the prevalence is higher at the lower end of the socioeconomic spectrum.

2.3 Toward a Theory of Immigrant Health

Interest in the healthy immigrant effect, the decline in immigrant health and role of culture in health has grown in recent years. To understand immigrant health issues the central question arises: what causes the deterioration in health? Health is a multi-dimensional condition and subject to multi-causality rather than a mono-centric etiology. To develop a conceptual framework I will begin with

- definitions of health, social and physical environments
- review of complementary theories and
- draw an integrative, holistic conceptual framework,
- as a guide to understand experiences of pregnancy, childbirth and the post-partum periods in immigrant Pakistani women in the U.S.

2.3.1 Definitions

2.3.1.1 Health. The International Health Conference in 1946 adopted the following definition of health and appears as such in the Preamble to the Constitution of the World Health Organization.

‘Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (W.H.O, 1946).

2.3.1.2 Social Environment. For the purpose of this dissertation Cassel’s (1976) definition of social environment is most suitable. He defined it as an environment where psychosocial factors such as ‘dominance hierarchies, social disorganization, rapid social change and status’ in society (marginal status and/or social isolation) play a central role (Cassel, 1976, pp. 111, 113, 118).

2.3.1.3 Physical Environment. Physical environment means living conditions and includes housing and neighborhood.

2.3.2 Complementary Theories

2.3.2.1 The concept of social capital.

Background The concept of social capital has been developed independently in economics, education and sociology (Stephens, 2008). The term was coined by an educator in 1916 (Woolcock, 1998) and later used by various researchers; Jane Jacobs, an urbanist, employed it to examine urban life in New York City (1961) and the economist Glenn Loury (1977) used it in his critique of neoclassical theories of racial inequality (Winter, 2000). The concept was further developed extensively by Pierre Bourdieu, a French sociologist, James Coleman, a sociological theorist, (1988) and Robert Putnam, a political scientist (1993).

Defining social capital

Bourdieu defines social capital as:

“the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance or recognition” (Bourdieu, 1986, p. 249).

Coleman defines social capital more for its function than for what it is. He defines it as:

“It is not a single entity, but a variety of different entities, with two elements in common: they all consist of some aspect of social structures, and they facilitate certain actions of actors--- whether persons or corporate actors--- within the structure” (Coleman, 1988b, p. S98).

Also, Coleman states:

“Social capital inheres in the structure of relations between actors and among actors” (Coleman, 1988b, p. S98)

Putnam looks at a societal level and defines social capital as the “trust, norms and networks” that facilitate and enhance mutual benefit (Putnam, Leonardi, & Nanetti, 1993).

Applying the concept All three definitions are inherently similar. Their premise is that social capital is a resource that an individual participating in a group can draw upon. However there are some differences. These differences are highlighted by their application. Whereas Putnam’s definition is similar to Coleman’s, he conceptualizes it somewhat differently. Putnam applies it to ‘system level’ behavior rather than at the individual level as Coleman does. Bourdieu looks at both individual (what Bourdieu refers to as *habitus*) and community (*field*) levels. The field consists of networks that enhance an individual’s social capital. However this enhancement is more of an economic and political reward for participation. Bourdieu identifies three dimensions of capital: economic, cultural and social capital (Bourdieu, 1986). The resource (capital) lies, to name a few, in a “family name” and connections (networks). It needs investment of time and money (group participation) by an individual to maintain and establish a network. This ultimately results in economic and political gains.

Coleman’s more functional view looks at “aspects of social structure” (Coleman, 1988b). These aspects include the obligations and expectations, norms, channels of information and (behavioral) sanctions. Participation here leads to enhancement of human capital, but no reference is made to economic capital. Putnam’s application is broader and incorporates individual participation at a micro level (bonding) with ramifications at a macro, regional or societal scale (bridging).

Social capital is shared. Unlike human capital, which is a private good, social capital is a resource available to all participating members. “The stock of social capital resides in network-relations rather than in individuals” (Hawe & Shiell, 2000, p. 873).

Elements of social capital Social capital is a resource. It can be classified into structural and cognitive elements (Ziersch, 2005). Structural elements include the formal and informal networks (Bourdieu), while cognitive elements are the trust and reciprocity (Putnam) that an individual invests by participation in a group.

Social capital has also been conceptualized as an outcome (A Portes, 1998; Ziersch, 2005). Portes views social support provided by family and kin as an outcome, and measures social capital in terms of level of social support. Flow of information (Hofferth, Boisjoly, & Duncan, 1995) and social cohesion (Macintyre & Ellaway, 2000) are other outcomes of networks and social capital (Ziersch, 2005).

Yet another element is relational social capital (Woolcock, 1998). Woolcock (1998), like Coleman, defines social capital in more practical terms: in terms of what it does. He identifies two forms of relational social capital: embeddedness and autonomy. This capital resides in an individual’s embeddedness in a network, whereas autonomy extends to a wider network of family, kin and friends.

Hawe and Sheill (2000) point out that unlike economic capital, which may depreciate over time, social capital does not. They argue that there is a multiplier effect and one individual’s use of a network’s social capital does not reduce the stock.

Family as a source of social capital Group participation starts within a family (Bourdieu, 1986; Coleman, 1988b; Putnam, 2000). Social capital is accumulated within the family and accrued over time. It extends outwards to include networks within the

extended family and friends. According to Putnam it extends from there to the community and society. It is transmissible and passed from parents to their children and has a powerful influence on outcomes. Some examples of this influence are presented below.

Coleman (1988) looked at high school graduation rates and found that family relations played an important part in predicting high school graduation. He found that the mother-father relationship had a strong influence on their children's education. Two parent households had higher social capital and better outcomes (low drop out rates and higher rate of high school graduation) when compared to single parent households (Coleman, 1988b; Hao, 1994). He found that parental involvement in the lives of their children (indicated high social capital) had a positive influence on the children (Coleman, 1988b).

To Bourdieu, social capital includes the position or social class of a family and the economic and cultural capital they possess. Economic capital lies in wealth accumulated by a family, and cultural capital includes education and tastes. It also depends on the networks of a family. Social capital lies in the ability of an individual to mobilize these networks and draw upon all these resources or social capital to ensure success (A Portes, 1998). In turn the individual invests in this capital by reciprocating: by investing time and money to maintain those networks.

Utilizing Bourdieu's model of social capital, Lareau examined how social class influences a child's education (Lareau, 2000). She found that parents belonging to a higher social class had vast resources (social capital) at their disposal and this translated into a very different educational/school experience for their children when compared to

children belonging to lower socio-economic class. Higher social capital was interpreted as higher parental involvement and intervention. Thus tailoring the public school experience to benefit an individual (Lareau, 2000).

Social capital also depends on the quality of networks (the social, economic and cultural capital they possess, their density and how well members know each other). Putnam argues that families are central to social capital. In fact he argues that loosening of familial bonds leads to a decline in social capital (Putnam, 2000). According to Putnam social capital lies in “social organization, such as civic participation, norms of reciprocity and trust in others” (Putnam, 2000).

Social capital and health Health is a complex outcome of biological, physiological, social, environmental and economic determinants (Baum, 1999; Dahlgren, 1991; Marmot, 2003). Individual characteristics (such as age, sex, genetic predispositions, the biological and physiological determinants), although central to understanding health status, are subject to external influences such as social and economic capital (Dahlgren, 1991; Kaplan, 1996). Economic capital can be measured by educational attainment, type of employment, access to healthcare and housing, whereas social capital contributes to attaining that economic capital. Lower economic status has been linked to poor health (Marmot, 2003). Some research has shifted away from an individual economic status, to a national level (Wilkinson, 1992). Wilkinson (1992) found that national mortality rates were more closely related to income distribution than individual income. Kawachi, Kennedy & Lochner (1997) found that mortality rates increased as income inequality rose, which they theorized was the result of disinvestment in social capital. Hence, economic capital is not exclusive of social capital (Kaplan, 1996;

Kawachi, Kennedy, Lochner, & Prothrow-Stith, 1997). These studies measured social trust, group membership and civic engagement and studied their relationship to health (mortality rate). They found that income inequality erodes social trust and leads to disinvestment in social capital (fall in group membership and civic engagement). This appears to be one of the pathways through which a widening gap in incomes (between the rich and the poor) exerts a negative effect on mortality rates (Kawachi, Kennedy, Lochner, & Prothrow-Stith, 1997).

An Australia based study (Ziersch, 2005) found that informal networks had a strong positive effect on mental health. Ziersch studied two suburban neighborhoods with largely immigrant populations. Access to help, sense of control, home ownership and high incomes were all correlated with better mental health. However Ziersch did not find any strong relationship of these factors to physical health (Ziersch, 2005).

In a Russian study, Rose (2000) found that social capital increased both physical and mental health levels more than individual human capital. He examined the effect of social capital on health and found that social exclusion or low levels of participation were related to poor health. He also found that those with a high level of involvement in informal networks reported worse emotional health. He attributed this to an anti-modern sentiment in a post USSR era, hence more as an outcome of self imposed marginalization. He argued that high levels of involvement in informal networks worked in favor of health in a 'pre-modern' societal context, whereas in a modern context this may indicate a rejection of modernization and retreat from societal changes (marginalization) (Rose, 2000). Sense of control was also highly correlated to better mental and emotional health.

In a study cardiologist Stewart Wolf found that an Italian-American community, in Pennsylvania in the 1960s, suffered 50% lower rates of heart attacks than surrounding communities. He found that this community exhibited close social relations, values such as family and religious traditions and intra-ethnic marriages (Hawe & Shiell, 2000).

Loss of social capital Just as social capital is accumulated and accrued over time, it can be lost. This may occur in two ways: structural and functional (Coleman, 1988a). Structural deficiency refers to an absence of family, while functional refers to deficient networks and relations between family members (Coleman, 1988a). Coleman argues that the absence of the nuclear family (parents, aunts, uncles and grandparents) results in a loss of social capital. There is also a loss when relationships are weak (functional) and networks are not reliable. A decline in embeddedness within a community (weakening bonds within networks) also results in loss of social capital (Coleman, 1988a).

Social capital can also be lost due to disinvestment. Disinvestment takes place when individuals (in a group) do not invest time and money in a network (Putnam, 2000). Decline in civic participation, membership in associations and loss of nuclear families may all contribute to declining social capital (Putnam, 2000). A lack of social trust and reciprocity can also lead to a weakening of bonds and networks and thus a further decline in social capital.

Emigration and social capital Social capital reserves change with emigration. Whereas émigrés usually perceive emigration as beneficial, Coleman (1990) and Putnam (2000) disagree.

“Emigration devalues one’s social capital, for most of one’s social connections must be left behind” (Putnam, 2000 pg. 390).

Since family and kinship are core networks, any disruption will lead to a loss of social capital, especially when an individual migrates to another geographical location (Coleman, 1988a). Both Putnam and Coleman argue that 'individual mobility' will weaken networks and lead to instability in social capital. As an individual relocates to a new place, new networks may develop, but that takes investment of time as well as acceptance into an already existing network that may prove problematic. A loss of social capital may result in lack of trust in people, fewer networks, shrinking channels of information and change in norms. A loss of sense of control may occur and change in expectations and sanctions may result in further decline in social capital.

Bourdieu argues that social capital is not exclusive of cultural and economic capital and hence is not a singular resource. He also argues that quality of networks and the ability to mobilize that network (access to collective resources) is central to social capital. There is also a differential in access to social capital for different members of a group. Power relations (institutional and hierarchical family relations), investment of time and money and how these are manifested through practice define access to a group's social capital. Thus immigrants' transition to a new set of networks may take time and is subject to all the conditions mentioned above.

Gender and social capital *Habitus, field* and their interface are central to Bourdieu's concept of social capital, and gender is an inherent part of *habitus*. The interface of *habitus* and *field* is a crucial conjunction because both *habitus* and *field* are mutable and are subject to changes. The *field* (social structure, societal norms, sociological and economic environment) modulates behavior and defines gender identity (part of *habitus*). However, roles are socially constructed. Thus *field* has a formative

influence over *habitus*. Therefore the meaning and structure of social capital will differ by gender. Social capital is embedded in participation, but structural elements of the *field* can be different for men and women. Therefore, levels of participation are different. Hodgkin (2008) examined the meaning of social capital for men and women, and found that women reported high levels of informal social participation (bonding), such as in social groups and community groups (Hodgkin, 2008). By contrast, men reported higher levels of formal participation (bridging) such as trade unions, political parties, sports clubs and social clubs (Hodgkin, 2008). Women who were more involved with informal groups, built networks within family and friends. Civic involvement also differed along gender lines. Women were more involved at the community level (E.g., schools). Women reported that their local involvement was rooted in their role as mothers (involvement was seen as crucial for their children's success) (Hodgkin, 2008). Their gender and role of mother influenced their level of social participation and definition of their social capital. Gender differences are more pronounced in Pakistani society, where gender roles are socially defined and are starkly different (Khan, 1999). Therefore social capital is not gender neutral.

2.3.2.2 Adaptation.

Health as an outcome of adaptation Adaptation situates an individual in a social and cultural context within the environment. Rappaport (1992) argues that the human environment encompasses the physical, social and economic components as well as other, symbolically conceived and socially constructed elements. He defines the latter as the "political, social, economic, religious, legal, recreational and aesthetic conventions,

and the physical products of organized activities, such as manufactured products, machines, transformations of the landscape, and so on” (Rappaport, 1992, p. 3).

McElroy defines adaptation as a ”process of change and adjustment”, that increases a population’s chances of survival in a new environment (McElroy, 1990). Adaptation also serves as a conceptual tool for organizing data on human responses to environmental stressors, disease, and disability, loss and life transition. These responses are varied and may include hormonal, immunologic, autonomic, cognitive and cultural responses (Becker, 1980). Some of these adaptations may prove detrimental to health as exemplified by the prevalence of sickle cell anemia¹ in the African American population. Environmental factors such as residential location also have profound affects on health (Diez Roux, et al., 2001).

Growing empirical evidence supports the existence of neighborhood effects on health (Diez Roux, et al., 2001) Higher incidence of heart diseases, allergic conditions, adverse birth outcomes, infectious diseases (Tuberculosis, AIDS), diabetes and obesity prevail in urban populations (DHHS, 2005a). Impoverished neighborhoods have long been linked with morbid health outcomes (J. W. Collins & D. Shay, 1994; Diez Roux, 2004; Diez Roux, et al., 2001). Among blacks, the incidence of low birth weight increases as median income declines (J. W. Collins, David, R. J., 1990).

Background of adaptation In the 1960s, more research began to focus on the influence of cultural variables on human biology (McElroy, 1990). Bio-cultural models incorporated both, biological and socio-cultural variables in order to understand the complexity of the evolutionary process of human adaptation to new physical and socio-

¹ This genetic mutation occurred (an evolutionary process) in Africa as a survival mechanism to combat malaria. The gene protects against malaria but at higher altitudes causes hemoglobin to clump and red blood cells to sickle, a shape that renders them more prone to damage (Beutler, 2006).

cultural environments. There is “evidence that environmental stress and deterioration are increasing, and the impact on the mental, physical and social health and well-being of populations is more significant now than in any previous time in history” (Pederson, 1996), pg 1). Understanding human behavioral responses to the environment, allows for preventing and limiting the negative impact of exposure. These responses constitute adaptive coping which can help limit human suffering.

Although, it is easy to understand the argument that adaptive responses of humans to their environments have measurable health consequences, critics point out that cultural adaptation is distinct from physiological adaptation (Alland, 1990). Alland (1990) argues that cultural adaptation occurs earlier than physiological adaptation. Cultural adaptation occurs at many levels. Cultural adaptation, it can be argued, occurs in two ways: a conservative adaptation in the form of transnationalism or establishment of ethnic networks or both, or in the form of acculturation and assimilation. In the first scenario they may try to keep their connection with their home countries viable. In this case they keep connected by frequent visits, use of phone and the internet, business arrangements and marriages: hence the term transnationals (Glick-Schiller, 1992). In some situations people try to recreate their old social and cultural environments, and try not to adopt local cultural norms (Berry, 1980). In the third situation they acculturate and assimilate whereby they adopt some local cultural norms and shed some old practices to assimilate (Berry, 1980). Adaptation thus eases the transition in a new or different environment.

Transnationalism

Transnationalism is a process by which immigrants forge and sustain networks and social connections between their countries of origin and the country to which they have immigrated (Glick-Schiller, 1992). These connections are

multi stranded and involve different depths of involvement. Some may involve family relations (Shaw, 2001), others business connections (Shaw, 2001), and still others who are involved in politics across international borders (Foner, 2000).

Many governments allow their citizens to hold dual citizenships. Mexico, Haiti and the Dominican Republic are among many who allow their citizens to keep their citizenship viable even after immigration to the U.S. According to Foner (2000), immigrants from the Dominican Republic may participate in Dominican politics and vote in elections by holding dual citizenship in both countries. Both Haiti and the Dominican Republic have sizeable immigrant populations, especially in urban enclaves, and their votes matter in U.S. elections. As a result many U.S. politicians travel to these nations to campaign (Foner, 2000).

Social connections are also maintained by actively investing in family left behind in home countries. Many immigrants send remittances to support their families. Some invest in property. Others invest in businesses that are bilateral with branches in both home and host countries (Shaw, 2001). Marriage is yet another mean of keeping old networks viable. Many Pakistani immigrants in the U.K prefer to marry their children within their families in Pakistan (Shaw, 2001). These arranged marriages help forge stronger ties with their home country and sustain cultural and religious norms (Shaw, 2001).

Technological advances have played a central role in facilitating this network of connections. Telephones, the internet, cheaper air fares and electronic money transfer systems have enabled today's immigrant to stay connected (Huynen, 2005).

Today's migrant is a product of a global community: a culturally, economically, socially and politically global individual.

2.4 Framework

Stock of social capital An individual's stock of social capital can be framed as follows in Figure 2.1:

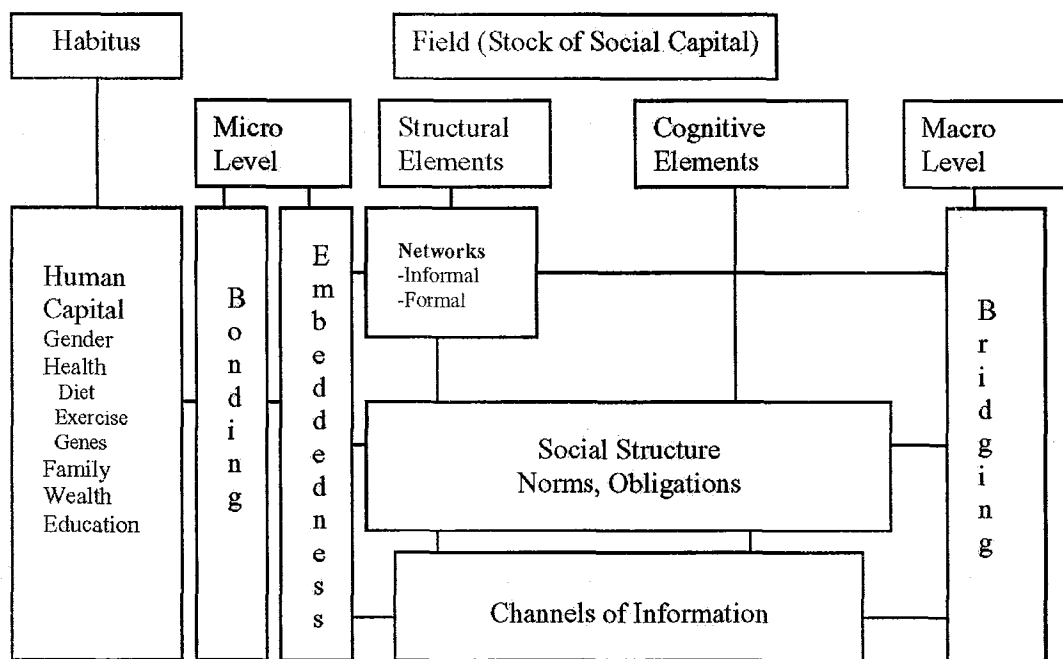


Figure 2.1 Stock of social capital.

Source: (Bourdieu, 1986; Coleman, 1988b; Putnam, 2000; Woolcock, 1998).

An individual's stock of social capital starts with the individual: Bourdieu's *habitus*. *Habitus* is defined by an individual's human capital. This includes gender, health, wealth, family connections and education. The *field* includes Putnam's networks at micro (bonding) and macro (bridging) levels. Micro level networks or bonding are a smaller, more intimate network of family and friends, whereas bridging occurs when an individual forms larger networks within a community and further beyond their intimate web of

networks. The ability to muster support or the quality of these networks depends on the degree of embeddedness within those networks, both formal (bridging) or informal (bonding). Coleman believes that quality of networks can translate into enhancement of social capital through channels of information and other forms of assistance, for example. Embeddedness at the micro level also influences the social structure of a society since it defines social norms and individual obligations to the group as a whole. Since social capital is a shared resource, member participation and contribution enhances the stock to individual social capital.

CHAPTER 3
REVIEW OF LITERATURE- PART 2
PAKISTAN: AN OVERVIEW

3.1 Demography

South Asia is comprised of Pakistan, India, Bangladesh, Nepal, Bhutan, Maldives and Sri Lanka (U.N, 2007). Historically part of the Indian subcontinent, Pakistan gained independence from the British Raj and India and established herself as an Islamic Republic in 1947. Nearly 97% of the population is Muslim (77% *Sunni*, 20% *Shia*) and 3% are citizens with other religions, including Christians and Hindus. Five major ethnic groups reside in the country that occupy spatially, geographically, linguistically and culturally distinct regions within the provinces (See attached map of Pakistan) (InfoPak, 2008). These are:

- Punjabis, the largest of the ethnic groups, from the plains of Punjab bordering India,
- Pathans from the North West Frontier Province, a mountainous terrain home to the second tallest peak in the world, the Karakoram 2,
- Sindhis from Sind which is mostly desert and borders India to the East,
- Baluchis, from Baluchistan which is a plateau borders Iran to the West,
- *Muhajirs* or immigrants from India at the time of partition (Gazdar, 2003; InfoPak, 2008).

The different ethnic groups speak different languages. In Pakistan eight major languages are spoken with Punjabi spoken by 48% of the total population. This is followed by Sindhi (spoken by 12% of the population), Saraiki, a Punjabi variant (by 10% of the population), followed by Pashto (8%), Baluchi (3%), Hindko (2%) and Barhui (1%). Urdu, the official language, is the native language of the *Muhajirs* who comprise 8% of the total population. Native speakers of English and other tongues comprise 8% of the population. English, however is taught to and spoken by many and is the *de facto* official language (InfoPak, 2008).

Pakistan is mostly rural. Nearly 66% of the total population lives in villages and 34% live in urban areas. Most of the urban population (57%) lives in 12 cities with populations more than 200,000. Major urban areas include the cities of Karachi (the largest), Lahore and Faisalabad.



Figure 3.1 Map of Pakistan.

Source : www.infopak.gov.pk (InfoPak, 2008).

Pakistan is a populous country. The total population is estimated at 158 million (U.N, 2007). The annual population growth rate is 1.82 due to a very high fertility rate of 3.99, which leads to a young population. The median age is 20 years with nearly 47% of the population under the age of 15, and 49% between the ages of 15 and 65. Only 3% are older than 65 years of age since life expectancy is around 63 years. The following table presents some data from the United Nations Common Database available.

Table 3.1 Population of Pakistan (U.N, 2007)

Population of Pakistan (2005)	
Total Urban population	56079000
Total Rural Population	105072000
Total Male Population	81.3 Million
Total Female Population	76.8 Million
Net Migration	-362000
Migration Rate	-2.4
Net International Migration	-1239420
Girls to Boys Ratio of Enrollment in Tertiary Education	0.88
Girls to Boys Ratio of Enrollment in Secondary Education	0.75
Births Attended by Skilled Health Personnel in percent	31%
Contraceptive Use (any method) percent in 2001	29%
Fertility Rate	3.99

Source: United Nations Common Database, 2007 (U.N, 2007)

Overall literacy is low. The country wide literacy rate is 51% country wide (63% for males and 39% for females). Literacy is higher in urban areas (69%) than in rural ones (41%).

3.2 Push Factors Favoring Emigration from Pakistan

South Asia is one of the poorest regions of the world with nearly 40% of the world's poorest residing in South Asian countries (Solimano, 2002). Although Pakistan's Gross Domestic Product (GDP) growth rate has increased from 5.7% in 2003 to 6.2% in 2006, but nearly 32.6% of the population lives below the United Nation's poverty line (of these 17% earn only \$1/day) (U.N, 2007). The annual per capita income is \$697 and the inflation rate is 9% (U.N, 2007). Although people migrate for reasons such as religious or political persecution, economy is the major driving force behind Pakistani migration (Gazdar, 2003). To explore the conditions that favor migration further, a brief overview of some indicators is presented below.

3.2.1 Labor Force Participation

Labor force participation is a measure of the strength of an economy, and is the ratio of people in the work force (employed, self employed and unemployed) to the total working age population. According to by Pakistan's Ministry of Labor and Overseas Pakistanis, labor force participation is low as compared to other South Asian countries. Pakistan's labor force participation rate is 53% (Hayat, 2007). Most men age 15 and above (84%) participate in the labor force, but few women (21%) work in the formal economy (Hayat, 2007). Women in rural areas have a higher labor force participation rate (16%) than women residing in urban areas (8%) (Hayat, 2007).

3.2.2 Employment

3.2.2.1 Types of employment. There are four major sectors of employment in Pakistan: the agricultural, service, industry and trade sectors (Hayat, 2007). Since nearly 66% of the population lives in rural areas, historically more people were employed in agriculture. However a steady decline in the share of agriculture has occurred in the total economy over the past years whereas the share of services, industry and trade has gone up (Hayat, 2007).

3.2.2.2 Employment to population rate. A second measure of an economy's success is the employment to population rate (proportion of a country's working age population that is gainfully employed for wages, not including farmers and the self employed) (Hayat, 2007). This is a measure of the economy's ability to create employment opportunities. In Pakistan the rate is 68% for men and 17% for women, which means that 32% of working age men do not have a job opportunity which makes migration an attractive option (Hayat, 2007).

3.2.2.3 Unemployment. The unemployment rate is an indicator of a nation's economy. The overall unemployment rate in Pakistan is 6% (Elahi, 2006; Hayat, 2007). The unemployment rate is 5.2% for males and 9% for females. In the under 25 age group it is even higher. It is the highest for the 15 to 25 years age group. Their unemployment rate comprises 43% of the total rate (Hayat, 2007). This is significant because this group not only comprises 20% of the total population, but is also expected to be economically active for a long time and high returns on educational and training investments are expected from them. Poor economic conditions and lack of opportunities make migration an option.

3.2.3 Trends in Migration

Two types of migration occur in developing countries: internal and international (Gazdar, 2003; I.O.M, 2005). Whereas the poorest segments of the population, those who may be low skilled or not educated, often migrate from one area within a country to another (usually from rural to urban areas in search of work), those who have the means, skills and education commonly opt to migrate internationally (Gazdar, 2003). As a result of limited economic opportunities, Pakistan has a significant diaspora population: an estimated 2 to 3 million people of Pakistani origin reside in developed countries (Gazdar, 2003).

3.2.4 Governmental Policy: Export of Manpower

Pakistan participates in extensive export of manpower (Hayat, 2007). Indeed emigration is actively supported by the Pakistani government (Gazdar, 2003). There is a ministry in charge of overseas Pakistanis that streamlines the emigration process by matching job seekers with jobs overseas and addressing their concerns. As a result Pakistan's net

international migration rate is -2.4 as compared to India with a net rate of -0.3 (U.N, 2007). According to the Bureau of Emigration and Overseas Employment of Pakistan, 184,274 Pakistanis left to work abroad in 2006 alone. These émigrés included people from a variety of professions and educational training (Foner, 2000; Hayat, 2007). The majority of these émigrés work in the Gulf States such as Saudi Arabia, Kuwait and United Arab Emirates. However a smaller proportion leaves to seek work in other countries including the U.S.A (Gazdar, 2003; Hayat, 2007; Shah, 1983). These two emigrating segments differ in that the Gulf market mainly recruits laborers and people involved in trades such as carpenters and masons (Shah, 1983), whereas people migrating to countries such as the U.S. or Canada are usually better educated and involved in technical professions (Gazdar, 2003). Another difference is that international emigrants to Europe, Australia and North America commonly settle permanently (Foner, 2000), whereas the Gulf States may grant residency, but have no provisions for naturalization (Gazdar, 2003; Shah, 1983). Most Gulf States also impose restrictions on family immigration so emigrants to these areas usually leave their families in Pakistan while they work overseas (Gazdar, 2003). In most cases it is the men who immigrate first and families that follow.

3.2.5 Remittances and the Economy

Emigration may lead to a brain drain situation, but can also help boost the economy. Therefore, although Pakistan suffers from a loss of skilled workers and labor, it receives remittances from overseas workers (Bouhga-Hagbe, 2006). These come in the form of capital and/or investments (Bouhga-Hagbe, 2006). Since a majority of the families of these émigrés are living in Pakistan the men send home remittances to support their

families. As a result of the sheer number of overseas Pakistanis, remittances contribute significantly to Pakistan's economy (Bouhga-Hagbe, 2006; Gazdar, 2003). In fact emigrants' remittances constitute a large proportion (4%) of Pakistan's economy.

Emigrants almost always send money to their families back home (Bouhga-Hagbe, 2006; Foner, 2000; Gazdar, 2003). This is especially true when they are the only family member emigrating (Foner, 2000; Gazdar, 2003). Remittances contribute significantly to a country's economy in two ways: strengthening the national currency (by inflow of foreign currencies) and their external positions by balancing of payments (Bouhga-Hagbe, 2006). In Pakistan's case this is significant since Pakistan remittances comprise 4% of the GDP which is equivalent to 22% export goods or services (Bouhga-Hagbe, 2006). Remittances from the U.S. comprise one third of the total remittances; émigrés sent back \$778 million in 2001-2002 (Gazdar, 2003). Therefore emigration is highly desirable in this part of the world.

3.3 Pakistani Emigration to the U.S.

The history of Pakistani immigration to the U.S. is not a long one. In effect it began after 1965. Although Pakistanis immigrated to the U.S. before 1965, these were not large numbers, due in part to Pakistan gaining independence in 1947 and also because U.S. immigration laws severely limited the number of immigrant visas from Asian countries until recent decades. The quota system in place since 1920 was based on national origin and it was not until 1946 that reforms were introduced. The Luce-Celler Act of 1946 ended the 29 year old ban on South Asian immigration, but the annual number of visas issued was quite limited (Batalova, 2008). The Immigration and Nationality Act amendments of 1965 abolished the quota system and allocated 20% of permanent

immigrant visas (out of a total 170,000) from countries outside the western hemisphere to skilled professionals regardless of their country of origin (Keely, 1971). The second salient feature of immigration reform was the inclusion of family reunification as a basis for immigration on the preference list (Batalova, 2008; Foner, 2000; Keely, 1971). In the case of Pakistanis, the earliest immigrants took advantage of the skilled visa category and it was not until later that visas were sought on family reunification grounds (Batalova, 2008). Today's Pakistani communities in the U.S. are a reflection of 1965 immigration reforms.

3.3.1 Who Migrates

3.3.1.1 The highly skilled immigrants. The 1965 law enabled immigrants from Asian countries to immigrate to the U.S. in larger numbers (Foner, 2000). The annual percentage of immigrants from Asia rose from 4.6% in 1953 to 15.8% in 1968 (Keely, 1971). Between 1953 and 1965, 1324 Pakistanis immigrated to the U.S. (166 annually); by 1967 that number had risen to 673 annually (Keely, 1971).

The significance of this change in immigration policy was twofold. On the one hand the U.S. gained skilled and highly skilled workers. On the other hand the sending countries experienced a loss of these same skilled people (Solimano, 2002). Before the 1965 amendments highly skilled professionals had originated from European countries; the term 'brain drain' was coined to describe this phenomenon (Foner, 2000; Fortney, 1972). By the 1990s a large proportion of immigrants were highly educated; nearly 40% of the foreign born in the U.S. held a tertiary degree in their field of specialization (Solimano, 2002). The U.S. is also one of the major educators of foreign students (Gazdar, 2003; Solimano, 2002). Upon completion of their higher education in the U.S.

many of these students later apply for change of visa status. In 1999 25% of the H1B visas, (visa for highly skilled workers) were issued to students enrolled in U.S. universities (Solimano, 2002).

According to the United States Educational Foundation in Pakistan there are over 7000 Pakistani students enrolled in universities across the U.S. The Foundation allocates over \$30 million to the Pakistan-U.S. Fulbright Program to enable eligible students from Pakistan to obtain higher education in the U.S. (USEFP, 2006). Representatives from different U.S. universities visit colleges and universities across Pakistan to promote their educational programs on a regular basis (USEFP, 2006). Test taking facilities, programs to assist with application process, and advisory support are available to ease the process.

3.3.1.2 Family reunification. Many people immigrate when naturalized family members take advantage of the family reunification visa program and sponsor their immigration. In fact more immigrants are now entering the U.S. based on this aspect of the immigration law than are skilled workers (Gazdar, 2003; I.O.M, 2005). According to the International Organization for Migration 19% of the total immigrant visas granted by the U.S. in 2001 went to the skilled category whereas 70% went to the reunification category (I.O.M, 2005).

3.2.1.3 Entrepreneurs. Third group immigrants are entrepreneurs- people involved in international businesses (Solimano, 2002). Solimano points out that there is a connection between ethnicity, entrepreneurship and migration, since some immigrant groups may dominate or are concentrated in a particular type of business. Many immigrant owned businesses start out as family run businesses with most of the family

working in the same business. In fact immigrant entrepreneurship is one of the hallmarks of the American history of immigration (Foner, 2000; Solimano, 2002).

3.4 Pakistani Society

3.4.1 Culture

Pakistan is one of the oldest continuously populated regions of the world. Her roots can be traced back to the Indus Valley Civilization some 5000 years ago. Subsequent invasions by the Persians, Greeks, Scythians, Arabs, Turks, Afghans, the Mughals (claim Mongolian ancestry) and the English, the people have old traditions (U.N, 2007). Religion plays a unifying role, but is secondary to ethnicity and kinship (*Biradari*), which are central to defining cultural identities. Defining Pakistani culture is problematic because it is derived from ethnicity and there are five numerically distinct ethnicities (geographically local to regions) and thus five major cultures that define people. Though they are distinct from each other, they have much in common and a society of shared traditions has been forged.

Pakistan has a patriarchal society (Jejeebhoy, 2001). This is evident by patrilineal descent, patrilocal residence and inheritance laws (Jejeebhoy, 2001; Winkvist & Akhtar, 2000). Men have much greater autonomy than women and have access to all types of resources and very few limitations on mobility whereas women live a more circumscribed life and play a dependent role (Khan, 1999; Mumtaz & Salway, 2007). This is in accordance with an honor code (*izzat*) (Khan, 1999). *Izzat* is a multifaceted concept and encompasses the reputation of a family, but most of it is concerned with ensuring and protecting women's virtue (Khan, 1999). *Izzat* prescribes *purdah*, which

literally translated means 'curtain' (direct application is conceptualized as the *burqa*), but in effect means segregation of the sexes with limited contact (Khan, 1999). Limitations on contact extend from not allowing girls to attend schools at all, to gender segregated schools, to separate 'women' compartments in theaters and trains, to limitations on mobility and autonomy. *Purdah* is also interpreted as a symbolic shelter that protects the honor of women (Papanek, 1971). The world outside the home is considered dangerous and women are perceived as vulnerable and in need of protection from unwanted advances from men (Mumtaz & Salway, 2005; Papanek, 1971). Women are viewed as dependents and their domain is their home while men are the providers, protectors and bread winners (Khan, 1999; Winkvist & Akhtar, 2000).

Besides ethnicity, class plays an important role in Pakistani society. Class has different meanings for rural and urban populations. In rural areas class depends on land ownership: the larger the land holding, the greater social and economic status (Hussain, 2005). However many land owning families are now diversifying with investments in industry and many maintain residences in urban areas also. On the other hand urban populations are more diverse and class stratification is complex. Urban populations cannot be simply divided along economic lines. Occupation, education and kinship also classify people (Hussain, 2005).

Family and kinship are a microcosm of Pakistani society (Gazdar, 2003). Extended families or kin, who may not be blood relations, are called '*biradari*'. *Biradaris* exist in all ethnic cultures in Pakistan, although they may be categorized as different tribes (*Yusufzai* or *Orakzai* in Pushtuns) in N.W.F.P, Baluchistan (*Marri*) and Sind (*Bhutto*), based on ancestral origin (*zats* or *quom* in Punjab; e.g, *Rajputs* or *Awans*) or

occupation (*Gujjar*, dairy farmers or *Arain*, farmers in Punjab) in others (Gazdar, 2003; Hussain, 2005). In most cases the last name or family name identifies a person's belonging to a certain group. For example Benazir Bhutto belonged to the Bhutto tribe of the Sind, a large land holding tribe.

Further social stratification is based on religious affiliation (Hussain, 2005). Although nearly 98% of the country's population is Muslim, religious affiliation is multilayered. *Sunnis* and *Shia* have branches with different ancestral origins such as *Sayeds* (also spelled as *Sayyid* or *Syed*), who claim to be direct descendents of the Prophet Muhammed (Peace be upon him), but may be *Shia* or *Sunni* (Hussain, 2005). Although these *biradari's* have very little influence in everyday life (especially in urban settings) they are especially important in decisions regarding marriage and a definite preference is given to marriage within a *biradari* (Mumtaz & Salway, 2005).

3.4.2 Gender and Society

Large gender differences occur in nearly all aspects of Pakistani society: male to female ratio, educational attainment, employment opportunities and political participation. See Table 3.2 below.

Table 3.2 Women's Participation in Pakistan

	Men	Women
Sex Ratio	108	100
Literacy Rate	63%	32%
Labor Force Participation	84%	21%
Political Participation (total seats in National Assembly)	82%	18%

Source: www.Infopak.gov.pk (Retrieved March 20, 2008)(InfoPak, 2008).

Gender disparities in educational attainment are significant. Overall literacy rate (defined as the ability to read a newspaper in native language) is 63% for men and 39% for women. The gap is even wider when urban to rural rates are compared. The women's literacy rate is 35% in urban areas whereas it is 7% in rural areas; only 1.2% had earned a master's degree.

For the few women who do obtain higher education the gender divide is evident in the type of professional training undertaken by men and women. More women enroll in the fields of medicine (55%) and education (75%) than in engineering (2.8%) or agriculture (10%), since medicine and education are respected professions and acceptable for women (Elahi, 2006). These professions also fit in with the concept of *purdah* since contact will be limited to women (women mostly specialize in obstetrics and pediatrics and teach at girl's institutions), and they are not in competition with their male counterparts (Papanek, 1971). Since the home is considered a woman's domain there are 'Home Economics' colleges exclusively for women to prepare them for their roles as housewives.

Even after completion of their training and education many women do not participate in the labor force. One reason for their low participation is the division of the labor market along gender lines, another is a mismatch between education/skills and job opportunities and most importantly marriage (Hayat, 2007). Marriage takes precedence over a career (Papanek, 1971).

Although commonalities exist Pakistani women are not a homogenous group; women's autonomy is a reflection of local culture and there are differences depending on ethnicity, region and class (Winkvist & Akhtar, 2000). Punjab is relatively more liberal than the other provinces (N.W.F.P or Sind and Baluchistan). Punjabi and *Mohajir* women, especially those living in urban areas, enjoy greater freedoms in autonomy, mobility and opportunity and a relatively higher percentage complete their education and many pursue careers (Mumtaz & Salway, 2005). Labor participation is greater for economically disadvantaged women in both rural and urban areas. However, because of their lack of education these women are generally employed in poor paying labor work such as domestic help or municipal cleaning in urban areas (Papanek, 1971). The overall consensus is that a woman's place is her home and working outside their home may damage their 'reputation' and 'prestige' (Papanek, 1971).

3.4.2.1 Gender roles. Pakistan has a patriarchal society. Men have greater authority in most spheres of life and women play a dependent role. This dependent role is fostered by limiting women's autonomy. Limitations on autonomy are defined by *purdah* and *izzat* and implemented by patriarchy making women socially and economically dependent on men. Jejeebhoy and Sathar studied a sample of Pakistani Punjabi women in 2001 and found that Pakistani women have limited authority over most of the family's

decisions such as choice in marriage, economic decisions and even seeking healthcare. Very few women choose their partner and matches are generally arranged by family members (Jejeebhoy, 2001). Their autonomy is particularly limited when it comes to economic decisions. Most only participate in minor economic decisions such as food purchase (51%) or purchase of other low ticket items. However 59% of their sample reported a say in their household spending and 70% said that they got pocket money; older women (those who had been married longer) had greater input in household affairs. Since men are in control of finances women depend on their male family members to decide when they can seek healthcare (Shaikh & Hatcher, 2005b).

Jejeebhoy and Sathar (2001) also found that Pakistani women had limited freedom of movement. They assessed the freedom of these women to travel unaccompanied to various places. They found that 57% could visit a friend's house alone, 35% could go shopping alone and 27% could visit a health center by themselves. Freedom of movement is moderated by age and marital status since unmarried young women had more restricted mobility than married and older women (Khan, 1999; Shaikh & Hatcher, 2005b).

Mobility is also influenced by locality and social status; more pronounced in rural than in urban areas. Social status is a measure of *izzat* you have in society hence the greater the social status in rural areas the greater limitations on women's mobility (Khan, 1999).

3.5 Healthcare System and Utilization

The healthcare system in Pakistan is comprised of public and private, and formal and informal systems. The government spends only 0.8% of their annual budget on provision of healthcare (Bangladesh spends 1.2% and Sri Lanka, 1.4%) (Shaikh & Hatcher, 2005b). The public system is composed of hospitals, basic health units, rural health centers, maternal child health centers and dispensaries (Ghaffar, Kazi, & Salman, 2000; Shaikh & Hatcher, 2005b). However, due to economic reasons there is a severe shortage of supplies and manpower. The private sector has taken up where the public system leaves, but since they operate on a profit, they are located in urban affluent areas and are quite expensive (Shaikh & Hatcher, 2005b). Nearly 76% of the money spent on healthcare comes out-of-pocket from private consumers (Shaikh & Hatcher, 2005b).

The public and private sectors are composed of formal and informal healthcare providers (Ghaffar, Kazi, & Salman, 2000; Shaikh & Hatcher, 2005b). The formal systems are composed of trained professionals such as physicians, surgeons and nurses (Ghaffar, et al., 2000; Shaikh & Hatcher, 2005b). The public system supports and trains an informal network of Lady Health Workers, who operate at the community level. These are mostly local women (some of whom were formerly traditional birth attendants) and offer maternal and childcare advice and referrals to trained healthcare providers.

The informal private sector is comprised of a very diverse group of healthcare providers. These include traditional birth attendants (*Dais*), homeopaths, *hakeems*, traditional/spiritual healers (*pir*, *faqeer*), *Unani* (Greco-Arab philosophy) practitioners, bone setters (*pehelwans*) and quacks (Ghaffar, et al., 2000; Shaikh & Hatcher, 2005b). Their utilization is rooted in cultural beliefs about specific illnesses, such as epilepsy, which is thought by some to be caused by paranormal forces (Shaikh & Hatcher, 2005a).

Other conditions for which informal providers may be sought include infertility and depression (Shaikh & Hatcher, 2005a). Although in some cases their training may not be formal (dais, traditional healers, bone setters), alternative providers play an important role in healthcare. In rural areas nearly 90% of deliveries are carried out by *dais*; nationwide 31% of all deliveries are attended by a trained professional (Shaikh & Hatcher, 2005b).

Alternative medical therapy is preferred and practiced by many. Homeopathy and *Unani* medicine are based on formal philosophies and there are institutions that offer training (Kazlev, 2004). *Unani* medicine and *Hikmat* are used interchangeably and *hakeems* are practitioners of the medicine (Kazlev, 2004).

Although there is a vast health network and a variety of providers exist, utilization is dependant on other less tangible factors (Shaikh & Hatcher, 2005b). These include cultural beliefs, socio-demographic status, women's autonomy, economic circumstances, accessibility issues and perception of service at healthcare facilities (Shaikh & Hatcher, 2005b). A brief review of how these factors influence issues related to women are presented below.

3.6 Pakistanis and Issues Related to Reproduction

3.6.1 Marriage

Arranged marriages are the norm, although some individuals are choosing their own partners (Khan, 1999; Shaw, 2001). Families prefer marriage among relatives or *biradari*, and it is not unusual for immigrants in other countries to arrange marriages for their children in Pakistan (Hussain, 2005; Jejeebhoy, 2001; Shaw, 2001). After marriage, sons may live in their parent's house with their wives. In many cases extended families (father's brothers and parents) may live together.

3.6.2 Role of Family

Although men play a central role in all decision making, it is women, especially the older female members of the household, who take charge when it comes to issues related to the social, cultural and medical aspects of reproduction (T. Ali, Ali, Waheed, & Memon, 2006; Shaikh & Hatcher, 2005b). Mothers or older sisters often act as match-makers and provide information (menstruation and sex related) before marriage. The mother-in-law, mother, sisters, or all of them, provide the bulk of information regarding health after marriage. This may range from advice on contraception (Kadir, Fikree, Khan, & Sajan, 2003) to home remedies for infertility to recommending a specific traditional informal provider (*spiritual* or *Unani*) (Bhatti, Fikree, & Khan, 1999). The role of the women in both households (parents' and in-laws) is that of providing support once the woman is pregnant. Support maybe physical help, taking over of chores, pampering or logistical support such as accompanying the pregnant woman for prenatal check ups.

There is greater preference for female physicians. Even though women may visit male physicians for general complaints female physicians are preferred when obstetric or gynecological care is sought. In most cases they are almost always accompanied by a family member. The mother or mother-in-law attends the birth of the grand child, however the father is not allowed inside the delivery room (Fisher, 2003). Men are not allowed near labor rooms because there are other women delivering and it is socially unacceptable to compromise their *purdah*.

3.6.3 Sex, Contraception and Conception

Pakistani women and men do not receive any formal education on sexual health, sex or pregnancy (T. Ali, et al., 2006); it is assumed that they will learn when the time comes and ignorance is equated with chastity. In a sample of 106 girls aged 10-19 years Ali, Ali, Memon and Waheed (2006) found that 98% received information regarding reproduction from their mothers. Although 80% of the participants associated menstruation with motherhood, 44% reported that they were shocked, 30% were fearful and 18% were stressed by their first menstrual cycle, since they had no prior knowledge about menstruation. Most of the girls felt shy about discussing menstruation and their bodies. A majority did not have any information about sexually transmitted diseases or self examination of the breast. Any open discussion of sexuality is considered inappropriate and parents fear that this may imply approval of premarital activity (Bott, 2003). Bott and Jejeebhoy (2003) found that mothers themselves do not have sufficient knowledge.

Most women and men have scant knowledge about contraception and the birth of a child is considered the culmination of the marriage (Fisher, 2003). As a result the first child is usually born within or after the first year of marriage and contraception is not practiced until after its arrival (Fisher, 2003). Being a mother is considered an honor (a higher honor than being a father) and a common saying depicts the honor as 'heaven lies under a mother's feet' (Bhatti, et al., 1999). Pregnancy is highly valued and celebrated, but most of the time it is kept secret until an advanced stage to give privacy to women and/or avoid feelings of embarrassment as pregnancy is associated with coitus (Mead, 1967b).

3.6.4 Infertility

Infertility causes great distress in women, especially in Pakistan's patriarchal society where a woman's role is based on her reproductive ability (Bhatti, et al., 1999). If a couple is childless after two or more years or even much earlier, relatives often refer them to infertility specialists (Fisher, 2003; Sami & Ali, 2006). Family pressure, especially from mothers-in-law, can be intense and drive women to seek help from gynecologists, local traditional healers or traditional birth attendants (Bhatti, et al., 1999). Usually the women feel that they are responsible for not conceiving and they may submit to a battery of tests, while the men generally do not provide a sample for even a simple sperm count (Bhatti, et al., 1999).

A childless marriage is a legitimate reason for divorce or second marriage and the family plays an important role in these healthcare decisions (Bhatti, et al., 1999; Fisher, 2003). The family may seek help from both formal and informal providers. Sami and Ali (2006) found that educational status predicted the provider selected since women of low educational and socio-economic background were more likely to seek help from spiritual healers, *hakeems* and *dais*. Bhatti et al. (1999) found that women went to extreme lengths to conceive, including blood tests, hystero-salpingograms (physicians), massages with poultices (*dais*) and *taweez* (amulet with Quranic verses) or *dum* (Quranic verses recited over some water or food to be eaten) by the local *pir* (spiritual healer). Women also sometimes believed that infertility was due to black magic (*kaala jadoo*) or *saaya* (possession by a spirit) and they may visit many *pirs* in order to be rid of the *jadoo* or *saaya* (Bhatti, et al., 1999).

3.6.5 Gender Preference

The gender of the baby is very significant in South Asian cultures. Boys are generally preferred over girls (Choudhry, 1997; Hussain, Fikree, & Berendes, 2000). Even though more men exist than women, boys are still preferred. According to Choudhry a common blessing bestowed on newly married women in Pakistan is “May you bathe in milk and bloom among sons” (milk = motherhood, and sons = prosperity) (1997, pg. 534). Boys are preferred over girls for a number of reasons. These include carrying on of the family name, economic help when they grow up and support in old age (Hussain, Fikree, & Berendes, 2000). Girls on the other hand are an economic burden because they will need dowries when they are married (Hussain, et al., 2000; Winkvist & Akhtar, 2000). Hussain et al. (2000) found that having more boys had a direct effect on increased use of contraception by both men and women. Gender preference extends to other realms of family life such as food allocation and results in under nutrition in girls and a higher mortality rate in girls under the age of four.

3.6.6 Diet in Pregnancy

Diet and physical activities (or avoidance thereof) are prescribed by cultural norms during pregnancy or the post-partum period (Choudhry, 1997). Foods are attributed with specific effects (*taseer*) on the body. Foods may have *hot* or *cold taseers* and these are often taken into consideration when choosing what to eat. The terms *hot* and *cold* do not refer to the temperature of the food, but rather its innate properties when ingested (Beck, 1969; Choudhry, 1997). People can ascribe specific effects to diet such as hot foods cause pimples, early maturation in girls, rise in blood pressure and even diarrhea (Inam, 2003). Some of the food items considered hot include beef, mutton, chicken, organ meat, eggs,

dried fruits (almonds, dates, walnuts etc.), garlic, butter and spicy foods (Beck, 1969; Inam, 2003). Cold foods may cause coughs, colds and congestion (Inam, 2003). Cold foods include squashes and similar vegetables, bananas, oranges, ice, cold water and ice cream (Beck, 1969; Inam, 2003). There are also 'inert' foods that do not exhibit hot or cold properties and these include melons, watermelons, papaya, spinach, pumpkin etc (Inam, 2003). A majority of people agreed that *hot* and *cold* properties exist and impact health (Inam, 2003). Foods may be *hot* or *cold*, but they may also be *badi* or gas producing (N. S. Ali, Azam, & Noor, 2003; Inam, 2003). Foods that are *badi* include cabbage, cauliflower, rice and fried foods (Inam, 2003).

Foods may be prescribed or restricted during the course of various illnesses or conditions including pregnancy. Special diets are adhered to during pregnancy and after the birth of the baby. In many South Asian cultures pregnancy is considered a *hot* condition and foods with cooling properties are advised in the early phases of pregnancy, while foods with *hot* properties are encouraged towards the end to help with labor for a successful delivery (N. Ali, Azam, S. Noor, R., 2004; Chaudry, 1999). Women are encouraged to increase consumption of milk and fruits during pregnancy. After childbirth women are advised not to eat too many *cold* foods because these might cause a chill hence, women avoid buttermilk, yogurt, and oranges. As nursing mothers may pass the chill on to their infants they usually drink warm water and keep their heads covered to avoid catching a chill. Liberal amounts of chilies and garlic, which are *hot* foods, are recommended in their diets (Beck, 1969).

Pakistani women may fast if the month of Ramadan falls during their pregnancies (Robinson, 2005). Fasting has religious and spiritual value for these women and they do not consider the practice harmful to their unborn child (Robinson and Raisler, 2005).

3.6.7 Childbirth

Childbirth is fraught with danger in developing countries. This is due to a variety of reasons which include inadequate antenatal care, shortage of trained personnel and inadequate observation of antiseptic techniques (W.H.O, 2005). These result in high preventable neonatal mortality rates (35/10,000 in Pakistan) (W.H.O, 2005). In Pakistan availability of skilled antenatal care depends on where one lives and as a result there are significant health disparities between urban and rural areas. Although facilities exist in rural areas, there is a shortage of trained professionals to man them. Consequently nearly 80% of deliveries are carried out by *dais* or traditional birth attendants (W.H.O, 2005). *Dais* do not receive any formal training and the information is passed down from mother to daughter informally (Upvall, Sochael, & Gonsalves, 2002). Although they play a significant and much needed role in delivery of healthcare *dais* are not equipped or trained to handle the complications that lead to the high neonatal and maternal mortality rates (Upvall, et al., 2002). In contrast most urban women deliver in hospitals or maternity clinics (facilities that may be public or private and only deal with deliveries), although home deliveries are also common (Upvall, et al., 2002).

One of the common concerns related to childbirth is pain relief. Not much data is available on analgesia during home or hospital delivery. However in a hospital based study of an affluent urban population a majority of pregnant women were familiar with epidural analgesia, but very few availed it (Minhas, Kamal, Afshan, & Raheel, 2005).

Many of these women were concerned that anesthesia may undermine the babies' health and prolong labor (Minhas, et al., 2005).

3.6.8 Post-partum Period

Many eastern cultures regard the post-partum period as one of the most vulnerable times in a woman's life (Choudhry, 1997; Mead, 1967a). The parturient is considered weak and the period of recovery may last from thirty to forty days. The Chinese call it 'doing the month' (Leung, 2005). In Pakistan it is called *Chilla* meaning 6 weeks. The woman is fed a special diet that consists of nuts, wheat germ, milk and ghee (clarified butter) and other fortifying *hot* foods (Choudhry, 1997). Many superstitions surround this period. Most parturient women do not leave the house for fear of having the 'evil eye' or *nazar* cast on them. Women may refrain from doing anything strenuous. The *dai*, traditional birth attendant may come in every day and massage the woman (Choudhry, 1997). Drinking warm water and warm baths are recommended. The other women, in the parturient family, often take over household duties so she can rest.

Immigrant women incorporate their cultural beliefs into their pregnancy, childbirth and post-partum experience. The extent to which cultural beliefs are held onto by South Asian immigrants in the United States is not known, but there is a strong indication from the literature of retention of cultural and traditional beliefs by immigrants. Messias (2002) found that Brazilian immigrant women incorporate traditional practices into western health practices. Most immigrant Indian women in South Africa observe traditional customs, but do not adhere to them strictly, rather, they move between newly adopted western practices and old traditions (Chalmers and Meyer, 1993).

3.6.9 Newborn Care

Newborn care practices influence neonatal health outcomes. These include feeding the baby, cord care, immunizations and general care (bathing and such). Fikree et al. (2005), found that feeding practices were varied in Pakistan. Many (41%) started breast feeding right away. However, some started with *ghutti* (traditional, herbal paste) (5.1%), animal or formula milk (3%) and *kahwa* (green tea) (5.1%). Breast milk was the preferred feed (98%), but some neonates (8%) were fed other feeds and started on breast milk after 24 hours because colostrum was considered 'dirty'. Supplementary foods were common (71.3%) even in the neonatal period and included honey (28%), *ghutti* (27%) and water (11%). *Ghutti* was consistent with cultural tradition and was attributed with medicinal properties such as laxative and effects the reduction of colic. 4.6% were fed another supplement called gripe water (Fikree, Ali, Durocher, & Rahbar, 2005). Almost all (81%) newborns were bathed immediately after birth because mothers felt that the vernix was 'dirty' and should be removed as soon as possible. Massage was a common practice (89%) because it was believed that massage helps muscle relaxation and the building of stronger bones. Mustard oil (75%) was the preferred choice for massage. Olive oil, ghee (clarified butter) and baby oil were also used (Fikree, et al., 2005). Cord care included the use of antibiotic ointments (19%), mustard oil (51%) and antibiotic powder (21%) (Fikree, et al., 2005).

3.6.10 Religious Beliefs

Religion plays an important role in decisions related to birth and death in Pakistan. According to Islam, procreation is one of the main reasons for man's existence. Therefore, abortion is forbidden in Islam. Although contraception is not forbidden it is

not encouraged either (Ghazi, 1993; Iyer, 2002). As a result abortion is illegal in Pakistan, but contraception is not illegal (Ghazi, 1993). One of the issues relevant here, more so for immigrants to developed countries, is elective abortion when a baby is diagnosed with some congenital problems that may be incompatible with life or may be severe enough to warrant an abortion. Hewison et al. (2007) found that immigrant Pakistani women in the U.K take religion into consideration when making decisions pertaining to healthcare, but it does not dictate medical decision making (Hewison, et al., 2007).

3.6.11 Pregnancy Related Complications

3.6.11.1 Depression. Depression in pregnancy has been linked with poor birth outcomes. It may result in low antenatal attendance, low birth weight and preterm delivery. Although the prevalence of depression (pre and postnatal) cannot be assumed since symptoms are not routinely recorded, a high incidence was found in the following studies. In a rural population (Punjabi) Rahman et al. (2003) found a high incidence of prenatal (25%) and post natal (28%) depression (diagnosed with ICD-10 criteria)(Rahman, 2003). They found that economic hardship, marital problems and lack of support due to relationship difficulties with in-laws were significantly associated with depression. Depression was also associated with the number of young children women already had and the gender of the children, although having a boy after two or more girls did not protect women from post natal depression. Family and social support, especially during *chilla* (post-partum forty day period), and presence of mothers were significantly protective. In Lahore (second largest city in Pakistan) Niaz (2004), using the same criteria (ICD-10) found a similar (25%) incidence of prenatal depression, while a

significant number (34.5%) were diagnosed with a generalized anxiety disorder (Niaz, 2004). In another urban study in Karachi (the largest city in Pakistan) Kazi et al. (2006) found that social relations and pregnancy concerns were more predictive of depressive symptoms than social conditions (Kazi, et al., 2006). Interestingly Hussain et al. (2000), found a very higher prevalence of depression in non-pregnant women in a rural population (57%) (Husain, 2000). No data was available to assess prevalence of depression in Pakistani immigrant women.

3.6.11.2 Birth weight. Pakistan has a high rate of low birth weight and has associated higher rates of infant mortality (75 per 1000 live births) and perinatal mortality. According to a World Health Organization report only 63% of babies weighed more than 2500 grams at birth and the rest were either low birth weight or very low birth weight (birth weight less than 1500 grams). Another study estimated the rate of low birth weight at 25% (Bhutta, et al., 2004). A smaller community based study found a rate of 4% ($n=3315$) in an urban population, which is comparable to that seen in many developed countries (Naheed, 2000).

The incidence of low birth weight is high in Pakistani immigrant populations. There are sizeable populations of Pakistani immigrants in the United Kingdom and in a retrospective data analysis Margetts et al. (2002), found a low birth weight rate of 7% for first generation immigrants. The rate was even higher (11%) in the second generation (born and raised in the U.K). The study also found that the incidence of low birth weight was higher in girls as compared to boys (Margetts, Mohd Yusof, Al Dallal, & Jackson, 2002). In another study conducted in Norway, 7.5% of babies born to mothers of Pakistani descent were low birth weight (Vangen, et al., 2002).

3.6.11.3 Perinatal and neonatal mortality. Perinatal mortality is defined as any stillbirth or death of a live birth within the first week of life (W.H.O, 2005). Neonatal mortality rate is defined as the number of deaths within the first 28 days of life per 1000 live births (W.H.O, 2005). According to the W.H.O Pakistan had a neonatal mortality rate of 53 and a perinatal mortality rate of 59 (50% of which are stillbirths) as compared with the U.S. rates of 5 and 7 respectively. Pakistani immigrants in Norway also had a high (14.9%) perinatal mortality rate when compared to the general population (9.5%) (Vangen, et al., 2002). Proctor and Smith, 1992, found a higher incidence of perinatal mortality in immigrants of Pakistani descent in the United Kingdom (Proctor & Smith, 1992). Another U.K based study found a rate of 18.8% in Pakistani immigrants (higher than Indian and Bangladeshi immigrants to the U.K) and was even higher than the rate in Pakistan (Raleigh, Botting, & Balarajan, 1990). No data is available from the U.S. for comparison.

3.6.11.4 Gestational diabetes. Pregnancy is a diabetogenic state and unmanaged gestational diabetes can result in higher fetal and maternal complications and mortality (Jawad & Irshaduddin, 1996; Randhawa, Moin, & Shoaib, 2003). Jawad and Irshaduddin (1996) reported a 3.4 % prevalence rate in an urban Pakistani population, whereas Randhawa et al. (2003) reported a 4.4% prevalence rate in another urban sample. Akhter et al., (1996) also reported a rate of 3.4% which is comparable to western prevalence rates. However, the rates of complications were much higher because of poor glycemic control in pregnant Pakistani women.

Pakistani immigrant pregnant women are at a high risk of developing gestational diabetes. Pakistani immigrant women in Norway had a higher prevalence (9/1000 births)

of gestational diabetes than Norwegian women (3.6/1000 births) and higher rates of maternal and fetal complications (Vangen, et al., 2003; Vangen, Stoltenberg, & Stray-Pedersen, 1999).

3.7 Pakistani Immigrants in the United States

According to Census 2000, 204,309 people of Pakistani descent live in the United States. Pakistani immigrants have almost tripled in numbers since 1980. The fastest growth was seen in the Asian Indian category (which includes Pakistani immigrants), which increased by almost 38% (Barnes, 2002). The Census does not have a separate category for Pakistanis, but they can check the 'Other' category and then specify their origin. Based on the 2000 Census, salient features of the Pakistani immigrants were as follows:

- The median age for Pakistani immigrants was 28 (Reeves, 2004). They are younger than the native population (median age 36.4) with nearly 90% younger than 54 years of age and only 4% over the age of 65. This compares to the U. S population where this group comprises nearly 13% of the total population (ACS, 2006).
- 55% are male and 44.5% are female (ACS, 2006).
- 41% entered the U.S. during the 1990s, whereas 30.9% entered before 1990 (ACS, 2006).
- 57% of men and 43% of women were foreign born (Reeves, 2004) and 59% men and 40% women were naturalized citizens (ACS, 2006)
- 54% of Pakistanis had a bachelor's or higher degree (compared to 27% of U.S. population) (Reeves, 2004).
- 13.5% spoke only English. 30% reported being able to speak English 'very well', and 86% reported being able to speak another language (ACS, 2006).
- Nearly 62% of Pakistani immigrants were married (ACS, 2006).

- 77% of Pakistani men participated in the labor force (Reeves, 2004).
- Nearly 42% of Pakistani women participated in the labor force (ACS, 2006).
- 39% Pakistani men were employed in managerial and other professional jobs. Sales and office related jobs accounted for the second highest percentage of employment for Pakistanis (30%).
- Their median household income was \$59,306 in 2000 (higher than the median income of U.S. population of \$48,451) (ACS, 2006).
- The poverty rate was higher (14%) in Pakistani immigrants than the total U.S. population (9.8%) (ACS, 2006).
- Housing, owner occupied and rental is equally distributed at 50% each (ACS, 2006)
- Nearly half of the Pakistani immigrants live in the New York/New Jersey, Houston, Chicago, Washington D.C and Los Angeles metropolitan areas.

CHAPTER 4

RESEARCH DESIGN

4.1 A Qualitative Paradigm

The study was an exploration of Pakistani immigrant women's experience of pregnancy, childbirth and post-partum in the U.S. It explored cultural and socio-economic changes after immigration, and how these immigrant women had adapted to this new socio-cultural environment, particularly during pregnancy, childbirth and post-partum period. The study employed a qualitative paradigm.

Qualitative research is a naturalistic approach (Denzin & Lincoln, 1998; Strauss & Corbin, 1998). It is based on a subjective, interpretive and reflexive perspective (Strauss & Corbin, 1998). These methods are used to gain insight into peoples' attitudes, behaviors, culture, values and aspirations to name a few from a vast array of human phenomena. The choice of qualitative methods was determined by the research questions, they were supported by literature review, and validated by a pilot study. Research questions pertained to the perceptions and experience of women and qualitative methods were best suited to understand such an experience. Literature review highlighted the need for research in this area, as not much is known about this immigrant population, hence it lent to a qualitative methodology. Therefore, a Grounded Theory approach was used. This combined aspects of observation and interviews to elucidate experience and Grounded Theory methods were also utilized to analyze interview data.

4.1.1 Pilot Study

In order to understand the role of culture in health outcomes in immigrant Pakistani women, a pilot study was conducted to explore the role of culture in health outcomes in Pakistani immigrant women in the U.S. A qualitative approach was adopted since this paradigm suited this exploratory study. Therefore, methods of detailed interviews and observation were employed. A sample of six women was identified by key informants in the community. I gained entrée through informal groups of women teaching the Quran to neighborhood Pakistani immigrant children and the local mosque. The key informant at the local mosque helped identify women who fit my inclusion criteria. After these women agreed to participate in the study, an interview date and time was scheduled. The interviews took place at the subject's residence. They lasted from ninety minutes to more than two hours. In most cases two or three trips were made and several phone calls were also made if some part of the interview needed further detail. The interviews were audio taped and participants were free to use Urdu or English. Interviews in Urdu were later translated and transcribed into English. The participant was asked to narrate her experiences of pregnancy, childbirth and post-partum in Pakistan and in the U.S. A list of questions was also at hand if the subject needed prompting. Observations were made in the participants' homes. I visited them at different times of day and spent some time with their families. The study was completed in six months.

The pilot study highlighted the importance of culture in pregnancy, childbirth and post-partum period. It also helped provide a focus for the study and facilitated the development of a conceptual framework that evolved from data analysis. Data were analyzed using the grounded theory approach. The analysis led to the concepts of social capital and adaptation. It emphasized the importance of culture, cultural practices and

beliefs, but most importantly it elucidated that for Pakistani immigrant women going through pregnancy, childbirth and post-partum periods social capital was embedded in their culture and cultural practices. It was revealed that, for these women, the social and cultural context was very important as a determinant of their perception of well being during this time.

The pilot study also validated the qualitative approach to data collection and analysis for the dissertation research. However, for a more comprehensive picture of Pakistani immigrants living in New Jersey, a quantitative analysis of Census 2000 data and a tour of the participants' neighborhood were also included for the dissertation research. Census data analysis was conducted to help identify neighborhoods with high Pakistani immigrant density in New Jersey and to explore their demographic characteristics. Tours of these neighborhoods were undertaken to describe their living environments and explored everyday life such as going shopping or bringing children to their schools.

4.1.2 Method

- In-depth analysis of data from the 2000 U.S. census on Pakistani immigrants living in New Jersey to obtain demographic information.
- A detailed description of the urban (Jersey City) and suburban towns identified as having sizeable populations of Pakistani immigrants by census analysis and interview data.
- In-depth interviews of 26 women, from Jersey City and from suburban towns in New Jersey.

4.1.2.1 Analysis of Census 2000. A detailed analysis of the 2000 Census was conducted. Census data is available to the public online at the census website. Data are available as summary files. Code books are also available to facilitate analyses. Data

were downloaded and analyzed to get a demographic profile of the Pakistani immigrant population living in New Jersey. SAS (Statistical Analysis Software) was employed to analyze the data. Pertinent files were identified in the data with the help of the code books and were extracted using SAS.

Census data are aggregated data and presented in four summary files. The files differed by level of detail. Summary file 1 and 2 contained 100% data collected on all the population. It covered data to the block and census tract levels. Summary file 4 presented only a sample of the population and contained more detailed data, but did not provide data on geographic areas with population less than 100 to protect privacy. Summary file 3 contained data on socio-economic, housing and household characteristics from the long form of the census.

Census data thus analyzed provided a demographic snapshot of the Pakistani immigrant population in New Jersey in 2000. Variables that were researched included largest population concentrations, socio-economic variables such as median income, home ownership and educational background, household characteristics such as family type and size, marital status and the number of children in each household.

4.1.2.2 Description of urban and suburban Pakistani immigrant communities.

Analysis of the Census 2000 data helped identify areas in New Jersey with the largest concentrations of Pakistani immigrants. Tours of urban and suburban towns, thus identified, were conducted to describe the environments. Interview data (below) also helped identify where Pakistani immigrants shopped, visited local mosques or community centers and worked. These tours helped enrich both the interview and census data. They allowed a glimpse of everyday life experiences of immigrant Pakistani women. Pertinent photographs were also taken.

4.1.2.3 Grounded Theory. Grounded Theory method was developed by Glaser and Strauss in 1967. It is an iterative and inductive process where theory emerges from the data or it is grounded in data. Theory is derived from the phenomenon that is being studied.

4.1.2.3.1 Target sample. Grounded Theory is an inductive method and is driven by data. Themes or categories and sub categories were indentified (description) and coded by analysis (conceptual ordering). A time was reached when no new categories or patterns emerged that could further expound the phenomenon under study. This was the point of saturation and a sample size was determined.

Sample Size Sample size was determined when the point of saturation was reached. It was determined by the researcher when that point was reached and was guided by the guidelines suggested by Strauss and Corbin (1998, p. 212):

- No new or relevant data seemed to emerge regarding a category
- The category was well developed in terms of its properties and dimensions and demonstrated variation
- The relationships among categories were well established and validated.

Target sample Theoretical sampling was employed. According to Corbin and Strauss (1998) it is best suited to the Grounded Theory method that the sample comprises subjects who have experienced the phenomenon under study. They are considered experts in that particular phenomenon and hence the data will be most informative. Thus the target sample was theoretical and was also subject to inclusion criteria (below). Such samples are helpful studies where cultural phenomena are being explored (Bernard,

2002). The participants in this research were identified by key informants who resided in the same neighborhood as the participants and were known to these women and the researcher. The subjects were recruited from Jersey City, NJ and suburban New Jersey towns.

Instrument The researcher was the instrument in this study. Her knowledge was derived from two sources; a literature review and her experience as a Pakistani immigrant woman. Her background as an immigrant, mother and physician and, shared language placed her in a unique situation to establish rapport with the participants. The researcher had an understanding of their shared culture, social values, pregnancy and childbirth experience and, had worked in obstetrics.

4.1.2.3.2 Inclusion criteria. To be interviewed these women had to be immigrants of Pakistani descent and had to have delivered at least one child in the U.S. and or in Pakistan.

4.1.2.3.3 Procedure, recording and transcription of data. After obtaining verbal consents, these women were provided a letter of consent approved by the Institutional Review Board of UMDNJ. The interviews took place in the participants' homes at a time convenient to them. Some lasted up to two hours and were sometimes completed in two sittings. Several telephone conversations also took place, if some point needed further exploration. The interviews were audio recorded with the participants' consent. Audio recording is a reliable method for interviewing (Bernard, 2002). It helped in providing an opportunity for the researcher to observe the interviewees and not have to rely on memory alone while later making field notes. Sometimes taking extensive notes during the interview may be distracting for the interviewee and at other times audio recording

may also be distracting (Bernard, 2002). Therefore, the choice was left to the interviewee. None of the women had any objections to being audio recorded. Choice of language was open to the participants. Most used Urdu (a native language of Pakistan), but there was a lot of English interspersed within the conversation. Later in the day detailed field notes were also made about the visit, the home and environment of the interviewee and other observations about the interview.

The study employed methods of interviews and observation to gather data on Pakistani immigrant women. The sample of women was identified by initial visits to the local mosques that also serve as community centers and informal gatherings where women teach children the Quran. The women were referred by an informant in both situations. Later study participants also referred other women. After an informal introduction by the informant I exchanged telephone numbers with the subjects. A few days later I called them and explained the study and if they were willing I set a time for an interview. All interviews took place at the subjects' homes. A letter of consent was given to the subjects explaining their role in the study, protection of their privacy and their right to withdraw if they deemed it necessary. The interviews were tape recorded and lasted anywhere from ninety minutes to more than two hours. In some cases a second visit was needed and many telephone conversations also took place. The interviews were conducted in *Urdu*, although many switched between Urdu and English. The interviews started out as conversations and I asked the subjects to narrate their experiences of pregnancy, childbirth and post-partum in Pakistan or the U.S. The interviews were later transcribed. I recorded detailed notes of my encounters with the subjects and transcribed those also.

After all interviews were transcribed data were analyzed using the grounded theory approach. Initially themes were coded manually. I also employed Envivo 7 to manage and code the data, but manual coding was the method of choice.

4.1.2.3.4 Interview questions. The following questions were used as a loose guide in the interviews. The questions were open-ended and were used as a guide to provide structure to the flow of the interview.

The participants were asked to recall their pregnancies.

Marriage and pregnancy related questions:

- Where were you born? What did your father do? Did your mother work? Your education?
- When did you get married? Was marriage arranged? How and when did you first find you were pregnant?
- How and when you first visited a healthcare provider (doctor or hospital)? Where and how did you obtain information on healthcare?
- Did you adhere to any special diet during and after pregnancy? What was different in the U.S.?
- Did you take any types of medications (traditional or western)?
- What was your pregnancy experience like?
- What was your childbirth experience? Did you get any pain relief?
- Where did you live during your pregnancy and post-partum?
- What was post your partum experience?

Family, friends, networks:

- What was your role in making healthcare decisions? Did your family play a role? And what was the role of your husband in making decisions pertaining to reproductive health?
- Did you have friends and family who helped during their pregnancies, childbirth and post-partum periods? Did any family member come from Pakistan for the delivery and post-partum period?
- What kind of help did the family provide?

Health, baby related questions:

- Did you worry or feel stressed? Any other pregnancy related condition? What did you do about it? How did you cope?
- What was the weight of the baby? Any baby problems?
- Do you believe in traditional beliefs surrounding pregnancy, childbirth and the post-partum period? Did you perform any special religious rituals? What was different in the U.S.? How did you feel about them?
- What is *ghutti*? Did you make special arrangements to feed it to your baby?
- Environment and place of residence related questions:
 - Why did you choose to live where you do?
 - Have you moved? Why?
 - What are the advantages or disadvantages of living in your neighborhoods?

4.1.2.3.5 Analyses. Grounded Theory method was employed to collect and analyze the data. Data collection and analyses were conducted simultaneously and theory began to take shape from the data and, developed and evolved as more data were analyzed (Strauss & Corbin, 1998). Data were collected using interviews, observations and field notes. As

data were collected and analyzed they were constantly compared with analyzed data in an iterative process.

As data were analyzed, constructs began emerging and led to concept development. An initial coding or open coding revealed variables describing certain phenomena. Variables were then categorized and labeled and a relation between them could be outlined. Later relationships between concepts were identified which led to generation of theory. The next step was axial coding where relationships between categories were subjected to a coding paradigm. Axial coding sought to identify causal relationships between categories and sub categories. As theory emerged it was constantly validated by the data.

4.2 Informed Consent and Ethical Considerations

The Institutional Review Board at UMDNJ reviewed the proposal and approved the study. The study has been reviewed annually by the UMDNJ IRB.

4.2.1 Informed Consent

The research was explained verbally and in detail and a copy of the consent was given to the participants. Consent had been translated into Urdu for those who were not fluent in English. The subjects were informed that the interviews were going to be audio taped and were asked if they felt comfortable with the interview being recorded. In the event that they had reservations, but still wanted to take part, notes could be taken. However, none of the participants had any objections to being audio-taped. They were also informed of their right to drop out of the study at any point, if they wanted to.

4.2.2 Confidentiality

Participants were assured of confidentiality. No questions of a sensitive nature such as immigration status or health history were asked. To protect the identity of the participants, once consent had been obtained, numeric identifiers were assigned and no names were used to link the data after collection was complete.

4.2.3 Audio Tapes

Since the interviews were to be audio taped, the subjects were informed of this before their consent. All the subjects were comfortable with this method. The tapes were stored in a secure room at the School of Nursing, locked in a cabinet. They were destroyed after transcription.

4.3 Validity

Since qualitative research is more subjective and interpretive, the canons of rigor applied to quantitative research are not meaningful when it comes to qualitative research (Strauss & Corbin, 1998). As such, the concepts of validity and reliability have been redefined by qualitative researchers to uphold rigor. Validity determines whether the research accurately measures what it set out to measure. Maxwell (1992) proposed 5 measures of validity in qualitative research. These include descriptive validity, interpretive validity, theoretical validity, generalizability and evaluative validity.

Descriptive validity The data must accurately reflect what the subject or participant said (Maxwell, 1992). This means that the transcription of the data must accurately reflect what the interviewee said. In order to ensure descriptive validity a second translator/transcriber (who shares the same culture and language) was asked to

transcribe two random taped interviews and then matched with the researcher's transcription. This ensured that the transcription and translation were accurate, and at the same time enabled the second transcriber to interpret data accuracy through hearing audible expressions on the tapes. The researcher also made note of the participant's demeanor, attitude and other emotions while the interview was being conducted to ensure accuracy of data when making field notes later.

Interpretive validity The accuracy with which the interpreter reports the participant's meaning (Maxwell, 1992). Field notes, voice on tape, observations of the researcher and a second transcriber ensured that the data were accurately interpreted. This was also aided by the researcher's shared culture and development of rapport with the participants.

Theoretical validity Does the theory offer an accurate explanation of the phenomenon under study?(Maxwell, 1992). Since theory emerges from data in Grounded Theory and is grounded in data, this method was most amenable to study this phenomenon. Secondly, in order to ensure theoretical validity the dissertation advisor reviewed conceptual ordering, categories, their relationships, diagrams and coding to verify emerging theory.

Generalizability The ability to apply the resulting theory universally (Maxwell, 1992). Since the emergent concepts and theory are based on the experience of a select group of people, generalizability will be limited and may only be applicable in a similar group. However, Maxwell (1992) proposes two levels of generalizability; abstract or external generalizability, and internal generalizability which is more specific to a

situation. The abstract theory is more of a holistic nature while specific theory may have limited applicability in similar specific situations. These will be addressed further in the discussion section.

Evaluative validity Assesses the evaluations drawn by the researcher (Maxwell, 1992). The research advisor reviewed the data independently to ensure evaluative validity.

4.4 Reliability

Reliability can be defined as the consistency of an instrument. It is the degree to which an instrument will measure the same phenomenon under similar circumstances. Since qualitative method is a naturalistic method and is based on insights, it will more likely yield similar results within a similar group with limited application universally or within a larger population: much like generalizability discussed above (Denzin & Lincoln, 1998). However, the ability to reproduce similar findings will enhance the credibility of the research. According to Strauss and Corbin (1998), research conducted within the same theoretical perspective of the original researcher, following similar methods of data collection and analysis other researchers should be able to come to a similar theoretical explanation of a phenomenon (Strauss & Corbin, 1998). According to Denzin and Lincoln (1998), researchers can ensure generalizability by varying the conditions of time and place while observations should be systematic and repeated, whereas in Grounded Theory methodology, this variety can be ensured by extensive theoretical sampling. As these variations are incorporated and analyzed, they contribute to the evolving theory, the emergent theory gains greater explanatory power.

In this research reliability issues were addressed by employing theoretical sampling. Participants were selected for their expertise on the subject under investigation: pregnancy, childbirth and post-partum experiences and their immigrant status. The sample included a range of immigrant women. Some of these women had immigrated in their childhoods and grew up in the U.S. Some had migrated in their adulthood having grown up in Pakistan. Some had married within their families, some marriages had been arranged while others had married by their own choice. Some experienced pregnancy both in Pakistan and the U.S., some only in the U.S. Some had their first child born in Pakistan, others in the U.S. Still others had gone back to Pakistan to deliver their second child. Some had large families in the U.S. while others had no family member in the U.S. Some of the families in the U.S. were in-laws, while in other instances it was their own parents. This method provided a wide range of experiences and very rich data that provided a great perspective.

4.5 Limitations

In this methodology, data analysis began with the first interview or first step in data collection. I took notes, made observations and analyzed the data constantly. According to Strauss and Corbin (1998) the researcher is 'immersed in data' and just as data is shaped by the researcher, the researcher is shaped by the data (Strauss & Corbin, 1998, p. 44). Maintaining a balance between objectivity and the required sensitivity became an issue because at times the narrative sounded very familiar. It felt as though someone else was narrating my own pregnancy and childbirth experiences. However, it also made me more sensitive to my participants' ethos and understood their experiences. By contrast, some women in my sample took it for granted that I would understand some things,

because of a shared culture, by saying “You know how it is...”, and would not elaborate. These women had to be gently prodded by using the list of questions I had created.

CHAPTER 5
THE PAKISTANI POPULATION IN NEW JERSEY

DEMOGRAPHICS

The first step of this research entailed a detailed analysis of the data provided by the census. A literature review had elucidated the need for more information on the Pakistani immigrant population and had highlighted differences between urban and suburban populations. A detailed analysis of the census data provided insights into where Pakistani immigrants lived, their employment status, income, information about their families and households. This demographic information provided a snapshot of the Pakistani immigrant population and a background for the research. This chapter is comprised of the findings of that analysis. Latest data were utilized hence census data collected in 2000 were used. Census data are public and available online. Data were downloaded and analyzed with the help of SAS (Statistical Analysis Software). This analysis provided a demographic profile of the Pakistani immigrant population living in New Jersey. It provided a cross section of the Pakistani immigrant community in New Jersey in 2000. Demographic characteristics included the age, residential location, residential status, immigrant status, employment status and other demographic variables. The data also indicated that certain areas of New Jersey had larger concentrations of Pakistani immigrants as compared to others. There were larger concentrations in some urban areas namely Jersey City and some suburban locations such as Edison and Woodbridge in Middlesex County. The chapter begins with a presentation of general demographic characteristics and in the second half it presents a comparison between Pakistani

immigrants living in urban and suburban areas and explores similarities and differences between the two communities.

Analysis of census data presented certain limitations when it came to different ethnic communities. There were limitations in the collection methodology, sampling, race reporting and the detail to which data were made available to the public. One of the limitations was the response rate since questionnaires were mailed to the public and relied on self reporting. The response rate was 67% for the census conducted in 2000 (Census, 2000). Although the 67% response rate was considered satisfactory, it should be noted that the response rate for different ethnic communities could not be measured and was not reported. Secondly, census data were collected using two forms; the long and short form. The short form was sent to all households (100%) identified with an address by the United States Postal Service while the long form was sent to limited number of households. In some urban areas that translated into 1 in every 8 households while in some rural areas it was 1 in 2 respondents (Census, 2000). Hence, there was a greater chance for ethnic urban communities to being under counted. Moreover, even though the reporting of race presented more detailed options in the 2000 census short form when compared to the 1990 census, it still depended on self report in case of immigrants from Pakistan. They had a choice of checking 'Other Asian' and then entering Pakistani manually. Data were extracted using specific SAS commands to search for data coded for people who had filled out the 'Other Asian' race box.

Another limitation was the extent to which detailed data were available to the public while protecting the privacy of the respondents. Summary Files 3 and 4 (based on the data from the long form) allowed access to data where the population count in a MCD

(Minor Civil Division) was higher than 100 people in a specific population group in a specific area which limited the data even further. Therefore the following analysis presents a cross section of the Pakistani immigrant population living in New Jersey in 2000.

5.1 Pakistani Immigrants in New Jersey

New Jersey is one of the most ethnically diverse states in the United States. In 2000 there were 12112 immigrants of Pakistani origin living in New Jersey (Census, 2001). This population was a relatively young one with nearly 40% of the population aged 20 or below. Immigrants were fairly evenly distributed by gender: 53% were male and 47% were female. Between the ages of 35 and 50 this distribution widened to 57% males and 43% females. The median age for men was 29 and 25 for women. The age groups were mapped as a pyramid below in Figure 5.1.

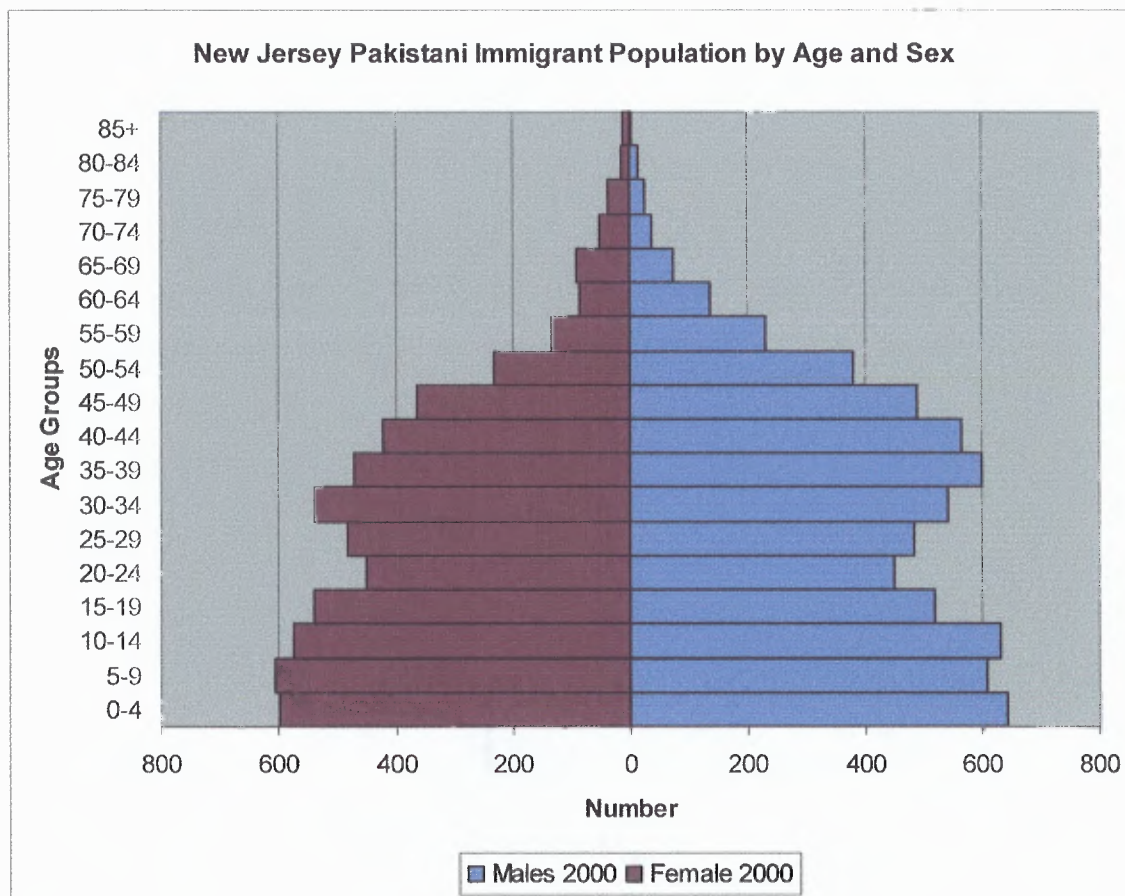


Figure 5.1 Population pyramid for Pakistani immigrants living in New Jersey in 2000 by age and sex.

Source : Census, 2001a, Census 2000 Summary File 2: 2000 Census of Population and Housing <http://www.census.gov/Press-Release/www/2001/sumfile2.html>, accessed February 25, 2008.

5.1.1 Family

In 2000 the Pakistani population was largely comprised of families. Nearly 70% of the population over the age of 15 years was married (67% men and 72% women). However some (13%) of these householders indicated that although they were married their spouses were not living with them (15% of men and 11% of women). Some (12%) reported that they were separated and a smaller proportion (2%) indicated that they were divorced. About 29% of the men and 22% of women age 15 and above were never married.

In 2000, there were 2866 Pakistani immigrant families living in New Jersey. The average family size was 4.5. Most families (65%) had children under the age of 18 residing in the same household. Since this was a predominantly young and married population, the largest proportion of these children was comprised by children under the age of 5. A small number (7%) of households had grandparents living in the same household(Census, 2001).

5.1.2 Education

A large proportion (39%) of the Pakistani immigrant population was going to school. Since this is a young population, 68% of those enrolled were in preschool thru grade 12, and 21% were attending colleges. More girls (81%) than boys (76%) were enrolled in school, but more men (23%) than women (18%) were enrolled in college.

The adult population was highly educated. A large proportion (42%) possessed a bachelor's degree and nearly 27% had graduate or professional degrees. Although more men (34%) than women (17%) had completed graduate or professional degrees, more women (45%) than men (41%) had a bachelor's degree. In contrast to these highly educated individuals some reported no schooling. Of these, more women (4%) than men (1%) reported no schooling.

5.1.3 Language

Most of the Pakistani population was bilingual or multi lingual. However, English proficiency was excellent and 64% said that they spoke English 'very well' while 23% said they could speak English 'well'. Only 10% reported that they did not speak English well, and 3% said that they did not speak any English.

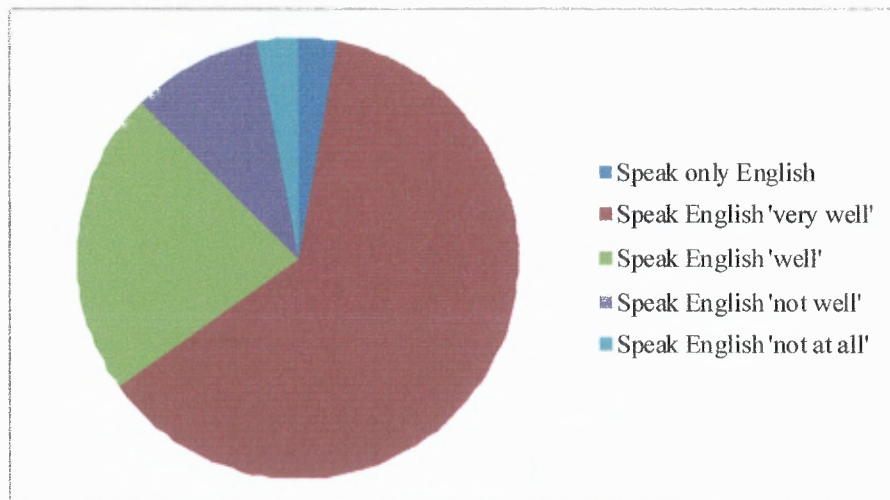


Figure 5.2 Language proficiency of the Pakistani immigrants in New Jersey in 2000.
 Source: Census. (2001b). Census 2000 Summary File 4 Census Department of Population and Housing,
<http://www.census.gov/Press-Release/www/2001/sumfile4.html>, accessed February 25, 2008.

5.1.4 Employment Status

The employment trends showed that the Pakistani immigrant population had a high employment rate and overall participation in the labor force was high. Nearly 95% men were employed and only 3% were unemployed (National unemployment rate was 6% for the same period). A large proportion (72%) of the population was more than 16 years old and eligible for employment. Of these 77% men and 38% women participated in the labor force, whereas 23% men and 59% women did not. Interestingly more (38%) of immigrant women participated in the labor force, much wider participation than their counterparts (21%) in Pakistan. No immigrant of Pakistani descent reported serving in the armed forces.

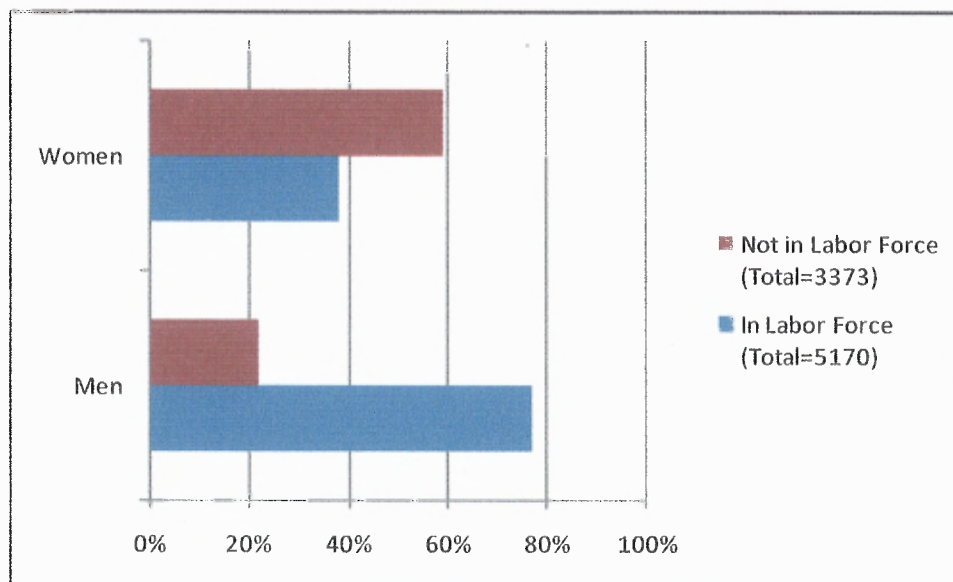


Figure 5.3 Labor participation of Pakistani immigrants in New Jersey in 2000.
 Source: Census. (2001b). Census 2000 Summary File 4 Census Department of Population and Housing, <http://www.census.gov/Press-Release/www/2001/sumfile4.html>, accessed February 25, 2008.

5.1.5 Occupation

Pakistani immigrants were employed in a variety of occupations (See Figure 5.3). A higher proportion of men (44%) served in managerial or other professional positions than in sales or office administration occupations (22%). Although 21% were involved in production or transportation occupations, only 8% were involved in service occupations such as protective services or food preparation. In the professional or managerial category most served as architects or engineers or as medical practitioners. No immigrant of Pakistani descent reported working on a farm or another farming related occupation.

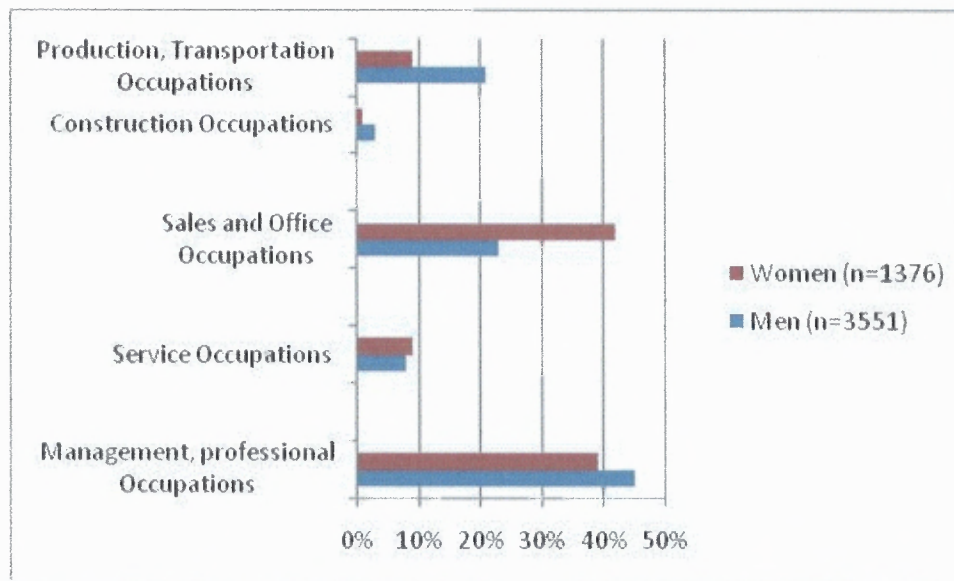


Figure 5.4 Occupations of the Pakistani immigrant population in New Jersey in 2000. Source: Census. (2001b). Census 2000 Summary File 4 Census Department of Population and Housing, <http://www.census.gov/Press-Release/www/2001/sumfile4.html>, accessed February 25, 2008.

There were some differences in employment based on gender. Although 39% women served in managerial or professional occupations more women (42%) were employed in the sales and office administration type occupations than men. In the professional category, there were more healthcare practitioners (39%) than architects or engineers (3%), and 16% of these were in education related professions. Another 9% were involved in service occupations such as healthcare support and food preparation.

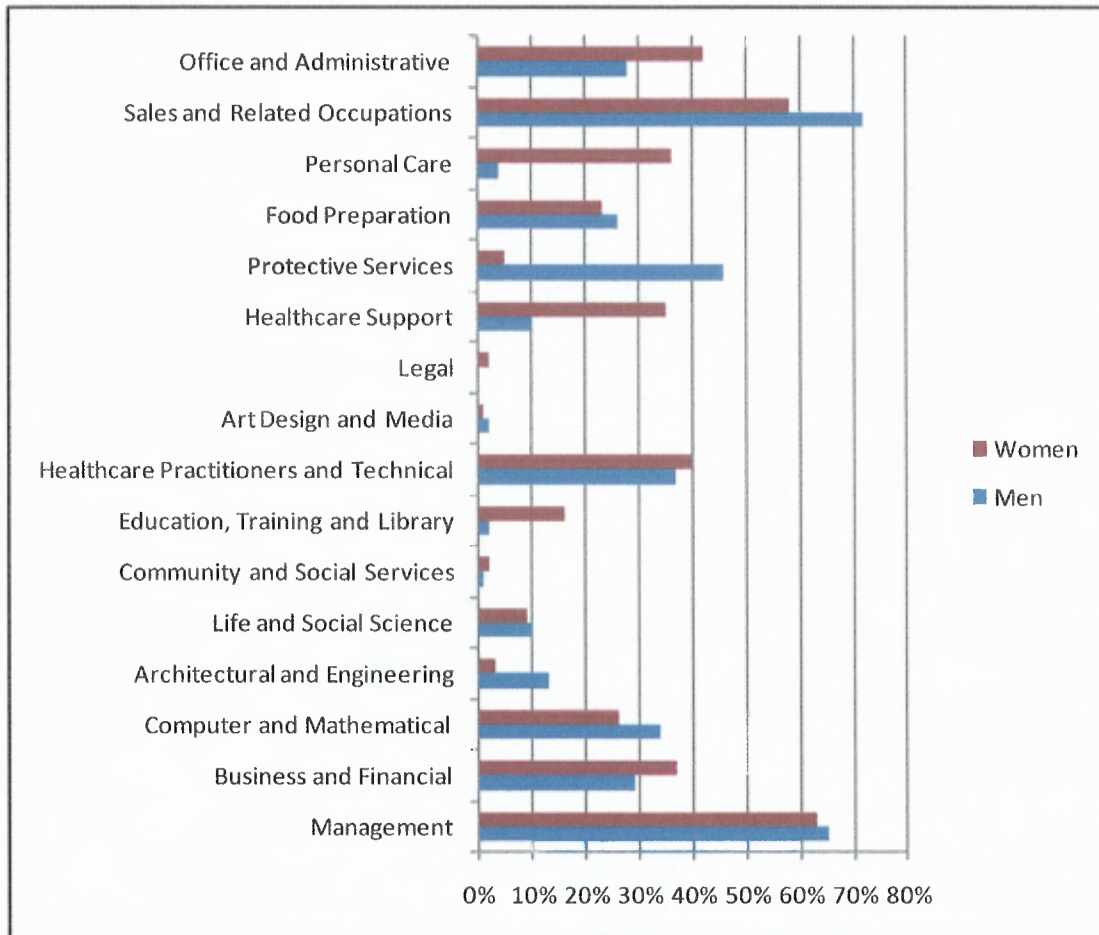


Figure 5.5 Gender differences in types of employment.

Source: Census. (2001b). Census 2000 Summary File 4 Census Department of Population and Housing, <http://www.census.gov/Press-Release/www/2001/sumfile4.html>, accessed February 25, 2008.

5.1.6 Household Income

Household incomes of Pakistani immigrants were comparable with the New Jersey average. The median household income of Pakistani immigrants was \$56,566 and the median income of New Jersey residents was \$53,118 in 1999, whereas the median income of the overall U.S. population was \$48,451.

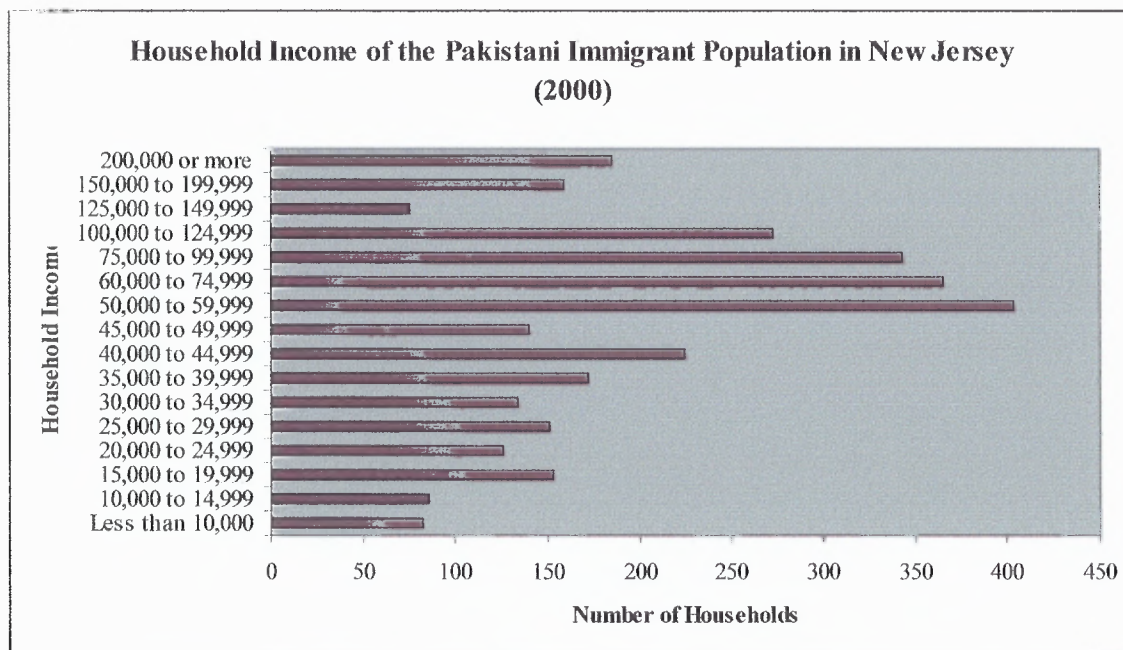


Figure 5.6 Household income of Pakistani immigrants in New Jersey in 1999.
Source: Census. (2001b). Census 2000 Summary File 4 Census Department of Population and Housing, <http://www.census.gov/Press-Release/www/2001/sumfile4.html>, accessed February 25, 2008.

Housing In 2000 nearly 47% of immigrants from Pakistan in New Jersey lived in homes that they owned. However, the number of immigrants living in rented houses was higher (53.3%). This was in contrast to the general housing trend in the United States where 67% of the population lived in homes that they owned and 33% rent them.

5.1.7 Immigration Status

All immigrants hope to become citizens of the United States one day. According to the census, 4313 of the responding Pakistani immigrants had naturalized and attained US citizenship. Hence, 35% of the Pakistani immigrants living in New Jersey were naturalized citizens in the year 2000. It was interesting to note that nearly all of the immigrants from the 1980 census had naturalized whereas only half of the immigrants enumerated by the census of 1990 and a third of the immigrants from 2000 had

naturalized. The trend suggested that earlier immigrants attained citizenship in ten years however immigrants who arrived after 1990 were taking much longer. The number of immigrants attaining citizenship had been almost similar every decade, but the number of those immigrating had increased. As a result, there was a larger proportion of immigrants who were not citizens. See following graph for more information.

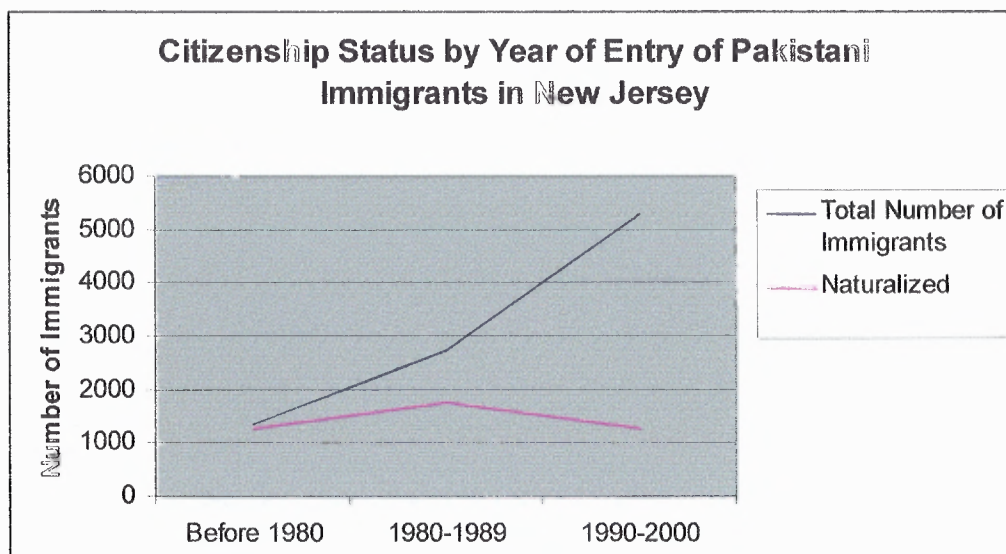


Figure 5.7 Citizenship by year of entry.

Source: Census. (2001b). Census 2000 Summary File 4 Census Department of Population and Housing, <http://www.census.gov/Press-Release/www/2001/sumfile4.html>, accessed February 25, 2008.

Data analysis also revealed that Pakistani immigrants were concentrated in certain parts of New Jersey. In the second half of this chapter demographic characteristics of Pakistani immigrants, living in various locations, were compared and data revealed some interesting similarities and contrasts. The following is the presentation of those data.

5.2 Pakistani Immigrant Population in New Jersey Counties

Pakistani immigrants lived in every county of New Jersey. However, some counties had a much higher concentration of Pakistani immigrants than others. In 2000, Middlesex, Hudson and Bergen counties had the highest numbers of Pakistani immigrants, whereas Cape May County had the smallest population. These counties also happened to be more densely populated than other New Jersey counties. It was not surprising since both Bergen and Hudson counties are located very close to New York City and Middlesex County has an excellent rail connection to New York also.

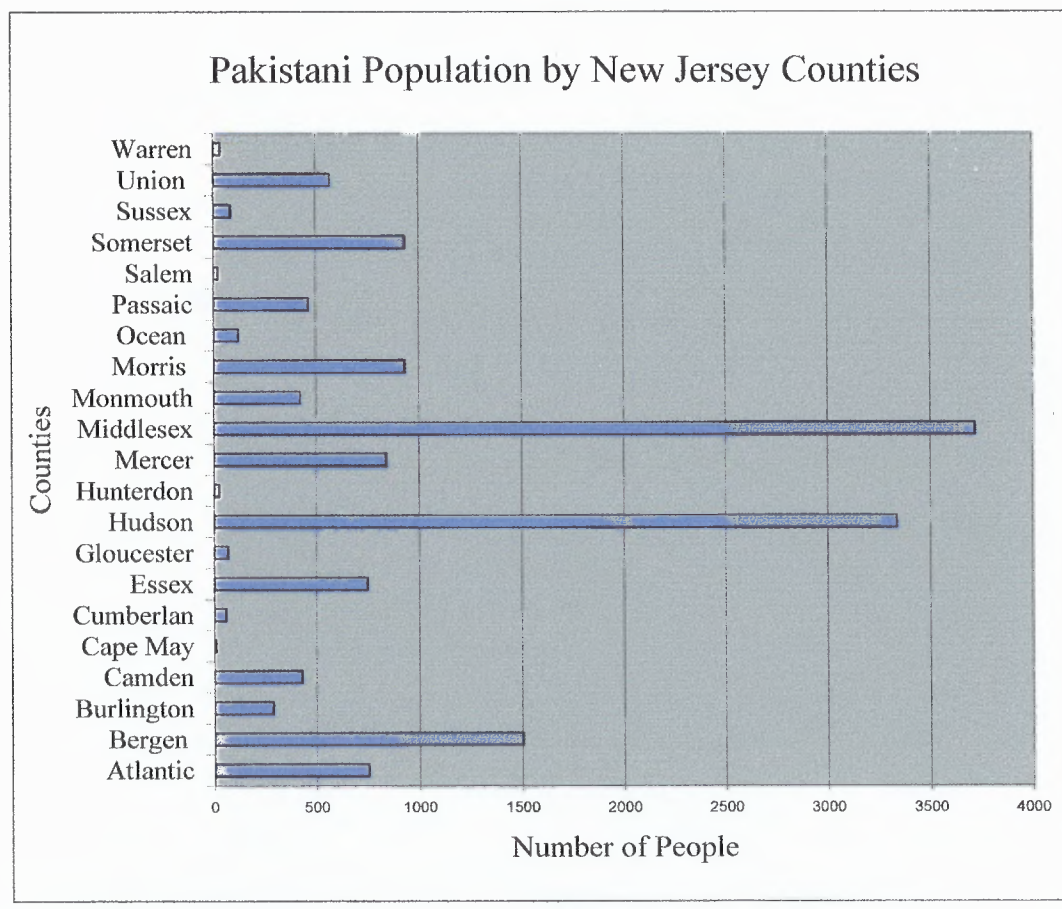


Figure 5.8 Pakistani population in New Jersey counties in 2000.
Source: Census, 2001a, Census 2000 Summary File 2: 2000 Census of Population and Housing
<http://www.census.gov/Press-Release/www/2001/sumfile2.html>, accessed February 25, 2008

5.3 Urban and Suburban Pakistani Immigrant Populations

Census data provided a wealth of information on the social and demographic characteristics of the Pakistani immigrant population. Following is an analysis of data provided by Census 2000 which compared and contrasted Pakistani immigrants who chose to live in urban and suburban areas and explored similarities and differences.

In 2000, Pakistani immigrants lived in all New Jersey counties. There were, however larger agglomerations in Middlesex, Hudson and Bergen counties. The largest number recorded in a single place was Jersey City in Hudson County (n=1878) this was followed by Edison (n=674), Woodbridge (n=526) and Old Bridge (n=467) in Middlesex County. For comparison between urban and suburban populations, Jersey City was selected to represent the urban population while Edison, Woodbridge and Old Bridge populations represented the suburban areas for comparison. However, the Census Bureau defines urban areas as those with population of more than 50,000 or core census block groups that have a population density of 1000 people per square mile. Interestingly Jersey City, Edison and Woodbridge all fall into the urban category by that definition. In fact most of northern New Jersey can be categorized as urban because New Jersey is so densely populated. Nevertheless the data suggested several differences in lifestyles between the locations that the census definition does not include or consider when defining urban and suburban locations. Figure 5.8 is a representation of the Pakistani immigrant density in northern New Jersey. The largest populations are concentrated in Hudson, Bergen and Middlesex Counties.

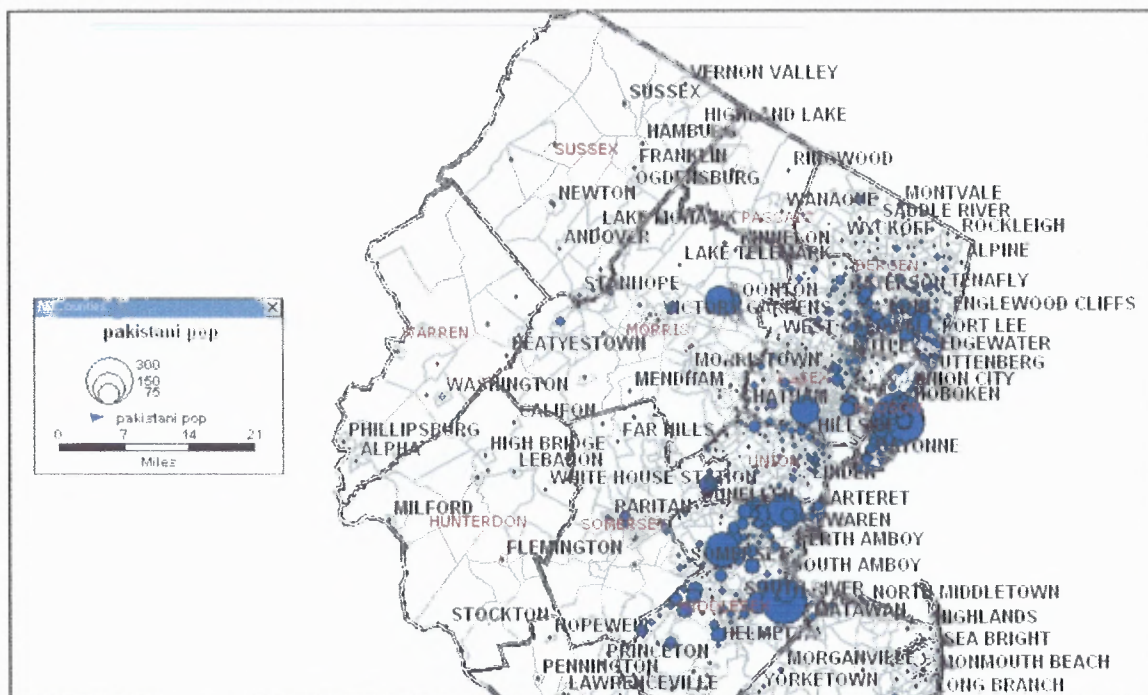


Figure 5.9 Population density of Pakistani immigrants in northern New Jersey
 Source: Census, 2001a, Census 2000 Summary File 2: 2000 Census of Population and Housing, <http://www.census.gov/Press-Release/www/2001/sumfile2.html>, accessed February 25, 2008.

Urban and suburban Pakistani immigrant populations shared some characteristics, but they were different in some aspects. Both were relatively young populations: The median ages were comparable at 27. However, the male to female ratio was higher in urban areas. More men (61%) than women (39%) lived in Jersey City as compared to the more evenly distributed population in suburban towns (49% men and 51% women). Household sizes were similar between the urban and suburban populations. However, the most significant difference was in household incomes. The median household income in the suburban populations was almost double that in Jersey City. Refer to Table 5.1.

Table 5.1 Urban and Suburban Immigrant Pakistani General Demographic Features

	Jersey City	Edison	Woodbridge	Old Bridge
Total Population	1878	674	526	467
Males	61%	53%	47%	49%
Females	39%	46%	53%	51%
Median Age	27.3	27	27	24.6
Household size	4.59	4.24	4.34	4.49
Median Income	\$37,171	\$68,295	\$51,944	\$66,750

Source: Census, 2001a, Census 2000 Summary File 2: 2000 Census of Population and Housing, <http://www.census.gov/Press-Release/www/2001/sumfile2.html>, accessed February 25, 2008.

5.3.1 Family Type

Pakistani immigrants lived in predominantly married couple households. Nearly 90% of the households in all locations reported that they were married couples and 10% were headed by single parents. Old Bridge had the largest (11%) number of the single parent households followed by Jersey City (8%), Edison (6%) and Woodbridge (5%). More single parent households were headed by males except in Woodbridge where a significantly larger number of families were headed by single women (60% of single parent households). This explained the large number of widows living in Woodbridge (10% of the total female population of Pakistanis in Woodbridge).

Most families had children. However, there were some differences in the ages of the children. More (70% or higher) suburban families reported having children who were younger than eighteen those living in Jersey City (64%). Although the ages of the responding population were comparable (see following section) hence, suburban couples may have delayed having children after marriage as compared with their urban counterparts.

5.3.2 Age

The age distribution of the urban and suburban populations was very similar. This was a young population and almost 76% of the population was below 40 years of age. Although the population was fairly evenly distributed by gender, there were more females than males especially under the age of twenty. The women were also slightly younger than the men.

5.3.3 Marital Status

A large proportion of both the urban and suburban Pakistani immigrant populations were married. Overall more suburban men (71%) than urban men were married (67%). The highest percentage of men who said they were never married lived in Old Bridge (34%). In Jersey City, 26% of currently married men were living alone (spouses absent). Although there were more single men in Jersey City, it was highly likely that they were married, but living alone. On the other hand a larger number of single men who had never married men lived in Old Bridge.

The characteristics of female urban and suburban populations appeared to be more similar, with comparable populations of urban and suburban women being single (never married) and married. The number of married women living alone was also comparable in urban and suburban women. However, a relatively large number (10%) of the Woodbridge women were widowed.

5.3.4 Educational Attainment

The Pakistani immigrant population was highly educated with a vast majority of both urban and suburban populations reporting a minimum of high school education. However, a greater majority of both suburban men and women had completed higher

education than the urban population. Although both men and women living in Jersey City had the highest number of people reporting a high school education (39.7% and 38.6% respectively), there were more men and women with bachelor's or master's degrees in the suburban towns.

Urban and suburban populations showed gender differences in educational attainment. A higher percentage of women (9.4%) reported no schooling, although the proportion was comparable for the urban and suburban populations. A similar percentage of men and women completed high school in both populations. However, more urban and suburban women (42.4% and 44.5% respectively) had completed some college, associate degree and bachelor's degrees than their male counterparts (38.2% and 39.8% respectively). On the other hand, more men (both urban and suburban) had completed a master's degree or professional schooling than women.

5.3.5 Employment Status

The employment rate among immigrant Pakistani men was high. Both urban and suburban populations reported more than 75% rate of employment. Quite a few of them worked through retirement age (urban: 82.7%, suburban: 90%). More suburban young men aged 16-19 years participated in the labor force than their urban counterparts (18% and 5.9% respectively). However, there were some differences among the suburban localities since most of the working 16-19 year olds lived in Old Bridge. Edison had the highest overall labor force participation rate (98%). Woodbridge was more comparable with Jersey City (74% and 75% respectively) while Old Bridge recorded an 83% rate.

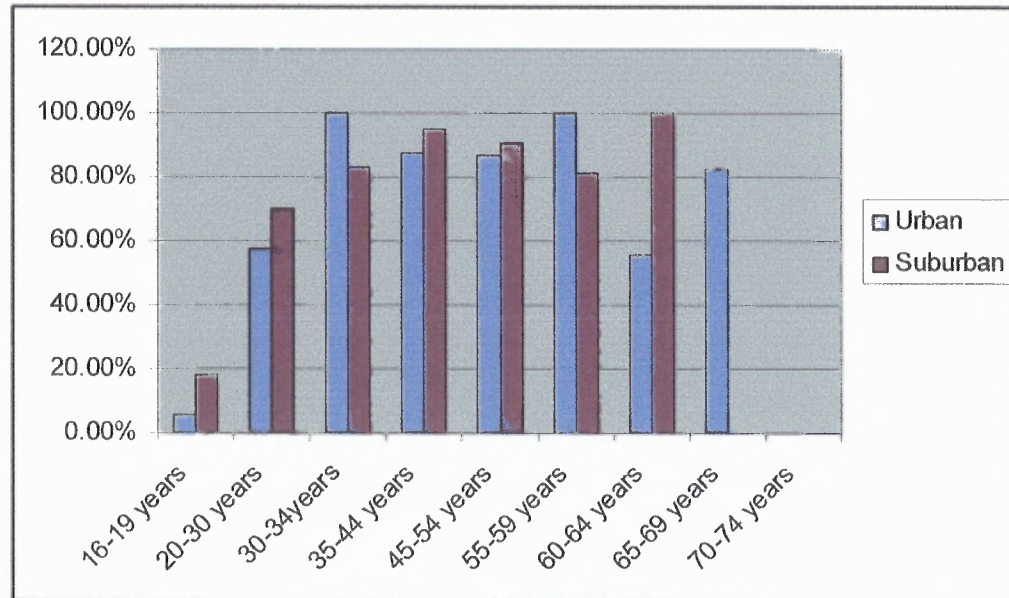


Figure 5.10 Labor force participation of immigrant Pakistani men.

Source: Census. (2001b). Census 2000 Summary File 4 Census Department of Population and Housing, <http://www.census.gov/Press-Release/www/2001/sumfile4.html>, accessed February 25, 2008.

The overall labor force participation rate for women was low. The urban and suburban difference was also striking. More suburban women worked than their urban counterparts (43% and 21% respectively) although more urban younger women (age group 20-30 years) than suburban were employed (44% and 31% respectively). However, more suburban older women participated in the labor force than their urban counterparts. The trend suggested that as suburban women grew older they found work outside their homes, whereas labor force participation rates fell as women grow older in the urban areas. The urban participation rates were more comparable to the labor force participation trends among women living in Pakistan.

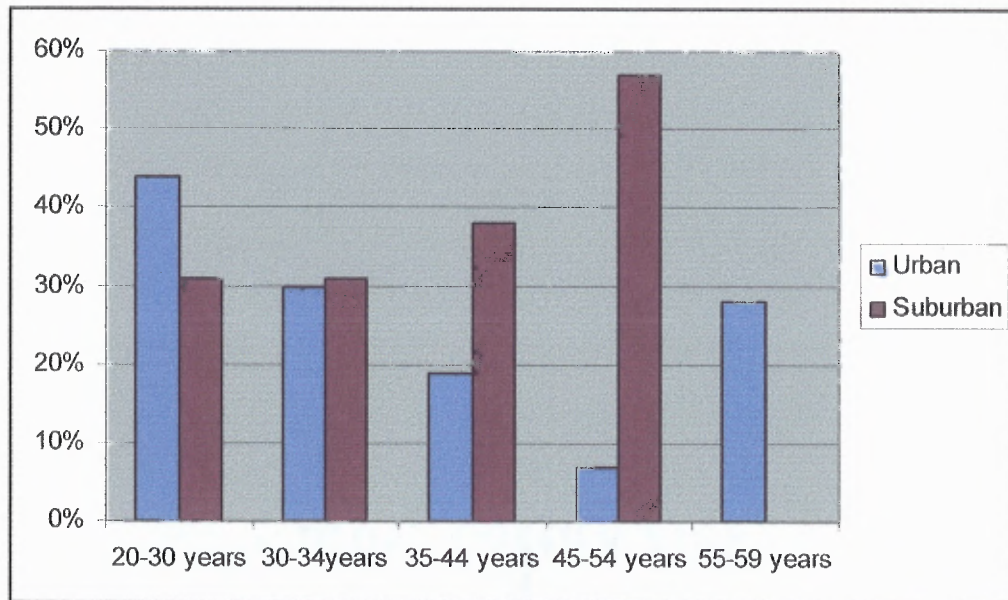


Figure 5.11 Labor force participation of Pakistani immigrant women.

Source: Census. (2001b). Census 2000 Summary File 4 Census Department of Population and Housing, <http://www.census.gov/Press-Release/www/2001/sumfile4.html>, accessed February 25, 2008.

5.3.6 Language Proficiency

Almost all these Pakistani immigrants could speak English. Although there were some minor urban and suburban differences in how they rated their fluency in English (51.7% urban and 62.9% suburban spoke English ‘very well’), an overwhelming majority of Pakistani immigrants spoke English well. It was also worth noting that almost all of them spoke another language (urban 92% and suburban 98%). Nearly 3% urban Pakistani immigrants said that they spoke no English at all.

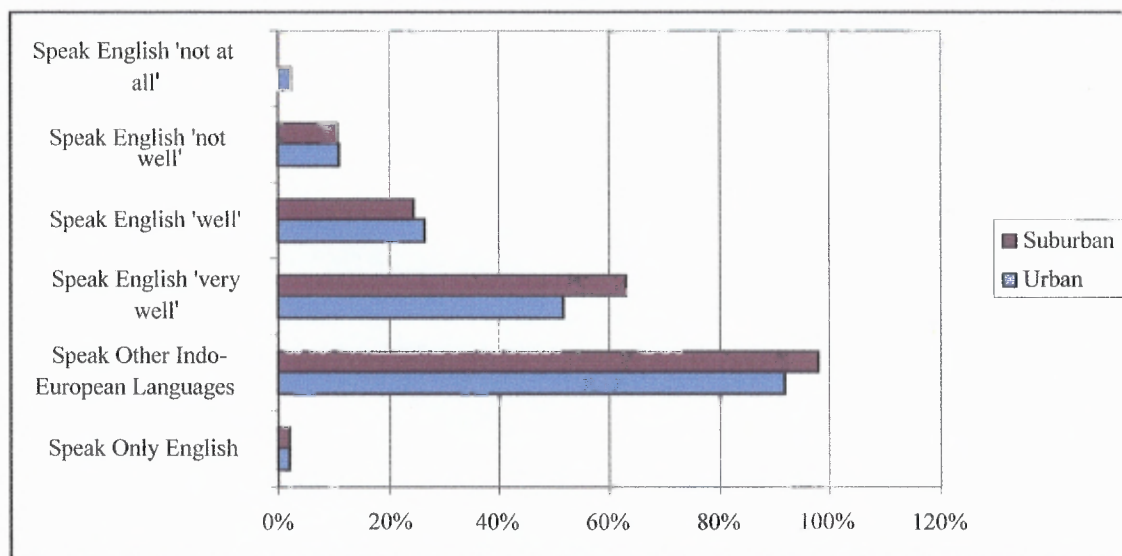


Figure 5.12 Pakistani immigrant's ability to speak English.

Source: Census. (2001b). Census 2000 Summary File 4 Census Department of Population and Housing, <http://www.census.gov/Press-Release/www/2001/sumfile4.html>, accessed February 25, 2008.

5.3.7 Place of Residence

The 2000 Census showed that the Pakistani Immigrant population had settled in various parts of New Jersey. However, several families reported that they had moved to or from other places. Some had moved to other states while some had moved to other locations within New Jersey. The suburban population (61.6%) had been more mobile than the urban immigrants (50%). While the suburban population moved from one suburban location to another, the urban immigrants displayed a preference to stay within the same city and county even when they did move to a new place (62%).

When Pakistani immigrants moved to another state, most (urban 88%, suburban 84%) moved to other northeastern states. However more suburban immigrants (13.4%) moved to the Midwest than urban immigrants (0%). The urban immigrants showed a preference to move to the southern states (11%).

5.3.8 Enrollment in College or Graduate Schools

Obtaining an education was important to Pakistani immigrants. Almost all school aged children were enrolled in school. However there were differences between urban and suburban families sending their children to college or in the pursuit of graduate education. More suburban (68%) college age (18-24 years) men were enrolled in college than their urban counterparts (47%), which meant that the chance of suburban boys attending college was 45% higher than urban boys. Interestingly college enrollment was higher in older urban men (ages 25-34=36% and ages 34 and above=16%) when compared to an age matched suburban population (26% and 6% respectively). This indicated that more adult urban men were going back to school for higher education than their suburban counterparts. However, more suburban men (29% had a master's degree) had reported completion of higher education than the urban men (13%). A similar number (urban:5%; suburban:4%) of urban and suburban college age (18-24) men were not enrolled in any college.

Urban and suburban differences in college enrollment were more pronounced in the immigrant women populations. Although the number of urban men (13%) and women (14%) enrolled in college was similar, the difference was wider between suburban men and women; more men (14%) than women (6.6%) were enrolled even though the population of women under 20 years was larger than the male population, both urban and suburban. Overall more 18- 24 year old women (urban:55% and suburban:78%) were enrolled in college when compared to their male counterparts (urban=47%, suburban=68%) which reflected the population numbers better. More older urban, age 25 and above, (18% and 19%) were obtaining higher education than suburban

women (15% and 7%) and the number of college aged (18-24 years) women not enrolled in college was higher in suburban women (11%). Refer to Table 5.2 below.

Table 5.2 Pakistani Immigrants Enrolled in College or Graduate School

Sex by College or Graduate School	Urban	Suburban
Male		
Enrolled in college	13%	14%
Ages 18-24	47%	68%
Ages 25-34	36%	26%
35+	16%	6%
Not enrolled Total	87%	86%
Ages 18-24	5%	4%
Females		
Enrolled in college	14%	6.6%
Ages 18-24	55%	78%
Ages 25-34	18%	15%
35+	19%	7%
Not enrolled Total	86%	93%
Ages 18-24	3%	11%

Source: Census. (2001b). Census 2000 Summary File 4 Census Department of Population and Housing, <http://www.census.gov/Press-Release/www/2001/sumfile4.html>, accessed February 25, 2008.

5.3.9 Industry

Pakistani immigrants were a diverse group involved in various trades. Almost 78% reported being involved in some form of industry. A large proportion of urban immigrants (31%) were involved in transportation, retail (19%) and healthcare (13%) and although the suburban population was also involved in transportation the proportion was smaller (26%); more men living in Old Bridge (50%) than the other suburban towns (Edison=14% and Woodbridge=10%) were employed in the transportation industry. Data indicated that they participated more in the taxi and limousine businesses than the public transportation sector. The largest proportion of suburban men were involved in finance and insurance (16%) followed by healthcare (15%) and retail (15%). There were

differences in the types of retail such as more men in Jersey City were involved in wholesale businesses while more suburban men were involved in retail stores selling jewelry, groceries and printed materials such as books and newspapers. There were more men involved in automobile repair and maintenance in Jersey City than the suburban towns. A larger proportion (55%) of men in Woodbridge was involved in mosques or other religious organizations than 35% who lived in Jersey City.

There were some differences within the suburban populations of Edison, Woodbridge and Old Bridge. Men residing and working in Old Bridge had more in common with men living in Jersey City when compared to those living in Edison and Woodbridge. However, in some areas such as the professional/technical category the percentage of men in Old Bridge was similar to Edison.

More suburban women (Edison=33.6%, Woodbridge=32.8%) reported participation in industry than urban immigrant women (12.5%). Although the participation of urban women was low a similar proportion (Urban=26%, suburban=25%) were involved in education and healthcareers. However, a larger proportion of suburban women (Woodbridge=34%) were involved in retail particularly the food business.

5.3.10 Occupation

Pakistani immigrant population was employed in a range of occupations. However there were some differences in the types of employment between the urban and suburban populations. More suburban (Edison=47%, Woodbridge=66% and Old Bridge=43%) men were management professionals than their urban counterparts (urban=24%), while more urban men are employed in sales (34%) and production (36%) occupations.

The management professional occupations were quite diverse and included management, finance, engineers, physicians and computer related occupations. More computer engineers resided in Old Bridge than in other suburban and urban locations, while more engineers lived in Woodbridge. The largest number of motor vehicle operators (taxis and limousines) lived in Jersey City (31%) followed by Old Bridge (50% of total male population).

The overall participation of women in the workforce was low. There were differences in the type of work they were involved in based on gender and locale. More women (52%) than men pursued careers in the sales industry than men (28%). More urban women (64%) worked in sales than suburban women (Edison=34%). Women were also management professionals. More suburban women (45%) pursued careers in management and other professional occupations than urban immigrant women (15.7%).

Similar to the men there were differences within the suburban community. Women living in Old Bridge shared many occupational preferences with urban women living in Jersey City. More women living in Old Bridge (63%) worked in sales than in Edison and Woodbridge (30%, 45% respectively). This was comparable to Old Bridge men sharing similar characteristics with men living in Jersey City.

Census data provided rich data on the Pakistani immigrant population. However, there were some limitations. Since most of the detailed data had to be extracted from Summary File 4, the sample size shrank inevitably. Summary File 4 reported on data from the long form. The long form was mailed to a sample population (15 million) unlike the short form that had been mailed to every mailing address the United States Postal Service provided. The response rate was lower for the long form (54%) when compared

to the short form (67%). The census data also restricted the data available if the responding population was fewer than 200 in order to protect the privacy of the people. This data, although rich, provided a snap shot of a cross section of the Pakistani immigrant population in New Jersey in 2000.

Secondly, there were the limitations to the level of inference one could achieve with quantitative data without venturing into making speculative statements. One could not answer the 'why' or 'how' questions such as why was the number of college age girls not enrolled in college when their population was greater than their male counterparts. One could infer that families were investing more in boys' education, but again we have to ask why? Or why did more immigrants reside in Jersey City? Or if they decided to move why did they prefer to move to another residence within the same city? Or why move to the suburbs? There were several more questions that begged further investigation and that census data could not answer.

CHAPTER 6

JERSEY CITY AND SUBURBAN NEW JERSEY

Tours of the neighborhoods where study participants lived were undertaken as part of the research. These tours provided rich detail and a context to the narrative of the participants' immigrant experience. Since most of the participants resided in Jersey City, Parsippany, Edison and Iselin these were the locations chosen for the tours. These women acted as guides and navigated the tours.

6.1 Jersey City

Half of my sample resides in Jersey City, NJ. Jersey City is the second largest city in New Jersey with a population of over 240,000 (Census, 2001). The seat of Hudson County, Jersey City is one of the oldest cities in the U.S. The city sits across the Hudson from Manhattan and is connected to New York City by the Holland Tunnel, PATH trains and several ferry lines. Jersey City is divided into several districts (See Figure 6.1).



Figure 6.1 Districts in Jersey City

Source: Destination Jersey City, 2009, <http://www.destinationjerseycity.com/maps.php> accessed 2009.

Each district has its own flavor, populations residing in it, architecture, housing prices and atmosphere.

Jersey City has undergone rapid change in recent years. The waterfront has been transformed over the past few years, especially in the aftermath of September 2001. Many new high rise buildings have sprouted along the old waterfront and a very modern and sleek looking downtown has emerged. The historic downtown area has also undergone gentrification and the old brownstone houses, arranged in rows along tree lined streets, present an elegant and historic atmosphere. Journal Square is a hub of activity with the PATH trains, buses and light-rail all converging at this location. Rows of

taxis line the street near the entrance to the PATH trains. McGinley Square houses St. Peter's College. The Bergen Lafayette district boasts two parks. Greenville hospital is located within the Greenville district. To the west along Route 440 is situated the Hackensack River Waterfront area. The thoroughfare is dotted with retail shopping outlets. The Heights, to the north, is situated on the Palisades as the name connotes and possesses the oldest house in Jersey City. The West Side is the home of New Jersey City University. All districts have distinct landmarks, but the social atmosphere comes from the people who inhabit the city.

I usually drive to Jersey City. Since I live and work in Essex County, there are two routes that I can take: Route 3 East or Route 280 East. Driving down Route 3 East, I merge onto Routes 1 and 9 South to get to Jersey City. As soon as I make the right hand turn there is a gas station on the right. Usually a carpet salesman has hung up synthetic area rugs along the roadside and the sight of a tiger or exotic flowers greets you in the form of a carpet. The gas station is owned and operated by a Pakistani immigrant. The prices are low, so I often stop. I am always surprised to be greeted in Urdu (Punjabi accented), but find myself smiling back. As I drive down Routes 1 and 9, also known as Tonnelle Avenue, there are some motels owned and operated by Indian immigrants and a Dunkin Donuts along the way. Once I turn left under the Pulaski Highway and head up Tonnelle Ave again I get to Newark Avenue at the junction of the Heights and Journal Square districts.

I have lived in New Jersey for twenty years and during that time Newark Avenue has grown from a handful of Indian grocery stores into a thriving and vibrant South Asian neighborhood with shops lining the block between Kennedy Boulevard on the East and

Tonnelle Avenue on the West. The businesses have spilled into the side streets and beyond Kennedy Boulevard. Even before I make the turn onto Newark Avenue there are restaurants and pizza parlors advertising *halal* or vegetarian foods. Along the road people are strolling in traditional saris or *shalwar kameez*. Many sit on their stoops watching the cars go by. As soon as I turn onto that stretch of Newark Avenue, now dubbed India Square, I am greeted by cheerfully colored buntings. The street lights have decorations on them, giving the area a feel of perpetual festivity. There are jewelers, grocers, restaurants, audio-video stores, electronic stores and money transfer agents. New on the scene are two beauty parlors where I can get my eyebrows threaded into shape for only \$3. Even on weekdays the place is bustling. On weekends you cannot find parking. Most of the shops are owned and operated by immigrants from India. There is a Bengali Sweet House and a Pakistani *halal* meat store; other than those two shops, most stores are Indian owned. There is also a White Castle restaurant at the corner of Kennedy Boulevard.

Most of the women I interviewed from Jersey City live in the vicinity of Journal Square or the Heights district. I asked them to allow me to accompany them on one of their shopping trips. Most informed me that they had separate shopping lists for different shopping expeditions. For groceries they headed to India Square for fresh vegetables, rice, *daals* (lentils) and other Asian groceries. You cannot find tamarind at an American grocer and most importantly the prices were a lot cheaper at the Indian grocery as compared with American grocers. The price of a gallon of milk was nearly one third less than that at Pathmark or Shoprite.

Yet another reason for the popularity of India Square is the location. Most women walked to the grocer. This is convenient and cheap. Many do not have cars and others

who do often prefer to walk and chat with friends that they encounter along the way. The chances of running into someone they knew were quite high. On occasion they bring home something a friend called and asked for. Most of the women were aware of each other's schedules and sometimes relied on each other's help. They informed me that a trip to Pathmark or Shoprite has to be planned since they are at some distance. One of the ladies arranges for her husband to leave the car at home on that particular day and the rest hitch a ride to the grocery store.

On my shopping trip with two of my participants to India Square, I discovered that the prices were indeed lower than the American grocers. In fact, they were lower than the Indian grocers in suburban neighborhoods. The array of vegetables was surprising: fresh okra, coriander, daicon and bitter gourd. The ladies then led me to the *halal* meat store at the corner of Kennedy Boulevard. There they placed an order for some ground beef and goat meat to be picked up on our way back.

We then made our way to one of the side streets, where we browsed through shops selling jewelry. Even during the day there were quite a few people shopping and street parking would have been impossible.

Gold prices have skyrocketed in recent years and many shops are now selling gold plated jewelry. The designs are traditional and the variety ranges from very cheap jewelry to silver with gold plating and real semiprecious stones. They are beautiful and much more affordable, and they informed me that no one need ever know if they were authentic! However, there are still more jewelry shops selling actual gold than those selling cheap replicas. Most jewelry shops selling gold have security doors and when you try to open the door someone on the inside buzzes you in. These shops offer a wide

variety of jewelry to choose from: light to heavy gold sets or simply rings or pairs of earrings. There are jewel encrusted designs or those decorated with *meena* (colored enamel). They have it all. You can get your jewelry repaired or order something custom; the jewelers are happy to accommodate.

An array of shops sells saris and dress material. Most Pakistani women prefer to get their clothes from Pakistan. This is not simple, but most have sisters or mothers or someone back home who gets clothes and ships them over. The ladies informed me that they sometimes visit the garment district in Manhattan to purchase material and other notions. They take the PATH train to midtown and walk to the shops selling different fabrics. Some have sewing machines and like to sew their own clothes. They also told me that there are several women in Jersey City who sew clothes for twenty-five to thirty dollars. Sometimes my informants stitch their own *shalwars* and ask the seamstress to sew their shirts for them. Most sari houses have ready-to-wear blouses (to be worn with saris) available for purchase, but most Pakistani women prefer blouses that are more modest and cover most of their arms and backs. Most do not wear the sari casually and prefer the traditional Pakistani dress. All wear their traditional clothes when going shopping for groceries or picking up children. Some told me that they wear their jeans with long tops and a scarf when they go shopping at the mall.

We also visited the Bengali Sweet House. It offers a range of *mithai* (sweets prepared with milk, sugar, butter or *desi ghee*, which is clarified butter, and flour in various combinations). There are *gulab jamuns* (brown elongated or round balls), *chum chum* (usually white, but sometimes covered in pink grated coconut), *barfi* (made from milk and sugar cut into cubes) and *kalakand* (similar to *barfi*, but more amorphous) and

the more expensive *kaju* (cashew) *mithai*. These shops are also famous for their *chaats* a concoction of chick peas, boiled potatoes, *sev* (crispy fried thin noodles) and yogurt topped with chutnies, green coriander, tomato and onions. We bought some *chaat* and *mithai* to be eaten later with tea at one of their homes.

The next stop on our tour was the *halal* Chinese restaurant. It is a Chinese restaurant, but with a difference. The Chinese are immigrants from India and they are Muslims. They serve *halal* food only. *halal* is the meat of permitted animals sacrificed in the name of Allah for the purpose of consumption. Permitted animals include goats, sheep, poultry, cows and camels; pigs are strictly prohibited. The other distinction is the taste of the food. The Indian Chinese immigrants prepare dishes with a definite South Asian flavor. The food is much spicier than usual and many vegetables are used that are available locally in areas where the Chinese have settled in India. It is the same with Chinese restaurants in Pakistan. Their shredded beef with peas is spicy, and their hot and sour soup is thicker and spicier than their American Chinese counterpart. The restaurant serves their food with condiments such as hot green chilli peppers in vinegar and a red chilli sauce. The experience is exotic in a very nostalgic way.

All the subjects living in Jersey City exclusively observed the *halal* meat rule. The women did not eat at any American fast food or at other non-*halal* restaurants. However, they informed me that the Muslim population of Jersey City had grown over the years, and now there were many American style foods available that were *halal*.

A growing Arab Muslim presence resides in Jersey City. Dotted along Kennedy and Bergen Boulevards are many *Baqalas* (shops in Arabic) and signs in Arabic advertising airfares and money transfer agencies. There is a famous *halal* Kennedy Fried

Chicken shop on Sip Avenue, where you can enjoy fried chicken 'Kentucky' style and order some falafel on the side. My informants lamented the fact that there were fewer *halal* restaurants in their vicinity than a few years ago. There are now more Indian owned restaurants on Newark Avenue as one woman observed:

"I did not have any specific cravings, but if I smelled something that the neighbors were cooking such as the smell of chilies, I had to knock at their door and ask for some. It was irresistible. They were my friends and I could not control myself. I used to make chat for myself. Even in those days Newark Avenue had a lot of *desi* [homeland] shops. Now even more. In fact, there used to be more *halal* stores here back then. There were many *halal* restaurants. Now, there were many within walking distance and we enjoyed that a lot. Now all that is left is the Shadman restaurant and you need a car to go there."

All of the restaurants lining Newark Avenue serve South Asian fare, but none are Pakistani. There are menus pasted in windows offering *dosas*, *idli* and other South Indian dishes. I inquired if there were any Pakistani restaurants or grocers in the area and they directed me to an area on Grove Street in the downtown area. I had been to the Pakistani grocer on Grove Street before, which is the oldest and only Pakistani grocer that I knew of in Jersey City. There is another a couple of blocks down the road, but the ladies informed me that one would need a car to go there from Journal Square, and since India Square is so close they preferred shopping there. Another reason the women gave was that Indian grocers were cheaper than the Pakistani grocer.

Some Pakistani travel agents and money transfer agents were located on the corner of Academy and Bergen Boulevard, a couple of blocks south from where my subjects live. For their travel needs most of my subjects preferred to buy their airline tickets to Pakistan from the Pakistani travel agents. They offer special rates and accommodate the traveler if there is an emergency. Usually it is not necessary to

purchase tickets well in advance of the travel dates, since many travel agents block out seats for their customers. Most agents prefer cash for the purchase.

The money transfer agents comprise another important part of my subjects' lives. Many of these women send money to Pakistan on a regular basis. They have families in Pakistan. Although money can be transferred via wire transfer through banks, most do not appreciate the hassle of one bank clearing the money and then waiting before the family in Pakistan can actually get the money, which may take more than ten days. They usually get the bank rate in exchange, which is usually a few rupees less than what you may get elsewhere in the black market. Most of the women preferred the system called *hundi*, whereby the customer gives money to an agent here in the U.S. and the Pakistani family member can collect it from the agent's representative in Pakistan within a few minutes of receipt in the U.S. Some *hundi* agents even delivered the money to the recipient's home in Pakistan. However, the Pakistani government has recently clamped down on such practices because the *hundi* system is an informal system and eludes government imposed taxes on foreign exchange. The government of Pakistan prefers to collect taxes on these remittances. Moneygram and Western Union are also used.

Although there is a strong Pakistani presence in the Journal Square area and other parts of Jersey City, one area is worthy of particular mention. Every Jersey City resident, when asked where most Pakistani immigrants live points you towards 'Pakistan Colony' off of Montgomery Street. I drove down Montgomery Street and was told to make a left on Mercer. As I turned the corner I noticed that the street was a loop. Most agreed that ninety percent of the families living there are Pakistani. As I tried to find parking I noticed that the street sign was a very familiar name. It said M.A. Jinnah, the name of the

founder of Pakistan, fondly called *Quaid-e-Azam* (great leader). As I took a closer look around the neighborhood, it appeared to be quite deserted. Although there were cars parked in most driveways, there were few people out and about. It was around 4 o'clock in the afternoon. It looked pretty quiet and peaceful. There was a mobile library van parked at one corner. Soon a boy emerged holding a few books. There were a few limousines (black cars) parked here or there, indicating residents engaged in the black car business. The only indication of a Pakistani presence was a lone man dressed in *shalwar kameez*, who stepped out to collect his mail.

From Montgomery Street I turned onto Grove Street. I found the familiar Khan Grocery at the corner, where you can find all types of Pakistani *masalas*, lentils, basmati rice and *naans* and any other obscure grocery item that you crave from Pakistan. They also offer *halal* meat. The Shadman Restaurant stood in its old place after having gone through many incarnations; at one point it was called Anarkali. They serve a complete Pakistani menu. You can find appetizers to main courses or order a *lassi* (drink made with yogurt and milk). They do not serve the Indian variety of mango *lassi*, but the actual Punjabi *lassi*. Their *seekh kababs* are delicious and their *naans* are fresh, crisp and mouthwatering. The area is familiar, but it looks very different from a few years ago. What is different are the other restaurants that have sprung up along Grove Street. They offer a variety of foods (Italian, Cuban, etc.) and have set up tables and chairs outside on the sidewalk, bistro style, in an inviting manner. They are cheerfully painted in bright colors. The atmosphere has a definite 'Greenwich Village vibe'. There is another Pakistani grocery store and a restaurant located on the next block. The name Medina is

painted on an orange background and it looks very chic. There are also a couple of *halal* meat and grocery stores on that block.

“Across from Shadman Restaurant is an old synagogue. It appears to be undergoing some renovations. This is the new home of a mosque, although they have been using part of it for prayers for the past decade. It has large stained glass windows, but the double wooden entrance doors and steps are sealed off with plastic sheeting. A smaller door to the side has the mosque’s name on it. There are large gatherings for Friday prayers every week. I have been informed that there are two other mosques in the area, where people congregate for prayers, lectures or breaking of fasts during the month of Ramadan.”

Several Islamic schools are located in Jersey City, where children or adults can attend classes on weekends. However, women in most neighborhoods use the services of someone who can teach the Quran. As a result they do not have to drive their children to a school and they prefer short lessons everyday to a long day over the weekend. Most children’s Quranic studies are finished by the time they are in first grade. They are taught how to recite the text in Arabic, but do not understand the spoken language. As a matter of fact nearly all non-Arabic speaking Muslims fall into this category: they are taught to read the Quran, but are not taught the Arabic language, so they do not understand the meaning. However, as children grow up they may take it upon themselves to understand the Quran and not just recite it, and that is why many adults go to Islamic schools or women attend the *dars* (lectures on Islam) to expand their knowledge in light of the Quran.

I usually scheduled my interviews during the day. The subjects preferred mid-morning when their children were at school and their husbands at work and they had a couple of hours free. I would arrive armed with my tape recorder. All the women graciously offered me tea and some other refreshments. Most lived in older four or five

story buildings. Their apartments were two or three bedrooms. They are decorated with knick knacks the ladies have accumulated from their trips to Pakistan. Every home has some verses from the Quran on the walls. Sometimes these are printed and framed, others had carved wooden verses and one had them in a small woven piece of carpet. Photos of family members were on shelves or on the walls: older men with prayer caps and women with *dupattas* covering their heads (presumably their parents), young children who were nieces and nephews. Most had cushions with embroidered covers from Pakistan adorning their sofas. Most of the living rooms served multiple purposes. They were TV rooms, children did their homework there, some ate in front of the TVs and one had a sewing machine tucked in one corner. Some had colorful bamboo blinds on their windows, called *chiks*. Since I visited in the middle of their mornings, there was always something cooking for lunch in the kitchen. The smell was very nostalgic, prompting memories of days when I would come home early from school. All these apartments reminded me of homes in Pakistan. They were modest and not lavishly decorated and were old, but looked comfortable. Most of these women complained of high heating costs because of leaky windows, but the apartment buildings were old and management only catered to dire emergencies. Some complained that the carpets were very old and feared they may have developed allergies because of them. They had one thing in common; they all loved living in Jersey City.

6.2 New Jersey Suburbs

My suburban sample of Pakistani immigrant women was spread over a large area of New Jersey, although they did live in suburban South Asian enclaves. Some lived in or near Parsippany-Troy Hills, NJ, while others resided in areas closer to the Iselin/Edison. Both Parsippany and Edison are home to large South Asian communities.

Parsippany-Troy Hills is located in northwest Morris County. Parsippany and neighboring towns (Boonton, Boonton Township and Rockaway and incorporated areas such as Lake Hiawatha) house a large number of Pakistani immigrants.

Edison lies in Middlesex County in central New Jersey. Edison also has a ring of neighboring towns with large numbers of Pakistani immigrants (notably Iselin, Avenel, Woodbridge and Old Bridge and the North Edison area).

Both locations are suburban, but have very different landscapes. While the Parsippany area has a more bucolic atmosphere with winding streets and houses on large lots, the Edison area looks far more densely populated. In both areas, there are many single family neighborhoods, but there are also a large number of apartment buildings and townhouse complexes. Both communities are major stops on railway lines and offer good commuter connections to New York City and other areas of New Jersey. Both offer a wide variety of South Asian retail outlets, although the Iselin/Edison area is much more developed than Parsippany. Most businesses in these shopping districts are owned by immigrants from India, but there are also a few Pakistani owned businesses.

6.2.1 Edison/Iselin Area

Edison and Iselin are located at exit 131 off the Garden State Parkway. As one drives down the Garden State Parkway one realizes that beyond the grassy berm along both sides of the parkway, there are houses and people's backyards. There are no tall concrete walls to divert the traffic noise and, although there is a narrow green belt along most of that stretch (from Exits 161 to 131), there are no barriers between the streaming traffic and the homes of many. This is after all New Jersey, one of the most densely populated states in the U.S.

At Exit 131 the ramp curves and you are confronted by a traffic light across from which you can see Menlo Park Station. At the junction of Route 27 you make a left turn and pass over the Garden State Parkway and make a second left. Drive a block and you are in the heart of the Oak Tree Road shopping district. All kinds of goods are on display. In one shop, sequined dresses and saris are on display. Next door there are gold sets and further down video and audio compact discs of various Indian Bollywood movies are for sale. A theater on Oak Tree screens Indian movies on a regular basis. There are a many restaurants to choose from. There are three Pakistani run restaurants on Oak Tree Road alone and there are more in the neighboring towns. Foodland, Shalimar and Shezan are also located on Oak Tree Road, all selling a variety of Pakistani culinary delights such as a variety of tandoori choices and traditional everyday fare such as cauliflower, okra and *channa daal* (lentils) with meat. Shezan has a banquet hall for rent and all the restaurants do catering for private parties. Shahnawaz is located off Oak Tree Road in the Clara Burton district of Edison and offers a lavish all-you-can-eat Sunday brunch. The array of food to choose from is great and the food is always very good.

Several ready-to-wear clothing stores are located here, but none are Pakistani owned. As in Jersey City, most women have their clothes shipped from Pakistan. Usually a family member in Pakistan or a friend visiting Pakistan is appointed to shop for clothes. All the women lamented the fact that there was no Pakistani clothing store in the Tri-state area. They informed me that sometimes someone has clothes shipped over with the intent of selling them. However, size and style were impediments to that venture and the fact that women haggled over prices did not help the situation.

Most Pakistani immigrant women in the suburbs visit Pakistan annually, where they spend considerable time in the bazaars either buying ready-to-wear clothes or material that they then have stitched by tailors. Sometimes due to the shortage of time they will pay extra money for tailors. The ready-to-wear clothing is quite popular in Pakistan, but is mostly targeted to the younger crowd.

The clothes available at Indian stores in Edison (or Jersey City for that matter) are very different from Pakistani traditional clothes. Women wear *shalwar kameez* mostly. *Shalwars* are baggy pants with drawstrings at the waist and the *kameez* is a long shirt (usually knee length) worn with *dupatta*, a long scarf of cotton or chiffon. Indians commonly wear *saris*. *Saris* are worn on special occasions in Pakistan and most women own just a few.

Indian fashions and styles may be different from Pakistan, but there are some high-end boutiques selling Indian designer clothes that many younger Pakistani immigrants frequent. Pakistan now has a flourishing fashion scene and many affluent Pakistani immigrants shop online or order designer clothes from Pakistan. Most plan on a month of shopping before any wedding plans are made. Just as a banquet hall is booked a

year in advance, shopping for wedding clothes is conducted within the same time frame. Sometimes organizations such as APPNA (Association of Physicians of Pakistani Descent in North America) hold annual meetings where many Pakistani designers are invited to set up stalls and these are quite successful. I was told that the Pakistani community in Edison was very social and that there were often dinners and other parties where a wardrobe full of Pakistani clothes comes in handy. Although there is a need for establishing some clothing outlets, there are not many business people interested in this type of retail in the Pakistani immigrant community. The Indian shops may alter any dress to your size, but there not many seamstresses in the area. In fact, many suburban immigrant women have never explored that option.

Next to Shezan Restaurant and Banquet Hall is Habib American Bank, and a few blocks east is the Indus American Bank. Both banks were founded to facilitate the business and personal needs of the local South Asian community. Their branches are located in areas with large South Asian populations such as Edison, Jersey City, Parsippany, New York City and Los Angeles. In fact, Habib American Bank was founded by the founders of Habib Bank Limited of Pakistan. Many Pakistani immigrants are patrons of the bank and also have dollar accounts in branches in Pakistan.

Sometimes there are cultural festivals such as *Eid Mela*. Every *Eid*, entertainment organizers rent a facility in the Edison area and arrange a large festival. There are all kinds of entertainment. Singers and actors from Pakistan perform and food stalls offer a variety of foods. There are also clothes for sale. There may even be a fashion show. People get together and attend these festivals. Some of the Pakistani restaurants offer Ramadan specials such as all-you-can-eat *iftar* (breaking of the fast). People can host

parties in these banquet facilities. Since Edison is located in central Jersey it is an ideal place to host such functions so that people can come from both North and South New Jersey.

Edison, Iselin, Woodbridge and Old Bridge have differing types of residential neighborhoods. North Edison has larger single family homes, but there are many apartment complexes along Oak Tree, Talmadge and Parsonage Roads. Old Bridge and Woodbridge also have mostly single family residences with some multi-family homes and apartments.

Driving down Oak Tree Road and Route 1 through Edison, one notices the sheer number of cars on the road. On any given afternoon, Route 1 is packed. There are shopping areas all around while a series of high tension power lines and towers are planted alongside the route. After all, Thomas Edison lived and worked in Edison's Menlo Park.

Four major thoroughways intersect in Middlesex County: Garden State Parkway, New Jersey Turnpike and Routes 78 and 287. The region is home to Rutgers University, and has a very ethnically diverse community. The mayor of Edison was born in South Korea. There are several synagogues, temples and mosques in the area catering to the needs of the many different faiths.

Many of the women I interviewed stated that there were two other reasons why Edison was a great place to live. First, they said that the school system, especially North Edison's J.P. Stevens High School, was one of the main reasons they had moved to that area. The second reason was its close proximity to Rutgers University. These women

believed that proximity to Rutgers would allow their children to stay at home while attending a great school.

6.2.2 Parsippany Area

Parsippany and her neighboring towns of Boonton and Rockaway house a large number of Pakistani immigrant families. These towns are located at the crossroads of Routes 287, 80 and 46 in northern New Jersey. Together they comprise a large area comprised of undulating terrain with hills and valleys with several lakes. Unlike Edison and Jersey City shops are not concentrated in any one particular location. A few located in the same place, but these do not have the same density or character and feel as the Edison and Jersey City areas. As one drives through Parsippany on Route 46 there are several Indian grocery and other stores around the Baldwin Road intersection. There are the staple grocery, music (audio/video) and clothing stores. There are two beauty parlors and a few take out restaurants. Another strip mall on the corner of Littleton Road houses another group of stores. Other restaurants and grocery stores are scattered throughout Parsippany, Rockaway and Boonton. Several mosques and weekend Islamic schools offer places to pray and seek knowledge of Islam.

All the women living in the area shopped locally. They prefer the Indian grocery stores for fresh vegetables or the local farmers' markets. They bought their *halal* meat from Khan Market located at the intersection of Route 46 and New Road in Parsippany. They once made weekly or bi-weekly trips to Jersey City or Edison/Iselin to purchase meat, but Khan Market has evolved into a large business over the years. It started out as a take out restaurant, but has now expanded to include a grocery store, *halal* meat and a money transfer facility. Khan's also sells Islamic books, Urdu digests, phone cards and

some electronic goods. It is interesting to note that all the cooks preparing the food and the butchers in the *halal* meat area are Spanish speaking immigrants. A large Latino community seems to frequent Khan Market. Many of the groceries on the shelves are not generally consumed by Pakistanis. Corn and flour tortillas sit next to *naan* breads, for example. In the phone card selection you can buy a card to call anywhere in South America and Asia.

As one turns onto Beverwyck Road from Route 46, the landscape changes from a retail dominated area to a residential setting. There are houses on both sides of the road. They sit on large green lots and have substantial front yards. It is quiet and few cars are on the roads during the day. It is even quieter in the evening. When I visited there were not many children playing in the large front yards. My subjects informed me that the children had packed schedules and that they had soccer games to go to after school. By the time they got back home, it was time to do their homework and eat dinner. The houses are located in several subdivisions and most look about the same age. There are bi-levels, colonials and split-levels with flowerbeds and trees shading the driveways. Parsippany's residential and retail areas are totally separate from each other.

Boonton has a slightly older feel. The women I interviewed lived a few blocks off Main Street. These houses sat on lots that are smaller than those in Parsippany. Many of the houses are multi-family and there are stairs leading up to the main entrance as Boonton is located on hilly terrain. Boonton is a stop on the New Jersey Transit Montclair-Boonton Line. It offers commuters easy access to New York City.

Boonton also caters to the immigrants' religious needs. A large Islamic Center is located in Boonton that is run by Pakistani immigrants. Another mosque in Rockaway

serves a larger more diverse Muslim community. Many Arab Americans live in neighboring areas. The Rockaway mosque was subject to some controversy a few years ago, when neighbors to the proposed site opposed the construction of a mosque in their neighborhood. The matter was decided in court and the mosque is now near completion. It has already opened its door for worshippers. People from neighboring areas come and offer prayers there.

It was through the aegis of women who were active members of the congregation at these local mosques that I gained entrée to the Pakistani immigrant community in these areas. These informants were very helpful in introducing me to my prospective interviewees. I arranged and scheduled the interviews at times when it suited the subjects. Some worked and asked me to come by in the evening. Some I interviewed in the morning when children were at school. In some cases I had to go back a second time and schedule these at a different time so that I could meet their families.

Both the Edison and Parsippany areas have large South Asian populations. Many immigrants are from India and Pakistan, and a host of other countries are represented in both areas. The houses that my subjects lived in were all single family residences. They were located in areas that though close to the commercial areas were still at such a distance that walking to them would have been difficult. All women drove their own cars. Most families owned two or more cars. The husbands worked in different parts of New Jersey and generally drove to work. Most of my subjects worked; and they too drove to and from work. The children are transported to and from schools in buses. Many families employed weekly or biweekly cleaning services and a landscaper to cut their lawns. Most had houses with large front yards and backyards with swing sets and barbeque grills. The

houses themselves were well kept. Some of the women preferred the ethnic look and had decorated their homes with artifacts they had bought on their visits to Pakistan. Some had a decidedly modern flair with very little color and sparse furnishings in the minimalist tradition. One lady had painted her kitchen and living rooms in saffron and vermilion colors, while another had an all white theme. There were oriental rugs on the floors and potted plants on pedestals. Many had family photos on display. Some bridal photographs in golden frames, some old and faded photos of their parents or grandparents and some chubby baby photos were on the walls or tucked in bookshelves. Some had framed Quranic verses on their walls.

Most of the houses had three or four bedrooms. One lady had her mother-in-law living in the same house. Her husband had applied for permanent residency for his widowed mother, who now lived with them. She had a bedroom with a separate bathroom, while her three children shared two rooms. One woman had rented out part of her mother/daughter type home. She said it helped with their mortgage. The homes were decorated tastefully, but modestly, and did not exude extravagance since all these families were working middle class families. I asked them how their homes compared with their homes in Pakistan and most said that now that they reflected on it, their homes were somewhat like their homes in Pakistan. There were differences such as the kitchens in the U.S. were always on the small side and that they missed the built-in cupboards in their bedrooms. They had closets, but the custom built-in wooden cupboards were nicer. Most used their garages for storage purposes. What they did not miss were the lizards in the hot summer months that swarm around electric lights in Pakistan!

CHAPTER 7

MAKING A HOME IN NEW JERSEY

7.1 The Study Participants

The study consisted of a sample of 26 Pakistani immigrant women who resided in various parts of New Jersey. Twelve of these women lived in suburban towns, while fourteen lived in urban areas of New Jersey. These included Jersey City and surrounding areas. See Table 7.1 below.

These women had immigrated to the U.S. at various times during the last three decades. Although their median age was slightly higher than the median age of Pakistani immigrants in New Jersey, they were all relatively young and the median age was 38. The average household size was 4. Twenty-five of these women were married and they had been married from 4 to 26 years. One was widowed a few years ago. All had given birth to one or more children in the U.S. The number of children varied in number from 4 to 1. The ages of the children varied from 21 years to a one month old baby.

All the women were relatively well educated. Seventeen of these women had completed a bachelor's degree, while four held a master's degree and five had completed eight to ten years of schooling. Six of these women had completed education in the U.S.: two had a master's degree and two had completed her bachelor's degree. Most of my participants said that they spoke English 'well'; only one woman said she spoke very little English. All suburban women owned and drove a car, while four women from urban areas had a driver's license and shared a car with her husband. Sixteen of these women worked, while the rest were home makers. Most of the suburban women worked and were employed in various sectors: they were substitute teachers, health management

professionals, public accountants, architects and in real estate. My urban participants worked in retail stores locally or were self employed. Most of these immigrant women had started working after their children had started pre-school or kindergarten, especially the full time workers.

These immigrant women originated from various provinces in Pakistan and belonged to different ethnic groups from Pakistan. These women were better educated than most Pakistani women and spoke several languages; besides English, most could speak at least two ethnic/local languages. Many of these immigrant women worked and they stressed that women should work to support their families. A few of them observed *purdah* and wore the *hijab* (head covering). They spaced the births of their children and their fertility rate was slightly lower than Pakistan (immigrants=3, Pakistan=4).

Their husbands were involved in various occupations and their socio-economic status was quite diverse. Their incomes ranged from \$150,000 to \$35,000. Most of the husbands held a bachelor's degree, while some had completed a master's degree and four were physicians. Fourteen worked full time, while eleven were self-employed. Many of these men were involved with occupations related to transportation. One owned a fleet (5) of New York City taxicabs; another operated a minibus operation and seven owned and drove limousines. Three worked in the field of architecture, while one had started his own business. One of these men ran a part-time auction business on Ebay, an internet based auction site. He imported or bought items and sold them over the internet and participated in trade shows. Some husbands worked in the information technology and data management sectors. Two men worked in accounting. The business owners were

involved in finance, pharmaceutical, healthcare provision, and retail stores and sports goods businesses.

Table 7.1 Urban and Suburban Women Comparison

	Urban	Suburban
Women's education		
Master's	1	3
Bachelor's	9	8
12 th grade	2	1
10 th grade	2	0
Husband's education		
Master's	3	8
Bachelor's	8	4
12 th grade	3	
Average Income	\$45,000	\$80,000
Home		
Own	4	12
Rent	10	
Average Rent/mortgage	\$17,00	\$3,200
Live with In-laws	3	3
Women Employment	7	10

Source: Data collected

7.2 Family and Gender in Pakistani Society

Family is the cornerstone in Pakistani society. In some parts of Pakistan (Baluchistan and the North West Frontier Province) people subscribe to tribal culture, while in other parts families are as extensive as any tribe. Extended families are the core networks. Parents raise their children and educate them, but family helps them find good jobs and suitable matches. Families are the core social networks and people invest in these networks in many ways to strengthen their ties (shared business partnerships, inter-marriages). There is a sense of obligation to the family that extends to all aspects of life.

Living in a joint family is not uncommon in Pakistan. This is an example of the extended family as the crux of the network. Sons will get married, but live with their

parents in the homes that they grew up in, or in some instance their families' ancestral homes, where generations before them have brought home their brides. All the women in my sample moved into their in-laws' home after marriage.

Another defining characteristic of Pakistani society is gender based organization. Gender is central to societal structure. It defines the roles of men and women and their spheres of influence. The women generally occupy the domestic sphere, while men are bread winners and move in spheres external to the domestic domain. There is also a power hierarchy. Fathers are heads of families and their seal of approval is essential to any decision making. However, mothers are held in great esteem and sisters and daughters are treated with gentle care. Both men and women depend on family networks equally, but in different ways.

The importance of gender began with the birth of the child. There were gender differences in investment in the child's future. While more money may have been spent on a son's education, gold jewelry may have been put away for a daughter's wedding. All women in my sample belonged to well-to-do, middle class families in Pakistan. Most of these women were better educated than a majority of the Pakistani female population (in Pakistan), but the differences in family investment were evident in the following excerpts from my interviews.

"I finished my matric [10th grade].... barely so. You know girls' education is not as important as boys'. It is not like I was going to work after marriage anyway. My brother went on to college, but he never liked study. Now [after immigration to the U.S.] I feel that I could have found a better paying job if I had completed some education. And my brother, who was forced by my parents to study, now runs the embroidery shop my father and his brothers used to run. So it is no use to him either."

“I wanted to study some more, but we are three sisters and our parents worried about our marriages. If you spend so much on education, then how can you marry off three daughters? My brothers went to college and one of them came to America to get a master’s degree. He asked my father for the money and my father sold some plots of land he owned to help him. He gave him all the money he had; now *bara bhai* [older brother] supports him.”

“My mother collected beautiful stuff for my marriage. She started soon after I was born. She collected embroidered bed covers, dinner sets and gold jewelry.”

Investment was based on gender and was determined by gender roles as defined by Pakistani society. In Pakistan, sons were assumed to be the future bread winners and heads of their households, and the responsibility of caring for aging parents would fall on their shoulders. Whereas girls would generally get married and move away, they would be mothers and wives. Therefore, parents of these women started assembling dowries early on and marrying their daughters took precedence over their education, while investing in their son’s education was a means to ensure future security. Although, all the women in my sample were educated, investment in these women’s education was meant to translate into a better match, wedding proposal and also becoming a good mother.

When the participant women lived in Pakistan, social networks were structured by cultural norms and these networks were mostly comprised of other women. Although men were an important component of these networks, male roles were very different from those of the women in these networks. These female networks were essential in issues pertaining to marriages, pregnancy, contraception, childbirth and post-partum, these networks comprise mothers, sisters, mothers-in-law, sisters-in-law, other female relatives and friends. The immigrant Pakistani women relied on their network of women for

support in such matters. Support could be in the form of emotional support, physical help and as conduits of information on a range of subjects. These subjects included, relationship advice, sex education, childbirth and child care. Women played a crucial role in finding matches and arranging marriages. For example, most of the marriages in my sample were arranged. In most cases the two families did not know each other and prospective spouses and their families were introduced by female family members and friends. Even if the man was of the participant's own choosing, the female family members of the two families approached each other with a formal proposal, after all it was a connection between two families and not just two individuals. It is a common saying in Pakistan that a *rishta* is a connection between two families and not just two individuals.

“Our parents knew each other from when they were in the army. My mother-in-law came to visit and decided she would propose for her son. We are five sisters. I was the closest in age to her son. She and my mother talked about it and then our fathers.”

The transliteration of the word *rishta* is connection (M. Ali, 2000). In the case of a marriage proposal it is an alliance or connection made between the two counterparts.

In some cases a couple may fall in love and want to get married, but the approval of their families is crucial. Even in such instances families will get together and ‘arrange’ a marriage, albeit the couple has initiated the process. One couple in my sample applied to the woman's aunt to act as mediator between the families. The aunt introduced the families and even though the woman's family wanted to marry their daughter within their *biradari* (extended family), they acquiesced to their daughter's wishes.

“I told my parents that I was interested in marrying my class fellow. When the time came they [groom's sisters and sister in-law] came and asked for my *rishta* [proposed formally].”

7.3 Immigration to the U.S.

Emigration is a long and established tradition in Pakistan and a multitude of Pakistanis are living abroad. Generally men migrate first and their families join them after the men settle. The women in my sample immigrated to the U.S. in three ways. Thirteen of these women married men settled in the U.S. and immigrated as a result. Three of these women had immigrated with their parents and grew up in the U.S. Both U.S. based men and women, seeking to get married, sought help from their families in Pakistan. In the case of the women, their parents sought the help of family in Pakistan to find a suitable match.

Ten participants had migrated with their husbands. Of these four had migrated at the same time as their husbands, while six had joined them after a few months. These couples sought a better financial future for their family and had decided to emigrate from Pakistan. In this pursuit, some applied to U.S. universities, for higher education, while some were sponsored by their family members already in the U.S.

7.3.1 American *Rishta* (marriage proposal)

Proposals of marriage from people living overseas are highly desirable in Pakistan. One subject explained

“I got married in the 3rd year of my B.A. In fact I completed my bachelor’s while I was pregnant with my first child. My father thought it was such a good *rishta* [marriage proposal] why delay? You can complete your degree if they [the in-laws] allow you to do after your marriage.”

Another subject said,

“Our marriage was arranged quickly. It happened in 15-20 days. My husband was visiting Pakistan from America and they [his family] were looking for a suitable girl. My neighbor’s sister was married in their [the husband’s] family and they recommended us. My father was very happy.”

Living abroad transforms the social status of a Pakistani expatriate, especially when he or she is trying to find a match in Pakistan. Sometimes this could mean marrying into a higher social class or it could lead to some other advantages such as marrying someone better educated. For example, some of these women married men who were a lot older than they were. While in some cases, the women's families did not check to confirm a suitor's employment or education. Marriages were arranged in most cases and families discounted the age difference on the basis of having their daughters live abroad. It may be inferred that in these cases there was a trade off between an opportunity to live abroad and marrying someone who was older than the acceptable norm. These women were aware that had the prospective husband been someone from within Pakistan, the age difference would have been taken into account.

“My husband is a lot older than me, but my father thought it did not matter. I would be going to America soon. Actually my step mother wanted to marry me off to someone from her side of the family who was younger than my husband.”

Although this was a second hand account, because only the wives were interviewed, the thirteen women who had married Pakistani men settled in the U.S. reported that it had been difficult for their spouses to find compatible women in the U.S. on their own. These suburban and urban immigrant men sought to marry someone from Pakistan for various reasons. For example, one of these men belonged to the *sayed* class (religious based class) and wanted to marry someone from that religious class. Most men had not dated and did not feel comfortable seeking marriage proposals through the matrimonial section of a newspaper. All of them applied to their families in Pakistan to

find someone suitable for them. Families played a central role in arranging marriages and their role has been discussed in greater detail later in the chapter.

There were three women in my sample who had immigrated to the U.S. with their parents and were permanent residents (green card holders) or naturalized citizens of the U.S. and had sponsored visas for their husbands after marriage. In these cases it was two of these women who returned to Pakistan to find a match. An American match also had advantages for the prospective spouse in Pakistan. For the men in Pakistan marriage to a U.S. citizen meant migrating to a better future. It meant greater financial security for the family. It also meant that the son would sponsor his brothers and parents, and eventually many from the family might emigrate. Hence, the social capital of the entire family would be enhanced. Many in my sample had done just that and now have extended family living in the U.S.

“After I finished my high school [in the U.S.] we went back to Karachi for the wedding. Since I was already engaged [marriage arranged and engaged over the phone] and we had filed for his visa he came here shortly after the wedding.”

The third woman married another immigrant who had immigrated with his parents as a child. The woman had grown up in Jersey City, while her husband had grown up in suburban New York. Although both the husband and the wife grew up in the U.S. their marriage was arranged by a common friend of their families. The woman was in her junior year at college when she got married. She completed her bachelor's degree after marriage. Her experience was similar to the experience of the immigrant women (in Pakistan) in that respect.

Thirteen men, who had migrated earlier, went back to Pakistan to get married. After the marriage in Pakistan they returned to their jobs in the U.S. and applied for their brides' immigration.

“My husband had a business visa, B visa and could visit me. He usually came every year. I joined him [in the U.S.] 3 years later.

All new brides lived with their in-laws for some period of time before their immigration process was completed. Some of these women left for the U.S. soon after marriage, while others waited for their husbands to sponsor a visa for them. Waiting time depended on the immigration status of the sponsoring spouse. If the sponsoring spouse was a citizen of the U.S., then immigration was expedited. However, if the spouse had a green card or permanent residency, then the husband or wife had to wait for a longer period in Pakistan (some women waited 2-3 years).

Some landed in urban areas such as Queens, NY, and Jersey City, NJ, while others went elsewhere to their universities or places of their husband's employment. All found that the U.S. was very different from Pakistan.

7.3.2 A New Beginning and Role of Networks

The twenty-three migrating women in my sample were thrilled at the prospect of moving to the U.S. These women prepared for their departure by buying new clothes and household necessities such as *masalas* (curry powder). Meanwhile, others sold their dowries since they would not be able to ship their furniture or cars, and some sold their gold jewelry to fund their education in the U.S.

“We had saved most of the money we got when we got married. You know my *jahez* [dowry] and people gave us a lot of *salamis* [gift money]. We sold that. We had also saved our salaries since we were living with my brother-in-law, we did not have too many expenses. Even then I

sold some of my jewelry to raise money for the masters. I also sold my car.”

Once they arrived in the U.S., these women found that migrating to a new country was a stressful experience. The move was experienced differently, depending on the existence of networks, the quality of those networks, and embeddedness of a person within those networks and the reciprocity and trust that exists within those networks.

“We did not have any relatives here [in the U.S.]. In fact the friends we had made here, we did not know them in Pakistan. They were all new people.”

“In the beginning it was very frustrating. You have the child to take care of and then you are all by yourself all day long. I did not know anyone here [U.S.]”

“I had some difficulties here. First the language problem. Second this was the first time I was away from my family.”

“It was very different from Pakistan. You know everything is very different. It is almost another world.”

My sample can be divided into two groups: those who had some family members or friends in the U.S. (twenty) and those who did not know anyone (four) other than their husbands (See Table 7.2a and 7.2b below). Most of these women were the first in their families to move to the U.S., and, therefore, their large family network was in Pakistan. Most had followed their husbands to the U.S., while some had arrived with their husbands. In these latter cases, it had been the first time that both the husband and the wife had been in the U.S. Some had come to obtain higher education and, therefore, went straight to their universities. Some had arrived bearing a visit visa that they hoped to convert to a working visa, and these usually had a friend or family to house them initially.

Table 7.2 a Existing Networks in the U.S.

No Family or Friends	Some Family	<i>Susraal</i> (In-Laws)
4	7	13

Source: Data collected.

Women who were sponsored by their husbands could further be divided into two groups: those whose husbands had migrated alone or those who had family in the U.S. In the first scenario, the men had established themselves either in a business or job, and had settled into an apartment in anticipation of the arrival of their wives. Some of these men had independent living arrangements, while some lived with their families in a joint family similar to the living arrangements in Pakistan.

Table 7.2b People Immigrating Women Initially Stayed With in the U.S.

Husband's Friends	In-laws	Own Family member	Alone
2	8	7	9

Source Data collected

The existence of social networks had an important affect on the migration experience. Women experienced an initial loss of social capital in the form of the loss of networks from Pakistan, but their migration experience was affected by the existing U.S. social networks and the quality of those networks. Women who arrived to an empty apartment often felt very lonely because their husbands worked, and they did not know anyone else initially. Working hours in the U.S. are longer than those in Pakistan. Men usually did not get home until very late at night. Some who were business owners had very erratic work schedules and their work hours were undefined. These women reported a stressful experience.

“It was an annoyance and since I used to be such a lazybones at home I felt it even more. I had to do every thing. I would get angry and very frustrated and sometimes would cry. What kind of misfortune was this? I came here in March and the weather did not get better until May. I was kind of stuck. My husband was working from morning until night. He would come home at 9 or 10 in the night. It was really lonely here. It took a long time to get used to this.”

Those who had their husband's family (*susraal*) in the U.S. faced different challenges. Women who got married in Pakistan and lived in their in-laws' homes in Pakistan arrived with dowries (gold, cash, land, furniture, electronics, etc.) and also had their families to support them (a cache of social capital than could be tapped into). Their time spent living in their *susraals* in Pakistan had also contributed towards their social capital. If the wife established good rapport with her in-laws, she could expect support from her *susraal* and vice versa. If a woman moved from her parents' home in Pakistan to a full *susraal* in the U.S., then she had very little capital to begin with. For example, she could not bring most of her dowry with her.

“We sold most of the stuff from my *jahez* [dowry] before coming here.”

“Since I was coming to the U.S. my family just made gold jewelry for me and did not bother with furniture and other things.”

“You know how it is in *susraals* (in-laws' house) you have a certain reserve. I would not ask specially for something.”

These women also did not have any member of their own family in the U.S. and had no established relations with her in-laws. These women experienced stress that was different from that experienced by women who were alone and did not know anyone. Pakistani cultural norms and expectations of the *susraal* were still applicable in the U.S. to these women, while the lonely women without an extended family had only a husband's

expectations to meet. Living in *susraals* was very different from living independently. These women were expected to become part of an existing household, where invariably the mother-in-law was in charge of the household.

“My mother-in-law goes with my husband and does grocery shopping mostly.”

“There are three families here and my mother in-law. Before my father-in-law passed away he used to live here also. I live upstairs. The other two brothers live on the main floor and one in the basement.”

In many cases, there were other married and unmarried siblings also living in the same household. Although these arrangements were not foreign to these women, because similar arrangements are very common in Pakistan, their position was more vulnerable and subject to stress because they did not have any of their old networks (family and friends in Pakistan) in place in the U.S. and they were not yet embedded in their husband's networks. In Pakistan they could visit their parents or friends when they needed some time to themselves. In the U.S. there was no one they could lean on initially, although they had their husbands. It is important to remember that most of these marriages were arranged and the couples had been married for a very short period of time in Pakistan before they were separated. Thus, they had not established a comfortable working relationship with each other. The initial period soon after arrival in the U.S. was the most stressful.

“I could not talk to my husband about little things (concerns with in-laws) back then.”

“My husband was there, but it was still early days [of our marriage].”

Three women had migrated with their parents at a young age. Two had returned to Pakistan to get married. These marriages had been arranged and these women did not know much about their spouses either. Since these men had been sponsored by their wives, they arrived to a house full of their in-laws (wives' families). In these cases the wives families helped the new son-in-law with everything from applying for their social security numbers to helping them pass their driving tests to finding jobs and apartments for them. This happened because of Pakistani cultural norms and expectations, which hold the son-in-law in great esteem and worthy of reverential treatment.

The immigrating daughters-in-law were not accorded a similar welcome or attention. For the new wives there was no hurry to get their social security cards or drivers licenses. The women speculated that this might have been because they were not immediately looking for a job; they were not expected to become totally independent so soon and hence did not need to drive. Instead, their husbands could drive them to wherever they wanted to be. Some *susraals* felt that there was no urgency to get a driver's license because it may be harmful for the pregnant woman.

“I could have gone for a learners' permit or something, but his family was very cautious and kept saying you have twins, you have twins.”

In some cases, mostly in the urban setting, the women still did not drive. Two of the women living in Jersey City preferred not to drive and made that choice.

The one woman, who had migrated with her parents and had married an immigrant, reported that she moved into an independent townhouse after she got married. Although her in-laws and her parents lived in New Jersey, she and her husband did not live with either family. Her experience with her in-laws was similar to the experience of

other women who had their *susraals* in the U.S. The significant difference was the presence of her parents, who provided the network many Pakistani immigrant women lost when they immigrated. The arrangement and preparations for her marriage were similar to those of the immigrant women in Pakistan. Her marriage was arranged and she had not known her husband before they got married. Her parents had given her a dowry (*jahez*) which had included furniture for her house, electronic items, bedding, and jewelry, clothes for her and her husband.

For Pakistani immigrant women the quality of this experience also depended on the quality of female networks. Women who had someone from their own family already in the U.S. reported less stress. However, the quality of this network depended on the relationship. If it was a sister, then the women reported less stress and felt cared for. In contrast, if their brother and sister-in-law were their immediate relatives in the U.S., these women reported that relationships with sisters-in-law determined the quality of that network. Hence if a relationship between the subject and her sister-in-law did not have trust, then there was very little reciprocity and little benefit from that relationship.

“At least I had my sister here. She was very helpful.”

“I stayed with my sisters. Both of them are my older sisters. They were both very helpful.”

“I craved *chaat* and *samosas*, but my sister-in-law did not make any and she never mentioned that there were all these restaurants in Jackson Heights.”

In some cases these women initially stayed with their husbands' friends. These were the women who had migrated with their husbands and both the husband and the wife did not have any family members in the U.S. Although, these were existing

networks, they were generally the husbands' friends and the wives were strangers. The women in my sample did not feel that those networks were reliable because they were their husbands' networks and they did not have an established relationship (embeddedness in that network) with the wife of their husband's friend. Hence relationships were viewed as more supportive to the husband and not necessarily to the wife.

“Initially we stayed with my husband's friend [who had suggested we come] in Queens. The friend was married and had a baby son. I did not know his wife at all and I think she was working on a degree or something at that time.”

A lack of proficiency in the English language can also pose considerable problems to an immigrant. Language skills depended on the medium of instruction in Pakistan. Five of these women had attended schools where all subjects (math and science, etc.) were taught in Urdu and they were not exposed to English until high school for a year or two. Hence they could not understand or speak English very well. They felt that a lack of their knowledge of English made life more complicated for them.

“Even when I try to speak my son says ‘let it go mom, stick to Urdu.’”

These mothers felt constrained by their deficiency and had to depend on others for help with hospital forms and insurance forms and such. This added to their stress.

“She [a friend who worked as a nurse in that hospital] told me to come over there and she would help me fill the paperwork. She also helped me. The papers included doctor's papers and registration card and such. She applied for Medicaid. She also helped me understand. Sometimes the doctor would say things, and since this was my first pregnancy she would translate and make me understand.”

“They asked me if I knew any English and I said I did not know too much, but my husband could translate for me.”

7.4 Settling in Urban and Suburban New Jersey

One of the questions I posed to all the study participants was, 'why did you choose this location (as your home)?' These were not the first apartments or houses that these women had lived in since they immigrated to the U.S. Most of these families had moved a few times. On average these women had moved twice. In the beginning some of them had shared apartments with friends or family members already in the U.S. In some cases the husband was already living in the U.S. and he shared his apartment with other single men.

"At that time he had a cousin and a friend living in the same apartment. They shared one bedroom and we were in the other."

After the wife arrived, the roommate invariably moved out. Couples who had arrived together shared an apartment with some friends or other family members, and moved out when they found a place in a few months time. Some of these women have been living with their in-laws after immigration.

With two exceptions, all of these women arrived in New York and settled in the borough of Queens in New York or New Jersey. Later, these families moved to other locations. Two women lived in the Midwest for sometime before arriving in New Jersey and another had lived in Connecticut for some time.

These women offered a list of reasons for their choice of residential location. The most common reason provided for their choice of location was their husband's job, but there were also other considerations. Most of the women who chose to live in Jersey City did not drive and appreciated the easy access to public transportation available in Jersey City. These women also thought that the convenience of having everything within walking distance in was very important. Even though some of them admitted that

sometimes, because of their close proximity to commercial areas, it could be a little loud in Jersey City.

By comparison, immigrant women in suburban towns preferred the quiet seclusion of suburban towns. These women identified several other reasons for their preference. These suburban women reported that school district performance and cultural diversity was also a consideration when they were debating their residential choice. As a result some of these women chose locations that were not close to their husband's work and in some cases the husbands had to commute several miles by car or train to their jobs. Some of these suburban women had made their decision based on proximity to other family members. All of these women had deliberated and made a conscious choice to suit their needs.

7.4.1 Pakistani Immigrant Women in Jersey City

I interviewed fourteen women from Jersey City. This community was characterized by some attributes. These women lived in a close knit community. Most lived within a few blocks of each other and these women relied on each other. They shopped together, went to the school to drop or pick their children up after school, and called each other on the phone nearly every day. They found that their ties had grown over the years, and they appreciated each other's support. Some had families in New Jersey, but did not live within easy reach of each other. Most of these women did not drive; in fact, only three possessed a driving license. Their husbands worked in New York City or in the surrounding New Jersey towns.

“Now, I have quite a few friends here in Jersey City mostly because my son goes to school with their children. We take turns picking them up from school. The school is not too far and we can walk there. In fact, we walk there together or meet up at the corner and then walk back

home together. It has been ten years since I came to the U.S. Now I have at least 10 women who I can call friends.”

The importance of these friendships lay in the nature of the support these women could exchange. Not only did they help and support each other in everyday life, these connections proved helpful in acquiring information on employment and emotional and physical support during times of need. The information ranged from insights into what public schools they could send their children to and when the time came for the children to go to high school, they used the Jersey City educational system to send their children to other more competitive school districts. Or try to qualify to enter Newark Academy, a highly successful and selective high school in New Jersey.

“One of my husband’s friends, who lived in Jersey City, told us about that. She said children could go to the Academy [Newark Academy] when they were 3 years old. She knew everything. She got my son enrolled into the school.”

Sometimes it is necessary for the mothers to talk to members of the school or board of education. Some of these mothers, who were not very fluent in English, or those who thought that they might be at a disadvantage when trying to understand some procedures, recruited help from their more knowledgeable friends. They would set up an appointment to go and visit the school together. In one instance a lady had to visit her child’s high school counselor, so she asked her friend who had older children to accompany her on that visit. She was able to understand the college application process more completely and was able to discuss her child’s progress and course selection more comfortably.

These channels of information were very informal and generally spread by word of mouth. At a time when one of these women's husbands was searching for a new business enterprise, he needed work to support his family in the interim period. He was introduced to and found a job driving a limousine with one of the other women's husband in the network. In another instance one of the women wanted to find a job for herself and found that she needed some computer knowledge for a particular kind of job. She contacted one of her friends, who introduced her to someone who ran a computer training institute in Jersey City. She enrolled and completed a course on Microsoft Office and successfully landed a job in a local Indian warehousing business off Newark Avenue.

Friendships extended beyond the mundane processes of life. Friends were needed in times of great sorrow and joy. It was a great comfort to have people who cared about you nearby when help was most needed. Some of these women faced times of immense grief, alone in a foreign land. If someone dear dies back home, it is almost impossible to return home in time for a funeral. According to Muslim tradition a person should be buried as soon as possible. Hence a person living in the U.S. may not reach Pakistan that same day. In such circumstances friends of these immigrant women not only stepped forward and helped with the matters of child care or food preparation, they offered money for airfare or helped drive the bereaved to and from the airport.

One of these women was faced with such a situation a few months earlier and she stated that she was grief stricken. Her husband called her friends for help. Even though it was very late at night, several women showed up. One contacted a connection within Pakistan International Airlines and got an emergency seat reserved. Airline tickets were quickly purchased and the lady was off to Pakistan the next morning. The friends then

helped the husband with caring for the older child, who had been left behind because he could not miss school. They brought him to and from school. They chalked up a schedule for food preparation and delivered it to the grieving husband everyday. The grieving mother could mourn at peace with the knowledge that her friends were there to take care and share her responsibilities even when she was away.

The same woman had found herself all alone a few years ago, soon after her arrival in the U.S., when her new born baby had been diagnosed with a volvulus, (intestinal twisting). She did not have many friends at the time, and had no one to help and offer her comfort. Her husband had to go back to work and she had to take care of the baby all by herself. She described the time as a harrowing experience and felt depressed for months afterwards.

“I would sit next to him all day in a chair and would come home in the evening. That was the time when I missed Pakistan the most. You know the time when I was pregnant or when I delivered the baby, I missed my family, but not this much, but the time when I had to walk that distance and then I would sit there alone.... (breaks down sobbing).”

She actually went to Pakistan to recuperate from her ordeal. A network of friends proved essential for emotional support.

Some of the networks of these urban dwelling women were exclusively female and did not include their friends' husbands. Some of these women's husbands were not even friends. These women met during the day when most of the husbands were at work. They planned their shopping trips together or attended a *dars* together and sometimes got together for lunch. These women had a circle of female friends in their neighborhoods and also socialized in a separate circle of family friends.

I found that some of these women had replicated their mothers' social lives in Pakistan. These women reported that their mothers also had great relationships with their

neighbors in Pakistan. Some of these women recalled their mothers going grocery shopping with their neighbors. These were planned trips and involved shopping. They would drive out on a designated day and buy meat, vegetables and fruits in bulk that they would divide amongst themselves later. After all no one could finish crates of oranges and several kilograms of potatoes

In Jersey City there are few street corners that do not have a convenience store. In most cases these women lived within walking distance of shopping, schools and transportation. Many of the couples did not own cars. Some could not afford one, but some preferred not to own one. Many of the women in my sample found it easier to walk to their destinations. There is also the PATH train that links Jersey City to New York City. Some of these women had lived in Queens or Brooklyn in New York before moving to Jersey City and found it convenient to move back and forth between the three neighborhoods. Many of these women kept their connections to these other locations viable by visiting and keeping up with their friends even though the distances was great. Having friends had enabled these women to adapt to their new surroundings. These women found these conveniences to be very important to their independence. They were not dependent on their husbands to move about.

“I am not dependent on my husband to drive me everywhere. I like living here because I can move around go anyplace I want to by myself and not be dependent on him- that is why I like to live in the city. I would never want to move. Even my kids do not want to move. It is so convenient everything is on walking distance. Everything is five steps away. I used to call a taxicab to go for my doctor’s appointment. Since my husband works in New York it’s very easy for me and it was very, very convenient. I did not expect him to come home and bring me to my appointment.”

Most of these urban women did not have any family in the U.S. when they first migrated here. They had felt alone and found it very hard to adjust and adapt. However, living in an environment with other Pakistani families helped the process of adaptation and eased their adjustment. I also found that women who did not have any family in the U.S. had supplanted their family with friends in the U.S. These friendships have proven to be quite important to these women.

Another notable point was that all of the participants living in Jersey City had migrated from busy inner cities of Pakistan. Most of them belonged to the Punjab in Pakistan. These women had found it very difficult to adapt to environments that were very different from their neighborhoods in Pakistan (some of these women had lived in suburban Connecticut, the Mid-West and rural Georgia before arriving in Jersey City). Their transition was easier if they lived in an urban setting. Of these women, those who had moved into neighborhoods with high a density of other Pakistani or South Asian immigrants adapted with greater ease and in shorter time as compared to those who had made homes in areas with low immigrant density. The social environment in Jersey City suited these women and helped them reestablish themselves after immigration. They preferred not to move from Jersey City and enjoyed their new homes away from home.

All the Jersey City women agreed that there were two reasons why they loved Jersey City: the Pakistani immigrant community and the conveniences. They felt that after their initial years of loneliness and trying to settle in the U.S., they had found people who were now their very good friends and who had in fact had become their surrogate families. They enjoyed the fact that their friends were only a few doorsteps away and they now enjoyed a camaraderie that had taken years of cultivation.

7.4.2 Pakistani Immigrant Women in Suburban New Jersey

The suburban Pakistani immigrant women I interviewed lived in different towns within Morris and Middlesex counties of New Jersey. These women had many things in common. All of these women had migrated from suburban areas in Pakistan. They had lived in various cities of Pakistan. Some came from the Punjab, while some came from Sindh or the NWFP (North West Frontier Province). They all spoke different languages at home, but shared Urdu and English as a common language. These women lived in various parts of New Jersey, and many of them were friends: three were related to each other. These women could not meet on a daily basis like their urban counterparts because they lived several miles apart and had to drive 30- 60 miles to visit each other: although, they maintained a connection via the telephone. These women planned visits for the weekends or excursions such as picnics or pumpkin picking expeditions in the fall. They had been friends for years and their children had grown up together.

Three of these women were related to one another. Two of them were sisters and the third was their sister-in-law. Initially the older sister had immigrated to the U.S. and later, upon acquiring U.S. citizenship, she had then sponsored her brother and sister and their families. The older sister had lived initially in Jersey City and after several years had moved to Parsippany. She felt that Parsippany shared some characteristics with Jersey City, but was better in terms of education for her children. Although she still maintained friendships in Jersey City, she had feared her only son might have joined a gang if she had stayed in Jersey City (because she associated large cities with youth gangs). She had found work, on a friend's recommendation, in the Parsippany school district. She had a vast circle of friends both in Jersey City and Parsippany, but most were immigrants from Pakistan.

Parsippany is a large town. Even though these three women lived in Parsippany their children attended different schools. These women reported that they were within ten minutes drive of each other's houses and could visit any time they wanted to. The older sister was widowed a few years ago and she said that having her siblings close by had provided a safety net. Having her family around was of great comfort to her. She received comfort and support from her family and friends.

This woman was the oldest in my sample and she had been in the U.S. the longest: twenty-eight years. Over the years she had befriended many families. This woman had two daughters and she wanted them to grow up in a Pakistani culture. Therefore, she chose Pakistani families who had girls. She reported that she and her friends chose Parsippany because they felt that the greater South Asian community provided a cultural background for their daughters' growth. They arranged elaborate *Eid-ul-Fitr* (end of the month of Ramadan) and *Eid-ul-Azha* parties for their daughters. They gathered to apply henna on the eve of *Eids* and exchanged gifts of glass bangles and sweets. On *Eid* they arranged potluck dinner parties so that friends from different parts of the tri-state area could get together once a year. The girls arranged *bhangra* (Punjabi dance) nights at their local high schools. They hung out together, watched movies together, visited amusement parks and some even went to the same college after high school graduation. They found that having a network of friends provided a nurturing and comfortable atmosphere (*mahole*) to raise their daughters.

Her friends also helped her brother and brother-in-law find jobs when they immigrated to the US. It had been a mid-career change for her brother and brother-in-law. Both of these men had been physicians in Pakistan and after passing the required

licensing examinations to become eligible to practice in the U.S., they found it difficult to find a job. These men found jobs with the help of their sister's network of friends. They set up offices and now have thriving practices in Jersey City and Parsippany.

Participants from the Edison area led similar suburban lives, but there were a few differences. Most of these women had never lived in large U.S. cities. Some of them had migrated with their husbands, who had immigrated in the pursuit of higher education. These families had settled in New Jersey mostly because that was where their husbands found their first job out of school. Some of these men had transitioned to a job in New York City, but had not moved there because it was very expensive and because of convenient train connections to New York from the Edison area. These families had initially rented apartments, but as time went by they saved for a down payment and bought houses.

These women remembered their first homes in a new country. They informed me that there were mostly small families with young children or newly married couples living in those apartment buildings. There were people of all nationalities living in those complexes. These women had Arab, Indian and Korean neighbors. These women had made friends with their neighbors. These friendships proved to be very important when these women needed help. One of the women went into labor and her neighbor from India drove her to the hospital and took care of the children until the husband came home. Another woman usually baby-sat for a neighbor after school until her full time working friend came home at six. These neighbors advised each other on education, employment and emotional issues. One of these women enrolled in a real estate course on the advice of a friend who was also her neighbor. This woman had a bachelor's degree from

Pakistan and wanted to work, but did not know where to start. She found that a real estate career suited her because she did not have to go back to school to start a new career. She said she would never have imagined this if it had not been for that piece of advice.

One advantage of living in the Edison area is that distant friends often visit. Since there is a vast variety of South Asian stores around Oak Tree Road, people from across New Jersey visit the area on a weekly or biweekly basis. They buy groceries in bulk so that they may last a few weeks. This provides an opportunity to visit friends in the neighborhood.

The suburban Pakistani immigrant women in my sample chose to live in the suburbs also on account of the schools. These mothers thought that their children were enrolled in school systems that would enable them to pursue higher education and reach their goals. In this pursuit some had chosen long commutes and the husbands drove long distances to get to work. One father worked as a doctor in Jersey City and drove there everyday from Parsippany. Many of these women had conferred with each other on schools before moving. All their children were enrolled in public schools.

Many of these informed me that they loved the openness and the greenery in the suburbs. Some of these women enjoyed gardening. One had a dog. All others thought that it was important for their children to have a yard to play in. These women preferred living in a suburban environment.

7.5 Different Physical Environment

Fourteen of the women in my sample lived in Jersey City, while the rest lived in suburban towns of New Jersey. Many of these women had lived in other parts of the U.S. (Queens and Brooklyn, NY, Kansas, Iowa and Connecticut) before moving to New

Jersey. I found that adaptation to their new environments was influenced by where these women had lived in Pakistan. A geographical background of Pakistani cities (below) provided some insights.

Cities are planned differently in Pakistan and the larger cities have become giant megapoli. Instead of suburban towns around a larger city, there are satellites that are part of the city. Since cities have grown outwardly from an inner core, there are areas that are very old in the heart of the cities. Some were even walled cities at one point in history. You can see preserved old city walls in some areas. The suburban growth was outward. One colony sprouted at the outskirts of the town and then another sprouted from the original suburb. As this concentric growth occurred, the density of the inner city homes eased and people could build homes on larger lots. Therefore, two people can be from the same city, but one may live in a large suburban home while the other lives in the inner city in a multi-story home. The inner cities are congested with narrow winding streets. Many streets are meant only for pedestrians and car owners usually park in clearings that may be at some distance from their homes. All the old commerce and trade is localized in these areas. Many modern businesses located in the suburban areas still have roots in the old city centers. For example, a glitzy furniture showroom in the suburbs will have many small carpenters in the inner city who are suppliers. Similarly, many ready-to-wear clothing boutiques will have inner city mini-factories manufacturing their products. There are vast differences in locality and living experiences within the same city.

Women who had lived in urban areas of Pakistani cities tended to feel more comfortable in urban settings in the U.S., and women who had lived in suburban areas in Pakistan preferred the suburban U.S. Both, the women now living in Jersey City and

suburban New Jersey, preferred living within a larger Pakistani community and women who had initially lived in rural Iowa and Kansas found that urban and suburban New Jersey had a Pakistani community that met many of their needs. The large Pakistani immigrant population of New Jersey has created a community. There are several mosques, *halal* meat shops, auto shops and medical practices that cater to the Pakistani community, and these are found located all over New Jersey in both urban and suburban areas.

7.5.1 Weather

“I could not go outside since it was very cold during the winter. It was my first winter, so I felt very cold.”

“But Connecticut is very cold and this was the first time I saw snow falling. I was very excited to see the first snowfall. Later, I was fed up with it because there were other concerns like how am I supposed to get out of the house with the little kids. You have to really bundle them up.”

All the women interviewed thought the weather was very different in the U.S. All the women, urban and suburban, agreed that initially they found the winters very cold. They hailed from the plains of Pakistan and were not accustomed to regular snowfalls. They enjoyed the falling snow in the beginning, but found that it could also become a problem. Women, who had very young children, feared that they might get sick if they were exposed to the cold very often, and hence ventured out only when necessary. Women who lived in the suburbs had to shovel the snow from their driveways. Urban women found that walking became quite difficult within the city.

Weather played an important role in shaping these women's experience in the early days after immigration. This was important point because these women's

circumstances had also changed. There were several changes from when they lived in Pakistan. Some of these women had to take a bus or subway to visit their doctor or clinic: in Pakistan they had a car or someone to drive them. Other women did not have anyone to babysit and had to bring their children out in the cold every time they had an errand to run, when they would have preferred not to (as they would have done in Pakistan). Driving conditions could be precarious and streets and sidewalks were piled high with snow. Sometimes buses and trains were delayed or running on altered schedules and these women had to wait in the cold.

All these women found that the cold did not matter to them after they had adapted. Their children played in the snow for hours, they shoveled the snow as a matter of routine and now went about their business as usual. However, it should be pointed out that their children are older now.

7.5.2 Mobility Issues

Many women found that mobility was their greatest concern after immigration. In Pakistan, they could hail a taxi, rickshaw or ask any number of their household men to drive them to their destination. Some even drove and owned their own cars. Most of the women who had lived in Pakistani suburban areas fell into the later category. They had owned cars and driven them in Pakistan, while the urban women had lived in close proximity to shopping areas and had walked or taken a taxi to run their errands. However, once they got to the U.S. they found that they were much more dependent on their husbands, who were not available all the time because of work schedules. These immigrant women felt that they had exchanged their independence for a dependent role, and this was stressful. Their perceived loss of mobility and hence independence stemmed

from several reasons. First, they often did not feel comfortable venturing out on their own. Some of these women felt they were unfamiliar with their new surroundings and would get lost. Other women felt that they just could not go out alone, while some did not have a driver's license or a car. Some could not afford a car in the beginning and had not travelled alone by bus in Pakistan. Some of the women who had worked in Pakistan found that their roles changed drastically after immigration. They were unemployed and also financially dependent on their husbands.

“I felt trapped because I drove in Pakistan and women who work are slightly different from home makers- definitely. I did not like going from being totally independent to being so dependent.”

“Over there [in Pakistan] if I wanted something I would send this boy who used to work for us. Everything was at the door step. He would run to the bazaar and get me *dahi bhalley* [yogurt and fried chickpea flour patties] or *samosas* [stuffed fried pastry] if I wanted them. Over here you can't go anywhere.”

I found that women who moved into urban neighborhoods enjoyed more freedom of movement than their suburban counterparts. A woman who had initially lived in Connecticut felt glad they had moved to Jersey City because she had never felt more isolated than when she had lived in suburban Connecticut. She reported that she had never felt lonelier in her life.

Most suburban women also reported a lack of convenient shops close by, and their total dependence on their husbands. If they needed something in an emergency, they had to wait until their husbands got home from work.

“My husband used to do all groceries and other things.”

“My husband had left for work when I broke my water. I did not know what it was so I called my friend. She said you need to get to the hospital and asked me where my husband was.”

“My greatest concern was that my husband was working in Manhattan, and if something like this happened, who would bring me to the hospital?”

By comparison the women living in urban areas such as Queens, New York or Jersey City could walk to nearby shops if the need arose even in the winter months.

Transportation options are limited in the suburbs. Transit buses have limited routes and most trains are used for commuting to New York. Even if these suburban women decided that they would go shopping or visit their doctor alone, there were bus schedules and bus stops to consider. Sometimes bus stops were located along major roads in towns and the women had to walk a long distance to get to the bus stop. Women in suburban towns generally preferred waiting for their husbands to drive them.

“We settled in Jersey City in 1993. My last one was born here. By that time I would go to doctor’s appointments on my own. Since my husband works in New York it’s very easy for me and it was very- very convenient. I did not expect him to come home and bring me to my appointment.”

“I would go grocery shopping with him after he got back from work at night sometime. He would get the weekend off. That was my only outing since he is not outgoing at all. Mostly we would visit some friend of his.”

Women who lived in urban centers of Pakistani cities generally preferred Jersey City in New Jersey. They found that they were more comfortable in that environment. Although, there were some safety concerns, they found their initial dependence on their husbands to be too restrictive. There were initial qualms about safety, but these women soon adapted by adopting certain measures. Most do not go out alone. Instead they walk together to their local schools, shops and on other errands. Most return home before dark. These women reported that they felt very comfortable when they are in a group, and have

never been a victim of a crime. Many of them stated that safety has also become an issue in Pakistan. These immigrant women have also adapted to the train system and the buses. These women started out by travelling with their husbands and now arrange to go to New York City's garment district to shop for material or to Queens, home of another large Pakistani community, to visit or shop. Some of these women have cars and plan shopping expeditions to the mall together.

“I do not drive. The trains are very convenient. There is bus transportation available. My husband has a car, but he takes the train to work. He takes me around.”

All the suburban women owned and drove a car. Although initially they too had to share their husband's car, or waited until their husbands got back from work to run their own errands. All these women now used their cars to get from one point to another and seldom considered taking a bus. They have adapted to their environment and solved their mobility issues.

7.5.3 Changed Lifestyle

Several changes in the environment had indirect effects on their health. These women found that they got considerably less exercise in the U.S. than in Pakistan. Most of these women were used to walking in Pakistan to shop or for pleasure. Once in the U.S., they found that walking depended on several factors. There was the weather to contend with, since it was much colder than in Pakistan. Their dependence on transportation, personal car or bus or train, increased because they found the distances were longer in the U.S. Most of these women were used to going out as a group or with their husbands for a stroll after dinner. They found that their husbands worked longer hours in the U.S. and were disinclined to go for a walk.

All of these women had never visited a gym in Pakistan. This would be considered inappropriate for women due to concerns for *purdah* (in this case exposure to unrelated men). However, most women in the U.S. adapted and found ways to incorporate exercise into their daily routines. Many of them had joined gyms and some set aside some time everyday to go for a brisk walk. Some started exercising after they learned that they had gestational diabetes, while others wanted to lose weight.

“I would take a walk now and then sometimes, but it was getting colder so it was tough, but I walked a lot during my first pregnancy. Over there [in Pakistan] the doctors stress on walking. So I would go out with my mom or an aunt and walked a lot. We would walk on the streets surrounding our house and sometimes walk to the next neighborhood. We would go out at night.”

“Now I have joined a gym. I have started going to a gym and have lost 10 pounds already. Well, now I had to lose the weight. I have been diagnosed with diabetes. That tension [of being diagnosed with diabetes] scared me into losing the weight.”

“I get up at 5 every morning so I can walk. Then I come back after an hour and start getting the kids ready for school.”

“Everything was normal until my eighth month, that’s when I had my glucose tolerance test. It tested a higher than normal.... I was told to take the brisk walks. I managed very well. I used to walk nearly every evening.”

7.5.4 Housing

Another important change was the housing in the U.S. Houses were built differently in Pakistan, and were suited to local weather. Winters were milder in most of Pakistan when compared to the northeastern regions of the U.S. and there was no need for central heating. Hence, these women usually heated their rooms with portable or small natural gas or electric heaters at night when it was colder. Since the temperature went up during the day, and when it was clear and sunny, people enjoyed the sun outdoors. Most of the

houses that these women had lived in possessed a front or back yard or a central courtyard with tall walls surrounding the periphery of the house. If they lived in smaller, more compact houses within the urban core of the city, they had flat roofs with walls around the perimeter where they could enjoy the sun or dry their laundry. The walls afforded privacy.

“Our house was small: the usual city houses. We have a courtyard once you come inside the main entrance. Then, there is a veranda and behind those are the bedrooms. We have a roof where we used to sit in the sun in winters and eat peanuts and oranges all afternoon.”

“They used to make her lie down in the sun for a little while every day in the courtyard.”

“Actually we designed my parents’ house in Lahore. It turned out very nicely. We had incorporated traditional elements like an inner courtyard that you could access through the living room. We left a large backyard for them to host large parties in.”

Some of these women felt that their apartments in the U.S. were very small when compared to their parents’ homes in Pakistan. Most of these women found that the wood construction, in the U.S., made the floors creak when they walked on them. Sometimes their neighbors complained if their children ran across the floors.

“I came to this same apartment. It has been a long time. At that time he [husband] had a cousin and a friend living in the same apartment. They shared one bedroom and we were in the other. So I landed in this apartment and ever since I am stuck here.”

Some of these women found that bathrooms in the U.S. had carpets. They recalled them laughingly now, but in the early days after immigration, they had been very careful not to get the carpet wet. One woman recalled that she missed the freshly washed bathrooms of Pakistan and feared that all the vacuuming could not get the carpet clean enough. These women also preferred to hand-wash their *shalwar kameez* dresses from

Pakistan, but did not relish dripping water over the carpet. Most of these women preferred tiles in their bathrooms and have had long since replaced the carpet.

Laundry dryers were also something new, but they appreciated the fact that they could get their clothes dried in no time. However, going to a laundromat and doing their laundry was something new. These women were used to washing and drying their clothes within their homes in Pakistan. The women who lived in apartments had their laundry rooms in the basements of their buildings, while those women who rented part of a multi-family house had to use the local laundromats.

Most of these women felt that these were minor details and they did not worry over them and adapted very quickly. All of these women had adapted to their environment, but it took some time.

7.6 Loss of Social and Cultural Capital

Generally most Pakistani immigrants experienced a loss of supporting networks on immigration. This loss was experienced differently by immigrating men and women. The difference can be explained if their experiences are viewed in a cultural context because the structure of the support networks is rooted in Pakistani culture. Furthermore, the loss occurred in different spheres of life based on gender and therefore the impact, even though it was felt by both, was different for men and women. The men mostly experienced an economic loss. This had an indirect, but potent impact on the women. However, these women experienced a more profound loss when they emigrated. This loss was not as tangible as their male counterparts, but influenced their life and shaped their immigration experience at a more emotional level. These women experienced a loss of their network of female family members. There was a loss of family, friends, confidants

and a loss of physical and emotional support networks. However, the loss was transient and as these immigrant women found ways to connect to their existing networks in Pakistan and to build new networks in the U.S.

According to their wives these Pakistani immigrant men suffered an economic loss initially. This resulted in two ways. The first was a loss of family and social networks. The second was a loss of educational credentials and consequently economic (earning) potential.

These women stated that their husbands had vast networks composed of family and friends in Pakistan. These networks could be depended on in times of need and could be activated to provide direct or indirect economic gain. Family name, trade and wealth, all contributed to their successes. Some of these men belonged to families with vast land holdings and had attended prestigious schools (usually these schools are very selective and expensive and honor a family history of attending the same school) which meant that they had large caches of social capital. All these factors affected their economic potential in Pakistan. Furthermore, since traditional gender roles are defined in Pakistani culture, it is the male who has the primary responsibility to provide for the family.

“My brother and sister-in-law are both well known in the field of architecture in Pakistan. My brother-in-law was the head of the architecture department in Punjab University and my sister-in-law taught at NCA [National College of Arts]. She later became the principal of NCA. One of my sisters-in-law is a gynecologist with a practice in Lahore.”

“My father had an extensive network of friends, which included film stars.”

“After graduation both my husband and I got jobs. I worked with a very prestigious architect in Pakistan for a while. I just walked into his

office and said 'I want a job'. It was a great experience. I worked for a year or a little over that."

These networks were weakened or lost their potential with immigration. However, networks still mattered and proved to be helpful, but in different ways. Friends and family networks already in place in the U.S. provided initial shelter and financial help. Some also helped the new émigré find a job, but the job might not have been as well paying (as compared to what they could earn in Pakistan) or matched the educational credentials of the émigré.

"Initially we stayed with my husband's friend."

"My older sister was here and we stayed with her."

"A friend of my husband told us about a job in a laboratory in Baltimore. He helped my husband get that first job."

The U.S. educational system also had an impact on these immigrants' experience. Some of these men experienced a loss of earning potential when their educational credentials were 'lost in translation', while others enhanced their earning potential. Some of these men had completed their bachelor's degrees in Pakistan and had secured admission to master's programs in U.S. universities. These men found jobs after completion of their education with greater ease than those who did not have an American degree, even though some men shared similar educational backgrounds. In one case three men graduated from the same college in Pakistan, two men applied to and completed their master's degrees from U.S. universities one did not. The two men with U.S. degrees got jobs in their area of expertise, while the third man started out working in a retail store. Although the third man held similar educational credentials he could not get a job in his field. The other men did not have any networks in place either, but found jobs because

they had an advanced degree from an American university. As a result there was a tremendous difference in their salaries. This economic gap was a direct result of loss of education credentials on immigration. The same person, now working in a retail store, had practiced and run a successful business in Pakistan based on the same educational qualification as his two friends in Pakistan. The two university graduates lived in homes they owned in the suburbs, while the man working in retail lived in Jersey City in a rented apartment. One woman, living in Jersey City, reported that her husband was an engineer in Pakistan who now worked managing a taxicab business because he could not find a job based on his qualifications in the U.S.

“My husband had found a job and he was working in shifts. Sometimes he was working mornings and sometimes evenings. He had not found a job in his trade, but had started working in a store. You are in a new place and trying to adjust.”

The two physicians in my sample worked in research facilities or in laboratories while completing the extensive requirements of the U.S. medical licensing board. These men had families to support and could not devote all their time to studying for their required licensing examinations. Hence, it took them some time to complete their requirements and find a position in a residency program. Even so they had to complete another three or more years in residency programs, which do not pay well, before these men could get a license to practice. In contrast, their counterparts in Pakistan had been practicing years earlier. Again, these men experienced an initial loss of social and economic capital on immigrating to the U.S.

Timing was another factor to consider. Men who had immigrated alone or those who were single did not have the added responsibility of a family to care or provide for. For example, those who had come to the U.S. for higher education, completed their

education, got jobs and sponsored the immigration of their wives. Other men who had immigrated alone had time to get a job or start a business before seeking to get married. In contrast, those who had immigrated with their families experienced greater economic hardship and often had to settle for any job, regardless of it being matched to their skills.

The financial situation directly affected economics decisions. Low economic status directed the choice of residential location and some of these Pakistani immigrant men had to look for areas with low cost rental properties. Many of these immigrant men worked in New York City because the city offered more job opportunities. However, it was expensive to live in New York so they had to find cheaper housing alternatives in New Jersey. Hence, many of these men chose to live in Jersey City. Although Jersey City has undergone a renaissance and housing prices had risen over the last ten years, yet there was a considerable difference in housing prices and rents between the New York City and Jersey City. As a result many chose to live near Newark Avenue or Grove Street because of quick PATH train connections. There was also the added advantage of the sheer number of apartments and multi-family homes available for rent in Jersey City. The urban women reported that there was always a vacancy and it was also easy to find a tenant to share the apartment or home.

Yet another benefit was the mobility afforded by having most necessities within a walk-able distance in Jersey City because some of these men found that they could not afford a car. There was the cost of the car, car insurance and monthly parking fees to consider because most of them rented apartments and did not have a house with a driveway or garage, which added to their monthly expenses.

There were other financial considerations. The men living in Jersey City sent more money in remittances to Pakistan which meant that their families in Pakistan belonged to a lower socio-economic class and were financially dependent on these men. This added to the financial responsibilities and expenses of these men and limited their disposable income even further.

The quality of social networks indirectly affected the opportunities available to these men. The men in my suburban sample were mostly professional men who had completed some kind of U.S. education. By contrast the men in Jersey City, who may have completed professional training in Pakistan, were limited in their search for employment because of lost educational credentials. Some of these men had changed their line of work and found other sources of income such as small business ownership. These included limousine services and dollar stores. One of these urban immigrant men had gained employment in the U.S. Post Office. All these men tapped into local networks when looking for a job. Men living in Jersey City, who lost their jobs and were looking for another, used their local network and often found temporary jobs driving a limousine or working in a friend's retail store, while continuing their job search. In contrast, suburban men who were between jobs freelanced in a professional capacity, while searching for a new job. These men asked their local friends with similar educational backgrounds for help with their resumes and applied to companies as recommended by their network. This translated into better paying jobs because of the quality of their networks.

These men also experienced a loss of cultural capital. This occurred with the restructuring of traditional gender roles. Although I did not interview the men, data

analysis provided some insights into gender roles in Pakistan. Many of these married couples shared a home with the men's parents where traditional gender roles were observed and a division of labor was part of the cultural structure. The women in the house managed domestic affairs, while the men were involved with earning money. Their mothers (the men's) were in charge of the households and while their sons were accorded preferential treatment and daughters-in-law were expected to respect cultural norms. These men had not cooked or taken part in cleaning the house or actively helped in taking care of a newborn baby. After immigration these men found that they had to take an active part in running the household. Their wives (who had depended on other women in the household for help in Pakistan) were now more dependent on their help. For example, their wives' mobility issues (such as women not being able to drive a car soon after immigration) added to their husband's responsibilities because they had to help shop for groceries and bring their wives to the laundry: chores they did not have to do in Pakistan. They had to take to additional domestic responsibilities when their wives became pregnant. These men shared a loss of social networks with their wives when they immigrated.

In some respects the loss of social capital experienced by the immigrating women was comparable to their male counterparts. Most of these women came from families in Pakistan where women did not work. They were educated, but these women did not anticipate working in Pakistan. However, they found that many women worked in the U.S. and that they could also find a job. I found that all who wanted to find a job were able to, regardless of their educational status or even fluency in speaking English. Most of the women started working to boost their combined income.

“After things settled I used to get the groceries and all. I also do the billing for my husband.”

“I tried Herbal Life at one time, then Avon. I am now doing Nutralite. Everything from home. I don’t work outside of my home.”

Their educational status mattered when it came to the type of job they could find. Having a master’s degree in Architecture from Kansas helped one woman find a job at a large architectural firm. However, she stated that her husband, who had similar credentials, found a job very easily, while she waited nearly a year before she found something. Meanwhile she worked at a retail outlet at a mall near her home. The women who had a tenth grade or high school equivalent education found work at local dollar stores and daycare centers. As a result many of the working women living in Jersey City worked locally in retail. Language proficiency and other limitations did not pose a great hurdle in finding low paying jobs. In contrast, suburban women with higher education found jobs as teachers, healthcare workers, accountants, real estate agent and architecture. Some of the suburban women, who had a bachelor’s degree from Pakistan, got their education credentials evaluated in the U.S. and found work as substitute teachers in their local schools. One woman enrolled in an undergraduate program and completed her education in the U.S. She was also raising three school going daughters at the time and took out student loans to fund her education.

“The job was in the Indian market. I worked there for year and half. I used to work from 7:30 to 5:30 every day.”

“I work in a day care center all week and on the weekends I work for ‘S *Bhai*’ [older brother, as a sign of respect], at his dollar store.”

“One of my friends started working in that company and then after a month I started work there also. She and I went to different interviews together. We were not that educated, but wanted to work. She told me she had found a job and recommended I try there also.”

Immigrating children also experienced a loss of cultural capital. Grandparents helped with child rearing in Pakistan. Women who had worked in Pakistan stated that they had hired help to look after older children, but the presence of a grandparent ensured the well being of their children. One woman remarked that she felt that the presence of grandparents acted as a buffer between children and the hired help or tired parents. She felt that in the U.S., her children came back from school to an empty house and missed their grandparents. She felt that her daughters also lost their support network and that this could not be replaced in the U.S., even though there were family members nearby who could offer support.

“I had a maid [in Pakistan] for both my daughters. I had someone who cooked. I never had that problem (problem of having/affording help). That is my biggest problem here. I am working now. I am not saying that there is not quality—that you cannot give to your family if you are home. You can. If you are [working] out of the home, you do overlook a few things. There is the time that you cannot give them. Some say that if you are working, then the time you spend with your kids is quality time, but I would say that that was true in Pakistan. My kids were never alone in Pakistan. There was either *dadi* [paternal grand mother] and *aayah* [nanny] or *nani* [maternal grandmother] and *aayah*. So they always had a compassionate person with someone else taking care of them who was responsible for their nitty gritty stuff like bathing them, etc. That isn't here. I could talk to them on the phone to solve some of their problems. You don't have that extended support system here. We don't have drivers here. If the girls have to do something at a time when you are not available, then you feel that there is that stress. My sister-in-law's daughters can ask her to bring them here or there. They have that feeling of ownership. My children don't feel comfortable asking her. They are reluctant. She asks them, but they are reluctant. They don't feel at ease. I was working full time and now it is a little relaxed and I can feel the difference in them.”

7.7 Negotiating Marriage in America

Many of these immigrant couples, both urban and suburban, found that gender roles were more flexible in the U.S. and husbands and wives had to share family responsibilities. This change occurred out of necessity. Since there were often very few family members nearby or in the U.S., these couples had to rely on each other for help and support. Often the husbands had been in the U.S. longer, while the wives were new to immigrant life. Most of the husbands were accommodating and understood the challenges these women were facing. They helped with housework and childcare especially during the early days of pregnancy when the women felt sick. They helped care for their newborns after delivery and were more involved in household decisions than when they were in Pakistan.

“I feel that we as parents were more involved with our second child than the first time around. Especially my husband..... I feel that difference. And I think he became a better father. He had a stronger bond... He has a big say in what is going on with the kids. He takes an active part.”

One woman recalled that she asked her husband to warm some formula for their baby one night, and thereafter it became customary for him to do that. He would later complain jokingly that if his father or brothers saw him doing that, he would not have been able to live that down for the rest of his life. There were role negotiations and both spouses found a comfortable middle in most cases.

“He is a good cook. He likes to cook. Sometimes he cooks a few dishes and we eat them all week long. But he does it only when he feels like it.”

“T loves to cook. He makes the best *nihari*. He is also very good at parenting. I think he is more maternal than I am.”

There were other responsibilities that these women started to share with their husbands. Both urban and suburban women dropped off and picked up their children from school. They brought their children to their doctor's appointments, shopped for groceries, and ran other errands. Some of the suburban women took over household accounts and managed their family bank accounts and other finances.

All the participants had never run an entire household and had never been in charge of financial issues in Pakistan. This was for several reasons. First, they had been young and unmarried and their parents took care of them. Secondly, after they got married, some moved into combined households where other people were charged with those responsibilities. Once they arrived in the U.S., they found that they shouldered the full responsibility of running a household. All these women adapted to life in the U.S., but this took some time. All these women were now involved in making financial decisions and the running of their households.

7.8 Social Environment

7.8.1 Social Support in the U.S.

All the study participants felt it took them longer to establish new social networks than to adapt to their new environment. These women felt that the loss of their female networks in Pakistan was irreplaceable. Over the years these women had negotiated their roles in their households, they had solved their mobility issues and learned to cope with the weather and had found friends, but the quality of their new social networks and their embeddedness in these new networks was still something that needed investment for future benefits.

“Yes there are many Pakistanis in Queens, but when you are new you don’t really know anyone. It is hard to go out by yourself and you go everywhere with your husband and you can’t befriend people right away. Now, I have many friends in Queens.”

They forged two types of new networks. Since their husbands had been in the U.S. longer, most of these women befriended the women in their husbands’ existing networks. These women were the wives of their husbands’ friends. The immigrant women also explored their neighbors and found people they could be friends with.

All these women established new networks, but there were some differences between the urban and suburban experience. Most urban immigrant women lived in close proximity to other Pakistani immigrants. These urban immigrant women found that there were other Pakistanis living in the same neighborhood: sometimes within the same building.

“My husband’s friend and his wife also helped a great deal. They lived in the same building and did not have a baby of their own. She liked to hold the baby. She would say ‘*Bhabi* you get some sleep, I will take the baby’.”

“There were six other Pakistani families in our building and every one had stopped by to ask if they could do something. They brought food for my husband while I was away.”

The experience of immigrant suburban women was somewhat different. While the urban Pakistani immigrant women’s network consisted of other Pakistani immigrants, suburban women had a more diverse group of friends. This resulted because firstly there were fewer Pakistani immigrants living close by and second, there was more ethnic diversity in the suburbs. These suburban immigrant women also found that common ground existed between peoples of different nationalities.

“There were not many Pakistanis in our apartment complex. There were some people from India across from us. They were very nice and helped me a lot.”

“There are a lot of Arabic friends around here and they told me that there was this clinic.”

Proximity played an important role in the development of these new social networks in both urban and suburban settings. Urban immigrant women did not profess a preference for Pakistani friends, and chalked it up to their availability and proximity (many lived in the same building or within the same block). Suburban women also stated that they became friends because of proximity.

Support networks were also composed of structural elements. Some of the urban women I interviewed found that there were government run programs that could work to their benefit. These programs included availability of early childhood programs such as Head Start in Jersey City, which enabled and empowered these immigrant women. As a result, they could contribute to the workforce and help support their own families. One woman started working as a substitute teacher because she was able to send her child to a preschool offered to three year olds in her Jersey City. This job enabled her to supplement her husband's salary and make a better living.

“Then in 2000 I started working as a substitute teacher. My youngest was 3 and she had started pre-school. By this time we had a state run preschool in our town. That is the only reason I could work, otherwise you cannot afford to pay for preschool on a substitute teacher's salary.”

7.8.2 New Norms, Expectations and Obligations

New Pakistani urban and suburban immigrant communities found ways to connect with each other and fulfill their common needs. In doing so these communities had not recreated their lost culture, but had created an adapted version of life in Pakistan.

7.8.2.1 Family and friends. The Pakistani-American society is not a replica of Pakistani society. Several adaptations have occurred to accommodate social changes. As a result an adapted set of new norms, expectations and obligations govern this community. For example, many of these women found that living in the U.S. they did not necessarily have to conform strictly to norms and expectations of Pakistani society.

One woman stated that she had a very large family in Pakistan. She had married and moved in with her in-laws who lived in the same city. Hence, her family size had nearly doubled after marriage. She said that that there was hardly any time to make or visit friends. In contrast, she has fewer members of her family in the U.S. and now has a large group of friends as compared to when she lived in Pakistan. She and many other women reported that the rules of friendship were different from the norms and expectations of family.

“I think friendship is the most beautiful relationship. In families you have too many expectations and there is a lot of politics: all those complications.”

Some of these women found that even though they had family in the U.S., it was neighbors who helped in everyday matters because they lived closest to them.

“Indeed when I had my third pregnancy, it was cold and I did not have the energy to walk to the bus stop, my friends helped a lot. One of their husbands collected my sons from my building and walked all these children to the bus stop. He would line them up. That was great help. I will never forget that help. May God bless them, give them a long life. In the afternoon my friend would bring the boys home.”

Immigrant urban and suburban women who did not have any family in the U.S. adopted surrogate families. These women expressed their deep embeddedness by referring to their friends as family members. These women always qualified their reference to a dear friend by adding ‘like my sister’ or ‘just like my aunt or mother.’

Their children addressed them as aunts and uncles: children in Pakistani society do not address an older person by their first name and add aunty or uncle as a sign of respect.

“All these friends are my relatives now. I have lived with them longer than I lived in my parents’ house. They are closer than family.”

“Now I have quite a few friends here in Jersey City. It has been ten years since I came to the U.S. Now I have at least 10 women who I can call friends.”

“When my second baby was born my neighbor, I call her Aunty [she is like an aunt to me], across the hall gave me a *jora* [unstitched material or stitched dress] and sent me food. She said I was like her daughter and she gave me a new suit.”

Immigrant Pakistani women who had family in the U.S. still observed some of the old norms of Pakistani society on special occasions such as *Eid*. These women had large family gatherings on *Eid* in Pakistan and have continued that tradition in the U.S.

While other Pakistani women who did not have family in the U.S., created new traditions. These have been agreed upon mutually within their circle of friends. These women celebrated *Eid* with their friends. These women pooled their money and engaged a catering hall or restaurant for the occasion or arranged a potluck dinner at one of their homes.

Immigrant urban and suburban Pakistani women also embraced some traditional American celebrations. Most of these émigrés enjoyed Halloween and Valentine’s Day. Some of the women who had recently migrated from Pakistan reported that Valentine’s Day was also getting very popular in Pakistan. Although one urban woman, who had now adopted a more religious lifestyle, thought that celebrating Valentine’s Day conflicted with the teachings of Islam because it encouraged interaction between the sexes and she now discouraged her children from taking part in these activities at school. However, all

these women said that they bought costumes for their children and went trick or treating on Halloween. They also celebrated the 4th of July and enjoyed their local fireworks.

7.8.2.2 Gender boundaries. There were other adaptations. Society in Pakistan is dichotomized along gender lines, but immigration redefined some of these boundaries, and there appeared to be greater integration of the sexes in the U.S. Mosques are one such example. Mosques are used exclusively by men in Pakistan, but there are some rare exceptions. One cultural change in the U.S. was the presence of women in mosques. Women accompanied their husbands for prayers, they participated in mosque activities (organizing food in Ramadan), and also brought their children for Sunday school. Women seldom went to pray in mosques in Pakistan. One participant remarked laughingly

“Who would have thought I would be in a mosque this often! [in Pakistan]”

Another woman offered this insight,

“I never went to mosques in Pakistan not even for *Eid* prayers.”

This change has resulted because the role of mosques is more expansive in immigrant communities. Mosques play a communal role in urban and suburban immigrant communities in New Jersey, as compared with the role of mosques in Pakistan. Not only do immigrants gather there for prayers, mosques also serve as Sunday schools for children and are used for traditional gatherings to celebrate religious cultural events such as *Eid* celebrations, *Aqiqa* (religious shaving of a baby's hair after birth) and *Qul* (third day after death) or *Chehlum* (forty days after death). This has resulted in a greater presence of women in mosques and the Pakistani immigrant communities have accepted

the presence of women in mosques. Women play an active role and volunteer as teachers in the Sunday schools run by mosque organizations. They volunteer in different religious events hosted by the mosques, especially in the month of Ramadan when daily evening meals are served to all fasting people who come for evening prayers. Some of the participants were recruited from their local mosques for this study.

Most schools are coeducational in the U.S. These immigrant women had the option of sending their children to all girls or all boys' schools, public and private, in Pakistan. All these women adapted to the norm of coeducation in the U.S. and enrolled their children, even when they had the option of and could afford to send their daughters to all girls Catholic schools. Although there may be other Pakistani immigrants who did otherwise, all the children in my sample attended public schools. Since some of these women had voiced concerns about raising daughters in the U.S., I asked some mothers how they felt about their daughters growing up in these coeducational public schools. Most women stated that they trusted their daughters to make the right decisions because their behavior depended on the atmosphere in the homes they grew up in (*ghar ka mahole*).

“It all depends on the *ghar ka mahole*. You raise them and teach them your values and then you trust in them.”

Most of these women (urban and suburban) felt it was tough to raise children in the U.S. These women felt this because they perceived too many cultural differences between Pakistan and the U.S. However, these women agreed that it was different for them because they had their pasts to compare their present lives to. These women recognized that their children had not experienced life in Pakistan and that this adapted atmosphere (*mahole*) was the only one they (their children) knew. They agreed that

indeed the atmosphere (*mahole*) of their homes was different from their parent's homes in Pakistan and that this was an adapted atmosphere. These women also recognized that their children were different from them.

7.8.2.3 Children and Islamic education. Another important cultural change was the establishment of Sunday schools. According to Islamic teachings, it is the obligation of parents to impart Islamic teachings to their children. In Pakistan, children receive some basic religious instruction as part of their general education curriculum. Some attend Islamic schools to obtain exclusive Islamic education, but the general mainstream education only includes one period of Islamic instruction a few days a week. Most people in Pakistan employed someone or have a grandparent teach their children at home how to recite the Quran. Therefore, the obligation of educating children about Islam is not solely the responsibility of the parents in Pakistan.

All of the women interviewed for this study felt that it was their obligation to impart some Islamic education to their children. After immigration these parents had to take extra steps to fulfill their obligations. Sunday schools emerged as a necessity because immigrant parents, who did not have to worry about Islamic studies in Pakistan, now felt the full burden of responsibility. Both urban and suburban families enrolled their children in Sunday schools for Islamic education. Immigrant children enrolled in Sunday schools were taught about the history of Islam, the *shria* law (Islamic laws governing life), *sunnah* (the life and ways of the prophet), *fiqah* (combination of *shria* and *sunnah*) and the tenets of Islam. Some schools also offered Urdu language classes and Arabic pronunciation or language classes. When I asked the women if the Sunday school curriculum was similar to their education in Pakistan, they stated that the Sunday schools

in the U.S. offered a more comprehensive Islamic education and this was tailored to a specific *fiqah*. There were different *sunni* and *shia* Sunday schools and, unlike Pakistan, the education their children were receiving was specialized and not the general non-denominational (within Islamic *fiqahs*) offered in Pakistani schools. I also asked these women if their children would understand Muslims belonging to other *fiqahs* in the same manner as they, the parents, did. Most thought their children would not have the same understanding of other Islamic *fiqahs*.

“*Alhamdulillah* [all praise for Allah], my children attend two days, Saturday and Sunday, of Islamic School. They are taught the basic tenets such as the five pillars of Islam: *salat* [prayer], fasting [in the month of Ramazan], *zakat* [obligatory payment of a portion of income to deserving poor] *hajj* [pilgrimage to Makkah once in lifetime] and *shahada* [the oneness of Allah]. They are taught about the *fiqah* and *tajweed* [reading the Quran with proper Arabic enunciation].”

Immigrant parents also wanted their children to learn to recite the Quran, which required more frequent instruction than a Sunday school could provide. Most of the suburban immigrant women found it difficult to find someone in their neighborhoods and did not have the convenience of having someone come to their homes so they hired online teachers from Pakistan to teach their children. Meanwhile, immigrant women living in Jersey City had the benefit of living in a Pakistani ethnic enclave where it was easy to hire someone for instruction.

“Sunday schools here are very different. First of all we did not have the Sunday school concept in Pakistan. We were done with classes in school and there was no need for a Sunday school. For Quran we had a *maulvi* [priest] sahib who used to come to our house.”

7.8.2.4 English as the first language. Many of these women were afraid that their future generations would lose their mother tongue. All of them tried to converse with their children in Urdu, but most reported mixed results. All these women agreed that children may speak to them in Urdu, but invariably spoke in English when talking to each other. Some children had developed their own code of behavior. They knew when to switch to Urdu and what English words were considered taboo in their household. Although most women took pride in the fact that their children could speak Urdu, they agreed that their children will not be able to read or write in Urdu. More urban women reported that their children spoke Urdu fluently than their suburban counterparts.

“They used to teach Urdu at the Sunday school, but now they have eliminated it. They thought it was taking too much time away from Islamic studies and was not too important. Anyway, my children speak Urdu, but will probably never be able to read or write it. They do read Arabic, but I wonder if that is going to help because they are somewhat similar. I don't know.”

There were other regional languages also spoken at home, but most women in my sample used Urdu when talking to their children. Both urban and suburban women reported mixed feelings about their loss. More urban women felt that Urdu was a connection to their homeland and therefore vital. While, more suburban felt that it was inevitable and that they did not consider it very important. Some urban women even said it was more important to learn to speak Spanish because they felt that it would help in the future.

“They [children] are all fluent in Urdu. They understand Punjabi. Every one wonders how they speak Urdu very well. I used to tell my son I don't understand English talk to me in Urdu. He would try, but his Urdu is like the Pathans [ethnic people from North West Pakistan who speak Pashto]. They talk in English when they talk amongst themselves, but they try to speak Urdu. I tell them your grandma and aunts do not speak

English and when you go to Pakistan you will not know how to communicate with them. When they visited, my family was very happy.”

7.8.2.5 Role of *purdah*. The literal meaning of *purdah* is ‘a curtain’ however, this is word has great significance in Islamic teachings. *Purdah* is not just a word; it is a concept. This concept applies to the individual and the community. When applied to an individual it prescribes certain behaviors. A very simple example is that women are required to dress modestly so that they do not attract the other sex while, men are required to lower their gaze and not ogle women. One interpretation of *purdah* dictates that women and men be segregated.

In the new and adapted social environment within the Pakistani immigrant community there is greater mingling of the sexes. However, *purdah* is still observed. For example, the participants observed that when people gathered at a mosque for *Eid* prayers or some other occasion the women and men used separate entrances and the enclosures were segregated. Three *shia* participants reported that when immigrants of the *shia* faith congregated in their mosques or *Imam bargahs* during the month of Muharram, to commemorate the martyrdom of Imam Hussain (grandson of the prophet Muhammad, peace be upon him), both men and women attended these large gatherings, but sat in separate enclosures.

By contrast, when the immigrant Pakistani community got together to celebrate the Pakistan Independence Day in New York City, women and men walked together in the parade and enjoyed the cultural show afterwards: sitting side by side.

Adaptations have also occurred in more intimate family settings. All these women (urban and suburban) agreed that there was less opportunity to observe *purdah* in the U.S. Most of these women observed that generally when they entertained men and women

occupied the same living room, but some still arranged for the women and men to sit in separate rooms. Sometimes if there was only one living room, women had to sit in one of the bedrooms. More urban immigrant women observed the segregated seating arrangements. In order to socialize more informally, some women in Jersey City hosted lunches and entertained their friends during the day when their husbands were at work.

I asked what my study participants felt about *purdah* in the U.S. and both urban and suburban women said that their attitudes had changed. Some of these women used to lead very conservative lives in Pakistan, but found that their husbands were very liberal and adapted to their husbands' lifestyles. Some of these men enjoyed an occasional alcoholic drink and did not observe the *halal* food obligation. More urban women reported becoming more conservative and had started to wear the *hijab* (head covering). Some of the women who had grown more religious after immigration attributed it to their age and maturity, while others felt that their network of friends and peers at the mosque they attended regularly had influenced their decision.

Some urban immigrant couples had adopted a more conservative lifestyle together, while sometimes it was only the women. One urban woman had chosen to wear the *hijab* after attending *dars* (sermons, lectures) at their local mosque. Her husband did not voice any objections, but she informed me that he was not enthusiastic about her decision and that he felt she was attracting undue attention when they went out, but that he supported her decision.

7.8.2.6 Social class permeability. Interestingly, I found that there were few social boundaries based on income or residential location. Data indicated that these immigrant women interacted with other people in three spheres. First, they interacted with their

neighbors, second their family members and thirdly with friends. Some made friends with their friends' networks, thereby expanding their social circle. Some of these women had lived in Jersey City initially and had moved to suburban towns, but kept in touch with friends that they had made when they had first arrived in the U.S. Many of these couples socialized with people they knew from Pakistan. Some of them were introduced by mutual friends or met in local mosques. Urban and suburban women recounted all the different people they knew and reported that their circle included yellow cab drivers, limousine drivers, pharmacists, business owners, insurance agents, real estate agents, architects, engineers, physicians, restaurant owners, home health aides, teachers, accountants and postal workers. When asked if that list was different from their circle of friends in Pakistan, they reported that their circle included mostly family members first and then some people from their husbands' work or some of their old school friends. Most of the suburban women agreed that they now had people of other ethnicities on their list of friends. They were friends with many Indian and Arab immigrants and Americans. These women found it strange, but welcomed and enjoyed their friends' different cultures. One woman regularly exchanged gifts with her American neighbor on Christmas. She would buy her something for Christmas and her neighbor got her gifts for *Eid*. Another woman learned how to make stuffed grape leaves and swapped recipes with her Arab friend.

7.9 Maintaining Old Networks

Immigration to the U.S. did not mean severance of all ties to Pakistan. Most of these women reported that they had well established links with Pakistan. There were several venues that kept them in close connection with their mother land. First, communication

over the telephone and the internet had become much easier and affordable over the years. Secondly, airfares offered direct flights to travel to Pakistan cutting the travel time considerably. Thirdly, there was a lot of information available (on the internet and with satellite TV) about Pakistan that make them feel very connected. They moved between the two countries freely and felt that they were citizens of both countries.

Telecommunications have been the chief method of communication for migrating Pakistani women. Some of these women, who had been in the U.S. longer, stated that calling Pakistan used to be very expensive twenty years ago. One woman recalled that the first minute used to be worth nearly \$4.50 and then the subsequent minutes would be half that price. The advent of calling cards lowered the rates to \$.11 per minute: an enormous difference from the 1980s. These women did not even have to go and buy these cards because they were available on the internet. Some of the suburban women send text messages to their families in Pakistan.

“I used to call her [mother] twice a week or so. Now I call her more often it’s cheaper. Now I can text her messages. I send her maybe four text messages every day. Or else I call them. I called both my parents just this morning. I’m very close to my mother.”

The internet has provided another venue for these families to congregate and keep in touch across vast distances. Most of these women had access to a computer and the internet. These women reported that computers had become readily available in Pakistan also and that helped them establish internet connections with their families. Lower internet access rates in Pakistan had also helped ease connecting families to each other. Most internet users reported that they had started using MSN Messenger first, or Yahoo Messenger, and could chat with their families and friends. These women had now

graduated to Skype and Oovoo, both of which enable multiple members to enjoy video chatting. However, more suburban women scheduled web-based family meetings and enjoyed exchanges with their family and friends in Pakistan than the urban women. However, there were some families in Pakistan, who did not have access to the internet and still used the phone exclusively. One urban woman reported that her mother had moved to her village (after all her children had married and moved away) and did not have access to even a telephone. The mother had to make a special trip into a nearby city in order to talk to her daughter in Jersey City.

“Well we did not have a phone in our home in Gujrat, so I used to call my mother twice a week. She had to come into the city for that. She lived in a village close by.”

“I love Oovoo. My parents and sisters log on and I can see them and talk to all of them consecutively.”

“I still call my father every weekend. If I don’t call, he calls me. I used to chat a lot, but before my younger child was born. He would not let me chat when he started crawling. Now it has been a while since I used a computer.”

Travelling to Pakistan has become easier, but expensive for these immigrant families. Although many of the participants complained that airfares had gone up considerably, they still tried to make frequent visits. These women reported that they could catch direct flights to Pakistan now that lasted only 13-14 hours (previously the same journey involved stops and could last 20 hours). However, these women reported that airfares had increased because of higher airport taxes. Some of these women also mentioned that their children had grown and had to pay adult airfare and that added to their expense. Some said that since their children were in higher grades at school, they could not afford to take time off school and had to travel during the ‘high’ season in

summer. These women informed me that summer travel was expensive and the weather was very hot in Pakistan, yet they tried to visit with their families often. As a result not all of these immigrants visited Pakistan frequently.

The most important reason these immigrant families had visited Pakistan was to visit with their parents. However, in some cases the parents of these immigrants had deceased. In other cases, their parents had immigrated to other parts of the world. Some of these women reported that like them, some of their siblings had also migrated to other countries and had sponsored immigration for their parents. These countries included Canada, United Kingdom and the Gulf States, Saudi Arabia, and the United Arab Emirates. Therefore, these families visited with their siblings in other parts of the world rather than in Pakistan. Some of these participants had sponsored their parents' immigration (for permanent residence status) to the U.S. Now their parents could visit them whenever they wanted to without having to apply for a visit visa. Some of the more affluent parents moved freely between Pakistan and the U.S. and took advantage of the mild winters in Pakistan and cooler summers in the U.S., giving the term 'snow-birds' an entirely different meaning.

Some of the more affluent suburban women visited Pakistan on an annual basis. These were the ones whose children were high school or college students. They planned their trips avoiding the 'high' season and travelled in the spring when the weather in Pakistan was better. Their trips included shopping and meeting with family members, but some cited other reasons. Some of these women also visited doctors in Pakistan. One woman went back to get a tubal ligation.

"I thought it was a minor procedure and I felt comfortable in her [her doctor] hands."

Many women brought back antibiotics and other medicines from Pakistan or asked some family members to ship medicines to them every month. Some of these women ordered medications, from Canada, online.

“Then I used to get people to send me antibiotics from Pakistan. For the child at least. You know we were young and never sick.”

Some women brought back clothes and sold them to their friends or at venues like *Eid* festivals. Some of these women (urban and suburban) had established an informal business in collaboration with female family members in Pakistan, who prepared and sent shipments of clothes to be sold in the U.S.

Some of the spouses of these immigrant women were involved in import businesses from Pakistan. Two urban men worked part-time, but were also involved in other businesses. They got their materials shipped from Pakistan and sold them online or distributed their wares to other sellers in the U.S. They attended trade fairs and sold their goods at these venues.

College education is more affordable in Pakistan as compared with the United States. Some of the participants wanted to send their children to Pakistan for higher education. Two of these women (one urban and one suburban) planned on sending their children to Pakistan to study medicine. These women felt that it was very expensive and competitive to send their children to medical school in the U.S. They reported that it also took much longer in the U.S. to complete a medical degree. One of these women was planning on moving back to Pakistan for a period of time so that her son could complete his degree in medicine.

“I am thinking of sending my son to Pakistan. He wants to be a doctor and it so hard over here. It takes too long and is very expensive. I

am planning on going back for a few years until he completes his degree and then come back.”

One urban immigrant woman had sent her toddler to Pakistan because she had an unplanned pregnancy soon after her first baby was born. She had to return to her job so she and her husband decided to send their baby off to live with her grandparents in Pakistan for two years.

All the women interviewed felt that television provided an important window into Pakistan. These women subscribed to satellite television or cable connections that offered Pakistani programming. Many of these women reported that they watched Pakistani channels exclusively, others also subscribed to Indian channels. These women got their news, watched drama serials (soaps) and talk shows on their favorite channels. Their children watched American shows, but they enjoyed mostly Pakistani channels. These women felt that they were embedded in Pakistan.

Most of these women and their husbands sent remittances to Pakistan. Most of these women sent money on a monthly basis, but on occasion sent more if needed. More women living in Jersey City sent home money on a regular basis than those living in the suburbs. The suburban immigrant women sent money when they had to set aside some money as *zakat* (obligatory deduction from income for the poor) or *sadqa* (voluntary charity for Allah). Women from Jersey City stated that they sent money to their parents to help them financially.

“You know retirement money is not enough and we have to support them [their parents]. We also send money to Pakistan on *Barri Eid* [*Eid-ul-azha*] for *qurbani* [sacrifice]. It is not a real *qurbani* here. You are handed a bag of meat and that also a day later. It doesn't feel like *qurbani*. So we send the money to my father in-law and he does it over there.”

“*Zakat* is due on my gold jewelry and I calculate the amount every year and send the money to my mother who then gives it to the people who need it. There are many families there [in Pakistan] who need money.”

Zakat and *sadqa* were observed by both urban and suburban women and depended on their religiosity. *Zakat* and *sadqa* are both forms of charity, but *zakat* is obligatory and *sadqa* was of a voluntary nature. If there were health or other problems, then women sometimes set aside some money as *sadqa* in the belief that this would ease family problems or after having delivered their baby they made a little offering. I found those women who reported that they were religious or those who had become more religious remitted *zakat* regularly (hence, more urban women). These women also felt obliged to calculate the *zakat* they owed on the quantity of gold jewelry they possessed.

Many immigrant families also sent money to Pakistan on *Eid ul Bakr*. This is the celebration after the annual *Hajj*. All Muslims, who can afford to, are required to offer a sacrificial animal (mostly a goat, camel or sheep or a cow). Many immigrant women reported that they sent money to Pakistan for this rite. Family members in Pakistan then performed the sacrifice in their names. Most of these women agreed that even if they performed their sacrifice in the U.S., and many people do, they did not know any poor people to whom to distribute the meat to since one third of the sacrificed animal must go to the poor. These women also felt that it did not feel right to get a bag full of meat a day after the *Eid* because *halal* meat shops close for the day of *Eid*. By contrast, these women recalled that butchers in Pakistan were in high demand on *Eid* because they went from house to house sacrificing and butchering animals.

7.10 Reprise: Urban-Suburban New Jersey

To recap, I will begin with a short description of my sample of participants followed by a discussion on shared and distinct characteristics of the urban and suburban immigrant Pakistani women. These women came from different cities in Pakistan. Although they all came from urban areas of Pakistan, their experiences varied by their origin, which may have been within different parts of the same city. Most had migrated after they got married to their spouse who had already been a resident of the U.S. Three had migrated as young women: of whom two had sponsored their spouses from Pakistan, while one was married in the U.S. to another immigrant. Some of these women had immigrated along with their husbands. Some of these women had experienced a pregnancy in Pakistan while others bore their children in the U.S. Their lives and experiences differed by their place of residence in the U.S. and were different than when they lived in Pakistan.

Data analysis provided some insights into residential choice. Many of the women who had lived in older inner city locations in Pakistan preferred living in Jersey City, while those women who had grown up in suburban neighborhoods in Pakistan preferred suburban locations in the U.S. One lady summed it thus:

“I know there is bad stuff in [Jersey City], but I love this city because I grew up in the Saddar area in Peshawar and you know how that is: full of life and busy. So since I grew up in a city, I like the life that is in a city. There is noise at night, but this is lively and this is what life should be like. I cannot imagine living in some remote corner where you cannot hear anything. My husband also grew up in a busy city, Karachi. It took a little getting used to, but I have adjusted very well. In fact our lease was expiring and we were looking for another, larger apartment and this is a little small and expensive, but we did not like anything. Some of the apartments we looked at were nice, but were in areas that were further from the center of Jersey City and it was quiet and you had to take a bus to get to any place. I asked my husband to renew this lease.”

The urban immigrant Pakistani women in my sample selected residential location based on the husband's job location, convenience, and Pakistani immigrant community and city life, in that order. Suburban women selected a residence based on local schools, culture (as in diversity and ethnic shops), jobs and the environment.

All the participants had adapted to life in the U.S., but some of these women tried to recreate some of the environment that they were used to while growing up in Pakistan. I asked them to look around and tell me if their homes in the U.S. looked anything like their parents' homes in Pakistan and many were surprised to note that there were many similarities. They noted that the houses here, in the U.S., were built differently, but the arrangement of their furniture and the way they had decorated did reflect their homes in Pakistan in little ways. However, this was not true in all cases. Some of these women had found that their circumstances had changed in the U.S. Some had enjoyed a better socio-economic status in Pakistan, while others had made a fortune here in the U.S. For example, being a physician from a lower socio-economic class in Pakistan did not mean a greater socio-economic status. Physicians might have enjoyed a better economic status, but social status was rooted in social capital in Pakistan and class played a role in defining socio-economic status. Therefore, physicians from humble backgrounds in Pakistan benefitted greatly from their education in the U.S. and enjoyed financial prosperity. Their lifestyle in the U.S. was not comparable to their families in Pakistan.

Most suburban families had chosen their residential location based on their perception of the quality of education in their chosen neighborhoods. Although all the women thought that education was very important and worried about their children's education, most of the suburban women actively researched the school districts when

they decided to move in that area. In contrast, the women in my urban sample did not mention schools as being one of their top priorities when finding a place to live. Moreover, these urban immigrants did not comment on the urban schools their children attended. When asked particularly about schooling, they informed me that they made sure their children did their homework and behaved well in school. These women visited their children's schools on some occasions, but asked their husbands to talk to the teachers if they felt the need. These women were confident that their children were doing well in school. Most of their children did not attend after school activities, but they did attend Quran learning sessions every evening from their local Quran teacher. By contrast, the immigrant women in the suburban areas attended all their children's school activities, but many of the suburban husbands did not attend most school functions and the women were sole attendees. Almost all suburban children took part in various after school activities such as soccer, tae kwon do, music or swimming. The suburban women scheduled their evenings around their children's schedules. They were actively engaged in their children's education by regularly emailing their children's teachers or visiting them and voicing their concerns.

In general, immigrant Pakistani women living in Jersey City were more religious than those living in the suburbs. Some observed the *hijab* while one wore a long *burqa* (coat like covering). The women attended local religious lectures or attended classes regularly. Their children finished learning the Quran at a younger age when compared with the suburban children. Suburban mothers also encouraged their children to learn to recite the Quran, but some of them hired online services from Pakistan to teach their children. The children logged into an online website after school for a lesson a few times

a week. Most suburban women did not attend any classes or lectures. Both urban and suburban women believed that they were responsible for their children's religious education and felt that religious education was an important part of their children's upbringing.

“It is tough to live here, but it is also tough to move from Jersey City. I grew up here. I have spent half my life here [Jersey City]. It is convenient of course and since I am now a little bit into religion I find that there are many people here who are motivated in that direction. Your children can mix with their children. There is the *Masjid* [Mosque] community plus there are friends and classes for children, Quran classes. Quran is not everything, but religious education is important. More than that, I am attached to ICNA center *Alhamdolillah* [All praise is for Allah]. The children go to a place on Kennedy 15 minutes away. I started courses over there and then my girls started making friends. Although they go there for classes every Saturday I want them to stay in touch after that also.

There is an Islamic school here and when your children are at that growing stage you want them to go to some place like that, but we could not afford it at that time in our life.”

All the women in my sample were educated: some more than others. However, the urban sample tended to have bachelors or high school level education, while the suburban women held a bachelors or higher qualification. Most urban immigrant women came from families where the education of women was thought important, but marriage took precedence. While most suburban women were allowed to complete their education before a decision about marriage was made. As a result, many of the urban women were married at a younger age than their suburban counterparts. There were exceptions to the rule and in some cases, when there were many daughters to be wed in a family (since it is the responsibility of the parents to find matches and wed their daughters), they were married at younger ages in both the urban and suburban sample.

There was also difference in the educational attainment of urban and suburban immigrant men. Most of the urban immigrant men in my sample had graduated with a bachelor's degree from Pakistan, while most of the men living in the suburbs had completed some higher education: some held a master's or MD from the U.S. There were also differences in the type of employment between urban and suburban families. Most of these urban immigrant men were self-employed or owned businesses. Some of them were employed in different companies (many of these men drove limousines for a living), but owned a business on the side. In comparison, one suburban immigrant drove a limousine; the rest were employed in a variety of professions: physicians, architects, accountants and financial advisors. Some of these suburban men had spent many years completing their education part time. By contrast, most of the suburban women in my sample did not work or worked part time only. Both urban and suburban women, despite their educational level, preferred to stay home or work part time. However, the type of employment differed by location. While urban women were employed in child care or retail or banking, their suburban counterparts were substitute teachers, architects and employed in the health care industry. All these women came from families where their mothers had been stay at home moms. One had worked for a while, but decided to stay home once her first child was born. They agreed that time spent with their children was very important to them.

Urban and suburban immigrants also differed in socio-economic status. The mean income of suburban families was higher than the urban sample. All suburban families owned their homes while the urban families mostly rented. However, living in Jersey City was not cheap, since real estate prices are high near choice locations such as the

PATH terminal in Journal Square. These families also had to rent monthly parking spaces and purchased monthly PATH train tickets. Urban immigrant families generally owned one car while the suburban families owned two or more cars per family. Both urban and suburban families had health insurance, but most urban families were covered by New Jersey Family Care or Medicaid, while the suburban families were covered by private insurance.

While the urban and suburban Pakistani immigrants may live different lives in their respective hometowns, collectively they are comparable in some aspects. These immigrants originated from different Pakistani cities (not from rural Pakistan). Many of them support families in Pakistan and send home remittances. They have kept in touch by visiting, calling and connecting via the internet regularly. These immigrants sponsored their families' immigration to the U.S. They are all raising their families in the best way they can and are looking to a secure future in the U.S. In conclusion, although many of these immigrant women felt dislocated initially after immigration, they adapted to their new physical and social environment and recreated some of their lost social capital.

CHAPTER 8

PREGNANCY, CHILDBIRTH AND POST-PARTUM PERIOD

8.1 Pregnant in Pakistan

Sixteen of the immigrating women experienced a pregnancy in Pakistan. Some of these women were waiting for their immigration process to complete, while some decided to migrate to the U.S. with their husbands and children. All of these women gave birth and completed their forty day post-partum period in Pakistan. Eighteen children were born to these women in Pakistan.

8.1.1 Pakistani Cultural Norms

8.1.1.1 Gender preference among Pakistani immigrants. Generally boys were preferred over girls, but the preference was not simple. Usually, it was not a pronounced preference in the first pregnancy, but there was an underlying yearning for a male offspring. This feeling was expressed by most of these women and also included women who had given birth in the U.S.

“I did not have a preference for a boy or a girl, but in Pakistani society they prefer boys. I might have wished in my heart somewhere, but *Alhamdulillah* [all praise is for Allah] I did not really wish for any particular sex. It was the first baby so it did not matter if it was boy or girl. I did not make any *mannat* [wish].”

“I asked her [sonographer] and she said it looks like girls. I thought okay. My husband’s family has a lot of girls. So I thought two more for the crowd! And I like girls, but frankly when I heard two- my heart sank a little. The second sonogram that was done at 5 months revealed 2 boys. I felt a little disappointed It could have been a boy and a girl.”

If a woman had a son, she felt relieved during her second pregnancy and felt no pressure. Many of these women who had a girl from their first pregnancy generally wanted the second to be a boy. The preference was not voiced overtly, but there were signs such as expensive gifts from the husbands after the birth of a son. There was no urban and suburban difference in this preference.

“I told my husband to bring me some clothes to wear on my way home. He brought this much embroidered suit with *dabka* [she laughs]. How will I pick the baby up? My sleeves had embroidery and the *dabka* [metallic woven thread] would scratch him. When Auntie came to visit me she said you look like a bride. She said my husband must be overjoyed to have a boy. He bought me gold bangles. When my *chilla* [forty days post-partum] ended he brought me to Jackson Heights and bought me the bangles. He told me to pick something and I like the bangles so he bought me the bangles.”

Why the gender preference? The preference was said to be rooted in the difficulty of raising girls in the U.S. Many participants were fearful of raising their daughters in U.S. society, although they yearned for daughters. These women feared that they would not have control over a range of issues such as proper dress, interaction with boys and other issues. The women reported that their daughters would not ‘listen’ to them on these issues. The honor of the family was at stake because the daughters represented the *izzat* (honor) of the family. More urban women than suburban women thought that girls should be modest and should not socialize with boys.

“I wanted to have a daughter very much. I hoped for a daughter. Then I realized that it was better if I had a boy. I cannot imagine being my husband’s daughter in America. I would have had a heart attack. He is a very broad minded person. He feels that there is no difference between a boy and a girl [implying that he would allow the children equal freedom]. I could not have borne that. For me that would have been a very tough thing. I thank God I don’t have a daughter. I loved wandering through the little girls’ aisles in the clothes section of department stores. They make lovely clothes for girls its not much fun in the boy’s section. But no it is

better this way. I would have gone mad. Between the two of us he has stronger convictions. He thinks that it is not any different for girls. That was a relief later on.”

“I don’t think, if I had a daughter that she would listen to me. I mean she would want to dress like the girls around her. I will be telling her to wear longer shirts that covered her back and not to wear deep neck shirts. I wear a scarf all the time. No, not a *hijab* [full head covering] just a scarf so that my chest area is covered, but would a daughter listen? My mother used to wear a *burqa* [a loose garment covering the entire body] as did most of the women in my family. I took to wearing a *chadder* [a large sheet like covering]. Even that upset my mother.”

8.1.1.2 Fertility. Fertility is another important cultural expectation. For these women starting a family immediately after marriage was a foregone conclusion. It was the next natural step. Most women in my sample did not practice any contraception and became pregnant soon after getting married. In some cases there was no knowledge of contraception, while for other women contraception was practiced in the early months, but soon abandoned. Both the families, the women’s parents and their in-laws, expected and encouraged the newlyweds to start a family. Furthermore, if they did not get pregnant within the first few months and had not used contraception then there was cause for concern. Even if the couple were deliberately planning on waiting to start a family, there were still concerns. Many members of their families and friends voiced concerns. Some were afraid that if oral contraception was practiced right after marriage, it may interfere with conception afterwards. Other issues included speculation concerning the fertility status of the new bride.

“We did not plan to have a baby until we had our master’s degrees. We used contraception. It was not very common for people to plan having babies. People used to ask my in-laws what was wrong. It was two years since we got married and there was no child.”

Friends and families of these women often offered suggestions to help the situation. Their suggestions ranged from advice to active intervention. Some followed simple advice like lying on their side after intercourse, while others were offered childcare help, if that was a concern, to facilitate conception. Others underwent and endured fertility tests that were often invasive and painful, sometimes by female relatives who happened to be doctors. Some of the women, who did not conceive in the first few months, underwent fertility tests in Pakistan because their husbands thought that getting them done in the U.S. would cost much more.

“People suggested that we have a baby and that my mother would look after it.”

“We really wanted to have a child right away. And we tried hard. For the first few months nothing happened. We kept trying, but nothing. And then one of his [husband’s] aunts who is a doctor said we should get all tests done and M also said we should get all tests done [fertility tests] here [in Pakistan]. So we went to Islamabad and there we got some tests done, two of them that tell you everything. So I had them done, but they were terrible tests. So she did them and said that they were both normal. But for this to take place one year had gone by. And finally I got pregnant. I was so happy, I was so excited.”

“I did not get pregnant in the beginning [two months after getting married] and visited a doctor. I went to the doctor’s and she said I had some growths [tumors] in the uterus. She said I may never be able to have a baby. She said the tumors may become cancerous and I needed to get treatment. We were very upset. That was the day my husband was planning on going back to the U.S. Everyone was very upset, even when he got back he said he felt very sad. A cousin of my husband’s is a doctor and she looked at my reports and said nothing [bad] is going to happen. She said many women have these and most of the time they do not interfere with a pregnancy. In a few days the test came out positive that I was pregnant.”

In some cases the urgency was created by the husband’s imminent return to the U.S. In instances where the husband had gone back to Pakistan to marry and had to return

after a certain period of time the urgency of getting pregnant was greater. Although women tried all available measures to fulfill their obligations, men were conspicuously missing from the fertility related questions and remedies. Men did not undergo any testing and were never suspect.

Interestingly secondary infertility was not a cause for great concern. Women who had difficulty getting pregnant a second time did not feel a great deal of concern even when they did not conceive for a period of time that was longer than the first. If they could not conceive quickly the first time, they had sought treatment very quickly. Yet the same women did not seek help even after a year of trying to get pregnant. However, they reported that they had felt depressed every time the test was negative.

“Question: Did you seek treatment?”

Answer: The first time we did. The second one no. It took us a year to conceive. It was depressing. Every time you bought the home test and you looked and there was nothing and it made me depressed.”

The same lady who had undergone extensive testing after having failed to conceive during the first two months had this to say about her subsequent pregnancies:

“All my kids are five years apart. I take a long time to conceive. I would try for a year before anything happened. The second time around I was visiting England and I did go for a checkup. My aunt said you’re here why not get it done. So I went and the doctors said your fine there’s nothing wrong with you. So I went for a vacation to Pakistan. I came back and a month later I got pregnant.”

Pregnancies were important, but they were not announced to the world. These women were superstitious and mostly kept the news within a small circle of close family and friends until the end of the first trimester. Two women did not make or buy many new clothes. They were afraid of *nazar* (evil eye). These women waited until four or five

months into their pregnancies before starting to shop for the baby or telling everyone in their families.

“We are superstitious and do not believe in making too many clothes and stuff before the baby is born.”

“I wanted to a lot, but I didn’t.”

“I had not bought a lot of stuff prior to the birth. It is not a good practice to buy stuff before the baby is born. You know the *nazar* [evil eye] might make things go wrong. So I had to use the woven cap from the hospital and added some of the hospital wraps to the blanket I had to bring the baby home. My sister went shopping that evening. She told my other sister to go buy some clothes.”

8.1.1.3 Embeddedness and quality of networks. Immigration to the U.S. can be a protracted process. In some cases the women (4 from my sample) waited for two or more years before they could join their husbands in the U.S. While they were waiting in Pakistan they lived with their in-laws as dictated by culture. The women considered this their ‘new home’. In some cases they lived in the husband’s father’s household (joint family), which included other married brothers and their families.

“My *susraal* consisted of my mother-in-law, two brothers-in-law and their wives, one of them has 3 children and the other is childless. It was a combined family system.”

Most of these women got pregnant before their husbands went back to the U.S. and delivered their babies in Pakistan. Even though the subjects may have resided with their in-laws, all of the women returned to their parent’s homes to deliver the baby as is customary.

Embeddedness is an aspect of social capital and the quality of networks depends on how much an individual is ‘embedded’ in that network (Putnam, 2000). In my sample, culture directed embeddedness. The analyses indicated that cultural norms obliged these women’s parents to provide support after her marriage, indicating deep embeddedness.

Although the women were married and were living with their husbands, they returned to their family home to deliver their babies and recuperate during their post-partum period.

“It was better if I was sent to my own home. They would take better care of me over there. So I was over there [mother’s] and went for doctors visits. I was there for six months with doctor visits and everything else it was all right and everything was all right.”

These women’s parents continued to support their daughters after they were married. These women were deeply embedded in their networks in Pakistan. For these women, the quality of networks and their embeddedness in these networks comprised the norms and expectations in Pakistani society. However, expectations were different for different spheres of married life. Although the parents of these women were expected by the in-laws to play a helpful role, the *susraal* (in-laws) were not expected by these women to support the pregnant women to the great lengths that their own families would. These women appreciated it if their *susraal* helped, but did not have great expectations. They preferred their own families to *susraals* during pregnancy, childbirth and post-partum.

“*Susraals* don’t help!! I went to my parents for my delivery.”

“I did not stay long at my parent’s after the baby because my sister-in-law was getting married after ten days and my *susraal* wanted me there so I went back. It is normal for women to stay for the whole 40 days, but it depends on your situation. So I went back. Over there everyone was very busy and I spent the whole night shivering. Then I didn’t know how to bathe the baby and was having trouble doing stuff like that, so my mother-in-law got worried that we might get sick and since they were so busy that taking care of a new born was going to be difficult, so she sent me back to my mother.”

“I was new to the area, but my sister in-law had been living here [in the U.S.] for quite some time, but she did not eat out that much and being Pakistani we have family politics... I can’t say why exactly.”

The quality of a network depends on individual relationships. One of the subjects was highly appreciative of her in-laws and described it thus:

“My mother-in-law was very good and I am very friendly to her. She did a lot of cooking too. Sometimes relationships sour if you live very close to each other! But in our case living close was better than those daughter-in-laws living farther.”

The norm was for Pakistani mothers, was to care for their pregnant daughters. Even when a woman grew up without a mother (one in my sample) and had no experience of maternal support during pregnancy, childbirth and post-partum in Pakistan, the expectation was expressed as a longing. Though this was not a loss of social capital, rather the absence of it, the woman expressed regret and longing for having missed that experience.

“Aunty [stepmom] did not help at all. She was busy with her own housework. Her attitude amounted to ‘it is your child and your responsibility so you do whatever you have to do’. I was breastfeeding and she had colic. She would cry a lot especially at night. In the beginning I did avoid some things, but started eating regular food very soon like after a week. Aunty did tell me, but she would not make anything for me. If I asked her for a cup of something, she would say you can make it yourself. Her role was such that she was of no help. I wished my mother had been there. Aunty was no help- imagine if the baby would cry all night she was sleeping in the next room and she would not get up once to ask what is wrong with the baby.”

“It was a big change for me especially when you cannot sleep at night. In the morning my mother used to come and take the baby so I could sleep for a couple of hours. She would play with him and change his diaper. Then she would come and give him back to me saying ‘here take your baby’. Then I would feed him and he would go back to sleep. Then I would get up and shower because it was very hot and rest. There was no work for me to do.”

Another aspect of having strong network support was the sharing of responsibilities. These pregnant women were generally accorded freedom from their responsibilities. These responsibilities included care for older children, house work, facility of taking time off from work or quitting their jobs altogether. One woman went to her parent's house several miles away for every delivery that she could, even though they lived in the same city in Pakistan. Her mother took care of her and her children, and this allowed her to rest and gain her strength back, before heading back to her *susraal*.

“My mother helped me a lot. Once you get to your mothers’ everything gets taken care of.”

“In Pakistan the child was cared for by all the family.”

“I had a few weeks leave [of absence from work] left after the baby was born, but I had to go back to work. I went back to Hyderabad with my mother. She stayed 3 or 4 months and after that my mother in-law came over.”

8.1.1.4 Family support in Pakistan. All these women, who had experienced a pregnancy in Pakistan, spent the last weeks of their pregnancies in their parent's home. The families of these women nurtured them and provided various forms of support. Support included financial help, help preparing for the baby (such as buying clothes for the baby), physical well being of the women, and sending them back to their husband's home with gifts for the in-laws after delivery.

Most of these women spent the last days before delivery resting and relaxing. Even women who worked took time off and returned home for delivery where help was available. Some of these women hired help, while others depended on their mothers and sisters for help. Some women hired a masseuse to help relax before delivery and as

therapy during the post-partum forty days. These women found a massage very comforting and energizing.

“You know you have help, your mother, good food and someone for *maalish* [massage].”

“Yes, there was somebody who used to come to massage everyday. She used to come before the baby was born and afterwards too. She used to massage with her feet specially my back because it used to hurt a lot. I used to lie on the side because of the baby. She would massage my back and my hips with her feet. You weigh a lot you don't do much, but you get tired. She would put oil in my hair and massage my head. She would knead my shoulders and arms. It is easy over there [Pakistan].”

Some of these masseuses were traditional birth attendants or *dais*. In rural Pakistan most deliveries are conducted by *dais*. However, my sample population originated from urban areas of Pakistan and did not think a *dai* should be delivering babies. All the women interviewed thought a *dai* was suitable for prenatal and postnatal help. They offered advice and massaged the women and their newborn babies. Although all women knew a *dai* in their neighborhood in Pakistan, many did not avail of their services. Women who had acquired more education seemed more disinclined to employ a *dai*. One described them as not being very hygienic and that she would not allow her to touch her baby.

“My husband would not let her massage the baby. He would take the baby and massage her with oil and then my mother would bathe her.”

“My mother called from USA and she advised me not to eat ‘hot’ foods since Pakistan is so hot. Now the woman servant, who was also a *dai*, was also advising me. She told me not to eat oily foods for the first 10 days of my *chilla*. She said I should eat dry stuff. No *desi ghee*, because I had a C-section the [so] ghee would not let the uterus contract.”

Choosing the right doctor was also important to these women and their families. Their families (in-laws and their own parents) chose their obstetrician based on

professional experience and reputation in the field. They wanted the best available doctor to care for these women and their unborn children.

“He had a brand new facility. He had an excellent team and also had a lot of interns who would come by to check up on you. The doctor himself checked up on me every few hours.”

“I was delivered by Dr. Rashid Latif, a very famous gynecologist of Pakistan. He delivered the first test tube baby in Pakistan.”

“Thank god they registered me. I wanted this hospital. I wanted to get it done here. There are lots of private hospitals, but I have this doctor who I visited for check ups. She told me that that was the best hospital.”

The quality of networks can also be gauged by the ease of access to health professionals. Some of these women were related to gynecologists and obstetricians, while some knew one personally or were introduced by a close personal friend or family member. This ease of connection afforded by social capital created an atmosphere of rapport between the pregnant woman and her doctor.

“There was a friend of mine who had a sister-in-law who was a gynecologist and was a good one, so I used to go to her. I would go to her for my monthly checkups and the injections. That made it very simple.”

“One of his [husband’s] aunts, who is a doctor, said we should get all tests done.”

“A cousin of my husband’s is a doctor and she looked at my reports and said nothing [bad] is going to happen.”

“My sister-in-law is a gynecologist and when people asked her why God did not give us any children, she would reply ‘God wants to give them a child, they don’t want it yet’.”

8.1.1.5 Special diets. Being embedded in a quality social network translated into better care for these women. Special diets were generally consumed during pregnancy and after birth. The pregnant women's mothers and sisters often prepared special foods. Most of these women noted that these concoctions were purported to provide energy and strength for giving birth. These special foods included *panjeeri* (roasted semolina, *desi ghee*, sugar and various nuts), *kaara* and *yakhni*, although eating a lot of fruit and milk were also frequently prescribed. Most of these women (whether pregnant in Pakistan or in the U.S., or urban or suburban) knew about these foods and their recipes, but were skeptical about their health benefits. *Panjeeri* was prepared with *sooji* (semolina) or *daal* (lentils: *moong*), four different kinds of nuts, *desi ghee* (clarified butter) and sugar. Although many of the women ate *panjeeri* in their first pregnancy, most thought it was very fattening and did not eat it in subsequent pregnancies. *Kaara* was prepared with butter, turmeric and warm milk. It could be sweetened with sugar and ground almonds were sometimes added to increase its benefits. It was taken during the first week post-partum and helped speed up the healing process. *Yakhni* was clear soup. The most preferred soup was chicken soup. Traditionally, soup made with goat meat was considered hot and not suitable for consumption in the post-partum period. Most of the pregnant women consumed soup for a few days post-partum. Who consumed these special preparations depended on the quality of networks. Women who delivered in their mother's home invariably ate more *panjeeri*, *kaara* and soup. The mothers not only prepared these foods, but they also encouraged the women to eat them.

“My mother used to give me *yakhni*. She prepared *yakhni* from home bred *desi* (free range, organic) chickens. Also she gave me milk. Those two she stressed and of course *panjeeri* made with *sooji*. I would take two tablespoons with milk every morning.”

“It gives you strength and power. You are very weak after a delivery. It is not a small thing. It is a great achievement. The *panjeeri* does help, it does accomplish something. However it is fattening.”

Many of these women also received financial help from their family network. This was in the form of all or partial payment of doctor’s fees and or hospital stay and expenses related to the baby. All of these women received cash (as gifts) from their extended families and friends after the delivery of their babies.

“My father bought a lot of stuff for the baby. He bought her a cot [crib], clothes and other such stuff.”

8.1.1.6 Child birth in Pakistan. Hospital experience also varied with the stock of social capital. Some hospitals in Pakistan required these pregnant women to register with their obstetric units and do so well in advance of their due dates. The women reported that registration procedures were cumbersome, but the women had their private doctors deliver their babies. Some of these women preferred maternity hospitals, which dealt solely with childbirth. Generally, women who knew someone at the hospital or maternity homes rated their experience better than those who did not have that connection.

“He had an excellent team and also had a lot of interns who would come by to check up on you. The doctor himself checked up on me every few hours. My husband is a doctor also so they were very mindful of that. He knew some of the other doctors there.”

“The hospital did not have a great atmosphere. There are bed pans on the floors, but over all it just felt cold. I mean the women were unpleasant and the nurses just keep telling you to stop making so much noise. The nurses especially in the delivery room were very nasty.”

Some of the women reported very low satisfaction with the hospital service that they received, while others rated it quite high. Some of the women thought that the staff was very unsupportive and they expressed a lack of trust.

“I was in a lot of pain and they were saying that it was normal constantly [in Pakistan]. They [hospital staff] would say ‘why are you complaining so much?’ ‘This is normal and happens’ I said I am in a lot of pain. But they insisted I should just bear it. It was my first child and didn’t know much. Nobody is allowed in there with you. It was only me and them.”

Most of these women stated that they did not receive any pain medication. One woman, who knew about epidural anesthesia, discussed pain management options with her obstetrician before her delivery and chose epidural anesthesia.

Many of the women reported that they had several members of their families at the hospitals with them. Members of their families helped in several ways. Sometimes the hospital was short on some supplies or medication, and in those situations male family members could purchase them. Many of these women had food brought in from their homes. They did not want to eat the food provided by the hospital because they “did not know what they [the hospital staff] put in it.” Their mothers or sisters at home prepared soups and other food and sent it to the hospital. One woman reported that the food at the hospital, where she delivered, was excellent and that she ate everything.

Only the mothers or sisters of the parturient accompanied them in the labor room. However, no family member was allowed in the delivery room.

8.1.1.7 Pregnancy and *chilla*, a time to take things easy.

“I must say that the way we are brought up culturally and psychologically, having a baby is ‘big deal’- you had done something very difficult and important.”

Pregnancy is considered a delicate condition in Pakistan, and special precautions are recommended. Many of these recommendations are rooted in culture and are observed as norms relating to the pregnant condition. These women, who belonged to different socio-economic backgrounds and had attained different levels of education, all observed some precautions when they were pregnant. The most commonly observed precaution was avoiding lifting anything that was heavy and climbing stairs. Rest was also highly recommended.

“In the beginning I avoided picking heavy items. They told me to rest, in fact bed rest was prescribed initially.”

“I was a little more careful and didn’t do any heavy lifting you know like heavy grocery bags. I took care to wear flat shoes. There were no stairs, so I didn’t face that.”

After the delivery these women also took certain precautions. While rest and massages topped the list, many women also observed dietary precautions. Some did not drink very cold water because it was thought to slow the process of involution (the uterus returning to its normal size after delivery). Boiled and cooled water was considered better than tap water. Some added cardamom or aniseed to the boiling water. Cardamom and aniseed were considered very effective for relieving gas.

“It is generally thought that you should not drink uncooked [or not boiled] water.”

“I always drank water boiled with black cardamom. I used to boil it. I never drank *katcha* [unboiled] water. It would be *badi* [gas producing]. I used to drink that lukewarm never cold even though it is

hard to drink it warm. But cold water makes your tummy lax and it never tightens.”

Hot and *cold* food properties were also considered when choosing food during the forty day post-partum period. Most women believed in food properties especially during *chilla* or post-partum forty days.

“I used to take care that I did not take any ‘cold’ foods.”

These immigrant women also believed that certain foods are *badi* or gas producing. This property was said to have an indirect affect on the baby. These women (both urban and suburban) agreed that when gas producing foods are ingested by the nursing mother she can pass that affect on to the baby. The baby may experience colic due to gas and be very cranky. They also agreed that the usual treatments for gas included mitigation by cutting intake of such foods, ingesting water boiled with cardamom and aniseeds, heating a pad and applying to the baby’s stomach area, holding the baby stomach side down on the lap or feeding it some Gripe Water. Gripe Water was an over-the-counter aqueous solution of bicarbonate of sodium and herbs available in Pakistan for colicky babies. Some women did not believe it helped, but most said it was harmless and very effective.

“I also believe in *taseer* [affect or property of food] of food, but not too much. I would also avoid *badi* vegetables. Potatoes, cauliflower, spinach can cause *badi* and spinach can cause diarrhea if you are breast feeding. No chick peas either. One should not eat things that can cause the baby problems. The baby gets tummy aches. One should also avoid *daal* some of them at least.”

Some of these women, especially those who grew up in the U.S., did not believe in food properties and there appeared to be no difference in beliefs based on family

background or education. Although some of these women did not observe or practice these culturally prescribed precautions, however, they were aware of the properties and could tell what foods are considered *hot*, *cold* or *badi*. They preferred not to avoid any particular food.

“I don’t really believe in *hot* and *cold* foods.”

“T’s aunt brought some *panjeeri* for me. I smelled it and you know they make it with *desi ghee* and I just said this will give me heart burn and thought please take this away”.

“Keep your head covered’ ‘don’t catch a chill’ and *hawa na lagey* [means if you are exposed to cold air you will catch a cold]‘do not go outside’ ‘don’t drink cold water’ ‘boil some water with green cardamom and drink that.”

One new mother asked a neighbor in Pakistan to perform a cleansing ritual or *dum* in order to get rid of bad and evil things. The woman burned some herbs and let the smoke permeate through the room, while chanting some Quranic verses to ward off evil. Both urban and suburban immigrant women believed in *jadoo* (magic: some more than others), and some urban women even wore a *taweez* (amulet with Quranic inscriptions) to protect against evil.

“My neighbor actually came in one day with some kind of smoking thing. There were some seeds of some sort that she had burned or something and they were giving out this thick smoke. She said it got rid of bad and evil things and purified the room.”

8.1.1.8 Naming the baby, *azan*, *ghutti* and *aqiq*. There were several mechanisms which solidified and promoted social capital. The new parents generally requested that their parents, or other usually older members of their families to name the baby as a sign of respect. According to religious custom they asked one of the

grandfathers or older brothers to recite the *azan* (call to prayer) in the baby's ear to invite it to become a Muslim and answer the call to prayer. The *azan* should be the first words that the baby hears. It is whispered into the right ear of the baby.

“My husband's older uncle did that [*azan*, call to prayer] for my older son.”

“My mother gave my daughter *ghutti*. My sister in-law suggested the name.”

Another custom which has roots in Islamic *Sunnah* (*Sunnah* of the prophet, the way of life as prescribed by the prophet) is *ghutti* or *tasmiya*. Two women stated that according to historic accounts people used to bring their newborns to the prophet Muhammad (peace be upon him) for blessing. The prophet would take some date pulp and let the baby taste it. It is believed that the person feeding the baby imparts some of their personality traits to the baby. Parents of newborns usually set great store by this tradition and thought carefully before asking a particular person to do the honors. It was invariably someone they respected and honored.

“I asked her [older sister] to because I wanted my daughter to grow up just like her; we believe that whoever feeds the baby her *ghutti*, the baby will take on some of their characteristics. And I believe it is really true because I see that she [my daughter] takes after her. In fact she is just like her. I don't know what she will be like when she grows up, but in these years she is amazingly like her.”

“I do believe in *ghutti*. It is *sunnat-e-rasool*. You should use honey or date. *Ghutti* imparts the personality of the person giving the *ghutti* to the child. Then more importantly it is *sunnah* and when it is *sunnah* and Allah told Rasool Allah to do it then we cannot do differently.”

Many immigrant women in my sample practiced this tradition with great fervor. They remembered who fed *ghutti* to which child and why they had asked that particular

person. This simple gesture had great meaning for both the inviting parent and the person feeding the baby. It strengthened their relationship.

Other religious traditions also served as reinvestment in social capital in Pakistan. Another religious tradition is that of *aqiqa*. Although not obligatory, it is recommended in Islamic teachings. Most of these women agreed that the *aqiqa* is usually performed on the seventh day after the birth of the baby. However, some women stated that they performed the *aqiqa* after their *chilla* was complete. Family and friends were invited to partake of dinner. A goat was sacrificed and the baby was cleansed and the baby's hair was shaved. A third of the sacrificed goat meat was, in accordance with religious custom, distributed amongst the poor to offer thanks to Allah for His blessing. Some of the women stated that if the baby was a boy, then circumcision was also performed at the time of the *aqiqa*. These mothers stated that this tradition was meant to announce and celebrate the birth of the child. This ceremony also served as a way to express gratitude to the family that had supported the pregnant women and her child. All these women stated that invited guests came bearing gifts or money. All these women celebrated the *aqiqa* of their babies who were born in Pakistan.

“My husband had arranged it. The *aqiqa* ceremony takes place on the seventh day. Food is prepared and family and friends gather to bring gifts for the baby. Some people give money, some bring gifts and others something made of gold for the baby. It depends on what you want to do. It was a party and it is arranged by the person [husband] who just became the father. He is supposed to bear that expense.”

“I had got *suntein* [circumcision] performed on my son on the seventh day. I got it done by a local *nai* [local barber, who performs circumcision].”

The arrival of the newborn is a joyous occasion. All the parents in my sample distributed sweets announcing the new arrival in Pakistan. The woman's family in many

cases presented the son-in-law's family with dress materials and many kilograms of *mithai* (sweets). The *mithai* and the dress material expressed and reinforced the social capital of the parturient.

“I went to my mother's house [after delivery] I did not go to my mother-in-law's house. They came over to my mother's house to visit us. They saw the baby and are very happy and my mother presented them *joray* [material for dresses]. They had said that they wanted material from Japan before hand. You know how it is. And also sweets were distributed. She gave *joray* to all of the than men and women in my in-laws' family.”

“When I went home my parents gave me presents for the in-laws: [They gave me] *Joray* for my *nands* [sisters-in-law] and mother-in-law and stuff for the baby. I don't remember if my *susraal* sent me stuff, but they must have.”

Another commonly observed cultural tradition is the celebration of the end of the post-partum period (forty days). Most of the women in my sample observed it in some form when they delivered their baby in Pakistan. At the end of the forty day period (*chilla*), the women bathed and cleansed themselves in a ritual bath (to become *paak* or pure again, so that they can pray and fast according to Islamic custom). They donned new clothes and the family gathered for lunch or dinner.

“They celebrated the end of my *chilla*. I dressed in new clothes (my mother-in-law gave them to me). I bathed. One is supposed to bathe on the 3rd, 6th day and so on.”

“Then there is the *chilla* ceremony. You bathe and dress up like a bride. It is not necessary, but you do dress up to look fresh.”

All these women stated that this was an important cultural ritual. These women stated that they had been bathing all the time: starting right after the birth of the baby. They had also resumed their prayers after active post-partum bleeding had stopped. They

said that traditionally the *chilla* marked the end of their sojourn at their parents' house and this was when they went back to their in-laws' or husband's house.

Even the government of Pakistan makes allowances for this tradition. One woman who had worked in a Pakistani government agency informed me that maternity leave included a forty day leave after the birth of the baby (leave of twelve weeks including four weeks before the birth of the baby). By contrast men did not get any designated leave for such circumstances. They had to take time from their vacation to visit their new born.

8.1.1.9 Role of men in pregnancy related issues. The men were conspicuous by their absence in the pregnancy related narratives. These women talked about conceiving the baby, pregnancies and childbirth, but did not mention their husbands very much. In some cases the husbands were absent because they had returned to the U.S. after getting married. While in others, these women had returned to their parents' homes for delivery and the husbands did not accompany them. These husbands continued with their jobs and could only get a few days leave when the baby was delivered. Even when the husband was present for the birth, he was not allowed in the delivery area because of concerns for other women's privacy and *pardah*. Even one husband who happened to be a physician was not allowed in the delivery room.

“My husband was right outside the door and he wanted to come in, but they would not let him.”

“My husband was not there since the army hospital does not allow any men into the maternity ward. No men are allowed in any ladies ward.”

Purdah means ‘curtain’ in the literal sense, but has a more nuanced meaning in Pakistan. It is not just the physical covering of the body. These women stated that

pardah, in the maternity wards, afforded women protection from shame such as exposure to men who were strangers. The women also did not discuss matters pertaining to pregnancy, childbirth or post-partum with their fathers, fathers-in-law or brothers. Sometimes they even felt embarrassed discussing these matters with their mothers. One woman said,

“It [pregnancy] is a woman’s work [pertaining to pregnancy such as caring for a pregnant woman].”

“Women do that kind of stuff- *aurtain hi karti hein*.”

“I used to talk to mother every weekend, but she and I did not discuss such matters. She did tell me to take care of myself, but you know pregnancy is still something that one doesn’t discuss like that. She was a simple lady.”

Although men may have been away and not in attendance at the time of the birth of their baby, this did not mean they were not missed. Women whose husbands were away and could not make it back stated that they missed their husbands. They thought it was very important for the fathers to be present for their child’s birth and they felt that husbands should share the joys and the caring for the baby. One woman stated,

“I just felt that he should have been there. Even though he would have not been able to help, but still it is better to have your husband with you. You know it is not the way over there for men to be in the delivery room. He is the father and I thought he should be there, but you know how people there will tell him you have to come all this way, so better wait until it is over [baby is here]. What will you do? My mother-in-law told him to come if he could, but the rest of the family kept telling him he did not have to. So he did not come over until after the baby was born.”

“I was a little tense about his not getting to Lahore on time. But he made it. He said he was getting 10 days off and he wanted to spend most of it after the baby arrived. He did not want to come early.”

One woman who happened to be a citizen of the U.S. and had come to the U.S. to deliver her baby said,

“My sisters wanted me to complete my *chilla* here in peace and quiet and not in such a rush. But I was missing my husband, I thought this was our first baby and our first *khushi* [happy event] and we should share it together.”

She left as soon as she got her baby's passport and ended up celebrating her *chilla* (end of forty day post-partum) in Pakistan. Therefore, although fathers may not have been present for the birth of their child, they were missed if they were away and their presence was comforting even if they were outside the delivery room.

8.1.2 Summing Up

Pakistani culture is central to understanding the experience of pregnancy, childbirth and post-partum period in immigrant Pakistani women. All these customs and traditions tended to strengthen and enhance the social capital of women. For Pakistani women their culture provided the capital that made their experience of pregnancy, childbirth and post-partum a positive one. They were able to mobilize their social networks in times of pregnancy, childbirth and post-partum period. This help enabled them to care for themselves and their new baby and provided them with a peaceful and nurturing environment to deliver their baby.

8.2 Pregnant in the U.S.

Twenty-six women had given birth to a child in the U.S. Fifty-one children were born to these women in the U.S. For some it was their first child, while others had given birth to older children in Pakistan. Eight of these immigrating women found that they were

pregnant soon after arrival in the U.S. In this situation, many of these women found themselves in a new social environment. Other women planned their pregnancies and allowed themselves time to adapt to their new social and physical environment. Their experiences of pregnancy, childbirth and post-partum period were similar in some respects, but there were some noteworthy differences.

8.2.1 New Environment, Uncertainties, Loss of Supporting Networks

“You are in a new place and trying to adjust. All that pressure and stress builds up.”

“I did not know anything or about what was going on around me.”

Most of these immigrating women initially stayed with friends or family. These women felt that were guests in someone's house. Four immigrant women stayed with members of their own family. Two women initially stayed with their husband's friends and did not know their hosts very well. Seven of these women initially lived with their in-laws (married sisters-in-law or their husband's parents). Some of these women had to share an apartment with their husband's roommates, while some only had their husbands. Most encountered a very new situation for the first time.

“In the beginning it was very frustrating. You have a child to take care of and then you are all by yourself all day long. I did not know anyone here. He [husband] did have some friends and later I made friends with a couple of his friends' wives. I was by myself all day and was totally dependent on my husband to bring me anywhere. I also resented having to do extra work because of these two people [roommates] in our house.”

These women experienced uncertainty about their future. Women who had arrived with their husbands stated that they did not know how long they would have to stay with their hosts before they found a place of their own. Moving into their own

apartment depended on when and where their husbands found jobs. Although most women found their hosts to be helpful they felt that they did not want to impose on their hosts' hospitality. Some of these women found themselves wondering if they were a burden. As a result, these women tried to chip in and help. Most started helping around the house. One woman started to babysit her host's baby. Another volunteered to cook the meals.

Six of these women shared a house with their husbands' parents and other married brothers. These women stated that they tried to fit into an existing social structure. By contrast, these women who were staying with their own families felt more comfortable than those who did not know their host.

Ten of these immigrating women also had older children.

In these circumstances some of these women found that they were pregnant.

8.2.2 Pregnancy Experience in the U.S.

The pregnancy experience depended on several variables. Most of the immigrating women identified the lack of supporting networks and unfamiliarity with the healthcare system as the most important factors that shaped their experience. Immigrant women who did not have any family in the U.S. felt more vulnerable and rated their experience lower than those who had an existing network.

8.2.2.1 Early days. Once these immigrant women found they were pregnant, circumstances changed. These women had to contend with the symptoms associated with pregnancy. Women who were pregnant for the first time stated that they did not know what to expect. Some women expressed shock at how sick that they had felt. They

recounted that they could not eat anything and various smells could trigger nausea. Some recalled that they could not step into a grocery store without feeling sick.

“One of the things that made me especially sick was bell peppers. I could not stand the smell when you start cooking them and my hosts liked them a lot! As soon as I smelled them cooking I felt like throwing up. Or sometimes just the smell of frying onions like at the beginning of cooking. I did not feel like eating anything.”

8.2.2.2 Loss of support networks and the pregnancy experience. For women, who had experienced a pregnancy prior to immigration, the experience in the U.S. was very different than in Pakistan. In Pakistan, their female networks had acted as supporters, protectors and nurturers. If the women did not feel like eating, they were urged to eat or offered their favorite foods. Their mothers went to great lengths to ensure their daughter's healthy pregnancy.

“Over in Pakistan my mother and mother-in-law would urge me to eat. They would cook things and took great pains and good care of me. Over here by myself I faced everything alone.”

Most of these new and pregnant immigrants were used to having help from other female family members or hired help. These women recalled that initially they found that they had to do everything themselves. These chores included childcare and household activities. These women speculated that they would have been engaged in similar activities in Pakistan, but they would have had help. In Pakistan, they had hired help and there were other women in the household who shared such responsibilities. If these women cooked the food, then someone else would prepare the vegetables. If they laid the table, someone else would clear it or help with doing the dishes. If these mothers were nursing their baby, there would be someone else who could tend to another child. Some

of these pregnant women felt that they were not equipped to handle all the chores, especially those who had older children.

“At home there was a lot of work to be done. There were four kids and on top of that if you are not that good at handling housework, things get very stressful. I have to admit I was not very- let's say capable. I had people around who helped me and now you have to learn to do a lot more than you are used to.”

What they missed most were their female family networks.

“That last month [of her pregnancy] was very tough. My sister [in Pakistan] went to my parent's house for delivery even after my mother had passed away. Home is home.”

Women who had older children stated that they did not have any time to relax and rest. They felt exhausted from taking care of their children and most reported that they did not have any time to take care of themselves.

“There was no one to look after me and I did not have time to take care of myself. I had 3 other children to look after. It was so much that I had no time for myself.”

“My older daughter was hardly 2 and a half and did not go to school. She would go around the apartment making a mess, a tipped over can of almonds here, something else there, but I could hardly move. The nausea would overtake me.”

These women felt overwhelmed and could not take good care of themselves. Some of these women felt so depressed or overwhelmed that they did not make any special food for themselves especially during their first U.S. pregnancy.

“I was on a tea and bread diet. I did not feel like getting up and making me something healthy. I did not eat much healthy food during that pregnancy maybe that is why I got diabetic”.

8.2.2.3 Quality of existing networks. Four of the pregnant women had all or some family in the U.S. Two of these women lived in Jersey City within a few blocks of their parents' homes. These women reported that their mothers helped them in many different ways. They prepared food and kept their pregnant daughters' refrigerators stocked in the early days of their pregnancies. They visited often and helped prepare for the arrival of the baby. Sometimes they also accompanied their daughters to their doctor's appointments. These mothers played their old culturally defined roles from Pakistan. They even prepared energy boosting pregnancy care foods such as *panjeeri*. These women also enjoyed baby showers.

"I used to visit my mother nearly everyday. I would stop by during my lunch break. My mother made *panjeeri* for me, but I did not want her to bother with making any special food for me. My family was close by and it felt like I was still in Pakistan. I was with family."

"I had a baby shower. My family had one and I also got one at work. My family arranged everything, thought it was good to bring gifts before the baby. My co-workers surprised me with one just before I was going on leave. We don't have baby showers in Pakistan. It was good."

The other two women stayed with their married sisters. Their sisters helped them through their pregnancies. One called their mother in Pakistan to ask for tips.

"My other sister came to take over the kids and then my older sister drove me to the hospital."

"My sister used to call my mother [in Pakistan] to ask her advice on what to feed me. She wanted to make sure she was doing the right thing. She said our mother would ask her and she would be answerable if I did not get the proper care. She asked about *yakhni* and our mother told her to use the neck of the goat and some meat from the rump to make soup and give me the clear soup not the meat. She [mother] also gave her [sister] the recipe and suggested that she make it in a large quantity and then give me some everyday. It keeps well in the fridge and she had little children and did not have too much time to make it everyday. I was to make sure I did not eat any *badi* [gas producing] foods because I was

nursing and because that would make the baby colicky. I was not given any *maash daal* or *channa daal* [types of lentils] anything was hard to digest.”

All four women agreed that having their family nearby made their experience of pregnancy free of stress.

Women who had moved into their in-laws house did not expect their in-laws to help them and stated that they were not very comfortable asking for support. Most of these pregnant women felt that they were obliged to continue with their self assigned chores, even when they would have rather have stayed in bed.

“Work was difficult. I tried to help my sister in-law as much as I could. I did not want people to say that I did not help. For example if my sister in-law was cooking *roti* [unleavened flat bread] and she rolled and spread on the *tawa* [flat metal pan] and I was the one cooking it, I could not stand after the 5th one. It hurt down there from standing for long.”

“I got up every day even when I did not feel I had the energy or the will. I just wanted to stay in bed and wait for the nausea to pass. What would they think [?]”

8.2.2.4 Healthcare system and the pregnancy experience. The new environment also had a new system of medical care. All the women reported that the U.S. system was very different from that in Pakistan, and they all felt it was not very consumer friendly. Many of these women remembered that they did not know where to start. They felt lost. Many women were helped by their hosts. Initially the women consulted the women in their host households, who offered advice. Many were introduced to the home pregnancy test.

“My sister-in-law and I went and bought a home test.”

“My host, the friend’s wife, suggested I do a home test.”

After a positive home test, the next step was to see a doctor. These women stated that they did not have any knowledge about how to secure medical care and most women did not have experience with procuring health insurance either. As a result, these women were not sure how they would pay or how much it would cost to have a baby.

“They [the hospital] never told me in advance [how much it would cost to deliver the baby].”

Some of these women were also concerned about the quality of care that they would receive because they did not know how to find information about their doctors' credentials.

“For example, here you are fishing for information that could have been very easily available to you in Pakistan. Someone just tells you what to do and sets you on the right path. Here [in the U.S.] you don't know anything and have to stress over every little detail, even finding a good doctor. In fact, you don't know if it was a good doctor. I could have chosen an incompetent doctor and I would not have known.”

Not all the men who had been living in the U.S. had purchased health insurance for their wives (and children) prior to their arrival. More suburban than urban men had health insurance coverage through their jobs. Therefore, more urban women found themselves pregnant and without health insurance. As a result, some of these women did not seek prenatal care. One woman went to the hospital when she went into labor.

“I did not go to a doctor. I just went straight to the hospital once I went into labor. We did not have any insurance. I don't know how we paid, but we started getting bills and we would look at them and wondered.”

One couple was very unsure and apprehensive and went to an emergency room complaining of a stomach ache.

“When I got here in July I got pregnant right away. I did not have any insurance or anything. So I went to the emergency room and told them

I had pain in my stomach [pointing to the general abdominal area]. I lied. They did some tests and found from the urine test that I was pregnant.”

Most women who lived in urban areas stated that once they went to the hospital, they could apply for some kind of insurance that covered their pregnancy and the unborn child. Additionally, some of these women found that their hosts (friends and family) had experienced similar situations and this provided valuable information.

“She [neighbor upstairs] guided me. She took me to the doctor and helped me get insurance. Then the doctor visits started.”

“She [friend] would come with me to the doctor and bring me back home.”

All the women who delivered in urban areas recalled that they were covered by Medicaid and that coverage extended to some time after the birth of the child.

“I went there and I said that my income was not that much so what was I supposed to do? So they told me that the next time you come bring your tax papers that you filed. Bring copies of your green cards and whatever documents that show your income. That is how it was done. I got approved. They have some kind of a system, [and] I didn't know how it worked. They only covered my son [apart from myself and the unborn child]. But I was only covered after the birth for three months. They only cover you if you are pregnant. That's what I think. And then the new baby is covered automatically. My insurance was canceled automatically after three months of giving birth.”

One of the urban women, who had borne a child in Pakistan before migrating to the U.S., practiced contraception to give herself time to adapt financially and socially. However, she found that even after a few years she could not afford private health insurance because her husband was self-employed and insurance was very expensive. She found information about insurance when she went to a community health center in their neighborhood.

"I thought there should be a gap in pregnancies. There were a couple of concerns for me. I did not have it in me to cope with another baby and secondly financially. We did not have any health insurance."

"I found a community health center. It is cheaper than a regular doctor. I found out about state insurance from them. When I found that I was pregnant I went straight to them. They suggested I apply for Medicaid. So for the second baby I had that. They also had an obstetrician. It covered me through my pregnancy, but later it covered both the girls, but not the adults. I had to go through paperwork and stuff, but I got it. The center was very busy and there was always a crowd, but it is cheaper and if you get there early enough you can beat the crowd."

One suburban woman without health insurance did not know about Medicaid and found that she did not qualify when the hospital social services tried to apply for her. Her husband was also self-employed and could not afford private health insurance, but they did not qualify for Medicaid either. Some urban and suburban couples, who did not qualify for Medicaid, found that they qualified for New Jersey Kid Care, which provided coverage for their children.

"My insurance was canceled automatically after three months of giving birth. And when I was pregnant with my third child one of my friends, a neighbor, told me that I could get some kind of family insurance, but I would have to contribute to it. And now we all have insurance. Family care it's called: New Jersey Family Care."

Even those couples who had well paying jobs were often confronted with a situation where the wife had not been added to the husband's health insurance and did not qualify for coverage because that pregnancy was deemed a pre-existing condition.

Health coverage was a very important to these women and some of them took extraordinary steps. Some of these urban women, who had initially lived in New York, continued to use New York State health insurance even after they had moved to Jersey City. As a result they had to go to Queens or Brooklyn for their monthly prenatal visits.

Other women, who did not qualify for Medicaid in New Jersey, wanted to move back to New York in order to keep their health coverage.

“I still had my New York insurance, so I had to go to Brooklyn for my monthly check-ups. When I went into labor I was worried I would not get to the hospital if we got stuck in traffic.”

There were cultural conflicts and also conflicts of belief. These women recounted that the hospital staff tried to help them apply for charity or Medicaid, but sometimes there were cultural and religious beliefs that forbade people from accepting any form of charity or hand outs. In one case the family belonged to the *sayyid* or *syed* class, who are believed to be descendents of the Prophet Muhammad (peace be upon him), and who could not accept charity under Islamic beliefs and tradition.

“The major issue we faced was when we got the hospital bill. I had asked them about billing. You know we were legal, but did not have any kind of assistance. No insurance. They asked if we would like to apply for charity and my husband, who is a *syed* [religious class said to be descendents of the Prophet], said no way we don't need any charity, we will pay ourselves. We were not expecting such a huge bill. We did not expect that at all. They never told me in advance. They don't tell you what to expect and later, after they provide you with whatever services, they bill you. They did everything. Their service was great, but they did not tell us anything about the bill. When the time came, at the time of discharge, they said you have to pay the bill. They had come in and told us about the different programs they had like WIC. But my husband said being *syed* we could not accept any kind of handout: out of the question. We could not get Medicaid at that time because I was still on visit visa. When the time came to pay the bill, turned out to be 10-12 thousand dollars. There was the epidural and the room and the doctor. We were very worried. My husband said he could not pay such an amount right away. The maximum I can give you right now it \$2000-\$3000. And that too was too much and we knew what that would mean. They said they would accept money in installments. My husband said please make the installments something I can afford to pay because he was still looking for a job suitable to his training. He was working two jobs as it is. They agreed on a schedule and we made cash payment right away and then at the end after we had paid nearly \$10,000 they gave us a break of \$2000. They said you are done. We are going to send you a letter.”

Most Pakistani immigrant women preferred female physicians and obstetricians because of concerns about *purdah*. However, there were some women who did not have a preference. One woman was delivered by a male obstetrician in Pakistan.

“I preferred a female doctor. The first time I went there [U.S. hospital clinic], there was a male doctor so I asked my friend [a nurse at the hospital clinic], you know how it is in Pakistan and I was new [if I could be seen by a female so] she arranged for a second appointment with a woman.”

“My husband would not allow a male doctor anywhere near me.”

“There was a Chinese man in my room when I had asked specifically there not be any men. They must have needed that man because I had told them I did not want any man in my room. But he was the one who gave me the epidural. I did not know at that time, but he came to visit afterwards to ask if I was okay. I asked him what he had done so he told me he gave me that injection.”

Interestingly, these women adapted to local cultural norms after a few years in the U.S. Some of these women, who had previously felt it was taboo, later chose doctors based on their health insurance or proximity to their residential locations and not because they were female..

“Dr. A is a fine doctor. He is Arabic and he is very close to the hospital and my house. Sometimes he would give medicines from his own office. You know samples and stuff.”

“My doctor was a male. I had requested a female previously, but the practice had two male doctors now so I thought why go anywhere else? They accepted my insurance and were located just down the road on Summit Ave in Hackensack.”

8.2.2.5 Health insurance and the pregnancy experience. The prenatal care experience was different in the U.S. and depended on two factors: where the women received care and their health insurance status. Women with private health insurance tended to follow their insurer’s recommended path. They found an in-network

obstetrician who followed a regimen of monthly and later weekly visits. These women were directed to a hospital where their obstetrician was affiliated and went there for delivery. These women stated that they did not have to worry about who paid for the hospital bills and other such concerns. They also reported that they were more informed and aware of financial concerns pertaining to delivery than when they were in Pakistan.

“I had insurance for my first child and things were very easy. I waited until my husband found this job [he had lost his previous job] and has insurance before getting pregnant again. I would not dare do it without having any insurance. What a headache!”

Women without any health insurance experienced their pregnancy in a very different way. Thirteen urban and suburban immigrant women found themselves without health insurance. They were uncertain, they did not know what to do and they were more apprehensive than those with health insurance. Some of the uncertainty arose from their immediate circle of acquaintances who had experienced similar situations. Most of these uninsured women were directed by their hosts or friends to go to certain hospitals that had been used by other Pakistani immigrants without insurance. Some whose husbands were unemployed were directed by their friends or families to apply for Medicaid. These women were enrolled in Medicaid or some other type of insurance (some women were not sure what insurance they had, if any). Medicaid covered these pregnancies and provided insurance for the newborn baby after delivery. Six urban women applied and received Medicaid coverage.

Since most of these women got pregnant soon after their arrival, or were pregnant when they arrived in the U.S., their pregnancy was considered a pre-existing condition. As a result, they were turned down for coverage by the private insurance companies that they contacted.

Some of these women chose hospital obstetric clinics for their prenatal care. The clinics had several obstetricians who managed the patients. Most of the women requested a female doctor. Some found private doctors who accepted Medicaid, while one woman expressed regret at not being aware of this fact when she was pregnant. She had chosen a hospital clinic where she waited for hours before it was her turn to be seen by a doctor.

“I found out about insurance once I got to the hospital. We knew that the hospital would arrange for Medicaid where pregnant women are concerned. That was the general understanding. In our neighborhood, the clinic is overcrowded with all Bengali, Sikh and other population that I could not find a chair for hours, more uncomfortable at the end of my pregnancy. I went in the morning and came home in the afternoon and this happened every single time. You can imagine.”

“At that time we did not know that Medicaid allowed us to go to a private doctor because my sister-in-law when she had given birth had returned to Pakistan to us for the delivery so she did not know.”

Apart from the long waiting times most women said their experience was favorable and that the doctors were empathetic. Although they felt alien to the environment, they felt confident in the care that they had received. They underwent the usual recommended tests at various stages of their pregnancies such as fetal ultrasounds and blood tests. One signed up for Lamaze classes. These women felt that their financial worries had been allayed and they should not complain about the long waiting times.

They highly rated the medical care they received in the U.S. Some felt it was much better here than in Pakistan; others thought it was comparable.

8.2.2.6 Some cultural differences.

Most of these immigrant women found that pregnancy was viewed differently by clinicians in the U.S. These mothers were used to the culturally defined ‘patient’ role of a pregnant woman in Pakistan. In the U.S. they found that their doctors encouraged them to lead normal lives and to take pregnancy in

their stride. The pregnant women did not have to take any special precautions or refrain from doing certain activities or other restrictions.

One woman recalled her pregnancy experience and the advice she received from her obstetrician in the U.S. She had some light bleeding during her first trimester and consulted with her doctor. As she described:

“I also had some spotting this time, but she [the doctor] said it is fine. She said you have a normal pregnancy and you will have a baby. If it was not meant to be or there was something wrong, the body will reject it. Bed rest will not do anything for you, not climbing stairs or such. You can lead a normal life. That was something very different.”

“They [Pakistani doctors] told me to rest. In fact, bed rest was prescribed initially. That was very different from my experience here [in the U.S.]. They did not tell me to do that. They said it was a normal pregnancy.”

The woman also consulted with her mother in Pakistan who was aghast at the suggestion of not taking any precautions such as resting and advised her daughter to ignore the doctor.

“When I called my mother she would say ‘are you crazy? You don’t know anything and this and that You should not do that’”.

These pregnant women found the idea different, but most accepted the change and tried to adapt.

Some women were surprised to find strangers come up to them and ask about their pregnancies in supermarkets or in the shopping malls. People in the U.S. were more open about pregnancy and did not try to hide it like in Pakistan. Some of these women were used to wearing large wraps when going out in Pakistan. One woman felt the change was welcome.

“People would stop and talk to me in grocery stores and talk about my pregnancy [in the U.S.]. I was very surprised. We used to hide under *chaddars* [large wraps] when we went out in Pakistan, as if we were ashamed of being pregnant. Over here they kind of celebrate pregnancy.”

8.2.2.7 Pregnancy and related health issues.

Smoking and alcohol consumption None of the women interviewed smoked or consumed alcohol during their pregnancies.

Gestational diabetes It was alarming to note that many women (seven out of twenty-six) developed gestational diabetes. This occurred in both urban and suburban populations and across socio-economic strata. All diagnosed women managed their elevated glucose levels with dietary control and regular monitoring.

“Everything was normal until my eighth month, that’s when I had my glucose tolerance test. And it tested higher than normal, so then I had to... they told me to go on a diet, a sugar free diet and I went to Saint Peter’s. They had a class to teach us. My doctor was affiliated with Saint Peter’s hospital. And people have told me it was a very good hospital. They showed me how to monitor my sugar with the machine. I would have to fax them a chart. They give me a chart that listed all the calories and foods. That also told me the amount of food I should be eating. I was told to take the brisk walks. I managed very well. I used to walk nearly every evening.”

Depression Although there were no formal diagnoses, many of these women reported symptoms of post-partum depression. They described a lack of interest in their life, many did not feel like eating and many reported bouts of uncontrollable crying. However, none of these women sought treatment for their depression.

“My children used to call me at the hospital and I would say ‘don’t call me’ I did not feel like talking to anybody. I wept and wept. I don’t know why and now one of its own it’s gone.”

”I could not eat anything. I just drank a lot of tea, no healthy stuff nothing. I looked awful”

Birthweight Most of these women reported that their babies had normal birthweights. Some of these women, those who had developed gestational diabetes, actually delivered heavier than normal babies.

8.2.3 Timing their Pregnancy

Most of these women believed that a pregnancy very soon after immigration contributed to their vulnerabilities. They recalled feeling excited yet overwhelmed by their move to the U.S., but their pregnancies complicated their situation and they felt it added to their problems. However, none of the women thought about terminating their pregnancies. They just felt that they would have preferred not to get pregnant so soon after immigration.

“My biggest setback or drawback was that I got pregnant so quickly after I got here. If there would have been 6 or 7 months before that, things would have been different.”

“We had not planned on having a baby right away. We used condoms for contraception, but a month after my arrival I felt terrible and a lot of nausea and vomiting. That was not the right time.”

These women cited many reasons for their desire to have delayed getting pregnant. They thought that they would have had time to adapt to their new environment. These mothers thought that information about health insurance, private and public, would have saved them a lot of anxiety and worry about the financial aspects of delivering a baby. In the U.S. these women were faced with a system about which they had little knowledge.

“They have some kind of a system. I didn’t know how it worked. They only covered my son [apart from me and the unborn child]. But I was only covered after the birth for three months. They only cover you if you are pregnant. That’s what I think. And then the new baby is covered automatically. My insurance was canceled automatically after three

months of giving birth. And when I was pregnant with my third child one of my friends- a neighbor told me that I could get some kind of family insurance, but I would have to contribute to it.”

Some of the immigrant couples employed the system to their advantage. One couple who had come to the U.S. for higher education was required to buy health insurance by their university. Both were master's students at the time. They had decided to settle in the U.S. after completing their education. They realized that they might not find jobs or be able to afford health insurance after college, so they planned their pregnancy to correspond with their last year in school. As they went into the writing phase of their theses, the woman got pregnant. By the time she was nearing completion of the thesis, she was due to deliver her baby. Her husband had finished early and had come to the New York-New Jersey area to find a job, while she got ready to deliver their baby. Since they had employed the system to their advantage, they felt in control of the situation and did not experience the stress the former couple had experienced.

“As a matter of fact, I was completing my thesis when I was 6 months pregnant. We had student health insurance and it covered my pregnancy. We did not pay a single penny. Actually, when we went to Kansas, we were required to get insurance.”

8.2.4 Child birth Experience

Each childbirth experience is unique and subject to differing circumstances depending on obstetric situations and the ease with which women deliver. Most of these women felt that they had received excellent care in the hospital in the U.S. Many rated their experience in Pakistan at par with American hospitals, while some stated that their hospital and delivery experience in Pakistan was atrocious. One woman recounted her experience in Pakistan thus,

“It took me ... a long time. Then the doctor came and the pain was excruciating and she said it’s time to push. It was so bad. There were two nurses. One was holding my one arm and the other was holding my shoulder. The doctor said that the cord was stuck around the baby and that I should have had a C-section. I was like- am I supposed to tell you this? That I should have a c-section. They had to cut and used suction. You know they call it vacuum delivery. Before this I was talking to them and they said you have to push. My arms were bruised from their holding them so tightly, the way the nurses were holding me. And to top it all, when the baby came out it was not crying. I said what’s wrong? They said nothing, but they called the child specialist. He came in hurriedly. After a few minutes the baby cried and they said it seemed alright, but that he had dislocated his shoulder slightly. That was because they had to pull him out, with a vacuum. That was scary and not a nice experience at all. There was no sympathy towards you: they were not encouraging you. [The nursing staff] was actually angry with me at that time because I was not doing this or that. I was doing what I could do.”

The same woman delivered her second child in the U.S. and had a much easier delivery.

She appreciated the technologically advanced maternity care that she experienced.

“I requested an epidural. I still remembered the pain of the last time. Sometimes people tell you [that] you forget after year. But I did not forget. But some people had warned me that you might get some complications due to the epidural. Like back problems. They give you the injection at a certain time. I felt the pain before I reached that stage. But at a certain degree of dilation they give you the epidural. You can look at your contractions on the machine next to the bed. It keeps a record of the contractions. I could see the graph, but didn’t feel anything. It was miraculous. Such a relief! You can feel the baby coming, but you don’t feel the pain. I could push when they told me to. They gave me an episiotomy, but I think it was a smaller cut. The amazing thing was that you deliver it in the same room that you were assigned for labor. You are not wheeled into another room. The same room that you’re staying in converted into a delivery table or bed. I mean the same bed. They had the lights and everything right there. It was a very nice room. It’s like a bedroom. It had a nice clean bathroom. The discomfort lasted through the night and then the sharper pains began in the morning. After they induced me I could feel the more sharper pains. My husband was in the same room all the time.”

Some women thought the Pakistani hospital experience was similar to the U.S.

and felt more comfortable in the hands of doctors they knew.

"I stayed for three days at the hospital [in Pakistan]. After that they shift you to a room, they gave me good breakfast. Just like over here, the nurses even wear similar dress. They give you a good breakfast and decent lunch, they change your sheets and give you pads and stuff. The baby is in the same room as you."

"Doctor Lubna was there. She is very nice. She has good hands. They had called her. She lived nearby."

"It was a brand new facility. They had the latest equipment and very clean. It was just like the maternity rooms here. Two to a room not like the old female wards where there were several women in the same ward and then they wheeled you out to the delivery room."

Another woman's experience in the U.S. was not so favorable:

"The delivery experience [in the U.S.] was not good. I went into labor in the morning, but the pains were light. As night approached, they got more severe and frequent so we went to the hospital emergency room. There was not too much dilation. The doctor checked, but the baby was too high. I could feel that the baby was not down. Then morning came and afternoon and I was screaming and screaming. Finally, the doctor cut the membranes and water broke and that helped. I was delivered at 2 PM. They did not offer any pain medication to me. I was very uncomfortable. I did not have any choice. I did not know much and we were new and apprehensive and were hesitant to ask. But it was terrible."

The birthing experience was felt at a personal level, but socio-economic and educational backgrounds modified this experience both in Pakistan and in the U.S. Some of the more educated women had read books on pregnancy and childbirth to prepare for the event. They had discussed their labor and pain management before they went in to deliver in Pakistan. However, one such woman felt that she had very little control when she delivered in the U.S. and felt helpless. Other women felt that they were better informed in the U.S. and their experience was rated better than in Pakistan. Some women, who had very little knowledge of pregnancy and childbirth and lacked proficiency in English, felt more apprehensive during childbirth in the U.S. because they did not understand what was going on and could not communicate freely with their doctors.

"I just felt I couldn't talk to my doctor."

There were other noticeable differences between the childbirth experience in Pakistan and the U.S. Having a network of support was crucial in Pakistan. In Pakistan the pregnant women had needed someone to stay with them, day and night, and someone else at home who could prepare food and send it to the hospital. The caretaker made sure that the parturient received the care that she needed. Sometimes even medications needed to be purchased from pharmacies that were located off the hospital premises. Food had to be brought in from home. However, these women found that they did not need that kind of support in the U.S. These women felt that even though they did not have the support networks in place, it turned out they did not need these.

“There are differences between here [in the U.S.] and Pakistan. You need somebody there to stay with you during the night. In the room somebody has to be there like my mother was with me. Over here I did not need anybody. If I needed something, somebody came to my room to help me. I think the greatest difference was that I was alone here and I didn't feel that. In the sense that over there my mother was running back and forth as they were telling us ‘we need this we need that’. She also helped me go to the bathroom. But here that did not happen. Everybody was very supportive here. Somebody would come in with a chart, somebody came in with medications, and somebody pops in and asks if the bleeding is not too much, the doctor also came in. I was alone in the room. I stayed there for two days and yet I did not feel alone. Food was delivered to my room. My food came from home in Pakistan. In Pakistan you realize that if you do not have another person, what are you going to do? That difference is there.”

However, these women did find comfort in having someone in the delivery room with them, which was something the women were not allowed in Pakistan, even if their husbands were doctors. These pregnant women felt that having their husbands in the same room helped forge a deeper connection between the couple and the newborn.

“I said to him ‘both of us gave birth today!’”

Another woman had her sister coach her through her delivery.

“My sister was very helpful. She said it was a happy pain and that I look at the positive side and disregard the pain.”

These women felt that the U.S. hospital staffs were very accommodating. They stated that their requests were honored. Most of these women were offered pain relief. Some declined to take an epidural, while some requested it. Some took some other form of injectable pain killer. Some of these women had a few reservations about the epidural. They feared that there may be side effects. Some of the women who decided to receive the epidural thought their babies might have been born sooner had they not taken it. These women stated that they felt completely numb and they did not know what and how to push after the epidural.

“After the shot [epidural] there was a lot of numbness and then they told me to push I just couldn’t do it. I mean I did not know how to push. I thought that I was pushing with all my might. But it wasn’t enough. If I look at my three deliveries, I think that this was the longest. They told me to push and I would push with all my might and nothing would happen. They kept saying push hard and push hard and would try to push. By the end I was totally exhausted and wished it was over.”

Many had requested vegetarian meals and received them.

Another culturally defined norm in Pakistan is women resting and taking it easy after giving birth. Women delivering in the U.S. found that their white American counterparts took things differently. One woman was surprised to find her white roommate at the hospital up and about one day after giving birth.

“Now the other occupant of the room arrived later. She arrived later in the night. She had had a daughter. I imagined she would be in a worse shape than I was in since I had delivered earlier. Next morning I am lying there barely moving and the lady in the next bed had woken up, showered and was wearing her own clothes [not the hospital gown] and sitting in a chair by the bed watching TV very comfortably. And I felt I had gone through the same and a few hours earlier than her and here I was lying in bed and she looked so fresh.”

The same woman compared herself to her neighbor thus:

“I must say that the way we are brought up culturally and psychologically having a baby is ‘big deal’. You had done something very difficult and important. You do not do anything [afterwards]. Here [in the U.S.] my sister said you should rest as much as you can. Since I was culturally programmed to ‘rest’ after the baby my sister brought everything in and put it right next to my bed.”

There were some cultural rituals that are performed at birth which were not practicable after delivery in the U.S. In Pakistan, all the rituals are performed automatically. People around the parturient knew what was to be done and they did it. The women did not have to think of all that needed to be done. In the U.S., such responsibilities fell on the new parents.

“Over there [in Pakistan] you don’t care about these things. They just happen automatically.”

8.2.4.1 Cultural and religious rituals after birth in the U.S. According to religious tradition all Muslim babies are required to hear the call to prayer in their ear soon after birth. However, in the U.S., this was often delayed and some fathers recited it once the baby got home after a few days. Some new fathers felt that they might err, and since this was a religious obligation, they requested an older visiting relative to do this. Some asked a friend who they deemed more versed in religious traditions. There were some who said that they forgot about this due to birth complications because they were worried.

“The second time around, thank God, my husband’s younger uncle was here [in the U.S.] on a visit. We had it [*azan*, call to prayer] done by an authentic Muslim!! [When the first child was born] we had forgot in all the commotion and waited until the baby was released from the ICU.”

“For the *azan* we had requested my husband’s friend. He is quite religious in the sense that he prays five times a day, so we thought he should be the one.”

Some hospitals in Queens, New York, cater to large Muslim populations. They have a *Maulana* (priest) on staff, who can perform the *azan* ritual.

“That hospital has the facility of the *azan* also. They have a *Maulana* on staff and he recites the *azan* in the baby’s ear. They have a large Muslim population. There are many Pakistani and Bangladeshis there. It seems like a hospital for Pakistani and Bangladeshi people.”

Another cultural tradition is *ghutti*. Since this is believed to impart certain personality traits to the baby, a lot of thought goes into the invitation. Some of these women, giving birth in the U.S., went to great lengths to get the right person to feed the *ghutti*. One woman had asked her mother to bring the *ghutti* with her from Pakistan after having her sister-in-law dip her finger in it.

“For the *ghutti* I had special instructions. I had decided that I wanted my *nand* (sister-in-law) to give my first child the *ghutti*. My mother especially bought some *ghutti* and went to her house to get her to dip her finger in the *ghutti*. Then when the baby was born my mother fed her the *ghutti* so in effect it was both my *nand* and my mother’s *ghutti*.”

Other new mothers did not perform the custom because their husbands did not believe in it. They had practiced it when in Pakistan because there were so many people in Pakistan who could override the husband’s decision. Some of the women performed the ritual because it was *sunnat* (life and teachings of the prophet) and in some cases the husbands insisted.

“I did not know the importance, but my husband even though he was not too religious back then had more information than I did and he told me.”

Some of these women did not get to feed their newborns *ghutti* in the U.S. They stated that they were exhausted after the delivery and did not remember until they

realized that the baby had already been fed a bottle by a nurse. They wondered if some of their child's behavior was to be a reflection of an unknown person's personality.

"The daughter born in America, no one fed her *ghutti*. I always wonder who gave her, her first feeding. Maybe it was a nurse. I keep telling her she is turning into a Spanish. The nurse took her to another room when she was born and gave her some water, so now I always say she has a lot of Spanish in her because either the nurse fed her or the baby was exchanged."

Some of these women thought this tradition might be culturally inappropriate and were unsure about what the hospital staff would say if they fed their babies some honey as *ghutti*, or another prepackaged herbal preparation. Some fed it to their babies anyway.

"You can also give the baby a drop of honey, but in the U.S. you cannot feed a new born honey for fear of something [botulism]."

8.2.4.2 Trying to tap into old networks. Some of these women wanted to have their mothers with them when they delivered their babies. They had a special relationship with their mothers and wanted to recreate the atmosphere in Pakistan. Some of these mothers were lucky to get a visa, others were denied a visa by the U.S. immigration for various reasons. Some of these pregnant women stated that they did not ask their mothers to come because their mothers had other obligations (young children) or were too old to travel.

"Since I am the only daughter you have a bond. She and I are very close."

"There was no one who could come over [from Pakistan] to help. My siblings were younger. My mother could not leave them. My mother-in-law was very old. She could not do much. My husband suggested my sister or one of his sisters living in the U.K. comes over, but it was difficult."

"No one came from Pakistan, we did not think about it."

The women, whose mothers could come to the U.S. for their daughter's deliveries, planned their mother's visit to coincide with their delivery. These women stated that they wanted most help after the baby was born. They felt that they could manage the pregnancy and childbirth, but they would need their mothers during their post-partum period. Although, in the U.S., it was the husbands who usually accompanied their wives to the delivery rooms, while their mothers waited outside.

“My mother arrived towards the end [of the pregnancy]. For the delivery I had asked my mom not to come before the baby is born because I needed help when I had to go back to work.”

“My mother was outside all this time praying for me. She recited many *aayahs*, *surah Yasin* in particular, from the Quran. My husband was by my side.”

Although all the women missed their female family network during pregnancy and childbirth, they felt that they needed the most help during their post-partum period.

8.2.5 Post-partum Period in the U.S.

The first thing the immigrant women, who had given birth in Pakistan, recalled on coming home from the hospital in the U.S. was how different this post-partum period was from their experience in Pakistan. These women recounted that there was no fanfare. There were no relatives waiting to celebrate the joyous occasion. No sweets were distributed and no congratulatory visits were made. Phone calls from Pakistan usually ended with women crying on both sides of the line, lamenting the distance that separated them. Their first post-partum experience in the U.S. was not comforting.

“My *chilla* just went by.... like it does over here. I did not have time to care for myself.”

“My recovery here was more of a ‘compulsory’ nature.”

"I had no time to recover. Like I had to bring the newborn to the doctor the very next day after I came home from the hospital, we stopped at Pathmark for some stuff [formula and diapers] on our way home from the hospital. There was no room for *nakheray* [expect pampering]."

Most of these women felt that they had to recover quickly. There was no one to help and hence no room for taking it easy for a few days. Most women felt that they needed that time, but there was no other way. Some of these women, if they had older children, felt overwhelmed by the added responsibilities of a newborn.

Those women who delivered their first baby in the U.S. felt they did not know what they were doing and how to handle the newborn.

"The second baby was colicky and she was crying all the time. She was tough. She would cry all day and night and would not sleep a wink. She would cry so much that I could not wait until my husband got home so I could hand her over and shut myself in my room for some time. She would not sleep. I gave her gas drops, everything, but nothing [worked]. I tried bathing her in warm water."

Some babies had neonatal problems, which compounded the situation. Two babies were admitted to the neonatal intensive care units. These mothers had to care for their sick babies (in the hospital) and felt that they had no time to recover from their delivery.

"I came home without my baby, who was still in the hospital for three or four more days. I had to go back to the hospital to nurse the baby, sometimes I would pump the milk and bring it in a bottle. We have to go there. The pumping experience was terrible."

"With the stitches it was agonizing to walk and I had great trouble walking to the hospital every morning. I would sit next to him all day in a chair [at the hospital] and would come home in the evening. That was the time when I missed Pakistan the most. You know the time when I was pregnant or when I delivered the baby I missed my family, but not this much."

"Allah have mercy I would wish if someone was there; they could come and sit with me. People would visit. My husband was working and

he did take a few days off in the beginning, but for how long? He could not have stayed with me. We needed that job.”

Many women felt that they did not take good care of themselves during their *chilla* and as a result now have health problems.

“All those things [special foods] they feed you actually give you strength. They help in old age. Look at my mother, she did not have any problems even when she was very old. I have back aches and my knees have started hurting because I did not take good care of myself in my *chilla*.”

These mothers felt that they did not have time to care for themselves. One woman complained that her uterus had prolapsed because she did not have time to take good care of herself during her *chilla*. She had other children and her husband worked two shifts, and she could not afford to pay for help.

“You just do not have the time. You are cooking and a baby screams you rush over to see what happened. You gave one a bath you are getting into hot then cold water.”

Many women realized that the physical symptoms subsided quickly. They found that the first week or two were the most challenging physically. One woman condensed her thoughts thus:

“In my experience a woman is functional ten days after delivery. The rest is your individual choice. You can rest for days and days if you like.”

Another woman thought that if there were other people around to share responsibilities, then it was easier to relax and recover, but this was not necessary.

“I feel that if you let yourself go you’ll become lazy and won’t have the energy and you cannot get anything done. If you knew that there is somebody who was going to do it, then you just relax.”

Many husbands stepped in to fill the void left by the loss of female family members. These women found their husbands to be very helpful. These women recalled that they had not expected their husbands to take such active roles in their babies' lives. These fathers helped with the newborn and tried to give their wives some time to themselves.

"I feel that we as parents were more involved with our second child than the first time around. Especially my husband. In Pakistan the child was cared for by all the family. And my husband's involvement was very little. Especially when the baby was a newborn. This one was totally different. He was very much involved."

These husbands helped, but had to get back to work and were not available most of the time.

These new mothers found that some friends and neighbors were very helpful. Some babysat the older children while the woman went to the hospital to deliver, others sent soups and other food and some even drove the laboring woman to their hospital.

"My friends were very helpful. They did not bring soup [*yakhni*] per se, but a lot of food. For a week, they used to bring something. One would bring something, the other would bring another, and usually it was so much that I would put it in the fridge and he [husband] could eat leftovers later."

"I thought it would not be so rushed and it would be slow in the beginning, and maybe I could drive myself to the hospital, but I asked a friend who was our neighbor to drive."

Women, who had experienced a *chilla* in Pakistan, noted that the post-partum experience was very different in the U.S. Immigration to the U.S. had weakened existing networks in Pakistan, and social networks in the U.S. were still new and untested. These women felt very alone and this caused many to feel depressed. As a result, many of these women recalled that they did not have the energy to make any special foods (foods they

were accustomed to eating in the post-partum period in Pakistan). Some of these new mothers made *yakhni* (soup), but only in the first week of their post-partum period.

“I had lost the weight so quickly. I was under a lot of stress you know with the housework and other things. I did not have the energy to take care of myself. I used to make some *yakhni* [soup] and would eat it with some toast all day.”

“The third time was stressful. I had no stress for the first one. I wasn't worried, but I was very stressed the last time around.”

However, it was the women who had spent some time in the U.S. building new networks who had the friends who helped. Women who became pregnant soon after they arrived did not have time to befriend many people; hence their second pregnancy and post-partum period were much easier with the help of their friends.

Some of these women were overwhelmed by their pregnancy and childbirth experience and returned to Pakistan. Others were still living with family and friends and felt that they were imposing on their hosts. One woman had two older children and felt that she could not take good care of them when she found out she was pregnant very soon after her second delivery (she had already given birth to a child in Pakistan and a second in the U.S.), so she decided to go back to Pakistan.

“Home [Pakistan] is home.”

“My third pregnancy I spent in Pakistan. I had two here [U.S.] and two over there [Pakistan]. I thought I would be with my mother and at least I will have the facility that the other children will be taken care of. And someone will take care of the newcomer as well. I had had a lot of practice, but still. At least the other kids will not be ignored. I spent 2 years over there. My husband stayed on. He would visit us. I would say that our financial situation was another factor. He still did not find a suitable job.”

“As soon as he [the baby] came home I went to Pakistan. It was ten days after he came home. My *chilla* was not over. It ended 2 days after I got to Pakistan. I stayed 7-8 months in Pakistan. There were all kinds of help available there. I did not have a thing to do. My mother cooked, my

sister took care of the baby. Everyone took turns caring for the baby. My mother asked me if I wanted a masseuse, but I said that time was long gone and I was alright just as I was. I had had no time or thought to take any care of myself because the baby had been so ill. Sitting in that chair day after day, my stitches took a long time to heal. It was very painful. Who could think about food at such a time. That was the last thing on my mind. Once I got back I ate everything.”

Some of these women who went back to Pakistan also had financial concerns. Their husbands were still struggling to find a better paying job, something more suited to their educational background. Other women could not afford to purchase health insurance and felt financially vulnerable.

Once in Pakistan these women were surrounded by their network of family, who performed their traditional roles to offer comfort and support. The women did not have to worry about finances and felt relieved.

Families in Pakistan also helped in other ways. One woman who worked in the U.S. found that she was pregnant soon after her first delivery. She had hired a babysitter for her first child and had resumed work. She was not planning on having a second child so soon after her first. She could not afford to pay for childcare for two. She and her husband made the tough choice of sending their older child to Pakistan to be cared for by grandparents. She said it was very hard, but there was no other way.

“I got pregnant again when my first baby was 8 months old. It was not a planned pregnancy. The second pregnancy was similar to the first. Not too bad. I was still working. But I had to send my older daughter to Pakistan when she was 12 months old. I sent her to my in-laws. We, both my husband and I, made the decision. Then I was working and what with the housework and taking care of the baby, it was very tough. Since my in-laws did not have small children in their house, I thought they would take very good care. I was comfortable. But I had a terrible time afterwards and even though at the time they said she was fine, later they told me she had a tough time adjusting also. They kept saying she was okay for my sake.”

8.2.6 Creating New Networks

8.2.6.1 Husbands in new networks. Pakistani immigrant husbands in the U.S. were more involved in the domestic sphere than most husbands in Pakistan. Most of the wives who had arrived with their husbands recalled that their husbands were not involved in household chores in Pakistan. These husbands had not participated in the everyday running of their households. Many of these husbands did not go grocery or other shopping or were not the party responsible for this. These wives recalled that in Pakistan women of the same household or friends got together and went shopping for clothes or the purchase of bulk groceries.

Most husbands, who had been in the U.S. longer, had to help their newly arrived wives in different ways after immigration. After immigration all these men found themselves in a situation where their wives were totally dependent on them. For example, since many of the women did not drive, the husbands were required to buy groceries and also to help with child care and household chores.

“I would go grocery shopping with him after he got back from work at night sometime.”

“I tried very hard and I have to tell you my husband was a great help. He would come home after work and would make bottles of milk and other chores. During my *chilla* I did not do much, he would change diapers and I thought I was obliging him by nursing his kids.”

These women were thankful if their husbands helped, but in their hearts they still could not reconcile with the fact that their husbands helped with housework. These women were very appreciative of the help and did not think that their husbands were obliged to help out, but the husbands helped anyway and the women appreciated it. In the

US, although this was not traditional, these new immigrant women started to rely on their husbands' help.

“Over here who is there to help you? I did not drive when I had the second one [child]. So when my husband came back from work we would go out together to get stuff, you know groceries and other shopping.”

“Those months were very hard. I used to call my mother and father and cry, but my husband helped me a lot. He was wonderful.

Did he learn how to cook?

She laughs out loud and says: No not that: all other kinds of help, but that. He said ‘you just cook some food, I will take care of the baby’.”

When asked why they did not try to hire some help, most of these women reported that they did not know how to go about looking for help. After a few years in the U.S., when they found out how and where to find help, they felt it was too expensive and that they could not afford to hire help. Some of the women tried babysitters, but felt they were not comfortable and did not trust them. In contrast, two women who had grown up in the U.S. felt differently. They hired babysitters when they wanted to start working after the birth of their babies. Both these women, who had grown up in the U.S., preferred to engage a babysitter in spite of the fact that their mothers were in the U.S. and had volunteered to help. They felt that their mothers should not be burdened and felt that they were getting old and should not be running after their children.

“I arranged for baby sitting. I asked around and finally found someone. We gave her \$70/week. I preferred a caring family instead of a nursery school. So I found someone near my mother's house. I had grown up in that neighborhood and I visited there nearly every day, so I kind of knew those people. Someone had told me they were interested. They were a Bengali family. My mother was getting old and did not have the energy and I did not expect her to care for my baby. They did their obligations towards us and I think it is unfair to burden them with our responsibilities.”

8.2.6.2 Friends and neighbors. All these women appreciated the help that they received from friends and neighbors during their pregnancy, childbirth and post-partum period. These women acknowledged that there was a vast difference between having friends to help and being alone in these situations. Although their husbands were very cooperative, the ladies insisted that having other women around made a vast difference. They recalled that their friends had helped in several ways. Many of these women did not have health insurance and some did not have sufficient funds to pay for doctor's visits. Their networks of friends lent money or provided information on procuring Medicaid. Some of these friends even accompanied them to the Medicaid offices to help fill out forms and apply. On one occasion the friend (from Pakistan) happened to be a nurse working at Elmhurst Hospital in Queens. She took it upon herself to accompany the pregnant woman to the clinic, get her registered and applied for healthcare. These women found that even though they might not have been fully versed in such matters, together with their networks of friends, they had managed to understand the healthcare system and navigated it successfully.

Neighbors had also stepped up and helped. Some women recalled how their neighbors had prepared food for the family when these pregnant women were at the hospital to deliver their babies, others had babysat older children and some had offered advice based on their experiences with the healthcare system. One immigrant woman did not have health insurance and her Arabic neighbor brought her to a local Health Center. There she was enrolled into a state-run program that covered pregnant women and their unborn children. After the birth of the baby, the woman and her friend went to the local WIC office together. Sometimes they would share or exchange the supplies they obtained

through WIC. The Arabic speaking friend from Egypt could use cheese in her cooking, while the Pakistani immigrant woman used more milk. They have been living next to each other for a long time and their bond has strengthened over time.

8.2.6.3 Time and friendships. The strength of a relationship can be measured by the degree of embeddedness. Embeddedness was deepened by mutual exchange of favors over time. Initially, these women met because of their proximity. These neighbors had met in the common areas of their buildings or waiting for their children to come home from school, and exchanged greetings and started a conversation. Most of these women started out by volunteering to help or by the simple gesture of sharing something they had cooked. They forged new friendships and started investing in them. These women found that as their new networks became stronger and they could rely on their support.

“I made a lot of friends in Jersey City. I make friends easily. I happen to be very talkative. I met several of these women at the bus stop where we would all wait for our children. Some I met in the apartment building hallways.”

“When I needed help I extended a hand, but they grabbed my whole arm. It made my life so much easier.”

“My neighbors were from India. The woman was vegetarian, but her husband enjoyed *biryani* so I sent some every time I made some.”

“One of my neighbors used to substitute and she told me to get my degrees evaluated and that is what I did. She was of Arabian descent and she lived here in this same building. Her son was the same age as my second and I got to be friends with her.”

8.2.6.4 Women with existing networks. The pregnancy and *chilla* experience of women who had grown up in the U.S. was different from their newly immigrated counterparts. By contrast, these women had adapted to their social and cultural environment in the U.S., and although they had grown up within a Pakistani family

structure, these women were less dependent on their networks. Even though culturally defined female networks were in place for these women, these women were not as dependent on them as compared with those women who had newly arrived in the U.S. These women preferred their independence and this was apparent in many ways. These women had sponsored their husbands' immigration and had initially lived with their parents after marriage, but they set up their own households very quickly: within a couple of months. These women lived independently in Jersey City, but chose to live close to their parents.

“Initially we lived with my parents, but after 3 months I felt like we should find a place of our own. Since I was independent and had a job, I thought we should have a place of our own. We found a place near my parents and also near my job. I went to my mother's every day for lunch.”

These women recalled that proximity to their parents' homes was helpful during the early days of pregnancy. They recounted that when pregnancy related nausea became unbearable, their mothers prepared food for them. Sometimes these women stopped by their parents' homes after work, ate and went home. After these women delivered their infants they went to their parent's houses, but stayed only a few days instead of forty days as the women from Pakistan had done. They recalled that their mothers had prepared some traditional soups and *panjeeri*, but these women went home and resumed their responsibilities very quickly. Although these women preferred their independence, they still used their female networks and relied on that support, but less so when compared to recent immigrants from Pakistan.

“I went to my parents' house. I did not stay long, just a week. I told you I don't like to bother people, so I wanted to go back home after a week. I feel most relaxed when I am home. My mom made breakfast of eggs and tea for me. She made *panjeeri*, *yakhni* and she would give me warm water at room temperature sometimes with ginger.”

“I started doing light housework and tried to get back into things quickly. I had to get back to work so I arranged baby sitting.”

All immigrant Pakistani women acknowledged that initially they were overwhelmed by their experience of pregnancy, childbirth and post-partum period in the U.S., but that over a period of time they had adapted to their new social and cultural environment. They had learned to navigate the healthcare system and now they felt more at home.

CHAPTER 9

CONCLUSIONS

The overarching aim of this research study was to explore the role of culture in immigrant health outcomes and the deterioration of immigrant health as time spent in the U.S. increases. A common explanation is that as immigrants acculturate and absorb native culture, their health outcomes deteriorate (such as increased rate of low birth weight babies and a high prevalence of diseases like early onset diabetes and hypertension). However, a literature review highlighted several shortcomings that begged deeper exploration.

The experiences of pregnancy, childbirth and the post-partum period in the Pakistani immigrant community were studied to provide insights into the role of culture in shaping these experiences. Moreover, the research examined how change in culture, social and physical environment shaped these experiences after immigration, and how these women adapted to a new social and physical environment. A Grounded Theory research approach was adopted and data were collected employing interviews of twenty-six women who had experienced pregnancy, childbirth and post-partum periods. A theoretical sample of women was selected. Sixteen of these women gave birth in Pakistan and in the U.S., while ten women experienced pregnancy only in the U.S. Nine of these women did not have any family or friends in the U.S., while some had families or in-laws in the U.S. Seven women were pregnant when they arrived in the U.S., while eleven became pregnant soon after immigration. Others planned their pregnancies, giving themselves time to adjust and adapt to their new social and physical environments.

9.1 The Sample of Urban and Suburban Pakistani Immigrant Women

The sample of 26 women was comprised of 14 women from Jersey City and 12 from the suburban towns of Edison and Parsippany. The sample was chosen based on the criteria that they had experienced pregnancy, childbirth and post-partum periods in Pakistan, the U.S. or both and that they resided in New Jersey towns with significant Pakistani populations. As interview data analysis began it became clear that both sets of women shared some characteristics, although there were some subtle differences. The immigrant streams were different and these differences began in Pakistan:

- The two groups originated from different areas in Pakistan.
- Their socio-economic backgrounds in Pakistan and current SES were different.
- Their levels of education and quality of education were different.

Most of the women living in Jersey City originated from smaller, more provincial towns in Pakistan. Even if they grew up in more cosmopolitan larger cities, they came from older centers of these cities. Their traditionalist families invested little in their education in accordance with cultural gender role expectations. Five of these women did not speak English very well.

All the women living in suburban towns (Edison, Parsippany) came from large cosmopolitan cities in Pakistan. Greater investment had been made in these women's education and they had received higher quality education in English.

Urban and suburban women in my sample shared many features. Most of their marriages had been arranged to men of their parents' choice. They were married at comparable ages (18-26). Marriage took precedence over education. Most of these women conceived and gave birth within a year of getting married. In Pakistan, these

women returned to their parents' homes during the last weeks before the birth of their babies. They had vast and strong networks in the home country. Their experiences of pregnancy and post-partum period in Pakistan were generally positive.

These women arrived in the U.S. with their husbands or after being sponsored for immigration by their husbands (3 women married men in Pakistan and sponsored immigration for them). Some of them arrived while pregnant, while eleven others conceived within the first year after arrival. Many of these women did not know anyone in the U.S. Some (3 urban and 3 suburban) lived with their in-laws.

This sample diversity presented an opportunity to study the health implications of socio-cultural change in different situations after immigration. However, it is important to stress that the study of pregnancy, childbirth and post-partum periods provided a glimpse into the lives of these women for short windows in time. These women narrated their experiences with reference to those year long periods that they experienced perhaps two or three times in their lifetimes.

Their lives have changed since their arrival in the U.S. (14-16 years ago) and especially since their first pregnancy in the U.S. What was true at the time of their first pregnancy in the U.S. was very different than their present situation. However, a comparison between the first and second pregnancy experiences in the U.S. elucidated the significance of the structure and function of new networks of support, their negotiated relationships (a reflection of social structural change) and changes in these women's perspectives. These complex and multi-dimensional processes were subject to pre-migration ideologies (e.g. orientation towards family and Pakistani cultural norms pertaining to in-laws), and the functions and compositions of these new networks

reflected the underlying needs in areas where these women felt most vulnerable. Both suburban and women living in Jersey City expressed their preference for living in a community where there were large numbers of other Pakistan immigrants. The research provided insights into the processes of re-building and redefining weakened social support networks, and the role of culture in the functions of these networks.

9.2 Research Limitations

The aim of this research was to document the pregnancy, childbirth and post-partum experience of a segment of the U.S. population that was under-represented in the literature. A three pronged approach was employed: an analysis of the Census 2000 data, a tour of the participants' neighborhoods and interviews with the participants were employed to explore the issue. Census data are aggregated data and are limited to reporting on populations of a minimum of 100 in order to protect the privacy of the respondents. Hence, the analysis on specific areas of New Jersey was limited by the data. A second limitation of census data is that they do not answer the 'why' question. For example, why do people choose to live in a neighborhood? To further explore the issue at hand a qualitative approach was needed.

Experiential studies and explorative research are suited to a qualitative methodology (Denzin & Lincoln, 1998; Bernard, 2002). Hence, a Grounded Theory methodology was chosen. A qualitative approach helped me develop rapport with the participants which allowed me to gain great insights into an emotionally vulnerable period of their lives that a quantitative approach may have overlooked. Grounded Theory method is an iterative process and data were analyzed as they were collected (Strauss &

Corbin, 1998). Its strength lay in the description and the inferences that were drawn from the data in a constant comparative method. The research was subjected to rigorous methods as outlined in the Methods section to ensure validity and reliability, and although, these findings may not represent all immigrants, similar results may be expected in a similar sample of immigrant Pakistani women under similar circumstances.

The sample of women who participated was based on the theoretical sampling technique proposed by Strauss and Corbin, 1998. These women had experienced the issue under exploration and were experts, and were best suited to contribute to the developing theory. Their perspectives elaborated on a spectrum of immigration related situations (the sample included women who had families in the U.S., women who did not have any friends or family in the U.S., women who lived with their in-laws etc.), and a range of their experiences of pregnancy, childbirth and post-partum experiences (giving birth in Pakistan and in the U.S., information on the U.S. healthcare system and accessibility, neonatal problems etc.). The data were rich and helped build a theory. Denzin (1988), argued that such an approach may lead to introduction of researcher bias because the researcher selects participants most likely to contribute to the developing theory and may ignore participants and data that do not support the emerging theory. Although the argument has merit, I found that this method allowed me to study the problem in greater depth because of the expertise of these women. The participants' experiences were shaped by a vast range of situations and I tried to interview women who could comment on every aspect identified by the collected data in an inductive manner. One aspect that may have been overlooked was infertility. However, I set out to explore the experiences of pregnancy, childbirth and post-partum period in immigrant Pakistani women and

imposed that limitation on myself. Although addressing this issue may have enriched my data, I wanted to focus on the cultural aspects of the pregnancy experience.

One limitation to this type of research is the role of the researcher. In order to maintain rigor a researcher must exhibit reflexivity and acknowledge their bias in shaping their research. Since I am of Pakistani origin and an immigrant and a mother maintaining objectivity was of great importance to me. I tried to remain as objective as I could in data collection by asking the women to narrate their experiences with very little prompting. Although these participants knew I shared their background, we were strangers and that maintained a certain reserve on their part. To address bias and validity issues in data analyses I was helped by independent analysts in the transcription phase (a Pakistani colleague), coding and analyses phases of data analyses (committee members). Even though objectivity was a goal, shared cultural experiences also meant shared ethos with the participants. I think this added to rather than detracted from the issue under study.

One prompt of this research was the phenomenon that immigrants often arrive in the U.S. in relatively better health than immigrants who have been in the U.S. longer. Although this research explored the issue there were some limitations. The study of pregnancy presented a window of a year or two in the lives of these women. This was not a longitudinal study and the data chronicled a specific cross-section in time. Hence, while the interviews provided rich detail of experiences, they were not life narratives. Moreover, these were retrospective accounts and occurred some time earlier. These women had been in the U.S. for an average of fourteen years and their circumstances (socio-economic, socio-cultural) had changed over the years.

9.3 The Research Questions

Question 1. What are the cultural practices of immigrant Pakistani women pre- and post-migration with respect to pregnancy, childbirth and post-partum?

In Pakistan, the experience of pregnancy, childbirth and post-partum periods is steeped in culture. These immigrant women recounted in great detail the stories of their marriage, their pregnancy, childbirth and post-partum period. The participants confirmed several cultural practices. Most of these women were married at an early age and in most cases marriage had taken precedence over education. These women acknowledged that in Pakistan pregnancy was highly valued and these women were encouraged to start families soon after they got married. Pregnancy was also considered a delicate condition. Most of the women who gave birth in Pakistan spent the last weeks of their pregnancy at their parents' homes. These women recalled the culturally embedded care that their mothers extended to them, and the special foods that their mothers prepared. These women were accompanied by their mothers in the labor rooms, although Pakistani hospitals did not allow family members in the delivery areas.

After the birth of the baby, these women's chosen elder male performed the religious and cultural obligation of reciting the call to prayer in the baby's ear. These women also practiced the cultural tradition of *ghutti* (the first food that a baby tastes as fed by a special person) and *aqiqa* (sacrificing a goat and shaving the baby's hair). The parents and in-laws celebrated the birth by distributing sweets. These women went back to their parents' homes to recuperate during their post-partum period. According to Pakistani tradition the post-partum period lasted forty days. The Pakistani government also honored this cultural practice and allowed six weeks leave to its pregnant employees.

These parturient women received special care during their post-partum period.

They were often fed special strength inducing preparations and foods that were culturally appropriate in the post-partum period. In general, these women believed that foods had properties and produced affects via ingestion. Several vegetables and meats were considered *hot* or *cold* or gas producing. These women believed that food ingested by them could affect their babies. For example, if they ingested gas producing foods, then their baby might suffer from colic. Some of these women also enjoyed massages. At the end of the forty day period (*chilla*) these women celebrated and proceeded home (their in-laws' home) with gifts for their in-laws.

After migration most of these women found that their family networks had weakened in terms of the provision of support. This loss was especially felt when these women became pregnant in the U.S. This loss was felt more acutely by women who did not have any member of their family in the U.S. Although some had their in-laws these women felt that the quality of support from their in-laws did not match the care and nurturing by their parents. Most of these women recalled being overwhelmed by their experience. These women recalled their first U.S. pregnancies as being very stressful. Some of these women (seven of twenty-six or 27%) developed gestational diabetes. Many of these women now feel relieved that their childbearing days are over, since many of these women did not plan on having more children.

While most of these women praised the care that they had received at U.S. hospitals, many of these women recalled not being able to perform certain traditional practices such as the recitation of the call to prayer and the feeding of the *ghutti* to the baby. Some of these women were happy to recall that there was a Muslim priest at their hospital who had performed the call to prayer. Some of these women stated that they had

sent money to relatives in Pakistan so that their baby's *aqiqa* could be celebrated. Other women had waited until they could visit Pakistan, where they performed this obligation. As a result, some women delayed performing this ritual for several years. Many of the women who did not have family in the U.S. stated that their post-partum period in the U.S. was the most stressful period of their lives. In contrast, those women who had families in the U.S. recalled that their mothers fulfilled their culturally (Pakistani) ingrained roles.

Most of these women recalled that they could not rest and relax during the post-partum period as was culturally practiced in Pakistan. Some of these women even thought that they suffered from weakness as a result and attributed some gynecological problems to their disrupted post-partum experience. Most of these women recalled being very depressed without their culturally embedded family networks.

Question 2. How did socio-cultural changes influence their childbearing experience?

Socio-cultural change had a profound affect on the childbearing experience of these women. Most of these women belonged to well-to-do families in Pakistan. Husbands of women who had migrated together a few years after marriage held professional degrees (physicians, engineers) and worked in their specialized fields. Some of these women also worked (architect and civil service) in Pakistan. They could afford maids who cooked and cleaned, and cared for their children. Some of these women had chauffeurs. All the women who lived in suburban areas in Pakistan owned cars. Many of the women stated that their parents lived in the same city as their in-laws and that meant a vast social network. Most of these women recalled the help and support that they received from their parents in Pakistan. This help had included financial and physical help and emotional

support. After immigration these women felt at a disadvantage. Many of the husbands of these women found themselves unemployed or earning a student's stipend after immigration. These women found themselves in a financially strapped situation. Many of these women were also pregnant.

These pregnant women encountered a new healthcare culture and found themselves negotiating a healthcare system that was totally alien. Most of these women had never heard of health insurance. Many of these women did not have health insurance coverage, while others could not afford it. This created an uncertain atmosphere. These once financially well-to-do women from Pakistan found themselves applying for charity care and Medicaid. Some of these women could not qualify for financial help and faced the prospect of paying cash for medical care. As a result, their childbearing experience was directly associated with the socio-cultural change that these women had experienced. These changes generally influenced their childbearing experience in a negative way. Many of these women recalled how depressed they felt; and what would otherwise have been a joyous occasion was fraught with anxiety.

Another important socio-cultural change was the modification of gender roles after immigration. These couples negotiated new roles. Many of these women's husbands found that they had to help their wives with their domestic chores. The pregnant women needed help to care for their older children, buy groceries, shop and do the laundry. Therefore, weakened social support networks were replaced in part by these women's husbands. Many of the women recalled that their husbands had supported them during their pregnancy and that this had a positive affect on their childbearing experience.

Question 3. What factors influence Pakistani immigrant women's experience with the U.S. healthcare system?

The most important factor influencing these women's experience with the U.S. healthcare system was the lack of information about the system. This included information on how to procure medical care, how to pay for care and where to go. Most of these women felt that such information was not readily available. They found that medical care was expensive and not easily accessible. Many were already pregnant when they first encountered the system. Some of these pregnant women went to the emergency room at a local hospital for prenatal care, where they were directed to go either to a doctor or come to the hospital maternity clinic. These women were unsure about how they would pay for care, and found that most insurance companies would not cover them even if they had the financial means.

Many of the women who were living in urban areas such as Jersey City and Queens (New York City) were guided by friends or family members to apply for government aid. These women found that qualification for Medicaid was not easy. Some of these pregnant women in New Jersey were denied coverage because they were not yet naturalized citizens. However, many of these (citizens and permanent residents) women found some type of government coverage in New York. Some suburban women received help, but their answers were vague concerning the type, and they did not acknowledge if they had accepted charity. Other women, who had health insurance coverage, recalled that they had an easier time and rated their experience favorably.

Generally these women felt that it was very important to have health insurance in the U.S. These women thought those who had health coverage could visit doctors more freely than those who had to pay out of pocket.

Question 4. How did Pakistani immigrant women adapt to their new social environment?

Pakistani immigrant women adapted to their new social environment through several mechanisms. Many of these women experienced a weakening of the social support provided by social networks upon migration because they did not have many members of their families in the U.S. These women adapted to this by investing in new networks of support.

These new networks started in their homes with their husbands. Many of these women found that their husbands were willing and supportive partners. These couples have negotiated their gender roles and now many women work and have taken on some of the responsibilities of their husbands (for example, paying bills). Initially, many of these immigrant women were dependent on their husbands because of limited transportation options. Now, all the women living in the suburbs drive, while most urban women walk or take public transportation or share a car with their husbands.

All these women have invested in extensive networks of friends. They have befriended their neighbors and negotiated relationships with their in-laws when present. These women invested in their new social networks by exchanging favors, which included sharing childcare responsibilities, financial help, and helping each other find jobs.

The new social environment also confronted these women with new norms and expectations. They found that many of the cultural norms and expectations in Pakistan were negotiable in the U.S. As a result, many of these women now work and help supplement their husbands' incomes. Most of these women acknowledge that girls' education is also very important and they expect that their daughters will work when they are old enough.

These women have also adapted to English as the language of choice of their children. The urban children speak better Urdu than their suburban counterparts.

Many of these women visit mosques regularly for Sunday schools or other religious celebrations. Some of these women found that their new social environment is more religion oriented than in Pakistan and have taken to observing the rules of *hijab*.

Question 5. What is the importance of transnational ties in the pregnancy process?

Transnational ties played an indirect role in many of these women's pregnancies. Most of these women had wished that their mothers had been in the U.S. for the birth of their children, but only a few could enjoy that comfort. Some women were staying with their husbands' friends and did not have a home of their own. Other women could not afford to pay for their mothers' journey. Some of the mothers of these women were too old and could not travel, while some had other children and could not get away. Some mothers applied for a visit visa, but were denied this and could not come even when they could afford to. Only two mothers were able to come to the U.S. for their daughters' deliveries. These two daughters recalled feeling relieved. Other pregnant women established contact with their mothers over the phone. Their mothers advised them on their diets, caring for themselves and their newborn babies and post-partum care. Some even recounted their mothers giving them recipes for *panjeeri* over the phone. Their mothers counseled these women through times of emotional distress. Some of these women recalled their mothers sending them care packages with maternity clothes and hand knitted sweaters and booties for their babies. Although these mothers could not join their daughters in the U.S., they helped these women through their pregnancies and post-partum period.

Question 6. Do socio-economic status and place of residence (suburban vs. urban) influence adjustment to the U.S. and childbearing experience?

Socio-economic status influenced these women's adjustment to life in the U.S. and their childbearing experience in several ways. Socio-economic status limited these women's choices. These choices included place of residence, ability to buy health insurance, and the perception of their pregnancy experience.

These women stated that socio-economic status was directly related to their choice of residence, although these women noted that the relationship between socio-economic status and residential choice had changed after several years in the U.S. Initially, their residential choice was more directly linked to their socio-economic status, but after some time in the U.S. their choice of residential location was based more on preference rather than on financial considerations. For example, some urban women who had lived in Pakistani cities preferred Jersey City over suburban locations. However, some of these women also noted that rents were cheaper in Jersey City and other urban women stated that Jersey City was closer to their husbands' work. Many suburban women chose their residential location based on local schools and the physical environment of their suburban neighborhood. Interestingly both urban and suburban women stated that they preferred to live in a community where many Pakistani immigrants lived: an ethnic enclave.

Residential location also influenced adjustment to the U.S. Women who had lived in urban centers of large cities in Pakistan stated that Jersey City fulfilled many of their social needs. Some of these women had lived in other parts of the U.S. before moving to Jersey City. These women recalled that they had felt very lonely in rural (Kansas) and suburban (Connecticut) America, and preferred the busy city life. These women also

preferred living in a large Pakistani immigrant community and Jersey City provided them with the social environment that was best suited to their adjustment needs. These women have created new social networks in Jersey City and built a more comfortable life for themselves.

Most of these urban immigrant women did not drive and felt that Jersey City provided easy walking access to shops and schools. Most of these women shop locally and walk their children to their schools. This convenience has diminished their dependence on their husbands.

Residential location also influenced suburban immigrant women's adjustment to life in the U.S. Many of these women came from suburban neighborhoods in Pakistan, but that was where the similarities ended and significant adaptations had to be made. This was partly due to modified gender roles after immigration to the U.S. especially as these women took up a host of new responsibilities. For example, some of these women had chauffeurs and did not drive in Pakistan, but now ran errands, shopped, worked and drove their children to and from school and after school activities. Most of these women agreed that they had to get in a car even if they had to buy a gallon of milk.

Their choice of residential location was itself an example of adjustment to life in the U.S. They had based their choice on local schools, the environment and their husbands' job. These women preferred suburban public schools for their children because they perceived that these schools offered their children a better environment and education than urban schools. In contrast, these women would never have enrolled their children in government-run public schools in Pakistan.

These women, like their urban counterparts, professed a preference for living in a large Pakistani community, although many of these women also acknowledged that there were more Indians than Pakistanis in their suburban neighborhoods, but at least they were *desi* (people from the same part of Asia).

Urban immigrant women felt that their pregnancy experience was better after they had time to adapt. Those immigrant women who lived in Jersey City were a close knit group of women. These women felt that the proximity of their friends made childbearing easier. These neighbors helped each other in many ways. These women shared childcare responsibilities if one of them was pregnant. They prepared food and provided other help during their friends' pregnancies. All this help was possible because of proximity.

In contrast, immigrant women in the suburbs often lived at some distance from their friends. Therefore, even though friends and family were willing to help, most of these women did not rely on their networks' help during pregnancy. Some of these women had befriended their neighbors, but only a few stated that they were very close. These suburban neighbors tended to be more international (Indians, Koreans) as compared with urban women and their neighbors. More urban women had Pakistani immigrant neighbors than suburban women. Most of these women recalled that their Pakistani friends had helped them after the birth of their children, but for a limited time. Some friends who worked could only visit on the weekend and brought some food. Therefore, most suburban women felt that both residential location and socio-economic status influenced their pregnancy experience.

9.4 How do you Transplant a Pakistani *habitus* into an American *Field*?

9.4.1 The New Jersey Pakistani Community

The social structure of the Pakistani immigrant community in New Jersey is different from the societal structure in Pakistan. In Pakistan, the social class is organized by gender, family name (families with enormous land holdings, industrialists), wealth, employment (army generals, judges, and high ranking bureaucrats), networks (politicians) and education (religious scholars, professors and intellectuals) and all these elements contribute to one's stock of social capital.

The men and women who immigrated to the U.S. were a selective group of people. Immigration had an equalizing affect to some degree on these individuals. With investment in education and entrepreneurial successes a new social order and structure emerged. Economic success equalized social and class differences from Pakistan and social class. As a result, there was greater social class permeability in New Jersey. Many of these immigrants have crossed (Pakistani) social class boundaries and integrated with higher and lower social classes from Pakistan because of their socio-economic status.

Many of these women also transcended ethnic boundaries and took an active part in local American politics. Many of these women were now naturalized U.S. citizens and took their civic duties seriously: for example, they voted in every election. Many suburban women stated that they had joined their local parent teacher organizations, while some husbands attended fundraisers for local politicians (Hodgkin, 2008). These immigrants have built bridges to the greater American community.

All these women also maintained their ties to Pakistan. These families still have most of their family members in Pakistan. Also, some of these immigrants had used the

Family Reunification Law to sponsor immigration for other family members and now have some family in the U.S. Some immigrants, those with entrepreneurial skills, used their connections to Pakistan to their advantage and set up transnational businesses. Many of these couples have invested money in Pakistan. Some bought real estate, while others invested in family businesses.

9.4.2 First Pregnancy in the U.S.

All migrating Pakistani women were thrilled at the idea of moving to the U.S. They perceived the move as beneficial. Many of them had never visited another country before. These women felt that they were embarking on an adventure. These women began by adapting at first to the idea at a cognitive level. This began long before they arrived in the U.S.; these women were aware that their social and physical environments would change. Many of these women did not know anyone in the U.S. and they knew that their old networks might not be accessible. They also knew that their physical environment would be new and unfamiliar.

In the midst of this move many of these women found that they were pregnant. Seven of the women arrived pregnant, while eleven conceived within a few months after arrival in the U.S. These pregnant women encountered several challenges:

- their culturally defined support networks were either absent or diminished considerably in the U.S. They had to rely on individual agency in the absence of functional networks of support.
- the existing networks (in-laws and husbands' friends) in the U.S. were weak (due to low levels of investment and embeddedness in these networks).
- they encountered barriers (due to lack of information, language, their pregnancy was a pre-existing condition) in accessing institutional resources (such as Medicaid or Family Care or private insurance).

- the physical environment and weather were different from Pakistan.
- their culturally ingrained behaviors of health seeking, accessing and consuming information, and construction of the pregnancy, childbirth and post-partum periods were not relevant and their point of reference had changed.

As a result these women felt overwhelmed and experienced stress. First, their networks in Pakistan had lost their functional value in the U.S. because they were inaccessible in terms of physical and financial support (although emotional support could still be obtained; at least partially). Additionally, these 'new' immigrants' embeddedness in their existing networks (in-laws and husbands' friends) was weak. To become functionally valuable these social networks needed time to develop trust and receive investment for reciprocity. Since these women either arrived pregnant, or became pregnant very soon after immigration, they did not have the time needed to invest and establish relationships. Hence, these women experienced weakened social ties and networks initially after immigration to the U.S. This outcome fits in with the conceptualization of loss or weakening of social capital upon immigration as described by Coleman (1990) and Portes (1998).

Another change with immigration occurred in the point of reference of these women. These women embodied a worldview (culturally imbued by growing up in Pakistani culture), learned behaviors and construction of meaning of pregnancy, childbirth and post-partum periods. These women experienced a conflict between their (Pakistani) cultural construction of the pregnancy and post-partum periods versus the cultural construction of these periods in the U.S. This rapid social and cultural change in a situation (pregnancy, post-partum period) that was deeply rooted in culture caused great psychological stress (Mead, 1967b; Cassel, 1976). Additionally, their situation within the

larger family oriented social context and their role within that structure had changed. Without the family structure (where decisions had been reached collectively, and information was accessible through these channels) these women and their husbands now became solely responsible for their healthcare in the U.S. The psychological stress from this social and cultural change was great

These women also encountered a healthcare system about which they had no knowledge. Their access to institutional resources such as private health insurance, Medicaid or Family Care or charity was limited by their lack of knowledge and also their immigration status in the U.S. (permanent residents or green card holders are not eligible to receive Medicaid in many states). Pregnancy was considered a pre-existing condition by private insurers (in the cases of women seeking to buy insurance after they found that they were pregnant). The cost of purchasing health insurance or paying out of pocket was prohibitory. As a result some did not seek pre-natal care until it was time to deliver the baby, while some had to pay out of pocket. The result was great financial hardship and stress. Although the resulting stress experienced by these women could not be measured directly, 6 of these women developed gestational diabetes during their first pregnancy in the U.S.

Post-partum was the most vulnerable period in the absence of or weakened social support networks and the emotional cost was great. Many of these women reported symptoms of post-partum depression and some went to Pakistan to recuperate in the comfort of their cultural support networks.

9.4.3 Subsequent Pregnancy in the U.S.

In contrast, the experience of women who became pregnant after a few years and had more time to adapt was more positive. What happened to change this perception? As time spent in the U.S. increased three things happened,

- New networks were established which reinforced their weakened social networks. These networks included the husbands, friends and neighbors, in-laws. These networks functioned as conduits of information (easing access to institutional resources such as healthcare, children's education), and provided physical help and emotional support.
- Relationships with their husbands and in-laws (if they were living in the U.S.) were negotiated.
- Change in point of reference; Reformulation of Pakistani cultural norms, expectations and cultural construction of gender.

Families still played a central role in Pakistani immigrant life, but there were significant modifications in the nature of this family structure. Kibria (1993) has suggested that immigrants try to structure their families in their new environment based on pre-migration ideologies. This was observed in the way these women tried to recreate their traditional social environment in the U.S. Many of these women, especially those who did not have members of their families in the U.S, 'adopted' families. This 'fictive' kinship helped immigrants cement new social relationships. Many of these women referred to their close friends as 'sisters'. These networks of friends supplanted the functions of earlier family based networks. As the functional quality of these networks improved, these new networks became effective sources of social support (financial help, emotional support) and conduits of information (e.g. on jobs, health insurance, children's education).

Some women perceived the weakening of culturally defined social structures upon immigration and saw this as beneficial (a negative effect of social structures in Pakistan). They believed that the social sanctions (such as those imposed by their in-laws) were sometimes very constraining in Pakistan. These women felt that immigration presented them with an opportunity to assert their independence and challenge culturally defined roles. Weak or absent social networks (although stressful in culturally meaningful situations like pregnancy) provided an opportunity to cross the gender divide (such as seeking employment, heretofore a male pursuit). Consequently, there was a rise in women's access to resources.

Other women felt that this independence came at a cost. This was felt more deeply by women who were less educated and proficient in English, and who found themselves at a disadvantage in their new environment. In the absence of a strong social network, these women had to rely on individual agency and often felt vulnerable.

Adaptation to social structural changes and the establishment of new networks of support occurred relatively rapidly, but change in culturally ingrained behavior was slow and psychological adaptation was slower. For example, there was shedding of some cultural norms (some of these women reflected that a *chilla* did not have to be forty days, while some dismissed their mothers' special *panjeeri* recipes as too fattening), while some were retained (*ghutti* and the azan). These women appeared to relinquish those practices that were more closely associated with their (mental and physical) wellbeing, while trying to preserve what they considered important for their babies. Additionally, one explanation may be that those practices were retained which could be observed with ease (without the need for strong networks of social support to provide the physical

support needed to enable these women longer periods of rest and special diets to recover). In any case, old practices gained new meanings and some Pakistani cultural norms were reformulated. Hence, by adopting shorter post-partum periods (*chilla*) of rest and abandoning the special dietary prescriptions, these women were acculturating, but identifying the health consequences of these practices would be difficult. However, shorter post-partum periods were associated with psychosocial stress and symptoms of depression. There was a clear link between the absence of strong, culturally defined networks of social support in the U.S, shorter post-partum periods and greater stress and depression.

Another aspect of the adaptation to weakened social structures in the U.S. was the negotiation of gender roles. The sharply defined gender roles in Pakistan became blurred after immigration to the U.S. Male and female domains began to overlap. The adaptation of culturally ingrained behaviors was slow, but with a changed social environment (weakened functional networks), pregnancies soon after migration and new physical environment required some changes. The husbands were the first link in these women's 'new' networks. These husbands performed some of the functions that these women's mothers had performed in Pakistan (accompanying these women in the delivery rooms). Later, many of these women joined the workforce and shared in their husbands' traditional gender roles. However, the gender based social hierarchy still persisted. Even though these women worked, their income was considered supplemental. These women were not career oriented, but worked in temporary positions (e.g. substitute teachers, real estate, cashiers), so that they could return to their cultural role of home maker when the need arose.

By the time these women conceived a second time in the U.S. there were two other changes that affected their experiences of pregnancy, childbirth and post-partum periods: their socio-economic status had improved in many cases and their understanding of healthcare in the U.S. was vastly improved.

9.4.4. Place and Social Networks

Residential preference (suburban New Jersey or Jersey City) was inherent in two factors:

- the background of these women in Pakistan.
- the difference in needs fulfilled by their networks in the U.S. or the functions of these networks.

The women living in Jersey City tended to originate in smaller, provincial towns or older inner city centers. They grew up in an environment that was conservative, where family networks were strong and social structure was very traditional and rigid, whereas the women in the suburbs grew up in a more liberal atmosphere in Pakistan. The women in Jersey City were more dependent on their networks in Jersey City, while the suburban women were not as dependent on their networks. The urban women's networks fulfilled their needs in areas where they felt most vulnerable (e.g. as in help where language may pose a problem). It is important to recall that these functions are separate from functions where cultural social support was crucial, such as pregnancy and post-partum period. In this instance both networks functioned in a similar way.

In terms of social capital and the fungibility of these social networks, the networks of women in Jersey City tended to be readily accessible (due in part to proximity and partially because of their mutual dependence on each other). The suburban women's networks were not readily accessible due to the distances that separated these

women. Although, both networks functioned as conduits of information, the urban women benefitted more from their networks where access to institutional resources was concerned. For example, pregnant women in Jersey City and the suburbs were confronted by a situation where they needed medical care (the first pregnancy after immigration). Both groups did not have the means to pay for obstetric services out of pocket, but while the networks of women in Jersey City helped them enroll in Medicaid (access other institutional resources) or lent money directly, the women in the suburbs did not receive such information (their network of friends were insured or were affluent and did not qualify for Medicaid). As a result, the suburban women experienced additional stress. With this information it can be inferred that women in Jersey City are more deeply embedded in their social networks and that the suburban women experienced a greater degree of isolation (urban women's reserves of social capital were greater than suburban women).

The social controls of these communities also differed. The women in Jersey City were more religious and conservative. This was reflected in their strict adherence to a *halal* diet and modest style of dress. Membership to a local mosque was also higher among this group. Even though different ethnic *halal* foods were available, the women in Jersey City preferred Pakistani cuisine. They also preferred their native language over English. Women in the suburbs presented a contrast, while they also proclaimed themselves to be somewhat religious; their membership to local mosques was low. Their community was more amorphous and social controls more flexible (they did not adhere to the *halal* diet strictly, dress code was not rigid).

9.5 Social Capital, Culture and Health

Social capital is a resource which is inherent in the social structures and social networks of a community (Coleman, 1988b; Putnam, et al., 1993). Social structures (norms and expectations and social networks) influence the social capital of a member of a community (Coleman, 1988b; Putnam, et al., 1993). Social capital lies in the functional value of social relationships (Bourdieu, 1986; Coleman, 1988b; Woolcock, 1998).

Theorists argue that social capital is derived from characteristics of the individual and social network. Putnam includes trust and embeddedness in his conceptualization of social capital (mutual trust and reciprocity deepen embeddedness in a community). Bourdieu (1986) emphasizes the functionality of social relationships by stressing their fungibility and resulting economic tradeoffs (e.g. in the form of subsidized loans or investment tips) (A Portes, 1998). According to Portes (1998), social capital is the "ability to secure benefits through membership in networks and other social structures." Woolcock (1998) also identifies embeddedness and autonomy as two aspects of social capital. He suggests that embeddedness functions at both a micro level (referring to connections between the state and society) as proposed by Putnam. He describes autonomy as the connections of individuals outside of their immediate circle of family and friends (Woolcock, 1998).

Coleman's (expectations) and Putnam's (norms, trust and social cohesiveness) positions also assume that social capital will have positive outcomes for a community. However, if social capital was measured by social cohesiveness then the Mafia has a lot of social capital (Szreter & Woolcock, 2004). Coleman has been criticized for not considering individual action and the reliance of an individual on family and the community to access resources (O'Brien, 2005). This suggests that there are limitations

to accessibility of group resources, and hence a greater role of social sanctions and societal controls (O'Brien, 2005; A Portes, 1998).

The above discussion shows social capital is a function of social structure. In the case of Pakistani immigrants, culture shaped the functions of immigrant networks in the U.S. Social functions and structures also reflected the needs of these immigrant women, and addressed the cultural deficits experienced by these women on immigration. An adherence to pre-migration ideologies was apparent in the structure of these new networks (e.g. the importance of family was reflected in the adoption of fictive kin as proposed by Kibria, 1993). Thus, networks (spouses, in-laws and fictive kinship) were reconstructed and resources (time, exchange of favors) were invested to strengthen these networks, deepening embeddedness and securing the ability to benefit from these networks.

The functions of these networks (see Table 9.1) also elucidate the significance of gender and gender roles in Pakistani culture. This was apparent in the structure of these women's recreated networks after immigration. These networks were predominantly female (especially among urban women living in Jersey City) and reflected the needs that they were fulfilling (or the ends or goals they achieved) and *purdah* between women and men.

Table 9.1 Functions of Pakistani Immigrant Women's Networks

	Urban	Sub
Function:		
Social support		
Picking up and dropping off children to and from school	X	
Shopping expeditions	X	X
Running errands (e.g. buying phone cards)	X	
Baby sitting for each other	X	X
Cooking food for a parturient family	X	X
Preparing soups for a friend after childbirth	X	X
Sharing the services of a Quran teaching woman	X	
Bearing each other's things to and from Pakistan	X	X
At their children's schools (in parent conferences)	X	
Telling each other what schools to apply for	X	X
Cooking for each other at birthday parties	X	X
Helping if a friend is ill	X	
Collective decision making	X	X
Sharing information on healthcare, welfare	X	
Economic Support		
Lend each other money	X	
Sometimes arrange a <i>kitty</i> (or money-go-rounds every participating woman contributes an amount every month, but one woman is given the entire amount in a monthly cycle until all the women get their turn).	X	X
Recommend a friend at a job.	X	X
Emotional Support		
In times of grief		
Stepping in to help with baby sitting, food preparation, money, airline tickets, airport transportation.	X	X
Pregnancy		
Baby gifts (after the baby is born)	X	X
Take care of the baby and give time to the mother to sleep, shower	X	

Source: Data collected.

9.5.1 Social Capital and Health Research

A large body of research has employed social capital as a variable in health research, but there are critics of the invoking social capital in health debates (Baum, 1999; Hawe & Shiell, 2000; Navarro, 2002, 2005). The concept, as it relates to health, is quite nebulous

and subject to contentious debate. There is a lack of consensus concerning the definition of social capital and its components (networks, norms, expectations, trust etc.). Most social capital theorists in health cannot agree on what comprises these components, let alone the means of measuring them (Hawe & Shiell, 2000; Szreter & Woolcock, 2004). As a result there is more confusion than clarity on the subject. The following discussion aims to reconcile the findings of this research and situate it within the larger body of published research.

There has been rising interest in linking social capital to health outcomes (both negative and positive outcomes have been linked with social capital). However, it has not been easy to link any specific type of capital to these outcomes (Baum, 1999). In the health literature, social networks, social support, trust, norms, and embeddedness have all been employed as indicators of social capital. Social capital has been linked to health three general ways. First was the affect of social networks, social support and embeddedness on individual attributes and activities (Berkman, Glass, Brissette, & Seeman, 2000). Second, Berkman et al. (2000) suggested that social networks may influence physiological stress responses and health behaviors. Third, Macintyre et al. (2002) suggested that norms, values and traditions also contribute to health outcomes. Additionally, Veenstra et al. (2005) reported less emotional stress with greater involvement in community groups.

Szreter and Woolcock (2004) in their review of social capital and its application in public health distinguished between social support networks as identified by Berkman et al. (1979, 2004) in their study of mortality rates in Alameda County in California, and the networks that Coleman (1988b) and Putnam et al. (1993) have conceptualized. Szreter

and Woolcock (2004) suggest that Coleman's and Putnam's networks are a variant of the social support networks as identified by Berkman et al. (2004), and these have some health related effects. Szreter and Woolcock (2004) cite a plethora of studies that link networks with several health outcomes although they argue against conflating these two 'types' of networks. Additionally, Berkman and Syme (1979) identified social networks as ties between individuals and their family members (spouses or other) and membership in groups (e.g. church groups). Although Szreter and Woolcock (2004) imply that Berkman's networks are different from Coleman's and Putnam's, yet membership in groups and related lower mortality rates (Berkman & Syme, 1979) echo Putnam's theorization of social capital. Seeman and Berkman (1988) explored the social networks further and argued that for relationships to have any positive effect on health there need to be deep ties; even the presence of a spouse or children of the elderly did not have an effect on the health of the elderly unless their relationship was close. Seeman et al. (1988) employ the term 'confident' to indicate depth of relationship. Again, this concept echoes embeddedness. The difference between the networks of social capital (as conceptualized by Coleman, 1988, and Putnam, 2000) and social support (Berkman & Syme, 1979) seem to be the function. The networks of social capital offer a wide range of support, while social support networks tend to be narrower in their focus in providing emotional and physical support.

If social capital is measured by membership (local mosque) and social cohesiveness as Putnam (2000) postulated, then the women in Jersey City possessed greater social capital. If acculturation and assimilation were measured, then it would appear that the women in Jersey City had low levels of acculturation as Berry (1980)

suggested. If health effects were predicted based on acculturation and social capital (as proposed by Putnam, 2000) then the women in Jersey City would be expected to have better health outcomes.

Social capital can have a community level influence on health outcomes. This influence can be either positive or negative. For example, a positive effect of a community's collective social capital can result in protecting and promoting their neighborhood's healthy environment (for example, green open spaces and low crime rates) (Putnam, et al., 1993), while a negative affect can be seen in the influence of income inequality on the health of a community (Baum, 1999; Kawachi, et al., 1997; Wilkinson, 1992).

Income inequality has been linked to higher mortality rates, difference in access to material and institutional resources such as housing and healthcare, and increased incidence of cardio-vascular disease in lower socio-economic neighborhoods (Diez Roux, et al., 2001; Wilkinson, 1992)). However, for these dimensions to have any kind of influence an individual has to be situated within a community. Therefore the existence of communities and individual membership are assumed. What about individuals who are new and have not become part of an existing community (for example, new immigrants)?

9.5.2 Culture, Acculturation, Assimilation and Social Capital

Another debate involves the use of culture in explaining health outcomes. Culture is cited freely in examining immigrant health. Immigrants arrive in better health, but it has been documented that immigrant health often deteriorates as time in the U.S. increases (Antecol, 2006; McDonald & Kennedy, 2004; Stephen, et al., 1994; Williams, 2005). Rumbaut (1997) refers to this as the "paradox of assimilation". The health advantage

diminishes by the second generation, which can translate into health disparities (Fennelly, 2005). Critics of acculturation and assimilation identify adoption of dominant cultural norms by immigrants as one determinant of their deteriorating health (Guendelman & English, 1995; L. M. Hunt, Comer, B., 2004). Hunt et al. (2004) argue that such an approach ignores the vast educational and socio-economic gap between the white majority and the immigrant and African American minorities and blames the immigrants and African Americans for their relatively poor health. As Hunt (2005) put it 'What's culture got to do with it?'

Immigrant communities provide the opportunity to study and gain insights into the affects of social relations and networks on social capital after migration and their affects on health (Coleman, 1988b; Granovetter, 1995; A. Portes & Sensenbrenner, 1993). Time and investment via reciprocity are crucial in enhancing trust and thereby increasing the capacity to access the social capital inherent in a community (Putnam, et al., 1993). However, trust and reciprocity need time to develop. Thus, established communities may offer a great resource (Portes & Sensenbrenner, 1993, referred to this as 'community solidarity'), but access to those resources depends on the embeddedness of a member in that community. Based on this premise a new immigrant may have less access when compared to those who have invested in and are already embedded in a community. Coleman (1990) and Portes (1998) have argued that migration disrupts or weakens the social ties of migrants (with support networks in their home countries) and their embeddedness in their 'new' home is weak. Therefore, any outcome of embeddedness within the 'new' community will take time to establish. Additionally,

rapid social and cultural changes and an absence of stable social ties and resources also contribute to poor health (Cassel, 1976).

As argued above, Pakistani culture strongly influences both the structure and function of these immigrant's social networks. In addition, Pakistani culture also constructed the meaning of the pregnancy, childbirth, and post-partum experience. In other words, Pakistani culture strongly influenced:

- the structure of networks
- the function of networks, and
- the meaning of pregnancy, childbirth, and the post-partum periods

The role of culture was highlighted when these women experienced a pregnancy soon after arrival in the U.S. The loss of functionality of Pakistani networks and their structurally weak networks in the U.S. emphasized the connection between culture and social capital. These women had lost their "ability to secure benefits through membership in networks and other social structures" on immigration as Portes (1998) suggested when he defined social capital. The cultural elements (social support, embeddedness in the family based on trust) were aligned with the functional elements of social capital. The weakening of the functional elements of their networks was compounded by the additional burden of change in the point of reference (the way of doing things-worldviews) of these women (e.g. social and cultural construction of the meaning of pregnancy, childbirth and post-partum periods).

The new networks were comprised of other Pakistani immigrants and family, and in-laws and functioned in the same way old networks in Pakistan did. It is also worth mentioning that the composition of the new networks in the U.S. was an affirmation of

the role of Pakistani culture. Group membership and social cohesiveness (as evidenced by strong community ties and mosque membership) was high. However, their dietary and language preferences (although they spoke English very well), and the structure of networks suggest that Pakistani immigrant women have not acculturated and assimilated in a broad sense. According to the dimensions of acculturation as proposed by Berry (1980), these women fell into the category of 'separation.' Separation occurs when an individual from the acculturating non-dominant group "values holding on to their original culture" and this is not a desirable outcome according to the assimilationist view (Berry, 1980; Ward, 1999). However, from the health point of view this would indicate that immigrants who held onto their cultural traditions would fare better than those who adopt the dominant cultural norms (Landale & Oropesa, 2001).

It is striking that those women who experienced a pregnancy soon after arrival in the U.S. (women who did not have the time or investment in new networks to function as surrogates of old networks in Pakistan), experienced great stress during that pregnancy, childbirth and post-partum period. Some even developed gestational diabetes. While women who had time to adapt reported less stress and rated their experience of pregnancy, childbirth and post-partum better. This is inconsistent with what the acculturation and assimilation literature proposes. These women reported better health outcomes after they had time to adapt to their new social surroundings.

The findings of this study support social capital theory. Loss or weakening of networks led to a stressful experience of pregnancy, childbirth and post-partum period. Whereas the experience was rated better after culturally defined replacement or surrogate networks had been established over time. Weakened social support in culturally

constructed situations proved to be crucial in determining the quality of the pregnancy, childbirth and post-partum experiences in Pakistani immigrant women.

9.5.3 Gender, Social Controls and Immigration

The social capital literature and research on culture propose that while there are benefits to membership in groups or adhering to cultural norms, there are also greater social controls and societal sanctions (O'Brien, 2005; A Portes, 1998; Swidler, 1986). Pakistani culture (and society), with its roots in Islamic culture, exerts great social controls (apparent in gender segregation, arranged marriages and definitions of modesty), and although immigration loosened some of these constraints (women finding employment, employment not considered a male pursuit, greater independence of women), most social controls were incorporated into the structure of new networks (dating, co-mingling or fraternizing of sexes, smoking and alcohol consumption by women were frowned on). Membership in mosques was high and some of these women adhered to the rules of *hijab*. However, very few women voiced dissent and most accepted these controls. Membership to these networks acted as a shield, isolating the members from external influences, preserving the culturally imbued worldviews, ingrained behaviors from Pakistan.

In summary: These women's experiences of pregnancy, childbirth and post-partum period in Pakistan were shaped by their social capital. Secondly, their social capital was rooted in Pakistani culture: culturally defined social support was crucial in shaping their pregnancy, childbirth and post-partum period experiences.

9.6 Policy Implications

This research identified some problems encountered by the new Pakistani immigrants. First, there is a lack of information available to immigrants seeking healthcare. Community based or faith based organizations or mosques can play a critical role in disseminating information on procuring or improving access to information on healthcare. Second, lack of English language proficiency was a barrier for some, especially in the urban population, hence information materials in Urdu may be helpful. Third, this group of immigrants is at a high risk of developing gestational diabetes and post-partum depression. Increasing awareness and improving cultural competence in healthcare professionals may improve pregnancy and post-partum experiences. Again, community based or faith based organizations or mosques can also play a role in health education and organizing support groups to target post-partum depression.

9.7 Future Research

This research highlighted some issues where future research may be directed. First, these immigrant women, especially during their first pregnancies in the U.S., were at a greater risk of developing gestational diabetes. A larger study on Pakistani immigrant women may help in exploring this phenomenon. Second, a study on the acculturation of immigrant Pakistani women may present an opportunity to study and compare health outcomes with other immigrant groups. Lastly, deeper understanding of gender role may offer insights into gender role negotiations in first and second generations of Pakistani immigrants. A study of Pakistani immigrant men may also be helpful.

APPENDIX

RESEARCH PARTICIPANTS; DATA FROM THE INTERVIEWS

A description of the sample of immigrant Pakistani women is presented below in tabular form.

	Total	Urban	Suburban
Sample	26	14	12
Median age	38	36	41
Total children	69	39	30
Born in Pakistan	18	11	7
Average years married	14	13	16
Years in U.S.		12.6	11
City of Origin in Pakistan		Lahore, Karachi, Shahdara, Jhang	Lahore Karachi, Islamabad
Time in U.S. Before 1st Pregnancy			
Arrived Pregnant		3	4
Less than a Year		6	5
More than a Year		5	3

Sample of Women Interviewed-Continued

		Urban	Suburban
Educational Attainment			
	High school	4	1
	Bachelors'	9	8
	Masters'	1	3
Employment			
	Home maker	7	2
	Employed	7	10
Husbands' Education			
	High school	3	
	Bachelors'	8	4
	Masters'	3	8
Employment		8 transportation/self- employed,	Physicians, engineers, finance, IT
Housing	Own	4	12
	Rent	10	
<i>Susraal</i> in the U.S.		7	6
Live with <i>susraal</i>		3	3

Sample of Women Interviewed-Continued

	Urban	Suburban
Husband lived in U.S.	6	7
Moved to the U.S. with parents	3	
Migrated with husband	2	8
after how many years of marriage	2-6 yr	1-10 yr
Age at marriage woman	18-24	18-26
Age difference between husband and wife	4-17 yrs	2-6 yrs
Marriage arranged	12	8
Marriage choice	2	4
Marriage arranged very quickly	3	
<i>Nikah</i> for sometime before marriage	2	
Marriage initiated by family	10	7
Friends	2	2
Did not know the groom's family	2	3
Married while still in college	4	2
Married within family	4	2
Lived with in laws (in Pakistan or U.S.)	14	12
Pregnancy after marriage		
within a few months	11	7
More than a year	3	5

Sample of Women Interviewed-Continued

	Urban	Suburban
Health insurance status at time of pregnancy		
no insurance	10	3
Health insurance status now		
private	3	7
Government	11	5
Believe in <i>ghutti</i>	14	12
fed <i>ghutti</i> to baby in the U.S.	8	3
<i>azan</i> in the U.S.	14	12
<i>aquiqa</i> in the U.S.	5	5
in Pakistan	7	3
not observed	2	4
Prepared and ate <i>panjeeri</i> in the U.S.	5	3
<i>kaara</i>	5	4
soup	9	8
Believe in food properties	14	10
Took food properties into consideration	9	6
Went to Pakistan soon after birth	5	4
Reported feeling depressed	7	5
Gestational diabetes	5	2

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