

TRANSCULTURAL NURSING

**THE ROLE OF THE HEALTH VISITOR
IN MULTI-CULTURAL SITUATIONS**

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To my father, Raymond Dobson,

With fondest love

I declare that this thesis has been composed by me
and that this work is entirely my own.

Signature Susan P. Johnson
Date 31st March 1987

ABSTRACT

This thesis considers the provision of culturally relevant health visiting in the multi-cultural context of contemporary Britain. It is suggested that the unicultural perspective within which the health visiting service currently operates is inappropriate. The transcultural perspective, in which all health visitors receive educational preparation in the discovery and utilization of knowledge relating to their client's cultural traditions, is presented as an alternative.

In illustration, the findings of a study utilizing ethnographic approaches and insights are presented. The study, which focuses on selected aspects of child bearing and child rearing in relation to a small Punjabi community in one city in the United Kingdom, is concerned specifically with health visiting's maternal and child health remit. It is argued that health visitors could, with appropriate education, use a similar approach to cultural discovery in everyday field practice.

The findings of the study indicate that, for accuracy and completeness of health visiting diagnoses relating to mothers and infants in the Punjabi community studied, cultural knowledge is essential. It is suggested that similar knowledge is needed in other multi-cultural situations if culturally relevant and effective health visiting is to be practised.

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Yet all experience is an arch wherethro'
Gleams that untravell'd world, whose margin fades
For ever and for ever when I move.

(Tennyson 1842
'Ulysses')

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TABLE OF CONTENTS

INTRODUCTION	16
1. Introduction	18
2. The Format of the Thesis	20
3. Definitions and Use of Terms	22
CHAPTER ONE	
THE ROLE OF THE HEALTH VISITOR	
THE UNICULTURAL PERSPECTIVE	28
1. Introduction	29
2. Historical Considerations	30
a) The Formative Years	31
b) Within the National Health Service	33
c) The Last Fifteen Years	35
3. The Unicultural Perspective	38
a) Characteristics of the Value System	39
i) Relevance of Cultural Knowledge	39
ii) Independence of the Practitioner	40
iii) Long-term Health Visitor-Client Relationships	41
iv) Selection of Specific Client Groups	42
v) Educational and Advisory Approaches	44
vi) The Notion of Individualism	45
vii) Western Scientific Health and Nutritional Knowledge	46
b) Characteristics of the Organizational Environment	47
i) Hierarchical and Bureaucratic Nature of the Organizational Environment	47
ii) Local health authority influence on Health Visitor Education	50
iii) Data on Ethnic Identity and Background	51
iv) Health of Infants and Pre-schoolers	52
c) Characteristics of the Educational System	54
i) Importance of Applicant Selection	54
ii) Disciplinary Flexibility within the Knowledge Base	56
iii) Variations in the Inclusion and Comprehensiveness of Cultural Components	58
iv) Individualized Approaches to Health Promotion	61
v) Interchange of Ideas and Value Orientations at Field Level	62
d) Summary	63
4. Consumer Considerations	66
5. A Unicultural Model of Health Visiting	69
6. Conclusion	72

CHAPTER TWO
THE CULTURAL DIMENSION OF HEALTH VISITING AND
NURSING - THOUGHTS, ISSUES AND DEVELOPMENTS

74

1. Introduction	75
2. Transcultural Nursing – Definition and Development	76
a) In the United States of America and Canada	76
b) Worldwide – Excluding the United Kingdom	80
c) Discussion	82
3. Multi-cultural Nursing within the United Kingdom	83
a) Awakening Interest	83
b) Other Health Caring Professionals	85
c) Trends within the Health Services	87
d) Nursing Education	88
e) The United Kingdom Health Visiting Syllabus	90
f) Discussion	92
4. Specific Aspects relating to Health Visiting’s Maternal and Child Health Remit in Multi-cultural Situations	93
a) Infant and Pre-school Nutrition	94
b) Immunization	96
c) Sources of Advice and Influence	99
5. The Relevance of Theoretical Thinking to Health Visiting	102
a) An Overview of the Development of Nursing Theory	103
b) Theoretical Thinking and Health Visiting	105
c) Clark’s Model for Health Visiting	108
d) Models for Health Visiting – The Cultural Dimension	112
i) Clark’s Model and the Cultural Dimension	112
ii) Health Visiting in a Multi-cultural Society – Field Level Considerations	116
iii) Cultural Discovery in Field Practice	120
e) Reciprocity in Health Visiting and Nursing	127
6. Summary	132

CHAPTER THREE
THE ROLE OF THE HEALTH VISITOR
THE TRANSCULTURAL PERSPECTIVE

134

1. Introduction	135
2. The Need for an Alternative Cultural Perspective for Health Visiting	136
3. The Transcultural Perspective	139
a) Characteristics of the Value System	141
i) Relevance of Cultural Knowledge	141
ii) Independence of the Practitioner	142
iii) Health Visitor-Client Relationships	143
iv) Selection of Specific Client Groups	144
v) Educational and Advisory Approaches	145
vi) Notions of Collectivism and Individualism	146
vii) Health and Nutritional Knowledge	147
b) Characteristics of the Organizational Environment	148
i) Hierarchical and Bureaucratic Organizational Environment	148
ii) Local health authority influence on Health Visitor Education	150
iii) Data on Ethnic Identity and Background	151

iv) Health of Infants and Pre-schoolers	152
c) Characteristics of the Educational System	153
i) Importance of Applicant Selection	153
ii) Disciplinary Flexibility within the Knowledge Base	154
iii) Variations in the Inclusion and Comprehensiveness of Cultural Components	155
iv) Individualized and Group Approaches to Health Promotion	157
v) Interchange of Ideas and Value Orientations at Field level	158
d) Summary	159
4. Transcultural Reciprocity	161
5. A Transcultural Model for Health Visiting	166
a) Client	166
b) Health Visitor	167
c) Health Visiting	168
d) Health	169
e) Environment	169
i) The Educational Dimension of the Health Visiting Service	169
ii) The Organizational Dimension of the Health Visiting Service	170
f) Summary	171
6. Considerations Regarding a Culturally Appropriate Mode of Health Visiting Practice for a Multi-cultural Society	173
7. Summary	179

CHAPTER FOUR
THE RESEARCH PROCESS - DISCUSSION AND DESCRIPTION **181**

1. Introduction	182
2. Planning the Study	184
a) The Focus of the Study	184
b) Research Methods	184
c) Nursing Research - The Use of Participant Observation and Ethnographic Interviewing	186
d) Selecting an Ethnic Minority Group	188
e) Sampling Strategies	189
3. Fieldwork and Data Analysis	192
a) Choice of Location	192
b) The Need for an Interpreter	192
c) Introductions to Families	193
d) Punjabi Culture	196
e) Data Collecting	197
f) Visit to the Punjab	202
g) Data Analysis	206
4. Discussion	207
a) Personal Insights	207
b) Preparation for Research into the Cultural Dimension of Health Visiting	209

c) Changing Contours of the Study	210
d) Presentation of Self	211
e) Ethical Considerations	213
f) Factors regarding Interviewing	215
g) Researcher Fatigue	218
5. Summary	219

CHAPTER FIVE

THE CULTURAL HERITAGE AND

THE SETTLEMENT OF THE PUNJABI COMMUNITY

221

1. Introduction	222
2. The Heritage	222
a) The Punjab	222
b) Languages Spoken	226
c) Religion	228
i) Islam	230
ii) Sikhism	232
d) Historical Perspectives and the Partition of India in 1947	233
e) Punjabi Family and Kinship Networks	237
i) The Family	237
ii) Kinship Networks	239
f) Caste, Clans and Lineages	240
g) Marriage	242
h) Purdah	243
i) Pollution	247
3. Overview of the Settlement of Indians and Pakistanis, particularly Punjabis, in the United Kingdom	249
a) The Pioneers	249
b) Increased Immigration	251
c) Re-establishment of Family Life and Consolidation of Ethnic Communities	253
d) The Second Generation	255
4. The <i>Bhatra</i> and the <i>Arain</i> Sub-Castes	255
a) The <i>Bhatra</i> Sikhs	255
b) The <i>Arain</i> Muslims	257
5. The Contribution of the Womenfolk to the Development of the Asian Communities in the United Kingdom	258
6. Summary	261

CHAPTER SIX

PRE-ENCOUNTER INFLUENCES

THE FAMILIES

263

1. Introduction	264
2. Socio-environmental Factors	267
a) Housing and Spatial Distribution of Sample Population	267
b) Origins and Religious Affiliation	270
c) Ages and Lengths of Residence	271
d) Economic Aspects	271
e) Language Fluency	273
f) Dress, Fashion and Jewellery	274

g) Family Compositions	279
h) Spatial Distribution and Use of Rooms	280
i) Room Usage	281
ii) Furnishings	282
iii) Wall Hangings and other Items of Décor	286
iv) Bathroom Facilities	287
i) Colour Usage	287
3. Aspects of Family and Community Life	291
a) Community Institutions and Solidarity	291
i) The <i>Bhatra</i> Community	292
ii) The Punjabi Muslim Community	296
b) Family Bonds and Relationships	297
i) Marriage	297
ii) Kinship Bonds	301
iii) Mothers-in-Law	302
4. Underlying Cultural Values	305
a) Junior to Senior	306
b) Female to Male	307
c) Impure to pure	313
5. Summary	315

CHAPTER SEVEN

PRE-ENCOUNTER INFLUENCES

CHILD BEARING AND CHILD REARING

316

1. Introduction	317
2. Family Size and Location of Deliveries	317
3. Child Bearing	318
a) Concern for Fecundity and the Importance of Male Progeny	318
b) Attitudes towards Family Planning Methods	319
c) Attitudes towards Pregnancy and Antenatal Care	320
d) Attendance at Antenatal Classes	321
e) Antenatal Guidance at Home	323
f) Dietary Considerations during Pregnancy	324
g) Deliveries	327
h) Hospital Facilities	328
i) The <i>Chalia</i>	329
4. Child Rearing	336
a) Feeding the Baby - Breast-feeding	336
b) Feeding the Baby - Bottle-feeding	338
c) Dietary Needs for Post-natal and Lactating Mothers	339
d) Naming the Baby	340
e) Customary Ceremonies for Infants	340
f) Infant Weaning and Child Feeding	342
g) Handling of Children and Approaches to Child Care	344
h) Immunization	346
i) Aspects of Child Development and Child Health	347
5. Underlying Cultural Values	352
a) Junior to Senior	352
b) Female to Male	352
c) Danger and Vulnerability	353
6. Summary	356

CHAPTER EIGHT**THE RELEVANCE OF THE FINDINGS TO HEALTH VISITING PRACTICE****357**

1. Introduction	358
2. The Antenatal mother	359
a) The Antenatal Remit of Health Visiting	359
b) The Cultural World of the Pregnant Punjabi Woman as Wife	361
c) Health Visiting the Pregnant Punjabi Woman as Wife	364
i) Diagnosis – Emotional Strain relating Wifehood	366
ii) Health Visiting Interventions Emotional Strain relating to Wifehood	377
iii) Conclusion	383
d) Being Pregnant in the Punjabi Community	383
e) Health Visiting the Antenatal Punjabi Mother	385
i) Diagnosis – Preparedness for Confinement	385
ii) Diagnosis – Preparedness for the <i>Puerperium</i>	392
iii) Diagnosis – Preparedness for Motherhood of a Newborn Infant	395
iv) Health Visiting Interventions – Preparedness for Confinement, the <i>Puerperium</i> , and Motherhood	396
3. The Post-natal Mother and Infant	399
a) The Post-natal Health Visiting Remit	399
b) The Post-natal Punjabi Mother and Infant	400
c) Health Visiting the Post-natal Punjabi Mother and Infant	402
i) Diagnosis – Management of the Transition to Motherhood of a Newborn Infant	402
ii) Diagnosis – Management of Infant Health Promotion	409
iii) Health Visiting Interventions – Management of the Transition to Motherhood of a Newborn Infant, and Management of Infant Health Promotion	413
4. Discussion	416

**CHAPTER NINE
CONCLUSIONS****425**

1. Conclusions	426
2. <i>Quo Vadis?</i>	428

APPENDICES

1.	Glossary	431
2.	List of Sample Mothers and Other Individuals and Families Interviewed	451
3.	Interview Schedule	455
4.	List of Foods	461
5.	Journal Publications	463

REFERENCES

477

MAPS

1.	The Punjab	223
2.	Heritage Areas of Sample Families with Reference to Punjabi Dialects	227
3.	Location of Families visited during Fieldwork	266

SCHEMA

164

PHOTOGRAPHS

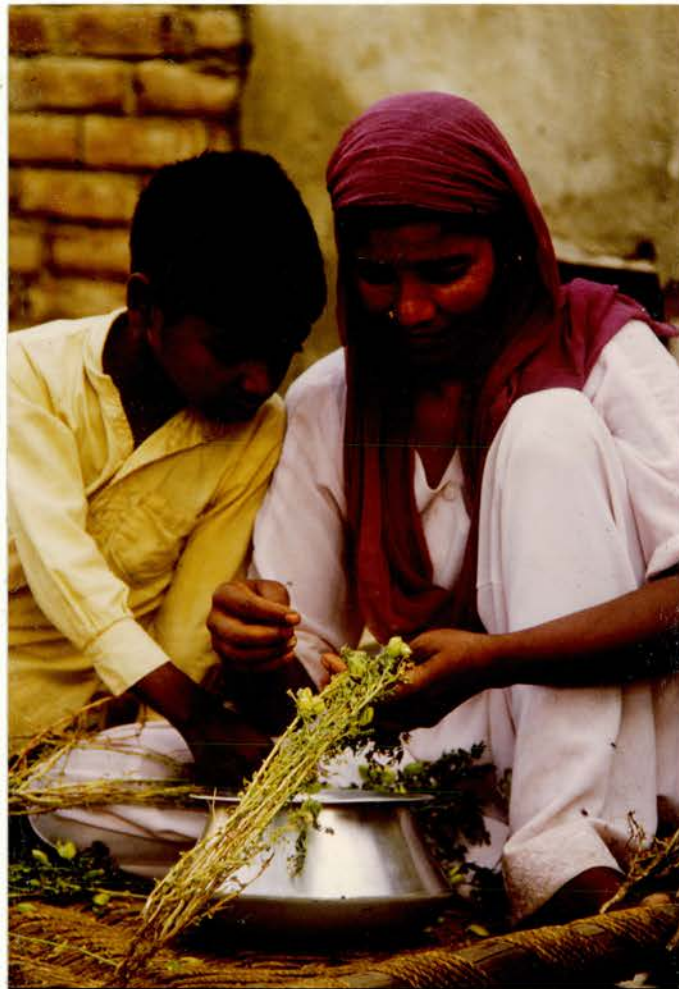
	Frontispiece	
	Punjabi Mother and Son	17
	Village Health Care Facilities	
4.1	Antenatal Home Visit - Pakistan	203
4.2	Village Medical Practitioner - India	203
4.3	Immunization Clinic - Community Nurse - Pakistan	204
4.4	Home Visiting - Village <i>dai</i> (Midwife) and Medical Intern - India	204
	The Punjab	
5.1	The Granary of the Sub-continent	225
5.2	Village Agricultural Scene	225
5.3	Looking towards the Mountains	229
5.4	A Village Pond	229
	Dress	
6.1	Old Lahore - Pakistan	278
6.2	At the Banglasahib <i>Gurdwara</i> - Delhi	278

PHOTOGRAPHS CONTINUED

Household Tasks		
6.3	Making Tea	284
6.4	The Hearth	284
6.5	Washing up	285
6.6	Kitchen Utensils and Steel Tableware	285
Colour		
6.7	Protecting the Banglasahib <i>Gurdwara</i> - Delhi Colours symbolic of the Sikh Faith	289
6.8	Colourful turbans - <i>Baisakhi Day</i> - India	289
Women relaxing		
6.9	By Tractor to the Fair - <i>Baisakhi Day</i> - India	295
6.10	On the Step - Townlife	295
Mother and Child		
7.1	Mother and her Newborn	332
7.2	Applying <i>Kol</i>	332
7.3	At the <i>Gurdwara</i>	350
7.4	Attending a Village Health Clinic	350

INTRODUCTION

- 1. Introduction**
- 2. The Format of the Thesis**
- 3. Definitions and Use of Terms**



Punjabi mother and son

1. INTRODUCTION

The need for cultural understanding and knowledge to be blended into health care practice has been well recognized both by theoretically oriented social scientists and by practitioners of health care as fundamental in the provision of a caring and relevant health service (e.g. Paul 1955; Crow 1977; Brownlee 1978). It is now over thirty years since Paul (1955), an anthropologist concerned about the failure of health care programmes in several countries, concluded that to help a community (and one could equally well substitute family, either nuclear or extended, for community), it is important to:

. . . learn to think like the people of that community. Before asking a group of people to assume new health habits, it is wise to ascertain the existing habits, how these habits are linked to one another, what functions they perform, and what they mean to those who practice them.

(Paul 1955:1)

Whilst this advice introduces a book describing programmes in other countries, it has relevance also for the delivery of culturally relevant health care in the United Kingdom. In this thesis, the focus of concern is the delivery of culturally relevant health visiting practice.

Although the idea of providing culturally sensitive and attuned care is not new to the health visiting profession as an ideal, in reality it has received scant consideration. For the most part, health visiting is an unsolicited, universalist, and nationwide public service which utilizes home visiting as the dominant approach for its health promotive activities. In attempting to provide a succinct and informal description of health visiting, Robertson (1981:111) notes that health visitors aim 'to improve public health by informing and encouraging people to remain healthy and by enabling them to make the best use of health

and social services'. In particular, health visitors 'call on families in their homes, especially where there are small children'. Although health visiting encompasses a variety of forms (e.g. counselling, health education), the role of the health visitor is essentially one of health promotion. With health visitors promoting their client's health most often in the client's home where the health visitor is a guest, the salience of the client's cultural way of life assumes particular importance. Indeed, if health visitors are to assist individuals, families and groups to attain and/or maintain optimal health and well-being throughout the life process, then their practice must be relevant both to their client's needs and to their client's way of life.

Visualized at a conceptual level, and reflected in the literature, health visitors are socialized, educated and organizationally supported to practise within what is, I suggest, a unicultural perspective. Although the presence of other cultural groups within society is recognized, and acknowledged in the professional code of conduct for health visitors (U.K.C.C. 1984:2), the health visiting service upholds the primacy of the dominant culture of the United Kingdom. In so doing, it fails to embrace adequately the multi-cultural nature of contemporary society. Not only is the possibility of a disparity between the client's and the health visitor's cultural background not fully recognized and addressed, but the relevance of cultural knowledge to client care receives little formal teaching in training establishments.

In this thesis it is suggested that if health visitors nationwide are to provide a culturally sensitive and effective service for a multi-cultural clientele, then the unicultural perspective is inappropriate. Instead, an alternative perspective is proposed in which all qualifying, and qualified, health visitors are prepared educationally to practise effectively in inter-cultural as well as intra-cultural

situations. It is suggested that this alternative perspective requires a value system and an organizational environment in which the cultural diversity that exists throughout the United Kingdom is recognized and responded to affirmatively.

Essentially, this thesis is concerned with the cultural dimension of health visiting practice. However, with the majority of the members of the dominant culture of the United Kingdom being white (see 'DOMINANT CULTURE' below), it is recognized that the sensitive issue of racial prejudice may intrude on the provision of health care in multi-cultural situations. It is also realized that the social perception of physical differences is subject continuously to the evaluation of British society. Nevertheless, culture is treated as an entity in itself and, as such, is addressed specifically.

2. THE FORMAT OF THE THESIS

In **Chapter One**, the cultural perspective within which the health visiting service currently operates, and as presented in the literature, is considered. This perspective is seen to be unicultural. Thereafter, issues and developments relating to the cultural dimension of health visiting, and nursing, are reviewed in **Chapter Two**. This review highlights the absence of a model which focuses specifically on the cultural dimension of health visiting practice.

In **Chapter Three**, the transcultural perspective is presented as an alternative cultural perspective for health visiting. This perspective requires all health visitors to be prepared educationally to discover and utilize data relating to their client's ethnic identity and background. Central to the practice of

transcultural health visiting is an emphasis on the importance of client-oriented care that recognizes the client's cultural traditions and values.

Chapters Four, Five, Six, and Seven are concerned specifically with the research study which considers relevant aspects of health visiting's maternal and child health remit in relation to child bearing and child rearing practices in a small Punjabi community in the United Kingdom. In selecting this community as the focus of an exploratory study, it was envisaged that ideas and insights would emerge that would have wider applicability. In **Chapter Four**, the research process, in which ethnographic approaches to data collection were utilized, is described and discussed. **Chapter Five** offers insights into the heritage and settlement of Punjabis in Britain and is provided as background information. The findings of the study are presented in **Chapters Six and Seven**.

Several photographs which depict differing aspects of Punjabi life have been included. These photographs were taken during my visit to India and Pakistan in 1984. It is hoped that they help to 'bring alive' various themes discussed in relation to the study and, to some extent, compensate for any loss of 'tangibility' that may have occurred in the endeavour to uphold as high a level of anonymity and confidentiality as possible in regard to the families who participated in the study.

In **Chapter Eight**, the relevance of the findings are discussed in conjunction with the diagnostic process of health visiting. Three hypothetical Punjabi clients are focused upon: the antenatal mother (both as wife and mother), the post-natal mother, and the infant. The importance of data relating to the client's ethnic identity and background is demonstrated as essential to health

visiting practice and, specifically, to diagnostic accuracy and completeness as well as to the effectiveness and cultural relevance of health visiting interventions.

In **Chapter Nine**, the relevance of the findings to the provision of culturally attuned health visiting practice is re-examined in regard to the health visitor's health promotive role in multi-cultural situations. The transcultural perspective is considered for its potential in the provision of a more culturally appropriate and effective service in contemporary Britain's multi-cultural society than the unicultural perspective in which health visiting currently operates.

3. DEFINITIONS AND USE OF TERMS

Although there are a number of male health visitors, it is still more usual for health visitors to be women. Hence, the feminine gender is used throughout this thesis in regard to health visitors. In the use of Punjabi terms, a mode of transliteration is employed which has been considered acceptable by several members of the families who participated in the study. On occasion, an anglicized form for the plural of certain Punjabi nouns is used. All Punjabi terms used in this thesis are defined in the Glossary (see Appendix One). The terms 'South Asian' and 'Asian' are both used to describe those people to whom the Indian Sub-continent is the land of their heritage.

CULTURE

Any discussion of the cultural dimension to nursing and health visiting assumes a basic understanding of the concept of 'culture'. Since Tylor's (1871:1) classic definition of culture as:

. . . that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society,

'culture', as an anthropological concept, 'has undergone many transformations and there is no present-day consensus about how the term should be used' (Leach 1982:39). Various writers, notably anthropologists, have provided their own definitions and insights into the meaning of culture. For instance, Eliot (1948:41) describes culture as 'a way of life' which is more than the mere 'sum of several activities'. Underlining the dynamic complexity and socially inherited nature of the concept, Lewis (1976:17) emphasizes that, 'subject to the vagaries of innovation and change', culture is passed on 'in a recognizable form from generation to generation'. In another definition, culture is viewed as 'an abstraction from the body of learned behaviour which a group of people, who share the same tradition, transmit entire to their children', thus highlighting the fact that the concept encompasses both the overarching institutions of a society as well as 'the small intimate habits of daily life, such as the way of preparing or eating food, or of hushing a child to sleep' (Mead 1953:9-10).

Spradley (1979:5) provides a more processual definition of the concept by defining culture as 'the acquired knowledge that people use to interpret experience and generate social behavior'. In similar vein, Frake (1977 - also in Spradley 1979:7) offers a navigational analogy, seeing culture not as providing 'a cognitive map, but rather a set of principles for map-making and navigation'. 'Different cultures are like different schools of navigation designed to cope with different terrains and seas'. Cast out 'into the imperfectly charted, continually shifting seas of everyday life', 'people are not just map-readers; they are map-makers' (Frake 1977:6-7). In these definitions of culture, the emphasis is placed on the 'insider's' rather than the 'outsider's' point of view (Spradley 1979:5).

Finally, as a nurse-anthropologist, Leininger (1978:491) offers the following definition of culture:

Culture is the learned and transmitted knowledge about a particular culture with its values, beliefs, rules of behavior, and life-style practices that guides a designated group in their thinking and actions in patterned ways.

Dynamic and encompassing in nature, culture includes both health and illness beliefs and practices. Therefore, through the very nature of their work, health visitors are involved inextricably in their clients' cultural way of life.

Throughout this thesis, 'culture' is used in reference to ethnic grouping. In order to reduce unnecessary confusion of terms, the term 'cross-cultural' has been avoided where possible.

DOMINANT CULTURE

Although it is difficult to define precisely, for the purposes of this thesis, and in relation to health visiting practice, the dominant culture of the United Kingdom is considered to be English (particularly Southern English), nuclear family-oriented and secular. The majority of the members of the dominant culture are white.

INTER-CULTURAL

This term is used to describe health visiting situations, relationships and practice in which the client and the health visitor are of differing cultural traditions (see 'TRANSCULTURAL' below).

INTRA-CULTURAL

This term is used to describe health visiting situations, relationships and practice in which the client and the health visitor are of the same cultural tradition.

UNICULTURAL

In this thesis, the term 'unicultural' is used in relation to an activity, situation, or perspective in which the primacy of the dominant culture of the United Kingdom is upheld, and in which only peripheral recognition is given to the presence of other cultural groups within society.

Thus, **unicultural health visiting** is the practice of health visiting in which the primacy of the dominant culture of the United Kingdom is upheld at educational, practice and organizational levels, with only peripheral recognition being given to other cultural groups within society. Health visitors who practise within the unicultural perspective are described as unicultural health visitors.

MULTI-CULTURAL

This term is used to imply the presence of, or in reference to, more than one culture, for instance, with regard to society and health visiting situations (see 'TRANSCULTURAL' below).

MULTI-CULTURAL HEALTH VISITING

This term is used in reference to inter-cultural health visiting practice and implies the presence and awareness of cultural differences between the health visitor and client. Multi-cultural health visiting practice lacks, however, an explicit sense of 'transcultural', that is, an interchange of cultural knowledge and respect between health visitor and client which is based on an affirmative desire to bridge and transcend cultural differences.

TRANSCULTURAL

In this thesis, this term is used to imply the presence of, or in reference to, more than one culture, and to denote the co-existence of an affirmative desire to bridge and transcend cultural differences within the health visitor-client relationship. In so doing, it implies a prescription for practice. Together with the terms 'inter-cultural' and 'multi-cultural', the term 'transcultural' may also be seen to be part of a three dimensional structure in which:

- 1) **inter-cultural** – denotes the presence of cultural differences.
- 2) **multi-cultural** – denotes both the presence and the awareness of cultural differences.
- 3) **transcultural** – denotes both the presence and the awareness of cultural differences together with the affirmative desire to bridge and transcend these differences.

Only in citing the works of other health professionals is the term 'transcultural' used differently, and then in accordance with the author's own usage.

TRANSCULTURAL HEALTH VISITING

This term is used to describe health visiting practice in which a cultural disparity exists between the client and the health visitor and in which there is the co-existence of an affirmative, conscious desire to both bridge and transcend cultural differences. Intrinsic to all transcultural health visiting is the concept of 'transcultural reciprocity', that is, the reciprocation of cultural knowledge and respect between the client and the health visitor. Health visitors who practise within the transcultural perspective are described as transcultural health visitors. Transcultural health visitors are visualized as helping each client maximize his, or her, potential to achieve optimal health and well-being in accord with their client's cultural traditions and values.

CHAPTER ONE

THE ROLE OF THE HEALTH VISITOR

THE UNICULTURAL PERSPECTIVE

- 1. Introduction**
- 2. Historical Considerations**
- 3. The Unicultural Perspective**
- 4. Consumer Considerations**
- 5. A Unicultural Model of Health Visiting**
- 6. Conclusion**

1. INTRODUCTION

Although the United Kingdom has become increasingly multi-cultural throughout the twentieth century, it is only during the past decade that the health visiting and nursing professions have begun to consider the extent to which they are providing a culturally relevant service. On the whole, health concerns are linked to factors relating to class, occupation and health region (e.g. D.H.S.S. 1976) rather than culture. Cultural concerns have remained peripheral, tending to receive attention only in areas with sizeable multi-racial as well as multi-cultural populations. Henley (1983), for instance, found a profound and widespread lack of tolerance of cultural diversity amongst both nursing and medical students during the years she spent researching and producing texts for health care professionals about the cultural traditions of Asian families in Britain. As a result, she is critical of what she terms the 'monocultural health care provision' for Britain's 'present multicultural society'. From her own experience, all groups of health care professionals must learn to 'stand back' from their own values and discover how 'equally real, equally valuable, and equally worthy of respect' are other peoples' cultural beliefs and values (Henley 1983:83,84,89).

Throughout the literature, the health visiting service is presented in unicultural terms, that is, the primacy of the dominant culture of the United Kingdom is upheld, with minimal recognition being given to other cultures. While there may be differing approaches (practically, educationally and organizationally) at local level to the needs and concerns of health visiting's multi-cultural clientele, it is only very recently that the need for a more culturally relevant approach to caring for a multi-cultural society has been

recognized at United Kingdom level of health visiting. As yet, there is no clearly stated United Kingdom health visiting policy to which the practising health visitor can refer. Hence, within this thesis, the health visiting service is presented as it is described and discussed within the nursing and health visiting literature which, I suggest, presents the service as operating within a unicultural perspective. Contributing to this unicultural perspective is the present lack of certainty that all health visitors nationwide are prepared educationally to provide culturally relevant and sensitive care in multi-cultural situations. Additional contributing factors include the service failing to cater for the potentially multi-cultural composition of its own membership, and the fact that, on a nationwide basis, the service does not actively encourage the discovery, use and development of other cultural approaches to health and well-being within health visiting practice.

2. HISTORICAL CONSIDERATIONS

In this section, I review the historical development of health visiting before considering, in the following section, various characteristics of the service as it is now. These characteristics, which I relate to the service's value system, organizational environment and educational system, are discussed with regard to the cultural dimension of health visiting. Finally, and in view of the unsolicited, outreach nature of health visiting practice, I consider the consumer perspective, but with special reference to research amongst ethnic minority groups.

A) THE FORMATIVE YEARS

Historically, the roots of the health visiting service rest in the days of the industrial revolution of the nineteenth century, an era when corporate health schemes were just emerging and state involvement in individual liberty was still considered unacceptable (see Baly 1984; Clark 1973; Dingwall 1974, 1977; Hicks 1976; Hobbs 1973; Robinson 1982). Although there had been a three-fold increase in the country's population between 1700 and 1850, the industrial revolution produced an even more dramatic increase in urban living, with a concomitant increase in the density of poverty, disease and squalor. Voluntary groups, many philanthropic in nature yet sometimes with a more self-protective intent, began to emerge, often in response to episodic outbreaks of cholera and typhoid. One such group was the Ladies Sanitary Reform Association which was formed in Manchester and Salford in 1862. Subsequently appointing a 'respectable working woman' to go 'from door to door among the poorer classes of the population, to teach and help them as opportunity offered' (McCleary 1933:85), this group is considered to be the direct antecedent of today's health visiting service. Then, as it is today, the service's overall remit (particularly regarding home visiting) can be described as being:

. . . concerned with teaching the principles of healthy living, building up families' and individuals' personal resources so that they can better cope with the normal crises of life.

(R.C.N. 1971:9)

By the turn of the century, there was increasing concern for the improvement of maternal and child health at a national level. In part, this was a result of the greater social awareness that was created by surveys such as those by Booth (1892) and Rowntree (1901) which detailed the vast amount of

poverty that existed amongst the urban working classes, the backbone of industrial Britain. Equally influential in increasing the nation's social conscience were the disturbing infant mortality rates which, in England and Wales, reached 163/1000 in 1899 (McCleary 1935:4-5), as were the unsatisfactory level of adult health which the recruitment of soldiers to fight the South African War highlighted. Enterprising local authorities began to encourage the promotion of milk depots, later to become infant welfare centres. In 1906, the Huddersfield Corporation Act requested that all births within the borough should be notified within forty-eight hours in order to make it possible for help and advice to be offered to all newly delivered mothers and their infants. By 1915, the notification of births was required for 'the whole country' within a time limit of thirty-six hours (McCleary 1933:91,93; Notification of Births (Extension) Act 1915).

During the early twentieth century, Liberal agitation for a comprehensive health and welfare system helped to stir the government into actively promoting the idea of a nationwide health visiting service, if only to help 'buy off socialist demands for radical change' (Dingwall 1976b:33; also 1977:22). While legitimized through its association with the infant welfare movement as well as through the enthusiastic support it received from various local authorities and medical officers of health, nevertheless the service's fortunes have tended to vary in relationship to the country's need for stronger military and working forces. In fact, it was not until the National Health Service Act in 1946 that local authorities were made statutorily responsible for providing a health visiting service.

The first health visitors came from varying educational backgrounds, some being university graduates, others doctors and sanitary inspectors. By 1918,

half were nurses, and, in 1925, midwifery was considered a necessary qualification for health visiting. Always a predominantly, if not totally, female occupation, it was not until 1972–73, when an 'obstetric nursing appreciation course' became an acceptable substitute for midwifery, and when a health visitor was redefined by statute as a 'person', that men became eligible for both training and certification (Wilkie 1979:94–97). Although one health visitor course was run as early as 1890 (O'Connell 1978:42), it was not until 1919 that a national training programme was begun. Dingwall (1976b:34) notes that nurse training as a precursor of health visiting was decided upon as a consequence of early twentieth century budgetary constraints; state-borne costs being reduced substantially by channelling trainees via the voluntary hospitals rather than providing a separate but longer, state-funded health visitor course. By 1928, training and certification had become mandatory for all initial appointments of full-time health visitors, although triple duty nurses (those combining district nursing, midwifery and health visiting functions) were allowed special dispensation, that is, until 1948 in England and Wales but, in Scotland, not until 1965 (McCleary 1935:32; O'Connell 1978:42; S.I. 1965). The Royal Sanitary Institute, rather than the General Nursing Council, became the first examining body, possibly a reflection of the fact that, at that time, nurse training rarely included knowledge of social conditions or infant hygiene (Lane-Clayton 1920:101–104).

B) WITHIN THE NATIONAL HEALTH SERVICE

Following the Second World War and the recommendations of the 1942 Beveridge Report (Social Insurance and Allied Services 1942), a comprehensive national network of health and social services, to be known as the 'welfare state', was outlined in the 1946 National Health Service Act. Envisaged as it

was to counteract and almost eradicate poverty and disease, it also eroded some of the health visitor's responsibilities. For instance, the infant life protection responsibilities that many health visitors undertook following the 1932 and 1933 Children and Young Persons Acts (according to McCleary [1935:100] 3,111 of the 3,347 official Infant Life Protection Visitors at the end of 1933 were health visitors) were taken over in 1948 by the social worker. Dissatisfied, health visitors, who were now employees of the National Health Service, requested an inquiry into their service. The ensuing Jameson Report (Ministry of Health et al. 1956) not only broadened the scope of their work, but re-emphasized the family as the focal unit of their concern, reminiscent of the pioneering intentions of the nineteenth century. This report recommended that health visitors should become 'general purpose' family visitors whose functions 'should primarily be health education and social advice' (Ministry of Health et al. 1956:vii-viii). These functions were subsequently, and more specifically, delineated in the 1969 Mayston Report (D.H.S.S. et al. 1969:21-24) which again noted the health visitor's remit as being concerned, on a continuing basis, not only for the individual but for the family as a whole.

A new syllabus for the expanded role of the service, as recommended in the 1956 Jameson Report, was needed. In planning this syllabus, the Council for the Training of Health Visitors, a statutory body established in 1962 for the recruitment as well as the training of health visitors, took note of the recently revised general nursing syllabus with the intent of ensuring a logical progression from one training to the next (Wilkie 1979:23-24). As one of the main stumbling blocks to revising the syllabus during the early 1960s turned out to be the diversity of existing trainings, areas of study able to provide a knowledge base which would 'permit modifications in the light of changes in the service' (Wilkie 1979:26) were eventually decided upon. The revised course

was constructed around five main themes, the outline of which is still in use. The various socio-medical aspects of individuals, groups and society covered in the first four sections of the syllabus were drawn together in the final section, the principles and practice of health visiting itself. It was decided that observational, organizational, relationship-building, and teaching skills should be both taught in college and developed during guided fieldwork practice. Nowadays, as all applicants must be general trained registered nurses, health visiting can be considered as a post-registration nursing qualification. The knowledge and skills learned and developed both during nurse training and while gaining obstetric experience, which include certain observational skills as well as knowledge of prenatal development and postnatal care (C.E.T.H.V. 1973:3), are thus both assumed and drawn upon.

C) THE LAST FIFTEEN YEARS

The 1970s was a time of considerable professional 'soul searching', that is, for a contemporary identity, viability and direction for and to the health visiting service. The Council, now known as the Council for the Education and Training of Health Visitors (the C.E.T.H.V.), formulated what it considered to be the service's central principles and functions. These principles and functions emphasized the generalist, preventive, continuing, and frequently unsolicited nature of the service rather than one of responding to crisis and specialist needs alone. Based on a belief in the value of health, which the Council considered to be as much a 'process of becoming' as a 'state of being' (C.E.T.H.V. 1977:21), the profession itself was stating its own philosophy, albeit couched in idealist terms. The four principles decided upon, each one being considered to be of equal importance, were the 'search for health needs', the 'stimulation of the awareness of health needs', the 'influence on policies

affecting health' and, lastly, the 'facilitation of health-enhancing activities' (C.E.T.H.V. 1977:9). Although there has been subsequent debate regarding these four principles, they would appear to have found acceptance with most practitioners.

Over the past fifteen years, various reports, acts and bills have brought about considerable changes for the health visiting service. With the 1973 National Health Service Reorganisation Act, which brought hospital and community health services administratively closer together, health visiting became responsible to nursing management and no longer responsible to the medical officers of health. Not only did this Act evoke dissatisfaction and turbulent reactions within the profession, but so did the recommendations of the Briggs Committee (Report of the Committee on Nursing 1972) which reviewed the role of community and hospital nurses and their educational requirements. Health visiting vigorously campaigned against many of the Committee's proposals, achieving a measure of success in maintaining a separate identity in the passing of the Nurses, Midwives and Health Visitors Act in 1979. Thereafter, the United Kingdom Central Council and the National Boards and Joint Committees took over the statutory responsibilities previously entrusted to the C.E.T.H.V.. However, as professional bodies, the Health Visitors' Association, the Scottish Health Visitors' Association and the Royal College of Nursing continued to represent the voices of individual health visitors.

For many, the maternal and child health remit, which includes the on-going care and surveillance of antenatal mothers as well as of the under-five year old population, is the one with which the health visitor is most readily identified. To a great extent, this remit of the health visitor is in keeping both with health visiting's early connections with the infant welfare movement and with the

1972 National Health Service (Qualifications of Health Visitors) Regulations' definition of a health visitor (S.I. 1972). Although in need of revision, this definition (which is similar to the one in the 1946 National Health Service Act) considers a health visitor to be:

... a person employed by a local health authority to visit people in their homes or elsewhere for the purpose of giving advice as to the care of young children, persons suffering from illness and expectant or nursing mothers, and as to the measures necessary to prevent the spread of infection.

(S.I. 1972:r.1[2])

While the maternal and child health remit continues to account for a sizeable proportion of most health visiting practice, the health visitor of today visits clients within the entire life-span continuum and is prepared educationally so to do. Not only is she concerned with the promotion of health and the prevention of ill-health but with the social well-being of individuals, families and other social groups within society. To fulfil these objectives, the health visitor liaises with other health and community workers.

Over the years, health visitors have endeavoured to respond to demographic and technological changes within society. For instance, technological advances have made it necessary for health visitors to be aware of ideas that are being discussed on the various television networks, while demographic changes in the population age ratios continue to challenge the service to reconsider its priorities. Gradually, British society has become increasingly multi-cultural and multi-racial, with immigrants (both white and black) arriving from a variety of countries, particularly since the late 1930s. Having emigrated to Britain for various reasons, including the political circumstance in their homelands (e.g. Poles and Greek Cypriots) and in response to labour shortages in Britain during the economic boom of the 1950s and 1960s (e.g. Jamaicans), many immigrants have settled subsequently in this

country. In many instances, the second and third generations continue to maintain their own cultural traditions and practices (Eyles 1982; Watson 1977). Therefore, the appropriateness of the health visiting service in relation to the multi-cultural society of today demands serious consideration.

Having initially been concerned with the squalor and disease of industrial nineteenth century Britain, health visitors today care for a multi-cultural society in which contemporary health services are funded nationally and organized bureaucratically. In a century where infectious diseases and infant mortality rates have been reduced dramatically, the health visiting service has evolved into a statutory and community-based, health promotive service with its own professional education and code of conduct. Today, health visiting not only is a post-nursing registration qualification but, since July 1983 (S.I. 1983a/b) is itself a registrable qualification. It is against this historical backdrop that the unicultural nature of the present day health visiting service is now discussed.

3. THE UNICULTURAL PERSPECTIVE

In this section, I review how contemporary health visiting is characterized in regard to the cultural dimension of its service. In all, sixteen characteristics are presented. Of these, seven relate to the service's value system, four to its educational system and seven to its organizational environment. After each characteristic, the numerical order which each characteristic assumes in a composite list presented at the end of this section is indicated (e.g. § 1, § 2, etc.). For the most part, it is the way in which these characteristics are operationalized nationwide, rather than the characteristics themselves, that makes them unicultural. While these characteristics should be viewed as important, they should in no way be considered as providing a comprehensive

characterization of the health visiting service, nor should the order in which they are discussed be seen to reflect an inherent hierarchical dimension within these characteristics.

A) CHARACTERISTICS OF THE VALUE SYSTEM

i) Relevance of cultural knowledge

Ostensibly, the health visiting service aims to meet 'the ever-changing needs of the great variety of human nature' (C.E.T.H.V. 1980:52) and to 'take account of' (previously to 'have regard to' [U.K.C.C. 1983:2]) 'the customs, values and spiritual beliefs of . . . clients' (U.K.C.C. 1984:2). Thus, the service is characterized by **the recognition given to the relevance of cultural knowledge to health visiting practice (§ 1)**, although if and how this is achieved is an area of health visiting that has been minimally researched. Little is known about how individual health visitors set about their work and what knowledge they draw upon to do so when working with communities, families and individuals whose values and beliefs differ from their own (Orr 1980:32). Issues relating to cultural understanding, cultural imposition and the acceptance of cultural diversity are only beginning to be considered seriously by the profession as a whole (consider Sharman 1985).

Although the health visiting profession acknowledges the relevance of cultural understanding, in reality training colleges and employing authorities continue to place varying emphases on cultural needs and insights (Sharman 1985:9). Thus, there is no certainty that all student, and qualified, health visitors nationwide receive educational preparation in the provision of culturally sensitive care (note While and Godfrey:1984). In addition, not all clients,

whatever their culture, can be reasonably assured of receiving care and advice that is culturally appropriate and meaningful in regard to their needs.

ii) Independence of the practitioner

The emphasis given to the independence of the individual practitioner within the context of health visiting policies (5 2) is a second characteristic of the value system of the health visiting service. Described as being 'a practitioner in her own right' who initiates 'contact with individuals and groups as well as accepting referrals from other agencies' (R.C.N. 1971:19), each health visitor exercises considerable independence in deciding whom she visits and how she deals with problems as they emerge. In a subsequent document, the Royal College of Nursing (R.C.N. 1983:32) again underlines this emphasis by noting that:

Within the field of the promotion of health and the prevention of illness . . . the health visitor has particular expertise and specialist skills, and exercises an independent role.

This emphasis on the individual practitioner's independence is one characteristic in which health visiting differs from most other fields of nursing practice (R.C.N. 1983:36). However, with fewer community trained nurses in senior managerial positions (Clode 1978:538; H.V.A. 1981:11) since the reorganization of the health services subsequent to 1973, it has become increasingly possible that a health visitor's professional colleagues and seniors may identify her all too readily with the curative role of a hospital nurse rather than the preventive, relatively autonomous one of a health visitor.

Whilst each health visitor has more opportunity to be less bureaucratic in approach and more directly responsive to current needs in the field, her practice is subject nevertheless to the health visiting policies of her employers.

Indeed, although much of her work tends to be non-visible to both her colleagues and her employers, control over her performance and 'use of initiative' (S.C.R.H.V.E.T.C. 1980:5) is exerted indirectly. Both the training and educational routes of initial and subsequent health visitor courses as well as the more bureaucratic and hierarchical channels of her employers are utilized to achieve this control. And, with there being no central commitment at United Kingdom level to the nationwide provision of culturally appropriate health visiting practice, nor to the educational preparation of all health visitors to deliver a culturally appropriate service, this control over the independence of the practitioner is uncultural in nature.

iii) Long-term health visitor-client relationships

Health visiting is also characterized by **the emphasis placed on the development and utilization of long-term health visitor-client relationships as a basis for health visiting practice (5 3)**. For instance, with regard to the health visitor's remit to families with children under five years old, it is hoped that a long-term, participatory relationship between the family and the health visitor will emerge. Notified of new births as well as of incoming families with children under five years old (that is, to the locality and/or a general practitioner's case load), the opportunities for health visitors to nurture long-term relationships - ones in which the families they visit may be encouraged to develop their own potential to achieve optimal health and well-being - are a continuing reality. Indeed, the practice of health visiting is considered to be a 'participative process' between the client and the health visitor, one that is undertaken:

. . . within the framework of the personal philosophy and cultural value systems of the client, and with self-determination accorded [to] the client, as far as is compatible with the rights and needs of others.

(C.E.T.H.V. 1977:30-31)

Not only is the health visitor someone 'who comes alongside the individual and family [,] to share her skills with them' (Raymond 1983b:221), but the client-health visitor relationship is a central feature of health visiting which the health visitor nurtures as a vehicle through which she can promote her client's potential to achieve optimal health and well-being (Clark 1985b:206-207; R.C.N. 1971:8).

Thus, within the client-health visitor relationship both parties are recognized as being active participants (R.C.N. 1983:31,41). However, even though there is a sense of interdependence within the relationship, not only is the client in a position to decline or ignore any advice or help that is offered, but he, or she, also holds the 'vital "knowledge base"', that is, 'about himself, his experiences, his environment and relationships' which the health visitor needs to tap if she is to provide 'quality of service' (R.C.N. 1983:41). Therefore, for effective long-term health visiting-client relationships to be established and maintained routinely between individuals of all cultural traditions, health visitors need to become proficient in both intra- and inter-cultural modes of communication. To date, there has been minimal discussion both about inter-cultural modes of communication in health visiting and about the building and maintenance of long-term inter-cultural health visitor-client relationships.

iv) Selection of specific client groups

A fourth characteristic of the health visitor service is **the emphasis accorded to the selection of specific client groups for the foci of health visiting energies and resources (§ 4)**. Not being limitless, health visiting

resources and energies need to be deployed as advantageously as possible. In deciding priorities, the life-span continuum is frequently used as a basis, with rites of passage and other life events and crises seen as potentially vulnerable times in most people's lives and therefore considered important (H.V.A. 1981:6-7; Wiseman 1980). Certain groups within society (e.g. the physically and mentally disabled) are considered to be more vulnerable than others to failure to achieve and maintain satisfying levels of health and well-being without support from the publicly funded health and welfare services. In addition, the R.C.N. (1971:7) suggests that:

There is vital work to be done with those under stress, such as the recently bereaved, and other groups including the school leaver, the middle-aged, the recently retired, and the elderly, who need special consideration given to their health problems.

To this abbreviated list of specific client groups, 'single parent families, members of ethnic minorities, and families affected by unemployment' (R.C.N. 1983:30) are also identified by the health visiting service as needing special consideration.

Although the needs of ethnic minority groups are thus acknowledged as requiring special consideration, there is no certainty that all health visitor students emerge proficient in the discovery and utilization of cultural knowledge in multi-cultural situations. In addition, little open appreciation has been given to the fact that being a member of a specific ethnic minority group may provide reasons for being less rather than more vulnerable to stress. In fact, ethnic minority membership may be a positive factor in the achievement and maintenance of a satisfying level of health and well-being and not a cause for concern, for example, where cultural traditions provide strong, supportive kinship networks.

v) Educational and advisory approaches

Another characteristic of the value system of the health visiting service is **the emphases accorded to educational and advisory approaches to the promotion of health and social well-being (§ 5)**. Indeed, not only can these emphases be considered to be the nub of the service's contribution to public health and well-being but, to a great extent, they also distinguish health visiting from most other fields of nursing, helping to provide health visiting with the more diffuse and nebulous image that it has. Encompassing both the notion of anticipatory guidance and the development of clients' coping strategies, this characteristic is a central feature of the health visitor's maternal and child health remit. It similarly extends to the service offered to clients at all stages of the life-span continuum, relating as much to the promotion of health amongst school children as to antenatal preparation, both activities tending to take place in institution-based settings.

Educational and advisory approaches, whether impromptu or planned, have moved on from 'carbolic powder to social counsel' (MacQueen 1962:866), and now also encompass the more sophisticated use of audio-visual technology. The health visitor of today needs to tailor her health education and advice to the values, symbolism and practices of a multi-cultural clientele, a need which only recently has begun to be discussed and expounded seriously (e.g. Mares et al. 1985). To offer advice that is not in keeping with a client's cultural traditions, including values, practices and preferred modes of learning, is to expect a higher level of ineffective outcomes (Brandl and Tilley 1981:26; Luker 1985:144).

vi) The notion of individualism

A sixth characteristic of the health visiting service is **the emphasis given to the notion of individualism (5 6)**. This characteristic reflects a belief in the right of the individual to free action which is an accepted feature of the dominant culture of the United Kingdom – the ‘Anglo-Saxon bloc’ of countries being noted as being particularly individualistic in outlook (Handy 1985:201). While individualism may be seen by many ‘as a blessing and a source of well-being’, for others ‘it is seen as alienating’ (Hofstede 1980:213). Professionally socialized – and, with most health visitors being from the ethnic majority (Pearson 1986:personal communication), also personally socialized – into the dominant cultural ethos, health visitors may, and do, place particular emphasis on the notion of individualism (note Robinson 1985b:78). For instance, in their advice to clients, health visitors may emphasize the need to find time for a personal life. And, even though health visitors are envisaged as ‘family visitors’ (see Clark 1973), for the most part, their work focuses on the individual within the family.

With Britain now being a multi-cultural society, more clients may both prefer and uphold a collectivist (group-oriented) approach to life. Hence, it is important that health visitors who support an individualistic approach to life also recognize that those who uphold collectivist approaches believe ‘maintaining the group’s well-being’ to be ‘the best guarantee for the individual’ person’s well-being (Hofstede 1980:216). For instance, the extended family nature of many Asian families in Britain may be seen as representing a collectivist outlook on life, in that it often has a ‘tremendous power over each individual member and is characterized by a strong cultural uniformity’ (Raymond 1983a:8). Therefore, if health visitors are to work successfully with

extended Asian family systems, they not only need to accept that individualism is not viewed positively by all cultural groups, but also need to be able to offer advice that is in keeping with more collectivist ideas.

vii) Western scientific health and nutritional knowledge

The primacy accorded to Western scientific health and nutritional knowledge (5 7) is a seventh characteristic of the value system of health visiting. Not only is this part of health visiting's dowry from general nursing which is re-emphasized during qualifying health visitor education, but this invariably is the frame of reference within which health visitors' professional colleagues (e.g. general practitioners, midwives and district nurses) also practice. Only in recent years has there been any serious discussion in the nursing and medical literature concerning other health and dietary belief systems, the efficacy of practices based on these systems, and how such practices can be utilized and blended with Western scientific health care practices (e.g. Dwivedi 1980; Helman 1984).

For the most part, Western health values and food categories are taught to, and by, health visitors. Based on the nursing and health visiting literature, little, if any, consideration is given to encouraging health visitors to appreciate alternative health beliefs and practices, to consider in what ways these are felt to be efficacious to those who follow them, and to know how to offer and adjust advice accordingly. Instead, there is a tendency to highlight negative features of non-Western health measures (for instance, excessive lead content in certain Asian eye liners [Healey and Aslam 1984]), or even to ignore altogether non-Western food classification systems which are being adhered to (such as the Asian 'hot-cold' food classification system [e.g. Health Education

Council 1980]). While such issues as lead content in Asian eye liners are important, nevertheless the tendency to highlight negative features of non-Western health and nutritional practices involves a degree of inter-cultural disregard.

B) CHARACTERISTICS OF THE ORGANIZATIONAL ENVIRONMENT

i) Hierarchical and bureaucratic nature of the organizational environment

The hierarchical and bureaucratic nature of the organizational environment (§ 8) is one characteristic which influences the breadth of health visiting practice. With the National Health Service Act of 1946, health visiting became part of the newly created comprehensive, bureaucratic and hierarchical government health service. Thereafter, the provision of a health visiting service became a statutory requirement of local authorities, with legislation defining overall objectives. With each area having its own problems and social priorities, varying levels of social deprivation, differing cultural patterns and geographical logistics influence the planning, staffing and delivery of the service that each authority provides (Hicks 1976:256). Indeed, priorities, philosophies, willingness to innovate and allocation of funds vary from authority to authority.

Although the Health Visitors' Association (H.V.A. 1981:10) offers independent professional guidelines for setting priorities according to caseload and staffing ratios, it remains the responsibility of each health visitor to assess the needs and resources of the families and individuals in her caseload, and to organize her work in accord with her composite responsibilities, that is, to her clients,

her employers, her colleagues and herself. In so doing, she draws upon her own professional and personal knowledge, experience and individuality. Even so, she acts within the constraints of her work situation and the demands of her employers, learning about local priorities through circulating memoranda, open discussions with colleagues and supervisors, as well as during in-service study sessions. In addition, she may glean local priorities by implication, such as through the lack of certain resources or the bias inherent in the selection of statistics requested from field staff (see Hobbs 1973:62-63).

Thus the health visitor of today practises within an organizational environment which is both hierarchical and bureaucratic in nature. It is also an environment in which there is no definite United Kingdom health visiting policy to ensure that the cultural needs of the service's clientele are considered as a central commitment rather than a peripheral issue. Hence, there is no certainty that all health visitors are actively encouraged and supported by her employers to provide a culturally relevant service in multi-cultural situations.

Since a health visiting certificate is a post-registration nursing qualification, health visitors have been socialized previously into the traditional and hierarchical hospital nursing sub-culture which tends to be authoritarian in nature (Dingwall 1976b:34; Leininger 1978:160-161; also Wilkie 1979:53-54). Indeed, one intended outcome of including sociological perspectives in health visiting curricula is the hope of helping students:

. . . overcome any rigidity or authoritarianism in approach which could have been acquired during the fairly traditional framework of the hospital setting.

(Owen 1983b:110)

While Clark (1973:3-8) found no evidence to support the stereotypical view of health visitors as being didactic and authoritarian in approach, Dingwall (1976b)

notes that both the attachments to general practitioner practices (in which many health visitors continue 'to assume a traditional nursing relationship to their practice doctors' [Dingwall 1976b:35]), and the health visiting hierarchy still appear to be authoritarian milieux. Even so, as Dixon (1976:271) cautions, there is always a need to:

. . . distinguish between the possibly authoritarian personalities of the individuals concerned and the generally authoritarian ideology of the milieu in which they . . . [find] themselves.

Although many mothers are unaware of the nursing backgrounds of their health visitors (e.g. Fox 1974:4), it is possibly the enforced hospital socialization that has helped to produce the authoritarian image that health visiting has acquired, that is, as much as from any supervisory roles that have been part of the health visitor's remit in previous years (Clark 1973:3-8; Jefferys 1965:126).

In a carefully researched but controversial (Brown 1965:523) post-war study by Adorno et al. (1950) of what was coined the 'authoritarian personality', it was suggested that there is a tendency for attitudes of ethnocentrism and authoritarianism to go together. Although Clark's (1973:4) study of health visiting does not support 'the stereotype of the authoritarian approach of the health visitor', no research has been undertaken that has considered ethnocentrism and health visiting (or nursing) as this relates to health visitors (or nurses) caring for clients whose cultural traditions differ from their own. In contrast, several research studies in the United States of America have looked at nurses' attitudes towards 'culturally different' patients, that is, patients with a cultural heritage 'identifiably different from that of the dominant American culture' (Bonaparte 1979). For instance, devising and using her own Cultural Attitude Scale, together with measuring nurses' levels of ego-defensiveness and open-closed mindedness, Bonaparte (1979) was able to indicate that the

more open-minded the nurse, the more positive are the attitudes she exhibits towards all patients with regard to nursing care-patient interactions and cultural attitudes and beliefs.

ii) Local health authority influence on health visitor education

The ability of local health authorities and boards to influence health visitor education towards local rather than nationwide needs and concerns (5 9) is another characteristic of the organizational environment. Local authorities, who sponsor many of the students and also employ the fieldwork teachers, are able to encourage particular emphasis to be accorded in the preparation of students to meet local needs. Indeed, in general, health visitor courses 'would appear to reflect the societies in which they are sited' (Sharman 1986a:personal communication). Thus, in areas with large, ethnically-diverse populations, college tutors and fieldwork teachers may place particular emphasis on cultural aspects, whereas, in areas with less ethnically-diverse populations, there may be little or no emphasis. As a result, the standard of cultural knowledge and field experience gained by qualifying health visitor students varies nationwide. And, with secondments for training being even more likely to be localized in the future, that is, according to a recent health visiting manpower survey (Burrell-Davis and Williams 1984:14), the likelihood of a recurrence of the inward-looking tendencies prevalent in the 1940s (O'Connell 1978:44) is increased.

Relatively few studies exist that attempt to define the major factors influencing the way in which health visiting is practised at field level. In one study, McClymont (1980), who sought to determine whether students were adequately prepared during their training for the reality of practice, discovered

that seventy-six per cent of the practising health visitors who participated in her study:

... found it necessary to change their perception of the health visitor role after qualification,

which she considered to be, not so much:

... an outright rejection of the tutors' perception of role, but a re-adjustment of priorities within the role content, made to realign themselves within the [Health] Authority group.
(McClymont 1980:82)

While the responses may have been guarded because of the researcher's professional status in the area, ninety-six per cent of the respondents considered their training to have been either 'useful or very useful' for practice, especially subjects with a ' "here and now" appeal of the real world' (McClymont 1980:77,83). Nevertheless, once employed, it seemed that they found it necessary to adapt to the priorities set by their employers and, to an extent, succumb to the influences of their colleagues, thus being prepared to conform and be conditioned to what was expected of them (McClymont 1980:70-71;74). Thus, employing authorities can influence the shape and practice of health visiting at field level and, in addition, can promote, or not promote, the local provision of culturally appropriate health visiting services. This, in turn, influences the fieldwork experience that student health visitors in their locality gain in regard to developing expertise in culturally attuned practice.

iii) Data on ethnic identity and background

The unicultural perspective is also characterized by **the lack of data on the ethnic identity and background of health visiting's clientele and the reluctance within the service to promote the routine collection of such data**



nationwide (§ 10). Even though the population of the United Kingdom has become increasingly multi-cultural since the 1930s, health visitors are still not encouraged to collect data on the ethnic identity and background of their clientele on a routine basis. One major factor inhibiting the decision as to whether or not data on the client's ethnic identity and background should be collected has been the fear of racial implications in so doing (see Bulmer 1980). Yet, without such 'essential background information' (Gray 1980:1042), the need to deploy financial (or other) resources, at both local and United Kingdom levels, for the development of more culturally appropriate health services is difficult to substantiate (Wandsworth 1979:7-8).

In general, the decision to provide a localized health visiting service which both considers and is responsive to the needs of clients from differing cultural backgrounds varies considerably from authority to authority. Both Lumb et al. (1981) and Hill (1980) describe research studies - based in Bradford and Southall respectively - that have helped to demonstrate the need to question and clarify assumptions made about the health needs of ethnic minority groups. These studies also highlight the need to seek out and utilize the positive factors that differing cultural traditions offer towards social and physical health; for instance, factors relating to illegitimacy, teenage pregnancies and smoking. Thus, by omitting to collect data on clients' ethnic identity and background on a nationwide basis, positive health related factors are left submerged and unrecognized.

iv) Health of infants and pre-schoolers

Another characteristic of the organizational environment is **the emphasis accorded to the health of infants and pre-schoolers (§ 11).** A proportionally

greater amount of concern, and consequent amount of service energies, continues to be directed to the promotion of health and the prevention of ill-health amongst the under-five year old population. While the health visitor is recognized increasingly as being concerned with the health of all family members, the focus still tends to be on the child within the family, with the health of the father invariably receiving the least concern of all (Orr 1985b:68). In addition to the inherent humanitarian concern that this characteristic involves, it may be viewed politically as a long-term national investment both for the containment of preventable epidemics and for producing a healthier working force for the future. As this aim includes the need for healthy offspring, emphasis is placed on a number of related objectives. These include family planning, particularly with regard to choosing to have a family, child spacing, and family size. The provision of antenatal education, with regard to both child bearing and child rearing, is also viewed as a societal responsibility (especially for *primagravidae* - that is, women pregnant for the first time) and is actively encouraged and supported by the health visiting service. Other emphases include the primacy of breast feeding as a form of infant nutrition, adherence to child immunization schedules by the under-five year old population, and routinized pre-school child development surveillance.

Child development surveillance, both on-going and at designated times throughout infancy and the pre-school years, constitutes a major component of the health visiting service to the under-five year old population. This component aims to ensure that each child develops towards his or her full potential for health and well-being. With their direct involvement in the developmental progress and school-preparedness of pre-school children from differing cultures, it is therefore surprising that health visitors have failed to make a clear contribution to the professional literature on this topic. Yet, for

sometime, educationalists have recognized and emphasized definite links between cultural grouping and under-achievement at school (Griffiths 1983; Taylor 1981; also Tomlinson 1981). And, whilst it is suggested that it is advantageous for the health visitor to speak Welsh in dominantly Welsh-speaking areas (note Bryant et al. 1979:357; also White 1986:personal communication), the health visiting literature fails to provide cultural insight into the promotion of the health of the Welsh pre-schooler.

C) CHARACTERISTICS OF THE EDUCATIONAL SYSTEM

i) Importance of applicant selection

One characteristic of the educational system is **the importance accorded to the selection of applicants for qualifying health visitor courses (5 12)**. Not only does the service seek applicants who have sufficient educational and professional qualifications for an intensive year of theoretical and practical studies, but also a willingness to work thereafter for the seconding authority or board. Health visiting, however, is an occupation in which central features include offering advice on maternal and child health concerns, helping parents deal 'with some of the social consequences of having children' (Dingwall 1977:21), and guiding clients from all backgrounds towards healthier ways of living. Therefore, the ability to establish and maintain sound inter-personal relationships assumes paramount importance. Hence, health visitors must have suitable personal qualities for forming and maintaining harmonious, long-term relationships with people of all ages and from various cultural backgrounds. Although it is not known to what extent differing personal qualities and abilities are important to the activity of health visiting, it is recognized that they demand serious consideration (Clark 1980a:419-420; Robinson 1982:83; Warner

1984:242). Hill (1982:289), for instance, suggests that personality tests can act as additional safeguards in health visitor selection, although she notes that they probably are 'more useful in highlighting unsuitable applicants than in seeking out the elusive "right" personality'.

While the educational system of the health visiting service is also the socialization process for the health visitor initiate, it is well recognized that each student health visitor brings with her the knowledge, attitudes and values that have emerged as a consequence of her own life and work experiences, in essence, her own personal biography (Dingwall 1977:29-30). Although increasingly more nurses are becoming health visitors earlier in their careers (note O'Connell 1978:52-53), those making the decision later on possibly will have had a wider variety of work experiences (not necessarily as nurses), and sometimes in other countries. Consequently, they will have had more opportunities to develop a greater wealth of knowledge and understanding of cultural diversity. These days, many health visitors are also bringing up their own families, with work paralleling, if not running secondary to, being a wife and mother (McClymont 1980:42). While marriage, parenthood, and various other life experiences provide health visitors with valuable personal insights (cf. Clark 1984:265), the personal characteristics and attributes consistent with 'good' health visiting practice, and particularly in regard to multi-cultural situations, have received minimal attention by researchers.

Several attributes, including empathy and flexibility, considered to be difficult to acquire during training or, as it was phrased, 'at this stage' (C.E.T.H.V. 1981:7) were noted by the C.E.T.H.V. to be essential in would-be applicants. In contrast, the ability to 'shake off' qualities considered necessary for hospital nursing, which Dingwall (1976b:34; see also Hunt 1972:20) believed

to be antithetical to those needed for health visiting, was mentioned in the Jameson Report, though it was hoped that:

. . . the particular group of nurses who have the qualifications of intelligence and personality that we should wish to see in future recruits

(Ministry of Health et al.
1956:130)

would have that ability. Unquestioning obedience was particularly noted as unacceptable. Even in 1920, while no one type of personality was seen as better than another for health visiting, the ability to appreciate and 'sympathise' (Lane-Clayton 1920:108) how a mother saw and responded to her situation was considered vital. Nevertheless, there has been no published research in which the abilities necessary for health visitors to work effectively with clients from diverse cultural backgrounds have been considered (cf. Bonaparte 1979).

ii) Disciplinary flexibility within the knowledge base

A second characteristic of the educational system is **the recognition of the need for disciplinary flexibility with regard to the knowledge base to qualifying health visitor education (§ 13)**. This flexibility is consistent with health visiting's aim of having a United Kingdom health visiting syllabus which is able to accommodate changes within society as well as new health concerns. While it is debatable that the knowledge and capabilities needed for understanding and helping human beings of all ages and from all backgrounds can be achieved satisfactorily in one year (the present length of training), health visitors still need to be adequately prepared to help groups, families and individuals from varying cultural backgrounds. They also need to be prepared to practise in a variety of locations, including attachment to a general medical practice, in a geographically defined area or 'patch', or connected to a hospital department. Because of this need for a breadth of knowledge and capabilities,

health visitor education has long acknowledged the need for disciplinary flexibility with regard to the knowledge base of qualifying courses.

During their qualifying education, the students become socialized into the 'world' of health visiting. In his research into the socialization of health visitor students, Dingwall (1976a:26) considered that the students were taught 'explicitly or implicitly what their society . . . and what individuals are like', with a variety of knowledge, such as medical, sociological and social policy, being drawn upon for this purpose. While Dingwall acknowledges that emphasis was placed on the importance of 'working within the context of their clients' own cultures' and providing equality of care to all clients, that is, 'treating different clients differently' (a feature he did not consider present in 'hospital nurses' theories'), even so, he felt that anyone 'out of line' with what health visitors considered to be 'the normal order of things' might be thought of as 'a special problem' (Dingwall 1976a:26-27). Although Dingwall's findings (which describe a somewhat inflexible approach to human diversity) relate to only one school of health visiting, there is a need for greater concern to be directed towards preparing all health visitors for the cultural diversity that a multi-cultural society embraces, as Sharman's (1985:9-10) discussion document indicates.

With the United Kingdom syllabus permitting flexibility in individual health visiting curricula with regard to the inclusion of knowledge from various disciplines, health visitor tutors can draw on a variety of sources of knowledge when developing their courses. For instance, since 1965, the inclusion of sociological concepts and studies has become a standard feature of health visitor courses, Owen (1983b) devoting a whole chapter to sociological perspectives in her standard text on health visiting. This, however, is not so for anthropological equivalents, certainly not nationally. Yet, the inclusion of

certain anthropological concepts (e.g. 'culture' and 'ethnocentrism'), insights and studies, would provide health visiting with a more appropriate knowledge basis for the development of a culturally attuned health visiting service.

iii) Variations in the inclusion and comprehensiveness of cultural components

Another characteristic of health visiting's educational system is **the variations that exist with regard to the inclusion and comprehensiveness of a cultural component in the curriculum developed by each educational institution nationwide (§ 14)**. With regard to this characteristic, the term 'component' refers to the overall contribution to the entire health visitor course. In all, little is known about the extent to which health visitors are guided and encouraged to become educationally competent to appreciate their client's cultural 'point of view, his relation to life, to realise **his** vision of **his** world' (Malinowski 1922:25), that is, with the intent of working more effectively in multi-cultural situations. Although many health care practitioners have developed, and are developing, considerable knowledge relating to, and expertise in, the provision of culturally sensitive care, Ballard (1979:147-148) points out that, in general, this has been acquired from *ad hoc* experience and with 'little institutional support and encouragement'. Ballard (1979) also criticizes the health and social services for the minimal amount of provision that they offer in the preparation of workers to provide a culturally relevant service to ethnic minority groups.

Over the course of their careers, most health visitors will care for clients from a variety of cultural backgrounds. However, if health visitors are to tread the 'delicate path between friendly advice, persuasion, and coercion' (Robinson

1982:85) in both inter-cultural and intra-cultural situations, then all health visitors need to become skilful at being professionally approachable, adaptable and acceptable to all clients of all cultures. Yet variations exist nationwide regarding the inclusion and comprehensiveness of a cultural component in individual health visiting curricula. Thus, the development of students' abilities to establish and maintain health visitor-client relationships in multi-cultural situations will vary considerably, as will students' abilities to collect, collate, analyze and utilize cultural data in everyday field practice.

If all health visitors are to be prepared educationally to care for a multi-cultural clientele, then they need a clear understanding of the concept of culture. They also need to appreciate the depth to which culture is expressed at the level of basic human needs, its variations of expression and its interwoven complexities. For health visitors to note a detail of custom and yet view it in isolation from the total culture in which it is rooted makes this detail of custom become almost 'as meaningless as' an 'isolated letter[s] of the alphabet' (Leach 1976:1). In addition, health visitors need to recognize that concepts pertinent to health visiting, such as 'help' and 'coping', may assume alternative contours from differing cultural perspectives. Therefore, not only is a sound knowledge of the cultural diversity relating to human needs and behaviour (for example, regarding family, marital and kinship dynamics) invaluable but also essential if health visitors are to provide a culturally relevant service to a multi-cultural clientele. At present, there is no certainty that all health visitor students nationwide both receive a comprehensive foundation component of cultural knowledge and develop the ability to practise effectively in multi-cultural situations before qualifying.

The educational preparation of health visitors to practise in multi-cultural situations should also involve the explicit recognition of the health visitors' as well as the clients' cultural background. Yet, the idea of a multi-directional approach to cultural understanding which acknowledges the potential varieties of cultural backgrounds of both clients and practitioners has received minimal recognition. In fact, this is an aspect which British nurses as well as health visitors have not truly addressed. Not only has little consideration been given to concerns relating to how health visitors from ethnic minority groups advise, counsel and educate clients from the dominant culture (cf. BURGESS 1982 - although concerning social workers in the United States of America), but, also, as to what alternative forms of practice should be incorporated in health visiting curricula designed for a multi-cultural studenthood.

In addition, there is no research in this country which has looked at the needs of health visitor tutors and fieldwork teachers in relation to planning and teaching cultural components and providing experience in developing students' expertise in multi-cultural practice. However, this area of concern has been addressed in a North American study by Jaffe Ruiz (1981). Concerned that the attitudes, beliefs and values of nursing faculty members may be transmitted to students both during clinical supervision and in the classroom, Jaffe Ruiz looked at faculty members' attitudes towards culturally different patients. Her findings demonstrate that faculty members who are closed-minded would be more resistant both to teaching about, and also to conveying a positive attitude towards, cultural differences than open-minded members might be. Recognizing this as an area requiring more research because of the importance faculty members 'assume in shaping policy both within their schools and in society', Jaffe Ruiz (1981:181) makes the pertinent comment that, even if cultural awareness is increased:

Merely acquiring new information is not sufficient if it is interpreted in the light of old beliefs.

Thus, when including a cultural foundation component in all health visiting curricula, cognizance needs to be taken not only of the knowledge base and the methods to be employed in the educational preparation of the students, but also the needs of the health visitor tutors and fieldwork teachers involved in teaching this component. This is an important concern that, to date, has not been addressed by the health visiting profession.

iv) Individualized approaches to health promotion

A fourth characteristic of the educational system is **the emphasis placed on using individualized approaches to health promotion (including health education) in field practice (§ 15)**. Both individualized and group approaches to health promotion and health education are included in all qualifying courses (e.g. S.C.R.H.V.E.T.C. 1980:13–15). Even so, for many health visitors, expertise in group teaching activities tends to be both poorly developed and little utilized (e.g. Jones and Barnes 1985; R.C.N. 1983:51). Although an integral aspect of health visiting since its beginnings, group education was considered in the Jameson Report to depend very much on the personal aptitude of the health visitor for its success and, therefore, while commended, seen more for those 'with a gift for this kind of work' (Ministry of Health et al. 1956:107; also Hobbs 1973:10–11). However, Hobbs' (1973) study, which looks at various factors that might influence whether or not group teaching is undertaken, does provide useful insight into this characteristic of the educational system of health visiting. The factors considered in Hobbs' study included teaching given during training, philosophies of employing authorities, availability of resources, accepted practice and encouragement offered at field level as well as personal factors relating to the individual health visitor. Not only do the findings

suggest that, for most of the health visitors interviewed, personal aptitude is not a major factor (thus seeming to be 'a direct negation of the Jameson contention' [Hobbs 1973:137]), but the employing authority emerges as a major influence with regard to the amount, if not the quality, of the group teaching provided (Hobbs 1973:136,141).

On the whole, it is noteworthy that much less regard has been paid to the health visitor's role in promoting health at community level, and the skills needed for so doing, than has been given to the promotion of health at individual and family levels. Only very recently has Orr (1985a) provided guidelines for health visitors to set about achieving this, guidelines in which she emphatically aligns health visiting with its responsibilities to health promotion at community level. Although more health visitors now visit families from the caseloads of general practitioners instead of families from one geographical area, the value of community approaches with ethnic minority groups has been demonstrated by the anti-'Asian rickets' campaign (Bahl 1981). Hence, current approaches to health promotion at community level are in need of careful reappraisal and development, particularly in regard to their relevance to the provision of effective practice in multi-cultural situations.

v) Interchange of ideas and value orientations at field level

The mechanism for the interchange of ideas and value orientations between college educators and local health authorities and boards (§ 16) can also be viewed as characterizing health visiting's educational system. Now incorporated into the U.K.C.C. and National Boards and Joint Committees for Nursing, Midwifery and Health Visiting, the C.E.T.H.V. always allowed the various training institutions considerable flexibility to design their own curricula within

the guidelines of the approved United Kingdom health visiting syllabus. In this way, new ideas could easily be developed both in the college and in fieldwork practice. For instance, the neighbourhood study, which is now one of the nationally required fieldwork projects, was pioneered by Southampton University (O'Connell 1978:63). Hence, a two-way exchange of ideas between the colleges and the employing authorities, that is, the so-called 'ivory tower' and the 'coal face' of health visiting (note Wilkie 1979:73), is made possible through the involvement of fieldwork teachers who share part of their caseloads with their students. With fieldwork teachers being involved in direct health visiting practice as employees of local health authorities and boards, as well as in college training programmes, opportunities are readily available between the service's educational and organizational systems for the interchange of knowledge and ideas relating to the development of culturally appropriate health visiting practice. Such developments, however, are not reflected in the health visiting literature.

D) SUMMARY

In the previous sub-section, sixteen characteristics of contemporary health visiting have been presented and discussed. To recapitulate, these characteristics are as follows:

- § 1. The recognition given to the relevance of cultural knowledge to health visiting practice.
- § 2. The emphasis given to the independence of the individual practitioner within the context of health visiting policies.
- § 3. The emphasis placed on the development and utilization of long-term health visitor-client relationships as a basis for health visiting practice.

- § 4. The emphasis accorded to the selection of specific client groups for the foci of health visiting energies and resources.
- § 5. The emphases accorded to educational and advisory approaches to the promotion of health and social well-being.
- § 6. The emphasis given to the notion of individualism.
- § 7. The primacy accorded to Western scientific health and nutritional knowledge.
- § 8. The hierarchical and bureaucratic nature of the organizational environment.
- § 9. The ability of local health authorities and boards to influence health visitor education towards local rather than nationwide needs and concerns.
- § 10. The lack of data on the ethnic identity and background of health visiting's clientele and the reluctance within the service to promote the routine collection of such data nationwide.
- § 11. The emphasis accorded to the health of infants and pre-schoolers.
- § 12. The importance accorded to the selection of applicants for qualifying health visitor courses.
- § 13. The recognition of the need for disciplinary flexibility with regard to the knowledge base to qualifying health visitor education.
- § 14. The variations that exist with regard to the inclusion and comprehensiveness of a cultural component in the curriculum developed by each educational institution nationwide.
- § 15. The emphasis placed on using individualized approaches to health promotion (including health education) in field practice.
- § 16. The mechanism for the interchange of ideas and value orientations between college educators and local health authorities and boards.

In presenting and discussing these sixteen characteristics, a unicultural perspective emerges, that is, the health visiting service upholds the primacy of

the dominant culture of the United Kingdom at practice, educational and organizational levels. Although cultural knowledge is acknowledged by the health visiting profession as basic to the provision of a consumer sensitive and relevant service, in reality little is known about the relevance of cultural factors in relation to many of these characteristics: for instance, the emphases on educational and advisory approaches and the development of long-term, health visiting-client relationships. This lack of knowledge is enhanced by the fact that standard organizational practice nationwide does not encourage clients to be identified according to their cultural group. In addition, not only has the primacy of Western scientific health and nutritional knowledge been challenged only very recently, but individualism tends to be valued in a distinctively ethnocentric way. Even so, and despite the hierarchical and bureaucratic nature of the organizational environment within which health visitors practise, individual practitioners are able to exercise sufficient independence to allow them to develop their own culturally sensitive modes of practice. However, in general, enthusiasm and initiative to provide culturally sensitive and relevant health visiting practice occurs in an *ad hoc* manner and not as a consequence of United Kingdom health visiting policy.

Devised to accommodate changes in society as well as new health concerns, the health visiting syllabus incorporates a strong element of flexibility within its framework. A built-in mechanism also exists for the interchange of ideas and value orientations between local authorities and boards (who employ the fieldwork teachers) and the college-based educators, allowing both parties to influence current thinking and practice. Yet, even though local initiative in some areas may ensure that qualifying students emerge as multi-culturally competent practitioners, a comprehensive foundation component of cultural knowledge and skills (including the collection, collation, analysis and utilization

of cultural data) is not part of all health visitor courses nationwide. Hence, there is no assurance that all health visitors are educated to provide a culturally sensitive and effective service to a multi-cultural clientele. And, while not necessarily voiced by individuals themselves, consumer dissatisfaction concerning the cultural relevance of health visiting practice may thus remain submerged, unheard and unanswered. This need to visualize the client's perspective with regard to the service health visiting provides, and especially in relation to the cultural dimension of care, is considered briefly in the following section.

4. CONSUMER CONSIDERATIONS

Very little is known about consumer perspectives of health visiting and what constitutes 'good' practice in consumer terms. Indeed, there is a greater preoccupation with what health visitors 'do' rather than the effectiveness, efficiency and social acceptability of what is done (Robinson 1982:40; also Luker 1982:22). In considering the consumer perspective, it will also be seen that there is a need for further knowledge in regard to inter-cultural health visiting practice.

In one study, based in Northern Ireland where health visiting staffing ratios are exceptionally favourable, Orr (1980) sought the views which lower social class mothers, with just one pre-schooler, held about the health visiting service. While casual, pre-pilot conversations, mostly with a variety of patients and clients in hospital and general practice waiting rooms and clinics, produced a variety of vague and even antagonistic replies about the service, in the main study, over half the respondents said that they 'would not like to do without the health visitor' (Orr 1980:72,76). Having observed that consumer satisfaction

appeared to relate to both relationship-centred and problem-oriented needs (cf. Robinson 1982:88), Orr concluded that:

The health visitor's social skills appear as important as her knowledge base and consideration should be given to this aspect of training.

(Orr 1980:80)

In another study of professional health care for parents with at least one child under one year, it was noted that health visitors were preferred if they were:

. . . friendly, approachable, ready to answer questions, ready to listen to problems, and quick to respond to pleas for help . . .

as well as having the ability to:

. . . boost the woman's confidence in herself as a mother.

(Field et al. 1982:300).

Similarly, in another study of consumer perspectives – this time of primiparous mothers from both middle and working class, ethnic-majority backgrounds – Foxman et al. (1982:304) found that accessibility, personality and other personal attributes, as well as the health visitor being prepared to spend time with the mother, were especially appreciated. Nevertheless, in both studies, sufficient consumer dissatisfaction was voiced to suggest that, for a service where the client does not choose her or his health visitor, more consideration needs to be given to improving communication and interpersonal relationship skills. This was noted as being especially important 'where the social and cultural distance between the health visitor and her clients is greatest' (Foxman et al. 1982:308).

Relatively few research studies focus on the perspectives of clients from ethnic minority groups. One doctoral study that does offer some insight into Asian women's own perspectives of health care services, as well as providing

cultural information (in this instance, of being *Pregnant in Britain* [Homans 1980]), is relatively inaccessible to most health visitors. However, two texts include chapters based on the findings of this study (Homans 1982;1983) in which pregnancy as a rite of passage and the mothers' perceptions of food during pregnancy are described. One of the findings of Homan's study was that Asian (and non-Asian) mothers received minimal dietary advice, certainly not until their pregnancies were well advanced. It was also found that Asian mothers received inadequate information about medical procedures such as epidural anaesthetics and induction of labour (Homans 1980:345;420). Whilst this study is concerned with antenatal care, the health visitor's role is not discussed.

In another study, this time of Asian mothers registered with a medical practice in Glasgow where almost twenty-five per cent of the practice's population are Asian, Gardee (1979:219) not only found that the child health clinics were popular because reassurance and advice were offered in a friendly atmosphere, but that the:

. . . general attitude of the mothers towards the health visitor was that of affection and the knowledge that she was approachable if there were any problems.

(Gardee 1979:217)

A similarly favourable view of the health visiting service was noted by Nath (1970) in her thesis about the lives of Pakistani and Indian women in Newcastle-upon-Tyne. She not only noticed that the women found that the clinics were places to meet and make friends but:

As they find the English children are healthy here, they are ready to follow most of the advice given by doctors, mid-wives and health visitors.

(Nath 1970:108)

Even though Gardee's and Nath's studies present favourable images of health visiting, Webb's (1981) 'phone-in' counselling project for London's Asian and Afro-Caribbean population elicited a vast number of health concerns which were not being answered by their community health services, presumably including health visiting. Their worries did not turn out to be those 'currently catered for by health education programmes, nor those perceived by the medical world' (Webb 1981:141). Many of the women who called requested a woman doctor, others a hurried reply lest their husband discovered that 'they were talking to a doctor or a health visitor without his knowledge' (Webb 1981:145). Not only did this phone-in service seem particularly successful amongst the Asian population, but its success was thought to be because advice and not prescription was offered, probably thus fitting into the client's accepted cultural pattern. In addition, the multi-lingual, volunteer staff (which included health visitors) running the service seemed to be better able to understand the client's 'cultural roots' and be willing to talk about the whole person and his or her family (Webb 1981:147). Concerned about the relevance of 'the current content of health education' (Webb 1981:141) in regard to Asian and Afro-Caribbean communities in London, this study indicates that the health related needs of the members of these communities are not truly known.

5. A UNICULTURAL MODEL OF HEALTH VISITING

Having considered consumer perspectives as well as sixteen characteristics of contemporary health visiting in Sections Three and Four, it is now possible to present a cultural model of health visiting. This model is presented as unicultural in nature, in keeping with the overall approach which these sixteen characteristics repeatedly underline. In embodying the conceptual domains of

'client', 'health visitor', 'health', 'health visiting' and 'environment', the now widely accepted conceptual basis for nursing models (i.e. 'person', 'environment', 'health' and 'nursing' [Fawcett 1984:5; Fitzpatrick and Whall 1983:7]) is addressed in health visiting terms. As abstract approximations of reality, conceptual models of health visiting allow health visitors to focus on specific frames of reference in which certain concepts are seen as both relevant and as aids to understanding. The utility of conceptual models is derived from 'the organization they provide for thinking, for observations, and for interpreting what is seen' (Fawcett 1984:3,4).

A central underlying premise of the unicultural model presented in this section is that the health visiting related needs of all cultural groups can be contained within an approach to practice in which the primacy of the values, beliefs and practices of the dominant culture of the United Kingdom is upheld at organizational, educational and practice levels. In addition, peripheral recognition is considered sufficient in regard to the beliefs, values and practices held by clients from other cultural traditions.

The five conceptual domains which form this **Unicultural Model of Health Visiting** are as follows:

(1) CLIENT

The client is assumed to be of the dominant culture of the United Kingdom.

This assumption is reflected throughout the service's educational and value systems as well as its organizational environment. Only peripheral recognition is given to the fact that the client may be of another cultural tradition.

(2) HEALTH VISITOR

The health visitor is assumed to be of the dominant culture of the United Kingdom.

Minimal recognition is given to the fact that the health visitor herself may be from another cultural tradition. Although there is disciplinary flexibility within the knowledge base to qualifying health visitor education, there is no certainty that all health visitors will emerge educationally prepared for multi-cultural practice.

(3) HEALTH

Health is viewed in unicultural terms.

The primacy of Western scientific and nutritional knowledge is universally upheld.

(4) HEALTH VISITING

(a) Health visiting is seen as a process in which health visitor-client relationships are viewed primarily as unicultural.

Inter-cultural health visitor-client relationships, and alternative emphases and approaches needed for inter-cultural health promotional activities, are regarded as anomalous.

(b) Data on the ethnic background and identity of health visiting's clientele are not collected routinely.

Consequently, the health visitor is unable to view the care she provides within cultural parameters, except when a decision to collect data on the client's ethnic background and identity has been made at local level or if the health visitor exercises her own independence in so doing.

(5) ENVIRONMENT

The environment in which health visiting occurs is viewed in unicultural terms.

Multi-cultural situations are considered as unusual, especially outside areas known to have a high density of multi-cultural and multi-racial communities. Both the organizational and educational dimensions of the health visiting service (which form part of the overall environment) conform to unicultural perspectives.

Together, these five conceptual domains form a unicultural model of health visiting, one which provides an inappropriate conceptual basis for a profession which seeks to promote the health and well-being of a multi-cultural society. This model is also inappropriate in that health visiting is an unsolicited service which utilizes predominantly educational and advisory approaches to promote the client's health and well-being. Hence, a model of health visiting needs a conceptual basis which takes into account both the cultural beliefs and practices of health visiting's multi-cultural clientele, and the need to enable health visitors to fulfil their health promotive role with cultural sensitivity and appropriateness.

6. CONCLUSION

It is the very inadequacy and inappropriateness of a unicultural perspective for a service which aims to promote the health and well-being of a multi-cultural society that my thesis addresses. Indeed, it is insufficient for the health visiting profession to advocate taking account of clients' 'customs, values and spiritual beliefs' (U.K.C.C. 1984:2), or to advocate working within clients' cultural value systems (C.E.T.H.V. 1977:30), without a firm commitment

to this principle, educationally, organizationally and in field practice, at United Kingdom as well as local levels of health visiting. Thus, an alternative and more multi-culturally sensitive perspective is needed, a perspective which is more aligned to the diverse cultural composition of contemporary British society. If health visitors nationwide are to be proficient in the provision of a culturally sensitive and relevant service, then they need to receive appropriate educational preparation. They also need encouragement and support, at local, national and United Kingdom levels, in so doing.

In Chapter Two, a number of issues and developments which relate to the cultural dimension of health visiting and nursing care, in Britain and worldwide, and the need for an alternative and more culturally appropriate perspective for contemporary health visiting will be considered and discussed. Thereafter, in Chapter Three, a transcultural perspective for health visiting will be presented.

CHAPTER TWO

THE CULTURAL DIMENSION OF HEALTH VISITING AND NURSING

THOUGHTS, ISSUES AND DEVELOPMENTS

- 1. Introduction**
- 2. Transcultural Nursing – Definition and Development**
- 3. Multi-cultural Nursing within the United Kingdom**
- 4. Specific Aspects relating to Health Visiting's
Maternal and Child Health Remit in Multi-cultural Situations**
- 5. The Relevance of Theoretical Thinking to Health Visiting**
- 6. Summary**

1. INTRODUCTION

Having described in Chapter One the cultural perspective within which health visiting currently operates, in this chapter I consider various issues and developments relating to the cultural dimension of both health visiting and nursing. Initially, I consider developments in transcultural and multi-cultural nursing, not only in the United Kingdom but in a number of other countries worldwide, especially in North America where transcultural nursing has been developed at a professional level. Thereafter, I consider three topics relating to the cultural dimension of health visiting's maternal and child health remit: nutrition, immunization and sources of advice and influence. It will be seen that these three topics have relevance to the fieldwork which focuses on aspects relating to child bearing and child rearing in a Punjabi community in Britain.

For health visiting to develop effectively the cultural dimension of its practice, conceptual clarity is needed to provide a sound basis for so doing. Therefore, in this chapter, the relevance and development of theoretical thinking in nursing and, specifically, health visiting is discussed. Emergent from this discussion is the fact that there is no model which focuses on the cultural dimension of health visiting. Yet, a model that addresses the health visitor-client interface as well as the cultural perspective within which the overall health visiting service operates is needed. Various issues relating to such a model are discussed, including the concept of 'reciprocity'. This concept will be seen to be intrinsic to the transcultural perspective of health visiting which I present in Chapter Three.

2. TRANSCULTURAL NURSING – DEFINITION AND DEVELOPMENT

A) IN THE UNITED STATES OF AMERICA AND CANADA

During the 1940s, nursing education in the United States of America began to recognize the need to address the cultural dimension of nursing care. One study that 'spearheaded midcentury educational reform in nursing' (Dougherty and Tripp-Reimer 1985:221) was conducted by the anthropologist, Esther Lucille Brown (1948). By the 1960s, there was an increased awareness that, if nurses were to care for patients and clients from 'diverse origins and life situations', then they needed to 'have considerable social science knowledge' (including sociology, social psychology and anthropology) 'at their disposal, as well as experience in using that knowledge' (Brown 1964:14; also Macgregor 1960). However, the development of transcultural nursing was pioneered by Leininger (1978) who, with others, has nurtured its development over the past two decades. Leininger (1978:493) defines transcultural nursing as focusing on:

. . . the comparative study and analysis of different cultures and subcultures with respect to nursing and health-illness caring practices, beliefs, and values with the goal of generating scientific and humanistic knowledge and of using this knowledge to provide culture-specific and culture-universal nursing care practices.

A more easily remembered, though less precise, explanatory quotation describes it as understanding and helping:

. . . cultural groups with their nursing and health care needs with full thought to their culture-specific values, beliefs and practices.
(Leininger 1978:8)

In her book *Transcultural Nursing : Concepts, Theories and Practices*, Leininger (1978) explains how, in the mid-1950s as a psychiatric clinical nurse specialist at a guidance home for disturbed children, she became increasingly

dissatisfied with the current psycho-analytical theories used to predict both child and adult behaviour as well as to determine nursing interventions. Caring for children from a variety of cultural backgrounds, such as Appalachian and Afro-American, she noticed that the children exhibited great behavioural differences in activities such as playing, eating and sleeping. Through subsequent studies in anthropology, in fact to doctoral level, she realized that anthropological knowledge and insights could help to provide nurses with 'a broad, comparative background' with which 'to understand human behavior and cultural groups' (Leininger 1978:21-23; note Chrisman 1982).

Since then, other nurses working in both the United States and Canada have continued to research and amass a growing body of transcultural nursing knowledge, including conceptual frameworks, for nurses to utilize (e.g. Orque 1983:37). Several texts and numerous articles on transcultural nursing care have been published (e.g Brink 1976; Leininger 1979; Satz 1982) and several university transcultural nursing programmes have been developed. In addition, a Transcultural Nursing Society, based at the University of Utah, actively helps to promote and disseminate information state-wide. Over the years, this Society's annual conferences have progressed from focusing on specific patient and client groups to the alignment of theoretical thinking with practice, as well as ethical issues (such as cultural imposition) involved in transcultural nursing.

By taking time to learn about the values and beliefs of groups from both the American Indian and American Gypsy cultures, three nurse researchers have emphasized the importance of nurses appreciating the different cultural viewpoints and needs expressed by members of these cultural groups. For instance, Aichlmayer (1969:23) underlines the importance of determining one's 'own role behavior within the context of the other person's culture', while

Anderson and Tighe (1973:285) recognize that cultural knowledge allowed them to visualize more clearly how cultural differences can be incorporated in the planning and delivery of comprehensive health care. Even so, Hagey and Buller (1983:29), when discussing a self-care programme for Canadian Indians, caution against cultural knowledge being used, or rather misused, as a means for manipulation.

As previously discussed, research studies by Bonaparte (1979) and Jaffe Ruiz (1981) consider nurses' attitudes towards 'culturally different' patients, Jaffe Ruiz specifically looking at the attitudes of nursing faculty. In another study, Morgan (1983) looks at white nursing students' attitudes towards black American patients. In so doing, Morgan addresses the sensitive and multi-dimensional question of racial prejudice. In addition, a number of nursing publications in the United States of America (e.g. White 1977; Baker and Cook 1983) appertain to 'ethnic people of color', a term frequently used to describe black individuals from a variety of ethnic groups, for instance, Chinese and Puerto Ricans. However, in emphasizing the black-white cultural dichotomy, there is always the possibility that, by so doing, there will be a diminution of sensitivity towards the cultural diversity within these broad groups. Indeed, studies such as Tripp-Reimer's (1983) concerning urban Greek immigrants, and Sohler's (1976) about a Belgian orthodox Jew, are important in that they demonstrate the diversity that exists within the white culture.

In both the United States of America and Canada, transcultural nursing has moved towards model and theory development. Leininger offers two models, the one being a 'theory generating model' for the study of transcultural nursing theory (Leininger 1981:13) which Griffith-Kenney (1986:17) cites as an example of nursing meta theory. Developed over several years (cf. Leininger 1978:39),

this model incorporates various transcultural nursing and ethnocaring constructs such as comfort, nurturance and succorance. More recently, Leininger has produced a 'Sunrise' model which is part of her nursing theory of 'transcultural care diversity and universality' (Leininger 1985a:209), a theory which Wenger (1985:287) describes as being concerned with 'the study of health and caring in the acculturation process'. Whilst the full explication of this theory is still 'in press' (see Leininger 1985b:197), it is briefly described by Leininger (1985a) in article form and also by a nurse researcher mentored by Leininger (Wenger 1985). As a conceptual model, Leininger's Sunrise model may be used for 'culturological interviews, assessments, and therapy goals'. This model especially emphasizes the goals of cultural accommodation, repatterning and preservation (see also Leininger 1984:116). Carpio (1981) offers another model, one which specifically helps to clarify some of the inter-cultural conflicts in which Canadian immigrant adolescents may be involved, for instance, with regard to the influence derived from various sources of information as well as pressures from other people. While several other North American nurse researchers provide other useful frameworks (e.g. Orque 1983) on which to base transcultural care, overall, the area of transcultural model and theory development remains relatively under-developed.

Finally, it should be noted that other nursing theorists who have developed models based on alternative perspectives (such as adaptation or self-care) usually consider cultural factors as being important to the conceptual basis of their models. For instance, in her systems model, Neuman (1985:21) includes 'sociocultural' as one of the interacting variables (or 'parts') of the human being which are enclosed by 'protective lines of defence and resistance', this model focusing on the concept of stress as well as possible stress reactions to

stressors. In another model of nursing, one which is based on the notion of self-care, Orem (1985:108) not only observes that

. . . the activities of self-care are learned according to the beliefs, habits, and practices that characterize the cultural way of life of the group to which the individual belongs,

but she also recognizes 'sociocultural orientation' to be one of several factors that set limits on the methods that nurses can select and use 'in meeting the self-care requisites of individuals' (Orem 1985:163). King (1981 - e.g. p. 115) also recognizes cultural factors as being important within her conceptual framework for nursing, a framework which focuses on personal, interpersonal and social systems. For instance, King (1981:4) sees health as relating to:

. . . the way individuals deal with the stresses of growth and development while functioning within the cultural pattern in which they were born and to which they attempt to conform.

B) WORLDWIDE - EXCLUDING THE UNITED KINGDOM

Many studies, worldwide, demonstrate the need for nurses to develop a sound knowledge of their clients' and patients' cultural traditions. Nurses' expectations of client and patient behaviour, as well as patients' responses to illness, are well recognized as being socio-culturally defined, with nurses' eyes invariably seeing 'what their society permits or directs them to see' (Bhanumathi 1977:20). Bhanumathi's (1977:21) study looks at nurses' conceptions 'toward "sick role" and "good patient" behaviour', comparing the 'attitude patterns of nurses' in India with those of nurses in the United States of America. Although the total sample is small and does not lend its findings to generalization, this study demonstrates the likelihood of patients being culturally confused about the demands placed on them if nursed in accord with cultural values that differ from their own, a factor which could inhibit their

recovery.

Another study, a long-term one, was set up by Davitz et al. (1977a/b) to look into nurses' inferences of pain and suffering. Analyzing over 500 questionnaires answered by female nurses from six different countries and working in various fields of nursing, they assert that a patient's ethnic background is one of the important variables involved. Not only does this study emphasize Japanese and Korean nurses as being particularly sensitive to suffering and pain in others, but it demonstrates how the notion of 'oriental stoicism' is misleading. While the sample representing the United States of America mainly consists of nurses from Anglo-Saxon and Germanic backgrounds and is therefore somewhat biased, this study nevertheless is valuable in that it highlights the diversity within the so-called Western and Oriental cultures as well as the possibility of cultural stereotyping adversely influencing professional practice.

Australian nursing journals also carry articles on multi-cultural issues, often concerning their Aboriginal peoples. For instance, Brandl and Tilley's (1981) perceptive paper, 'Marching to a different drum', emphasizes the value of anthropological insight with regard to health care action. Describing aspects of health-care delivery in an Australian Aboriginal community, they stress the importance of recognizing alternative, culturally based styles of learning, noting that, on the whole, human beings are reluctant to change the learning patterns of their own cultural upbringing. They observe that Australian Aboriginal styles of learning carry a different shift of emphasis from those of the European-Australian population. One example quoted is the Aboriginal use of teaching through reinforcement of correct behaviour and, if possible, avoidance of mentioning mistakes. Comparing Australian non-Aboriginal with Australian

Aboriginal styles of learning, Brandl and Tilley (1981:26) observe:

In our own society we pay a lot of attention to mistakes and sometimes forget to notice when people are doing things competently and quietly. A Pakistani teacher told us, 'Westerners work on negative reinforcement. If you're doing a job well, nobody cares. It's only when you make mistakes that you get attention.'

For Aborigines too, drawing attention to mistakes is embarrassing and works against learning correct behaviour.

C) DISCUSSION

Much has been written which indicates that nursing care in its broadest sense is more relevant when cultural values and ways are taken into account. Texts by Branch and Paxton (1976), Brownlee (1978), Orque et al. (1983) and Spradley (1982), together with Tripp-Reimer et al.'s (1984) comprehensive overview of cultural assessment, all offer useful guidelines for nurses and, for that matter, other health care workers practising in multi-cultural situations. In addition, not only is the transcultural approach to nursing care considered repeatedly to provide benefits to the client but, as Cohen (1982) suggests, also to the nurse. Asserting that 'the transcultural nurse does not return empty-handed' (Cohen 1982:14), she considers the potential benefits that the nurse receives to include:

. . . growth as an independent practitioner, fulfillment of professional responsibilities, and development of a comparative perspective.

(Cohen:1982:10)

Even so, it is 'no longer sufficient' (Tripp-Reimer 1984b:254) to state that nurses need to be sensitive to the culture of their clients. Research priorities in cultural diversity, according to Tripp-Reimer (1984b:254-255), now need to be focused on 'theoretical development, and application [of research findings] to clinical nursing practice'.

3. MULTI-CULTURAL NURSING WITHIN THE UNITED KINGDOM

A) AWAKENING INTEREST

Since the 1970s, the need for more culturally appropriate care to be offered to clients and patients is being acknowledged increasingly by the British nursing profession within its published literature. For instance, in 1974, Alexander's award-winning essay emphasized that:

A knowledge of different patterns of culture is an asset to any worker concerned with health, since it increases understanding of the needs of people from different backgrounds.

(Alexander 1974:632)

Although nursing publications have sometimes offered abridged, stereotyped versions of the cultural background and traditions of ethnic minority groups (e.g. Griffin 1972:122), the need for nurses in the United Kingdom to understand the cultural traditions of their patients and clients has tended to gain greater acceptance in recent years. Indeed, if nursing care studies can be considered to act as thermometers of ground level interest and approaches, then the emergence in the early 1970s of a few studies with a clearer multi-cultural nursing care content, and more clearly indexed as such in the nursing bibliography, indicate an awakening interest. Even so, one article written by an Indian student nurse (Kaur 1974) about an Indian patient contains surprisingly little reference to cultural needs. This, however, may be more a reflection of the focus of general nursing education at that time rather than a lack of genuine concern on her part (cf. Viridi 1984).

Gradually, since the mid-1970s, and even more noticeably during the 1980s, more articles, papers, reports and even a few texts have been published which relate to multi-cultural issues regarding practices of, and policies for, nursing

care, administration and education, with a considerable number relating to health visiting. This increase is possibly a reflection not only of changes within the nursing profession, but within the country as a whole and the interplay between both, such areas of change being by no means mutually exclusive. In her article 'Nursing in a changing society', Auld (1979:289) suggests that nurses have 'become more a part of society' over the last two decades, and that this has engendered a greater awareness within the profession of the significance of social change. Even so, she considers the horizons of the nursing profession to be 'somewhat narrow' (Auld 1979:287), with inadequate recognition being paid to changes in society that are relevant to nursing practice. Thus, to separate the development of multi-cultural nursing practice from developments within the health and social services as a whole is to divorce nursing from its wider and more realistic setting; changes in one area frequently percolating, albeit slowly, to another.

Although Lobo (1978), Henley (1979), Mares (1982) and Mares et al. (1985) have provided texts regarding the cultural dimension of health care in Britain, Sampson (1982) is the only nurse to have published a text which, in its entirety, focuses on cultural and religious aspects of nursing. Various articles, though altogether not so numerous, have embraced a fairly wide scope of concerns relating to clients' and patients' cultural traditions and needs, often with regard to specific fields of nursing practice. The promotion of the nursing process has stimulated further interest. In fact, one portrayal of inter-cultural sensitivity is offered by Crow (1977) in a study which uses the nursing process as a basis for the nursing care given to a Polish patient. In another article, Burrows (1983) emphasizes the need for the inclusion of ethnographic perspectives within nursing curricula. This article forms a significant watershed within the British nursing literature in that Burrows not only challenges the

ethnocentricity of nursing education, but in that she discusses various ways in which a foundation of anthropological knowledge might be included within nursing education. Rather than nurse educators adhering to one single strategy when developing cultural content in nursing curricula, she considers that:

A combination of strategies is probably preferable, so that a broad foundation of anthropological knowledge is provided and followed throughout the course by reference to cultural dimensions as a curriculum thread.

(Burrows 1983:484)

B) OTHER HEALTH CARING PROFESSIONALS

Only in the 1980s does the British nursing profession begin to consider the need for culturally based policies and to make such views more widely known; Slack's (1981) contribution to one of the Open University texts being one such instance. Other groups of health and social service personnel have tended to lead the way. For instance, as a social services officer, Coombe made recommendations in 1976 for the improvement of communication between professionals and minority ethnic groups in both the health and social services. These recommendations related to staff recruitment and training, interpreter services and the use of the media. Also during the 1970s, several articles were published in the nursing press which were written by social workers and which were both culturally sensitive and relevant to nursing (e.g. Bhaduri [1979] and Davie [1979]). In the one study, Davie describes using a task-centred casework approach which she felt helped the father of an Asian teenager with coeliac disease to become more of a participant and an 'equal' (Davie 1979:38) in the planning and provision of care. In the other, Bhaduri describes cultural factors surrounding the terminal illness of a Bangladeshi boy, and also her own reactions to the interpersonal tensions that resulted.

Members of the medical profession have also shown interest in the provision of, or more truly the concern for the lack of, culturally relevant health care. Glasgow (e.g. Dunnigan 1981; Gardee 1979; Goel et al. 1978) and Bradford, West Yorkshire (e.g. Dodge 1969; Horne 1978; Lumb et al. 1981; Rowell and Rack 1979; Selig 1981) are two cities where, for many years, there has been much interest in the cultural dimension of medical care, especially relating to maternal health, psychiatry and health education. Nevertheless, it was not until 1981 that a national multi-disciplinary resource, reference, educational and research Centre for Ethnic Minorities Health Studies was established, in fact, in Bradford. More recently, Helman (1984) has produced a text, *Culture, Health and Illness*, which links British medical practice with anthropology.

Numerous social scientists and non-nursing health professionals from both within (e.g. Attariwala 1977; Dwivedi 1980; Helman 1981) and without their own cultural group (e.g. Abbas 1981; Ballard 1979; Homans 1980; Kitzinger 1977) have offered useful and illuminative cultural insights for nurses to draw upon. For instance, Dwivedi's (1980) article on the use of 'Indian notions in counselling situations' brings home the different approaches to counselling that can be employed by those conversant with their client's religion and culture. Illustrated throughout with parables, mythological stories and notions, such as the notion of Karmic debt which is derived from the Karmic theory of the Upanishads and emphasizes that we have to face our problems sooner or later, these alternative approaches to counselling are directed specifically towards reducing emotional stress (Dwivedi 1980:11). Indeed, cursorily to discredit non-Westernized health systems is to undermine approaches, treatments and therapies for care and cure, many of which have been known to be efficacious for centuries and considered culturally satisfying.

C) TRENDS WITHIN THE HEALTH SERVICES

Overall, there is a trend within the health services towards isolated pockets of interest in the cultural dimension of health care rather than a nationwide policy concerning the same. While reports of various natures have emerged from differing health authorities and universities (e.g. Brent 1981; Manchester 1981; Rees 1981; University of Manchester 1981), the Department of Health and Social Security's recent report entitled *Services for Under Fives from Ethnic Minority Communities* (D.H.S.S. 1984) indicates a degree of open recognition emerging at national level.

Generally, the health professions have not been explicit and are divided concerning the extent to which the cultural dimension should be catered for in the planning and provision of their services. There appears to be no comprehensive study published regarding multi-cultural policies and practices of health and nursing care services on a par with Young and Connelly's (1981) study concerning local authority departments. In this study, Young and Connelly (1981:163) claim that:

Often deprived of authoritative discussion in a policy forum, developments in education and social services practice have largely followed from the perplexity, curiosity, commitment and enthusiasm of particular practitioners and field managers and their ability to take their colleagues with them.

On the whole, the health professions continue to look at the uptake of health services (e.g. Ronalds et al. 1977) rather than the needs and satisfactions felt by consumers themselves from their own particular cultural stance.

D) NURSING EDUCATION

Essentially, nurses, in whatever field of practice, are trained and educated at basic and post-basic levels for a qualification which allows them to work anywhere throughout the United Kingdom. Current trends and expected areas of competence are reflected in standard texts and, perhaps, more importantly in examination papers. Gradually, standard texts (e.g. Roper's [1982] *Principles of Nursing*; also Slack's [1978] *School Nursing*, Illing and Donovan's [1981] *District Nursing*, and Clark and Henderson's [1983] *Community Health*) are discussing cultural issues. Even so, it is still more usual for these issues to be considered as a separate entity, Roper's (1982) text being an exception in that it provides references on cultural issues throughout. Very few texts (e.g. Collins and Parker 1983; Brain and Martin 1983) include photographs and drawings that reflect multi-cultural (and multi-racial) situations which, as well as portraying reality, help to provide a visual sense of identity for ethnic minority nurses. Several photographs in the latest pamphlets for health visitor applicants are now beginning to include members of ethnic minority groups, both clients and health visitors (e.g. C.E.T.H.V. [1982a/b]), thus implicitly acknowledging that health visitors both serve, and are part of, a multi-cultural society.

A review of a number of examination papers produced over the past five to ten years for, or in preparation for, a number of nursing registers – that is, midwifery and general, paediatric, district nursing, but excluding health visiting (see below) – similarly affirms this tendency of not including questions that specifically ask for the client's cultural needs to be discussed. While the use of non-specific terms for surnames (for instance, the use of colours [e.g. 'Mister Green'] or countries [e.g. 'Baby Scotland']) might be considered to encompass ethnic minority patients, it would then seem unnecessary to use, as does

happen, ethnic-specific surnames for questions about ethnic minority patients.

In reviewing examination papers for a variety of nursing degrees at two educational establishments, several questions relating to patients' and clients' cultures were noted to have been included, thus reflecting the inclusion of cultural knowledge relevant to nursing care in the curricula of these two establishments. Even so, it is the central nursing bodies who ultimately are responsible for standards in nursing education. Indeed, it is presumably against these central standards of education and training that case studies and questions in revision texts for nurses are chosen, texts which act as guides to some nurses for apportioning the time they spend revising different topics. Out of three such texts (Copcutt 1983; Hull and Isaacs 1982; Middleton 1983), only three case histories relate to ethnic minority patients and each one focuses on pulmonary tuberculosis. However, in Brain and Martin's (1985) more recent *Examination Guide for Nursery Nurses*, fourteen of its 160 multiple-choice questions and two of its sixteen essay topics focus directly on cultural issues. While this increased emphasis indicates that more recognition is now being given to cultural factors, it is noteworthy that neither of the essays on cultural issues is included in the eight specimen essays provided.

With regard to both the health visiting syllabus for the United Kingdom (which is discussed further in the following section) and the 1981 revision of the syllabus for the University of London's Diploma in Nursing, reference is made in both syllabi to the inclusion of 'socio-cultural' topics. Even so, much of the responsibility for this inclusion in regard to both qualifications rests with the individual educational institutions, although curriculum approval is sanctioned at national level. In addition, some centres prefer to use 'on-going assessments' and 'continuous assignments' instead of examinations for all, or

part, of their courses. Hence, it is difficult to determine to what extent students who study for either qualification are prepared educationally to practise in multi-cultural situations. By corresponding with tutors at a number of centres for health visitor education, as well as one where the Diploma in Nursing is taught (all in areas known to include sizeable ethnic minority communities), I am assured that every year their examinations include at least one question on cultural issues, that is, in centres where written examinations are used. Even so, because health visiting 'courses would appear to reflect the societies in which they are sited' (Sharman 1986a:personal communication), there is no certainty that individual health visiting courses prepare their qualifying students to practise effectively in multi-cultural situations.

E) THE UNITED KINGDOM HEALTH VISITING SYLLABUS

In a recent discussion paper which is concerned with the development of health visiting curricula and is entitled *Ethnic Minority Groups*, Sharman (1985:9-10) notes that all qualifying health visiting courses should reflect the needs and reality of the 'wider society'. Thus, Sharman reiterates a view expressed by Loveland in 1971 that, irrespective of the autonomy that educational institutions have in interpreting the United Kingdom syllabus to suit local needs, health visiting:

. . . courses should be broad enough to fit the student to practise in any area within the United Kingdom;
(Loveland 1971:86)

basic training thus enabling the qualified health visitor to work countrywide. However, not only does Sharman (1986a:personal communication; also 1985:7) suggest from the arguments produced in this discussion paper that the United Kingdom is 'multi-racial and multi-cultural', but she also recommends the use of 'an integrated multi-racial and multi-cultural approach' (Sharman 1985:9) for

all qualifying and post-qualifying health visitor education.

Subsequent to the 1965 revision of the health visiting syllabus, the inclusion of sociological perspectives is now well-established in all curricula countrywide (Owen 1983b:105). Nevertheless, while some training institutions may, and do, include cultural perspectives (especially in areas with sizeable black communities), the concept of culture in its anthropological sense has not been embraced countrywide. There has also been minimal discussion in the published health visiting literature on topics such as ethnocentrism and cultural values in relation to health visiting practice. In addition, little has been written about how knowledge concerning cultural diversity and the discovery of cultural information, as well as concerning practising effectively in multi-cultural situations, can best be taught. At present, there is a shortage of health visiting and nursing studies which provide insight into the cultural traditions and values of differing ethnic groups countrywide. This means that health visitor tutors have little health visiting related material to draw upon that provides culturally sensitive insights to practice. Hence, many health visitor students neither start their training with much previous understanding of cultural diversity as it relates to nursing and/or health visiting practice, nor do they necessarily gain such knowledge during their qualifying health visitor education.

Without the acquisition of culturally related skills and knowledge as a nationwide prerequisite to becoming a qualified health visitor, the development of an ability to work effectively in multi-cultural situations is, in many instances, learnt 'on the job', or not at all. This is in keeping with a unicultural perspective. However, dependence on knowledge imparted on the job from the more to the less 'experienced', means that the 'experienced' person requires

not only the knowledge and skills in question but also the ability to impart them fruitfully to others (Shepherd 1984:287). Although Shepherd (1984) is discussing the pitfalls of learning 'on the job' with regard to the police force, it is similarly unacceptable to leave the development of the skills and knowledge needed for health visiting in multi-cultural situations until the need arises.

There will always be practitioners who are both motivated and especially talented to work inter-culturally, and who may be drawn to this type of work because of their abilities. Even so, without a sound foundation of cultural knowledge being mandatory in basic health visiting education nationwide, there is no assurance that all health visitors, once qualified, are prepared educationally to practise confidently and effectively within their prospective clients' cultural value system. Hence, there is a need for cultural knowledge, theoretical and practical, to be included in all basic health visiting education, rather than the provision of such knowledge being left to the discretion of individual centres of health visitor education.

F) DISCUSSION

Health visitors and nurses in the United Kingdom are now looking more closely at their practice in multi-cultural situations. Gradually, more research studies and projects by health visitors and nurses are emerging, such as those by Marks (1979), Rhodes (1985a/b), Rousseau (1983a/b), Webb (1981) and Whitethread (1981) which have considered and brought to light cultural factors involved in infant feeding, schoolchildren's eating habits, the presentation and definition of health problems as well as stoma care. Nevertheless, there continues to be a need for health visitors and nurses to develop approaches to practice which take their clients' cultural beliefs, values and ideas into full

account. Serious consideration also needs to be given to ensuring that all student health visitors (and student nurses) are provided with a sound educational foundation in the provision of effective health visiting in multi-cultural situations. In addition, the need for health visitors to be culturally sensitive to their clients' culture is heightened by the fact that health visitors work within a guest capacity when visiting clients in their homes (see Karseras 1981:1).

4. SPECIFIC ASPECTS RELATING TO HEALTH VISITING'S MATERNAL AND CHILD HEALTH REMIT IN MULTI-CULTURAL SITUATIONS

In this section, I consider the cultural dimension of three aspects relating to health visiting families with young children: infant and pre-school nutrition, immunization and sources of advice and influence. Special reference is made to ethnic minority groups from the Indian Sub-continent in that the cultural background of the families who participated in the research study related to this part of the world. It will be seen in Chapters Six and Seven that the fieldwork focuses on cultural factors relating to child bearing as well as child rearing. Although visiting the antenatal mother is recognized as part of the health visitor's remit (see Ministry of Health et al. 1956:119; H.V.A. 1981:10; Kerr 1983:258), the cultural dimension of this remit has received minimal attention in the British nursing press. To an extent, this may be because, in their practice, health visitors seldom discuss the needs of the 'expectant mother' (note Clark 1972:118). Indeed, until the 1980s, Kitzinger's (1977) article, which presents an anthropologist's view of 'immigrant women in childbirth', is one of the few articles in the nursing press which addresses, in its entirety, the culturally related needs of the pregnant woman in regard to multi-cultural situations.

However, since 1981, there have been several articles in nursing and health visiting journals (e.g. Abraham 1982; Mayor 1984; Turrell 1985) – at least two being written by health visitors – in which health care professionals share their experiences, ideas and knowledge concerning the provision of culturally sensitive antenatal care.

A) INFANT AND PRE-SCHOOL NUTRITION

Various nurses, dieticians and doctors have discussed some of the uncertainties which confront mothers of Asian communities when deciding how, when, and on what to feed their infants and pre-schoolers. For instance, Knight, who spent a day with a Bengali nurse who visited Bengali mothers in London's Tower Hamlets, noted that:

. . . in hospital here they see the English mothers bottle-feeding . . . and they think it must be better . . . When it is time for a child to be weaned on to solid foods, there are further problems. The tinned baby foods are not *Halal* (food allowed by the Muslim religion), so children may be given a very restricted and unnutritious diet.

(Knight 1979:36-37)

In two articles, a nutritionist (Hunt [1976]) and a health visitor (Loynes 1979) consider the health visitor to have an important role in helping Asian mothers in Britain make minor modifications to their traditional foods, including ensuring that compensation is made for possible dietary deficiencies such as vitamin D, iron and vitamin B12. Other nutritionists also discuss various aspects of Asian diets. For instance, Attariwala (1977:251), who includes a 'typical Asian meal pattern', notes 'how difficult it is to change food habits and acquire new tastes'. According to another nutritionist:

In the Indian sub-continent there is only one transition – from milk feeds to various curries and chappatties – compared with this country where weaning is followed by junior dinners and then adult dinners. Asian mothers confronted for the first time with the choice of infant foods without any guidance often adopt the most undesirable feeding pattern.

(Shukla 1980:525)

Indeed, Jivani (1978), a paediatrician who sees many of the nutritional problems amongst Asian immigrant children to be the result of inadequate weaning practices, offers general guidelines to health workers to help them to attune their advice in accord with religio-cultural customs.

Research into dietary practices amongst ethnic minority communities has been undertaken in various parts of the country. For instance, in Glasgow, research continues into the causation and prevention of what has been termed 'Asian rickets' as well as osteomalacia (Robertson et al. 1982). In another Glasgow-based study, Goel et al. (1978) looked into feeding practices amongst immigrant families. Comparing the 'health and nutritional state of Asian, African and Chinese children' with 'Scottish' (that is, 'local white') children from the same district in Glasgow, they note that the immigrant families were strongly influenced by infant feeding practices in the United Kingdom (Goel et al. 1978:1181–1182). In a subsequent publication, Goel [1981] observes that, in relation to the introduction of solids, the Chinese population in Glasgow appeared:

. . . to be unaffected by British methods with most babies not receiving solids until after nine months.

(Goel [1981]:20)

In another study, Wolverhampton-based, Evans et al. (1976) comment upon a lack of breast feeding as well as an early weaning of infants of Asian immigrants. Not only does their survey indicate 'a dramatic reduction in the duration and incidence of breast feeding on arrival in the United Kingdom' by Asian mothers, but that there is also 'a fall' and 'a progressive decline

thereafter' in 'the age of weaning' (Evans et al. 1976:610).

In London, Tann and Wheeler (1980) contacted twenty families through health personnel and social workers from amongst the 20,000 or so 'London Chinese' who form a 'homogeneous, tightly-knit, mutually supportive community' (Tann and Wheeler 1980:20). It emerged that these mothers:

. . . adopted a feeding pattern for their infants which is a synthesis of Hong Kong and British practices . . . The Chinese children were thriving on their Sino-British diet.

(Tann and Wheeler 1980:23)

Tann and Wheeler emphasize that health workers need to take cultural factors, as well as the language barrier, into account. They also highlight the fact that powdered milk and proprietary baby foods are valued by Chinese parents because they are 'associated' with 'the growth of strong, healthy, élite babies'. *Congee* and boiled rice are seen as 'strong' foods and as necessary for initiating the child into the full Chinese dietary pattern, thus emphasizing the intertwining nature of culture and dietary preferences and practices (Tann and Wheeler 1980:23).

B) IMMUNIZATION

Brownlee (1978:177) notes that certain cultural groups believe in divine predetermination of human events and may therefore consider misfortune to be part of God's plan. Indeed, preventive measures are seen by some as verging on blasphemy (note Bunting 1984:12). Even so, little has been written about cultural attitudes towards immunization, nor, for that matter, about measures used towards achieving primary prevention of ill-health. Yet, the importance accredited to maintaining low levels of communicable disease throughout the country makes this topic an important aspect of the health visitor's child health

remit.

Factors significant in the reduction of, and increased resistance to, communicable diseases in Britain during the last century have included advances in sanitation, cleaner water supplies, improved nutrition and better housing. This reduction has been enhanced by a nationwide programme of voluntary immunization amongst children. The use of chemotherapy and antibiotics has also helped to alter the course of many infectious diseases, including tuberculosis and measles.

The prevalence of different infectious diseases varies from country to country. In some countries, such as those in the Indian Sub-continent, statistical accuracy may be marred by logistical problems and, more basically, by the lack of medical facilities to confirm diagnosis. For example, in regard to the virus of poliomyelitis, which is endemic in countries where traditional sanitation habits persist, sub-clinical infections frequently provide immunity early in life (Office of Health Economics 1963:6). Consequently, the need for immunization against acute poliomyelitis may not, at first, be fully appreciated by immigrants who have moved from a country with endemic poliomyelitis to one where this is not a concern. In addition, the poor results from live oral polio vaccine, which may be less effective in sub-tropical countries (Dick 1978:142), may have left people disillusioned about the effectiveness of immunization programmes. Thus, a variety of attitudes towards, and experiences of, immunization procedures may be present amongst the more recent immigrant members of ethnic minority communities in Britain.

The question of tuberculosis surveillance amongst immigrant populations in Britain is one that has been addressed by various members of the medical

profession (e.g. Dick 1978:92; Khogali 1979; Lobo 1978:48–52). In 1978, the Joint Tuberculosis Committee (p. 1039) commented that many Asians came from countries where about half the population was infected with the tubercle bacillus by the age of ten years old. In addition, Asian children born in the United Kingdom, and who have not developed a natural immunity to the tubercle bacillus, may be at risk if taken to India or Pakistan, for:

When they are taken to their parents' native village, they are 'on show' to all the older members of the extended family, and to all the friends and neighbours. It is very likely that one of the elderly well-wishers, who wants to cuddle, kiss and admire the children, has a low grade but infectious variety of tuberculosis.
(Lobo 1978:50)

As Indian and Pakistani families living in Britain appear to be more susceptible to tuberculosis than are 'English' families (Lobo 1978:48), specific anti-tuberculosis routines have been advocated by a number of health authorities and boards.

In 1973, a comparative study of thirty-three Indian and Pakistani immigrants and thirty-three British born white mothers in Birmingham showed that the proportion of mothers completing a full course of diphtheria, pertussis and tetanus immunization was the same (that is, seventy-three per cent) for both groups (Ronalds et al. 1977:283). In another comparative study, this time of children from families registered with one general medical practice in Edinburgh, it was demonstrated that there was no significant difference between the uptake of immunization by children from 'immigrant Pakistani' families and the uptake by 'native-born Scots children in the same area' (Gaskell 1969:220–221). Both these studies, however, were undertaken prior to the controversy that occurred in the 1970s over the safety and efficacy of pertussis vaccine. Brought to the public notice through the national press and other mass media, this controversy adversely influenced parental acceptance of

pertussis immunization and, in some families, this extended to immunization procedures as a whole. The extent to which this controversy influenced the views and decisions made by parents from ethnic minority communities would appear to be unknown (note While 1986:56).

An additional point of relevance is Knight's (1979:37) comment that Bengalis are generally 'very willing to have injections'. Even so, not only is she possibly referring to curing rather than preventing illness, but it cannot be assumed that people from different ethnic groups from the Indian Sub-continent hold similar beliefs.

C) SOURCES OF ADVICE AND INFLUENCE

A person's network . . . forms a social environment from and through which pressure is exerted to influence his behaviour.
(Boissevain 1974:27)

Superficially, one might expect health visitors to be very influential in advising and encouraging ethnic minority parents to take up child immunization programmes as well as concerning decisions relating to infant nutrition, possibly more so regarding immunization as this relates to a specific nursing procedure. Yet, in situations where the health visitor and the client are from different cultures, should the health visitor fail to indicate a good understanding of the client's culture, the client may prefer to trust sources of advice and influence from within her or his own cultural group rather than advice provided by health visitors or other health professionals (note Rowell and Rack 1979:7).

Concerning decision-making relating to child nutrition, Dawar (1979:30) reminds health visitors that amongst Asian families, not only are the ideas and preferences of the mother-in-law (and even the sister-in-law) considered to be

influential, but frequently are more influential than those held by the child's mother. The traditional healers (e.g. *hakims*) are also considered respected advisers on health matters in Asian communities. These healers are able to offer advice that is culturally attuned, both in the type of advice provided and the manner in which it is given (Webb 1981:147). In addition, Webb (1981) notes that the power of the male section of the Asian communities should never be forgotten, as it is frequently the menfolk who make the decisions regarding where to shop and when health clinics should be attended (Webb 1981:145; also Turrell 1985:46). In discussing the attendance of antenatal clinics by a young Pakistani woman accustomed to a rural life-style in the Sub-continent, Rack (1978:32) observes that she may never have been called upon previously:

... to cope with problems on her own [,] to make any decisions on her own, or indeed to visualize herself as a person on her own. Any dealings which the family may have had with authority or external agencies, will have been handled by her elders.

In her London-based, multi-ethnic study of infant feeding practices, Marks (1979:272-273) found that the Asian families she interviewed might consult either the health visitor or the doctor but never the chemist, nor, it would seem, their friends. However, her comparison with other ethnic minority groups, such as West Indians, may be somewhat misleading inasmuch as it is possible that more Asian than West Indian mothers have close family members living nearby to turn to for advice.

The strength of personal influence on promoting behavioural change regarding preventive health practices has long been accepted. When discussing a study of the public's acceptance of a Salk polio vaccine programme in the United States of America in the 1950s, Glasser (1958:145) deduced from the evidence:

. . . that people tend to behave in this aspect of their lives as in others, the way their friends do – providing they know what their friends have done. The social activity of talking about vaccination is thus a major determinant of vaccination itself.

Nevertheless, an experimental Bristol-based study, conducted by the Health Education Council in 1973, demonstrated that television had been a most effective medium in promoting attitude change towards measles and measles vaccination (Health Education Council 1974:20). Even so, as only a few Asian families were respondents in this study, it provides little indication of the influence of television as a medium for health promotion amongst Asian families.

In 1966, Kasl and Cobb published their analysis of health behaviour, postulating a relationship between perceived threat of disease and health behaviour. They put forward ethnic origin as one of the influencing determinants together with factual information, importance of health as an entity, past utilization of medical services, and level of education (Kasl and Cobb 1966:252). Rowell and Rack (1979:3) offer another model which specifically relates to the 'health education needs of a minority ethnic group'. While noting that both the innovation and the recognition of the need to change may arise from within or outwith the community in question, their model nevertheless portrays a sense of visual hierarchy, with more information and innovation moving diagrammatically in a downwards direction – from the health education specialist to community members – than upwards (Rowell and Rack 1979:12). Even so, their ideas add weight to the fact that health visitors, who are constantly acting as health educators, and social advisers, need to utilize culturally relevant approaches to the planning and the provision of care.

5. THE RELEVANCE OF THEORETICAL THINKING TO HEALTH VISITING

In the previous sections of this chapter, the development of the cultural dimension of nursing and health visiting, especially in North America and the United Kingdom, has been described and discussed. Broader issues, such as nursing education, and more specific foci, such as aspects of health visiting's maternal and child health remit, have been considered. It has been seen that only very recently has there been an increased concern for the nationwide provision of a health visiting service in which health visitors are prepared educationally to provide culturally attuned care. In this section, the general relevance of theoretical thinking to nursing and health visiting – and, specifically, where this has been related to the cultural dimension of practice – is considered.

Even though the need for a clear conceptual basis to nursing, both the well and the sick, was advocated by Nightingale in 1860 in her *Notes on Nursing*, theoretical development in health visiting is still very much in its infancy. In fact, it is only since the 1950s that the nursing professions in North America and in the United Kingdom have looked again at the need for a sound and explicit conceptual basis to practice (e.g. Chapman 1972; N.D.C.G. 1973; Norris 1982). Therefore, an overview of some of the developments in theoretical thinking in nursing, as well as in health visiting, is pertinent before an alternative to the unicultural model of health visiting described in Chapter One is considered. From this discussion, it will be seen that no model of health visiting focuses specifically on the cultural dimension of health visiting practice, nor does any model incorporate explicitly conceptual insights relevant to multi-cultural practice.

A) AN OVERVIEW OF THE DEVELOPMENT OF NURSING THEORY

Theoretical thinking in nursing is more developed in the United States of America than in the United Kingdom. Many of the earliest North American nurse theorists were graduates of Columbia University's Teachers College (Meleis 1985:15), with several theorists (e.g. Neuman [1982], Orem [1985], Rogers [1970]) attesting the genesis of their theories to the need to devise a curriculum conceptually based on what 'nursing' truly is (Neuman and Young 1972; Meleis 1985). Although nurse scholars debate over issues such as the value inherent in developing a unified model of nursing as opposed to the benefits of theoretical pluralism (e.g. Riehl and Roy 1980; Stevens 1984:xiii), the need for clear theoretical thinking as a basis for nursing practice is receiving more widespread acceptance in the United States of America and Canada. Indeed, Canadian professional standards for nursing practice now require that 'a conceptual model for nursing be the basis for the independent part of that practice' (C.N.A. 1980:3).

Nevertheless, in the United Kingdom, and certainly up until the 1980s, there has been a degree of reluctance to develop an explicit theoretical basis to practice within both nursing and health visiting. To an extent, this may be due to the 'penchant for impenetrable terminology' (Smith 1981:83) that many theorists seem to have developed in the name of intellectual precision, thereby daunting nurses who have not enjoyed similar access to the academic world (Wright 1986:40). For others, "'Excuse me, Professor, but have you seen my patient?'" (Graham 1972:408) possibly sums up the concern that many British nurses have felt about the ability of nursing theories to relate to the real world of nursing practice. In addition, the 'utter semantic confusion' (McFarlane 1976:448) regarding the almost casual interchange of theoretical terminology

may have in itself made unclear what is supposedly meant to provide clarification. Intellectual time has been spent 'quibbling over labels', such as what constitutes a theory. This has led to a 'syntactical distraction' whereby the actual 'substance of the given thesis' may be overlooked (Stevens 1984:xii; also Flaskerud and Halloran 1980:2).

Essentially, a theory is recognized as being a 'systematically related set of statements, including some lawlike generalizations, that is empirically testable' (Rudner 1966:10; see also Jacox 1974:8). Theory development, however, 'extends from the most primitive to the most sophisticated formulation' (Stevens 1984:xii), Stevens proffering a dual structural classification: theory that describes, and theory that explains nursing phenomena (Stevens 1984:1-5). An alternative four-level hierarchy of theory development is suggested by Dickoff and James (1968:200-201), one which closely parallels the classification of Walker and Avant (1983:8; see Leddy and Pepper 1985:116) which follows a hierarchy which extends from description through explanation to prediction and control. This fourth, prescriptive level has come to be known as practice theory, which for some theorists (e.g. King 1984) is untenable but, for others, is considered to be both possible and acceptable (Newman 1972:452-453). Practice theory, however, is not value free, for, in selecting desired goals, the nurse researcher expresses 'positive and/or negative values' (Chapman 1976b:6; also Robinson 1985a:181).

It is only in the past decade that nursing theory has begun to be considered seriously in the United Kingdom. Models of, and for, nursing are now being discussed more widely in the nursing press (e.g. Aggleton and Chalmers 1984). Although the terms 'model' and 'theory' are sometimes used interchangeably, they are not one and the same. While models are approximations or

abstractions of reality which order, classify and systematize the 'selected components of the phenomena' that they 'serve to depict' (Bush 1979:16), the phenomena under consideration are not sufficiently precise and limited, the concepts frequently are not defined with sufficient clarity, and interrelational statements necessary to constitute a theory are absent. While 'all theories purport to represent some aspect of real world phenomena', and may be considered to be models, 'the converse is not true' (Lancaster and Lancaster 1981:33). The relevance of theoretical thinking (i.e. nursing-specific thinking) has only just begun to reach the grass-roots level in British nursing through the use of models, and the seminal endeavours of the North American nurse theorists are now beginning to be utilized, questioned, modified and amended (note Hardy 1986).

B) THEORETICAL THINKING AND HEALTH VISITING

Nursing, as Hardy (1978:41) emphasizes, has a mandate from society to use both its specialized body of knowledge and its skills for the betterment of humanity, while keeping pace with the changes in society's health goals. It is this body of nursing-specific knowledge that British nurses and health visitors have not clearly explicated. In a time of increased financial stringency within the health services, the relevance and effectiveness of health visiting practices is of immense import. Yet, until health visiting has a clearly articulated theoretical basis, it will remain difficult for the service to substantiate the relevance and effectiveness of its client-oriented activities. Incipient theory, however, abounds both in the private images of practice which each health visitor holds and in the accepted patterns of health visiting practice that are passed on within the profession, both formally and informally. Health visitors must continue to clarify what health visiting really is by drawing together

conceptual commonalities, clarifying their relevance with intellectual diligence, precision and imagination. For, in a phrase used by Rogers (1984), 'it is easy to see the seeds in the apple' but it 'requires imagination to see the apple in the seeds'.

With the intention of their model being used in a variety of settings and patient/client groups, three British nurses, Roper, Logan and Tierney (1985a/b; 1986) have developed and refined (over the past ten years) a model for nursing which focuses on twelve 'activities of living'. This model, which incorporates the nursing process, expressly emphasizes the individuality of the person. Nursing action is concerned with helping the patient or client prevent, solve, alleviate and cope with actual, or potential, problems which interfere with his ability to achieve his full potential for independence (aided independence where appropriate) in each activity of living, and with regard to both his place on his life-span and his particular circumstance (Roper et al. 1983:7; 1985a:63-65). 'Sociocultural' is included as one of the five categories of factors recognized as influencing each activity of living. Although the term 'sociocultural' is not explicitly defined, it is used to relate to multiple factors such as society, culture, religion, occupational group and the community to which the patient or client belongs.

Essentially, the Roper, Logan, Tierney model is intended to both reflect and guide the reality of nursing practice. As such, it is primarily visualized as 'a working model' rather than 'a model for testing' (Tierney 1986:personal communication). Although this model offers a conceptual system which health visitors might use to guide their practice (Alexander 1983:59-60), as yet, it does not appear to have been widely used by health visiting practitioners in contrast with its wide acceptance amongst nurses throughout the United Kingdom.

Neither is it included in the six theory outlines that Orr (1985b:92-93) describes in regard to individual and family health visiting practice. To an extent, this lack of acceptance by health visitors may be because the explanatory text addresses itself more forcefully to patient rather than client care, and less obviously to composite clientele.

While there has been a lack of open discussion regarding the use of nursing theories in health visiting practice, Luker (1980:56) selected King's (1971) conceptual framework for nursing as her frame of reference in her doctoral study of the effects of focused health visitor intervention on elderly women. In her thesis, Luker considers King's (1971:25) definition of nursing to apply to health visiting 'in that it encompasses a developmental perspective which health visitors tend to favour' (Luker 1980:58). Nevertheless, in her contributions to the published literature, she does not especially promote the use of King's (1971) conceptual framework for nursing (nor King's [1981] subsequent theory for nursing) for health visiting practice. This, possibly, is because she considers that, as 'individuals' and not composite clientele (such as the family) are included in King's (1971:25) definition of nursing, King's definition is too narrow for the breadth of health visiting practice (Luker 1980:58). This need for nursing theory to be relevant to family situations as well as to individual clients has since been addressed in a text edited by Clements and Roberts (1983). In this text, numerous nurse theorists take up the challenge of applying their theory to family situations, many finding this to be more difficult than they had expected (Clements and Roberts 1983:xi). Finally, while Luker does not favour any one particular framework for health visiting practice, she does advocate that health visiting care should be structured upon a philosophical foundation of known dimensions, a definable frame of reference, whether this is a body systems, a needs, a disease, or an

activities of daily living oriented framework (Luker 1979:1488).

Other health visitors have also considered and contributed to various facets of theoretical thinking in health visiting, although none specifically to the cultural dimension of practice. For instance, and as noted in Chapter One, a Working Group of the Education Committee of the C.E.T.H.V. (1977) investigated the principles of health visiting. These investigators helped to make explicit several premises which they considered fundamental to health visiting practice. Even so, as a level of theory development, their work is at a descriptive level. Indeed, Capel (1978:36) considered that a 'coherent body of thought' was still needed to explain rather than simply describe health visiting practice. Robinson (1982:24) has also added conceptual insight into the practice of health visiting, proffering two differing theoretical perspectives within which she suggests student health visitors are taught implicitly to practise: the one, clinical and problem-oriented, the other, relationship-centred. Robinson (1982:85) points out that, depending upon which theoretical perspective is given greater emphasis, not only may individual health visitors 'define their objectives and priorities by fundamentally different criteria', but without truly recognizing the basis of their decision making.

C) CLARK'S MODEL FOR HEALTH VISITING

More recently, in taking up the gauntlet of delineating a clearer theoretical foundation to health visiting, Clark (1985b) has developed a systems-based conceptual model for health visiting which she also sees as one 'which can be used in any field of nursing' (Clark 1982:129). Visualized as within a shared environment, the client and health visiting systems are linked by a 'connective' (Chin 1961:207) which allows for the 'autonomy and individuality' of each

system and the 'limited and special nature of the relationship between them' (Clark 1985b:249). Rather than being depicted as 'a series of separate horizontal lines' (Clark 1980c:535), the connective is envisaged as a 'continuous spiral' which reflects the 'serial' nature of health visitor-client interaction through time (Clark 1986:102). Emphasizing that a model for health visiting must be in keeping with 'health visiting practice and ideology', Clark (1985b:147; also 159) considers that such a model must be relevant to a family (or a group) as a unit as well as to individual clients, and should focus upon 'needs rather than problems; stability rather than change; and continuity over time' (Clark 1986:99).

Based on her analysis of tape recorded client-health visitor interactions (and subsequent health visitors' reflections on them), the 'prescriptive literature' (Clark 1985b:166) and her own experience as a practising health visitor, Clark (1985b:169) argues for a conceptual 'constellation' comprising: 'health', 'need', 'prevention' and 'coping'. These she sees as forming 'a metaparadigm' ('paradigm' in Clark 1986:99) 'of health visiting within the metaparadigm of nursing'. In this model, which has a well-defined preventive orientation, health visiting is seen as being concerned with client needs. Needs are defined as 'tangible and intangible items' which each person must have in 'satisfactory amounts in order to attain and maintain' a 'dynamic equilibrium, a state of balance' between themselves and the environment (Clark 1986:99). Health depends on the fulfilment of these needs, and a health 'problem' results from either under- or over-fulfilment (an imbalance which may be actual or potential) of these needs; for example, from a lack of knowledge (Clark 1985a:24; 1985b:293). Although Clark (1985b:148) rejects the idea of health visiting being concerned primarily with problems (a view not held by all health visitors [e.g. Luker 1985:129-130] or clients [e.g. Clark 1984:267]), she

nevertheless retains the term as one of the 'elements' (Clark 1986:99) of her model but with a specified needs-related definition. In utilizing Chin's (1961:205) notion of a 'dynamic equilibrium' (whereby the equilibrium 'shifts to a new position of balance' after each disturbance), Clark adds a developmental dimension to her model, thus allowing for growth, development and progress within either or both systems (Clark 1985b:187-188).

Following Neuman's (1982) ideas, both the client-system and the health visitor-system are each envisaged as a 'core' surrounded by 'rings'. These 'rings' offer the encircled system protection against harmful 'stressors' (such as social isolation, poor housing and workload pressures), yet admit inputs which are beneficial in meeting the system's needs (Clark 1985b:192,250,273; 1986:101). Reference is made to various factors that are considered to form part of the health visitor-system (Clark 1980a:419; 1985b:233), and the model directs its primary focus to how the activity of health visiting can help to retain, maintain and strengthen the client-system's 'defences'. Although the goal of health promotion, as such, was 'rarely mentioned explicitly' in the research findings, Clark (1985b:225) found the accounts of health visiting practice contained in the research data to be 'entirely consistent with this goal'. 'Making a relationship', together with 'helping people to cope' and 'just checking', emerged from the findings as health visiting goals considered intermediate to the promotion of health. Even so, prevention (primary, secondary and tertiary) is presented as the dominant mode of health visiting intervention. Through various strategies, such as anticipatory guidance and health teaching, the health visitor aims to maintain and, over time, to improve her client's health. This is achieved by 'heading off harmful stressors' (whether physiological, psychosocial, environmental, behavioural or developmental) by 'enhancing' her client's 'resistance resources and coping abilities, and by

facilitating the entry of beneficial inputs' (Clark 1986:100). 'Coping' is seen as the activity by which the client 'strives to maintain' his or her system's equilibrium (Clark 1986:99).

Essentially, Clark (1985b:190) sees the core of her model to be:

the conceptualisation of health visiting as a particular kind of social interaction which takes place within the framework of a particular kind of professional-client relationship.

In using a 'connective', and, in so doing, drawing upon Chin's (1961:207-208) 'intersystem' ideas, she allows 'the social contract or mutual role expectations which exist between a professional and a client' (Clark 1985b:188) to be visualized separately. The negotiation of a relationship, especially one based on trust, is seen as an important stage in the health visitor-client consultation (Clark 1985b:264,275), with recognition being given to the existence of a definite reciprocal element within the health visitor-client relationship (e.g. Clark 1982:131; 1985b:191,194).

By concentrating on the actual health visitor-client encounter, Clark has formulated a model for health visiting which has been found to be of use in field practice (Clark 1986:97). Representing an important theoretical step forward for health visiting, Clark's model provides a springboard for further theoretical thinking. In addition, because of their visual simplicity, the various diagrammatic representations of differing aspects of the model provide easily remembered *aides mémoire* for the practising health visitor to utilize (note Meleis 1985:328). And, although emphasis is placed on the nature of the connective as being:

. . . determined, or at least influenced, by . . . the environmental context which the health visitor and the client both share, for example the culture in which they both live, and the health care system,

(Clark 1985b:249,250)

minimal emphasis (both in the model and throughout Clark's discussions relating to her model) is given to the influence cultural factors have on the process of health visiting. Yet, inasmuch as Clark has drawn on Antonovsky's (1979) ideas of generalized resistance resources to stressors, it is possible that she is in accord with his belief that 'probably the most powerful' resource of all is to be found in the 'ready answers provided by one's culture and its social structure' (Antonovsky 1979:119). Nevertheless, this is not made explicit in her thesis.

Thus, while Clark has contributed substantially both to the development of theoretical thinking in health visiting and to the provision of an orientation to practice, for which she has developed a needs-based system of records, her model does not link health visiting to the reality of the multi-cultural society which it serves. Not only will this be discussed further in the next section, but also how a model for health visiting in a multi-cultural society might be envisaged.

D) MODELS FOR HEALTH VISITING – THE CULTURAL DIMENSION

i) Clark's model and the cultural dimension

In the previous section, it was seen that Clark's (1985b) systems-based model does not address the cultural dimension of health visiting practice. Indeed, Clark rarely use the word 'culture', or allied terms, in regard to her model. And, although she presents 'socio-cultural' as one of the four components in her diagrammatic representation of the client-system (for which

she uses very similar terminology to that used by Neuman [1982:12–13]), Clark's diagram is preceded by the observation (and a discussion in which examples are provided) that the data suggest that health visitors view the client as a person 'made up of physical, psychological, social and developmental components' (Clark 1985b:237–239). The terms used for the five 'types of stressors' chosen for the 'Family Assessment/Plan' include neither the term 'cultural' nor the term 'socio-cultural'. Instead, the terms used for the five types of stressors are: 'physiological, psycho-social, environmental, behavioural (lifestyle), and developmental (life events)' (Clark 1985b:288,299). However, Clark does use the term 'culture' when discussing the 'connective' between the health visiting-system and the client-system. Indeed, when noting that the environmental context influences the connective between the two systems, Clark (1985b:250) refers to this as being shared by both the client and the health visitor and, as previously noted, cites 'the culture in which they both live' as an example. In so doing, she presents this feature of her model as within a unicultural perspective.

Whilst Clark appears to consider the terms 'social' and 'socio-cultural' as interchangeable, she omits to define her use of the term 'social'. When she does provide a direct example pertaining to social factors, this example relates to the health visitor's concern that the mother will make friends within the village and that her toddler will both mix with other children and join the local playgroup (Clark 1985b:238). The various sample documentation forms that she offers for health visiting practice also fail to provide adequate clarification of her use of the term 'social' (note Clark 1985a:24; 1986:104; also 1985b:299). Thus, it is difficult to ascertain to what extent Clark envisages her model relating to the practice of health visiting in a multi-cultural society.

As previously noted, Clark's model is based, in part, on the prescriptive health visiting literature which, as seen in Chapter One, presents health visiting within a unicultural perspective. The model is also based on the findings of tape recorded interviews of only ten selected health visitors and ten selected families in one area of South East England, the final selection of the ten (from a total of thirty-one) families being made 'mainly on pragmatic grounds', such as 'the completeness of the data set' and 'the quality of the recordings' (Clark 1985b:52). Nevertheless, Clark (1985b:52) endeavoured 'to ensure variety', for instance, with regard to parity and social class. However, the information provided on 'ethnic origin' is imprecise. Five of the ten sample families are described as 'both parents born in UK', whilst one is described as 'both parents non-UK', and four as 'mixed' in regard to 'ethnic origin' (Clark 1985b:51). Even so, one family is identified within a transcript as being 'a small, tightly knit Irish family' (Clark 1985b:236) and, elsewhere, a mother is noted as being unable to 'speak English very well' (Clark 1985b:232). In another transcript, reference is made to an 'extended family' (Clark 1985b:252). Thus, it would seem that not all the families selected were of the dominant culture. In addition, the research area was noted as having a moderately high immigrant population (Clark 1985b:49). Nevertheless, cultural aspects are not focused upon, not even in regard to the unmarried mother (living with her parents) whose child was fathered by 'a Pakistani' (Clark 1985b:280). Hence, not only is it difficult to determine the extent to which Clark views her model as relating to multi-cultural health visiting situations, but it cannot be presumed that the four concepts which form Clark's paradigm are adequate for health visiting in a multi-cultural society.

Although Clark (1985b:175) observes in her thesis that the health visitor's role is to identify, detect and meet needs, she does not address how this

occurs in multi-cultural situations. The possibility of cultural disparities between the health visitor and the client are neither highlighted nor explored. Indeed, Clark (1980b:487) herself acknowledges that her diagrammatic representation of the health visitor-client consultation presents the client-system as 'homogenous and passive' and omits to take into account 'the infinite variety of clients and client response'. At times, Clark's writings about her model suggest a degree of professional dominance. For instance, she does not consistently make explicit that it is the client who attains and maintains health, as in the following quotation:

The health visitor's job is to maintain the [client's] steady state by ensuring the fulfilment of needs by heading off harmful stressors, and by building up the person's defences against them.

(Clark 1985a:24)

Another example is the health visitor 'systematically surveying the client system for breaches in its integrity' (Clark 1985b:295), an idea which incorporates the concept of 'just checking'. However, the lack of emphasis on the client's contribution to the consultation may account for why the facilitating nature of health visiting does not always emerge clearly. Although systems terminology provides a somewhat impersonal tone, a more facilitating approach would be for the health visitor 'to help the client to survey his own system for breaches in its integrity'.

Clark (1982:133) does recognize that common goals are not necessarily shared by the health visitor and the client. She also recognizes the autonomy of the client in her use of Chin's (1961) intersystem connective, and when observing that counselling involves the individual being assisted 'to make his own decision from among the choices available to him' (Clark 1985b:219 - quoting Nurse 1980:2). Even so, for the most part, Clark's model is described with regard to interventions that the health visitor makes, with the model's

potential to delineate client involvement receiving minimal exploration. Yet, client involvement is a fundamental necessity in 'making a relationship' and in 'helping people to cope' (Clark 1985b:225). It is also a basic prerequisite if the identification of stressors in clients' lives and of the available resources each client has to ward off, or manage, those stressors is to be a collaborative process between the health visitor and the client.

ii) Health visiting in a multi-cultural society

Field level considerations

In a multi-cultural society, health visitor-client encounters cannot be presumed to be intra-cultural. Therefore, for Clark's model to be relevant to contemporary British society, it must be clearly linked to the multi-cultural composition of health visiting's clientele. This, I suggest, would involve the interactionist features of the model being conceptualized with regard to inter- as well as intra-cultural health visitor-client encounters, taking into account the need for health visitors to discern and utilize data relating to their clients' ethnic identity and background. In so doing, Clark's model would relate more explicitly to the client's ability not only to promote his or her own health but also within the parameters of his or her own culture.

In addition to Clark's model for health visiting needing to be more clearly linked to the reality of health visitors serving a multi-cultural clientele, a model focusing entirely on the cultural dimension is needed to provide a clearer conceptual basis to health visiting in a multi-cultural society. Not only does such a model need to address the cultural perspective of the overall health visiting service, but also the practice of culturally relevant health visiting at field level. As this includes both inter- and intra-cultural health visitor-client

encounters, the model requires explicit interactionist features. With this in mind, the concept of reciprocity (as relating to nursing and health visiting) will be considered in a subsequent sub-section of this chapter. Thereafter, in Chapter Three, this concept will be re-discussed, but in relation to the transcultural perspective of health visiting. However, a central requirement to providing a culturally relevant health visiting service is the feasibility, and potential of, health visitors discovering and utilizing cultural data in everyday field practice. This concern will also be considered and, in so doing, the experience and insight of North American nurses who have developed, and continue to develop, transcultural and multi-cultural nursing at a professional level will be drawn upon.

Essentially, the aim of transcultural nursing is to provide care that is congruent with the client's values, norms and practices. This means that the nurse must be able to identify her client's 'major [cultural] values, beliefs and behaviors', certainly 'as they influence and relate to [the] particular clinical setting or health problem' (Tripp-Reimer et al. 1984:79). Cultures, however, are dynamic, and an individual never learns his culture in its entirety, only the contours as these relate to the life he leads (Orque 1983:12). Therefore, a fundamental prerequisite to the provision of culturally attuned nursing care is that the nurse must be proficient in discovering cultural information for herself, drawing upon, but not being dependent upon, the wealth of cultural knowledge available in the literature.

Several North American nursing models focus specifically on the cultural dimension of nursing care, providing nurses with cultural assessment guides for ascertaining culturally relevant and client-oriented data at field level. These guides are intended to enable the nurse to visualize her client's health related

needs and concerns in the context of the client's culture, and as expressed and experienced by the client, so helping her to offer more culturally sensitive and appropriate nursing care (note Orque et al. 1983).

One of the most comprehensive assessment guides is Brownlee's (1978) 'cross-cultural guide for health workers'. In covering the following topics:

General community information, communication, language, the family, politics, economics, education, religion, health beliefs and practices, traditional and modern health systems,

Brownlee utilizes a very understandable 'What-Why-How' approach to data collection. This guide, however, is criticized as being too comprehensive for individual client assessments, and better suited for community assessments and nursing education curricula (Tripp-Reimer et al. 1984:79).

Leininger (1985a:211) offers another guide which includes a diagrammatic model. Seven cultural components:

Technological factors, religious and philosophical factors, kinship and social factors, cultural values and beliefs, political and legal factors, economic factors, educational factors,

are depicted within a semi-circle (or 'Sunrise') which represents the client's social structure and world view. These components are seen as influencing the client's 'care and health patterns and expressions' and as being important to nursing actions and decisions, especially cultural care preservation, accommodation and repatterning.

A third assessment guide, Orque's (1983:10,37) 'ethnic/cultural system framework', incorporates a different range of cultural components, eight in all:

Religion, art and history, value orientations, social groups' interactive patterns, language and communication process, healing beliefs and practices, family life processes, diet.

These are depicted as segments of a wheel, the hub of which represents basic human needs. The wheel may also be envisaged as set within a triangle with the apices located in three interconnecting systems: biological, sociological and psychological.

In providing an overview of cultural assessment guides, Tripp-Reimer et al. (1984:80) proffer four dominant focal areas which nine recognized guides cover, some more comprehensively than others: values, beliefs, customs and social structure components. Although cultural assessment guides/models vary, they provide cognitive maps to direct the nurse's thinking along clearly defined lines. As maps, they aim to direct attention to aspects 'that will provide the most information relevant to the purpose of the observation' (Visintainer 1986:33), in these instances, to discover health related cultural knowledge about clients and patients. By the inclusion of what is deemed to be relevant to the purpose, maps thereby exclude what the map-maker considers irrelevant or less relevant. However, while 'the effectiveness of maps depends on their ability to abstract accurately the essential aspects of the territory' under consideration, 'the goodness-of-fit becomes the responsibility of the map-user not the map-maker' (Visintainer 1986:35). Therefore, although cultural assessment guides provide health visitors with cognitive maps (each relating to differing terrains within the cultural dimension of care) for use in field practice, how they are used depends on the health visitors' skills and abilities in cultural discovery. If, then, health visitors are to glean health related cultural knowledge about their clients in everyday field practice, they need relevant skills and abilities to so do; a cognitive map, however helpful, is not enough.

Ethnographic approaches to data collection (which include ethnographic interviewing, participation and observation) are well-recognized approaches to

eliciting cultural information. Indeed, various North American (and other) nurses advocate the use of ethnographic approaches to cultural discovery in nursing practice (e.g. Leininger 1984) as well as emphasizing the relevance of anthropological perspectives, knowledge and insights to the provision of culturally relevant nursing care (e.g. Brandl and Tilley 1981:28; Dougherty and Tripp-Reimer 1985:220-224; Wenger 1985:314 – note also Chrisman 1982). These approaches have received little attention within nursing circles in the United Kingdom. For ethnographic approaches to data collection to be accepted as integral to the provision of a culturally relevant health visiting service, two conditions must be met. First, it must be feasible for health visitors to use them in everyday field practice, and, second, health visitors need to learn skills and abilities in ethnographic approaches to data collection, preferably, as Wenger (1985:292) advocates, under the mentorship of someone well-versed in their use. In using these approaches, health visitors need to be aware of the ethnocentricity of their own world view. Therefore, they need to emancipate themselves affirmatively and consistently from their own cultural view, allowing themselves to become 'perceptive, sensitive, and receptive' to diverse cultural beliefs and ways of living (Leininger 1984:113).

iii) Cultural discovery in field practice

In Chapter One, health visiting was seen to be an unsolicited, client-oriented service based on a participative process between the health visitor and the client. Health visitors aim to establish and, thereafter, maintain a health visitor-client relationship within which the client can receive empathy, support, guidance and health related knowledge in a way that she or he finds acceptable. However, for this to occur in a culturally attuned manner, whether in intra- or inter-cultural situations, the health visitor must be able to visualize

her client within the context of his or her culture. Only by so doing can she begin to discern how her client perceives his or her health related needs and concerns, what culturally defined avenues are open to her client to deal with them, and what cultural values influence her client's decision making. This, then, involves the health visitor being able to perceive, interpret and collate a wide range of cultural cues, utilizing an appropriate cognitive map for so doing.

Although not described as they relate to the cultural dimension of nursing care, Carnevali's (1983:48-58; 1984:28) seven elements of the diagnostic process in nursing provide insight into the process of eliciting and interpreting culturally related nursing data. These elements are:

pre-encounter influences, entry into the field, developing cue clusters, activation of diagnostic explanations, directed data search, evaluation of diagnostic possibilities, and assignment of a diagnostic label.

If viewed as they might relate to health visiting in multi-cultural situations, these elements help to shed light on the reality of the collection, collation, analysis and utilization of cultural data by health visitors in field practice. However, 'rather than rigid steps', these seven elements are intended as 'a potential pattern of use' (Carnevali 1984:28).

It is only very recently that the concept of nursing diagnosis has been introduced into the United Kingdom (Draper 1986:37; cf. Gebbie and Lavin 1974:250). For the most part, the term 'diagnosis' has been viewed in relation to 'the process by which medical practitioners synthesise data into a succinct statement of a problem' amenable to medical therapy (Draper 1986:37). Applied to health visiting, a diagnosis is a label given to an actual or potential client problem, or concern, which is known to be amenable to health visiting intervention (Dougherty 1985:787; Draper 1986:37; Gebbie and Lavin 1974:250). It encompasses both the client problem and the probable reason for the same

(Bower 1982:125–126). Reached through a process involving data collection, diagnostic judgement and diagnostic labelling (Gordon 1982:13–14), the accuracy of the diagnosis 'rests on the completeness of the data collection phase' and the health visitor's 'ability to interpret the data' (Bower 1982:126). Should the client assessment be made within the conceptual parameters of a model for health visiting, the diagnosis is formulated in accord with that model. For example, a diagnosis in accord with Clark's model is the label given to an 'actual or potential imbalance in the [client's] health equilibrium' (Clark 1985b:293). Whilst nursing diagnosis is both process and product, in this sub-section, it is the process that is considered and explored.

The first of Carnevali's seven elements is concerned with '**pre-encounter influences**' which shape the nature of how subsequent information is acquired, processed and labelled. Pre-encounter influences include the health visitor's education and experience, the environment in which health visitor–client encounters take place (e.g. client's home, child health clinic), the problems that clients usually present, and the time available for each client. Thus, the diagnostic process is shaped by the service's educational system and its organizational environment, together with the values which permeate both. For instance, only if it is United Kingdom health visiting policy that all health visitors should be educated to become proficient in collecting data about their clients' ethnic identity and background will diagnoses (and subsequent interventions) be based routinely on cultural data. The policies of the local health authorities and boards are also influential in shaping the diagnostic process. For example, the priority accorded to specific client groups influences the type of experience and areas of expertise that each health visitor gains and develops. In addition, locally determined staffing ratios influence the time health visitors have available to care for each client. Therefore, where time is

at a premium, it becomes especially important that health visitors are adept at recognizing cues that carry cultural significance. In this way, they are able to glean pertinent cultural information without spending unnecessary time pursuing inappropriate avenues of inquiry. However, for this level of proficiency to be realized, the health visitor needs to develop (through tuition and field experience) a store of health visiting knowledge relating to the traditions of several cultures and as appertaining to a variety of client groups.

Pre-encounter influences also include information about the individual client and the locality in which he, or she, lives. Hence, the health visitor's work situation is an important factor. For example, a health visitor attached to a general practitioner's surgery has greater ease of access to her client's medical history. However, should the general practitioner's caseload be drawn from a wide catchment area, she may have difficulty developing an adequate knowledge of her client's neighbourhood and, therefore, be less able to appreciate her client in the context of his or her own locality.

'Entry into the field' is Carnevali's second element. This relates to the actual encounter and, therefore, includes both the health visitor-client relationship and the context and circumstance in which the encounter takes place. In multi-cultural situations, this encompasses the health visitor's ability to establish and maintain inter-cultural health visitor-client relationships. It also includes her ability to convey to her client her concern to understand, respect and offer care in accord with the client's cultural world and as the client sees this to be. This element sets the stage 'for efficient data sharing' (Carnevali 1983:53). In Carnevali's (1983:53) words, the purpose of entering the 'data field' is:

. . . to notice the cues, sort out the relevant from the irrelevant ones, and organize them into related clusters – in a limited time period. This involves helping the client provide relevant data as efficiently and comfortably as possible.

'Developing cue clusters' forms the third element of the process. Based on past experience and knowledge, the health visitor learns to recognize and coalesce cues that, in unison, provide significant cultural information relating to the focus of health visiting concern. This element is concerned with perceiving and coalescing individual cues into patterns of recognition and organization that are both meaningful to the individual health visitor, and relevant to health visiting practice. Subsequently, these 'knowledge packets' may be retrieved to 'serve as guides to further observation and thinking' (Carnevali 1983:33). For instance, drawing upon her cultural knowledge base, the health visitor identifies disparate cues which, coalesced, help her to discern the cultural values that govern and direct her client's life. By so doing, she is then able to tailor her advice more closely to the reality of her client's situation. With new cultural insights being added to previous insights, the health visitor builds up a store of knowledge based on individual and coalesced cues, a store that is reconsidered, revised and added to with each client contact.

In addition to identifying and addressing immediate health concerns, health visiting practice involves identifying potential areas for health promotion which the health visitor can address at future visits. Therefore the health visitor intentionally clusters cues that relate to the client's way of life in general as well as to the client's immediate concerns. For example, by accumulating cultural information regarding colour preferences and usage, the health visitor coalesces cues into a knowledge packet which she can draw upon to design culturally appropriate health education material as well as to use in the formation of diagnoses.

With an ever-increasing wealth of knowledge about various cultures as they relate to various client groups and client situations, the health visitor develops a fund of culturally related health visiting knowledge. This forms a 'cerebral library' (Carnevali 1983:56) which can be activated to provide possible diagnostic explanations for what is perceived in subsequent health visitor-client encounters. This allows her to move into the fourth element, that is, the **'activation of possible diagnostic explanations'**. While in each client encounter notable individual cues as well as cue clusters may activate her cultural knowledge base (so helping her to identify client problems more astutely), the health visitor maintains an open mind, constantly reviewing the alternative ways in which the data may be interpreted. Throughout, 'the movement from [client] data to diagnosis does not seem to occur in one giant mental leap, but rather, in tentative testing steps' (Carnevali 1983:55).

The fifth element is the **'directed data search'**. As the health visitor becomes more experienced in cultural discovery, she begins to know what cues may reap greater rewards than others for cultural understanding in various situations, and with regard to varying client groups and varying health visiting problems. Her accumulated cultural knowledge base allows her to look for, notice and zero in on specific cultural information. For example, over a period of time, she may have clustered cues relating to thresholds, knowing that these are well-recognized in the anthropological literature for their cultural significance in regard to transitions. Such cues may relate to locations (e.g. door lintels), to symbolic entities (e.g. rites of passage such as marriage and childbirth) and, also, to functions attributed to certain people (e.g. mothers-in-law having gatekeeping functions in extended Indian families). Then, at a later date, when helping a client cope with a transition period in life, she is able to draw upon her cultural knowledge of thresholds and channel her

'data search' in this direction.

The final two elements are the '**evaluation of diagnostic possibilities**' (Carnevali 1983:57) and the '**assignment of a diagnostic label**'. These elements include the health visitor being cautious to make a diagnosis that can be substantiated by the client data and, therefore, being constantly alert to other diagnostic possibilities. In multi-cultural situations, the culturally conscious health visitor ensures that any diagnosis is reached not only with regard to data relating to the client's ethnic identity and background, but to how the situation or problem is described and experienced by the client. Thus, the identification and validation of client problems (actual and potential) is a mutual activity undertaken by the client (who holds the cultural data base) as well as by the health visitor. In addition, the client is helped to handle actual, or potential, problems and concerns with full regard to the cultural parameters within which he or she lives.

By considering Carnevali's seven elements of the nursing diagnostic process as they might relate to the cultural dimension of health visiting, it has been possible to look more precisely at the process of gleaning and utilizing cultural data in multi-cultural health visiting situations. Whilst this discussion regarding Carnevali's ideas is but exploratory, it helps to illuminate some of the dynamics involved in providing a culturally relevant health visiting service at field level. This illumination, in turn, highlights the fact that if a model of health visiting is to be relevant to the delivery of culturally sensitive and appropriate care, then the health visitor-client interface must be taken into account, that is, in addition to addressing the overall health visiting service which both educates and supports the practitioner in the field. While this sub-section has made reference to some of the practical and conceptual skills and abilities needed to

provide a culturally attuned health visiting service at field level, the next section will look at one concept related to the maintenance of the health visitor-client relationship, namely reciprocity.

E) RECIPROCITY IN HEALTH VISITING AND NURSING

'Reciprocity' as a term refers to either a state or a relationship in which there is mutual action, influence, giving and taking, or a correspondence between two parties or things. As terms, 'reciprocity' and 'reciprocal' are used frequently in relation to 'transactions in which some sort of exchange occurs . . . whether immediate or deferred' (MacCormack 1976:90). In this sub-section, the concept of 'reciprocity' will be considered in relation to nursing and health visiting. For the most part, this concept is used in connection with nurse-patient relationships as well as with the nursing process. Although seldom given a cultural emphasis, reciprocity will be seen in Chapter Three to be integral to the transcultural perspective of health visiting.

On the whole, the reciprocal nature of nurse-patient and nurse-client relationships has been more clearly emphasized in the North American nursing literature than it has in the British nursing literature. Not only do Leddy and Pepper (1985:240) consider 'reciprocal relationships' to be 'the basis of the nursing process' but, in relation to paediatric nursing care in Canada, Grossman-Schulz and Feeley (1984:42) consider 'a genuinely supportive relationship' to be 'predicated on a sense of mutual reciprocity rather than unidirectional aid'. King (1981) also discusses the reciprocal nature of nurse-client relationships which she views as intrinsic to her theory of goal attainment. According to King (1981:150), the nurse and client are:

. . . in a reciprocal relationship in that the nurse has special knowledge and skills to communicate appropriate information to help [the] client set goals; [the] client has information about self and perceptions of problems or concerns that when communicated to [the] nurse will help in mutual goal setting.

'Past experiences, present needs, expectations, and goals' are seen as influencing how both the nurse and the client 'reacts to the other', with 'a reciprocal spiral' developing in which 'the individuals continue to interact or withdraw from the situation' (King 1981:84). Both nurse-client interactions and subsequent nurse-client transactions are 'seen as reciprocal' (King 1981:81,84).

For Travelbee (1971:119,124), the purpose of nursing is accomplished through a 'human-to-human relationship' between the nurse and the patient (whom she refers to as the 'ill person'). This relationship is seen to be 'a reciprocal process' in which 'the barriers of title, position and status must be transcended' if the nurse and the ill person are to perceive the other as a human being. The terminus of all nursing endeavour, according to Travelbee (1971:120), is 'rapport' which she equates with the concepts of 'human-to-human relationship' and 'relatedness'. Rapport is only experienced, and a human-to-human relationship established, once the nurse and the ill person have progressed through four sequential stages: the original encounter, emerging identities, empathy, and sympathy. The relationship is considered to be reciprocal in that both the ill person and the nurse 'engage in similar activities' (e.g. observation and learning) as they move through each of the four stages (Travelbee 1971:124,150). For the most part, Travelbee's work is concerned with assisting individuals and families to cope with, and to prevent, the experience of illness and suffering and, if necessary, to find meaning in such experiences.

The presence of 'a reciprocal relationship' is also an integral feature of Williamson's (1981) systems-based model of 'mutual interaction', a North

American nursing model which embodies the concepts of 'collaboration' and 'collegial negotiation' between client and nurse. In this model, not only are 'interdependence, sharing and trust' visualized as evolving (with 'dominance and dependence' diminishing), but the phase in which goals are mutually determined is seen as representing 'a reciprocal relationship based on equal but different contributions of nurse and client' (Williamson 1981:105-106). More specifically in relation to community nursing, Spradley (1981) observes that all stages of client-community nurse relationships involve 'reciprocal influence and exchange'. Not only does 'nurse-client interaction' (which is visualized conceptually as a 'permeable structure') involve 'mutuality and cooperation', but there is also a 'two-way sharing of information, ideas, feelings, concerns, and ultimately, self'. In this way, both the nurse and the client 'maintain a reciprocal exchange of information and trust through interaction' (Spradley 1981:99,100,102).

In addition to this North American emphasis on the reciprocal nature of nurse-client and nurse-patient relationships, the concept of reciprocity has received some emphasis within the British nursing literature, again with regard to the reciprocal nature of nurse-patient relationships. For example, McFarlane and Castledine (1982:5,7) consider nursing to be 'essentially a reciprocal and dynamically changing relationship between patient and nurse'. The concept of 'reciprocity' is also referred to, but not emphasized, in Chapman's (1985:81-95; also 1976a, 1980) model of 'the nurse-patient interaction process'. This model conceptualizes nurse-patient interaction as a form of social exchange which is 'viewed in the light of the nurse and patient seeking to meet their own needs and goals'. 'Debts' are incurred by both the nurse and the patient, and may be 'cancelled out' due to 'the multiplicity of interaction situations' whereby a balance will occur over time as both the patient's and the nurse's needs are

fulfilled through the nurse-patient interaction process (Chapman 1976a:111,117).

Although reference is made in the British nursing literature to the reciprocal nature of nurse-patient relationships, the concept of 'reciprocity' has not been discussed to any depth within the health visiting literature. To an extent, this may be because more attention has been given to the health visitor stages than to the client stages of the health visiting process (note Clark 1980b:487; cf. Henley 1986:25). For instance, although the C.E.T.H.V. (1977:30; also R.C.N. 1983:41) consider that the 'seeking out of [health] needs must . . . be a participative process' between the client and the health visitor, the concept of reciprocity is not discussed.

In her thesis *Health Visiting and the Elderly*, Luker (1980:57) suggests that a reciprocal relationship between the health visitor and client:

. . . could be said to be unrealistic in some circumstances where the client is unable because of his physical and mental condition to participate and assist in determining his own goals.

To an extent, Luker's comment reflects an observation made by Gouldner (1960:178) that:

. . . the norm of reciprocity cannot apply with full force in relations with children, old people, or with those who are mentally and physically handicapped.

Even so, not only does Clark (1985b:191) see the process of health visiting as being 'mediated by the process of reciprocal influence' between the client and the health visitor, but also considers this to be a basic assumption underlying her model for health visiting.

In providing an interpretation of 'reciprocity' as a 'spectrum of reciprocities', Sahlins (1972) highlights the complexity of this concept. His spectrum

emphasizes that there is 'a whole class of exchanges, a continuum of forms' in which the 'expectation of returns' is coloured by the 'spirit of exchange' (Sahlins 1972:191-192). By presenting the concept of reciprocity as a spectrum (one which ranges between two extremes ['generalized' and 'negative'] with the notion of 'balanced' reciprocity at the midpoint), Sahlins provides a conceptual flexibility which allows the concept of reciprocity to be useful to the breadth of health visiting practice. With health visiting being a participative process between the health visitor and the client, not only is Sahlins' notion of 'negative reciprocity' undesirable in health visitor-client relationships, but the centralized position of 'balanced reciprocity' represents the ideal.

Because there are no cultural differences to be bridged between the client and the health visitor in intra-cultural health visitor-client relationships, the ideal of 'balanced reciprocity' will be more easily facilitated and attained. In multi-cultural situations, however, not only must the health visitor have the skills and abilities for establishing and maintaining inter-cultural health visitor-client relationships, but she must also have the affirmative desire to understand and respect her client as a cultural being. Given that a unicultural perspective fails to ensure that all health visitors are prepared educationally to promote inter-cultural health visitor-client relationships, there is no assurance that the health visitor will have the requisite skills and abilities to facilitate and achieve 'balanced reciprocity' in multi-cultural situations.

Essentially, health visiting is an unsolicited service. Therefore, health visiting practice must be relevant to the needs and concerns as expressed by clients themselves if health visitors are to be effective in promoting their clients' health and well-being. However, to understand what a client considers to be his or her needs and concerns, the health visitor-client relationship must

be such that the client is willing to define and discuss them. To achieve this level of understanding, the health visitor-client relationship requires to be based on the concept of reciprocity, for instance, the reciprocation of knowledge and respect. In multi-cultural situations, reciprocity needs to be visualized in inter-cultural terms, a factor that has not received consideration in the health visiting literature. Therefore, in Chapter Three, the concept of reciprocity will be reconsidered but in regard to the cultural dimension of health visiting practice, and the concept of 'transcultural reciprocity' will be presented as an intrinsic feature of transcultural health visiting practice.

6. SUMMARY

In this chapter, I have considered transcultural and multi-cultural nursing as they have developed in various countries where professional nursing is practised. In addition, I have looked at a number of issues that are closely aligned to the provision of culturally sensitive nursing care and, in so doing, I have focused particularly on health visiting in the United Kingdom. I have also discussed three topics which are central to the maternal and child health remit of the health visiting service and which will be seen in Chapter Four to relate to the fieldwork. It was also noted that the discipline of anthropology has long been recognized in North America as providing a depth of understanding of human behaviour capable of enhancing nursing care in multi-cultural situations. It does not seem, however, to have made an impact on, or a contribution to, nursing in the United Kingdom comparable to its contribution in the United States of America. Indeed, a quotation from Leininger's book, *Nursing and Anthropology : Two Worlds to Blend*, is as relevant in this country at the present time as it was in the United States in the early 1970s:

It is rather strange that nursing and anthropology have been largely orbiting in their own spheres for many years, with only limited awareness of and interest in each others' fields and contributions to mankind.

(Leininger 1970:1)

Finally, in that an alternative cultural perspective for health visiting requires a clear conceptual basis, the relevance and development of theoretical thinking to health visiting, and nursing, has been discussed and described. Various health visitors were seen to have contributed to developing health visiting's theoretical foundations, with Clark's (1985b) systems-based model being the most recent important contribution. Nevertheless, no model addresses specifically the cultural dimension of health visiting. Not only is there a need for such a model, but one is required that is relevant to contemporary health visiting's multi-cultural clientele. This need will be addressed in the following chapter when a transcultural model of health visiting will be presented as more relevant to the role of the health visitor in contemporary multi-cultural Britain. In this model, the concept of reciprocity, which has been discussed in this chapter as it relates to nursing and health visiting, will be seen to assume transcultural dimensions.

CHAPTER THREE

THE ROLE OF THE HEALTH VISITOR THE TRANSCULTURAL PERSPECTIVE

- 1. Introduction**
- 2. The Need for an Alternative Cultural Perspective
for Health Visiting**
- 3. The Transcultural Perspective**
- 4. Transcultural Reciprocity**
- 5. A Transcultural Model for Health Visiting**
- 6. Considerations Regarding a Culturally
Appropriate Mode of Health Visiting Practice
for a Multi-cultural Society**
- 7. Summary**

1. INTRODUCTION

In this chapter, I present a transcultural perspective of health visiting, a perspective which, I suggest, is more in keeping with the multi-cultural composition and needs of contemporary British society than the unicultural perspective within which health visiting currently operates. Underpinning the transcultural perspective is both the notion of respect for the individual as a cultural being and the need for the health visiting service to be affirmatively responsive to the cultural diversity of contemporary multi-cultural Britain. This transcultural perspective of health visiting aims to relate to the following statements of nursing practice which are to be found both in the 1973 International Council of Nurses Code for Nurses (see I.C.N. 1977:xii-xiii) and in the U.K.C.C.'s (1984) Code of Professional Conduct for the Nurse, Midwife and Health Visitor:

Inherent in nursing is respect for life, dignity and rights of man. It is unrestricted by considerations of nationality, race, creed, colour, age, sex, politics or social status.

(I.C.N. 1977:xii)

The nurse, in providing care, promotes an environment in which the values, customs and spiritual beliefs of the individual are respected.

(I.C.N. 1977:xii)

Each registered . . . health visitor is accountable for his or her practice, and, in the exercise of professional accountability shall . . . take account of the customs, values and spiritual beliefs of patients/clients.

(U.K.C.C. 1984:2)

Sixteen characteristics (with similar foci to those discussed in relation to the unicultural perspective) are described as they relate to the transcultural perspective of health visiting. These characteristics are linked to the same five conceptual domains which formed the basis for the unicultural model of health

visiting. Although the same conceptual domains as used in the unicultural model are used in the presentation of a transcultural model for health visiting, they are described in transcultural terms.

2. THE NEED FOR AN ALTERNATIVE CULTURAL PERSPECTIVE FOR HEALTH VISITING

In Chapter One, sixteen characteristics relating to the value and educational systems as well as the organizational environment of contemporary health visiting were described, using the literature as a basis for so doing. Health visiting was seen to operate within a unicultural perspective. Thereafter, based on this characterization of health visiting, a unicultural model of health visiting was presented. This model focused on the domains of 'client', 'health visitor', 'health visiting', 'health' and 'environment'. Whilst the presence of other cultural groups in society are recognized within this unicultural perspective of health visiting, it was seen that the service nevertheless upholds the primacy of the dominant culture of the United Kingdom at practice, educational and organizational levels. In so doing, the multi-cultural composition of contemporary British society is not taken affirmatively into account in United Kingdom health visiting policies, at least, such that the practitioner in the field is aware of this affirmation.

Not only is there a lack of data on the ethnic identity and background of the service's clientele, but there is also a reluctance within the service to promote the collection of such data as routine field practice. For instance, there is a lack of health visiting related data concerning the cultural dimension of the developmental progress of children (e.g. school preparedness) despite

educational research findings indicating that culture is an important factor in relation to that progress. While the reluctance for cultural data to be collected routinely may be seen to be racially and politically expedient, it precludes the emergence of data that could be used to improve health visiting at both community and individual levels. For instance, without the collection of cultural data on the under-five year old population, the service is unable to assess and evaluate the cultural dimension of its child health remit. In general, both the collection of data on ethnic identity and background, and the alignment of health visiting services to the cultural composition of differing localities, are more a result of local initiative and enthusiasm (e.g. Bradford, West Yorkshire) than United Kingdom health visiting policy.

Although nursing in the United Kingdom is beginning to advocate the need for transcultural approaches to care (e.g. Wilkinson 1986:51), these have been part of nursing practice in the United States and Canada for some time, as seen in Chapter Two. However, with each country having differing historical backgrounds, it is understandable that the ways in which the differing nursing professions have responded to the multi-cultural composition of their country's population will be dissimilar. Nevertheless, with the U.K.C.C. (1984:2) code of professional conduct for health visitors emphasizing the need for health visiting practice to take into account each client's 'customs, values and spiritual beliefs', health visiting must look anew at the cultural perspective within which it currently operates. In so doing, it must also consider the ethnocentricity of its own values, attitudes and practices.

In addition to developing the ability to emancipate themselves from their own cultural view (note Barnard and Good 1984:182), health visitors need to be well-versed in collecting, collating, analyzing and utilizing cultural data if they

are to provide a culturally attuned service for a multi-cultural clientele. To achieve this, the health visitor must be adept at recognizing features of a client's culture which have relevance, whether directly or indirectly, to the promotion of the client's health and well-being. Such features include aspects of both the overarching institutions of the culture (e.g. religious practices and kinship networks) as well as the 'minutiae' of everyday life (e.g. cultural ways of caring for young children). The health visitor also needs to discover features which may be of particular relevance to health educational activities, for instance, colour symbolism. Then, in the collation and analysis of this data, underlying cultural values can be elicited and, thereafter, considered in regard to how they relate to the promotion of the client's health.

As noted in Chapter Two, there is no certainty that either health visitor or nurse education currently prepares all its practitioners to care for a multi-cultural society. Standard texts, revision texts and various examination papers reiterate this fact. For the most part, health visiting curricula reflect the population in which individual educational institutions are sited rather than British society as a whole (Sharman 1986a:personal communication). Hence, there is always the possibility of wide variations in the amount and type of preparation that qualifying health visitors receive for practising in multi-cultural situations.

For the most part, the responsibility of ensuring that student health visitors are prepared educationally to care for a culturally diverse clientele rests with the individual educational establishments, the United Kingdom health visiting syllabus providing considerable flexibility regarding curricula content. Sharman's (1985) discussion paper, *Ethnic Minority Groups*, has helped to provide a more clearly defined statement (certainly at English National Board

level [Sharman 1986b:personal communication]) that all qualifying health visiting courses should prepare their students to care for a multi-cultural clientele. However, there is still no certainty that all qualifying courses ensure that their students emerge prepared educationally for inter- as well as intra-cultural practice. Nor are practitioners, thereafter, supported within an organizational environment which is affirmatively responsive to the health needs and concerns of a multi-cultural clientele. Hence, an alternative perspective to the present unicultural perspective is required. Not only does this alternative perspective need to be one in which all practitioners are prepared educationally for inter-cultural practice, but also one in which they are supported organizationally in so doing.

3. THE TRANSCULTURAL PERSPECTIVE

An alternative cultural perspective, one within which the health visiting service can serve its multi-cultural clientele with greater cultural relevance and effectiveness than the unicultural perspective permits, is, I suggest, the transcultural perspective. In using the term 'transcultural', not only is the presence and the awareness of more than one culture implied, but also the co-existence of an affirmative desire to bridge and transcend cultural differences. It is this additional affirmative desire to both bridge and transcend cultural differences that distinguishes the notion of 'transcultural' practice from both 'inter-cultural' and 'multi-cultural' practice in this thesis.

Essentially, transcultural health visiting is visualized as a collaborative process in which the health visitor intentionally strives (note Travelbee 1971:119) to understand her client's culture and to develop a health visitor-client relationship through which she can both ascertain her client's

needs and help her client maximize his or her potential to achieve optimal health and well-being. Transcendence of cultural differences within health visitor-client relationships is visualized as essential if health visitors are to practise effectively in multi-cultural situations. 'Optimal' is seen both as contingent on unfolding circumstances and as mutually defined by both the client and the health visitor, or on behalf of the client if the client is entirely dependent (e.g. an infant).

In describing the transcultural perspective, similar foci to those used in characterizing the unicultural perspective are employed. Once again, seven characteristics relate to health visiting's value system, four to its educational system and five to its organizational environment. In addition, links are made to the conceptual domains of 'client', 'health visitor', 'health visiting', 'health' and 'environment' which, thereafter, are presented as the conceptual basis of a transcultural model for health visiting. Although links are made between the various characteristics and the five conceptual domains, they are not considered absolute in that characteristics may also be interrelated to other domains. In addition, the organizational environment and the educational system of the health visiting service are referred to in the model as the organizational and educational dimensions of the 'environment' domain. Thus, they are seen as part of the wider environmental dimensions of multi-cultural Britain. Again, the numerical position that each characteristic assumes in the subsequent composite list is indicated (e.g. § 1, § 2 etc.).

A) CHARACTERISTICS OF THE VALUE SYSTEM

i) Relevance of cultural knowledge

A fundamental characteristic of the value system of the transcultural perspective is **the affirmative emphasis accorded to the relevance of cultural knowledge to health visiting practice (§ 1)**. Not only is the importance of taking account of the cultural beliefs, values and practices of the service's clientele underlined by the code of professional conduct for health visitors, but the service also provides active encouragement and support for culturally attuned practice within both its educational system and its organizational environment. In helping clients maximize their potential to achieve optimal health and well-being, both the health visitor and the client determine what cultural resources are available to the client as well as the client's ability to utilize these resources. In helping the client to maximize his or her own potential for optimal health, the health visitor assumes a facilitating role in which not only are the client's individual preferences and capabilities taken into account, but also the client's cultural orientation. Within the transcultural perspective, all health visitors are prepared educationally to be proficient in collecting cultural data and to appreciate the relevance that this knowledge provides for enhancing the care and advice they offer their clientele. Cultural factors are recognized as relating to all areas of health visiting (e.g. maternal and child health, care of the elderly).

Having developed skills in collecting, collating, analyzing and utilizing cultural data during their qualifying courses, and/or subsequently, health visitors are encouraged to develop their own body of culturally related health visiting knowledge, and so be less reliant on information provided by other

health professionals and social scientists. By developing skills in cultural discovery, health visitors become personally aware of the variations that exist within and between cultural groups, including the cultural diversity within both white and black communities. With increased sensitivity to the dynamic element of culture, each health visitor is better able to avoid culturally stereotyping her clients. Whilst each health visitor is encouraged to build her own fund of culturally related health visiting knowledge, the need for cultural knowledge based on formal health visiting research studies is recognized and financially supported.

Overall, this characteristic of the transcultural perspective is one that pervades all aspects of health visiting, although it especially relates to both the 'health visiting' domain and to the organizational and educational dimensions of the 'environmental' domain of a transcultural model for health visiting.

ii) Independence of the practitioner

The emphasis accorded to the independence of the individual practitioner within the context of transcultural health visiting policies (§ 2) is another characteristic of transcultural health visiting. This characteristic is one which permits the health visitor to utilize approaches to practice which she herself considers to be most appropriate for her client. It also allows each health visitor the scope to develop and refine alternative modes of transcultural practices. Although the health visitor has a degree of independence which permits her to utilize approaches to practice which may be culturally inappropriate for her client, such approaches to practice are considered unacceptable.

During her qualifying health visitor education, each health visitor is socialized into practising within the transcultural perspective with the intent that she will utilize transcultural practices in all multi-cultural situations. Not only is it ensured that all qualifying, and qualified, health visitors are conversant with, adept at, and creative in using transcultural modes of practice, but that the organizational environment within which they work provides active encouragement and support for transcultural health visiting practice.

This characteristic is seen as relating to the 'health visitor' domain of a transcultural model for health visiting.

iii) Health visitor-client relationships

The emphasis placed on the use of inter- as well as intra-cultural skills and abilities in the development of all health visitor-client relationships (§ 3) is another characteristic of the value system of the transcultural perspective. Inter-cultural as well as intra-cultural skills and abilities relating to the establishment and maintenance of health visitor-client relationships are seen as essential for every health visitor to develop both during, and after, qualifying health visitor courses. Hence, all stages of inter- and intra-cultural relationship building, maintenance and dissolution are included in the communication and interpersonal skills taught and developed during qualifying and post-qualifying health visitor courses.

The notion of health visiting being a 'participative process' (C.E.T.H.V. 1977:30) between client and health visitor is actively emphasized, a process within which the client's 'personal philosophy and cultural value system[s]' is respected (C.E.T.H.V. 1977:30). A sense of interdependence and a willingness to

reciprocate cultural knowledge and respect with the intent that the relationship might be built on inter-cultural understanding and respect at an inter-personal level is considered integral to the transcultural health visitor-client relationship (note Byrne and Thompson 1978:128). The reciprocation of cultural knowledge and respect within the health visitor-client relationship (known as 'transcultural reciprocity') is considered to be a pivotal feature within the transcultural perspective, and will be discussed further in Section Four of this chapter.

This third characteristic is linked to the 'health visiting' domain of a transcultural model for health visiting.

iv) Selection of specific client groups

The transcultural perspective of health visiting is characterized by **the emphasis accorded to the selection of specific client groups for the foci of health visiting energies and resources wherein ethnic minority groups are excluded for reasons appertaining to their ethnic identity and background alone (§ 4)**. Only if there are additional factors (such as recent immigrant status, linguistic barriers and sickle cell anaemia) to direct such a decision are members of ethnic minority groups seen as belonging to a 'specific client group'. Instead, 'specific client groups' (which, for example, may be based on life-span, life events or life crises) are recognized as including members of all cultural groups. While immigrants may also be considered to form a 'specific client group' for the focus of additional health visiting energies and resources, the term 'immigrant' is not seen as applying to second and subsequent generations, nor is it viewed as relating only to black immigrants.

This fourth characteristic of the transcultural perspective is linked to the 'client' domain of a transcultural model for health visiting.

v) Educational and advisory approaches

The emphases accorded to educational and advisory approaches that are culturally relevant to the promotion of health and well-being of a multi-cultural clientele (§ 5) characterize the transcultural as well as the unicultural perspective of health visiting. Concepts (e.g. 'coping' [Clark 1985b:169]) relating to the goals (e.g. 'helping people to cope' [Clark 1985b:225]) pertinent to this characteristic are recognized explicitly as encompassing a range of cultural variations. Hence, health visitors working within a transcultural perspective aim to discover cultural knowledge in order that their health education and social advice might be culturally attuned to their client's cultural traditions and values.

Affirmatively recognized within transcultural health visiting is the importance of cultural values and value systems, what they signify to each client (whether an individual, family or community), and how they are expressed. In utilizing educational and advisory approaches to practice, the transcultural health visitor is aware that an 'emotional tone' (Bateson 1958:2, also 220) permeates each culture, that is, an 'ethos' which, 'like a flavor' (Kroeber 1948:294; also Bock 1974:371), accounts for the overall coherence and orientation of the cultural value system. In addition, the transcultural health visitor recognizes the importance of regularly considering and clarifying her own cultural values (both personal and professional [see McFarlane 1982]), as well as the importance of being alert to the fact that the ethnocentricity of her own values may inhibit her ability to provide culturally relevant health

education and social advice in multi-cultural situations.

Within the transcultural perspective, all cultural groups are recognized as having their own value orientations, forms of symbolism and preferred modes of learning. Because transcultural health visitors are conscious of the importance these features of their clients' cultural traditions and practices hold, they therefore shape their practice accordingly. As health visitors are prepared educationally to discover the beliefs, values and practices of their multi-cultural clientele through ethnographic approaches, health visiting texts provide guidelines for cultural discovery. They also provide knowledge relating to transcultural approaches to health promotion, including health education and the provision of social advice. In developing a repertoire of transcultural skills and abilities, each health visitor develops increasing expertise in being adaptable in her use of culturally attuned approaches in everyday field practice. She also increases her ability to discern and transcend inter-cultural differences that exist between herself and her clients.

This characteristic of transcultural health visiting is related to the 'health visiting' domain of a transcultural model for health visiting.

vi) Notions of collectivism and individualism

The transcultural perspective of health visiting is characterized by **the acceptance of the notion of collectivism as well as the notion of individualism (§ 6)**. Health visitors are prepared educationally to appreciate both collectivist and individualist approaches to living. For example, clients may belong to social groups which favour collectivist approaches to life in which the welfare of the individual is seen to be part of a corporate concern.

For these clients, the health visitor is able to provide advice that is relevant to such an approach, whether or not she herself is in accord with such an outlook in life. And, should the health visitor adhere to collectivist principles, her educational preparation allows her to provide advice that is attuned to an individualist approach. Thus, not only are transcultural health visitors prepared educationally to accept group-oriented as well as individual-oriented life-styles, but are able to promote health effectively within collectivist as well as individualist approaches to practice.

This sixth characteristic relates to the 'client' domain of a transcultural model for health visiting.

vii) Health and nutritional knowledge

Another characteristic of the transcultural perspective is **the recognition given to health and nutritional knowledge that is accepted as being both culturally relevant and efficacious to a multi-cultural clientele, whether or not this knowledge is based on Western science (§ 7)**. The transcultural health visitor recognizes and respects the health and nutritional beliefs held by her clients even though these beliefs may differ from her own, and whether or not these beliefs and practices are based on Western science. At all times, the health visitor aims to offer advice which is in keeping with her client's cultural traditions and practices. Even so, such advice is offered only when this is ethically acceptable within the health visitor's code of professional conduct. In some instances, when giving advice, transcultural health visitors may be able to dovetail the ideas and practices based on Western science with ideas and practices based on other belief systems. For example, when advising on antenatal nutrition, the health visitor may suggest foods that are mutually

relevant to sound antenatal nutritional advice based on two differing nutritional belief systems.

The promotion of the health and well-being of individuals, groups, communities and, ultimately, society is the overall goal of transcultural health visiting. 'Health' (which has its derivation in the Old English word *'haelth'* meaning 'whole') conceptually carries both inter- and intra-cultural emphases. However, unlike the unicultural perspective which emphasizes the intra-cultural variations of 'health' (for instance, 'health' is usually discussed with regard to being either 'a state of being' or 'a process of becoming' [C.E.T.H.V. 1977:20-21]), the transcultural perspective emphasizes the presence of both inter-cultural (note Tripp-Reimer 1984a:101) and intra-cultural (note Keller 1981) variations of 'health'. Thus, in the transcultural perspective, inter-cultural and intra-cultural variations of 'health' (and, similarly, of 'well-being') are both recognized and explored.

This seventh characteristic of the value system of health visiting relates to the 'health' domain of a transcultural model for health visiting.

B) CHARACTERISTICS OF THE ORGANIZATIONAL ENVIRONMENT

i) Hierarchical and bureaucratic organizational environment.

The transcultural perspective is characterized by **the affirmative support which is accorded to transcultural health visiting practices within the hierarchical and bureaucratic organizational environment (§ 8)**. Not only does United Kingdom health visiting policy actively support the belief that

health visitors should 'take account of the customs, values and spiritual beliefs of . . . [their] clients' (U.K.C.C. 1984:2), but affirmatively supports health visitors in bridging and transcending cultural differences in health visitor-client encounters. Indeed, a clearly defined United Kingdom health visiting policy openly promotes and supports transcultural practices in multi-cultural situations nationwide. With a clearly defined commitment at United Kingdom level to the transcultural perspective, the development of a culturally responsive health visiting service is therefore not dependent on local enthusiasm and initiatives alone. In addition, practitioners are encouraged to initiate and undertake field level research into transcultural issues, and this is seen as part of this same commitment to the transcultural perspective.

Within a transcultural perspective, there is an open commitment at both United Kingdom and local levels to ensure that Britain's multi-cultural society is offered culturally relevant health visiting care. Recognizing the importance of the cultural dimension of practice, health visitors are encouraged to collect, collate, analyze and utilize data relating to the client's cultural traditions and values as an on-going, client-centred activity in their field practice. Care, however, is exercised to ensure that such data are only utilized for the client's benefit. The need for health visitors to receive in-service education on topics such as the concept of culture, transcultural health visiting practices, and ethnographic approaches to data collection is openly acknowledged and catered for.

This characteristic, which is transcultural in the way in which it is operationalized, is related to the organizational dimension of the 'environment' domain of a transcultural model for health visiting.

ii) Local health authority influence on health visitor education

Another characteristic of the transcultural perspective is **the commitment of all local health authorities and boards to ensuring that student health visitors (who are gaining their qualifying practical experience in their localities) develop a sound grounding in practical aspects of cultural diversity, as well as receive adequate experience in providing culturally relevant care (§ 9)**. It is recognized affirmatively at field level that all clients should be able to be confident that every qualified health visitor has received adequate training and education in understanding the concept of culture (and allied concepts such as ethnocentrism), in the collection, collation and analysis of data on the client's ethnic identity and background and in the provision of culturally sensitive and relevant care. With the power of a commitment at United Kingdom level to ensure that this occurs routinely nationwide, the assurance that every student health visitor receives adequate experience in providing culturally sensitive and relevant care during supervised field practice (as well as in the classroom) is not a decision made only at local level. Thus, the transcultural perspective ensures that all qualifying health visitors develop sufficient competence in practising transculturally, and that local authorities and boards do not emphasize unduly local rather than nationwide needs and concerns when this detracts students from gaining adequate experience in transcultural practice.

This characteristic relates to the organizational dimension of the 'environment' domain of a transcultural model for health visiting.

iii) Data on ethnic identity and background

The transcultural health visiting service is characterized by **the emphasis placed on the routine collection of data on the ethnic identity and background of health visiting's clientele, and the provision of organizational support for the collection of such data in field practice nationwide (§ 10).** All health visitors are trained in utilizing ethnographic approaches to data collection as a means of discovering cultural knowledge as an on-going activity in whatever location they are practising. The use of skills in the collection of data relating to the client's ethnic identity and background, which are learnt and refined during both qualifying and post-qualifying courses (e.g. in-service education), is encouraged and supported by the local authorities and boards with whom health visitors are employed.

Essentially, the collection of data on the clients' ethnic identity and background is seen as a prerequisite for transcultural health visiting practice. Not only is this form of data considered fundamental to the provision of a culturally relevant health visiting service at practice level, but it is also considered important for the planning and provision of culturally relevant services at national and United Kingdom levels. In defining the term 'ethnic group', experience is drawn upon that has been gained in areas where data on clients' ethnic identity and background has been collected for health professional purposes over a length of time.

This characteristic of the transcultural perspective is one that relates to the 'client' domain of a transcultural model for health visiting.

iv) Health of infants and pre-schoolers

The emphases accorded both to promoting the health of infants and pre-schoolers, and to the importance of cultural factors in relation to the service's child health remit (§ 11) also characterize the transcultural perspective. Data relating to the ethnic identity and background of the under-five year old population are seen as essential in order that the health visiting related needs of infants and pre-schoolers may be better understood and responded to at local, national and United Kingdom levels of health visiting. Cultural factors, together with socio-economic factors, are recognized as important in regard to the various aspects of health visiting's child health remit, aspects such as: anticipatory guidance, developmental surveillance, nutrition counselling and immunization programmes. Indeed, the growth and the developmental progress of the under-five year old population is viewed affirmatively within cultural dimensions.

Within the transcultural perspective, the health visitor aims to understand how culture influences factors relating to the maternal and child health remit of the health visiting service (e.g. family planning decisions), and affirmatively seeks ways to transcend inter-cultural differences when working with parents (or/and significant others). This she does to help ensure that infants and young children grow as healthily as possible within their own cultural traditions. Indeed, cultural factors influencing the ways in which parents (and other people who are directly responsible for the upbringing of young children, such as foster parents) nurture their offspring are considered particularly relevant to the health and development of infants and pre-schoolers. For instance, cultural knowledge relating to the sources of advice and influence which parents use is seen as essential if health visitors are to work

successfully and effectively with parents from differing cultural traditions. Research relating to the cultural dimension of health visiting's child health remit is also considered vital to the improvement and maintenance of the health of the under-five year old population.

This characteristic is related to both the 'client' domain of a transcultural model for health visiting and to the organizational dimension (within which provision is made for the various child health services that are available countrywide) of the 'environment' domain of a transcultural model for health visiting.

C) CHARACTERISTICS OF THE EDUCATIONAL SYSTEM

i) Importance of applicant selection

The importance accorded to the selection of student health visitors who have suitable qualities and abilities for transcultural practice (5 12) is a characteristic of the educational system of the transcultural health visiting service. As in the unicultural perspective, suitable personal qualities and abilities of the health visitor applicant are seen as important criteria for entry into qualifying health visitor courses, in addition to appropriate educational and professional qualifications. However, within the transcultural perspective, qualities and abilities are viewed with specific regard to the cultural dimension of health visiting practice, especially with regard to health visitor-client relationships. Thus, empathy, adaptability and the awareness of one's own ethnocentricity are included amongst others as qualities and abilities needed for successfully developing and maintaining short- and long-term, inter-cultural

and intra-cultural, health visitor-client relationships. It is intended that qualities and abilities conducive to transcultural health visiting will be developed further during the socialization process of qualifying health visitor education, and subsequently. Research into the abilities and qualities needed for working effectively in inter-cultural and intra-cultural situations is considered important.

This characteristic is related to the 'health visitor' domain of a transcultural model for health visiting.

ii) Disciplinary flexibility within the knowledge base

A second characteristic of the educational system of the transcultural perspective is **the recognition of the need for disciplinary flexibility with regard to the knowledge base to qualifying health visitor education, thus allowing for the inclusion of anthropological concepts and insights in curricula nationwide (§ 13)**. The United Kingdom syllabus allows individual health visiting educational establishments flexibility in regard to the inclusion and exclusion of subject matter in their curricula where this is in keeping with overall United Kingdom health visiting objectives. However, with United Kingdom health visiting policies affirmatively recognizing that health visiting serves a multi-cultural society, the inclusion of a cultural component is considered compulsory for all curricula nationwide. This component provides a foundation of cultural knowledge as well as cultural information relating to all aspects of health visiting. Thus, knowledge relating to cultural diversity and cultural discovery is part of all health visiting curricula. Anthropological knowledge (e.g. concerning approaches and insights to cultural discovery) is valued and forms an important part of the cultural component in health visitor education. This is in addition to sociological knowledge (which has been part

of health visiting curricula for many years), and other sources of knowledge relevant to the provision of a transcultural health visiting service.

This characteristic is related to the educational dimension of the 'environment' domain of a transcultural model for health visiting.

iii) Variations in the inclusion and comprehensiveness of cultural components

The transcultural perspective of health visiting is characterized by **the inclusion of a comprehensive component of culturally related health visiting knowledge which includes ethnographic approaches to data collection and the development and utilization of transcultural modes of health visiting practice (§ 14)**. In addition to cultural knowledge being regarded as important to all aspects of health visiting, neither the health visitor nor the client is assumed to be a member of the dominant culture of the United Kingdom.

Programmes in transcultural health visiting are developed and refined by each establishment for health visitor education, and in accord with United Kingdom health visiting guidelines. These guidelines demand a comprehensive component of culturally related health visiting knowledge as compulsory for all qualifying health visitor courses. With the primary focus of anthropology being the study of cultural groups, anthropological concepts (such as 'culture' and 'ethnocentrism'), insights and studies are seen as providing health visitors with a firm grounding in cultural understanding. By including anthropological knowledge in addition to sociological knowledge in all health visitor curricula, the inclusion of knowledge relating to ethnic groups as well as approaches to collecting cultural data is assured. In addition, the relevance of cultural factors

to all aspects of health visiting practice is threaded throughout the entire course.

During their supervised fieldwork, student health visitors receive practical experience in transcultural health visiting activities. Not only is it considered essential that transcultural health visitors develop skills in ethnographic approaches to data collection before qualifying, but they must also gain expertise in using cultural data within transcultural modes of practice. Skills and competence gained in ethnographic data collection and analysis are seen to have relevance for both inter- and intra-cultural situations, providing insight into the health visitor's own culture as much as into cultures other than her own (e.g. insight provided by Charsley [1985] with regard to the dominant culture of the United Kingdom).

The importance of health visitor tutors and fieldwork teachers being able to teach transcultural health visiting approaches and practices is recognized, and provision is made for college tutors and fieldwork teachers to develop the requisite expertise. Not only are opportunities provided for tutors to share their ideas and experiences in developing cultural components in health visiting curricula, but the nursing and health visiting literature is utilized as a forum for so doing. Where possible, anthropologists are among those invited to participate in the planning and teaching of cultural components and, also, in helping to prepare relevant educational resource materials (e.g. texts and video programmes relating to cultural diversity, cultural discovery and transcultural health visiting practices). Standard texts, examination papers and on-going assessments reflect the presence of a cultural component within all qualifying health visitor courses. In addition, research studies are considered important to the development and evaluation of cultural inclusion in health visitor

education.

This characteristic is related to the educational dimension of the 'environment' domain of a transcultural model for health visiting.

iv) Individualized and group approaches to health promotion

The transcultural perspective of the educational system of health visiting is characterized by **the emphasis on developing and utilizing a range of culturally appropriate approaches to health promotion (including health education) in field practice (§ 15)**. Within the transcultural perspective, the promotion of health is a central focus. Therefore, 'health' as a concept assumes a definite promotional emphasis with an inherent concern for the prevention of ill-health (note Capel 1978:37; Owen 1983a:37; Clark 1985b:163-164). This health promotional emphasis can be aligned with Brubaker's (1983:12) idea of health care being 'directed towards high-level well-ness' wherein 'disease prevention and health maintenance' are considered as 'pre-requisites or by-products'. In addition, the transcultural perspective recognizes inter- and intra-cultural variations within the concept of health.

The acquisition of skills needed for utilizing both individualist and collectivist (group-oriented) approaches to health promotion in intra- and inter-cultural situations is considered an important part of qualifying health visitor education. Transcultural health visitors are actively encouraged during qualifying, and post-qualifying, education to develop and refine a repertoire of approaches to health promotion which they can draw upon in both one-to-one and group (e.g. extended family) situations. Each health visitor gains practical confidence in using a range of approaches, whether during home visiting or in

other locations where they practise (e.g. clinics, schools), as well as with differing social groups (e.g. mother and toddler groups, religious organizations). In accord with the transcultural perspective, health visitors are prepared educationally to identify their clients' cultural values, beliefs and practices when promoting health (whether at individual, family, group or community levels) and to select and utilize approaches most appropriate for so doing.

This characteristic is related to the 'health visiting' domain of a transcultural model for health visiting.

v) Interchange of ideas and value orientations at field level

The fifth characteristic of the educational system of transcultural health visiting is **the utilization of the mechanism for the interchange of ideas and value orientations between college educators and local health authorities and boards for developing imaginative and progressive transcultural health visitor programmes which are both relevant to the locality and to nationwide health visiting needs (§ 16)**. In guiding student health visitors through their fieldwork practice, fieldwork teachers (who are employees of the local health authorities and boards) have a key role in promoting the exchange of ideas and value orientations between the college-based educators and members of the local health authorities and boards. This mechanism for interchange is valued for the potential it holds for providing members within both the organizational and the educational environments of health visiting to collaborate in developing and refining transcultural health visiting practices and, thus, mutually contribute to the development of transcultural health visiting.

This characteristic of the transcultural perspective is related to both the organizational and educational dimensions of the 'environment' domain of a transcultural model for health visiting.

D) SUMMARY

In describing the transcultural perspective, similar foci to those used to characterize the unicultural perspective in Chapter One have been employed. As in the unicultural perspective, these characteristics do not purport to be totally comprehensive, nor does the order in which they are presented reflect an inherent hierarchical dimension. In addition, they are not visualized as being mutually exclusive. Instead, an interrelatedness and interdependency exists between the various characteristics. For instance, the values of the health visiting service relate to both the organizational and the educational systems and, to an extent, the organizational and educational systems are interdependent. Several characteristics contain catalytic power in their ability to enhance the transcultural nature of health visiting, particularly the following characteristics: the emphasis on cultural knowledge (§ 1) as a value-related characteristic, the routine collection of data on the client's ethnic identity and background in field practice (§ 10) and the inclusion of a cultural component in all qualifying health visitor education (§ 14). Each characteristic, however, carries its own importance which may vary according to circumstance.

The following is a composite list of the sixteen characteristics of the transcultural perspective of health visiting:

- § 1. The affirmative emphasis accorded to the relevance of cultural knowledge to health visiting practice.
- § 2. The emphasis accorded to the independence of the individual practitioner within the context of transcultural health visiting policies.
- § 3. The emphasis placed on the use of inter- as well as intra-cultural skills and abilities in the development of all health visitor-client relationships.
- § 4. The emphasis accorded to the selection of specific client groups for the foci of health visiting energies and resources wherein ethnic minority groups are excluded for reasons appertaining to their ethnic identity and background alone.
- § 5. The emphases accorded to educational and advisory approaches that are culturally relevant to the promotion of health and well-being of a multi-cultural clientele.
- § 6. The acceptance of the notion of collectivism as well as the notion of individualism.
- § 7. The recognition given to health and nutritional knowledge that is accepted as being both culturally relevant and efficacious to a multi-cultural clientele, whether or not this knowledge is based on Western science.
- § 8. The affirmative support which is accorded to transcultural health visiting practices within the hierarchical and bureaucratic organizational environment.
- § 9. The commitment of all local health authorities and boards to ensuring that student health visitors (who are gaining their qualifying practical experience in their localities) develop a sound grounding in practical aspects of cultural diversity, as well as receive adequate experience in providing culturally relevant care.
- § 10. The emphasis placed on the routine collection of data on the ethnic identity and background of health visiting's clientele, and the provision of organizational support for the collection of such data in field practice nationwide.

- § 11. The emphases accorded both to promoting the health of infants and pre-schoolers, and to the importance of cultural factors in relation to the service's child health remit.
- § 12. The importance accorded to the selection of student health visitors who have suitable qualities and abilities for transcultural practice.
- § 13. The recognition of the need for disciplinary flexibility with regard to the knowledge base to qualifying health visitor education, thus allowing for the inclusion of anthropological concepts and insights in curricula nationwide.
- § 14. The inclusion of a comprehensive component of culturally related health visiting knowledge which includes ethnographic approaches to data collection and the development and utilization of transcultural modes of health visiting practice.
- § 15. The emphasis on developing and utilizing a range of culturally appropriate approaches to health promotion (including health education) in field practice.
- § 16. The utilization of the mechanism for the interchange of ideas and value orientations between college educators and local health authorities and boards for developing imaginative and progressive transcultural health visitor programmes which are both relevant to the locality and to nationwide health visiting needs.

4. TRANSCULTURAL RECIPROCITY

In this chapter, it has been seen that the aim of transcultural health visiting is to provide a service that is as culturally relevant and appropriate as possible for all clients from all cultural traditions. In endeavouring to provide care that is congruent with her client's cultural traditions, the transcultural health visitor recognizes that the client (whether individual, family, community, or other social group) has cultural knowledge, values, practices and resources which are relevant to the way in which he, or she, can maximize his, or her, own potential to achieve optimal health and well-being. Not only is the client's health and well-being mutually defined by the client and the health visitor in regard to the

client's cultural perspective, but the meaning accorded to the term 'optimal' is seen in relation to the client's culture as well as the client's changing circumstances. Throughout, both the client and the health visitor are visualized as actively collaborating in promoting the client's health and well-being within the parameters of the client's own cultural traditions.

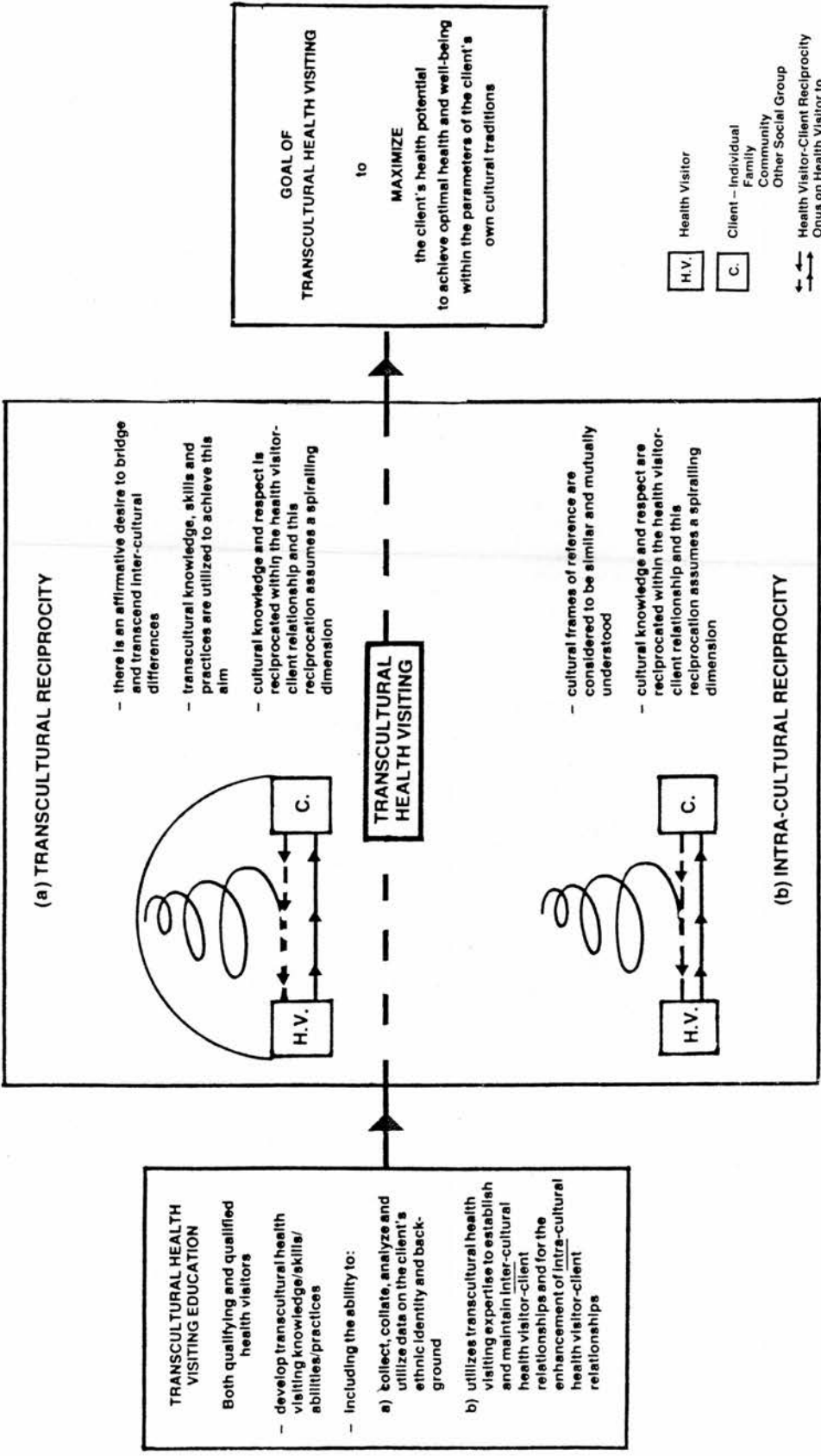
In Chapter Two, it was seen that the notion of reciprocity is intrinsic, and vital, to health visitor-client relationships. This includes the reciprocation of cultural knowledge and respect. In view of the unsolicited nature of health visiting, the health visitor carries the onus for initiating and maintaining the process of reciprocity. In all health visitor-client encounters, the health visitor aims to develop a relationship through which 'balanced reciprocity' (Sahlins 1972:194-195) can be attained (if possible) and, thereafter, maintained. Whilst reciprocation of cultural knowledge and respect is envisaged as occurring within both inter- and intra-cultural health visitor-client relationships (see Schema p. 164), in inter-cultural relationships it assumes a transcultural emphasis. Within the transcultural perspective, this is known as 'transcultural reciprocity', and is visualized as an interpersonal process which allows health visiting practice in inter-cultural situations to become more culturally attuned and client-oriented.

Acknowledging that transcultural reciprocity will not necessarily be a smooth inter-cultural process, the transcultural health visitor not only desires, but intentionally and continuously strives, to establish and maintain a health visitor-client relationship in which the reciprocation of cultural knowledge and respect can be realized. Thus, she has an affirmative desire to both bridge and transcend cultural differences in all inter-cultural health visitor-client encounters. During the process of transcultural reciprocity, the health visitor

receives information from her client which relates both to her client's cultural traditions and to her client's health needs and concerns. The health visitor reciprocates by offering culturally attuned professional knowledge, advice and guidance as well as affirmative respect for her client as a cultural being. Not only is transcultural reciprocity envisaged as including cognitive, affective and practical components, but as assuming a spiralling dimension through time as the health visitor-client relationship becomes increasingly more collaborative. Throughout, the transcultural health visitor endeavours to emancipate herself from her own cultural view, recognizing the limitations that her own ethnocentricity places on her ability to practise effectively in inter-cultural situations.

Conceptually, 'transcultural reciprocity' can be considered to be subsumed by a number of sub-concepts. In addition to 'respect', these would include 'empathy', 'adaptability' and 'awareness of one's own ethnocentricity'. If viewed within cultural parameters, several of Travelbee's (1971) ideas can be seen to add insight into the conceptual totality of 'transcultural reciprocity', for example, Travelbee's (1971:132,135) notion of 'emerging identities'. This idea involves the nurse being 'able to transcend herself to some extent' in order to perceive the 'uniqueness' of the other person and to 'establish a bond' with this person. Travelbee (1971:203) also develops the idea of a person being able to expand his or her 'empathic boundaries' in order to develop empathy with those who are dissimilar from oneself.

Proficiency in transcultural reciprocity is also visualized as enhancing the health visitor's ability to practise intra-culturally. With a heightened appreciation of differing cultural traditions (including both the overarching features and the minutiae of everyday life), the transcultural health visitor gains



SCHEMA (Dobson 1987) TRANSCULTURAL HEALTH VISITING

increased insight into her own cultural values, beliefs and practices and, consequently, those of clients from the same cultural tradition as herself. In intra-cultural health visiting-client relationships, cultural frames of reference are considered to be similar and mutually understood, the client and the health visitor being on a similar 'cultural wavelength'. Thus, 'intra-cultural reciprocity' is envisaged as being established and maintained with minimal cultural difficulties. As in inter-cultural situations, through discussion, negotiation and collaboration, the health visitor and the client work towards maximizing the client's health potential within the parameters of the client's cultural values and traditions. Likewise, the health visitor and the client (or the person on whom certain clients [e.g. infants] are dependent) together define 'optimal health and well-being'. As in transcultural reciprocity, reciprocation assumes a spiralling dimension through time as the health visitor-client relationship becomes more collaborative in nature.

With reciprocity being a core feature of transcultural health visiting, health visitor education (both qualifying and post-qualified) prepares all health visitors to reciprocate cultural respect and knowledge in all health visitor-client encounters. This, then, involves health visitors learning to establish and, thereafter, maintain health visitor-client relationships in both inter- and intra-cultural situations. Proficiency in collecting, collating, analyzing and utilizing data relating to the ethnic identity and background of health visiting's clientele is considered essential, as is the development of expertise in transcultural health visiting practice. In addition, transcultural health visitors are visualized as receiving organizational support (at both United Kingdom and local levels of health visiting) for the provision of culturally attuned care in everyday field practice, utilizing the process of transcultural and intra-cultural reciprocity in so doing.

5. A TRANSCULTURAL MODEL FOR HEALTH VISITING

In presenting sixteen characteristics of the transcultural health visiting service in Section Three of this chapter, links were made with the same five conceptual domains utilized in the unicultural model, that is, 'client', 'health visitor', 'health visiting', 'health' and 'environment'. Described in transcultural terms, these five domains are also used to form the basis of the transcultural model for health visiting presented below. Within the 'environment' domain, which is visualized conceptually as being multi-cultural Britain, two dimensions specific to the health visiting service have been highlighted, that is, the service's organizational environment and its educational system. Drawing on the characteristics of the transcultural perspective, each of the five domains are now summarized.

A) CLIENT

Within a transcultural model for health visiting, clients are explicitly recognized as cultural beings. Clients are recognized as upholding cultural traditions, including values and practices, which both shape their understanding of the meaning of 'health' and influence the choices they make in life, both for themselves and for those who are dependent upon them (e.g. their children). Hence, data on the ethnic identity and background of each client are considered vital for health visiting practice to be culturally relevant and effective. Unless in combination with a factor causing concern (such as a linguistic barrier or sickle cell anaemia), a client's ethnic identity and background is not considered a criterion for the client to be identified as

belonging to a 'specific client group'. However, each 'specific client group' (whether based on life-span, life events or life crises etc.) is recognized as including (at least, potentially) clients from all ethnic groups within the United Kingdom.

B) HEALTH VISITOR

Within the overall hierarchical and bureaucratic organizational environment of the transcultural health visiting service, the health visitor has a greater degree of independence in how she practises than have many nurses in other fields of nursing. Suitable personal qualities and abilities for practising transculturally are considered important, especially as health visiting is an occupation which, for the most part, utilizes educational and advisory approaches for the promotion of health of individuals, families, groups and communities. Transcultural health visitors are selected as much for their personal qualities and abilities as for their professional and educational qualifications. It is also expected that qualities and abilities conducive to transcultural health visiting will be developed further during the socialization process of qualifying health visitor education, and subsequently.

Within the transcultural perspective, the cultural tradition of the health visitor is not assumed to be that of the dominant culture of the United Kingdom. With this in mind, each health visitor is educated to appreciate the need for using culturally sensitive approaches to practice in multi-cultural situations, and to become competent and imaginative in developing transcultural approaches to practice. Although each health visitor has sufficient freedom to utilize unicultural approaches in multi-cultural situations if she so wishes, she is expected and encouraged to practise transculturally. In addition,

because it is accepted that health visitors and clients may belong to any cultural tradition, it is anticipated that cultural differences between health visitors and clients may vary considerably.

C) HEALTH VISITING

The transcultural health visiting service takes into account the fact that in caring for a multi-cultural society, a variety of inter-cultural disparities between the health visitor and the client will occur. Thus, it is recognized that in order for health visitors to practise transculturally in a variety of multi-cultural situations, they need adequate preparation for bridging and transcending a wide variety of cultural differences. The importance of health visitors having personal qualities and abilities conducive to transcultural practice is recognized with regard to the selection of applicants for health visitor education.

All health visitors are prepared educationally to discover health visiting related knowledge concerning their clients' cultural traditions on a routine basis in field practice, and in developing expertise in using this knowledge for the provision of culturally relevant care. In addition, transcultural health visiting includes developing, refining and utilizing a range of educational and advisory approaches to health promotion for use in multi-cultural situations within each of the service's remits (e.g. maternal and child health). The cultural dimension of building, maintaining and dissolving all inter- and intra-cultural relationships is also recognized as fundamental to skilful transcultural health visiting practice.

D) HEALTH

Health is viewed in multi-cultural terms wherein Western scientific health and nutritional knowledge is not accorded the primacy that it has within the unicultural perspective. In their practice, transcultural health visitors provide advice which is in accord with their client's own cultural health and nutritional belief system, unless such advice is unacceptable within the code of professional conduct for health visitors.

E) ENVIRONMENT

i) The educational dimension of the health visiting service

The educational system of the transcultural health visiting service places an affirmative emphasis on the relevance of cultural knowledge to health visiting practice. The inclusion of a comprehensive cultural component is considered essential in all curricula nationwide, and is supported by United Kingdom health visiting policy. Each cultural component includes both the knowledge of anthropological concepts (e.g. 'culture' and 'ethnocentrism') and knowledge relating to the skills and abilities needed for the collection of cultural data, as well as the development of transcultural practices. In addition, cultural factors relating to all aspects of health visiting are threaded throughout the entire course. Anthropological studies and insights (together with sociological equivalents) as well as ethnographic methods of data collection are included in all courses nationwide. While the inclusion of a cultural component in all qualifying courses is in keeping with United Kingdom health visiting policies and is considered compulsory, the planning of individual curricula remains with the college tutors themselves to determine.

College tutors and fieldwork teachers are provided with adequate grounding in cultural knowledge and transcultural practices in order that they may teach cultural components competently and confidently, both in college based courses and in the supervision of fieldwork practice. Fieldwork teachers are valued for the link they provide for the interchange of ideas and value orientations between the local health authorities and boards (who are their employers) and the college educators. Adequate cultural resource materials are available and, where possible, the expertise of anthropologists (and/or others with similar expertise in cultural knowledge) are drawn upon both to help teach cultural components and to help prepare resource materials. Research into developing cultural components in health visitor courses is both encouraged and financially supported.

ii) The organizational dimension of the health visiting service

The organizational dimension of the transcultural health visiting service provides affirmative support for the relevance of cultural knowledge to health visiting practice. The need for health visiting practice to relate to the cultural traditions (including values and practices) of its multi-cultural clientele is actively supported by United Kingdom health visiting policies. The discovery and utilization of data on the ethnic identity and background of the service's clientele is considered essential to field practice, the primary purpose of collecting this data being to ensure that health visiting is practised in a culturally sensitive and relevant manner. In addition, emphasis is given to the identification of cultural factors which enhance health and well-being (e.g. factors relating to family support systems, smoking etc.), as well as concerns which both negatively affect a client's health and well-being and appear to be culturally related (e.g. where ethnic grouping relates to a lack of

school-preparedness).

All qualifying health visitor students are assured of gaining adequate fieldwork experience in transcultural health visiting practices and, thereafter, being able to work with any health authority or board in the knowledge that transcultural approaches to health visiting practice will be encouraged and supported. Fieldwork teachers are seen to provide an important link for the interchange of ideas and value orientations between the local health authorities and boards and the college educators.

F) SUMMARY

An underlying premise of a transcultural model for health visiting is that the health visiting service should be responsive to the multi-cultural composition of the society which it serves. In order to establish and maintain a health visitor-client relationship through which the health visitor can help her client maximize his or her potential to achieve optimal health and well-being, health visitors are encouraged to affirmatively endeavour to bridge and transcend inter-cultural client-health visitor differences. Not only are data relating to each client's ethnic identity and background considered essential to the provision of a transculturally sensitive health visiting service, but the ability of health visitors to collect, collate, analyze and utilize such data is recognized as a fundamental necessity. Both an educational system and an organizational environment which provides affirmative and collaborative encouragement and support for transcultural approaches to health visiting practice is considered important and, indeed, essential.

The five conceptual domains of a **transcultural model for health visiting** are as follows:

(1) CLIENT

The client is not assumed to belong to any one specific cultural tradition.

The cultural tradition to which the client belongs is not assumed to be the dominant cultural tradition of the United Kingdom. This assumption is reflected throughout the service's educational and value systems as well as its organizational environment.

(2) HEALTH VISITOR

The health visitor is not assumed to belong to any one specific cultural tradition.

The cultural tradition to which the health visitor belongs is not assumed to be the dominant cultural tradition of the United Kingdom. This assumption is reflected throughout the service's educational and value systems as well as its organizational environment.

(3) HEALTH VISITING

(a) Health visiting is seen as a process in which client-health visitor relationships are viewed in transcultural terms.

All health visitors are prepared educationally for inter- and intra-cultural practice. This preparation includes the development of skills and abilities needed for initiating and maintaining inter- and intra-cultural health visitor-client relationships. Transcultural health visiting practices involve the affirmative bridging and transcendence of inter-cultural health visiting-client differences where these occur.

- (b) Data on the ethnic identity and background of health visiting's clientele are collected and utilized routinely in field practice.**

Transcultural modes of practice are recognized as being based on data relating to the client's ethnic identity and background.

(4) HEALTH

Health is defined within a variety of culturally distinctive ways.

(5) ENVIRONMENT

The environment in which health visiting occurs is viewed in multi-cultural terms.

Both the educational system and organizational environment of the health visiting service (which form part of the overall 'environment') provide affirmative encouragement and support for transcultural health visiting practices.

6. CONSIDERATIONS REGARDING A CULTURALLY APPROPRIATE MODE OF HEALTH VISITING PRACTICE FOR A MULTI-CULTURAL SOCIETY

Basic to the need for a culturally appropriate perspective for health visiting (and, in this thesis, the transcultural perspective is put forward as such a perspective) are three assumptions:

- (1) That, not only are health beliefs and behaviour culturally determined but, for health promotional activities to be relevant and beneficial to the individual or people whom the health visitor intends to help, then full cognizance must also be taken of the client's cultural traditions, values

and practices (note Paul 1955; Kasl and Cobb 1966; Brownlee 1978).

- (2) That qualifying health visitor education is to prepare the student for nationwide practice in which account is taken of the 'customs, values and spiritual beliefs' (U.K.C.C. 1984:2) of every client.
- (3) That contemporary British society is multi-cultural in composition, an assumption which is acknowledged repeatedly within the British nursing and health visiting literature (e.g. Henley 1983; Sharman 1985).

Given that contemporary health visiting is concerned primarily with effectively promoting the health of British society and, therefore, the health of multi-cultural Britain, then for the health visiting service to be culturally responsive and relevant to its multi-cultural clientele (whether at individual, family, social group or community levels), all health visitors must be able to discern and take into account their client's cultural traditions and, thereby, their values, beliefs and practices.

In Chapter One, it was seen that health visitors are socialized, educated and organizationally supported to practise within a unicultural perspective of health visiting. This perspective is one in which the primacy of the dominant culture of the United Kingdom is upheld at United Kingdom health visiting policy level, with only peripheral recognition being accorded to other cultures. Although, within the unicultural perspective, the relevance of culture to health visiting practice is recognized in the U.K.C.C. (1984:2) code of professional conduct for health visitors, all health visitors being considered to be:

. . . accountable for his or her practice, and in the exercise of professional accountability shall . . . take account of the customs, values and spiritual beliefs . . . of clients,

nevertheless, there has been minimal emphasis given to the need for all health visitors nationwide to be prepared educationally for inter-cultural practice. In fact, it was seen that, as yet, United Kingdom health visiting policy does not ensure that all qualifying health visitors emerge proficient in collecting, collating, analyzing and utilizing data on the ethnic identity and background of their clientele. Hence, there is a lack of nationwide certainty that all qualifying health visitors receive educational preparation in the provision of culturally sensitive and effective care in multi-cultural situations.

Within the unicultural perspective, a foundation component of cultural knowledge and skills relating to health visiting practice is not compulsory in all qualifying health visiting education nationwide. It was seen that the decision as to whether or not such a component is included in each health visiting curriculum is, in fact, made at local level, although there has been increased emphasis since 1985 on the need for curricula to relate to the multi-cultural composition of British society. Should a qualifying health visiting course not include a component on cultural knowledge and skills relating to health visiting practices (as may happen in areas where clients from ethnic minority groups are few in number), the emergent health visitor will have received inadequate educational preparation in the provision of culturally relevant and effective care in multi-cultural health visiting situations.

With health visiting being an unsolicited service, the health visitor is a 'guest' in her client's home. Hence, it is important that the service she provides is sensitive and relevant to her client's way of life, that is, if she is to achieve her objective of helping her client to maximize his or her potential for optimal health and well-being. Therefore, to achieve this, each health visitor

must be able to view her clients as cultural beings whose health beliefs and behaviour are closely linked to their cultural values, beliefs and practices. Each health visitor also needs to understand the meaning of culture and, specifically, as it relates to the practice of health visiting. In addition, she must be able to collect, collate, analyze and utilize health visiting related data on the ethnic identity and background of her clientele, endeavouring to emancipate herself from her own cultural view in so doing.

In this chapter, the transcultural perspective is presented as an alternative cultural perspective for health visiting in contemporary multi-cultural Britain. Within this perspective, the health visiting service is envisaged as ensuring that all qualifying health visitors receive adequate educational preparation for providing a culturally sensitive and relevant service with the intent of achieving more effective health visiting outcomes. In addition, encouragement and support for transcultural practices is ensured from within the organizational environment. A critical factor in providing a transcultural health visiting service is that, in her everyday field practice, each health visitor must be able to elicit and interpret information relating to her client's culture and, thereafter, to blend this knowledge into the care that she provides. Cultures, however, are dynamic entities and individual clients also vary as to how they adhere to the traditions, values and practices of their cultural heritage. Health visitors therefore cannot rely on knowledge gained from the literature alone, although such knowledge provides a useful foundation for cultural understanding. Hence, a central feature of the transcultural health visiting service is that each health visitor receives educational preparation in becoming proficient in the collection, collation, analysis and utilization of data on the ethnic identity and background of her clientele in the course of everyday field practice.

Given that all health visitors were to be prepared educationally:

- to collect and collate data about their clients' cultural traditions, especially data relating to their clients' values as well as health beliefs and practices,
- to analyze this data with regard to health visiting related problems and concerns,
- and to utilize this data for promoting their clients' health and well-being, including the provision of culturally relevant health education and social advice,
- and that it was seen that health visiting outcomes based on this mode of practice could be anticipated as being both culturally sensitive and effective in regard to the needs of contemporary health visiting's multi-cultural clientele,

then this mode of practice can be presented as appropriate for health visiting in a multi-cultural society. This being so, then the transcultural perspective which is visualized as supporting this mode of practice nationwide can be said to provide a more appropriate cultural perspective for health visiting in contemporary multi-cultural Britain than the unicultural perspective.

In this thesis, it is suggested that the use of ethnographic insights and approaches to data collection can provide practising health visitors with a mode of cultural discovery which is suited to the practice of health visiting in the field. It is also suggested that this approach to cultural discovery can provide practitioners with cultural data which, when collated and analyzed, can be utilized in client-oriented health visiting practice, and will help to increase the effectiveness of health visiting outcomes by its cultural appropriateness. If it can be seen that ethnographic approaches and insights to data collection

can:

- provide health visitors with an approach to discovering health visiting related knowledge about their client's ethnic identity and background during their everyday field practice,
- and that this data then allows them to provide more sensitive, relevant and effective care for a multi-cultural clientele,

then abilities and skills in ethnographic approaches to data collection can be said to have relevance to contemporary health visiting practice. This being so, the acquisition of ethnographic skills and abilities during qualifying and post-qualifying health visitor education also has relevance to the provision of more appropriate health visiting practice in multi-cultural situations. Indeed, a cultural perspective of health visiting which encourages this approach to data collection on a nationwide basis could be said to ensure that health visiting practice is more culturally attuned to the needs of its multi-cultural clientele than a perspective that does not encourage such an approach.

The following five chapters relate to a study which was undertaken with the intent of eliciting cultural information relevant to health visiting's maternal and child health remit. In addition to focusing on various aspects of child bearing and child rearing, this study considers features of family and community life in relation to one cultural group in the United Kingdom. In presenting this study, a four-fold format is utilized in which the research process is described and discussed in Chapter Four, the heritage and settlement of the cultural group to which the respondents belonged are described in Chapter Five, and the findings of the study are presented in Chapters Six and Seven. Thereafter, in Chapter Eight, the relevance of the findings to health visiting practice is discussed with

the intent of demonstrating how more effective health visiting practice can be anticipated in multi-cultural situations if knowledge relating to the client's ethnic identity and background is taken into full consideration.

Both the fieldwork situation and the fact that the researcher introduced herself to the respondents as a health visitor (although non-practising) provide the findings of this study with a similar basis to that of a practising health visitor collecting cultural information during her everyday field practice. It is suggested that this study helps to demonstrate the feasibility of health visitors (who have previously developed an understanding of ethnographic approaches and insights) collecting, collating, analyzing and utilizing health visiting related cultural knowledge in their everyday field practice.

7. SUMMARY

In this chapter, the transcultural perspective of health visiting has been presented as being more culturally appropriate than the unicultural perspective, that is, to the cultural traditions, values and practices of contemporary health visiting's multi-cultural clientele. Among the sixteen characteristics visualized as depicting the transcultural perspective, the need for all health visitors to be able to collect, collate, analyze and utilize data relating to their clientele's varying cultures was seen to be a fundamental necessity to achieving a culturally relevant health visiting service. Adequate educational preparation in transcultural health visiting skills, abilities and practices, together with active organizational support for transcultural approaches to client care in field practice, was seen to be essential. A transcultural model for health visiting which focused on five conceptual domains: 'client', 'health visitor', 'health

visiting', 'health', and 'environment' was also presented.

The concept of 'transcultural reciprocity' was visualized as a concept central to all transcultural health visiting. Proficiency gained in 'transcultural reciprocity' was also seen as enhancing intra-cultural understanding. Finally, the importance of all health visitors being able to discover and utilize cultural knowledge about their clientele was emphasized. This was seen as essential if health visiting is to provide a culturally appropriate service to British society, a society which is now accepted (certainly within the nursing and health visiting literature) as being multi-cultural in composition. In providing approaches and insights to cultural discovery, ethnographic research methods were considered valued tools which health visitors in their everyday practice can utilize in an attenuated form to glean cultural knowledge. The utilization of this knowledge was anticipated as enhancing the effectiveness of health visiting practice in multi-cultural situations.

CHAPTER FOUR

THE RESEARCH PROCESS

DISCUSSION AND DESCRIPTION

- 1. Introduction**
- 2. Planning the Study**
- 3. Fieldwork and Data Analysis**
- 4. Discussion**
- 5. Summary**

1. INTRODUCTION

In this chapter, I describe the research process pertaining to a study that is concerned with cultural knowledge relevant to health visiting's maternal and child health remit. This study looks in-depth at aspects of child bearing and child rearing as these activities relate to members of one cultural group in the United Kingdom. As this study draws on anthropological approaches and insights to cultural discovery, these are discussed in some detail. In addition, the various stages of the research process – that is, planning the study, the fieldwork and the data analysis – are described, as are a number of issues relating to the overall research process.

From the context of the fieldwork, it is suggested that the findings of this study are similar to those that a practising health visitor, visiting families from a similar Punjabi community, might elicit in the course of her everyday field practice, given that her workload was not unduly demanding and that she had developed previously skills and abilities in ethnographic approaches to data collection, collation and analysis. For instance, it should be noted that most of the interviews took place between 10 a.m. and 5 p.m., Monday to Friday, thus within conventional health visiting hours. All respondents were aware that the interviewer was a health visitor (although a non-practising one) and that the information provided was to be directed towards the increase of understanding by health visitors of the families' cultural traditions. It is suggested that this study helps demonstrate that information about clients' ethnic identity and background can be uncovered by health visitors in everyday field practice. It is also suggested that such information is required for the provision of culturally sensitive and relevant health visiting care.

Encompassed within the overall research process, as described in this chapter, are various aspects of the first two elements of the diagnostic process of health visiting (as presented in Chapter Two). For instance, the previous professional and personal experience and education (especially inter-cultural) of the researcher/health visitor should be envisaged as 'pre-encounter influences' (element one). Another aspect of this same element is the researcher's/health visitor's knowledge of ethnographic approaches to cultural discovery, knowledge which determines both the information that is discovered and the way in which it is acquired. Several sub-sections of this chapter particularly include pre-encounter influences, namely:

Research methods; Introduction to families; Personal insights;
Preparation for research into the cultural dimension of health visiting.

Similarly, factors relating to 'entry into the field' (element two) are discussed particularly within the following sub-sections:

Data collecting; Changing contours of the study; Presentation of self;
Factors regarding interviewing.

This second element is concerned with 'setting the stage' for efficient data sharing (Carnevali 1983:53) and includes the relevance of human relationship skills to the discovery of cultural information.

2. PLANNING THE STUDY

A) THE FOCUS OF THE STUDY

In Chapter One, it was seen that the health visiting service is characterized (§ 11) by an emphasis on the health of infants and pre-schoolers, and that a substantial part of the responsibilities and workload of practising health visitors continues to be directed towards the under five year old population (Clark 1981:30-31). Although the maternal and child health remit is recognized as an important focus for health visiting's energies and resources, few studies consider the cultural dimension of this remit. Therefore, a study which aimed to provide an in-depth understanding of the culture of one ethnic minority group, and with especial regard to aspects of maternal and child health, was needed. With this in mind, a descriptive study which utilized ethnographic approaches and insights to gain in-depth understanding of the culture of one ethnic minority group in the United Kingdom, and with particular emphasis on features relating to health visiting's maternal and child health remit, seemed appropriate (see Krauz and Miller 1974:101).

B) RESEARCH METHODS

For a study aiming to discover and describe cultural factors relating to health visiting's maternal and child health remit, an anthropological approach seemed most appropriate, insomuch that the insights and methods used within anthropology have been developed specifically to discover and analyze cultural knowledge. As nursing research studies in Britain seldom draw on anthropological insights and methods, they are discussed in some detail.

The activity of learning about a culture in 'the field' and the final description is known as ethnography. As a research method, ethnography involves systematically discovering and describing the regularities and variations of human social life with the intent of understanding the structure and organizational principles of a specific cultural group (Bock 1974:382; also Spradley 1980:13). For health visitors in field practice, conventional anthropological methods would be utilized in a more restricted sense (as in this study), but with a similar intent to provide cultural insight and understanding (see Dobson 1986 in Appendix Five).

Participant-observation and ethnographic interviewing are two methods pivotal to much anthropological fieldwork. Participation, then:

. . . involves attendance at cultural functions, interactions with persons being observed, observation of activities, and, in some instances, direct participation in events and on-going life patterns,

while observational activities focus:

. . . on behaviours as well as on the settings and circumstances in which behaviours are seen.

(Robertson and Boyle 1984:45)

Many sociological researchers distinguish between the degrees of participation and observation, following an abstract continuum from complete observation through to full participation with varying admixtures of the two along this continuum (Junker 1960:35-39; also Gold 1958). However, in anthropological research, oscillation between these divisions is accepted practice.

For many, the role of interviewer is considered part of being a 'participant-observer' (Pearsall 1965:37), though the activities of participant-observation and interviewing are usually discussed separately (e.g. Spradley 1979; 1980). Ethnographic interviewing, which has been described as

a 'purposive conversation' (Madge 1953:144), can be viewed as a form of social interaction that is structured by both the respondent and the interviewer (Hammersley and Atkinson 1983:112-113). By using a style of questioning that is sufficiently flexible to appear natural to both the respondent and the interview situation, it is hoped that the respondent will express her or his ideas with the variations and nuances that the formality of a questionnaire, for instance, would inhibit (Schatzman and Strauss 1973:72-73).

Thus, by observing, participating and interviewing, I hoped to come closer to understanding the 'social fabric' of one cultural group. As I specifically wished to understand family life, it was also the very minutiae, the 'small intimate habits of daily life' which are invariably taken for granted, 'such as the way of preparing or eating food, or of hushing a child to sleep' (Mead 1953:10; see also Malinowski 1922:18-19) that needed to be noted and discussed. Far from being inconsequential, the minutiae of life often reflect, in microcosm, the basic structures of the overall culture. As well as drawing upon my own experience, I found Brownlee's (1978) text especially attuned to transcultural research into family health. Hilger's (1966) field guide is also another useful source of ideas to consider when studying 'child life'; likewise Kay (1982) for studying aspects relating to pregnancy and childbirth.

C) NURSING RESEARCH - THE USE OF PARTICIPANT OBSERVATION AND ETHNOGRAPHIC INTERVIEWING

Although participant observation and ethnographic interviewing techniques have been used in the United States and Canada by a number of nurse-researchers such as Bushnell (1982), Field (1983), Horn (1975) and Ragucci (1971), they have received minimal attention, as primary methods, from

nurse-researchers in Britain. Indeed, there are very few studies relating to health visiting (or nursing) by health visitors, nurses, anthropologists, or sociologists in which they have been used.

In one sociological study, Dingwall (1974:76) used predominantly observational methods to discover how health visitors are socialized through their training into 'the world of health visiting'. In two other studies, both concerned with psychiatric nursing practice, Towell (1975) and Cormack (1976) used participant-observation as the primary method. While Towell (1975:39) selected a participant-as-observer approach, Cormack (1976:20) chose the role of observer-as-participant, although he was only a participant inasmuch as he was 'physically present in the environment'. In two other nursing studies, both participant-observation and interviewing were used to discover conceptual categories. In the one study, the intent was to shed light on how student nurses viewed both their work and their training (Melia 1981). In the other study, the intent was to provide a better understanding of the care given to 'the long-term sick in the community' (Kratz 1974).

In addition, several ethnographic interviews (based on ideas suggested by Spradley [1979]) were used in another nursing research study in the United Kingdom. Seeking to identify factors which determined the food consumption of primary schoolchildren in one area of Scotland, Rousseau (1983a) found ethnographic interviewing enabled her to discover concepts the children used for classifying their 'eating experience' (Rousseau 1983a:165), particularly the foods they took to school for their morning break. This study provides insight into the values that children give to foods and, as such, a knowledge base for health visitors and others involved in health education to draw upon. It also underlines the importance of consumer acceptability as it is defined by children

themselves (Rousseau 1983a:225; 1983b:110-111).

D) SELECTING AN ETHNIC MINORITY GROUP

My initial decision was the outcome of an extensive literature review of current health concerns regarding ethnic minority groups in Britain, as well as from personal communication with a number of health and community workers throughout the country. On many accounts, a Pakistani Muslim community seemed to be a suitable ethnic minority group for my study. Numerous studies, texts and articles focused on the needs of families from the Indian Sub-continent (e.g. Runnymede Trust 1980:112). Smith (1979:535-536; quoting O'Brien 1979:8) was reminding nurses and others involved in health education that Britain now has one of the largest 'Muslim communities outside the Islamic world'. In addition, the Pakistani culture was one with which the researcher was unfamiliar. According to Burtonwood (1984) - and with reference to the work of Simmel (1908:145) and Schutz (1964) - it is:

. . . the stranger who can see the taken-for-granted nature of culture or what passes for certainty in a particular culture.
(Burtonwood 1984:278).

Indeed, to ensure the degree of detachment which, together with a sense of involvement, is considered necessary in descriptive studies where participant-observation methods are being considered (Mead 1970:248), it is advisable, though not essential, that a culture sufficiently dissimilar to that of the researcher's be studied.

As relatively few Pakistani families settled in Britain before the mid-1960s (Jeffery 1976:46-47), it was possible to anticipate that a Pakistani Muslim community would include many families who previously had been used to a different health care system. In addition, they might find it unusual, possibly

even intrusive, for a health visitor to offer advice, and on a continuing basis, about child care and other family matters. Also, with the Islamic philosophy pervading many facets of everyday life, it could be anticipated that emergent religio-cultural beliefs and practices, such as those relating to dietary decisions, would have relevance to health visiting practice.

My aim, then, was to elicit not only cultural features that were related specifically to maternal and child health in a Pakistani Muslim community, but also the ways in which these unfolded and intertwined (both overtly and covertly) within the wider cultural scene, with the hope of developing a greater understanding of their cultural significance. However, as well as finding a community from which families would be willing to participate, the need for an interpreter was a major consideration and one that was to influence my study as a whole.

E) SAMPLING STRATEGIES

Sampling difficulties are a recurrent feature of many British-based research studies amongst ethnic-minority groups. Being an 'outsider' and unconnected to any ethnic minority group in the United Kingdom, I decided to select sampling strategies according to circumstances as they unfolded during fieldwork. In most instances, there is no easy method of obtaining a sample frame that will allow probability sampling. Jeffery (1976:71), for example, noted that her prospects for drawing up a satisfactory random sample of Pakistani families in Bristol was slight and, instead, decided to rely on the help of personal contacts. Likewise, Saifullah-Khan (1974:756-757) depended on personal contacts in her study of Mirpuris in Bradford.

Anwar (1979), however, was able to carry out a household survey to provide the sample frame he required, one which he subsequently considered helped him avoid 'being identified with one particular person or faction' (Anwar 1979:230-231). He credits the fact that he was able to obtain this sample frame to having already conducted a research study in the same area, being of the same ethnic background as his respondents, as well as working with the Community Relations Council. This, in turn, contrasts with the situation faced by Thomas and Ghuman (1976). In their study of a small, cohesive Sikh community, they found the only feasible approach was to allow the president of the temple to select which families would be interviewed, and also to accept his presence during the interviews (Ghuman 1980:310-311; also Thomas and Ghuman 1976:5).

Non-probability, particularly opportunistic and judgemental, modes of sampling have been used in many anthropological studies, their use being justified by the need to establish the rapport and intimacy needed to acquire the necessary depth of knowledge. Indeed, Honigmann (1970:271) defends the credibility of non-probability sampling in ethnographic studies on the grounds that:

. . . a common culture is reflected in practically every person, event, and artifact belonging to a common system.

Judgemental sampling occurs when the informants are selected according to the 'qualities', invariably ones connected to their social status or previous experience, 'which endow them with special knowledge' (Honigmann 1970:268), knowledge that is related to the focus of the research. However, the term 'opportunistic sampling' refers to when a researcher must depend on working as resourcefully and as opportunistically as he can in order to glean relevant

information. Thus, it might be that:

. . . he observes whatever children or mothers are available, visits receptive households, tests willing adults, records remarks he overhears or has volunteered to him, and attends almost any public meetings, church services, and entertainments that he happens to hear about.

(Honigmann 1970:269)

'Snowballing' is yet another non-probability strategy and one that has been found appropriate in studies amongst ethnic minority groups. This strategy relies on:

. . . the chain reaction built up from a few contacts which facilitates the interviewing of their friends, relations or colleagues, providing a system through which a special group, which is difficult to penetrate otherwise and for which no sampling frame exists, may be investigated.

(Krausz and Miller 1974:37)

'Snowballing' has been used as a strategy in a study in Sheffield by Rowley and Tipple (1974:82) and by Dosanjh in his study in Nottingham and Derby; Dosanjh (1976:91) noting that, in addition to saving time, it allows trust to be 'established without question'. Even so, bias is a major drawback as respondents tend to be from a few closed circles.

In some measure, all three strategies, judgemental, opportunistic and snowballing, were used during the fieldwork. However, constrained by circumstances, 'a sample of convenience', that is, 'whatever sample happens to be accessible' (Brim and Spain 1974:86), had to be accepted.

3. FIELDWORK AND DATA ANALYSIS

Fieldwork, that is the overlapping activities of negotiating access and data collection, took place from late May until Christmas 1981.

A) CHOICE OF LOCATION

In many towns and cities in the United Kingdom, families from one ethnic minority group frequently live in close proximity to one another. However, in other towns and cities, such families are more widely dispersed, the ethnic minority community to which they belong being without geographical contiguity, yet linked by its socio-moral institutions. After much consideration, I chose a city with a widely dispersed Pakistani Muslim population, and where I was offered the assurance of help in meeting families. However, there were no precise population statistics regarding ethnic minority groups in this city, figures provided by the local Community Relations Council being approximations. Even so, an alternative approach to drawing up a sample frame would have been to approach every health visitor in the city for a list of the Pakistani mothers with a child under five years whom they visited. As it turned out, members of the health visiting management agreed to discuss my study with their fieldstaff and those who were able and willing to help were allowed to do so.

B) THE NEED FOR AN INTERPRETER

With no knowledge of any of the languages of the Sub-continent, one of my first concerns was the fact that I probably would need an interpreter.

Although I was introduced to someone who was recommended as a possible interpreter, the availability of a convenient mode of transport seemed, understandably, to be an important factor. A car would have been beyond my financial means. However, by enquiring how health visitors managed to converse with the Pakistani families they visited, I discovered that many of the mothers with children under-five years old were relatively fluent anglophones.

A study, then, that focused on the selection of English-speaking, Pakistani Muslim mothers seemed feasible. As it turned out, I interviewed twenty-four families each with a child under five, as well as a number of other families and individuals, without the need for an interpreter. On the five occasions that I did need an interpreter, in two instances the husband answered my questions, both the husband and a married daughter in another family, and in a fourth home, a teenage daughter helped as needed, while, in a fifth home, a cousin translated. Although some of the mothers-in-law understood and spoke some English, there was always someone else in the home able and willing to translate.

C) INTRODUCTIONS TO FAMILIES

With the scattered nature of the Pakistani population, access through people working directly with the entire community obviously would have been advantageous, certainly as far as time was concerned. Unfortunately, much time during the early stages was spent less profitably because the initial assurances of help towards meeting Pakistani families not only were postponed, but they 'melted away'. Even so, it is very probable that indirect support 'behind the scenes', so to speak, was provided. However, the reluctance to help by those who previously had offered help was never truly explained, nor understood. After several months had elapsed, I expressed a

certain amount of dissatisfaction which at least did produce a more openly declared refusal of direct help. It was suggested that it would be better that I continued to work through the health visiting service with whom, by then, I had begun negotiating.

Throughout the fieldwork, I met at least seventeen health visitors, twelve of whom were able and willing either to introduce me to, or else provide me with names and addresses of, families with a child under five. In this way, I was allowed to utilize the health visitors' 'goodwill'. With the full knowledge of the general practitioners with whom they worked, these health visitors introduced me themselves to eight families, prepared another five to expect a visit from me, and gave me the names and addresses of another twelve families. A further four families' names and addresses were provided by a religious leader, a general practitioner, a shopkeeper and one of the mothers already interviewed. In all, I interviewed twenty-nine mothers, all married and living with their husbands, each with at least one child under five. Introductions to other individuals and families without children under five followed along similar lines, although these referrals were provided by members of ethnic minority organizations as well as Indian mothers, a religious leader, a general practitioner and health visitors.

Families came from differing parts of the city and lived in a variety of housing types. Ten families, whom I interviewed nearer the end of my fieldwork, lived in part of the city that, hitherto, I had been unaware could furnish me with a substantial number of interviews. The fact that it did was the fortuitous outcome of mishearing an address given to me over the telephone. I mistook 'road' for 'row'. I was passed from one Pakistani family to another for directions. By the time I reached my destination, I had met four

families living relatively near to one another. I subsequently approached the health visitors attached to medical practices in the area as well as the health visiting management responsible to that part of the city.

Families were referred for various reasons. At times, a mother was suggested, by both general practitioners and health visitors, because she had experiences of marriage and motherhood which, if she was willing to discuss them with me, would be particularly culturally illuminating. At other times, health visitors gave me the names of all the Pakistani and Indian families in their caseloads with indications as to whom I would be able to converse with in English. These referrals could be considered as forming a judgemental sub-sample.

While, for the most part, I relied on health visitors as sources of referrals, 'snowballing' as a means of gaining referrals was occasionally attempted. This strategy succeeded only to a limited degree. Three mothers told me of five other mothers who were either relations or friends, four of whom I interviewed, although only one became part of the twenty-nine families central to my study. It was, however, from conversations with mothers and families met in this way that I gained some exceptionally personal as well as humourously told insights into features of their lives and cultural traditions. For instance, it was during one such visit, that a husband described the *hajj* (the Islamic pilgrimage to Mecca and Medina), drawing upon his own personal experience to do so, and with his young daughter listening enthralled as he spoke.

Nearer the completion of the fieldwork, I used the telephone directory in an attempt to locate an Indian family – by then the sample base had broadened to include Indian Sikh families (see below) – with the hope of interviewing a

mother who had had the opportunity for advanced educational attainment that my sample of Pakistani mothers included. However, this did not turn out to be a very satisfactory method, partly because Sikh and Hindu names are very similar.

D) PUNJABI CULTURE

Several health visitors and doctors talked about Indian Sikh as well as Pakistani Muslim families. With my slow progression in gaining access to meeting and interviewing families, I decided to consider widening my sample to include families of the Sikh faith. Occasionally, a health visitor seemed to find difficulty in distinguishing an Indian Sikh mother from a Pakistani Muslim mother. To an extent this was understandable, for every Sikh and Muslim family I met spoke a dialect of Punjabi, nearly all the women wore Punjabi-style clothes, both groups enjoyed a similar type of diet and, for all, the joint family system was a guiding force if not a living reality. While divided on religious grounds and having separate kinship networks, it was possible, nevertheless, to consider both groups as one, with a Punjabi culture pervading and unifying them, certainly as far as many of the features regarding maternal and child care were concerned (Jeffery 1980:personal communication). To what extent the families viewed themselves as one cultural group was not determined, though one mother considered Pakistani and Indian Punjabis as having similar outlooks.

The Punjabi culture in Britain has been well described by Singh (1980:3-6) and, although his article is mainly about Sikh communities, he refers the reader to Anwar's (1979) study for a parallel account of Pakistani Punjabis. More recently, Ballard (1983:117) comments on the cultural similarity of Mirpuris from

Pakistan and Sikhs from the Jullundur district of the Indian Punjab, two groups now living in Britain. Indeed, ethnic, national and religious differences have assumed varying levels of importance during the differing stages of settlement of Punjabis in this country (Dahya 1974:86-87). Taylor's (1976) study of Indian and Pakistani youths in Newcastle-upon-Tyne - in which the fathers and/or grandfathers of the majority of respondents, Hindus, Sikhs and Muslims, are all Punjabis - is one that has focused on the Punjabi culture, if by consequence rather than design. In so doing, this study straddles religious and national differences (likewise Beard 1982:420; Hahlo 1980:295; Jeffery 1976).

Thus, the decision taken after two months of fieldwork (that is, in late July) to include Sikh families, not only extended the religious breadth of the study but drew upon the notion of a Punjabi culture that transcended national and religious differences. While this decision somewhat eased my access to a larger number of families, some of whom I met numerous times, it also extended my secondary literature review to embrace an understanding of both the Sikh and the Islamic ways of life, as well as a closer appreciation of the Punjabi culture.

E) DATA COLLECTING

Most of the visits took place between 10 a.m. and 5 p.m., Monday and Friday. On the whole, it seemed that I was either immediately invited in or else offered an alternative time, also between these same hours. While these times presumably were convenient to the mothers themselves, they were also very similar to the home visiting hours of many health visitors. Postponements, if made more than once, were regarded eventually as alternative modes of refusals. These occurred several times and, if I had been of the same cultural

background, no doubt I would have been more certain, a factor that Dosanjh (1976:93) also comments upon.

My first visit to a Pakistani family was in early July 1981. This visit was organized through the determination of one health visitor who had helped to start language classes for immigrant mothers before a more formal system was started in the city. By talking with a few families and observing family interaction, I was able to draw up an interview schedule (see Appendix Three) which focused on several themes. In so doing, I also drew upon ideas gleaned from my review of the literature as well as my experience as a health visitor. These themes related to pregnancy, infant feeding, immunization, child development surveillance and sources of advice and influence regarding maternal and child health. This schedule was used only with families who fulfilled the criteria of having at least one child under five years old. It both helped to focus conversations and made it easier for recording personal base line information, such as age, religious affiliation and considered linguistic ability. Questions were frequently rephrased to blend into a more conversational approach. Only one person, a husband, insisted on filling in the schedule himself but, as the children of that family turned out to be over five years old, this information was considered as additional.

As mothers invariably seemed to enjoy discussing their pregnancies (note Newson and Newson 1963:19), I frequently found it more suitable to move onto the questions about infant feeding and pre- and post-natal care rather than following the original format. A few schedules took about one hour to complete. Other schedules took many hours to complete, partly because of the numerous interruptions of family life. A few other schedules took two visits to complete. However, these longer and repeated visits provided a wealth of

cultural insight into family life, for, as Bott (1957:6) notes:

Unless one is invited inside a home one cannot learn much about a family as a working group.

The only other location where I was able to watch family and, indeed, community interaction was in the Sikh temple. Here, I could observe a larger number of Punjabis spontaneously interacting amongst one another as individuals and families, other than within their homes.

Throughout my fieldwork, I made notes, first in a condensed style and later in an expanded format (see Spradley 1980:69–71). In addition to completing the interview schedule, I sometimes made notes during a visit, such as the ingredients of certain Punjabi foods, but, mostly, notes were written shortly after a visit, perhaps in a nearby café. In the evenings, I typed up each visit describing the people present, the home surroundings and the various human activities and interaction that had taken place. Thus, I built up a series of family files together with a journal of my day to day activities, personal impressions and ideas. At each subsequent interview, I developed, where possible, new avenues of interest and thoughts that had emerged from previous conversations with families and sometimes from parallel reading.

As one member of the health visiting management had asked me expressly not to use a taperecorder, I decided to maintain this practice throughout my initial fieldwork. In a number of studies amongst ethnic minority groups, the decision whether or not to use a tape recorder seems to have been influenced by the concern that it might undermine the establishment of trust as well as being an inhibiting factor in itself. Thus, while Homans (1980:171–172) taped her interviews, Nesbitt (1980:36) preferred not to as she considered this might introduce a 'strained self-consciousness'. Later, however, during the analysis

stage when I revisited several families to review various topics and expand on them, I was able to use the microcassette that I had taken with me on my visit to India and Pakistan (see below) where I used it for dictating field notes as well as recording conversations, music and environmental sounds.

One mother, whom I met several times, agreed to classify, in accordance with the 'hot' (*garam*) and 'cold' (*thanda*) nutritional belief system, the foods shown in a contemporary pamphlet for Asian families distributed by the Health Education Council (1980). This pamphlet includes colour photographs of forty-four different foods, dividing them according to their ascribed physiological provision towards maintaining health in accord with the Western scientific nutritional belief system. Additional information was provided by another family, both families being from the Sikh community (see Appendix Four).

Negotiations towards meeting families proved to be multi-stranded with the constant necessity of maintaining links of one form or another, however tenuous, with each possible avenue of access to the Punjabi community. In all, I made over twenty-five visits to eleven locations where health visitors were based. Seven offices used by health visitors were located in the premises of general practitioners. Through these visits I met, as previously noted, seventeen health visitors, twelve of whom were able to refer families to me. Eight visits (to four differing locations) were also made to members of the health visiting management. In addition, with most of the health visitors, I was able to discuss their work with the Asian families in their caseload. Not only did such discussions tend to cover, albeit superficially, a number of topics relating to their own experiences (such as adjusting to the presence of seemingly dominant mothers-in-law), but an interest in learning more about

cultural practices often emerged. Although a few of the health visitors seemed knowledgeable about Punjabi culture (e.g. the health visitor who had organized language classes [see above]), most appeared to have only a superficial level of knowledge of Punjabi culture.

I also met with nine of the general practitioners who cared for the families I visited, only one being an Asian. The Asian doctor, who was of the Islamic faith, reminded me that a similar ethnic heritage is not always an assurance of cultural understanding between doctor and client if their life experiences are sufficiently different. Discussions also took place with three other doctors, including an administrative member of the local community health services. Additional visits were made to health education services, a tuberculosis surveillance unit and a local branch of the Samaritans. Several visits were also made to organizations which existed specifically for the needs of local ethnic minority groups and the promotion of racial harmony. In all, I made twenty-one visits to such organizations, eight of which were to talk with members of the local Community Relations Council, although three of these eight visits were made prior to May 1981. While a number of these visits were specifically to meet and talk with individual members, other visits were made in order to attend classes. These classes included ones which combined improving linguistic skills with knowledge important to caring for a home and family, such as cookery and health care knowledge. A number of 'open days' were also attended where various members of these same organizations were also met, albeit briefly and on a more informal basis. Several visits were made to a number of other cities to determine what health services were being provided elsewhere for ethnic minority communities.

By the end of October 1981, only eleven interview schedules had been completed, several families being either ineligible or unwilling. During November, I interviewed another eleven families, and in December, a further seven. In all, I made a total of sixty-six visits to the twenty-nine families who answered the interview schedule, with several families willing to be visited more than once. Visits to other families and individuals were additional to these. Although I had intended to interview more families, I decided to conclude the fieldwork towards the end of December 1981.

F) VISIT TO THE PUNJAB

Walking through a mock Indian village in London's 'Museum of Mankind', I visually realized how restricted my understanding of Punjabi village life was, particularly as it would be for the womenfolk, the world the tourist to the Punjab areas of India and Pakistan seldom sees. At various times during the fieldwork, respondents remarked on their difficulty in explaining life in the Punjab. As a consequence, I decided to visit the Indian and Pakistani Punjab during March and April 1984, trusting that my inability to speak Punjabi would not prove too inconvenient. By this time, I had analyzed most of my findings and knew what facets of Punjabi life I was interested especially in understanding better (see Dobson 1985 in Appendix Five).

The unsettled political situation in the Indian Punjab made it impossible for me to arrange a firm itinerary before leaving Britain. Being particularly interested in the minutiae of family life (e.g. homekeeping, cooking, child bearing and health care in both rural and urban settings), I sought out an appropriate range of contacts. As it transpired, I was helped by various people as well as organizations with community outreach activities (medical, social and

Village health care facilities



4 .1 Antenatal home visit – Pakistan



4 .2 Village medical practitioner – India

Village health care facilities



4 .3 Immunization clinic – community nurse – Pakistan



4 .4 Home visiting – village **dai** (midwife) and medical intern – India

religious) who were able to take me to visit many families. In most instances, I visited cities, towns and villages in areas where families I had met in Britain came from or had relatives.

As well as providing me with the opportunity to sense something of the cultural and environmental change that occurs when one leaves the Sub-continent for a life in Britain, I also had the opportunity to use other forms of data collection, particularly photography and tape-recording. The current stage of my analysis provided me with a thematic framework for my photographic work. Constantly alert for new and on-going ideas, I also concentrated on theme by theme, spontaneous non-verbal communication between mother and child being one of the more elusive to capture on film. Not only do photographs provide a comprehensive, though static, review of a situation (note Collier 1967; Crane and Angrosino 1974:157-176), but they can also help to generate conversation about family members and cultural events. In addition, such discussions add a greater sense of informality to a visit as well as providing a useful approach to cultural discovery.

While much time was spent observing and participating in various activities, such as village midwifery classes and religious services, I was also able to talk with many people, frequently in English, and, if not, then through translators. Although my visit to India and Pakistan only offered me a glimpse into Punjabi life, and as such was like a 'living' text, this personal experience provided me with a greater sense of confidence and authenticity both in the further analysis and in the writing up of my findings.

G) DATA ANALYSIS

Rather than being a distinct stage in qualitative research, data analysis is, to varying degrees, threaded throughout the research process. This occurs both informally as ideas and hunches that occur to the researcher, and more formally in the writing up of field notes, as well as later in the final selection, interpretation and presentation of data (Hammersley and Atkinson 1983:174).

At the conclusion of the fieldwork stage, I comprehensively reviewed and collated the twenty-nine interview schedules. Then, following ideas used by Saifullah-Khan (1974:759) as well as Webb and Webb (1932:85-86; also Lofland 1971:120), I photocopied the family files and the journal, thereafter assigning categories to the contents of each chunk of information, cross-referencing as necessary. By further re-photocopying, each category had its own file which contained all the material allocated to it. These formed the basis for further analysis.

My final analysis follows a descriptive format and is presented in Chapters Six and Seven. In Chapter Six, a description of the Punjabi mothers' world is provided. This includes various aspects of community life and kinship bonds together with some important cultural values which dominated the mothers' daily lives. In Chapter Seven, a child bearing and child rearing career is presented. Though seemingly linear, in reality many mothers were bringing up more than one child, child bearing and child rearing occurring simultaneously in life. I also consider cultural values, specifically those pertaining to child bearing and child rearing, which are emergent from the findings. Thereafter, in Chapter Eight, the findings in both Chapters Six and Seven are linked to health visiting practice and, specifically, to three client groups: the antenatal mother

(as both wife and mother), the post-natal mother, and the infant.

Descriptive in nature, my analysis pertains to the cultural traditions (particularly those that have significance for the practice of maternal and child health visiting) of one group of Punjabis living and bringing up their families in Britain. However, to appreciate the cultural traditions of these Punjabi families, the cultural 'backdrop' – that is, the historical, political, environmental and religious heritage as well as structural aspects of Punjabi social life in the Sub-continent – is essential and has therefore been included (see Chapter Five). In addition, photographs taken during my visit to the Punjab are used as a pictorial expression, emphasizing themes discussed in my findings, such as the use of colour as well as environmental change.

4. DISCUSSION

A) PERSONAL INSIGHTS

Invariably all research is constrained by some difficulties, yet released from others. On the one hand, the fact that I chose to support myself financially through much of this study, certainly for the first three years, influenced the choice of location for my fieldwork and the time spent data collecting. Perhaps it even enhanced the feelings of frustration I felt when access to families seemed more difficult than envisaged.

Each research study has its inherent biases which the researcher brings consciously, or unconsciously, to the study and which, in some way, influences the study from its inception through to its final stages. In studies utilizing

anthropological approaches and techniques, the researcher (to all intents and purposes) can be considered to be a 'human' research 'instrument' (Powdermaker 1967:19). Because it is more methodologically candid in descriptive studies for the researcher to nail his or her colours to the mast, so to speak, I offer a glimpse into 'my world'.

Seven years of working with, and amongst, the *Inuit* as an outpost nurse/nurse practitioner in northern Canadian settlements has given me the opportunity to learn to work inter-culturally, as well as the freedom to work creatively in that idiom. Much of this work (e.g. home visiting, child development surveillance and family counselling) hold similarities to health visiting. It is to these years of my life that I ascribe much of my knowledge, skills and beliefs regarding infant and child care, as well as to my years in Britain as a student midwife and, later, as a health visitor. Several times during the research, in order to offer reassurance that I was both willing to listen to and accept alternative cultural traditions, I would describe distinctive *Inuit* ways and my acceptance of them.

To an extent, my interest in cultural diversity stems from a life that, from childhood until recently, has included living and working in various countries. While Britain is the 'land of my heritage', it is only here, and possibly because least expected, that I recall having felt what is known as 'cultural shock'. Thus, although my personal and professional backgrounds in themselves have provided me with the experience and interest relevant to this type of research topic, one can only surmise what cultural gap has been crossed during the study itself.

B) PREPARATION FOR RESEARCH INTO THE CULTURAL DIMENSION OF HEALTH VISITING

The ideas and approaches that I followed during my study developed and became crystallized from a combination of sources. Over the years, my ability to provide culturally attuned health care has been developed informally, almost by 'osmosis'. However, in 1980, and thereby before starting the research, I was invited to join a three-day 'cross-cultural education course' organized by and for the members of the Royal Canadian Mounted Police in the area in Northern Canada where I was then living.

Before, during and subsequent to data collection, I absorbed as much anthropological understanding as time allowed. For instance, before beginning fieldwork, I attended a considerable number of lectures, tutorials and seminars provided for first year and fourth year undergraduate courses in social anthropology. Throughout the years to which this research study relates, I also attended lectures on social work amongst ethnic minority groups, a course organized by the Health Visitors' Association (July 1982) entitled 'Social Anthropology and the Health Visitor', as well as courses on Hindu philosophy and the Islamic world. One family, who had been reluctant to explain pictures in their home which portrayed episodes from Hindu mythology, began to do so, so it seemed, once I was able to identify some of the gods from the Hindu pantheon. Throughout all stages of my research, I have drawn widely upon anthropological studies and texts in addition to the literature concerning the cultural dimension of health and nursing care.

C) CHANGING CONTOURS OF THE STUDY

My initial choice of location was coloured by my need for accommodation that was within my budgetary constraints, that is, in addition to the assurance of support in finding families for my study. The fact that I eventually decided to consider a Punjabi-speaking community as an operational ethnic group rested on the willingness of others to help me to meet families and, thereafter, on the families themselves being agreeable to participate. In this way, the contours of my study were redefined during the fieldwork stage, a feature it would seem of many studies using an ethnographic approach. Indeed, not only do Hammersley and Atkinson (1983:28,56) note that ethnographic research is 'replete with the unexpected' and 'cannot be programmed', but they point out that the activities of negotiating access and data collection invariably overlap and, hence, cannot be truly considered as entirely separate phases.

How people interact with the researcher, whether agreeing to help, helping or otherwise, they and their actions become part of the research, offering insight into differing modes of cultural behaviour. For instance, refusals to participate, and there were in fact very few of these, seemed to hinge on decisions made by, or with regard to, more senior members of the family. The presence and preferences of a mother-in-law certainly appeared to be crucial. Reasons why people are agreeable to help and become involved in a research study are obviously numerous. Mead (1969:362) suggests that in anthropological-type research, the researcher, in the end, depends on:

. . . enlisting the intellectual curiosity that complements his own research interests,

as well as enjoyment of the research enterprise itself.

I introduced myself throughout as a non-practising health visitor who was undertaking a research study focusing on maternal and child health, as well as explaining who had given me their name. It is very probable that the fact that people talked with me about their lives and cultural traditions reflected, in part, the regard they felt for their health visitors and general practitioners. At times, I felt that some mothers considered me as a confidential person who was outside the kin network, and with whom they could express their frustrations if they so wished. Throughout, I felt that, had I been in the capacity of a practising health visitor, the knowledge I gained during my visits about Punjabi culture would have added considerably to my ability to provide these families with health visiting advice that was culturally attuned.

D) PRESENTATION OF SELF

How we present ourselves, or at least appear, to the people we hope to learn from is closely linked to the response we receive and what information is proffered (Berreman 1962:5; Beteille 1975). Even so, it is necessary to remember:

. . . that people's definition of what one is and what one is doing rarely corresponds with one's own definition,
(Byerly 1976:159)

a factor which varies between respondents and through time (Robertson and Boyle 1984:46). Not only did my mode of self-introduction seem to legitimize my study, making it understandable to both the respondents and the sources of referral, but it was one that I felt I could identify and feel comfortable with (see Gold 1958:218). To be interviewing mothers and other family members in their homes about their lives, particularly regarding maternal and child health care, was not dissimilar to actual health visiting practice (note Dingwall 1976c:37). However, the selection of what to observe, and thereby what is not observed,

and likewise what to ask (Agar 1980:48), assumed a specifically cultural emphasis.

When researched by one person, a culture is experienced and understood through 'one temperament, one sex, one age, and one set of personality preferences' (Mead 1970:253). For instance, how gender influences the research process is a topic that has been addressed by various female researchers, including Ardener (1984) Briggs (1970), Dube (1975) and Fischer (1970) as anthropologists, and Easterday et al. (1982) as sociologists. Being female was an important factor that made it possible for me to interview mothers with few restrictions. Indeed, one source of referral, a male health visitor, spoke of seldom being allowed to visit Pakistani mothers because he was a man. Only one husband had given him permission to do so.

Restrictions relating to gender also circumscribe male researchers. For instance, Thomas and Ghuman (1976:29) 'never saw a glimpse of a woman' in their study of social and religious features of a Sikh community. And, in his study of Punjabi child rearing practices, Dosanjh (1976) carefully ensured that either his wife or his niece accompanied him although, in most instances, both parents were present during the interviews. Having commented that a female interviewer may have been a 'more suitable person to interview Punjabi mothers', Dosanjh (1976:91) notes that, even then, if the husband considers that his presence as well as his permission is essential, then any discussion on sexually-related matters will be inhibited. It was my experience, however, that a mother-in-law, rather than a husband, was likely to be present. Although husbands participated in several interviews, the more sexually-orientated information was usually given in the privacy of a one-to-one situation, although occasionally when female siblings were present.

Throughout, I decided to wear clothes that I hoped would help to make the families feel more at ease with me, and, possibly, me with them. Although strict purdah did not appear to be followed by the families that I visited, I nevertheless wore clothes that covered me from neck to wrist to ankle, hoping thereby to maintain personal modesty of dress. To what extent this made a difference can only be conjectured (see Papanek 1964:161). Only later, during my visit to the Punjab, when I wore the usual Punjabi clothing, was this ever commented upon, and then favourably.

I was asked frequently if I were married. The discovery that I was unmarried invariably produced concerned replies. Only by assuring people that God looked after me did I seem to be able to ease myself regularly and speedily from what seemed to many to be viewed as less than a satisfactory life-style. Even so, during the fieldwork, not only did one Punjabi mother ask me to discuss family planning with her and also to accompany her to a family planning appointment, but on several occasions marital disharmony and disillusionment were discussed at length. For an unmarried health visitor, it is always difficult to know how one's marital status is viewed by members of one's own culture, let alone by members of another culture. Perhaps the fact that one is willing to listen empathetically is part of the answer, even in a research capacity.

E) ETHICAL CONSIDERATIONS

In that I was both a health visitor, although non-practising, and a researcher, it is possible that the individuals and families who participated in the study would have assumed that the information that they provided would be considered confidential. Even so, confidentiality and anonymity were

promised. In fact, I felt some mothers took the opportunity to express the frustrations of their personal lives for these very reasons. Throughout, I seldom knew how many of the families that I interviewed were related to, or friends with, one another, nor whether the visits were discussed amongst themselves. Occasionally a family was prepared for the type of questions I would ask, and indeed, on one visit, I found a particular Punjabi food had been prepared. A family that I had previously visited turned out to be their friends and had told them that I was interested in foods prepared specifically for post-natal Punjabi mothers.

On several occasions, when I was seeking access to families, both in this country and later when I visited India and Pakistan, I was questioned about the underlying motives regarding my research, sometimes subtly and at other times directly. In planning to study the culture of an ethnic minority group at a time when the possibility of an ethnic question in the forthcoming census was a controversial issue (note Bulmer 1980) and racial issues sensitive, as ever, in themselves, I expected and accepted that those considering helping me would also exercise the right to 'vet' me, that is, not only question but even test me.

Several such episodes occurred. In one instance, not only was I encouraged to talk about my religious convictions but also my attitudes towards African people as well as Asians. Another time, the focus was on my ability to relate to white people. In this instance, I immediately sensed on arriving that, rather than (or additional to) meeting a Pakistani family as I had thought might happen, I would be tested in some way. Indeed, I spent the afternoon helping to lay a carpet, talking with a group of older ladies and listening to a girl on probation reciting lines for a play she was in. Although I was a little surprised, I respected the need for such caution, caution that was

confirmed in a discussion at the end of the afternoon. Families also exercised this right. On one visit, a husband, who had previously emphasized that he did not wish to discuss either his family or his religion, emerged, to my surprise, from under the duvet while I was interviewing his wife in their small bed-sit. Assuring me that he soon knew with whom he could be friendly, he spontaneously began discussing his family life. While this was a more humorous episode, others were in a more serious vein.

F) FACTORS REGARDING INTERVIEWING

In his study, Dosanjh (1976), himself from the Punjab, discusses how easily wrong conclusions can be reached when the interviewer is from a different ethnic background from that of his or her respondents. Subtleties of linguistic expression, such as gestures and vocal tone, can easily be missed or misinterpreted, even when the words themselves are understood. For this reason, he advocates that the interviewer should be of the same ethnic background as the respondent, or, if not, then their linguistic fluency should be clearly and precisely documented (Dosanjh 1976:90).

Many studies of Asian communities have been undertaken by researchers from the same linguistic-regional group, for instance Anwar (1979:228-229) and Ghuman (1980:310), while other researchers have drawn upon the linguistic ability they have developed while living in the Sub-continent (e.g. Jeffery 1976:72; Nesbitt 1980:39). Homans (1980:141-142), however, employed an interpreter for her interviews with Asian mothers and, in her thesis, discusses at length the criteria she used for selecting an interpreter. These included being both a wife and a mother as well as having the freedom to visit as and when convenient for both the respondents and the clinic schedules.

While many of the mothers I interviewed conversed very fluently in English, in a few families this was not so. Nevertheless, sometimes it was because of this very difficulty that new topics were broached, food cravings and aversions of pregnancy being one example. My own facility to feel culturally at ease and to cover the various themes, while moving with the pace the respondent seemed to prefer, improved over time. Sometimes I realized that I was being over-conscious as to whether I was conforming to the culturally appropriate behaviour expected of a guest, my only previous contact with Punjabis having been in the Sub-continent and of a transient nature. Not only were the majority of the respondents conversationally fluent in English, but a variety of British accents was used, affirming the relative mobility of the Punjabi population in Britain, whether for marital or economic reasons. Although I was at a disadvantage by not being bilingual, I feel that the research situation did portray, or at least shed some light on, the inter-cultural situation present when linguistic barriers between health visitors and clients are virtually absent. Given the same interest and preparation, it could be envisaged that health visitors would be equally able to discover a similar fund of cultural knowledge.

Although an interview schedule lends a more formal and semi-structured format to an interview (Pelto and Pelto 1978:78), rather than being an inhibiting factor, it may help to provide the respondent with a clearer understanding of the research focus (see Bott 1957:21). Many questions relied on recalling past events and decisions, sometimes several years previously. Nevertheless, pregnancies and childbirth are important milestones in most women's lives. Even so, 'memory acts selectively' (Moser and Kalton 1971:331), and while people do not usually intend to provide false information:

. . . they do have their own biases in the recollection of events, tending to remember only things they want to remember or deem it important to remember.

(Atkinson 1971:80)

In discussing the reliability of retrospective data, Dosanjh (1976), whose study closely adheres to the study by Newson and Newson (1963), considers that:

Although exact details are likely to be forgotten [,] the essence tends to be remembered.

(Dosanjh 1976:105)

Orr's (1980) study of consumer views of health visiting also relied on 'retrospective recall of events' (Orr 1980:43) and likewise involved the inherent liability to memory distortion that, inevitably, is difficult to assess.

Invariably, families were reticent in suggesting ways in which maternal and child health care for Asians could be improved. Indeed, this type of information seldom emerged, except indirectly when various actual experiences were discussed. Although this may have been because I was from a different ethnic and racial background, in many ways this reticence was not really surprising, insomuch as it appears to be a recurrent reality in much nursing research (Nehring and Geach 1973). In fact, not only is it considered unusual for people to criticize when participating in research studies, but when criticisms are made, they would appear to be 'all the more meaningful because they represent very sharp criticisms' (Payne 1951:23-24). Throughout, partly because the political climate in Britain was somewhat sensitive at that time, together with the fact that I was relatively unknown to the respondents, I avoided questions about economic aspects of their lives. Thus, my findings are restricted in their socio-economic content.

G) RESEARCHER FATIGUE

Traversing the city by bus and visiting here and there on foot offered a closer feel for the areas where families lived. However, not only was it time-consuming but, during inclement weather, it could also be truly wearisome. On one instance, deciding to take a short cut across an extensive housing estate on a rainy day, I slipped climbing a grassed slope. Being far from the only café in the area, I doused myself down in a nearby educational centre, trying to appear as inconspicuous as I could. Disheartened but still determined to resume my plans, the next visit turned out to be one of the most productive of all my one-visit interviews.

Visiting from house to house, explaining the purpose of my study to someone on their doorstep, was not so dissimilar to health visiting, although I balked at explaining to one mother the nature of my study through an intercom which was at pavement level and beside a busy bus stop. Twice I talked with shopkeepers to ask if I might visit their homes and talk with their wives. Both times, having waited until business seemed quiet, I nevertheless found myself explaining my study in the presence of several customers as well.

Tentatively, I had considered finishing data collecting by the end of the year, that is, in December 1981, though hoping to have met more families than I did. Having trudged through deep snow to keep an appointment in a distant part of the city and finding no answer, I decided to conclude my fieldwork just before Christmas. By this time, the local bus service had assumed negative proportions and researcher fatigue had set in, that is, from the logistics of the study not the visits themselves which were precious opportunities to understand another culture.

5. SUMMARY

In this chapter, I have considered the various stages of the research process, from the planning and the fieldwork to the subsequent data analysis. In so doing, I hope to have provided a comprehensive basis for the findings to be evaluated by others. Essentially, this study is both descriptive and exploratory in nature, and focuses on the cultural traditions, values and practices of a group of Punjabi mothers in the United Kingdom, all with one child under five years old. The findings relate to the activities of child bearing and rearing, thus providing cultural information relevant to the maternal and child health remit of health visiting.

As the majority of the mothers were conversant in the English language, most of the interviews were conducted without the need for a translator. In utilizing participant-observation and ethnographic interviewing as approaches to data collection, anthropological research methods were drawn upon with the intent of providing cultural insight. It is suggested that the fieldwork situation bore similarities to the situation which a health visitor would experience in everyday field practice. Finally, as little nursing research within the United Kingdom has drawn upon anthropological research methods, these approaches to cultural discovery have been discussed in some detail. It is envisaged that these methods could also be drawn upon by practising health visitors if such approaches to cultural discovery were part of health visiting education.

Based on the available literature, and with information provided by the families themselves, the following chapter (Chapter Five) sets the scene for a

better understanding of the cultural heritage of the families who participated in the study. In ascribing a singular ethnic label (i.e. 'Punjabi') to the families studied, it should be recognized that differences (for instance, regarding religious beliefs) existed.

CHAPTER FIVE

THE CULTURAL HERITAGE AND THE SETTLEMENT OF THE PUNJABI COMMUNITY

- 1. Introduction**
- 2. The Heritage**
- 3. Overview of the Settlement of Indians and
Pakistanis, particularly Punjabis,
in the United Kingdom**
- 4. The *Bhatra* and the *Arain* Sub-Castes**
- 5. The Contribution of the Womenfolk to
the Development of the Asian Communities
in the United Kingdom**
- 6. Summary**

1. INTRODUCTION

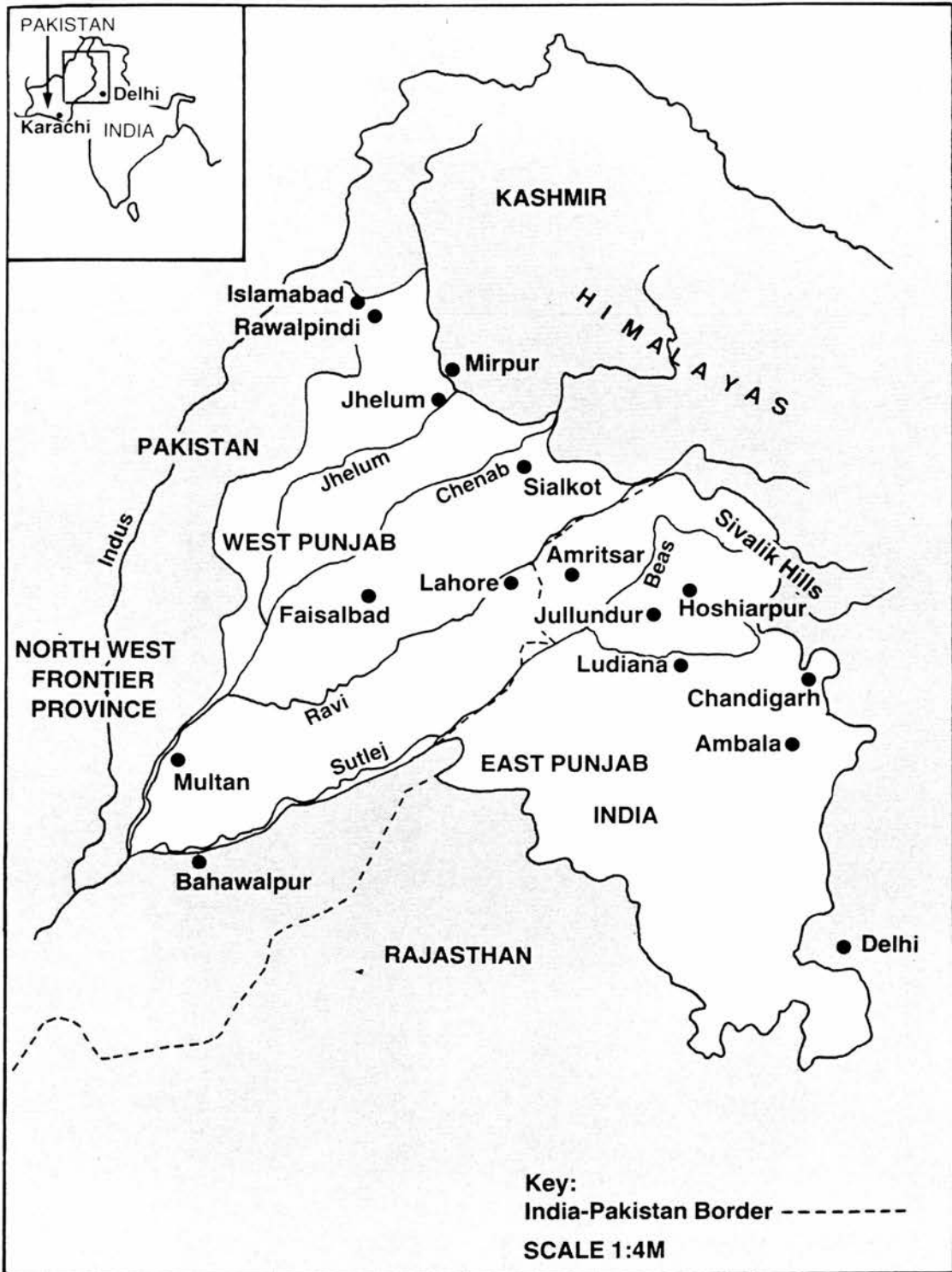
For many Pakistanis and Indians living in the United Kingdom, the Punjab acts as a heritage and reference point for their cultural traditions, even though religious affiliation tends to create a marked division between them. In this chapter, my orientation is first to focus on some of the geographical, linguistic, historical, religious and social features of the Punjab and its people. The intent is to provide insight into the cultural norms, values and beliefs held by Punjabis living in the United Kingdom. I then look at the settlement of Indians and Pakistanis in the United Kingdom, particularly Punjabis, and discuss the two sub-caste groups to which a number of respondents in the study belonged. Finally, I consider some of the features of the contribution of Asian women towards the development of Asian communities in Britain, drawing on both the literature and personal communications in so doing. The knowledge base that this chapter encompasses can be considered as 'pre-encounter influences', the first element of the diagnostic process of health visiting as described in Chapter Two.

2. THE HERITAGE

A) THE PUNJAB

As frontiersmen and women in the Sub-continent, Punjabis have faced recurrent invasions over the centuries, developing both a resilience and a sense of adventure that, together with necessity, have led many of them overseas to find employment and new homes. In fact, it has been said of the Punjabi that:

THE PUNJAB
PRIOR TO THE DIVISION OF THE INDIAN PUNJAB IN 1966
 (Adapted from Taylor 1976:13)



MAP 1

. . . he will not hesitate to walk the universe in search of the atom. The [This] characteristic tends to make him more mobile as well as more enterprising.

(Nair 1961:104)

By virtue of their geographical location, most invaders have entered the Indian Sub-continent via the vast plains of the Punjab, crossing the mountain passes on their northern and western borders. Consequently, the people of the Punjab have developed an unusual capacity for adjustment to change, which makes them one of the least 'rooted' communities in India, mentally, culturally and physically (Nair 1961:112). Additionally, many Indian Punjabi families have at least one member who served and travelled abroad with the army during the British *Raj*, widening their horizons further in the process.

The Punjab has been aptly described by Singh (1963:3) as 'a scalene triangle balanced on its sharpest angle'. A geographically distinct unity in the north-western part of the Indian Sub-continent, the Punjab is a vast wheat-growing plain demarcated and dissected by five major rivers flowing from the mountain ranges on its northern borders. Bounded to the west by the River Indus, the five rivers of the Punjab (*panj-ab* - 'the land of the five waters') are the Jhelum, Chenab, Beas, Ravi and Sutlej. Here:

. . . in the intra-fluvial tracts or *doabs* between these rivers and in the western half of the tract between the Sutlej and the Jumna live people who speak the Punjabi language and describe themselves as the people of the Punjab.

(Singh K. 1963:3-4)

Until the mid-nineteenth century, the Punjabi plains were covered with large tracts of forest which teemed with a variety of wildlife. Today, while cities and towns such as Lahore, Multan, Sialkot and Ludhiana (which date back to before the fifteenth century) continue to flourish, the life-style of the Punjab is still predominantly rural and, as such, is dominated by both its terrain and its

The Punjab



5 .1 The granary of the sub-continent



5 .2 Village agricultural scene

seasonal variations.

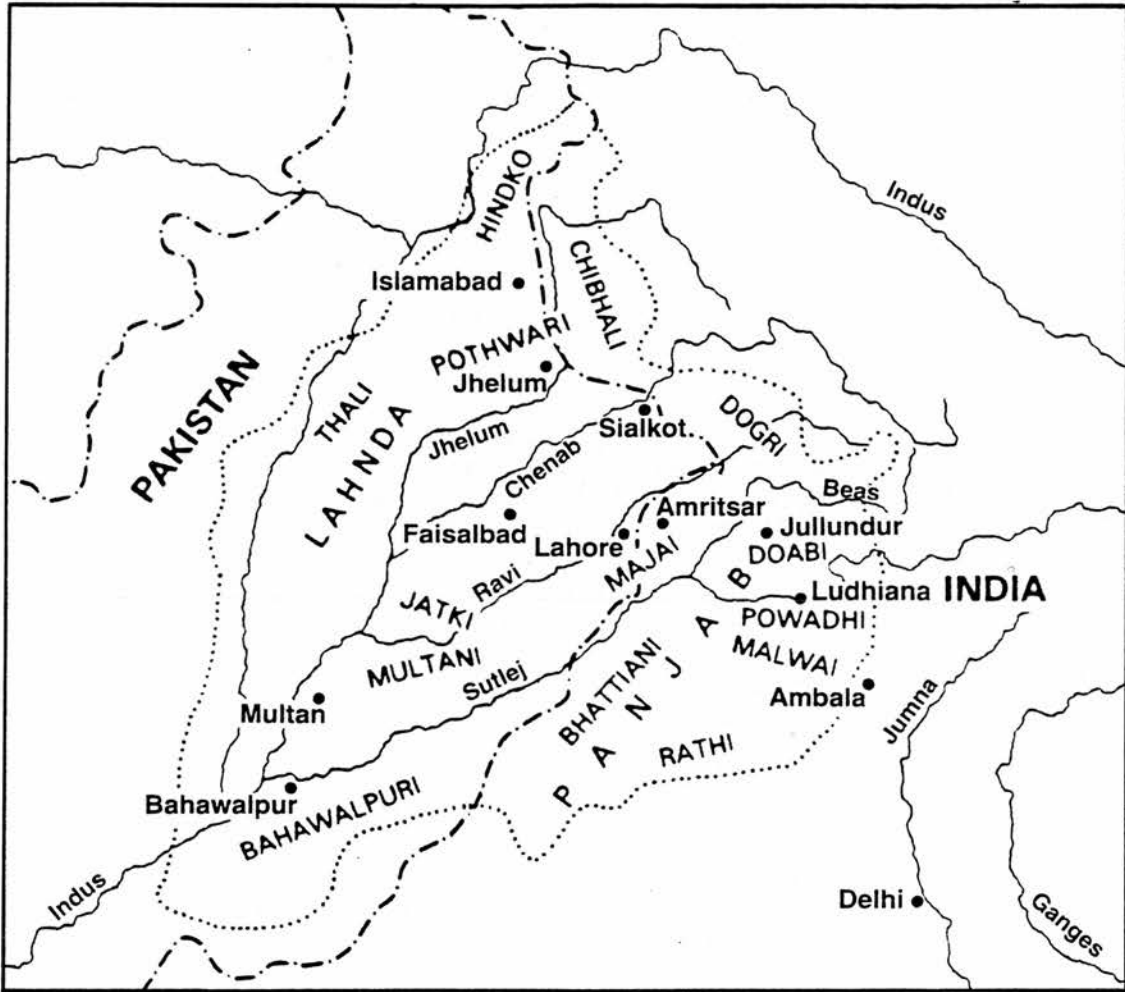
The Punjabi springtime arrives in February following the winter rains. As well as being blossom time, crops such as wheat, sugar cane, barley and a variety of vegetables (including carrots, spinach and cauliflower) are grown, maturing as the days move into the scorching, dusty days of summer when dust devils may spiral across the land. Canals, tube-wells and bullock-turned water-wheels are used to irrigate the fields and orchards. At the end of June, the second monsoons arrive and last about two months. The dust begins to settle and life takes on a new freshness, with much of the land becoming temporarily swamp-like. New crops such as rice and maize are sown, mangoes and other fruits ripen, and there is a general air of rejoicing. Finally, wintertime comes again with its sunny days but cold and frosty nights, and the year completes its seasonal cycle.

Not only is the Punjab considered to be the cradle of Indian civilization, possibly dating back to 3000 B.C., but, by virtue of its geographical location, as previously mentioned, it has been settled and resettled by numerous conquerors. Over time, various alien religions (e.g. Islam), languages (e.g. Persian, Arabic, Pushto and Turkish), races and customs have been absorbed, giving a composite nature to the Punjabi people and their language.

B) LANGUAGES SPOKEN

The Punjabi language with its dialectal variations is used by about thirty million people, that is, in both the Pakistani and the Indian regions of the Punjab (Tolstaya 1981:1), as shown in Map 2. Though it is usually written in the *Gurmukhi* script, the Arabo-Persian and the *Devanagri* scripts are also used,

**HERITAGE AREAS OF 'SAMPLE' FAMILIES
WITH REFERENCE TO PUNJABI DIALECTS**
(Adapted from Tolstaya 1981:79)



MAP 2

the former in the western Punjab and the latter in the east. The *Gurmukhi* (literally: 'proceeding from the mouth of the Guru') script, which is written from left to right, was first used by the Sikh Gurus whose holy book, the *Adi Granth*, often referred to as the *Guru Granth Sahib*, was written in this script in 1604. Since India became a republic in 1950, Punjabi has been recognized as the official language of the Indian Punjab and is used in primary and higher education.

Urdu, a Turkish word meaning 'army', was developed during the time of the Mughal empire. The Persian of the conquering Mughals, which included both Arabic and central Asiatic Turkish words, became admixed with the local dialect of Hindi (i.e. *Braj Bhasa* - see Tisdall 1911:1), and developed into a hybrid language. Urdu is currently considered the official language of Pakistan, with Punjabi ranking as one of the major non-official languages. Urdu is written in the Arabo-Persian script which, like *Gurmukhi*, is written from right to left.

C) RELIGION

With its roots in the Aryan invasion of the Sub-continent (approximately 2,500 - 2,000 B.C.), Hinduism was for many centuries the dominant religion in the Punjab. Only after numerous Islamic conquests, particularly following the invasion of Mahmud of Ghazni in 1001 A.D., did Islam take on any major significance. Sikhism is an even newer religion, founded by Guru Nanak in the late fifteenth century and nurtured to maturity by the subsequent nine Gurus. Unlike Islam, Sikhism emerged from the Punjab itself, with Amritsar being regarded as its holiest city.

The Punjab



5 .3 Looking towards the mountains



5 .4 A village pond

Today, Sikhism and Islam are the dominant religions of the Punjab. Both religions are monotheistic, each advocating submission to the will of God, Islam by its very name. Frequent calls to prayer and holy recitations from Islamic mosques and Sikh *gurdwaras* (temples) throughout the countryside are audible confirmation of the pervasiveness of religion in this area, reaffirmed by the regular display of religious pictures and signs in the majority of homes. Both Sikhism and Islam have been influenced by local Punjabi customary practices. For instance, sexual segregation is followed in many *gurdwaras*, and, similarly, certain Punjabi marriage practices are followed by Islamic adherents, neither with the sanction of their corresponding religions (Cole and Sambhi 1978:109; Jeffery 1976:11). In fact, the sexual equality that both religions uphold cannot truly be considered a secular reality in what is a patriarchal society where women assume subordinate roles in both private and public arenas.

i) Islam

Originating in Arabia, Islam dates back to the seventh century A.D.. Its doctrines are based on the 'words' of Allah as revealed through the Archangel Gabriel to the Prophet Muhammad. These revelations were later written down and are known collectively as the *Qur'an*, which literally means 'recitation'.

Orthopractic in nature, Islam not only gives clear direction to all aspects of life, the secular and the religious being seen as interrelated, but it incorporates a certain degree of flexibility and reasonableness in its injunctions, for instance concerning fasting. Opposing idolatry and various social injustices present at the time of its inception, Islam not only gave greater social equality, respect and security to women than they had been used to, but placed great emphasis

on the stability of family life. Various Biblical figures such as Moses and Christ are recognized as prophets preceding Muhammad.

Anybody who says and believes that 'There is no deity but Allah, and Muhammad is his Messenger' is considered to be a Muslim. This proclamation of the faith is known as the *kalimah* and this belief represents the first of the five pillars of Islam, the others being the formalized prayers (*namaz*) which should be said on a clean, clear space facing Mecca, almsgiving (*zakat*), fasting (*roza*) – especially during *Ramadan*, the month during which the Prophet is believed to have received the first revelation – and, finally, the performance of pilgrimage (*hajj*) to the Holy Places, that is, Mecca and Medina. While prayers may be offered anywhere, it is usually only the menfolk who offer them in the mosque. Women mostly pray at home and read the *Qur'an*, whether individually, in family groups or in other all-female gatherings.

Differing interpretations and explanations have brought about the emergence of various sects within Islam, the major ones being the *Sunni* and the *Shia* sects, the former predominating in Pakistan where Islam is the State religion. A proselytizing faith, initially carried abroad by traders and conquering armies, Islam is now followed by almost one fifth of the world's population. Islam, however, is a religion without an organized priesthood, religious leadership being offered by the *imams*, and Islamic law being decided through separate courts of jurisprudence, the interpretation and enactment of which, in Pakistan, would appear to have become sterner in recent years (Brodie 1984a/b). In Pakistan, large hospitals often have a small mosque within their precincts.

ii) Sikhism

Cole and Sambhi (1978:4-5,67) assert that Sikhism is considered to have grown out of a general, north-west Indian, contextually-Hindu yet religiously varied environment, particularly noting the Sant devotional tradition which repudiated caste distinctions and idol worship. Singh (1953:182-183), however, considers Guru Nanak to have aimed at reforming Hinduism, so doing with reference to Islam.

Both Hindu and Muslim dissenters became Nanak's disciples, or *shish*, a Sanskrit word from which the word 'Sikh' is derived. The Sikh *Panth* (community) was later joined by many Jats, a warrior-like agricultural tribe from the central Punjab. Jat customs and values, as well as the then current economic problems and Mughal hostility, helped influence the development of militancy within the *Panth* (McLeod 1976:12-13). Because of this Mughal hostility, the sixth Guru, Hargobind, left the plains and moved north of Chandigarh to the relative safety of the Sivalik hills, a stronghold of the *Devi*, or *Sakti*, cult. This, in turn, influenced the Sikh culture, particularly during the time of the last Guru, Gobind Singh. As a word *sakti* means power, but, as a cultic term, *Sakti* refers to the worship of the Mother Goddess Devi, Siva's consort who is also known in her other forms of manifestation as Parvati, Kali and Durga (McLeod 1976:13).

On *Baisakhi* Day in 1699, Guru Gobind Singh tested the bravery and loyalty of his followers and instituted a body of saint-soldiers which was to be known as the *Khalsa* or 'the pure'. Having demonstrated unconditional obedience, five of his followers, now known as the *panj pyares*, were given *amrit* ('nectar') which had been, and still is, symbolically stirred with a steel sword, as a form

of initiation. Thereafter, each Sikh male was to use the title *Singh* (a lion) and each woman, *Kaur* (princess) (Cole and Sambhi 1978:36,113; also McLeod 1984:81). All were to wear the five 'K's (the 'articles' of the faith which all begin with the letter 'K') and abide by several injunctions which included, for the men, the wearing of turbans. The five 'K's are the *kara* (steel bangle), *kes* (unshorn hair), *kachha* (shorts), *khanga* (a comb to wear in the hair), and, lastly, the *kirpan*, (a type of sword). There is some uncertainty as to the exact original symbolism meant by the five 'K's, though various military and ascetic reasons have been suggested (see Singh K. 1953:31; Singh A. 1981:101-104).

The Sikh scriptures, the *Adi Granth* (which were written in medieval Punjabi) were decreed by the last Guru, Gobind Singh, to become the eternal Guru, a lasting embodiment of the 'Living Spirit' of the Gurus themselves and, like them, to be revered but not worshipped (Singh 1981:95). Normatively, Sikhism offers full equality to women in all spheres of life, extending this attitude to all human beings and their systems of belief. It expresses in practical forms the notion of human equality and the rejection of ritual purity, for instance through the *langar*, the corporate meal given at the *gurdwara*, as well as in the sharing of the sacramental food, the *prasad*, from a single and thus shared bowl.

D) HISTORICAL PERSPECTIVES AND THE PARTITION OF INDIA IN 1947.

Religious disagreement has been a recurring, centuries-old feature of political life in the Sub-continent. The Muslims, while never conquering the entire Sub-continent, ruled the Punjab during the Mughal empire, each emperor showing varying consideration for his Hindu and Sikh subjects. In previous Islamic dynasties, not only were heavy poll taxes levied on the Hindu

population, but conquerors such as Mahmud of Ghazni and Timur, both ardent Muslims, ruthlessly set about suppressing Hinduism.

Akbar, however, being more liberal in approach, not only abolished the poll taxes but attempted to synthesize Muslim and Hindu thoughts and beliefs into a universal faith. In contrast, Auranzeb's subsequent fifty-year reign was one of suppressing minority religions, and it was during this time that the Sikh Gurus felt compelled to militarize their faith. Later, after Gobind Singh's death in 1708, the Sikhs retaliated and managed to conquer much of the Punjab. However, this period of Sikh domination was short-lived, and it was only in the late eighteenth century, when Ranjit Singh consolidated the various Sikh factions, that the Sikhs were able to claim a homeland and, until his death, have untrammelled religious freedom. As Maharajah of the Punjab, Ranjit Singh not only defied the usual oriental protocol by maintaining 'the common touch' with his subjects, but respected the institutions of non-Sikh religious communities, even participating himself in their festivals. He also allowed the Muslims to have a separate judicial system based on the *Sharia* (the Islamic legal code). With a carefully trained army, his kingdom became one to be reckoned with by other neighbouring powers, as well as by the British.

The Portuguese were the first Europeans to challenge Arab power as traders to the Sub-continent, and they, in turn, were challenged by the British and the French. Trading companies, particularly the British East India Company, gradually assumed political and military functions. Clive's defeat of the Mughal forces in 1757 is considered conventionally to be the beginning of British rule in India which expanded in fact, if not in name, through serial annexation and subsidiary alliances with various Indian states. The Industrial Revolution, the rise of Christian evangelical movements, and the opening of the Suez Canal

were all factors contributing to the arrival and expansion of the British presence in India. After Ranjit Singh's death, the British defeated the Punjabis, installed very able administrators, made legal and agrarian reforms, and later received Sikh military loyalty in the Sepoy Mutiny of 1857. This mutiny was India's first major challenge to British rule and, in response to this, in 1858 the British Crown instead of the British East India Company assumed responsibility for governing India.

It is with this historical backdrop of intercurrent religio-political strife and distrust that a growing desire for self-rule developed during the twentieth century. All-India movements began to be formed, becoming mass-based with Gandhi's revolutionary ideas of non-violent civil disobedience in the 1930s. Even so, religious and economic reasons continued to hinder the viability of Hindu-Muslim unity. Leading Muslim thinkers and politicians, such as Muhammad Iqbal and Jinnah, felt that an Islamic state free from Hindu domination was the only way to safeguard Muslim minority rights.

While seeking independence for India, Gandhi nevertheless envisioned a united India, whereas Jinnah, who led the Muslim League, believed that democracy was alien to Hindu society and that Muslims should be given a state, later to be called Pakistan, of their own. Feelings ran high and severe rioting, mostly between Hindus and Muslims, broke out in Calcutta in August 1946. By the winter, it had moved westward to the Punjab. Because they were both easily identifiable and numerically in the minority, Singh (1953:150-151) considers that the Sikhs became the targets of Muslim hatred. Many atrocities were committed and Sikh villages burnt and looted, though retaliation was probably not the true underlying reason as very few Sikhs had been involved in the riots in the east. Civil life in the Punjab came to a standstill.

With overt feelings of hostility between Punjabi Sikhs and Muslims very much a reality, partition of British India took place in August 1947. Two independent nations based on religious majorities and contiguity were created, princely states being left to accede to either India or Pakistan. The Sikh leaders also agreed to the division of the Punjab for, although it meant dividing their community, they desired a homeland of their own.

Many Sikhs had previously left the eastern Punjab to build canals and irrigation systems in the western section, frequently becoming landowners in these Canal Colonies, with Muslim peasants tilling the soil. At Partition, Sikh landowners were ousted, even murdered, and, before long, terrified Sikhs and Hindus were on the move to the Indian border. A two-way exodus of about ten million people ensued with little financial compensation for those who had become homeless and landless. For many, it meant death as both sides committed merciless atrocities one upon the other.

A time of vast human tragedy and bitterness, Partition left both parts of the now divided Punjab with many problems to solve. Not only were innumerable refugees needing to be cared for, resettled and integrated, but political issues regarding boundary disputes and control of the headquarters of the five rivers needed resolving. Partition for the Punjabi people was a time of immense human tragedy, possibly more so than in any other part of the Sub-continent, and also a time of tremendous economic upheaval.

E) PUNJABI FAMILY AND KINSHIP NETWORKS

i) The Family

In understanding Punjabi kinship networks, it is important first to consider what is implied by the term 'family'. As a basic unit of kinship, the term 'family' in 'its widest sense' refers to 'all relatives living together or recognized as a social unit, including adopted persons' (Theodorson and Theodorson 1970:146). The core of a family is the unit of the mother-plus-dependent children and when a father is joined to this, a nuclear or conjugal family results (Keesing 1975:35). And, should 'one or more other relatives who do not form a second nuclear family' live with a nuclear family, this family composition is known as a 'stem family' (Theodorson and Theodorson 1970:150). In contrast to how the term 'family' is defined, it is worth noting that the term 'household' uses spatial propinquity and residence, not kinship, as its definitive referents (Bender 1967:493).

In the Sub-continent, the joint or co-parcenary family is considered an important institution, though some writers question its prevalence (Dube 1963:177; Goode 1982:99). A joint family has been defined as one where:

. . . two or more lineally related kinsfolk of the same sex, their spouses and offspring, occupy a single homestead and are jointly subject to the same authority or single head.

(R.A.I. 1951:72)

In the Indian joint family, co-parceners are male persons who have the right to the products of the family property, which should be passed down intact from one generation to the next (Goode 1982:94).

Patrilineal descent, patrilocality and patriarchal authority are central features of the Punjabi joint family. Traditionally, both the budget and the maintenance of the family property should be of a joint nature, with the eldest male maintaining authority (Anwar 1979:52-59; Goode 1982:99). While respect should be accorded to the head of the joint family, he in turn is expected to consult the other family members when making decisions, a belief in mutual obligations running parallel with the right to exercise authority (Ballard 1972:18). In more recent times, and in Britain also, a Punjabi family may still consider itself joint while only engaging in social exchanges and a certain amount of shared ownership of property, although parents still encourage their married sons, either collectively or separately, to continue to live close to the parental household (Singh H. 1977:37).

This need for a certain fluidity in the meaning of 'jointness' has been commented upon and accepted by several writers, physical separateness not necessarily detracting from the nature of jointness if strong family obligations continue. These may be in the form of financial remittances or transglobal consultations for, although spatial changes may occur, the ideology and moral issues that bind a joint family need not necessarily change (Anwar 1979:52-57; Ballard 1972:14-15; Singh H. 1977:37). Although writing about life in Britain, Bell (1968:58) descriptively expresses this notion of jointness when he notes that for:

. . . many 'Indian families' in this country the head is in a village in Northern India and what appears to be an Indian family is merely a section of a joint family still connected by a 4,000 mile umbilical cord to 'home'.

For this study, the Royal Anthropological Institute's (R.A.I. 1951:72) definition is accepted but qualified by the notion that while a joint family aims towards

co-residence, commensality, joint property ownership and even a 'common family cult' (Hewitt 1968:78), it permits physical, structural and emotional variations where the essence of jointness between members remains.

ii) Kinship Networks

For a Punjabi, the wider kin network, that is the *biraderi* (the brotherhood), acts as a social environment which exerts a powerful force, both covertly and overtly on an individual's behaviour. *Biraderi* boundaries tend to be very imprecise, and while a *biraderi* is usually composed of relatives who are outwith the nuclear family unit and amongst whom both a 'brotherly' sentiment and a system of mutual relationships are supposed to prevail, it may extend to include non-kin (Anwar 1979:64). Definitive variations exist and Saifullah-Khan (1974) makes reference to the larger network which forms a potential source of relationships, the *biraderi* of 'recognition', as well as the one where actual relationships exist, the *biraderi* of 'participation' (Saifullah-Khan 1974:178; 1977:61).

Strong emphasis is placed on loyalty, both to one's *biraderi* as well as to the maintenance of *izzat*, that is group prestige or honour. In turn, the *biraderi* can be expected to act as a mutual support system whenever its members require financial, emotional and even physical assistance over and above what the immediate family can provide. Village, caste, linguistic and religious groups may also act as alternative sources of social influence and assistance.

Within the *biraderi*, Punjabis follow a system of gift exchange, *vartan bhanji*. Literally meaning 'dealing in gifts', *vartan bhanji* also takes on the connotation of dealing in 'relationships' which are expressed through subtleties implied in

the gifts exchanged. Rules of reciprocity and disequilibrium exist, for while:

A gift (*bhaji*) is expected to be matched with a gift at appropriate occasions . . . the gift should never be equivalent in value. The values must always be in imbalance. An exactly balanced gift will signal the dissolution of the relationship – a situation of no insignificant consequences.

(Wakil 1970:702)

However, *vartan bhanji* not only involves the exchange of sweets, fruits, food, money and yards of cloth, but extends to exchange of services, favours, similar treatment, entertainment and participation in ceremonial events (Anwar 1979:68). Gifts are exchanged at special times such as births, marriages and even before journeys to and from the Sub-continent, material objects becoming the 'chains along which social relationships run' (Evans-Pritchard 1940:89).

Wakil (1970:703) notes that latent if not overt competition is present in the *biraderi* concept, though more related to keeping 'the Joneses down' rather than keeping up with the Joneses. Nevertheless, the system does serve to support the weaker and needier as well as the stronger members of the community, concerns and troubles being preferentially coped with within the group rather than through more official channels.

F) CASTE, CLANS AND LINEAGES

Clans and lineages, as part of the overall caste system, are important divisions in the Punjabi social structure. Rooted in Hinduism and disavowed by Islam and Sikhism, the caste system remains a current structural reality amongst non-Hindu Punjabis, persisting with a customary rather than a religious basis amongst both Muslims and Sikhs (Jyoti 1983:14-15; Nesbitt 1980:53; Nyrop et al. 1975:148; Saifullah-Khan 1977:60). In fact, all ten of the Sikh Gurus married within their own caste (all were *Khatri*s) and according to

clan exogamy. McLeod (1976) considers this anomaly to have been the utilization of a social convention stripped of its religious significance, the Gurus being, in his view:

. . . opposed to the discriminatory aspects of the vertical relationship while continuing to accept the socially beneficial pattern of horizontal connections.

(McLeod 1976:90-91; cf. Cole and Sambhi 1978:21-22).

In the strict Hindu tradition, castes – which are also known as *varnas* or ‘colours’ as they were originally (that is, in Aryan times) based on skin colouring – are unilineal, endogamous descent groups, invariably patrilineal. Degrees of ritual purity, justified by Hindu scriptures and legends, act as a basis for ranking and, together with occupational inter-group dependence, they form a hierarchically-ordered social system (Bock 1974:156-157). Nevertheless, certain qualities of variability, fluidity and indefinability permeate this seemingly rigid system. Indeed, throughout much of north-west India, it is typical for one term, such as *jat* (usually meaning the endogamous sub-caste), to be used for the various levels of segmentation within the overall caste system, with the ‘sort of unit’ being referred to only becoming obvious within the general context of the conversation (Parry 1979:131). In the Punjab, the *jat* (sub-caste) is considered to be the more socially meaningful term on a day to day basis (Nesbitt 1980:52).

Particularly amongst the Sikhs, there may be a further sub-division of sub-castes into clans. Like castes, clans follow the unilineal principle and usually have a founder ancestor, ancestress or deity around whom a certain degree of obscurity frequently exists. Clan members tend to view each other as relatives despite a lack of exact genealogical connections and lack of residential propinquity, instead being unified by the clan name and certain clan

symbols and ceremonies (Bock 1974:152; Goode 1982:113; Sharma 1980:144,175). Marriage at clan level, unlike at caste and sub-caste levels, is usually exogamous rather than endogamous, that is outside the 'given social group' (Bock 1974:108) as opposed to within it. Clans may be subdivided and these sub-divisions are called lineages or sub-clans.

G) MARRIAGE

Islam and Sikhism have their own, often differing, injunctions concerning marriage as an institution. Even so, both are affected by the underlying Punjabi social structure and traditions, particularly the very sensitive notion of *izzat* and the patriarchal joint family system, as well as a certain amount of the socio-religious ideologies of Hinduism (Jeffery 1976:8,11; Jyoti 1983:10). For Sikhs as for Hindus, the normative ideal is that marriage should be a religious sacrament, 'indissoluble and a permanent union which is compulsory for everybody' (Jyoti 1983:11). For Muslims, marriage is viewed as a civil contract and one that can be dissolved, though more easily by the husband than by the wife. Nevertheless, reconciliation is actively encouraged (Lemu and Heeren 1978:21; also Jeffery 1976:11), the need for a stable family life being a central feature of Islamic belief.

Traditionally, not only were parents in the Hindu joint family morally obliged to find mates for their children and the children to accept their choice, but the marriage contract was considered to be an agreement between two families rather than between two young people. With the marital choice being seen as subordinate to group ends, love between husband and wife was expected to be the result of marriage and not a prelude to it (Jyoti 1983:182; also Ross 1961:251 - both with reference to Tagore 1920). Similar ideas would still seem

to continue, though modified, particularly regarding mate selection amongst both Muslims and Sikhs (Jeffery 1976:30; Jyoti 1983:187-189).

The idea of marriage as an arranged alliance between family groups is primarily concerned with the begetting of heirs as well as the formation of 'a knot in the network of kinship links' (Mair 1977:19). While incompatibility is not usually dismissed, marriage is seen as a:

. . . serious concern to a much larger number of people than the spouses themselves. Hence it is hedged about with rules and ceremonies to a much greater extent than it is in those societies, which . . . are exceptional, that make an ideal of 'marriage for love'.

(Mair 1977:19)

As any marital disputes may become a threat to both family honour and kinship alliances (Jyoti 1983:16), daughters are socialized to accept a subordinate role as young wives in a joint family. Thus, in reality, customary practices may contrast markedly with religiously-defined beliefs in equality.

H) PURDAH

Intimately linked with the notion of joint family *izzat* and the arranged marriage system is the institution of purdah (*parda* - a word meaning curtain or veil). Complex and variable, it affects the social, economic and political status of women. Through numerous symbolic and structural devices, it aims not only to shelter women from socially undesirable sexual encounters which might cast doubt on paternity and thereby inheritance, but also to reduce tensions in socially ambiguous situations, particularly where non-kin are included in patrilineal joint family systems.

There is some evidence that high-ranking women in pre-Islamic India were kept secluded and their movements restricted. Thereafter, the developments of purdah within Hindu societies is thought to have been in response to Islamic influences, but shaped according to Hindu sub-cultures (Jacobson 1982:86-87). Not only does purdah play a part in how families strive to ensure that their womenfolk marry status equals and avoid marital misalliances, but purdah also makes it difficult for the women to become economically independent of the male members of the family (Sharma 1980:14-15,201-202).

For Hindus, purdah is based on 'a set of avoidance rules between a woman and her male affines' (Papanek 1982b:194), especially those to whom her husband also owes respect and whom he theoretically should never disobey or quarrel with, making purdah most apparent within the affinal home and village. For Muslims, however, purdah especially applies to those men who are outside the immediate kin unit (Papanek 1982a:3). Vatuk (1982:68) suggests that, in many modern Indian Muslim communities, purdah is only observed 'with reference to the social approval of persons whose opinions about one's respectability matter' and, when one is anonymous, the veil becomes unnecessary.

According to Sharma (1980:3-4), women in South Asia 'bear a special responsibility for family honour', with men carrying this same responsibility, though less precariously. She also notes that, in most ethnographic accounts, purdah in India has been viewed primarily as an Islamic phenomenon with little 'discussion of the way in which purdah practices of different castes and communities in India are integrated' (Sharma 1980:5-6). Doctrinally, Sikhism does not sanction social separation of men and women, thereby differing from Islam (Cole and Sambhi 1978:109; also *Qur'an* - *Sura* 24:31 in Dawood

1974:216). Sikh women have always been regarded both as being eligible to lead mixed congregations in worship and for their bravery as warriors. Little has been documented, however, as to how this is effected in practice with regard to the customary Indian tradition of circumspect female behaviour and the maintenance of joint family *izzat*.

Although he does not define the term 'purdah', Singh (1958:502-503) throws some light on the variations that may exist. In describing a Sikh village near Amritsar, he emphasizes that, for the most part, the women do not observe purdah. Indeed, the women are seen as being excellent horsewomen who are ready to work in the fields alongside the men. Several are also considered 'undisputed heads' of their families. Even so, purdah is strictly observed by the young brides and by the *Jagirdar* families (landowning families who are regarded to have high status in the village). Because these women may not veil their faces in the *gurdwara*, they 'usually sit a little farther away from the persons from whom they should hide their faces', that is, their 'father-in-law and elder brother-in-law'. However, once a woman reaches thirty-five or forty years of age, 'she discards purdah and moves in and out of the house very freely'. Thus, Singh's (1958) study asserts that a form of purdah, though in the wider and less Islamic-specific sense of the term, may be practised at customary level.

On a day to day basis, it is usual for levels of female social invisibility, with consequent public passivity, to be controlled by the senior women of the family household. Whilst the senior women take on the social responsibility of maintaining family *izzat*, they do so in accord with the views of the male members of the family. For, not only can family *izzat* be easily jeopardized by immodest female behaviour, but a husband is judged by the qualities of his

wife and daughters (see Saifullah-Khan 1976:107; Wilson 1978:5) as well as by his ability to protect and provide for them. Though male honour depends on female *sharm* (a sense of 'shame'), men are expected to make it easier for women to maintain this, for instance, by giving warning of their arrival as well as keeping the time spent in the woman's world to a minimum (Jeffery 1979:104; Vatuk 1982:72).

Spatial segregation, which is not always economically possible, is one physical means of sexual division. One such form of spatial segregation is the *zenana* (women's quarters) which aims to offer female seclusion, even solidarity, but not isolation. Separate men's quarters are a corollary feature (Papanek 1982a:9; also Eglar 1960:30). In Pakistan, public buildings, institutions and transport frequently accommodate physical, if not visual, *purdah* requirements.

Bodily concealment of the most personal and communicative features of a woman, and to a certain extent men also, is expected. The *salwar-kameez* (trousers and tunic) which covers the body from head to toe has become the traditional attire of the Punjabi woman. A *dupatta* (chiffon or muslin scarf – also known as a *chunni*) or *chaddar* (shawl) is used to cover the hair, and also the face when required, as well as discreetly hiding the female form. Even where it has been dispensed with as a head covering, its vestigial use would seem to convey a continued symbolic function. While the wearing of a *burqa* (an over-garment which acts as a more complete form of bodily concealment) can be considered as a portable form of seclusion for Muslim women, even this does not necessarily free a woman from being harassed by men if she is without a male chaperone (Jeffery 1979:154–155).

Purdah may also be observed by discreet deportment, a certain shyness of manner, softness of speech, the wearing of subdued colours, the avoidance of eye contact and by turning the face. Thus female modesty and propriety may be maintained where social interaction amongst males is required. The veil, unlike the *burqa*, can be used expressively, even to the extent that it is almost an extension of a woman's social personality. As a means of covering the face, together with a lowered gaze, bending or even crouching, it is used to denote respect to elders and, similarly, respect in religious contexts. A veil may also be used as a symbol of conjunction as in the Hindu and Sikh marriage services where it both figuratively and literally links bride to groom (Sharma 1978:231; also Nesbitt 1980:216).

I) POLLUTION

Douglas (1966:115; 1968:340) considers pollution beliefs as best understood by visualizing the human body as 'a symbol of society' with the powers and dangers credited to the social structure being reproduced in microcosm on the human body. Pollution beliefs invariably protect the most vulnerable domains of a culture, helping to deal with culturally ambiguous events, frequently ones relating to products or functions of human physiology such as blood and excreta as well as hair and nail clippings. As cooking food is also considered by many to be the beginning of ingestion, it likewise may be viewed as susceptible to pollution. Strength may be lost or danger transmitted. One sex may be endangered by contact with the other, invariably males by females. Not only may beliefs mirror the hierarchy that exists within a society but each society assents to such notions by formulating and adhering to its own pollution and purification rituals (Douglas 1966:3-4; 1975:60-63).

In the Sub-continent, women in Hindu, Sikh and Islamic societies are respected for their uterine potential, but, by the same token, they are a cause for concern as the 'purity' of the family blood may be defiled through female sexual indiscretion. Thus purdah is legitimized in a patriarchal society where the control of sexuality takes on paramount importance. Islamic and Sikh pollution and purification beliefs and requirements in India are discussed more extensively by Jeffery (1979:110-114) and Hershman (1974:285-286).

In Muslim societies, women are generally seen as vulnerable to sexual advances, whereas in Hindu societies, avoidance rules are as much to protect men as women (Papanek 1982a:36). The Indian woman assumes an ambivalent dual role, for though she is venerated as a mother, as a wife she is considered to be sexually threatening, even sexually debilitating (Lannoy 1971:114-115). Restrictions on both mobility and involvement in religious practices as well as bathing rituals are frequently demanded, certainly with regard to cultural impurities relating to menstruation, childbirth and sexual intercourse. These practices may also be viewed as a way of circumscribing the world of women, especially the younger women. By keeping them from the male spheres, their power in the political, economic and religious arenas is thus reduced. Indeed, with reference to north-west India, Sharma (1978:225) notes three forms of social subordination: junior to senior, female to male, and impure to pure.

3. OVERVIEW OF THE SETTLEMENT OF INDIANS AND PAKISTANIS, PARTICULARLY PUNJABIS, IN THE UNITED KINGDOM.

Over the past century, and for a variety of reasons, Indians and Pakistanis, especially those from rural areas of the Punjab, have travelled abroad. Forming a far-reaching 'mosaic of overseas settlements' (Mayer 1959:1), Punjabis, and notably the Sikhs, would appear to have particularly strong propensities to emigrate both within India (for instance, when the Canal Colonies were established [Nair 1961:103-104]) and worldwide. Once people have experienced breaking the bonds which hold them to the place where they have spent their childhood (Lee 1969:291), it would appear that they are more likely to emigrate than those without this previous experience.

During the mid- to late nineteenth and early twentieth centuries, many Punjabis became indentured labourers in British colonies, such as Fiji, Mauritius and Trinidad. Others joined steamship companies and sailed to many countries including Britain. As early as 1887, Sikh troops were amongst those attending Queen Victoria's Jubilee celebrations in London (Singh K. 1953:120). In fact, many Punjabis, Muslims as well as Sikhs, were recruited into the British Army in India (Anwar 1979:21; Hiro 1971:119) and, later, into the British armed forces during both World Wars when some found themselves stationed in Britain.

A) THE PIONEERS

As a useful framework for considering the evolution of 'South Asian' settlements within Britain, Ballard and Ballard (1977:20-21) have suggested four phases. Although chronologically-ordered, considerable variation exists in the

timing and duration of each phase as well as in the particular characteristics of each group of immigrants.

Initially, there is a pioneering phase which dates back to the late nineteenth century when merchant seamen, from areas which, for the most part, are now in north-east Pakistan, decided to take up shore-based occupations in Britain. Frequently they found work in seaports, though many also found work inland in various other towns and cities, particularly where a shortage of labour and relatively cheap housing co-existed. Although 'Asiatics' could be found 'from Plymouth to Ben Lomond, and from Aberdeen to Hastings' as far back as the 1870s (Salter 1873:220-221), very few of them put down permanent roots in this country until after the First World War.

One of the earliest groups, about seven in all, were the *Bhatra* Sikhs who arrived in Glasgow in 1924 (Singh H. 1977:10) when Britain was the only country in the Empire with an 'open-door' policy. Belonging to a vendor sub-caste, the *Bhatra* Sikhs were known in the Punjab for being pedlars, small shopkeepers and itinerant fortune-tellers (Ghuman 1980:309). They, and other Punjabis who arrived in the inter-war years, earned a somewhat precarious living as hawkers and pedlars, usually selling clothes and smaller items such as jewellery (Nesbitt 1980:61). By travelling the length and breadth of the country and by offering housewives acceptable terms of credit, they managed to make an economic niche for themselves (Taylor 1976:47-48). These men were to be the 'fore-runners of the post-war migrants' (Dahya 1972:25).

B) INCREASED IMMIGRATION

While many of the earliest immigrants saw themselves as sojourners who eventually planned to retire to the Punjab, they nevertheless formed the bridgehead for the influx of immigrants who arrived soon after the Second World War as well as during the late 1950s and early 1960s. Ballard and Ballard (1977) consider this time of noticeably increased immigration as the second of their phases.

Britain's post-war economic boom produced an increased demand for unskilled labour which was answered, in many areas, by employing Punjabi immigrants. Emigration became a worthwhile venture. Some immigrants used the financial compensation they had received as a result of being uprooted, either during Partition or with the building of the Mangla Dam in Mirpur in the 1960s, Mirpuris being essentially Punjabi in culture (Saifullah-Khan 1974:5). Ex-army officers were able to use the emigration vouchers they had been offered in 1962 (Anwar 1979:22).

Systems of voluntary, exclusively-male, chain migration frequently developed. A previous immigrant would financially sponsor another kinsman or friend and then help him to settle and find work (Jeffery 1976:48). If it were not possible to find work in one town, immigrants would be passed on to other village kinsmen elsewhere until they were successful in finding employment (Bell 1968:54; Goodall 1968:71). Frequently, this would be in the textile mills and heavy engineering industries of the North and the Midlands of England. A trend towards groups of Punjabis from one small area in the Sub-continent being localized in specific towns and cities emerged. Whilst willing to work long and unsocial hours and prepared to live frugally and in all-male

households in order to be able to pay back their fares as well as make remittances to help support their families in the Sub-continent, most of them planned on eventually returning to the Punjab (Aurora 1967:52-53; Ballard and Ballard 1977:31-33; Dahya 1972:30).

Unlike the West Indians, the Indians and Pakistanis had:

. . . never visualized their migration in socio-cultural terms. For them, the economic was the sole motive for migration.
(Hiro 1971:123)

During the decades following the Second World War, most of the legislation regarding immigration policies, Indian, Pakistani and British, tended to be prohibitive. This legislation noticeably affected the ease with which Indians and Pakistanis could emigrate from the Sub-continent and, thus, caused a great deal of concern amongst those already living in Britain. For instance, the impending Commonwealth Immigrants Act, which was passed in 1962, created such fear that future entry into Britain would be barred, that a sharp increase in immigration ensued and the homes of resident Punjabis virtually became reception centres. In later years, the 1971 Immigration Act (which came into force in 1973 and gave the 'right of abode' in Britain to people defined as 'patrial' [see Runnymede Trust 1980:35-36]), together with the 1973 Pakistan Act, brought about an increased number of applications for United Kingdom citizenship.

C) RE-ESTABLISHMENT OF FAMILY LIFE AND CONSOLIDATION OF ETHNIC COMMUNITIES

Some Punjabis had already decided to bring over their wives and children, though this usually meant they were then less able to provide financially for their other kinsfolk in the Punjab (Jeffery 1976:65). The marked contrast between the households where at least one nuclear family resided and the austere atmosphere of the 'bachelor households' has been well described by Aurora (1967:60). Few women, certainly amongst the Pakistanis, emigrated to Britain until after the immigration restrictions began to tighten up. Even then, older daughters would often be left behind with other relatives, thus maintaining the unequal, if less so, ratio of more men than women. Whether wives, brides, widowed mothers or unmarried sisters, the women who emigrated to the United Kingdom at this time were invariably dependants of male immigrants (Desai 1963:8; Runnymede Trust 1980:11-12).

This period, one of establishing and re-establishing conjugal and extended family life, together with a greater consolidation of Asian communities, marks Ballard and Ballard's third phase. Increasingly, families began to purchase their own homes, often by pooling their financial resources to buy what invariably was older, inner-city property. For the Sikh communities, this period was most noticeable in the 1960s, whereas most Muslim Punjabis only moved into this phase in more recent times.

During this third phase, various Punjabi social institutions were re-created and have been well described by Hiro (1971:126-155), Ballard and Ballard (1977:35-37) and Singh (1980). These included numerous cultural activities, such as traditional rituals, gift exchange systems and varying forms of purdah,

and indeed *izzat* could now be lost and won in the British social arena as well as in the home village in the Punjab. Asian-run businesses and services began to flourish in response to the needs of the increased ethnic minority market. Vernacular newsmagazines, Asian cinemas, grocers and *halal* butchers, mosques and *gurdwaras* were among the many institutions that emerged and helped to create more ethnically pronounced and relatively self-sufficient Punjabi communities. By and large, these communities sought to establish their own distinctive, cultural identity (Dahya 1974:90-95; Srivastava 1975:61-62).

In the early days of immigration, many Sikhs had found it necessary to remove their beards and turbans in order to gain employment, a requirement not considered necessary for operating tanks during the Second World War (Hiro 1971:141). In the hope of avoiding cultural and racial discrimination, many Punjabis maintained a low public profile. For similar reasons, many became self-employed and/or part of the ethnic economic infrastructure which had developed to serve both minority and majority ethnic communities. Rather than competing for whatever existed, they preferred to discover 'new needs, unfulfilled or incipient demands', transferring the astute understanding of trading gained in 'the bazaars of Southern Asia' to the British markets (Werbner 1980:84-85). Indeed:

By creating a self-contained life of their own and by being genuinely indifferent to British social life, many Asians saved themselves from the indignities and rebuffs inflicted on the West Indians.

(Hiro 1971:129; also Anwar 1979:215).

D) THE SECOND GENERATION

The emergence of a British-born, or at least British-educated, second generation, which Taylor (1976) describes as 'the half-way generation', forms the last of Ballard and Ballard's (1977) four phases. This is a phase that has only been reached by groups that have been established in Britain for some time. Socialized into two very different cultures, at home and at school, it would seem that, not only are almost all of this second generation:

. . . returning to follow a modified version of Punjabi cultural norms in their late teens and early twenties,
(Ballard and Ballard 1977:44)

but many of them have become skilled at living in both cultural worlds, Punjabi and non-Punjabi.

4. THE *BHATRA* AND THE *ARAIN* SUB-CASTES

The following section offers historical insights into the two sub-castes to which many of the families, Muslim and Sikh, who participated in the study belonged.

A) THE *BHATRA* SIKHS

Several accounts of the ancestral origins of the *Bhatra* have been documented, that is, about the times predating their conversion to Sikhism (Ibbetson 1883:301; Rose 1911:93-94; Nesbitt 1980:56-61). In one legend, a Brahman, Changa Bhatra, was converted to Sikhism during Guru Nanak's supposed visit to Sri Lanka (Nesbitt 1980:56-59). Many of Changa Bhatra's followers accompanied the Guru back to India, first settling in the Bijnor district

of Uttar Pradesh and later moving west to Hoshiarpur and Sialkot. During the late nineteenth century, Rose (1911:94) not only noted that a moiety of the *Bhatras* in Sialkot were 'true Sikhs, observing all the Sikh customs', but also commented on their itinerant activities. These were said to include hawking small hardware for sale, practising astrology and palmistry as well as the task of piercing children's ears and noses in order to insert ear and nose rings (see also Ibbetson 1883:301).

Hindbalraj Singh (1977), himself a *Bhatra*, offers the greatest insight into the development of the *Bhatra* communities in Britain. Originating from about ten villages in the rural districts around Sialkot, most of the *Bhatra* families had lived for many generations on family plots of land until Partition. Even so, many of them had depended on itinerant peddling activities for a stable source of income and were well-known for their geographical mobility throughout India. Not only would 'different village sets (and often single villages)' specialize in different aspects of peddling, but would work in different 'areas of India' in order to avoid being in direct competition with one another (Singh 1977:9).

As well as the first group of *Bhatras* who arrived in Britain in 1924 and who were based in Glasgow, and a subsequent 'larger expedition' in 1933 (Singh 1977:10), a certain amount of male, chain migration, often transient in nature, occurred until 1947. Initially, many lived in ports such as Bristol, Cardiff, and Southampton. Later on, others moved inland to cities such as Birmingham, Manchester and Nottingham. During Partition, the *Bhatra* Sikhs fled from the Sialkot area (which, thereafter, was in Pakistan) to India to find new homes for themselves in and around cities such as Amritsar and Delhi. Some, with kinsmen in Britain, migrated to Britain. By 1977, the *Bhatra* population

throughout Britain was thought to number over 20,000 (Singh H. 1977:4).

B) THE *ARAIN* MUSLIMS

In 1883, the *Arains* (also known as *Rains*) could be 'found in great numbers' throughout most of 'the Eastern Plains and throughout the Rawalpindi and Multan divisions' (Ibbetson 1883:267) in the Punjab where they formed a sub-caste of market gardeners and vegetable growers. West of Lahore, however, the name *Arain* was used invariably in reference to the occupation rather than the sub-caste. Describing them as 'admirable cultivators, skilful and industrious', Ibbetson (1883:267) pointed out that the *Arains* not only appeared to be a 'true *Panjab* tribe' but were also, without exception, Muslims. According to Rose (1911:14), the *Arains* originally came from the regions of the lower Indus and moved from there into the Punjab as well as north-east towards the river Jumna. More recently, Eglar (1960:61), in her study of Punjabi village life in newly-formed Pakistan, refers to women of 'the *arain*, the vegetable growers' caste, who bring vegetables from the neighbouring village' for sale. Smith (1960:165) also mentions the *Arains* and their numerical importance around Amritsar and Lahore.

Despite the equalizing function of the Islamic faith, sub-caste membership still holds a position of importance in Britain both in the formation of social networks and in the arrangement of marriages. Although little mention seems to have been made regarding the presence of members of the *Arain* sub-caste in Britain, Werbner (1980:92-93) does note that the Pakistani textile trading community in Manchester includes a considerable number of *Arains*. In her thesis (which also focuses on Manchester), she speaks of their upward mobility within the caste system, a system that she believes to have very similar

features to the Hindu system but with an Islamic sense of equality, both legally and religiously, and without the overriding notion of a hierarchy based on levels of purity (Werbner 1979:27-28,35,48-49). In addition, Elahi (1967:6), in his study of Pakistanis in Glasgow, not only refers to the term *quom*, a form of sub-caste, being used in this community, but gives *Rain* as one such group.

5. THE CONTRIBUTION OF THE WOMENFOLK TO THE DEVELOPMENT OF THE ASIAN COMMUNITIES IN THE UNITED KINGDOM

For the most part, the contribution that Asian, particularly Punjabi, women have made to the stability, consolidation and expansion of Asian communities in Britain has received minimal consideration, certainly within the published literature; an observation which Nath (1970:21) and Parmar (1982:236) also make. Few female researchers (who, due to cultural norms, have easier access to interviewing women) have sought to determine the women's world or their contribution to the development and, thereby, the overall history of the Asian communities in the United Kingdom. Women tend to be viewed only in their parental capacity rather than in their additional capacity to develop and contribute to community life in a wider sense. Insights offered by Jeffery (1976), Saifullah-Khan (1979) and Parmar (1982) are notable exceptions inasmuch as these researchers look at the part Asian women have played in the migration process, their contribution to the household economy, and their willingness to counter differing forms of discrimination. In addition, Wilson's (1978) text, *Finding a Voice*, is exceptional in that it is entirely concerned with the lives of Asian women in Britain.

In 1964, Uberoi (1964:40) predicted that the women (in this instance, Sikh women) would have a substantial influence in affecting the pattern of life

developing in the Southall Asian community following the influx of immigrants from the Sub-continent in the 1960s. Considering that too little information had been paid to this feature of the community's development, Uberoi (1964:40) also observed that:

. . . the Sikh men in Southall themselves tend, traditionally, to underestimate the importance of their women.

By the mid-1970s, many women (again in Southall, but also elsewhere) were noted to be both working and managing their homes, frequently because of economic necessity, yet having to weigh the social costs involved in making such a decision (Dhanjal 1976:110-111; Saifullah-Khan 1979:123). Some women were working as shopkeepers, others as teachers, nurses and secretaries, while others worked at home or in factories. Sometimes wives worked to allow their husbands either to avoid the night shift or else work shorter hours (Anwar 1979:134). As an overall consequence, more women were beginning to have an economic stake in the family. This was a new situation in itself (Dhanjal 1976:111; cf. Dahya 1965:319) and, especially so, if compared with Horowitz and Kishwar's (1982:15-16) findings that rural Punjabi Sikh women have little or no control over the domestic purse and/or household decision making, whatever their age and contrary to what they term to be 'prevalent myths'.

In many ways the rapid increase in the Asian economic infrastructure in the 1960s seems to have paralleled the arrival of the womenfolk. In addition, much of the impetus to set up businesses (e.g. draperies, goldsmiths, estate agents and mortgage companies [Hiro 1971:151-155]) would seem to have been in response to female rather than male immigration, with such enterprises then adding to subsequent entrepreneurial confidence and further expansion to non-Asian consumers and clientele. In all, the part the women have played towards the revival and growth of inner-city areas (Brown 1981:49), albeit

'behind the scenes', is one that has been minimally documented. Yet, without the women's stimulus to the development of Asian communities in Britain, directly or indirectly, an essentially uneven picture results.

Another area that similarly has not been explored in the light of female dynamics is the increase in ethnic pride that would seem to have been spurred on, at times even retrieved, with the arrival of Asian women and children. Although not explicitly giving this emphasis, Ballard and Ballard (1977:37) do note that it was at this time that the Sikh men began 'feeling confident enough to make a public statement of their ethnic identity', growing their hair and beards and wearing turbans again. Ballard and Ballard (1977:36) also refer to 'gossip and scandal' as 'securing conformity to the ideal, traditional norms' of Punjabi culture (men also being capable of feeling *sharm*, a term usually used in reference to women). This, possibly, was also female in origin inasmuch that until then there appears to have been minimal censure, for instance, with regard to religious laxity and sexual impropriety.

Hiro (1971:169) intimates that the women form the central arch of Asian families and that the 'proverbial submissiveness of the Indian women' is deceptive in that under 'the coat of plasticity and self-effacement there lies granite'. Even so, for the most part, Asian women are portrayed as passive, conforming and, at times, almost 'caged' within purdah restrictions. Indeed, little emphasis is accorded in the published literature as to how they play their vital roles in bringing up the next generation, selecting marriage partners (note Nath 1970:62), helping to maintain community cohesion (for instance, through *vartan bhanji*) as well as providing a more secure home-base for the menfolk.

Increasingly more Punjabi women living in Britain have grown up in Britain. For some, childhood memories include those of life as it was when their fathers travelled the length and breadth of the country selling goods and clothing to housewives, often living in the vans that they travelled in to save the cost of lodgings. Sometimes, as children, they too were mobile, growing up in differing parts of the country, living in various homes and attending school in various towns and cities. For others, childhood memories are of years spent in East Africa or/and the Sub-continent. In addition, a number of Punjabi wives can reflect on years spent in the Sub-continent with their affinal relations, while their husbands earned a livelihood in Britain. Although Ballard and Ballard (1977:33) note that, for these wives, 'daily life will continue much the same', such a conclusion may too easily be reached. In my own fieldwork, one wife spoke of how she had not managed to conceive a child before her husband left for Britain. As a result, for her, life in the affinal home was not at all easy or happy. On later joining him, life in Britain brought progeny and consequent happiness despite the fact that she was one of the first Muslim women to settle in the city and, therefore, found herself with little female Punjabi company. While this is but one example, it nevertheless is one glimpse into what is a virtually undocumented area, that is, the history of the Asian female population and their contribution to the development of Asian communities in Britain.

6. SUMMARY

In this chapter, I have offered insights into life in the Punjab as a backcloth to understanding Punjabi cultural life in Britain. As well as discussing a variety of geographical, historical and religious features, I have also described family and kinship networks, paying special attention to the institutions of marriage

and purdah as well as the notion of pollution. Thereafter, following Ballard and Ballard's (1977) four-fold approach to the settlement process of Asian immigrants, I have considered, in some detail, the development of Asian communities in Britain, including the women's contribution and the presence of the *Bhatra* and *Arain* sub-castes. In so doing, the scene is set for the following two chapters in which various aspects of family life and child bearing and child rearing, as they relate to one relatively small Punjabi community in Britain and, more particularly, to twenty-nine families within this community is described.

CHAPTER SIX

PRE-ENCOUNTER INFLUENCES

THE FAMILIES

- 1. Introduction**
- 2. Socio-Environmental Factors**
- 3. Aspects of Family and Community Life**
- 4. Underlying Cultural Values**
- 5. Summary**

1. INTRODUCTION

In this chapter and the following chapter (Chapter Seven), I present the findings of a study which is concerned with the activities of child bearing and child rearing as they relate to family life in a small Punjabi community in one city in the United Kingdom. The study aimed to discover and describe cultural information relevant to health visiting's maternal and child health remit. In this chapter (Chapter Six), I initially describe various socio-environmental details regarding the community and, thereafter, features of family and community life. Then, in Chapter Seven, I specifically focus on the activities of child bearing and child rearing. In both chapters I also consider underlying cultural values.

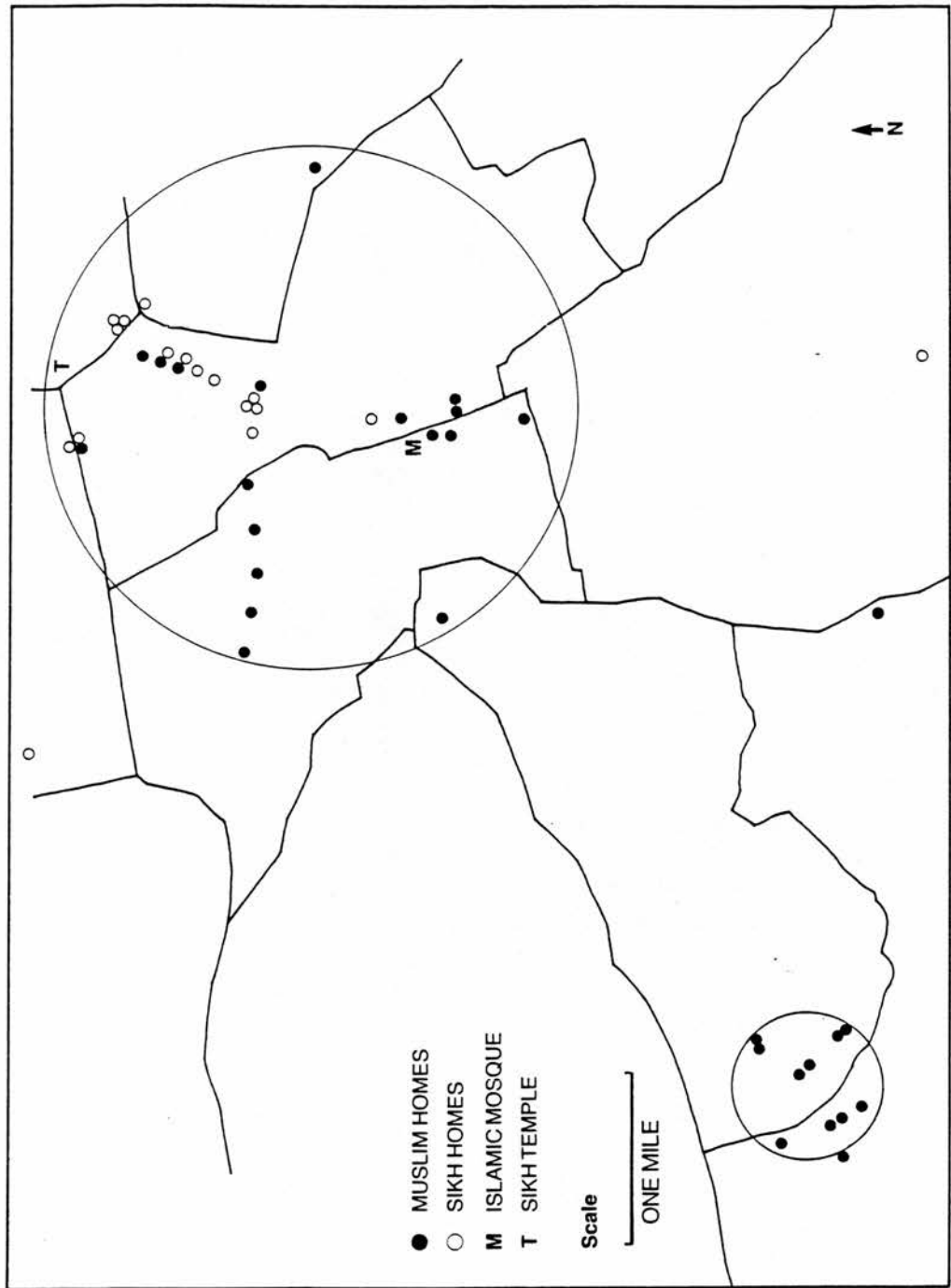
In Chapter Eight, the relevance of the findings are discussed as they relate to health visiting three hypothetical clients from the Punjabi community studied: the antenatal mother, the post-natal mother and the infant. For the purposes of this discussion, the findings in both Chapters Six and Seven are used in conjunction with the diagnostic process of health visiting (as described in Chapter Two). Hence, the findings should be regarded as 'pre-encounter influences', the first of the seven elements of the diagnostic process. As pre-encounter influences, it is envisaged that the findings would be utilized in composite form by the practising health visitor. As Benner (1984:9) observes, 'the proficient [nurse] compares past whole situations with current whole situations'. Although separated into two distinct chapters, the findings should therefore be considered as interrelated.

The formatting utilized in this chapter and Chapter Seven is based on ideas drawn from various sources. In addition to those previously stated in the text

(note Chapter Four), these sources include Brownlee's (1978) cultural assessment guide, the health visiting literature (e.g. the emphasis on life processes as foci for health visiting practice), health visiting education (e.g. the neighbourhood study [note Chapter One]), and the researcher's experience both as a health visitor in the United Kingdom and as an outpost nurse in Northern Canadian arctic settlements.

Twenty-nine families from this community constituted the sample population, and all were adherents of either Islam or Sikhism. In addition, various other individuals and families were respondents at differing times before, during and after the main period of fieldwork. All these families and individuals have been assigned a number (e.g. #1,#2) if they are one of the sample families with whom an interview schedule was completed, or a letter (e.g. #A,#B) if they are not one of the sample families. A composite list of the respondents and their corresponding numerical or alphabetical designations is to be found in Appendix Two. These designations are used throughout Chapters Six and Seven to indicate the source of an item of information, such as a direct quotation, a description of a respondent's own life experiences, or information provided which relates to other Punjabis in the same community. Whilst the majority of the Sikh respondents were from the *Bhatra* sub-caste, not all of them were. Therefore, with regard to Chapters Six and Seven, the term '*Bhatra*' refers specifically to members of the *Bhatra* community and 'Sikh' to both the *Bhatra* and non-*Bhatra* Sikh respondents.

**DISTRIBUTION OF THE 47 HOMES VISITED,
INCLUDING THOSE OF THE 29 'SAMPLE' FAMILIES**



MAP 3

2. SOCIO-ENVIRONMENTAL FACTORS

A) HOUSING AND SPATIAL DISTRIBUTION OF SAMPLE POPULATION

Altogether I visited forty-seven homes and, in so doing, I covered a wide range of housing types and locations throughout the city, each location having varying community resources. All but three of the homes were within two circumscribed areas:

- i) on the south-western perimeter of the city,
less than a mile in diameter
(11 families);
- ii) in the central and north-eastern section of
the city, just under three miles in diameter
(36 families).

Within these two areas, the twenty-nine families which form the sample population can be spatially distributed into three distinct locations:

- 1) Ten families, all Muslims, live within a mile of each other on the city outskirts in an area where about one hundred Pakistani families are thought to reside. Seven of the families live on a spacious though barren and well-concreted council housing estate which mainly comprises of vertical and longitudinal multi-storey apartment blocks, most of which are not in the best state of external repair. These families live in two-level, maisonette-type as well as one-floor apartments of various proportions, at various levels and with varying outlooks.

While this estate commands an enviable, panoramic view and has its own large shopping and community centres, the majority of homes, and indeed those of all the respondents, are without gardens. Grassed and concreted open-plan areas, lacking flowering shrubs and mature trees, provide bleak alternatives. For mothers with young children, crossing the numerous wide roads can be hazardous except where under- and over-passes, which are frequently graffiti-covered, have been built. A busy railway line dissects the estate but does not offer any additional access to the city or neighbouring towns.

Vandalism and crime, together with minimal health facilities and a lack of social amenities (such as launderettes and a police station), make this one of the city's least desirable residential areas. While it may not be too difficult for those who move here from other cities in the United Kingdom to adjust to living in this housing estate, for those leaving a rural Punjabi life it will constitute a radical environmental change.

The remaining three families live nearby on a small, privately-owned housing scheme in detached and semi-detached, two-storied houses with their own front and back gardens. Two of the three houses have garages. Away from the shopping centre and the busy major roads, this scheme offers a fairly peaceful environment for its inhabitants and does not seem to suffer the vandalism that the nearby council housing scheme does. While these families are more able to afford a home in a more peaceful location, several families on the council estate have been cautious in not accepting certain homes offered to them which are in areas of increased vandalism and crime, possibly on the advice of other Punjabis.

2) Nine families are Sikhs, eight of whom live in privately-owned, older property in the north-east section of the city, mostly within one and a half miles of each other. Not only does the location of these homes offer propinquity to relatives and other *biraderi* members, but also proximity (if only by a direct bus route) to the local Sikh *gurdwara* which functions as a religious community centre.

Five of these families live in privately-owned flats in what is mostly nineteenth century property, invariably with a communal staircase and, in several instances, with the use of a grassed area at the back of the building. Of the remaining three families, one lives in a Victorian terraced house and another in a more imposing semi-detached, stone house with front and back gardens. The third family live in a council flat on a bleak, relatively down-trodden housing estate some distance away, though on the same side of the city. Schools, health facilities, various community amenities as well as numerous shops are all within easy reach of all the Sikh homes. In the area where most of the Sikh families live, there are also several Asian-run stores selling Asian foods and commodities, for instance, Punjabi-type dress materials, Indian video films and sub-tropical fruits and vegetables such as aubergines, *karela*, *thoria* (*okra*) and mangoes.

3) The remaining ten families are Muslims, and these families live in housing ranging from a bed-sit in someone else's flat to a modern, privately-owned, three-level suburban row house. On the whole, they live in the more densely populated, central and north-eastern areas of the city and again in what is mostly nineteenth century property. While several of the families live close to the mosque, others live in the same vicinity as the Sikh families. Most homes are close to stores selling *halal* meat (meat slaughtered

according to Islamic prescription) and other Indo-Pakistani foods.

Several families speak of preferring a home in a quiet area where they can hope to live peacefully and avoid any racial harassment. Caution is frequently exercised before front doors are opened, family members either calling out in Punjabi or looking first through the front window or through the letter box. Many doors have peep-holes, perhaps for this very reason, though their use also serves to allow a wife to veil herself if necessary.

B) ORIGINS AND RELIGIOUS AFFILIATION

Religious affiliation divides the twenty-nine families, twenty families being at least nominally of the Islamic faith and the remaining nine being Sikhs, mostly from the *Bhatra* sub-caste. The long-established families within the Punjabi Muslim community are reported to be predominantly from the *Arain* sub-caste and of the *Sunni* sect.

Nearly all the twenty-nine sample mothers, most of whom are in their twenties, were born and have spent many of their formative years in towns and villages either in the Punjab or elsewhere within the Sub-continent. Sikh mothers mention Ambala, Amritsar, Delhi, Jullundur, Ludhiana and Sialkot as places in which, or near to which, they or their parents have lived and where they still have relatives; whereas Bahawalpur, Faisalbad, Islamabad, Jhelum, Karachi, Lahore, Multan and Jullundur are referred to by the Muslim mothers. Several families also mention post-Partition dislocations. Nevertheless, only two of the five mothers who were born before 1947 have been directly involved themselves and, in both instances, they moved from India to Pakistan.

C) AGES AND LENGTHS OF RESIDENCE

There is a marked difference between the length of time the Muslim and Sikh sample mothers have been resident in this country, possibly due to varying economic and political pressures in the Punjab as well as to the effects of changes in the immigration laws. On the whole, the Muslim mothers have lived here for fewer years than have the nine Sikh mothers, eight of whom have been here for between ten and twenty-nine years; in fact, three of the Sikh mothers were born, raised and educated in this country. In contrast, only eight of the twenty Muslim mothers have lived here longer than six years and, though one mother has lived in this country for twenty-four years, none were born here.

D) ECONOMIC ASPECTS

Most families are involved in self-employed businesses of their own or those belonging to relatives or friends. These include management of a guest house, grocery stores (at least one selling *halal* meat) as well as drapery concerns with offshoot market stalls in outlying locations. Although these businesses offer a degree of economic self-determination, they frequently involve long and unsocial hours. Bus driving, factory work and motor mechanics are three other occupations that have been mentioned. Only three of the husbands are unemployed, two having moved from other cities in the hope of finding employment.

Some of the husbands work quite close to their homes and are thus able to return home for lunch or, as one young man (#11) casually describes, to:

quickly rustle something up!

However, it is not so easy for other husbands to return home during their working day, particularly those who are in the north-west part of the city. Consequently, evenings or weekends often become the only times when many families can eat all together.

Several wives help in the family businesses, but most are solely involved in caring for the family and the home. A few Muslim wives speak of having worked, for instance, in the jewellery trade, in a biscuit factory and, both in this country and in Pakistan, as teachers of Urdu, mathematics and physical education. One mother had been interested in becoming a doctor but her father, a doctor himself, preferred her to marry. Amongst the *Bhatra* community, it is very unusual for a wife to work outside the home or the family shop (#7), a feature which Singh (1977:22) suggests to be part of the moral order of the *Bhatras*.

For families involved in grocery businesses, shopping for food and household commodities is made that much easier, thus reducing the need for many wives to leave the house (e.g. #23). Several wives speak of driving to a larger Punjabi community where certain items, such as *ghee*, can be bought in bulk at much reduced costs (e.g. #F). Also, by joining a common fund or 'pot', a number of families have intermittent access to a more substantial amount of money, by turn or when seen to be in need (see Dhanjal 1976:114; Singh H. 1977:24; Werbner 1981:222). In one Punjabi-run store, any failure of Punjabi customers to keep up with payments due is kept in check by the visual access of the payments book by others of the wider *biraderi*, the notion of *izzat* acting as a central feature to this method of control.

E) LANGUAGE FLUENCY

In response to being asked to make a very basic assessment of their own and their spouse's fluency in understanding, speaking and reading various languages – particularly English, Punjabi and Urdu – all the parents, except for one Urdu-speaking Muslim mother, claim to be fluent in spoken Punjabi, although few are Punjabi literates. Urdu, however, is spoken and read by all the Muslim fathers as well as by most of their wives. In addition, the majority of sample mothers possess a reasonably good command of spoken English, some possibly understanding more than they can speak (which also seems to be so for a number of mothers-in-law [e.g. #11]). A variety of British dialects is to be heard, clearly reflecting the mobility of some of the mothers within this country.

Only nineteen of the mothers are able to read English. This is in contrast with their husbands, all of whom can read and write English (most husbands claim a degree of literacy in more than one language). Just one parent, a slightly older lady, claims a total lack of literacy in all three languages. A number of parents are also able to understand some Hindi, Persian, Arabic, French and Gaelic. To be literate in both Urdu and English not only requires a certain degree of mental flexibility but also a degree of manual dexterity (that is, to re-adjust from a language written from right to left to one written in the opposite direction) which, in some instances, may have relevance for child development assessments. Conversely, a lack of literacy in English reduces a mother's self-sufficiency, and, indeed, one mother cites her difficulty in completing hospital menus as one example of what this means for her.

Frequently I have been conscious that these mothers not only have a consistent gentleness of manner but speak in softly modulated tones of voice, extra expression often being conveyed by eye, facial and hand movements rather than greater variations in vocal range. Amongst the Sikh mothers there appears to be a greater use and width of vocal energy and a more definite forthrightness of vocal expression, though only, it seems, in situations where the respondent, myself, children and similarly-aged female relatives are present.

F) DRESS, FASHION AND JEWELLERY

Adhering to Punjabi codes of modesty, publicly and privately, every mother wears the traditional and eminently functional *salwar-kameez*, or 'suit' as they are sometimes called. This is a style based on clothing worn during the time of the Mughul Empire and one which aims to ensure maximum bodily concealment. Usually made of light material in matching or contrasting colours, these trouser and tunic outfits are incomplete without a *chunni* (scarf - also known as a *dupatta*) or a *chaddar* (a shawl) either worn across the shoulders or else kept near at hand in readiness to cover the hair and face as necessary.

Most of the women design and make their own outfits which involves minimal wastage of material. Designs follow the vagaries of Punjabi fashion, slimmer versions of the *salwar* (trousers) being known as *pyjamas*. Western-style dresses are only to be seen on small children, though occasionally on older girls when they are worn over trousers. Jerseys, cardigans, full-length coats and occasionally fur jackets are effective in providing additional warmth for the British climate. I have been assured several times that most Punjabis are well accustomed in the Sub-continent to

coping with spells of cold and wet weather.

For special occasions (such as weddings) a *garara*, a flared type of *salwar* usually made of brocade or other expensive materials and based on Mughul court dress (Ikramullah n.d. [1947-54]:30), may be preferred by both Muslim women and girls. The sari, however, is an acceptable alternative for a Sikh woman, but only if she is married. For more festive occasions such as *Diwali*, an Indian religious festival celebrated in the autumn, the Sikh women also choose more opulent materials, adding gold- and silver-coloured ornamentations.

Footwear, on the whole, tends to be non-ostentatious, with low heels and no heels being preferred, certainly for everyday wear, as are open sandals which are worn over socks on cooler days. Sometimes the Muslim women wear shorter (possibly less time-consuming) hairstyles, but most keep their hair long, tying it back in a single plait or bunch, or else coiled in a bun at the back of the head. Amongst the *Bhatra*, it is usual for the women to wear their hair as a long single plait which is thickened and decorated with a *parandian* (black or coloured threads). At other times, their hair is worn as a bun, and on special occasions, such as a home-blessing, beautified with flowers (#B). While it is customary for the *Bhatra* Sikh women to leave their hair loose only during a period of mourning, it is also usual for those who have become fully initiated into the Sikh faith to wear the *khanga*, the small comb which is one of the five 'K's (articles of the Sikh faith), in their hair.

Most of the mothers use cosmetics, although to varying degrees. Amongst the *Bhatra* community, whilst married women are expected to wear cosmetics, it is unacceptable for the unmarried women and girls to do so. A *thuri* (a red

'streak' along the hair parting) and a *bindi* (a small circle usually red and made of paste, plastic or even nail varnish and placed centrally on the forehead) are often, and only, worn by the married Sikh women. The use of *kol* or *surma* (a type of black eye liner) is seldom to be seen, although it can be noticed in various photographs.

Very distinctive jewellery, frequently made of Indian gold, is worn by the *Bhatra* women (see Nesbitt 1980:70). Items of jewellery that are regularly worn include gold earrings – often designed as a series of cascades and frequently two to three inches long, with the weight taken up by a thread looped over the earlobes – as well as gold hair clasps, gold nose-rings and other nose jewels and studs. Other pieces of traditional jewellery include bangles, necklaces, anklets and rings as well as the *tika*, a pendant worn over the centre of the forehead both by new brides and on very special occasions, in fact, by Muslims as well as by Sikhs. A distinctive style of *Bhatra* ring is a red jewel set in a slim, diamond-shaped gold setting. Certain pieces of jewellery are wedding gifts, earrings and nose-rings being traditionally given by the *Bhatra* bride's parents and hair clasps by the groom's parents (#7). Understandably, great concern and distress is felt if any of this jewellery is lost or needs to be sold (#G,#N).

Various pieces of *Bhatra* neck jewellery carry religio-cultural significance, such as the gold locket which one young girl wears from a black thread and which contains a picture of one of the Sikh Gurus. An attractive gold and enamel necklace depicting a Guru's face on its centrepiece section, as well as miniature forms, worn pendant-fashion, of the *khanda* (a special two-edged sword) and the *kirpan* (which, together with the *khanda*, forms the emblem of Sikhism) are other such pieces of jewellery worn by *Bhatra* women. Golden

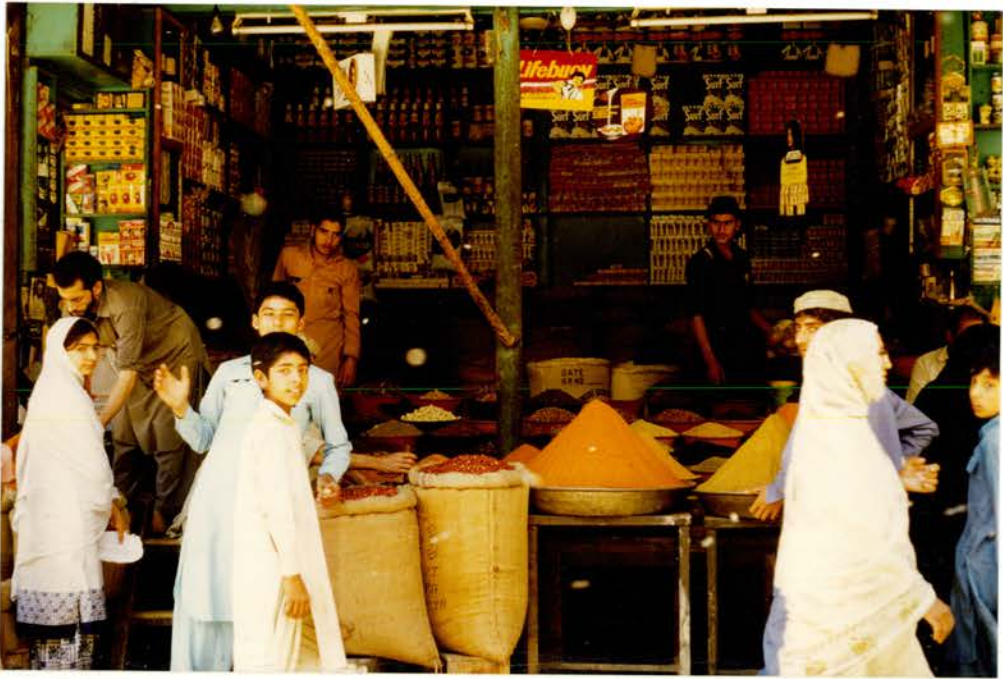
ruchya (amulets) on black threads are also worn by the *Bhatra* women and children, providing divine assurance for certain future needs and hopes. For instance, a *ruchya* may be worn to overcome chronic complaints, such as headaches, or after a miscarriage to help ensure that a subsequent pregnancy will be carried to full term.

Less flamboyant jewellery seems to be worn, at least routinely, by the Muslim women. While nose-jewels, earrings and bangles are frequently worn, other pieces of jewellery seem to be kept for more special occasions.

Amongst the menfolk, both Sikh and Muslim, there is a greater adherence to western-style dress, ranging from the more casual styles to tailored suits which, probably, are not so different from urban sartorial styles currently worn in the Sub-continent. The *lungi*, a loose, wrap-around skirt-like garment, as well as the man's version of the *salwar-kameez*, are worn by some of the Muslim men as they relax in the privacy of their own homes.

With the Sikh religion placing such strong emphasis on unshorn hair, for the women as well as for the men, it is only amongst the Muslim menfolk that short hair is consistently preferred. However, not all the Sikh men regularly wear a turban, but, being socially and religiously symbolic rather than merely functional, most wear one at the *gurdwara* and on special occasions. Once his hair is long enough, a young *Bhatra* boy will have his hair pulled together onto the top of his head and, when feasible, plaited and coiled into a 'top-knot'. This may then be covered and kept in place with either a small net, a crocheted *jallee* (a net-like covering) or a small handkerchief, perhaps even a *putka* (a larger piece of cloth) or possibly a warmer knitted covering which is also called a turban.

Dress



6 .1 Old Lahore – Pakistan



6 .2 At the Banglasahib **Gurdwara** – Dehli

Brightly coloured and patterned turbans tend to be worn for important functions and at celebrations, saffron being a particularly propitious colour worn at weddings, certainly by the groom. Each turban length is about five yards long. Starched first, they are wound at least five times round the head in a distinctive style, the starch occasionally causing part of the hairline to be rubbed away.

While Muslim men may wear turbans when in the Punjab – in one home there is a fairly recent photograph taken in Pakistan of the wife's brother attired in a starched and fanned turban, wearing brocade leggings and embroidered Turkish-style slippers (#15) – simpler headwear, such as small brimless hats, are more usual in this country.

G) FAMILY COMPOSITIONS

Of the twenty sample Muslim families, thirteen live as nuclear family households and four as three-generational joint family households. Of the remaining three families, two are two-generational, stem-type families (#15 – an unmarried brother lives here; #24 – a female cousin whose husband has deserted her lives here) and the third, a two-generational household where a younger, but unrelated, nuclear family co-resides (#4). Another family takes in a paying lodger (#8). Several nuclear families speak of having relatives elsewhere in the city, for instance siblings or parents (#17,#18), while others talk of friendships with other Punjabis who have been their neighbours in the Sub-continent.

Amongst the Sikh families, who are predominantly of the *Bhatra* sub-caste, four live as nuclear sub-units within joint family households, and a fifth as a

stem-type family where a widowed mother lives with her youngest son and his family. Another home is a two-generational household where two brothers and their own families live together – both nuclear families having been reasonably mobile throughout their married lives. The remaining two families live independent nuclear existences, both families relating to members of the local Sikh community, although one lives distant from the main location of Sikh homes.

Overall, there is a noticeable preference amongst the Sikhs for families to live in close proximity to one another. For instance, one of the non-sample Sikh families lives in what appears to be an independent nuclear household but, by being directly across a narrow road from the husband's parental home, they could be considered to be part of a localized joint family. At least two other Sikh families live close by in this quiet road, forming a compound-like area of *biraderi* and joint family members.

H) SPATIAL DISTRIBUTION AND USE OF ROOMS

While a definite trend in the way rooms are used, furniture placed and décor preferred is noticeable, the part played by variables such as the amount of space available, presence of toddlers, agility of older family members, finances and even personal preference in the internal apportionment and appearance of each home are topics that I have not broached with the families. Nevertheless, one could expect that they have adapted their homes, where possible, to fit in with cultural norms and expectations.

i) Room Usage

In many homes, both Sikh and Muslim, a degree of sexual stratification is demonstrable in the utility of the rooms. Many homes have a *betak* or 'best' room, which is usually better furnished and immaculately clean, located towards the front of the home. Often this room is used primarily by the menfolk and their guests, with the rooms more frequently used by the womenfolk and children being towards the back of the home. Small details reiterate this feature. For instance, in one home (#7) the wife displays in the kitchen the certificate she has been awarded for some studies she has taken, whereas her husband's certificates are on display in the front room (the *betak*). In another family (#20), the wife had helped design the house. She explained that their front room is for the men who often like to discuss business together, whilst the adjoining living-room and kitchen are primarily for the women and children. A certain flexibility obviously exists inasmuch that the interview took place in the front room, possibly because I was considered as a guest and at a time when the husband was away. In this particular home, the front room is separated from the family-room by sliding glass doors, so offering a definite yet visually-incomplete division.

In two homes, one Muslim (#23) and one Sikh (#11), which lend themselves to vertical stratification of room usage, the upper floor/s are mainly used by the menfolk and the lower floor/s are mainly used by the womenfolk. While the vertical structuring of the homes and the locations of the kitchens may encourage such an allocation of room usage, it in no way enforces it.

ii) Furnishings

Most living rooms are carpeted. Sofas and comfortable armchairs, of serviceable vinyl materials as well as of plusher fabrics, tend to be dispersed round the sides of the rooms leaving an open central area. Generally, there is a noticeable preference for low-level tables which appear to be easy to use by both adults and children alike, whether they sit on a sofa or on a carpeted floor.

As well as two families mentioning that they sit on the floor to eat (#14,#18), sometimes mothers can be seen to iron (#24) and dressmake (#6) using the floor as a working surface. Those attending gatherings to read the *Qur'an* in their homes, as well as services in the mosque or the *gurdwara*, also sit on the floor which is covered with cloths and/or carpets. Even so, sitting on the floor is less customary here than it is in the Punjab. In fact, one mother (#6) discussed the trouble she had had with her knee since visiting the Punjab where she had spent much more time crouching, for example, over the *chula* (hearth).

In the joint family households, nuclear family sub-units tend to have a room of their own which frequently has a bed-sit appearance with a small sofa and table additional to the basic bedroom furniture. As most interviews have taken place in the living rooms, in the 'bed-sits' or in the kitchen areas, I have seen only a few dining-rooms, that is, unless they were part of a dining-cum-living room when conventional dining-room tables and chairs were seen to be favoured.

Several women speak of decorating the home themselves, wallpapering and painting as well as making furnishings such as curtains and cushions (#7,#14,#29,#F). Not only is this done to save money but, possibly, to avoid having unnecessary workmen in the home. Laundry facilities vary from home to home. For those who do not own a washing machine or a tumble drier, laundrettes are the usual alternative, when available. In a few homes, coal fires can be seen, but, by and large, gas or electricity is preferred. For the mothers who have been more used to an open hearth on which to cook, there may be an uncertainty in using alternative forms of fuel, and I have wondered if this was why one mother turned up the gas flames before leaving the kitchen stove to talk with me (#8).

Kitchens are invariably the domain of the womenfolk and are where two or more women will often work or chat together while keeping an eye on the children. Frequently a settee and a low-level table are part of the kitchen furniture. In one Sikh home (#29), the women use a room adjoining the kitchen in which there is both a divan and a semi-circular sofa. During my visit, the matriarch of this household, who explained that she was indisposed, rested on the divan while happily involving herself in the interview.

Typical Punjabi kitchen utensils and steelware, such as gently curved iron griddles used for cooking *chapattis* (griddles which seem more suited to the shape of a Punjabi *chula* than an electric stove), as well as steel tumblers and steel compartmentalized plates are used both in the homes and in the *gurdwara*. Another housewife uses a large plastic bin to store the large amount of *chapatti* flour she needs, the bin being reminiscent of the large storage bins used in many Punjabi homes in the Sub-continent.

Household tasks



6 .3 Making tea



6 .4 The hearth

Dress



6 .5 Washing up



6 .6 Kitchen utensils and steel tableware

iii) Wall Hangings and other Items of Décor

Wall hangings depicting the *Ka'aba* (the Holy shrine at Mecca) and/or views of Medina as well as Islamic scripts are to be seen in all the Muslim homes. Similarly, pictures of various Gurus (particularly Gurus Nanak and Gobind Singh) and photographs of the Golden Temple at Amritsar can be seen in most Sikh homes, together with pictures of stories from Hindu mythology, including several of *Mata Devi* (Mother Goddess), otherwise known as *Sher-vali*. Family photographs are on display in practically every home.

In order to signify the birth of a baby boy, and very occasionally a new home, the door lintels in the Sikh homes are decorated with the *schree*, bundles of leaves tied with red and white *mawly* threads and interspersed with colourful baubles and artificial flowers and fruit. Leaves of the *Acuba japonica* (L.) are chosen for the *schree* and are only replaced with new ones when the next boy is born, otherwise they are left indefinitely. Only once have I seen these on the outer door and this was in a staircase where all the occupants were from the Sub-continent.

Ornaments and trinkets as well as the occasional Christian-style artifact – for instance, a plaque of 'Bless this house', a cross and a picture of what is possibly St George slaying the dragon – can be seen displayed on shelves, walls and in glass-doored cabinets in a number of the homes. Plants are few, sometimes artificial, but usually grown for culinary use (e.g. coriander). Budgerigars and fish have been the only pets I have seen. Telephones, televisions and video-recorders are commonplace.

iv) Bathroom Facilities

Many homes have shower units as well as baths. Jugs and buckets are often kept in the baths, jug washes being preferred, especially by older members of the families (e.g. #7). During one interview, a daughter offered her mother a bowl of water and a towel so that she could wash her hands before eating (#11). A regular feature in many bathrooms is a container placed on the right hand side of the lavatory bowl. It takes many forms, often a jug with a curved spout or even a milk bottle but, nevertheless, usually similar to the *lota* which, in the Punjab, is used specifically for this purpose. At all times, other than after urination alone, the left hand only is used for cleansing, using water poured out of the container which is held in the right hand. Most lavatories have a source of clean water from either a tap or a bucket kept filled for this purpose.

The strictness with which this Punjabi code of hygiene is maintained is illustrated in one story about the problem a group of ladies had when using lavatory facilities along the motorway. Having flushed the lavatory once, these ladies had resorted to flushing it again in order to obtain a source of relatively clean, flowing water. Similarly, because of insufficient hygienic facilities at their school, that is, by Punjabi standards, school children wishing to use the lavatory may prefer to wait until they return home to do so.

I) COLOUR USAGE

Not only do varying cultural groups categorize and name colours differently, but their significance is frequently culture-specific (Bock 1974:47-49; Porter and Mikellides 1976:15-16). The effect colour has on individuals occurs at both

conscious and unconscious levels and has particular relevance for health education (Bartholet 1968).

Superficially at least, colour usage, preference and relevance seem to be closely allied with religious affiliation. Greater preference for bolder and more ostentatious colours is shown by the *Bhatra* Sikhs, demonstrated in the décor of their homes and *gurdwara* and, to some extent, in the colours worn by the womenfolk. Gold, silver and other brightly coloured tinsel decorations are liberally used by the Sikhs to decorate their homes during joyous occasions (such as *Diwali*) and, at all times in the *Baba da Cumra*, the room where the *Durbar Sahib* (the religious service) takes place. The religious pictures that many Sikh families have in their homes reflect this same liveliness of colour choice. Contrastingly, many of the Muslim women wear less vivid, and thereby probably less visually-attracting colours, except for celebrations such as weddings and parties, possibly in accord with Islamic rules of modesty. Although green is a colour frequently associated with the Islamic faith, it does not seem to be especially emphasized by the Muslim families as a colour choice for clothing or for furnishing their homes.

Reds and golds are considered particularly suitable for both Sikh and Muslim bridal outfits, and are therefore probably more significant of Punjabi cultural norms rather than of any religious affiliation. Red is a colour that is related directly to marital status and is used for the streaks of colour which decorate the *Bhatra* women's hair partings and, often, the *bindis* that they wear on their foreheads. Saffron is considered to be a propitious colour and is favoured by the *Bhatra* groom and even the male wedding guests for their turbans. In one photograph of a *Bhatra* groom and his male guests, many of the men are wearing vivid blue suits with saffron-coloured turbans, a very

Colour



6 .7 Protecting the Banglasahib **Gurdwara** – Dehli
Colours symbolic of the Sikh Faith



6 .8 Colourful turbans – **Baisakhi Day** – India

similar colour combination to that worn by the *Akalis* (a strictly devout group of Sikh adherents) and possibly, in this context, carrying a degree of religious significance. On the whole, the *Bhatra* menfolk prefer more sombre colours (such as browns and burgundies) for the turbans they wear for their working day, colours which are both more serviceable and more socially discreet. Brightly coloured and patterned turbans are worn at festival times and for special functions and events, such as the opening of a new store. Colour usage may also be clan-specific. For instance, *Bhatra* women of the *Landa* clan will never wear pink as this would be against the clan code (see below).

For both Muslims and Sikhs, white is a colour which is symbolic of purity and holiness. White and lighter colours tend to be worn by both the older and the widowed *Bhatra* women (e.g. #7), symbolizing a more religiously attuned period of their life. White clothing is also worn by Muslims making the *haji*, whilst the *chauri* (flywhisk), which is wafted over the *Guru Granth Sahib* during services in the *gurdwara*, is made of white hair. Similarly, the mares ridden at *Bhatra* weddings by the groom and his *subala* (young male attendant) are white, being symbolic of the virginity and, thus, the sexual purity of the bride. Indeed, with regard to the symbolic meaning of the colour white, Constantinides (1977:81) notes that in Islamic society 'God is white', while within Hindu society, which has influenced much of Punjabi culture, the purest of the four *varnas* (that is, the *Brahman* category) is considered as 'white' (Birren 1978:9).

A certain interweaving of both Punjabi and non-Punjabi culture-specific colour usage operates. At two birthday parties, to which Punjabi and non-Punjabi children were invited, I noticed that pink icing was used to decorate the girl's cake and blue the boy's cake. At the one party, coloured

paper hats were being worn by the children. Though red, white and blue hats were available to choose from – it was not long after a Royal wedding – at least three of the Sikh boys, without hesitation, chose hats that were red, a colour that *Bhatra* families associate with birth and fertility. Red is also considered a colour able to provide protection. Of comparative interest is the classification of colours which Werbner (1979:137–141) puts forward in her thesis about the Punjabi Muslim community in Manchester, many of whom are *Arains*. While aligning white, black and red with male–female and pure–impure continua, she nevertheless makes no mention of any inclusion of non–Punjabi colour symbolism.

3. ASPECTS OF FAMILY AND COMMUNITY LIFE

However adventurous and resilient a Punjabi immigrant may be, it is understandable that he or she will attempt, whether consciously or unconsciously, to recreate, perpetuate and as necessary adapt proven, valued and preferred methods of social interaction, family bonds, and community institutions and solidarity. In this section, I look at various aspects of family and community life as they relate to this one group of Punjabi families.

A) COMMUNITY INSTITUTIONS AND SOLIDARITY

Despite linguistic similarity, the families are divided by their religious affiliation. For the Sikhs, not only is religion a unifying factor, but the majority belong to the *Bhatra* sub–caste which assumes *biraderi* proportions. Many of the long–established Muslim families also belong to one *jat* (sub–caste), that of the *Arain* (or *Rain*) sub–caste. They too consider:

. . . themselves of one *biraderi*. They are . . . quite close-knit and have something in common. If someone is not *Rain*, then they would feel different.

(#M)

In the Punjab, members of the *Arain jat* would usually farm for others. However, many have since become richer and are now able to afford land of their own (#M).

i) The *Bhatra* Community

Within the *Bhatra* community, there are a number of clans (*jats*): *Bhaker*, *Digwa*, *Khusbia*, *Landa*, *Potiwal*, *Rathur* and *Raud* being cited as examples. Each clan bifurcates into sub-clans or lineages, each with its own code of behaviour. For instance, one lineage of the *Landa* clan, while praying to all gods, particularly pray to *Gulabi* (which, translated means 'pink' – lit. 'rosewater'). It is considered an insult to *Gulabi* for any of the women of this lineage to wear pink. Similarly, in January they do not burn popcorn at the *Lohri* festival, nor, as a sign of respect, may they rejoice or wash themselves or their clothes for several days before this festival.

Such codes of lineage behaviour are passed down through the generations, new wives learning the code of their husbands' lineage from both their mothers-in-law and from observation. In particular, new brides can assimilate the norms of the lineage of the family they have joined (#7) during the first forty days after marriage when they are freed from housework.

A *Bhatra* woman first belongs to her father's and then to her husband's clan. She must marry a husband from outside the clans of both her parents, whether he is from India or the United Kingdom. A son, however, can marry into his mother's though never into his father's clan. In this country, while it is

permissible for a bride and groom to be chosen from the same community, they should never be close relatives, although this rule of clan exogamy is said to be broken occasionally. After marriage, the *Bhatra* wife still continues to be recognized as a daughter of her father's clan (*thee-thiani*) and will be accepted as such by other members of the clan living elsewhere (#7).

Being a smaller and more self-contained community with a faith that allows non-converts to participate, it is easier for outsiders to detect and observe the various other institutions through which solidarity is offered within the *Bhatra* community. For instance, the *gurdwara* provides an important focal point for promoting community cohesion, families gathering together not only to worship but also to take regular turns in hosting the *langar* (the community meal). In addition to the usual services, special services (for instance, to commemorate holy days) also bring members of the *Bhatra* community together, providing the women with opportunities to sit and converse in the *gurdwara* kitchen, at the *langar*, and in the *Baba da Cumra*. *Bhatra* women also gather in each other's homes to celebrate fast days, for the blessing of a new home, and to attend a *gon*, the party given for pregnant mothers. Access to family and *biraderi* support, both physical and emotional, is also greatly enhanced by the close proximity of *Bhatra* homes to one another, as well as by the use of the telephone which, with letter writing, helps to make links with natal and other kin elsewhere much easier to maintain (e.g. #6,#7).

Biraderi interaction is also strengthened by the sharing of video-cassettes as well as by the on-going practice of *vartan bhanji* – the culturally defined form of gift giving through which negative as well as affirmative statements of kinship support can be voiced symbolically. Even so, watching video films probably now 'home-bases' more Sikh wives than in the days when to see an

Indian film meant the opportunity of going out to the cinema. Gifts exchanged through *vartan bhanji* often include lengths of material for the *salwar-kameez* suits as well as various amounts of sugar. The amount given depends very much on 'how close' people are as relatives and friends. To leave anyone out or to return a gift implies strongly negative feelings. For a wedding, approximately two pounds of sugar is given with the formal invitation, whether or not the recipient plans to attend. For the naming ceremony, several lengths of dress material and, possibly, six pounds of sugar is considered suitable. The sense of indebtedness that is part of *vartan bhanji*, as well as the idea of reciprocity, was demonstrated by a Sikh father (#Q) when he hesitated before giving me the name of a fellow Sikh who might be willing to talk with me. He commented that this would entitle this person to expect a return favour of a similar nature from him.

Gifts are also given at the *gurdwara*, though with a different rationale and without a defined code as to how much is suitable. Milk, sugar, fruit, lengths of brocade material (which are used to protect the Holy Scriptures) as well as money are placed before the *Guru Granth Sahib* and in front of the congregation, financial gifts being documented and verbally announced during the service. Generosity and commitment to both the faith and to the community that unifies them is thus openly declared. In fact, fines are levied on families who fail to attend the *gurdwara* service each week, presumably to deter backsliding from this commitment.

The way in which the dictates of Punjabi ladies' fashion are followed provides another insight into cultural norms shaping *Bhatra* community interaction. To be the first person to wear the latest style, colour or material is what is important rather than to be the only one to do so, unlike the usual

Women relaxing



6 .9 By tractor to the fair – **Baisakhi Day** – India



6 .10 On the step – townlife

non-Punjabi social norm in this country. Thus, to be seen wearing the same suit as another Sikh woman is acceptable and is not a cause for embarrassment or disappointment.

It is in these various ways that community solidarity not only is affirmed but proves itself to be a powerful social force, offering social strength in time of need as well as maintaining orthodoxy of community loyalty and *izzat*, so binding the *Bhatra* community together.

ii) The Punjabi Muslim Community

Over the previous two decades, there has been a marked expansion of the Punjabi Muslim community which may account for the community seeming to be less unified than the *Bhatra* community. Even so, gatherings where a meal is shared following a combined reading of parts of the *Qur'an*, and coffee mornings held in each other's homes, as well as activities organized by the local Pakistani Women's Association, such as visiting a coastal resort to celebrate *Eid* (an important Islamic festival), act as opportunities for the women to socialize with each other on a wider scale.

Several mothers have spoken about being supported, financially and physically, by *biraderi* and family members, for instance, one separated wife (#N) who is reluctant to turn to social services for assistance, and another (#C), also a non-sample mother, who has been deserted and left alone to care for a newborn child. Within the Muslim community, as within the Sikh community, exchanging video-cassettes amongst friends and family members increases social interaction, though sometimes less favourably when cassettes are not returned (e.g. #17).

B) FAMILY BONDS AND RELATIONSHIPS

Discussing community solidarity, family bonds and the social interaction of individuals within the family group can be likened to describing a nest of Ukrainian dolls. Not only is each doll a separate and important entity in itself, but the careful fit and interdependence of each is relevant to the strength and uniqueness of the unified whole. Likewise, to understand the cultural relevance and fit of the various relationships within Punjabi family groups is basic to the clearer understanding of the whole Punjabi cultural system.

i) Marriage

A Punjabi daughter is thought of as a guest in her natal home, particularly amongst the *Bhatra* Sikhs where the rule of clan exogamy means she will be given in marriage to another family. She learns the art of home-making from a young age and, after her schooling is completed, she stays at home to improve her household skills in preparation for marriage. As a wife, she is the one who usually will be parted from the relatives who have loved and understood her through childhood, though she may be fortunate enough to live near a married sister if she has one. Invariably, it is the husband who remains in the natal *Bhatra* home, thus allowing the close bond that many Punjabi sons have with their mothers to continue (note Hershman 1974:275-276). For the three-generational joint families (both Muslim and Sikh) in my study, the wives had entered mutually-supportive family frameworks. However, for many of the nuclear families where couples are separated (often transglobally) from their natal kin, numerous readjustments to ideas and expectations of family life and support systems have been necessary.

Marriages are mostly arranged, although I am informed that more couples are now being given the opportunity to meet, or at least see photographs of each other, and to have some say in the final choice. Parents are considered to have more experience of life, to have the welfare of their children at heart and, certainly for the Muslims, the responsibility of again caring for their daughter should the marriage fail. A *vichola*, a match-making intermediary or, as one mother (#6) put it, 'someone who knows someone', is said to be frequently an instrumental figure in the arrangements. One Sikh father (#8), speaking of how he had trusted his mother's judgement, humourously added that you then 'have someone to blame!' - even so, small comfort for an unhappy spouse. Although one husband (#3) had asked specifically for a wife from this country, quite a number of the Muslim wives have come over from the Punjab, the wedding ceremony taking place either in this country (e.g. #23) or in Pakistan (e.g. #20). When possible, Muslim families prefer to arrange marriages between close family members. The Sikh families, however, usually find marriage partners within the United Kingdom.

Reluctant to leave her career as a teacher, one older Muslim mother (#20) with a widowed mother described how she eventually had been persuaded (particularly by her male relatives) to marry; a decision with which she is happy enough now. Others speak radiantly of their arranged marriage partner, 'arranged marriages are lovely' being one glowing affirmation (#1), though three wives (#C,#D,#N), all from non-sample families, have had less than favourable marital experiences and are all separated from their husbands.

Amongst the *Bhatra* community, once an engagement is planned, the members of the woman's family ensure as best they can that she does not see her husband-to-be. Should both the bride- and the groom-to-be live in the

same community, this may necessitate the bride-to-be's absence from the *gurdwara* until the marriage service takes place, particularly if they live in the same community. Several wives have spoken of having little idea before they were married of the more intimate aspects of marital relationships. They have also spoken about the difficulties Punjabi women face in this community where it is relatively easy for their husbands to meet non-Punjabi women, for instance in the public houses where some husbands go to meet friends (for the Sikhs, this is despite religious injunctions against the consumption of alcohol).

Although she is expected to conform to strict standards of behaviour as a wife and mother, a Punjabi wife may find that her husband has 'double standards' for himself. As she is not expected to argue if her husband is angry with her, and certainly not to make a scene publicly, it is for others within the family or the *biraderi* to persuade him to apologise. Even so, an astute wife finds discreet yet effective ways of personally making her husband aware of her disapproval (#7,#D,#B). One wife (#G) amusingly recounted one way in which she had ensured effectively that her husband knew she meant business when he started coming home late at night. This she did not only by threatening but by carrying out her threat of burning a page of a book he had recently bought, and was enjoying reading, for every minute that he was late after eleven-thirty p.m..

A Muslim woman invests her life in her home and her family. If they are taken away from her 'she has nothing left . . . they are her life' (#24). In fact, she may hesitate to seek a divorce because her opportunities thereafter for remarriage will become limited. Equally daunting would be the anticipation of shouldering the financial cost of marrying any daughters she might have, that is, in addition to assuring her daughters' in-laws of her ability to contribute to

the affinal households. Thus, not only would she have her own but also her daughters' future happiness to consider (#D). Nowadays, under Islamic law, more women are accorded the right to keep their children, one mother (#E) explaining that, if children of divorced parents are infants and still breast-feeding, then they stay with their mother, otherwise they remain with their father. Only once the children reach fourteen years of age may they have a say in the choice.

Amongst the *Bhatra*, divorce is a rare occurrence. Any children born in wedlock are considered, at least by the community, to belong to the husband's family (#8). While lack of male issue might be considered a valid reason in the Punjab for remarriage, that is, with the first wife's permission (two wives have spoken of this with regard to their parents' marriages), it is not an accepted part of Punjabi life in the United Kingdom (#4,#7).

One approach to coping with the possibility of male infidelity occurring once a Muslim marriage has been arranged between a Punjabi man in this country and a young woman from Pakistan was described by one Muslim woman (#D). This is for the couple to be legally married in a registry office, leaving the religious wedding ceremony (which is considered maritally binding in the eyes of the Islamic community) until what is considered tantamount to an engagement period has been completed. Then, should the religious service not take place, the woman will not feel the stigma of divorce by Islamic standards, though she will have the inconvenience of the legalities of the British divorce proceedings.

In joint family households, open demonstrations of affection between husband and wife are not usually encouraged, yet some husbands, perhaps

influenced by non-Punjabi social norms, are expecting more companionship from their wives. Many wives have similar expectations. Nevertheless, the greater social freedom accorded to the menfolk makes marital infidelity easier for them than it does for the women. With regard to this, one distressed wife questioningly implored, though perhaps not correctly:

Don't these white girls know that every Sikh man is married?
They are all married!

She tearfully recounted how she had not only expected married life to be happy but how she had envisaged greater freedom even, for instance, in deciding what clothes to wear. Despite continuously expecting life to improve, she had decided to accept it as it was, adding a little scathingly that 'Sikh women don't get depressed' (#B).

Despite recurring reference to men following 'double standards', I have observed several husbands showing a certain amount of open affection for their wives, one husband (#14) claiming that marriage 'settles a man'. Two other men have commented that non-Punjabi social life in this country tends to revolve around smoking, drinking and sex.

ii) Kinship Bonds

Where nuclear families are separated from their kinfolk, compensatory mechanisms are used to replace the loss of immediate physical and emotional support. Indeed, although undercurrents of rift obviously do exist in many joint family households, the ability of the joint family system to act as a bulwark in times of need is valued. While migration may bring certain benefits, several mothers have spoken of instances where separation from close family members have been distressful, the personal help that normally they could have expected

being unavailable.

Transglobal emotional bonds are kept alive by various means. For example, one family asked the paternal grandmother, who lived in Pakistan, to choose the name for their newborn girl. Offering a choice of two names, the grandmother left the ultimate choice to the parents. Though all this had involved a delay in registering the baby's name, the father explained that they did not want their family in Pakistan to feel forgotten (#14). In addition, visits to and fro between this country and the Sub-continent help to keep a sense of family jointness alive. Not only do wives visit the Punjab to care for aged and ailing relatives (#6,#20) and to take the children for a visit (#8), but relatives also come over on visits to this country. In one home, relatives who were staying with the family had travelled from Pakistan in preparation for going on the *hajj* with the family they were visiting (#2).

Sadness, however, can result from the inability to respond to transglobal joint family needs. For instance, one mother (#F) told me of her brother who had died of cancer the year he had planned to marry. Not telling her of his illness, he had written urging her to visit and bring with her the daughter of hers that he had always been especially fond of and had loved to carry around on his shoulders. Unable at the time to go and visit him, and not realizing why he had asked, she now reflects on his unfulfilled request with profound regret.

iii) Mothers-in-law

One of the pivotal relationships which a young wife must develop carefully is the one she has with her mother-in-law. Her happiness in her new home will very much depend on how well she is liked and accepted by her

mother-in-law. It will also be affected by the willingness of her husband to intervene should disputes occur. While reference to discord rather than continuing harmony have been voiced more readily with regard to relationships between mothers-in-law and daughters-in-law, and therefore possibly unevenly weighted, such complaints do shed light on expectations of intra-family relationships.

Various mothers, both Muslims and Sikhs, speak about the difficulties they have living with their mothers-in-law. These invariably centre around the power that mothers-in-law have as senior women in the joint family system, and the way in which they use this power. Frequently, dissatisfactions relate to what is felt to be lack of understanding and personal caring. As young wives, they may have to do exactly as their mothers-in-law say, indeed, some are not able to go anywhere or do anything without their mothers-in-law's consent (#7,#25). Certainly mothers-in-law seem to have had the veto as to whether or not a young wife will talk with me, though never in instances where I have already spoken with an adult male member of the household. Even so, in numerous instances, the role played by the mother-in-law in guiding and assisting in child care is both respected and appreciated, and when it is absent (possibly because of global separation) or withheld, it is actively missed (#7,#9,#11,#23,#B). Occasionally a Muslim mother has spoken of turning to her own mother for help, for instance before and after childbirth (#12).

For a new wife, certainly amongst the *Bhatra* community, settling in can be traumatic, particularly if she is made aware that she was not really the family's first preference as a marriage partner for their son, even if the son is satisfied. Initially, she may not know if she is doing things the way she should, each family having its own code of behaviour and family cults. However, through

trial and error, she learns what is expected of her, or as one *Bhatra* mother (#7) put it:

You make a mistake, maybe get your head blown off, then you know not to do it again.

The urgency to demonstrate her ability to produce offspring, and particularly a son, may add further strain to her already sensitive position with her affinal kin. Not only did I receive a rather droll look when I asked a young *Bhatra* wife if she was pregnant, unfortunately in the presence of her mother-in-law, but I was also informed summarily that she had only been married three months (#11). Another mother (#7) described how distressed she, as a newly wedded wife, became when, each day at breakfast, her mother-in-law would inquire how she 'felt'. This, in fact, was a daily inquiry not as to how she felt but whether or not she was menstruating. Eventually, her husband intervened and asked his mother to stop her regular enquiries.

With little chance of 'escape' from a difficult relationship with her mother-in-law, nor the opportunity to share her feelings with other young wives, a daughter-in-law (certainly amongst the *Bhatra* Sikhs whose marriages invariably are arranged according to clan exogamy) will still be concerned to uphold the honour of her natal family. Because of this, she will usually feel she must acquiesce in the demands of her mother-in-law. In addition to working in the house, this may involve more physical contact, such as massaging her for long periods of time. She therefore learns to keep silent and turn away when provoked.

Life may be a little more egalitarian in households where two or more two-generational families reside together. Certainly one wife (#5) from one such household, when asked about the apportionment of various household

activities (particularly with regard to cooking) said that:

Whoever wants to cook, does it. They cook whatever they like.

It is usually the youngest son, though sometimes the one who relates best to the parents, who continues to live in the family home once the decision for other married sons to live elsewhere has been made. This decision is usually made by the senior male member. Several wives have referred to the close bond between mother and son. Although one mother has mentioned that she would like her husband to be more involved in their own nuclear family (#A), many fathers seem to actively care for their children. Indeed, during my visits, several fathers have been openly affectionate towards their own children (e.g.#2) and those of other relatives (e.g. #23).

4. UNDERLYING CULTURAL VALUES

Central to many modes of expression of Punjabi life is the maintenance of traditional cultural norms which, on the one hand, may be orthodoxly maintained – for instance one *Bhatra* mother considers her community to be following many cultural norms adhered to in the Punjab forty years ago – while, on the other hand, they may be modified and even dispensed with as deemed fit.

The depth to which certain Punjabi values pervade personal as well as public life may not be easy for a casual visitor to assess. Skilful presentation of cultural ways – in order to be favourably accepted by non-Punjabi society (and, in so doing, allowing the desired level of integration) – will not necessarily mean the loss of, but rather the more covert expression of cultural signs, signals and value orientations. Brown (1970) describes these as

'compromises . . . of outward forms rather than of inward realities' (Brown 1970:225; note Barth 1969:10). Differences between Muslim and Sikh communities, together with the fact that only a relatively small number of families was interviewed, does mean that only trends, rather than facts which can be generalized, can be offered. Nevertheless, these do provide insight into the 'inward realities', many of which focus around the notional dyadic relationships of junior to senior, female to male and impure to pure (see Sharma 1978:225). In this chapter, all three dyadic relationships are considered, providing insight into codes of conduct which are based upon, and governed by, underlying cultural values.

A) JUNIOR TO SENIOR

Following patriarchal traditions, authority within a Punjabi family usually runs parallel with seniority, with ultimate control remaining with the menfolk, including decisions regarding sons leaving to live elsewhere. Veiling and lowering the eyes are used by the *Bhatra* women to denote respect, and *Bhatra* sons are taught to touch the feet of their elders as a form of respectful greeting (#A). A *Bhatra* wife, but not an unmarried girl or woman, will do likewise or, alternatively, just touch the knees of her husband's elders (#7). Hershman (1977:273) suggests that it is because of her assumed virginity that, in India, a girl or an unmarried woman will not be expected to use this form of respectful greeting. In addition, a *Bhatra* Sikh daughter-in-law will never consider approaching her father-in-law directly unless it is a matter of very serious concern.

More submissive personalities are possibly able to cope better, at least ostensibly, with dominating senior kinfolk. One Muslim wife (#6), who is

prepared to do as her mother-in-law directs, is less willing to follow the dictates of her uncle-in-law. Another wife (#B) speaks of the frustration she felt when her newly acquired furniture was 'siphoned off' for the senior affinal household, something she could do little to change. Even so, she manages to insist that her children go to bed at a regular time each night, going against the more traditional and more *laissez-faire* ideas held by the older members of the family. Intergenerational love and caring are less powerfully stated, though the combined choosing of the baby's name (#14 - already described) can be cited as one very real example.

At times, disapproval is voiced regarding the less caring attitudes that appear to be shown by non-Punjabis towards older people (e.g.#8,#D). Amongst Punjabis, a belief in a sense of mutual interdependence of young and old exists, being nicely portrayed by one father (#8) who proudly showed me photographs of his prematurely born son. He suggested that, in years to come, his son would be able to look at the photographs and realize how much time and care they, as parents, had shown him as a baby, and so care for them in return as they grow older. A Punjabi son certainly is expected to look after his mother as well as his wife, but possibly his mother more than his wife (#7). As they grow older, and while still maintaining authority within the home, parents are usually able to take life a little easier, at least physically, and find more time for personal religious activities, if so desired.

B) FEMALE TO MALE

While sexual equality is normatively professed by the Sikh religion, with Islam stressing complementary, mutual interdependence, Punjabi society nevertheless is expressedly patriarchal; the use of overtly male terminology for

the community network, that is the *biraderi* (brotherhood), reaffirming this fact. Even older women, who have a fair degree of authority, are usually ultimately subject to male dominance, male *izzat* encompassing both a virile sense of dominance as well as the ability to protect and provide for their womenfolk. In many homes, male *izzat* is also reflected spatially, for example, by the use of a front room (the *betak*) for the men to entertain their guests and friends, thus symbolically combining the protective and the dominating features of this aspect of Punjabi life. In addition, greater status in the eyes of the Punjabi community is achieved if a husband is able to 'home-base' his wife as this demands a certain level of economic achievement (#L). While a 'home-based' wife may find herself much more secluded and lonely than the idea of sexual segregation or *purdah* is supposed to involve, strict *purdah* is not followed by the families who participated in this study.

To an extent, attitudes regarding sexual equality have been modified amongst the Muslim community, possibly because more live as nuclear families. One wife (#6) told me how her unmarried sister was considering joining the police force, the fact that trousers may be worn by female police officers making the police force more acceptable to the Islamic code of modesty. Even so, whether her sister would be able to continue with such a career would very much depend on her future husband's views.

On marriage, a *Bhatra* wife assumes a new first as well as a new family name. This name may be based on the first letter on a randomly opened page of the *Guru Granth Sahib* during the first service held at the gurdwara after the marriage. Nevertheless, her mother-in-law will speak to her as the *vodi* (wife or bride) of her son. Only her natal family and her husband, if he so wishes, will continue to use her maiden names. In addition, *Bhatra* wives do not

usually work outside the confines of their homes and the family businesses. Though relatively free to pursue outside activities which are related directly to the running of the home and family, as well as making friends with non-Punjabi women, their energies are expected to be directed towards the needs of the family as a whole rather than following any notion of individualism. For instance, the secretarial course one wife (#7) took and appeared to have enjoyed was to allow her to participate in the family business.

Almost a 'god-like' element is said to be accorded to the Sikh male (#A), and the desire to produce male progeny the wish of every married *Bhatra* couple. Two fasts are held by the married *Bhatra* women of this particular community. The one *vrth* (fast) is the *Swag Phag*, which the *Bhatra* wives hold in November to honour their husbands. No food or drink is taken from daybreak until the moon is sighted. Before moonrise, the women gather together to recount various legends relating to this fast. *Purnmashi* is another fast which each of the *Bhatra* families keep on the day of the full moon of each lunar month. In the hope of being blessed with a son, this fast is commenced on the birthday of Guru Nanak and is often kept for a whole year. In a number of *Bhatra* homes there is a picture of *Sher-vali*, 'she who belongs to the tiger', a goddess from the Hindu pantheon. Mothers 'desperate' (#7) to produce a son will offer prayers to *Sher-vali* because she is believed to be powerfully able to help those who long to have children or who particularly seek continued health (#A). Even so, it is to the Sikh Gurus that their initial prayers for help are offered.

Both within Islam and Sikhism (religions which historically have male figures as inspirational leaders), it is the men who are usually the leading religious officiants. Hence, the menfolk are accorded publicly greater functional status in

the religious arenas, although it is acceptable for the Sikh women to lead public services (see Dhanjal 1976:109). Even though both these monotheistic religions cherish the belief that the individual may have a direct relationship with God, formal religious (particularly Islamic) practice also reflects the patriarchal norms of Punjabi society. Similarly, this overall patriarchal outlook is emphasized by the importance which the Sikhs place on male progeny. This is demonstrated both by displaying the *schree* for male offspring only and by the greater social freedom that men have, in which 'double standards' of morality are allowed with minimal censure. Against this patriarchal background, wives learn to become skilful in achieving individual aims.

During several visits, I noticed husbands showing spontaneous open affection towards their children, both girls and boys, as well as warm caring attitudes towards their wives. One Muslim wife (#9), who gently commented that her husband was 'very pleased with her', described how he had taken the unusual step of taking two weeks off from his work to care for her after their first baby was born. Although, as a nuclear family they have no close relatives to turn to for personal help, even so, this was considered to be an unusually public gesture of conjugal caring.

Concern for sexual modesty and propriety is integral to the daily life of the Punjabi woman. With the *salwar-kameez* allowing bodily concealment in accord with both Islamic and Sikh injunctions against clothing that 'breed[s] lustful thoughts' (Cole and Sambhi 1978:109), the *dupatta* acts as a veil to a lesser or greater degree. For the *Bhatra* wife, not only is it imperative that she veils both her hair and her face before her husband's male elders, but, if they are somewhere in the house, she should always be ready to veil and not be caught unawares. Before going to the *gurdwara* or anywhere where she takes

off her coat, a similar preparedness should be shown by making certain her *dupatta* is in place before putting on her coat. Turning away as well as veiling is an added precaution. Indeed, I witnessed a trio of young wives, who were making *pooris* (fried cakes of unleavened bread) in the *gurdwara* kitchen, not only veil but turn completely round to face the wall when an older male affine, who wished to speak with the more senior women, signalled his entry.

It was only in the *gurdwara* that I visually became aware of the strictness with which the *Bhatra* women veil before their male affines. Thereafter, I became more attuned to the subtler forms of maintaining *izzat* that take place in non-Punjabi locations. While the notion of *purdah* is not accepted by the *Bhatra* community, being against Sikh religious injunctions, a code of behaviour is maintained regarding veiling and sexual segregation. Except for those old enough not to have any elder male affines before whom they should veil, *Bhatra* wives cover their faces in the *Baba da Cumra* with *dupattas* of varying widths and, as one mother (#7) humourously commented, some veil themselves 'to their knees'. While many also lower their gaze, others seem to look surreptitiously through their veils relatively unnoticed. Sexual segregation is customary in the *Baba da Cumra*, with small boys sitting with the men if the women's side becomes overcrowded. This segregation is maintained in the *langar* (this word is also used for the community dining room) to allow the women to eat unveiled. This same rationale accounts, at least partly, for why the men and women in one joint household eat separately (#29).

On two occasions, I observed subtle and fleeting insights into *Bhatra* sexual propriety. One occasion occurred in the *langar* when a young unmarried woman hurried past several men but slipped and fell. One man immediately began to put out his hand to help her but stopped himself, and she, obviously

embarrassed, righted herself, hurrying away as fast as she could. Thus, cultural norms appeared to control the expression of human caring reactions. Another time, at a children's group in a community hall, a Sikh wife (#B) noticed that one of her male affines had arrived and would see her unveiled. She immediately and ingeniously busied herself with something which required her to look the other way, so maintaining a delicate, but acceptable, balance of Punjabi norms within a setting which also demanded the continuance of non-Punjabi social norms. If faced in the street with a similar situation, a *Bhatra* wife will turn sideways, look away, or hope to be able to 'run into a shop' (#7).

Amongst Muslims, *dupattas* or headscarves are used to cover the hair when outside. Veiling to the extent of covering the face was never witnessed, and a *burqa*, the more complete over-garment worn outside the home in Pakistan, never seen. Two Muslim wives (#12,#25) have spoken about Pakistani husbands having to change their ideas in this country and trust their wives more. One wife told me that her husband has given his permission for the male health visitor to see the family in his absence (#12,#25). For some wives (e.g. #6), working in the family shop has been a way to meet more people and to make new friends. Yet, husbands often prefer their wives not to work, maintaining the home being considered more than sufficient for a wife and mother to do (e.g. #20). Lack of sexual segregation in swimming pools at some secondary schools and certainly one community centre is seen as precluding those who want to take up swimming from so doing. In fact, one mother (#4) asked me to make inquiries for her. For some wives, culturally defined modesty extends to medical examinations by male doctors. Even though their husbands may be agreeable, nevertheless some women feel unable to be examined by a male doctor, while others hold more liberal views.

C) IMPURE TO PURE

The importance accorded to not defiling that which is considered culturally pure when in an impure condition is evident in various aspects of a Punjabi woman's life. For instance, when menstruating, a *Bhatra* woman 'feels she has done something to God or God's House' (#G) if she omits to bathe before going to the *gurdwara*. In fact, she may prefer not to go at all. In the *gurdwara*, she sits at a distance from the *Guru Granth Sahib*. No woman overlooks this ritual distancing as all are in fear of God. Likewise, to touch an object in the home that carries religious significance (not only religious texts but also items such as wall-hangings depicting the Gurus) without bathing first will induce similar feelings. Even so, while bathing allows a woman to feel that she is not defiling the house of God, bathing does not prevent her from endangering a newborn baby's well-being. In no circumstance will a menstruating *Bhatra* woman ever visit the house of a newborn infant. Similarly, a menstruating Muslim woman must bathe before attending the mosque (although the womenfolk in any case seldom attend the mosque), nor may she touch the *Qur'an* or read the *namaz* without bathing first. Following sexual intercourse and before resuming her daily tasks, a Punjabi woman, whether Muslim or Sikh, is supposed to bathe and wash her hair, though this requirement may not be closely adhered to in the United Kingdom – one *Bhatra* wife laughingly commenting that 'you would always be washing!' (#7).

As the right hand is the one considered symbolically to be 'clean', and therefore reserved for clean tasks and gift-giving, it is the left hand that is used to perform unclean tasks such as toilet needs. Food is eaten invariably with the right hand, although sometimes the left hand is used, perhaps to anchor a *chapatti* while the right hand tears off a piece, although both

functions frequently are performed deftly by the right hand. Amongst the *Bhatra*, the *prasad*, the sanctified food that is distributed to the congregation at the *gurdwara* services, is given from the officiant's right hand. Though received in cupped hands, it is then held in the left while taken to the mouth by the right hand. The *Rakhti* bracelets, which commemorate the Sikh festival acknowledging the caring and protection expected of brothers for their sisters, are placed on the brother's right wrist.

Amongst the *Bhatra* families, care is taken when laundering clothes so that women's lower garments, that is those worn below the waist, are not washed with men's clothing. Mothers-in-law are said to be strict about this rule and I have been told about a mother-in-law in India who would only pick up her daughter-in-law's clothing with a stick (though not so her daughters' clothing) whereas she would pick up a man's clothes with her hands (cf. Thompson 1922:31). Thus, it would seem that clothing that has been close to a woman's genital organs is inherently polluted. According to one wife, 'it is the men who are more concerned than the women are' (#10). In addition, a *Bhatra* Sikh's turban, which one wife (#7) expressed as signifying his crown (as a husband is considered to be like a king in the home), is always washed separately and by hand, never with any other clothing, not even his own. Although there would appear to be a hierarchy of pollution levels, further information would be needed to confirm this. Similar emphasis on the division of the upper and lower parts of the body regarding pollution beliefs is also noted by Sutherland (1975:264-271) but in relation to Gypsies in California.

5. SUMMARY

In this chapter I have described various socio-environmental and cultural features relating to a number of families and individuals from one ethnic minority community which, while sharing a Punjabi culture, is divided by religious affiliation. While neither social class differences nor (due to linguistic limitations) inter-generational variations regarding the various cultural traditions of this community have been ascertained, many features of family and community life (including underlying cultural values) have been considered. These features are ones which, directly or indirectly, influence the world of the Punjabi wife and mother and, thereby, are relevant to the maternal and child health remit of the health visiting service. In the next chapter, I look specifically at a child bearing and child rearing career as followed by members of the same Punjabi community. As in this chapter, I discuss underlying cultural values but, this time, particularly as they relate to motherhood.

CHAPTER SEVEN

PRE-ENCOUNTER INFLUENCES

CHILD BEARING AND CHILD REARING

- 1. Introduction**
- 2. Family Size and Location of Deliveries**
- 3. Child Bearing**
- 4. Child Rearing**
- 5. Underlying Cultural Values**
- 6. Summary**

1. INTRODUCTION

In this chapter, I specifically look at cultural factors relating to maternal and child health and utilize a child bearing and child rearing career in so doing. Throughout, the findings should be regarded in conjunction with the findings presented in the previous chapter which provide an understanding of how and where the families live, together with a number of cultural features that shape their lives. For the purpose of the discussion in Chapter Eight, in which the relevance of the findings are discussed in conjunction with the diagnostic process of health visiting (see Chapter Two) and with regard to three hypothetical clients, the findings in this chapter should be viewed as 'pre-encounter influences'.

2. FAMILY SIZE AND LOCATION OF DELIVERIES

Within the twenty-nine sample families there are seventy-two living children, each nuclear family having at least one child under five years old. Most wives were married during their late teens or early twenties. In twenty-three of the families there are three or fewer children. The six mothers with more than three children are all amongst the thirteen mothers who are twenty-six years old, or older. While Sikh family size ranges between one and seven children and Muslim families between one and five, small sample sizing prevents any speculation regarding the influence of religious affiliation on family size.

In seventeen families there are more boys than girls, with four other families having an equal ratio of boys to girls. Only one family is without a living son, the mother having had a very traumatic obstetric history. Eleven of the children have been delivered in the Punjab, one being born in hospital, the others delivered by the village *dai* (midwife) in either the mother's natal or affinal home. For example, two Muslim mothers (#13,#15) delivered their firstborn in their natal home in the Punjab, whilst a third (#14) delivered in her affinal home (also in the Punjab) because her mother had died. Not only have all the deliveries in the United Kingdom taken place in hospital, but in nine towns and cities countrywide. Several miscarriages, stillbirths and neonatal deaths have been mentioned.

3. CHILD BEARING

A) CONCERN FOR FECUNDITY AND THE IMPORTANCE OF MALE PROGENY

The need to bear a living child in order to demonstrate fecundity can, in itself, be a cause of strain for a new wife whose acceptance by her in-laws (for instance, amongst the Sikh families) will be enhanced by her ability to achieve motherhood, particularly if she produces a son. The birth of a child (especially a son) to a *Bhatra* mother is cause for much celebration. In one joint family household (#11), the men started celebrating at least two weeks before the arrival of a firstborn, possibly contributing to the need for the mother's admission to hospital in order to rest and allow her blood pressure to settle.

Patrilineal in outlook, irrespective of religious bias, Punjabi society favours the male progeny as inheritors. Girls eventually will marry, usually leaving their

natal kin unless they marry a close relative, as may occur amongst Muslim families (#M). A family with more girls than boys may find, in the long term, the expenses incurred in marrying their daughters to be an unequally balanced financial outlay. For this reason, a mother may be more prepared to consider sterilization at a time when she has more sons than daughters (#7,#21).

Faced with the inability to conceive, the inability to conceive sons, or because of previous traumatic experiences, mothers turn to a variety of sources for help. These include religio-cultural sources as well as Western medical consultation. In addition to praying to Guru Nanak, some of the *Bhatra* wives keep the fast of *Purnmashi*, whilst other wives also seek the powerful assistance of *Sher-vali* (#A). In addition, the wearing of a *ruchya* received from a *baba* or *devi* (both are names given by the *Bhatras* to male [*baba*] and female [*devi*] faith healers) is also felt by some of the *Bhatra* families to be of assistance, particularly to prevent the recurrence of a miscarriage. One Muslim couple (#27), who in this country have lost all of their offspring in very early infancy (both male and female), explained how they had sought the help of a *hakim* (physician) in Pakistan. After this they produced two viable children, one in Pakistan and the other in this country. Their belief in the ability of this *hakim* to help them produce children able to sustain life and grow, appeared to be absolute.

B) ATTITUDES TOWARDS FAMILY PLANNING METHODS

A Punjabi wife's life is very home-centred. Encouraged to bear and raise children, she may find that there will be family pressure on her (not only from her husband but also from her mother-in-law) to continue having children, although she herself would prefer not to. For instance, one *Bhatra* mother

spoke about how her in-laws had been annoyed that her husband had signed sterilization papers and how they had persuaded him to have them torn up. However, sterilization was agreed to after her next child, her fourth. Another mother, also keen to be sterilized after her third child, found herself with similar family opposition. As she felt emotionally unable to face not only another pregnancy, but also the post-partum period and then caring for another infant as well as taking on the additional ensuing life-long responsibilities, the family eventually relented.

Although the study does not focus specifically on family planning methods, at times mothers have mentioned methods they have used, such as interuterine devices and the 'pill'. One comment was that 'Indian women' (#7) prefer not to use the cap or creams. Both Qureshi (1985:14) and Skinner (1979:60,89) note that, for Asian women, the use of vaginal contraceptives means touching an area of their body that is regarded as a taboo area. Even so, Skinner places greater emphasis on the lack of privacy in many Asian homes, as does Bunting (1984:14) who also recognizes the difficulty of insertion when only the left hand may be used. Describing a 'traditional form' of vaginal pessary used as a form of contraception in the Sub-continent, Skinner (1979:89) suggests that there is 'little real support' for emphasis being placed on the concept of taboo.

C) ATTITUDES TOWARDS PREGNANCY AND ANTENATAL CARE

Though ideas are changing, it is customary for a newly married wife to have little knowledge of either pregnancy or childbirth. In the hope of reducing the likelihood of culturally precocious sexual involvement which could damage the family's honour, great importance is placed on pre-marital virginity. Knowledge about sexual matters is withheld and there is a certain disinclination

to encourage daughters to continue at school beyond the statutory requirements (#M,#B).

Attitudes towards sexual modesty regarding pregnancy and childbirth, described by one informant as 'cultural shyness' (#L), seem to be dependent on both the individual and the social situation. Several mothers have spoken of their feelings about male doctors undertaking their antenatal care and, though a husband may not mind, his wife might find it emotionally disturbing. In fact several mothers, both Muslim and Sikh, have female general practitioners (#16,#23,#K). However, one mother, whose father is a doctor, has clearly stated that she views doctors in an entirely professional capacity whether or not they are male or female.

The Sikh women seem particularly ready to report their pregnancies to their doctor during the first and second months of the first trimester for, as one put it, she 'wants to know' (#7). The Muslim women recall reporting their pregnancies a little later, during the second and third months in first pregnancies and frequently after four months in subsequent pregnancies. They comment that sometimes this is because they want to be certain, sometimes due to shyness and, in later pregnancies, because they are either more assured or much busier at home. It was only the occasional mother who mentioned not being able to report a pregnancy earlier, for instance, due to moving from one town to another.

D) ATTENDANCE AT ANTENATAL CLASSES

Twenty-six (seventeen Muslim and nine Sikh) of the mothers were asked if they had attended antenatal classes. Of these, only three (one Muslim and two

Sikh) mothers have ever attended an antenatal class, and not one mother has attended in the city where the study is located and where a large proportion of the deliveries have taken place (forty-one of the seventy-two living children). One mother (#5), who attended a series of classes which she found both enjoyable and helpful, mentioned that she would have liked to have been invited again during her second pregnancy. Another mother (#22) had attended two classes, the content of one of them proving useful when she delivered, while a third mother (#19), who not only grew up in a medical family in Pakistan but also knew some English on arriving in this country, offered harsh criticism. She described the class she went to as 'Rubbish . . . boring'. While not interested in attending further classes, she did read the literature available at the antenatal clinic.

'Too busy' and 'no time' were frequent comments given as to why many others chose not to attend antenatal classes. Expanding on her negative response, one of the Muslim mothers (#12) who has lived in this country for many years explained that she was confident in not going to classes because so many people have successful pregnancies without attending. Even so, she had been worried about having a handicapped baby and, though her husband had reassured her that it was up to God (Allah), she felt that another time she would discuss such a worry with others outside the family.

Although most mothers are conversant in the English language, this may not necessarily have been so during their first delivery. Indeed, previous language ability is a factor that possibly should be taken more into consideration when decisions are made as to whether or not to invite a mother to antenatal classes during subsequent pregnancies.

E) ANTENATAL GUIDANCE AT HOME

Guidance from mothers and mothers-in-law is respected. Frequently they have brought up many children themselves, for instance, one mother-in-law has raised fifteen children (#11) and another twelve (#29). Consequently and understandably, they are recognized as being very knowledgeable about child care, and certainly are close at hand to give advice as it is required. Just the fact that her mother was nearby and watching how she was keeping was reassurance enough for one mother during her first pregnancy (#12). In another home, the mother-in-law (#11) considers that pregnant mothers are often made to worry too much by non-Punjabi advisers. On the whole, she feels that a pregnant mother should carry on her life as usual while taking a rest each afternoon.

One young mother (#5), the one who enjoyed the antenatal classes she attended, explained that many people in this country do not understand much about the Indian ways of what is correct for a woman to do when she is pregnant, a time when the whole body is 'upset by pregnancy'. For instance, a pregnant mother should not put her hands from cold water into hot water. She should also have hot drinks rather than cold drinks. Another belief, certainly held by the *Bhatra* families, is that a woman who has had a recent miscarriage should not 'cast her shadow' (*perchaava*) on a pregnant woman - which might happen if she stands too close - for fear that it would be harmful to the pregnancy.

F) DIETARY CONSIDERATIONS DURING PREGNANCY

Several themes have emerged regarding dietary norms, preferences and aversions during pregnancy. A recurrent theme is that a pregnant woman should eat the 'same as usual' (#1,#7,#14,#15,#17,#20,#23,#25,#28,#29) and 'as normally' (#2,#27). Occasionally, emphasis has been placed on the need for extra meat, fish, chicken and fresh fruit (#28). Milk has also been mentioned several times as being important in a pregnant woman's diet, although it is possible that a mother who has lived much of her life in the Sub-continent may be unused to drinking milk. I have also been reminded that:

In Pakistan, only the rich can eat differently. For most people, it is curry and *chapattis*. If you lived on a farm, perhaps then fresh produce such as fruit might be available.

(#3)

As Punjabis regularly drink tea where the milk, sugar, tea and water are all boiled together, tea can be an important dietary source of milk.

During pregnancy:

Some women may have a fancy for one food. Some like chillis, others fruit or rice, while others may go off a food such as meat.

(#1)

Not every mother spoke of experiencing such dietary changes but those that did, found themselves craving for fresh fruits, sour and spicy foods or rice, both cooked and raw (note Nichter and Nichter 1983:240). Many of these foods were Punjabi or sub-tropical - chillis, *imbeli* (tamarind), mangoes, and *pakorras* being amongst those mentioned.

As well as having early morning sickness and heartburn during pregnancy, mothers report experiencing food aversions which particularly focused on meat dishes and the smell of food cooking. Two mothers have felt unable to cook at

all. Other aversions include oranges, mangoes, and carbonated drinks such as coca cola and ginger ale.

Only one mother (#4) has mentioned craving for and eating substances other than normal food (i.e. a *pica*). In this instance, it was reddish-coloured soil, possibly clay which is a recognized *pica* amongst pregnant women in the Punjab (Kumari 1984:personal communication) and elsewhere (Lackey 1978:125). She described how she would go out at night during her last two pregnancies to find the soil she craved, jokingly adding that next time she went to Pakistan she would bring some back for her next pregnancy. When she told her doctor, he suggested that she needed iron tablets. These she was unable to take as they made her feel nauseated. Reference has also been made by one mother (#G) to knowing a pregnant Punjabi woman who had eaten chalk and another who had eaten pieces of coal.

In her study, *Pregnant in Britain*, Homans (1980:265,267) considers food cravings of pregnancy amongst a group of Asian women (most of whom were Punjabi) to be socially constructed and to be concessions made to the bearers of new life, life which may enhance the status of the social group. One of her Sikh informants suggests that the foods for which a pregnant woman craves are also indicative of the sex of her unborn child (Homans 1980:284).

Among the Sikh families visited, reference is made to the avoidance of *garam* ('hot') foods during the early months of pregnancy, one mother (#10) indicating up to the third month and another (#29) up to the sixth month (see Appendix Four for list of 'hot-tepid-cold' foods). It is thought that too much *garam* food may disturb a pregnancy, possibly causing a miscarriage especially up to the third month. However, if a mother particularly craves a certain *garam*

food, she will be allowed a small amount. Pregnancy itself is considered throughout to be a 'hot' condition. Too much 'cold' foods and liquids may also be avoided lest they too affect the pregnancy adversely (#29). One Muslim mother (#12), who does not consciously follow this 'hot-cold' food and bodily conditions classificatory system, notes that it also holds relevance for couples planning to conceive.

Punjeeri, otherwise known as *dabra* by the Muslim families, is a food that *Bhatra* mothers-in-law make for their pregnant daughters-in-law during the last months of pregnancy. Being *garam*, punjeeri is not taken in any quantity, if at all, until the ninth month. During the seventh (preferably) or ninth month of a pregnancy (#29,#G), the *Bhatra* family holds a *gon* (a *punjeeri* party) for the mother-to-be, the mother-in-law being responsible for organizing and financing it. In one home, the *gon* was omitted as the mother-in-law was abroad at the time (#10). At this all-female party (to which married and unmarried women are invited) each guest, using her right hand, puts a portion of *punjeeri* into the expectant mother's *dupatta* which she holds out on her lap in readiness. Eaten mostly after delivery, *punjeeri* is viewed as being able to 'put strength into you' (e.g. #26) and, as one mother wryly notes, so that the mother can get back to 'working in the kitchen again' (#G).

Several recipes for *punjeeri* and *dabra* are used. One recipe for *dabra* consists of butter and sugar mixed together with crushed or milled almonds, coconut and pistachio nuts. With *sundh* (ginger) and *chapatti* flour added to make it into a firm consistency, it is particularly aromatic when warmed. Another recipe for *dabra* includes coconut, poppy seeds, almonds, *ghee* (clarified butter) and sultanas (#6). A third recipe, this time for *punjeeri*, begins with semolina and *chapatti* flour being dry roasted in an ungreased frypan until

lightly browned. Equal amounts of clarified butter and sugar are then added and, finally, pistachio nuts and almonds. Not only is *punjeeri* nourishing, but it is expensive both in the United Kingdom and in the Punjab. However, some mothers find it to be 'too greasy' (#15) or that it 'makes you fat' (#19), while several say that they leave it for either their husbands or their children to eat.

G) DELIVERIES

The little knowledge that I have gleaned about the type of preparation that pregnant women have received regarding childbirth indicates a tendency towards minimal preparation. While one mother told me that her mother-in-law had explained that delivering the baby 'would hurt like hell' (#10), another mother (#25) remarked that no one had really explained to her how it would be. Although people had told her about the pain involved, she knew little, for instance, about how to breathe during labour. As her first birth had been induced, she was also totally unprepared during her second labour for how it would be when her waters broke, as they did, at home.

A variety of complications of labour and childbirth have been referred to including prematurity, intravenous inductions, caesarian sections and forceps deliveries. One mother (#14), who in the Punjab had had the same *dai* for all her deliveries (all of which had been fairly easy and quick), not only found herself with an intravenous infusion and an epidural anaesthetic for her delivery in this country but was uncertain as to why these had been necessary. Another mother (#9), who had been given an epidural anaesthetic for her first birth but not for the next, commented that the second labour might have seemed less painful if she had known what to expect.

Only in very exceptional circumstances would a *Bhatra* mother consider returning to her natal home to deliver as this would bring *sharm* (a sense of shame) to both her affinal and natal kin. For those without family close by, female friends and even a landlady have been relied on for help, such as calling for an ambulance when labour was established (#3). While one Muslim mother from a nuclear family says she would like to have a home delivery if she had female kin nearby (#9), another, a Sikh mother (#7), always looks forward to being in hospital and regards the hospital where she had delivered two of her babies as a 'five star hotel'. In fact, she would love to have a baby for someone else just to be able to go and be looked after by the nurses there, and also to provide her with an opportunity to be away from the home for a while. Another mother (#5), a fluent anglophone, while realizing others thought highly of this same hospital, spoke of being displeased with the care she had received. Not only was an injection needle left in her thigh during delivery (possibly ready for the precise moment to administer the medication that was in the attached syringe) but she remembered being ignored after the delivery when she asked someone to check on her blood loss.

H) HOSPITAL FACILITIES

As most mothers are fluent in the English language, the need for, and use of, an interpreter is a topic that was seldom discussed. However, one husband (#8), whose wife knows minimal English, has commented on how tiring it can be to speak through an interpreter.

Religio-cultural dietary norms and preferences are usually accommodated by ordering either a diet that avoids the prohibited meats (that is, non-beef diets for Sikhs and non-pork diets for Muslims) or by choosing a vegetarian diet.

While one mother (#25) says she selects whatever she thinks will be 'all right' such as salads and fish, another (#24) chooses 'simpler things' like rolls and cornflakes for breakfast, with her husband bringing in cooked foods for her to eat. One husband (#8) has pointed out that Asians are not the only people who take food in for their relatives. Other patients will not have eaten and their families will bring food in for them (#17). Flasks of tea are also taken in, though several mothers indicate that they drink British-style tea. Not only is Punjabi-style tea made with the ingredients boiled up together, but frequently aromatically enhanced with cardamoms, so making it a distinctively different beverage.

As a looser style of *salwar-kameez* is worn at night at home, in hospital a woman might feel embarrassed if expected to wear a hospital nightgown (#7). In hospital, as at home, jug washes and not baths are often preferred methods of washing as it is usually considered cleaner to wash in flowing water (#7,#25). Also, in order to follow customary methods of cleansing after attending to vaginal loss or defecation, it is necessary for mothers to find a jug to use. Hence, one which is intended for measuring urine may be used if nothing more suitable is at hand. A bidet was found by one mother to be an ideal alternative (#25).

I) THE *CHALIA*

The *chalia*, or the customary forty-day post-partum period, is kept by mothers when it is socially possible, that is, when female kinsfolk are close at hand to offer both emotional and physical help. Amongst the Muslims, this is known as the *sawa maheena* which translates as one and a quarter lunar months and, therefore, is approximately thirty-seven days.

One Muslim mother (#1), who did not keep the *sawa maheena* despite living in a joint family household, laughingly comments that she does not know anyone who has done so. While many mothers living in joint family households benefitted from the bonus of having other women at hand to help them during the post-partum period, mothers in nuclear households often have had to 'get on and do things for themselves' (#6).

For forty days following childbirth, the *Bhatra* mother maintains the *chalia*, a time when she is considered to be culturally 'unclean' or 'polluted'. During this time, the mother passes through a transitional state (a rite of passage) when she moves from being a wife to being a wife and mother, particularly after her first-born. Indeed, the *chalia* is a time when the mother and child are offered emotional and physical support and protection, the mother regaining her strength and adjusting to her new responsibilities. Her 'social return from childbirth' (Gennep 1960:43,46) does not necessarily coincide, however, with her physiological recovery. For the *Bhatra*, the gradual reincorporation into the *Bhatra* community culminates on the fortieth day in the ritual bath (for both the mother and the baby) and subsequent attendance at the *gurdwara* for the *mata takon*, that is, the 'bowing before God' when the baby is presented officially in 'God's House' (#G). To an extent, the *mata takon* can be likened to the churching of women that is still practised in different parts of Britain (see Homans 1982:257-258; McDonald 1978:1021; Staton 1980:259). A celebration party is held at the family's home after the *mata takon*.

Amongst the *Bhatra* families, the *chalia* should be kept both by the mother and the baby and is in no way connected with whether or not the mother has stopped bleeding vaginally. Mother and baby are meant to remain indoors, in draught-free rooms, for the full forty days. However, as the baby is considered

the most vulnerable to evil forces, the baby might keep the full *chalia* though the mother does not. For a male baby, especially the firstborn male, the *chalia* is strictly enforced. It is less strictly enforced for a female infant. During this time, no menstruating woman should visit, though this rule is not always strictly followed. Anyone wearing a *ruchya* should either remove it or else not visit at all, otherwise harm might occur to either the mother or the child. Not only might the power inherent in the *ruchya* have an adverse effect on a newly delivered mother and child, but its own powers might be weakened in their presence.

Additional to the baths that the newly delivered *Bhatra* mother takes routinely, several ritual baths are taken, the first of which may be taken while she is still in hospital. These ritual baths are taken at different times during the post-partum period, for instance on the seventh, eighth or thirteenth day post-partum, as well as on the twenty-first and the fortieth day, families varying a little with regard to when the earlier ones are taken. With each ritual bath, the post-partum mother becomes progressively purer in cultural terms. In the winter months, she may possibly take a jug-wash in front of the fire. The bath that signifies that the mother is considered ritually clean enough to work in the house and the kitchen again is called the *chaunka chalia*. Either the thirteenth or the twenty-first day may be chosen for the *chaunka chalia*, depending on circumstances, particularly with regard to the mother's physical well-being. The baby also receives a ritual bath at similar times. Grains of rice, one pound and twenty-five pence and some *gur* (a form of cane sugar) are placed between the feet during both the mother's and the baby's baths.

After the forty days are over, and before the baby is taken to anyone else's house, *Bhatra* mothers and their infants attend the *gurdwara* for the *mata*

Mother and child



7 .1 Mother with her newborn



7 .2 Applying kol

takon. Having bathed and dressed in clean clothes, the mother and child usually attend one of the regular services, although they may request a special one. This attendance at the *gurdwara* can be seen to be a time when mother and child are once again integrated into the community. For those who find strength by praying to *Sher-vali*, a special thanksgiving is also made at this time.

Following a miscarriage, restrictions on a *Bhatra* wife's mobility are even more carefully controlled by her mother-in-law who ensures that her daughter-in-law neither leaves the house nor 'casts her shadow' (*perchaava*) over her female in-laws, such as her sister-in-law. Miscarriage is considered by the *Bhatra* to be a hundred-fold more polluting than childbirth (#7). According to Lozoff et al. (1975:356), miscarriage is said to combine 'two of the most polluting circumstances in Indian life', that is, 'death and childbirth'.

One mother (#G) described her experiences following a miscarriage nine years previously, adding that it has changed little since then. Initially she was encouraged to stay with her own mother, but missing her own home and nuclear family, she returned home. As she was taken to her bedroom, all the other doors in the house were closed with everyone keeping out of sight. Until the forty days were over, no one else apart from her mother-in-law and her husband came into the room. And, when she went either to the bathroom or to the kitchen, 'everybody kept out of the road' (#G).

At the end of the forty days, she was taken by her mother-in-law to one of the public baths for the 'ritual bath' (which had to be taken outside the home) where, as well as bathing, she also washed and dried her hair. The Brylcreem needed for oiling her hair was bought specially so that she did not use what

was available in the house, insomuch that no one else should use it thereafter. On the way back home, her mother-in-law took her to a fruit shop and bought her five different kinds of fruit, the choice of which was non-specific. These she took home and shared amongst the other family members, thus signifying that 'she would become fertile again' (#G).

Amongst the Muslim Punjabi community, the approximately forty-day post-partum period (which is a Punjabi rather than an Islamic practice) is called the *sawa maheena*. Like the *chalia*, it is also a time when both the mother and the baby should remain in the house. Although one mother (#23) spoke of only going outside the home if she was in a car, presumably from one home to another, due to changing circumstances, it is not always possible for the *sawa maheena* to be maintained. For the first six days, according to one informant (#E), the mother should only have a towel wash, taking her first full bath after the sixth day. This post-partum period is a time when 'women are weaker, their nerves are weaker, everything is weaker' (#E), hence it is important for the mother to prevent undue stress on her body, some mothers preferring not to read, knit or sew lest this might permanently affect their eyes. In the wintertime, the post-natal mother may avoid doing any washing up as putting the hands into cold water during this 'weaker' time might make her permanently 'rheumatic or similar' (#E) (note Good 1980:148).

During the *sawa maheena*, the mother is forbidden to touch the *Qur'an*, though she may listen to it being read. She is also not allowed to read the *namaz*, the formalized prayers and actions orthodoxly followed five times a day, though she may offer other prayers (#M). Although few women attend the mosque routinely, attendance is acceptable if she bathes beforehand, particularly if she no longer has any vaginal blood loss (#E).

Mothers referred to their mothers, mothers-in-law and, occasionally, other female kin (such as sisters-in-law) as those who provided them with the most help in caring for their first baby. Only the Muslim mothers, five in all, named their mothers as providing the most help. These included two mothers who delivered in their natal homes in Pakistan, and three others who delivered in this country, one of whom was already living with her mother, and another who went to live with her mother for the first six months after her first child was born. One Muslim mother (#20) told how her sister had come from Pakistan to be with her for one of her births, although after a previous delivery her husband had employed one of the ladies who usually worked in their shop to help her care for both the baby and the home. In nuclear family households, a husband's ability and willingness to help may be much appreciated where the wife is without traditional female family support.

Amongst the Sikh families interviewed, members of the natal family were never referred to as offering the most help in caring for either the first or the latest baby, though they may have been of some help, possibly sometimes offering advice on the telephone. However, a *Bhatra* mother-in-law is expected to sleep near her newly-delivered daughter-in-law to help her care for the infant. Indirectly, her presence acts as a form of contraception (#7,#29). One mother (#7) spoke adversely of her mother-in-law leaving her alone after only one night to care for her firstborn by herself. Although she found her subsequent babies easier to cope with, she spent a great deal of time crying as she learnt to cope with her firstborn.

4. CHILD REARING

A) FEEDING THE BABY – BREAST-FEEDING

Despite the findings on infant feeding being based on recall and thereby tentative, a number of interesting facts and speculations emerge. Thirty-nine of the seventy-two babies born and being raised had been breast-fed, fully or partially, for a variable period of time declining over the first six to eight weeks, approximately the length of the full *chalia*. Except for one mother who breast-fed all the children born to her in India, whether female or male, only male infants (six in all) and two female infants, who might be considered to be very precious because they were born after several neonatal deaths, were breast-fed for more than two months. Whilst the two female infants were breast-fed for over a year, only two of the six male infants were breast-fed for more than six months, one for nine months and the other for a year.

In the first six weeks of life, there is minimal difference between whether boys or girls, Sikh or Muslim, are breast-fed. Bearing in mind the small sample size, the probability of an infant being breast-fed seems to have a certain amount of relationship to the order of birth as twenty of the twenty-nine firstborn were breast-fed compared with eleven of the twenty-one secondborn and four of the eleven thirdborn. Although four of the six of the fourthborn were breast-fed, infants of fifth and subsequent pregnancies were not breast-fed at all. These figures exclude the infants who died neonatally. Similar findings were found by Goel et al. (1978:1182) in their multi-ethnic study (which included Punjabi families), that is, that 'the child's position in the family affected the decision about whether to breast- or bottle-feed'.

While persuasion from nursing and medical personnel seems to have some influence on whether or not a mother starts and continues to breast-feed, the home environment is probably more important. For example, a joint family household provides greater ease for the *chalia* to be maintained. Thus, being 'at home all this while' (#10,#11), a *Bhatra* mother might be more prepared to breast-feed, at least for a short while. Amongst the *Bhatra* families, a mother deciding to breast-feed will have her nipples ritually cleansed, a ritual which may be performed in hospital, though in the privacy of a family visit. As soon as it is feasible to do so, money (one pound and twenty-five pence) is dipped into water into which grains of rice and *gur* have been added, and a young girl will wipe this across the mother's right nipple five times (#29) (cf. Gideon 1962:1228-1229). Colostrum as well as the ensuing breast milk is given to the *Bhatra* baby (#29).

Several mothers have explained why they had, or had not, chosen to breast-feed. One father of a non-sample family emphasized the intimacy that breast-feeding affords for mother and baby (#H). Both husbands and mothers-in-law are considered influential with regard to decisions relating to breast-feeding. Indeed, one mother (#12) who had been enjoying breast-feeding her child, changed to bottle-feeding on the advice of her mother-in-law in Pakistan when both she and the baby had been troubled for some time with loose bowel motions. Another mother (#12) stopped because her husband preferred her not to breast-feed, while a third, who commented that 'half the ward were breast-feeding', discontinued because she found it too painful. 'No time for working when you breast-feed' (#26) as well as not having enough milk (e.g. #17) were other reasons given and, in fact, by two weeks post-partum, fifteen of the thirty-nine breast-fed babies were remembered as receiving bottle-feeds.

Plentiful milk supplies are viewed both positively and negatively. Having breast-fed both her children for long periods of time, both over a year, one mother (#27) smilingly announced that she had had more milk than the child needed. Another mother (#15), however, decided to bottle-feed her second and subsequent children as she had had so much milk when she fed her first baby that she was 'always dripping'. Although one Sikh father (#8) feels that:

In the U.K. it is not easy for a woman to breast-feed if she is shopping or visiting elsewhere. She would have to stay home as she can't go far if she is breast-feeding,

another view is that there was always another room to go to if privacy is the concern (#9).

B) FEEDING THE BABY – BOTTLE-FEEDING

Thirty-five babies and children either had been or are still continuing to be bottle-fed, some only occasionally. Powdered milks of various proprietary brands are mentioned. Bottle-feeding is not necessarily viewed as easier than breast-feeding, one comment being that 'you still have to get up in the night' (#25). Amongst the Sikh families, all the infants born in the United Kingdom were being bottle-fed by eight weeks. Watching one fourteen month girl happily bottle-feeding her three year old brother who likes to be 'babied', I could not help but wonder how soon the idea of bottle-feeding is learnt (#5).

In two Muslim homes, I have been visually aware as to how the baby's bottles were being sterilized. The one mother (#17) used a sterilization unit routinely and easily. In the other home (#C), though the family owned a sterilization unit (and the use of sterilizing tablets were being encouraged by the health visitor), the unit had been put away in a relatively inaccessible part of a kitchen cupboard. In fact, the family seemed disinclined to use this

method, instead preferring to boil the baby's bottles. This may have been because many Punjabis consider only flowing water to be sufficiently adequate for cleansing purposes (see Ballard [1983]:13).

C) DIETARY NEEDS FOR POST-NATAL AND LACTATING MOTHERS

The Sikh mothers are the most forthcoming about what foods a lactating mother should eat and those she should avoid. Both Sikh and Muslim mothers refer to *punjeeri* and *dabra* (which is usually not eaten until after the birth) as especially nourishing.

Several Muslim mothers recommend that a lactating mother should drink extra milk, that is, while continuing to eat her usual diet. In addition, very spicy foods (such as *pakorras* and curries which have been heavily spiced with chillis) as well as chutneys, peppers and various fruits and vegetables (such as grapes, oranges, mangoes and corn on the cob), which might affect the baby's digestive system, should be avoided. Sikh families, however, consider that food solid enough to have to bite into it (such as meat) should not be eaten during the early part of the post-partum period (#5). Instead, nutritious liquids, such as chicken or vegetable soup, chicken gravy, rice or lentils (that have been blended into a watery consistency) as well as milk, should be taken. *Garam* foods are also recommended, not only *punjeeri* but *dahl*, *kedgerree*, green lentils, spinach and rice. Fish and fresh fruit have also been mentioned.

D) NAMING THE BABY

At the *mata takon*, the first letter on a page of the *Guru Granth Sahib*, (opened at random during the service), or from any other part of the scriptures on that page, may be selected for the first letter of a Sikh baby's name, which is then announced publicly. Alternatively, the name may be chosen at home or by a *baba* in India. In England and Wales, where a baby need not be registered until forty-two days after the birth, the name that the child is known by, that is, the one given during or after the *mata takon*, may be the same as the one found on his or her birth certificate. However, in Scotland, where a baby must be legally registered by twenty-one days after the birth, this will not be so. Frequently, names rhyming with the names of other siblings seem to be favoured for the Sikh children. By school age, sons, in particular, might use anglicized names to avoid being teased, and often one is chosen with the same initial as their Punjabi name. One baby was named by the hospital nurses and this name has been kept as his anglicized name (#B). In other instances, the mother has been the one to choose the daughter's name and the husband or a friend, the boy's name (#9,#J). As previously mentioned, the grandparents may be asked to name the baby (#14).

E) CUSTOMARY CEREMONIES FOR INFANTS

Unlike the Sikhs, who orthodoxly do not cut their children's hair – neither the girls' nor the boys' hair – the hair of the Muslim infants is shaved some days after birth. In Pakistan, a barber comes to the home to shave the baby's head on the third, fifth or seventh day. Both finger and toe nails of a Muslim baby are trimmed at this time and these hair and nail clippings are put 'somewhere clean' (#D) which may be in the ground in part of the home, in the

rafters or else in water, perhaps a river. In this country, however, the father or uncle of the child, if possible a *hajji* (that is someone who has been on a *hajj* [#28]), is the one to shave the hair, using a pair of scissors (or an electric or safety razor) to do so. On one baby, only the scalp hair and not the plentiful hair on one baby's forehead had been shaved, and, on another, the hair around the whorl on the crown had been left (#C). In this community, hair and nail clippings from this ceremony are placed in the garbage.

Differing reasons for shaving the hair were proffered. One father explained that by removing the hair of the newborn, strong hair then grows, also noting that, in Pakistan, a child's hair would be shaved throughout childhood, particularly in the hot weather. One other reason given was that these hair and nail clippings are 'like presents from God for they were given when the baby was inside the mother' (#D). However, another mother explained that the hair is shaved because the child is polluted through the process of childbirth (#23).

The Muslim call to prayer (the *azan*) should be the first words that a newborn Muslim baby hears, spoken by a male Muslim first into the infant's right ear and then the left (#D,#M). Islamic practices also include the circumcision of all male Muslims. In Pakistan, circumcision is frequently performed before the *sawa maheena* is over. While several children's names are said to be on hospital waiting lists for circumcision, some parents turn to private doctors, if not in the same city then in one with a larger Muslim community. Being without medical necessity, circumcision for religious reasons is not considered by the local health authorities as acceptable under the National Health Service.

F) INFANT WEANING AND CHILD FEEDING

As my visits have not coincided regularly with times when infants and children were eating, information on infant weaning and child feeding practices has largely been based on parental recall rather than personal observation. Hence, a certain amount of caution is necessitated in regard to the accuracy of some of the information provided. For instance, I accompanied the parents of one non-sample family to their child's routine health and development check. Having visited their home previously, where I had watched their nine month old daughter enjoying feeding herself *pakoras* and tomato ketchup, I was a surprised to hear the father inform the doctor that she was taking custard, rice and milk. However correct his answer was, it did not indicate the full range of foods that she was then eating (#1).

While only two mothers have spoken about not introducing first foods until their child is nearly a year old (#2,#16), four mothers have not yet begun to introduce their youngest child to foods as they are still considered too young (all are four months or younger). Of the others, twenty-two recall beginning to wean their youngest child between three and six months old.

Rice, baby rusks, cereals as well as bananas, eggs and egg custards are mentioned regularly as foods first introduced into a baby's diet, often from tins or packets, several well-known brand names being quoted regularly. The Sikh mothers also mention strained soup (#5), tastes of meat, fish curries and chicken casseroles as well as *chapattis* and *dahl* as being amongst the earlier flavours and foods introduced. Meat tends to be introduced later and then from the food made for the rest of the family rather than from tins and packets of baby foods. In Muslim homes which uphold Islamic dietary proscriptions,

this ensures that the child only has meat that is *halal*. While fruit is frequently mentioned by Muslim families, only one mention has been made by any of the Sikh families.

On the whole, spiced foods are considered unsuitable for very young children. However, one mother, who had been cautious not to introduce spicy foods too early with her first two children, found that, as schoolchildren, they were still not keen on spicy foods. Hence, she decided to start her youngest child straight onto the family curries and *chapattis* so that he had little chance to dislike them (#7). Snacks seen to be preferred by pre-schoolers include almonds and grapes as well as sweets.

Many mothers, whether breast- or bottle-feeding, have given vitamins to their infants, although not always on a regular basis. These they have purchased from health clinics or chemists and, occasionally, on a doctor's prescription, for instance for one prematurely born infant (#8). No mention has been made about the prevention of 'Asian' rickets which has been a concern in other Punjabi communities, nor has any mention been made with regard to any of the children having suffered, or to be suffering, clinically from this condition.

Who makes decisions regarding changes to a child's diet is, on the whole, dependent on whether the parents live in a two-generational or three-generational household. When living in a three-generational household, it is only the occasional mother (e.g. #7,#23,#28) who considers herself to be the one to make such decisions. However, as two-generational households predominate, especially amongst the Muslim households, a greater number of mothers and occasionally fathers are the ones instrumental in making such changes (i.e. in seventeen of the twenty Muslim families and in four of the

eight Sikh families, with the question being omitted in one home).

Many families include school children, some of whom take packed lunches with them to school, whilst others return home for lunch. Meals served are sometimes decidedly British, and, at other times, Punjabi. Many families seem to enjoy both types of cuisine. One son, home from school for lunch during my visit, was provided with a generous plateful of fishcakes, baked beans, peas, chips and fried eggs, whereas in another home I was informed that Muslims can buy *halal* sausages. In yet another home, I have been offered a piece of sponge cake made at school by one of the daughters. At two birthday parties that I was invited to, small cakes, jellies and trifles as well as iced birthday cakes decorated with candles had been made for everyone to eat, with pink icing for the girl's and blue for the boy's birthday cake. In most homes, meals tend to be served as needed, small children being fed when they are hungry. If possible, the rest of the family will eat together, usually in the evening.

G) HANDLING OF CHILDREN AND APPROACHES TO CHILD CARE

Many Punjabis, both as children and as young men and women, are involved in caring for younger siblings and other related children. One husband, on first coming to this country, had stayed with a close relative. While living with this family, he had learnt how to cope with young children, an asset which his wife appreciated when they began their own family (#9). An older sibling in another family told me how she had helped her mother with the younger children, bathing, dressing and feeding them, though never changing their nappies (#8). In another home, a young aunt used to be the one who regularly took her nephew to the child health clinic (#2) despite the embarrassment it caused her, other mothers tending to think the child was hers.

The immediacy of physical closeness that several young children showed when their fathers came home during my visits visually emphasized the existence of warm paternal involvement in children's upbringing in Punjabi homes (e.g. #2,#23,#1). Even so, the day to day responsibilities of the children's upbringing belongs to the womenfolk and is eased when shared. With minimal family support, one mother (#3), who copes with cramped housing conditions, feels the strain, especially as her husband is having business difficulties and is unable to be of much emotional support. A similar situation was described by another wife when, as a young married couple with a new baby, their life-style had been much the same (#5). Indeed, a young wife needing to help her husband build up a small family business may well find herself looking after their baby in a room at the back of a shop (#3,#5), that is, if she is without either relatives nearby to look after their baby or the use of crèche facilities.

After a long visit to Pakistan, one infant son has become so used to being held by many relatives and always cuddled to sleep that he no longer accepts being laid in his cot and left to settle himself to sleep (#9). Although I have only met a limited number of families, there seem to be several distinctive ways of handling children that I have observed on different occasions. Sometimes a mother will place her infant face downwards across her knees and, with one hand on his head and the other on his bottom, rock him in a see-saw fashion to sleep. At other times, babies are comforted by having their temples rubbed quite briskly (#4,#1), while patting a baby's forehead with the palm of the hand is also used in settling an infant. Firm hand movements using the palm of the hand from the centre of the face towards the one ear and then the other is also distinctive, and nostrils are seen to be dried with a similar double action, first across one nostril and then across the other

(#7,#19). There also seems to be a distinctive, casual 'hoick' to the shoulders that a newly toddling youngster may receive to propel him into motion, almost like lifting up a rag doll. These and other ways of handling small children are used easily and unconsciously and no doubt learnt by observing other Punjabi mothers.

Just three visits have coincided with the time a child or infant was being bathed. In two homes, the toddler was being washed in a dual-basin kitchen sink with a swivel tap which, on reflection, possibly would not be dissimilar to washing a child under a pump in the courtyard of a home in the Punjab. The baby, however, was being bathed by the living room fire. Seated on the floor, the mother (#14) dressed her baby daughter with the baby laid across her knees and proceeded to apply *surma* to her eyelids. The father explained that the *surma* keeps the eyes good so that people do not need to use glasses. The only other baby that I have seen who had *surma* applied to his eyelids was also born to a mother who had spent a fair amount of her married life in the Punjab and had had several children born to her during that time. One older sibling confided that she herself does not like *kol* (which is similar to *surma*) being used but that her mother does, while one wife (#G) has explained that her husband does not like her to use it. I am also informed that mothers, especially the younger ones, are aware of the possibility of unsuitable levels of lead content in *surma* (#G).

H) IMMUNIZATION

Over two thirds of the parents are 'happy' to have their children immunized, believing that 'it keeps them healthy' (#10) and, 'if it is good for him in the future, then it is good' (#11). Even though there have been other more neutral

comments, the need for immunization is generally accepted, 'anything suggested by the doctor' being one such comment (#13).

Many parents receive postal notification as to when immunization is due, turning to health visitors and general practitioners as well as close family members if they need advice. Parents, however, vary in their ability to identify the diseases included in the immunization schedule, many accepting 'all that is offered'. Nearly half the parents do not have any personal records of their children's immunization, others for only some of their children, while several are content in the knowledge that they can ask at the doctor's surgery if they need to know details.

Overall, immunization is accepted but, despite parents being conversant in English, few parents are knowledgeable of individual diseases that their children are being protected against. This is despite the risks of pertussis vaccine having been a controversial issue in recent years. As young children are sometimes taken to the Punjab to visit relatives, typhoid and cholera are also amongst the diseases small children have been immunized against but are not part of the routine immunization schedule. A few children have received protection against tuberculosis but always in a city elsewhere. For instance, in a city not too far distant and where many families visit, babies are given B.C.G. vaccination routinely after birth.

I) ASPECTS OF CHILD DEVELOPMENT AND CHILD HEALTH

There is seldom a home where other children are not about to help amuse and care for a young baby or toddler. Sometimes, non-Punjabi friends and neighbours help and, during one visit, a white (*gora* - meaning 'fair-skinned')

neighbour left her children with the family (#27), while at one of the birthday parties, a white schoolgirl was the one who organized the games (#7). Even so, most pre-schoolers learn to speak Punjabi before learning English. For some pre-schoolers, the first time they may be faced with the need to learn English may be at nursery school, especially if their mothers prefer to use Punjabi at home (e.g. #9). Many adults as well as older children seem at ease moving between Punjabi and English when talking with one another, one person explaining that certain ideas are often easier to express in one language than in the other.

In addition to nursery school being a place where Punjabi pre-schoolers will mix with non-Punjabis of their own age, various community groups also offer other opportunities, such as one group for boys only that I visited with a couple of mothers on two occasions. The one time, the boys were enjoying a 'cowboy evening' while, on the other evening, they had just finished having a Hallowe'en party, one son winning a prize for the turnip which his mother had made into a Chinese mandarin's face, pigtail and moustache included (#7).

Girls appear to receive somewhat firmer discipline than do the boys. They are expected to be responsible towards other siblings and adults, and to assume various increasing responsibilities and caring attitudes within the home. Not only did I watch the little girl who playfully fed her brother like a baby, but also a couple of schoolgirls who delighted in serving afternoon tea (#7,#20) and also another who prepared a mustard foot bath for her mother's aching feet (#7).

Carpeted floors, often wall-to-wall, allow little children to play comfortably on the floor and infants to crawl and learn to walk without the need for socks

and shoes, that is, as long as the room is heated. Sturdy wheeled toys, miniature tea sets, 'action men', coin collections, crayonning books and comics are amongst the numerous toys that I have seen being played with by children of various ages. Television and video recorders are popular, video films such as *Jaws* being highly favoured (e.g. #7). Sibling rivalry may be expressed not only over wanting to have the same tricycle (#17) but also over the question of which television channel should be viewed (#20).

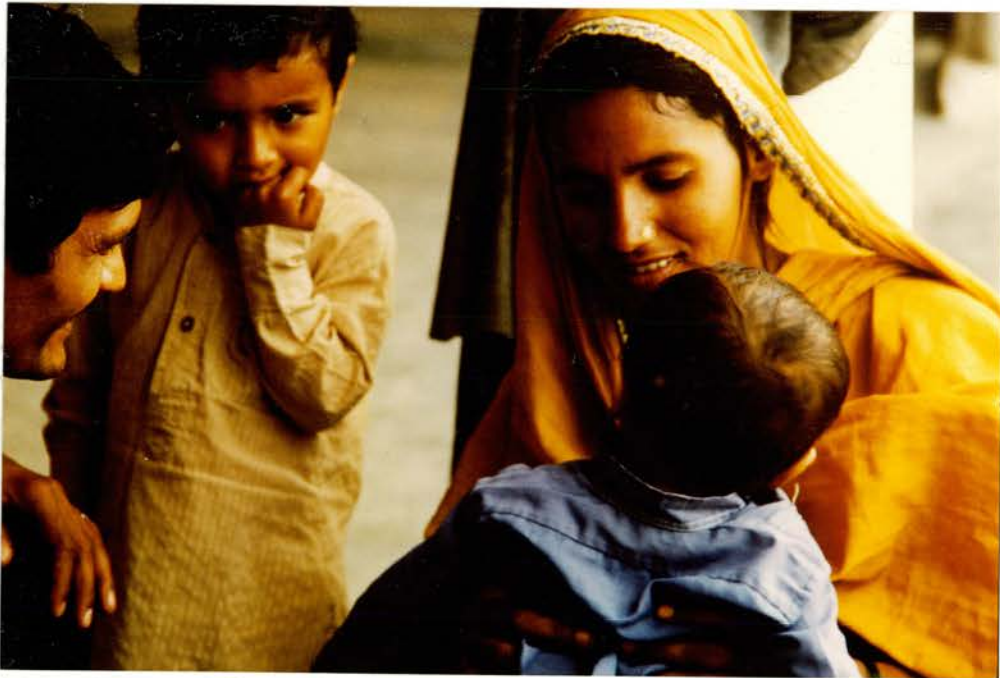
Mothers take their young children both to local health clinics and to general practitioners' surgeries for child development assessments. Only one mother, who lives a reasonable distance from her doctor's practice, has said that she finds it difficult to attend the regular check-ups for her second child, but explained that the health visitor comes to see him at their home. When asked about these developmental assessments, most mothers have given me answers that referred to either the whole body being checked over or certain parts of the body, such as the chest, heart, eyes and legs. Little mention has been made about either fine or gross motor abilities being checked, comments such as 'how he holds things' (#9), 'if he can sit up' (#29) being few and far between. To an extent, this may have been because it was usually near the end of an interview when I asked these questions. However, it is also possible that little is explained during such assessments, hence, parents having minimal indication of what is being considered or what developmental progress to anticipate next. For instance, at one developmental assessment that I attended, a father (#1) was asked by the doctor if he had noticed if his child had ever had a squint. Although an anglophone, as were most of the parents interviewed, the father did not appear to understand this term yet gave an affirmative reply, to which the doctor quietly said that she would ask again but made no attempt to explain.

Mother and child



7 .3

At the **Gurdwara**



7 .4

Attending a village health clinic

One mother (#12), who not only spoke to me about a television programme on the pertussis vaccine that she had watched but also asked me if I knew of any mother and toddler group nearby, has been the only mother to speak spontaneously, and in great detail, about her son's developmental assessments. She not only explained that the doctor had listened to his heart and chest and checked whether he was urinating satisfactorily, but that she had also been asked about his teeth and when he had started walking. She described a rattle being used to test his hearing and, on reflection, she thought that her son's eyesight was probably being tested when the doctor held out a piece of fluff and encouraged her son to take it with his fingers. No other mother has vocalized this amount of awareness of the various ways in which her child has been assessed developmentally.

Without exception, every family considers the general practitioner to be the person outside the family to whom they go for advice concerning their children's health. Though one mother says she never contacts the health visitor herself, a few others do. Certainly mothers have taken the opportunity to ask for advice during the times I have accompanied health visitors on their visits. Occasionally, chemists are seen as sources of advice, for instance, on how to care for children's colds as well as how to treat small injuries.

Only one mother has mentioned the doctor at the health clinic (#2) and this was regarding check-ups and injections only. The decision to take a child to see the doctor or to the clinic is invariably made by the mother or the father, even when they live in a joint family household. Even so, husbands or another family member are sometimes needed to translate and/or take them in the car (#23) and, at times, even to make the appointment, for instance if the telephone is in the shop (#6).

5. UNDERLYING CULTURAL VALUES

A) JUNIOR TO SENIOR

The importance of progeny to the joint family, certainly amongst the *Bhatra* community, is reflected in the fact that senior family members are noted to be influential in decision making when sterilization is being considered (note Zaklama 1984:65). The eagerness of Sikh wives to confirm pregnancies at an early stage may also have some connection with the status that pregnancy offers within the joint family.

Pregnant and delivered mothers indicate that they follow the advice of their mothers, mothers-in-law and other senior female kinsfolk regarding aspects of child bearing and child rearing for deferential reasons as well as for filial regard. The fact that they have raised successfully, and possibly still are raising a family, offers definite and sometimes even visual reassurance without which a young wife, especially a *primagravida* (a woman who is pregnant for the first time), may feel bereft. However, where help is not so readily available, hospital care is viewed by some as a time when they are able to recover physically after the baby is born as well as having a break from the activities of their home environment (#7,#9). On the whole, mothers do speak of themselves as being the person who decides when to make changes in their children's diet.

B) FEMALE TO MALE

The notion of female modesty (together with the notion of patriarchal dominance) permeates the whole fabric of a Punjabi woman's life. Even where

the womenfolk may be interacting in predominantly non-Punjabi locations, such as hospitals and child health clinics, many mothers continue to maintain this sense of modesty. Thus a preference for female doctors and culturally modest hospital attire can readily be appreciated.

Although breast-feeding is usually continued for a little longer than the duration of the *chalia*, whether coincidentally or not, the fact that only boys and 'very precious' babies have been the ones breast-fed for a long time would seem to intimate that greater status is placed on this form of infant feeding. Of comparative note are the findings of another study amongst Punjabi mothers (mostly Sikhs and Hindus) in which Dosanjh (1976:181) found that the male infants were breast-fed for a longer time than were the female infants.

It also seems that sons receive less discipline in the home, at least from their mothers, than do daughters, and if this is so, it may be linked to the greater social freedom that is given to the Punjabi male. Several wives have referred to husbands having to trust them in various social situations, one husband accepting the fact that the health visitor was male. This was the only time a mother has indicated to me that her husband's permission is needed before a health visitor can visit, although one father teasingly suggested it depended 'who was the boss!' (#5). He also added that the menfolk have little to do with decisions concerning the children until they are older, perhaps nearing school age.

C) DANGER AND VULNERABILITY

At various times of the life-span (and especially in relation to a *Bhatra* woman's reproductive career), there is a strong awareness of being vulnerable

both to factors recognized as culturally polluting and to the power of extraneous influences, such as 'the evil eye'. Indeed, not only are there times when a person is especially vulnerable to cultural pollution and/or evil forces, but there are times when a person is able to 'harm' others with this contagion. Consequently, there is a parallel awareness for the need to protect or seek protection, both in secular and religious spheres. Maloney (1976) suggests baleful or powerful as alternative and more appropriate adjectives to how the evil eye is understood in the Sub-continent (Maloney 1976:108-109).

Indians traditionally believe that the eyes not only are for seeing but that they also 'transmit various emotions and functions of the mind' such as 'envy, malice, love, wisdom, and protection' (Maloney 1976:130, also 126-127). A third eye, which is considered to be located in the centre of the forehead, in fact where the *bindi* is placed, is felt to be the point from which a person's psychic powers may emanate. Various methods may be used to divert such powers, including the use of the colour red which is considered sufficiently potent to divert the evil eye. Fetuses, babies and young children are believed to be more vulnerable to the evil eye than are adults because they lack the force of personality to deflect its influence (Maloney 1976:105). However, though a number of mothers in my study spoke of various pollution beliefs, they in no way imparted a notion of fear and dread, but rather a cautionary following of customary habits which are felt to help ensure satisfactory outcomes.

As well as being a rite of passage, the *chalia* also functions as a rite of protection for the baby. Being particularly vulnerable, a *Bhatra* baby will be kept at home (particularly if a male infant) for the full forty days when, 'if anyone is going to do anything evil to the baby, it will take effect then' (#G). Not only is a baby vulnerable in early infancy but also in the womb, and

anyone who has recently miscarried is on no account to 'cast her shadow' (*perchaava*) over a pregnant mother, that is, to pass close by her (#G).

Several of the *Bhatra* mothers assured me that they would never visit someone, apart from a member of their own family, who had just had a baby and, if they were wearing a *ruchya*, they would remove it first. For a *Bhatra* Sikh to contravene these customs knowingly is seen as its having been done on purpose, probably with malicious intent or, as one mother (#G) put it, as being 'spiteful to the family with the baby if you know what is the right way'. Even though the wearing of a *ruchya* is felt to offer protection of a religious nature against most things, and is likened to a Christian wearing a pendant of St Christopher or a cross for protective reasons, its powers can also be affected in certain circumstances. Inside a *ruchya*, which some of the *Bhatra* mothers and children wear, there is a portion of a religious item that has been blessed, such as a piece of a flag from a *gurdwara* in India.

Various other methods are used to help ensure that a new infant is protected. For a male *Bhatra* Sikh infant, the *schree* is hung from the lintel of the door where the baby will go when he returns from hospital, as well as over the main outside door. With orange-red threads holding the leaves in place, the *schree*, which is hung by a daughter of the clan, serves to help 'cast away any evil or anything like that' (#G). Families vary as to whether they protect more than two lintels. Amongst the *Bhatra* community, infants and young children frequently wear a *thaga* (black thread) which may be tied around both ankles, both wrists and also the waist. These also offer protection from the evil eye, although one father informed me that the black threads on a baby's wrists provide an indication of weight gain (#8). Both customs are maintained under the supervision of the *Bhatra* mother-in-law.

Although it is usual for non-Punjabis to compliment a mother on the looks of her baby, amongst the *Bhatra* community such praise is cause for concern. A mother might reflect on 'why she said that' (#G), and wonder if the person's glance had been envious. Should something unfavourable subsequently happen to the child, she may wonder if such praise had been influential in causing misfortune to occur. Another method to divert attention from a *Bhatra* baby's looks is to place a black mark on the baby's forehead or elsewhere on the baby's face (#G). In this as in other ways mentioned, families hope to ward off evil forces and provide protection for their various family members at times when they are known to be most vulnerable to cultural pollution and powerful forces.

6. SUMMARY

Throughout this chapter, I have brought together various features that are part of a married Punjabi woman's child bearing and child rearing career, again considering underlying cultural values. In the next chapter, I draw on the findings of both Chapter Six and Chapter Seven to demonstrate the relevance of the findings to the provision of culturally relevant and client-centred health visiting practice, that is, with the anticipation of more effective health visiting interventions. For this discussion, which relates to health visiting's maternal and child health remit, three hypothetical clients have been selected: the antenatal mother, the post-natal mother and the infant. In discussing the relevance of the findings, the diagnostic process of health visiting, as described in Chapter Two, is utilized.

CHAPTER EIGHT

THE RELEVANCE OF THE FINDINGS

TO HEALTH VISITING PRACTICE

- 1. Introduction**
- 2. The Antenatal Mother**
- 3. The Post-natal Mother and Infant**
- 4. Discussion**

1. INTRODUCTION

In this chapter, the findings presented in Chapters Six and Seven are drawn together and linked to three specific client groups to demonstrate that if effective, client-oriented health visiting interventions are to be anticipated then health visiting practice must be based on knowledge and understanding of the client's cultural traditions and values. To describe how the findings ('pre-encounter influences') might be considered, and their relevance to maternal and child health visiting practice, I have selected three hypothetical clients from the cultural group on which the study was based: the antenatal mother, the post-natal mother and the infant. Whilst the fieldwork seldom included a visit to an antenatal mother, there is sufficient information relating to the antenatal period to provide a focus for discussion. Several health visiting diagnoses (i.e. considered amenable to health visiting intervention) are presented as relevant to the maternal and child health remit of health visiting. Although these diagnoses form the basis for the discussion of the relevance of the findings, it should be noted that there is no formal classification of health visiting diagnoses. Throughout this discussion, the findings are linked to other pre-encounter influences which include knowledge from the literature (e.g. as presented in Chapter Five) and to cultural insight gained during my visit to the Sub-continent. The health visitor-client relationship is envisaged as being inter-cultural unless otherwise stated.

As previously noted, the data collected during the fieldwork does not purport to be exhaustive but, instead, what a health visitor during her initial assessment visit, and/or over a number of visits (as would occur in long-term health visitor-client relationships), could elicit when visiting mothers and

infants from a similar Punjabi community, or a hypothetical situation relating to the same Punjabi community. Indeed, the timing, nature, and content of the interviews paralleled conventional health visiting practice. For instance, not only were many of the interviews approximately one hour in duration, but all the interviews took place during conventional health visiting working hours (i.e. between 10 a.m. and 5 p.m., Monday to Friday). In addition, all respondents were aware that the researcher was a qualified health visitor, although in a non-practising capacity.

Within each discussion of the three hypothetical clients, a three-fold approach is followed. Firstly, the remit of health visiting is described in regard to each specific client group. Thereafter, an overview of the findings relating to each hypothetical client is provided. For the antenatal mother, this discussion is separated into the Punjabi woman as wife and as pregnant mother. The discussion relating to the Punjabi woman as wife should also be considered relevant to the post-natal mother. Finally, the relevance of the findings to health visiting practice is discussed in regard to the three hypothetical clients and to a number of specific health visiting diagnoses.

2. THE ANTENATAL MOTHER

A) THE ANTENATAL REMIT OF HEALTH VISITING

Pregnancy is one particular time in a woman's life when the health visiting service focuses on the health and well-being of the woman. The mother has become the human environment in which a member of a future generation is growing. After the child is born, the health visiting service continues to be concerned about the child's physical and socio-emotional environment and,

therefore, also continues to be concerned about the health and well-being of the child's mother and father (or whoever is caring for the child) until the child has reached school age.

Depending on her caseload, and giving priority to the *primagravida* (a woman who is pregnant for the first time) for whom pregnancy is a totally new experience, the health visitor aims to visit the antenatal mother once, or twice, before her confinement. During these visits, an assessment is made of actual or potential problems which the mother and the health visitor see as inhibiting the promotion of the mother's and the baby's health and well-being both during pregnancy and after the baby is born. By and large, the health visitor focuses on the mother's preparedness for confinement and motherhood as well as her socio-emotional health and well-being during pregnancy. Each visit offers the health visitor a further opportunity to develop a better understanding of the mother's life. These visits also allow her to establish a relationship with the mother as a basis for future visits after the baby is born. Being a guest in the mother's home, the health visitor's practice must therefore be appropriate to the mother's needs. If the health visitor is to be invited to return, she must demonstrate that she can provide the mother with knowledge relevant to actual and potential health problems that the mother has or foresees occurring. In addition, the health visitor must provide the mother with a sense of increased assurance that, as a consequence of the visit, the mother will be able to cope better with any health related problems.

To a great extent, the pregnant mother's bio-physiological problems will be discussed by other health professionals at antenatal clinic appointments. Even so, clinic appointments do not offer much opportunity for the discussion of socio-emotional problems, nor may the mother feel able to discuss such

problems openly at antenatal classes. However, by visiting the mother antenatally, the health visitor provides her with an opportunity to talk at length, and in the privacy of her home, about socio-emotional (and physical) problems. As these problems may relate to wifehood as well as to motherhood, the health visitor needs to visualize the married antenatal Punjabi woman as a wife as well as a pregnant mother.

Thus, when visiting the pregnant woman, who is both wife and mother, the health visitor aims to discover actual and potential health related problems that can be alleviated, overcome, deflected or avoided. This she does by asking appropriate questions and by allowing the mother to ventilate her feelings, express her needs, and consider ways of coping with any difficulties that she has or foresees occurring. In so doing, the health visitor aims to help the mother review and, where possible, resolve difficulties that might increase the mother's vulnerability to post-partum depression (note Affonso 1984:164). Essentially, by assuming a listening, counselling and advisory role, the health visitor hopes to ensure that the baby is born into as secure and as loving a home environment as possible.

B) THE CULTURAL WORLD OF THE PREGNANT PUNJABI WOMAN AS WIFE

In this section, the important findings (pre-encounter influences) relating to the pregnant Punjabi woman as wife are drawn together. These findings are ones which the health visitor needs to recognize and consider when visiting a pregnant wife from the cultural group studied. References are provided (e.g. p. 296) of examples relating to the findings mentioned. As pre-encounter influences, the findings represent knowledge which the transcultural health visitor recognizes as being reshaped both by the context and circumstance of

the client's situation and by the client's interpretation of her culture. Thus, the health visitor is aware that her knowledge and experience of Punjabi culture is subject to constant revision. The important findings relating to the pregnant Punjabi woman as wife are:

1. The patriarchal, patrilocal and patrilineal nature of Punjabi society (pp. 292–293,297,306,310,318). On marriage, Punjabi wives traditionally join the joint affinal household. Amongst the *Bhatra* community, male progeny perpetuate the lineage and are especially desired.
2. The pervasiveness of religious beliefs and practices. Not only is religious affiliation (whether to Islam or to Sikhism) identifiable by the display of religious artifacts in every home (p. 286), but religion provides a reason for the women to gather together (e.g. to read the *Qu'ran* or for the services at the *gurdwara*).
3. The continuance of the joint family system. Where it is not feasible for family members to live in close proximity to each other (e.g. due to migration either within Britain or transglobally), links are maintained by other means (p. 302). Within the joint family household, the mother-in-law dominates the female hierarchy. Nevertheless, in accord with the patriarchal nature of the Punjabi family system (p. 306), the senior women are subject to the dominance of the male family members.
4. The view of the *biraderi* as a cohesive and mutually supportive social network which also acts as a form of social control (pp. 296,299). For the *Arain* and the *Bhatra* families, the *biraderi* follows sub-caste

divisions (pp. 291–292). Maintenance of intra-*biraderi* cohesiveness amongst the *Bhatra* includes the custom of *vartan bhanji* as well as an emphasis on attendance at the *gurdwara*.

5. The maintenance of the custom of arranged marriages. The choice of bride for groom is a parental decision which is often made through an intermediary (p. 298).
6. The relevance of religious affiliation to marriage customs. Whilst divorce is acceptable (but in no way desired) by the Muslim families (pp. 299–300), it is considered exceptional amongst the *Bhatra* Sikhs (p. 300). Exogamous marriage customs (e.g. regarding clan proscriptions) are upheld by the *Bhatra* Sikhs (pp. 292–293,297), while marriages of close relatives are preferred within the Muslim community (p. 319).
7. The maintenance of *izzat*. For a wife, this includes upholding the *izzat* of her affinal family by maintaining sexual propriety (pp. 308,310–313) as well as showing respect for the senior family members (pp. 306,311). This includes *Bhatra* wives veiling before their male affines.
8. The assumption of junior status within the female hierarchy of the joint family household by the wife on marriage (p. 303). For the newly wed *Bhatra* wife, adjusting to her affinal family includes learning a new code of lineage behaviour (pp. 292,304). Whilst the traditional power of the senior members of the joint family is reduced in nuclear family households, it nevertheless continues.

9. The importance of demonstrating fecundity early in marriage, especially amongst the *Bhatra* families (p. 304). Special emphasis is placed on bearing a son (p. 318).

10. The maintenance of Punjabi cultural traditions, with adjustments being made within non-Punjabi settings (e.g. facial veiling omitted by *Bhatra* wives in public places other than at the *gurdwara* [pp. 311-312]). In addition to those identified above (i.e. 1-9), these traditions also relate to language (pp. 273-274), dress (pp. 274-279), dietary beliefs (pp. 325-326), and code of hygiene (p. 287). The *Bhatra* community is considered to be especially conservative with regard to the cultural traditions that the community upholds (p. 305).

C) HEALTH VISITING THE PREGNANT PUNJABI WOMAN AS WIFE

In this section, the findings are discussed in relation to health visiting a hypothetical pregnant Punjabi wife from the community studied. As previously noted, health visiting's antenatal remit includes helping the pregnant woman with actual and potential socio-emotional problems. In addition to being concerned about the wife's well-being, the health visitor is concerned that the child will be born into as loving and as secure a home environment as possible, so allowing the child to maximize his or her own potential for health and well-being. For the purpose of this discussion, the health visiting diagnosis of 'emotional strain relating to wifeness' is focused upon. It is envisaged that a health visitor (whether practising within a unicultural or a transcultural perspective) would seek purposively to identify whether or not the pregnant wife was experiencing emotional strain relating to wifeness and, if she was, whether or not she was coping effectively with the strain.

To make such a diagnosis, whether as a 'strength-oriented diagnosis' (Risner 1986:157) whereby the diagnosis is stated positively (e.g. effectively coping with emotional strain) or as an actual or potential health problem, the health visitor invites the wife to talk about any problems she has relating to wifehood. From both the discussion and from her observations, the health visitor clusters cues that provide her with insight into what married life means for her client. For instance, the health visitor determines what adjustments the wife (especially a newly wedded wife) is having to make as a consequence of marriage, such as: adjusting to a new locality and developing a new socio-emotional support system. Irrespective of the duration of the marriage, she discovers if there are any other problems relating to wifehood that the wife wishes to discuss. This she does with the intent of revealing those factors predisposing to emotional strain relating to wifehood. It is suggested that the following are four possible factors predisposing to emotional strain relating to wifehood which emerge from the findings and which are non-culture specific:

- difficulty in adjusting to a new marriage,
- difficulty in adjusting to a new locality on marriage,
- difficulty in developing a new socio-emotional support system,
- marital discord not related to being newly wed.

The findings, however, illustrate that Punjabi marital and family dynamics differ in many ways from those of the dominant culture. Because of these differences, it is suggested that a unicultural health visitor would have difficulty identifying sources of emotional strain relating to wifehood that the Punjabi wife might experience. Unlike a typical married Punjabi couple, a typical married couple within the dominant culture choose each other and primarily view themselves as a nuclear family unit. Not only does the wider family

system no longer exert a major influence on the lives of most married couples in the dominant culture, but, in time of need, it is both accepted and usual for the wife to turn to any relative or friend in whom she feels able to confide.

It is also suggested that, for lack of a cognitive map oriented to cultural discovery in multi-cultural situations, not only would the unicultural health visitor miss diagnostically important cues, but she would be more likely to make culturally inappropriate inferences from the cues that she does elicit. Hence, she would be less able to move accurately within the fourth and fifth elements of the diagnostic process than would a health visitor educationally prepared to practise skilfully in multi-cultural situations. Therefore, the health visitor must look beyond the dominant cultural perspective if she is to make a culturally relevant and astute diagnosis from which to plan appropriate and effective health visiting interventions for a Punjabi wife.

i) Diagnosis – Emotional strain relating to wifehood

In the following four sub-sections, the findings are considered in relation to the four, previously noted, possible factors predisposing to emotional strain relating to wifehood. These discussions especially relate to the fourth and fifth elements of the diagnostic process of health visiting. By drawing on cultural knowledge that she already has pertaining to the wife's community, or a similar Punjabi community, the health visitor is able to direct her data searches and seek out possible diagnostic explanations with greater precision. However, she also diagnoses with regard to both the context and circumstance of the wife's situation and the wife's personal value system.

a) Difficulty in adjusting to a new marriage.

'Difficulty in adjusting to a new marriage' is one factor that may predispose to emotional strain relating to wifehood. Therefore, in diagnosing the presence or absence of emotional strain relating to wifehood, the health visitor needs to be aware of possible constraints which a newly wed Punjabi wife's cultural traditions place on her. For instance, the health visitor not only needs to realize that Punjabi marriages invariably are arranged, but that they are marital alliances that link two joint families together. And, with it being important to demonstrate fecundity early in marriage (note Homans 1982:235), certainly amongst the *Bhatra* families, the pregnant wife may still be adjusting to a relatively new marriage.

In arranging a Punjabi marriage, the compatibility of the two joint families is considered a vital, indeed an essential, pre-condition to the overall happiness of the couple and, therefore, accorded paramount importance. In this way, Punjabi marriages contrast with the dominant cultural view of marriage wherein a typical marriage is a partnership between two individuals who have chosen each other. Educationally prepared to practise within the dominant cultural ethos and, in most instances, also belonging to the dominant culture, the unicultural health visitor may find this custom's collective intention to be somewhat alien and, possibly, unacceptable to her own value system. Nevertheless, to fulfil her health promotive role, the health visitor needs to emancipate herself from her own cultural view if she is to comprehend how the custom of arranged marriages may, or may not, be a factor relating to the presence of emotional strain. However, it has been seen in Chapter One that, within the unicultural perspective, health visitors are not educationally prepared on a routine basis to achieve this level of cultural emancipation in field

practice.

In both the dominant and the Punjabi cultures, the newly married couple learns to adjust to a shared relationship. For the Punjabi wife, however, married life traditionally begins in the joint affinal household and not as a nuclear existence as is typical in the dominant culture. And, because a Punjabi marriage usually is arranged, not only must love and companionship develop after the wedding (and not before), but frequently within the wider family setting. Although a love-match might emerge, the choice may also turn out to be one with which the couple are mutually dissatisfied. Thus, the arranged marriage system may, or may not, be a factor predisposing to emotional strain. When it is, it is one that contrasts strongly with the typical marital situation in the dominant culture.

Should the newly wedded Punjabi wife begin married life in the joint family household, she also assumes junior status within the female hierarchy. Thus, she begins married life by being dominated by her mother-in-law, someone whom she has known scarcely, if at all, until after the wedding. For some Punjabi couples, however, married life begins as a nuclear existence. In such instances, the wife does not necessarily have to be as skilful in managing as many new human relationships at one time as she does when she joins a joint family household. Even so, it may be a more lonely existence than she has hitherto known if she has always lived in a joint family household. And, unlike marriage in the dominant culture, the nuclear Punjabi couple probably will have immense personal adjustments to make having known little about each other prior to marriage. Nevertheless, if sufficient wisdom and sensitivity has been accorded to mate selection, these adjustments may have been minimized.

To elicit possible explanations of emotional strain, the health visitor also needs to recognize the power that the mother-in-law in a joint Punjabi family wields amongst the female members, and how pressure can still be exerted indirectly, even when families are not sharing the same house. Indeed, the findings clearly illustrate the influential position that the mother-in-law traditionally enjoys in the joint Punjabi family. To an extent, the unicultural health visitor may be aware that the mother-in-law is a powerful member in the joint Punjabi family, perhaps from stern looks that the mother-in-law may give, as mentioned by one health visitor during the fieldwork. However, if the health visitor is to determine if a newly married Punjabi wife is facing emotional strain, she needs to be alert to this possibility, and the difficulties that the wife may have coping with the a tense relationship with her mother-in-law. Indeed, if a wife's every move (at least as it appears to her) seems to be monitored by her mother-in-law (p. 303), and she is being criticized for not remembering the affinal family's code of lineage behaviour (p. 304), she may be unable to ventilate her feelings adequately. Any strain that she feels may also be enhanced by her junior status within the joint affinal household, and may preclude her from vocalizing her dissatisfactions to other members of her husband's family. For the *Bhatra* wife, the need to maintain her natal family's *izzat* by coping with marital difficulties without complaint may also add to this strain. Thus, when linked to other relevant cultural factors, the presence of a dominating mother-in-law is a possible factor which may make it difficult for a newly married Punjabi wife to adjust easily to married life and, indeed, may be a predisposing factor relating to emotional strain in marriages of longer duration. It is also a factor which is atypical in the dominant culture of contemporary Britain where it is unusual for married couples to live with the parents of either spouse.

To detect the presence of emotional strain, the findings suggest that the health visitor also needs to be alert to intra-cultural differences (e.g. those that align with religious and/or sub-caste divisions). For instance, by custom the *Bhatra* wife must marry outwith both her mother's and her father's clans, whilst the Muslim families are reported as preferring marriages between closely related family members. As a consequence, the newly wedded Muslim wife may not need to adjust to as many new relationships and personalities as would the *Bhatra* wife who has married into the community from elsewhere. Indeed, not only does the health visitor need to be alert to intra-cultural variations, such as these which might predispose to emotional strain relating to wifehood, but to any possible 'data gaps' (Risner 1986:129) in order to ensure the sufficiency of data necessary for diagnostic accuracy.

The findings also indicate that emotional strain may be related to emphasis placed on the maintenance of family *izzat*. For example, the new *Bhatra* wife is expected to uphold both the *izzat* of her affinal family by maintaining the Punjabi code of female sexual propriety as well as the *izzat* of her natal family by adjusting smoothly, and without complaint, to living with her affinal family. Although the Punjabi husband also has his family *izzat* to uphold, and is himself under the domination of the senior male family members, the restrictions placed on the Punjabi wife are more constraining than those placed on her husband. In reaching her diagnosis, the health visitor must be sensitive to the fact that the wife may hesitate to vocalize negative feelings lest, in so doing, this reflects adversely on the *izzat* of her natal family should members of her affinal family realize that she has voiced her dissatisfactions. In fact, in various aspects (such as subordination to her mother-in-law), the restrictions on the wife are more intense than they are in a typical marriage of the dominant culture where both the wife and the husband have more freedom to express

their own individual identities, publicly and privately.

b) Difficulty in adjusting to a new locality on marriage

'Difficulty in adjusting to a new locality on marriage' is another possible factor predisposing to emotional strain relating to wifeness. By and large, the Punjabi wife must adjust to a new locality on marriage, her husband remaining on his 'home-ground'. This is evident particularly amongst the *Bhatra* community and in joint Muslim households where the Punjabi husband is less likely to have to adjust to a new locality after marriage than is his wife. Where the couple begin married life in the joint family household, the close relationship that Punjabi sons traditionally have with their mothers (p. 297) remains a continuing and visible reality which the wife must accept and to which she must adjust. This, then, contrasts with a typical marriage of the dominant culture where it is acceptable for a couple to live in the wife's home (should she have a home of her own prior to marriage), and/or to live near the wife's, in preference to the husband's, place of employment.

As the findings indicate, the Punjabi wife may have to adjust to a new locality as the consequence of either internal (within Britain) or transglobal migration. Brides are selected from the Sub-continent (especially by members of the Muslim community) as well as from other towns and cities within the United Kingdom. Thus, environmental adjustments for the wife can involve adjusting either to a new country or to another Punjabi community in Britain. For Punjabi women migrating from the Sub-continent, either to be married, as newly wedded wives, or to join husbands employed in Britain, this migration involves fundamental environmental adjustments, as my visit to the Sub-continent powerfully brought home to me. Not only is the climate and the

landscape very different, but the secular nature of contemporary Britain contrasts markedly with the audio-visual pervasiveness of religious practices in everyday life in the Sub-continent (Dobson 1985 – see Appendix Five).

Internal migration within Britain can also bring its contingent strains, for instance, where a wife moves to a much more orthodox community (e.g. the *Bhatra* community) than her natal community. Whilst adjusting to environmental change inherent in migration is not peculiar to Punjabi marriages, both Punjabi marriage customs (e.g. clan exogamy) and the fact that this is a small Punjabi community that looks elsewhere for brides means that newly wedded wives frequently have to adjust to a new locality. This need to adjust to a new locality may also be coupled with other culturally related, or non-culturally related, factors that, in unison, predispose a level of emotional strain with which the wife may have difficulty coping effectively.

c) Difficulty in developing a new socio-emotional support system

All marriages which involve the wife, or both spouses, moving locality (for instance, for reasons relating to employment) also involve the wife needing to develop a new socio-emotional support system. However, Punjabi marriage customs in themselves may make 'difficulty in developing a new socio-emotional support system' a third possible predisposing factor to emotional strain relating to wifedom. Indeed, Kakar (1978:72) observes that when an Indian girl marries, she is 'transplanted from her home into the unfamiliar, initially forbidding environment of her in-laws'. In a moment of crisis or loneliness, she may have no one from her natal family, or community, to whom she can turn. Whilst this is not the situation in all Punjabi marriages, it is an important factor that the health visitor needs to consider, especially in

this, and similar, numerically small Punjabi communities in which families frequently must find brides from other Punjabi communities in Britain and the Sub-continent.

Differences between Muslim and Sikh marriage customs may carry their own distinctive relevance. For example, the *Bhatra* wife (who must marry according to clan exogamy) often has to develop a new socio-emotional support system unless she has married within the community (which, at present, is unusual) or already has a sister who has married into this community. As the restrictions placed on many *Bhatra* wives preclude the development of friendships outwith her affinal family, it may be a long time before a new *Bhatra* wife is able to establish a trusting friendship with someone outwith the affinal family. Therefore, if the wife is not well-accepted by her mother-in-law (e.g. the mother-in-law had wished her son to marry someone else), and/or if the wife is unable to make friendships within the affinal family, this will be a particularly stressful situation. And, because the wife is expected to show deferential respect to her mother-in-law, coupled with the possibility of a close mother-son relationship, the husband may support his mother in preference to his wife should there be friction between his mother and his wife. This, then, may be an additional source of strain relating to wifehood.

As well as indicating that difficulty in developing a new socio-emotional support system may be a possible factor predisposing to emotional strain relating to wifehood, the findings also illustrate a number of culturally defined ways in which the wives find companionship within their cultural group. In particular, the affinal family and the affinal *biraderi* are sources of female friendship and support. Amongst the *Bhatra* families, the women also gather together at differing times, either in all-female or in mixed (but usually

segregated) company, both at the *gurdwara* and in each other's homes. Such gatherings include those for the celebration of religious festivals and fast days, for special blessings (e.g. of a new home), and for celebrations related to pregnancy (e.g. the *gon*). Amongst the Muslims, opportunities for the women to socialize together include reading the *Qu'ran* in one another's homes, regular coffee mornings, and joining a local Pakistani women's organization (p. 296). Working in the family shop may also provide opportunities to meet other people and make friends (p. 312). These, then, would be important factors relating to a positive diagnosis, for example, adequately coping with emotional strain relating to wifehood, particularly in regard to developing a new socio-emotional support system.

d) Marital discord not related to being newly wed.

'Marital discord not related to being newly wed' is another possible predisposing factor which the health visitor must consider when diagnosing emotional strain relating to wifehood. Indeed, the findings indicate that, if the health visitor is to make an accurate diagnosis of emotional strain relating to wifehood on which to base sound interventions, not only must she understand Punjabi marital and family dynamics but also the culturally defined options available to the wife who is facing marital discord.

With mate selection being decided by others on behalf of the couple, both the husband and/or the wife may be unhappy about the choice. The husband, however, has greater freedom than his wife for seeking alternative companionship and sexual satisfaction outwith the marriage (pp. 299-300). Indeed, one of the possible factors relating to emotional strain may be a husband's infidelity. Whilst male infidelity is in no way culture-specific, the

findings highlight the fact that the *izzat* of the Punjabi wife's natal family depends on her accepting such difficulties with equanimity. Even so, where marital discord is exceptionally serious, desertion and divorce may be contemplated by either spouse. Yet, the possible consequences of these options may increase, rather than lessen, the wife's emotional strain if these are recognized as bringing other culturally defined difficulties in their wake.

The findings also highlight the fact that religio-culturally defined differences are particularly important regarding the option of divorce. For example, the possibility of divorce is unlikely to be considered amongst Sikh families, yet considered, but with reluctance, amongst Muslim families (pp. 299–300). Dissolution of marriage, like its arrangement, extends beyond the couple themselves. On the whole, a *Bhatra* wife is expected to conform to the religious expectations of the Sikh religion which views marriage as a sacred and indissoluble institution. Whilst divorce is an alternative that an unhappy Sikh wife in contemporary Britain may choose, her own remarriage prospects within Punjabi society are reduced severely thereafter. Should her family arrange another marriage, her reduced eligibility may result in personal compatibility being ignored entirely. In addition to reducing the *Bhatra* wife's own remarriage prospects, divorce lowers the *izzat* of her natal family, making it difficult, thereafter, for other members of her natal family to find suitable marriage partners. And because the children of the marriage are seen traditionally as belonging to the joint affinal family and not to the couple alone (p. 300), the divorced *Bhatra* wife, by social convention, may be constrained to relinquish her children to her affinal family. In particular, the affinal *Bhatra* family may wish to care for a female child of the marriage lest the unacceptable possibility of an endogamous (at clan level) marriage should be arranged inadvertently. *Bhatra* marriage proscriptions traditionally demand that

a daughter marries outwith her father's and her mother's clans (pp. 292–293).

For Muslims, marriage is a civil institution and divorce is acceptable. However, where children are involved, the Muslim wife may be constrained to relinquish her children (who, as in Sikh marriages, are seen as belonging to the affinal family) to her husband's family. For most mothers, this would be an enormous wrench. As the one wife in the study noted, to a Muslim mother, her children are 'her life' (p. 299). Nevertheless, a divorced Muslim mother who wished to fight for the custody of her children might find herself facing social opposition from her husband's family (unless the children were very young [p. 300]), even though, socially and legally, the dominant culture usually favours the mother having custody of her children.

Although the wives interviewed in this community never spoke about physical wife abuse, this is a concern in other Punjabi communities (Anonymous 1980;1986:personal communications) as it is in non-Punjabi British society. Hence, this would be a 'data gap' that a health visitor concerned about a serious marital situation would need to consider. In the Sub-continent, wife abuse (including alleged 'dowry deaths' relating to unmet dowry demands) is reported frequently in the Indian national press (e.g. *Indian Express* 1984:6) and is a central concern of the Indian feminist journal *Manushi*. In Britain, however, certainly amongst the Sikh communities, regulations are instituted at differing times to curb undue escalation of marriage dowries with the intent of reducing inter-family tensions that can otherwise ensue (#7). Even so, the health visitor may need to discover information concerning dowries as they relate to arranged marriages, the findings providing minimal information (note jewellery [p. 276]).

By tradition, the *biraderi* endeavours to rectify serious instances of marital disharmony and division. Nurtured carefully through the maintenance of customs such as *vartan bhanji*, the self-supporting kinship network of the *biraderi* is a definite strength of Punjabi culture. For example, two wives interviewed during the fieldwork and who had been deserted by their husbands were each being housed and financially supported by their husband's *biraderi*, thus drawing on the protective element of the *izzat* of the affinal *biraderi*. As most of the wives, whether in Pakistan, India, or the United Kingdom, as married or unmarried women, will have been used to being dependent on kin for support throughout most of their lives, it can be surmised that they would find it difficult to be a woman alone, both emotionally and economically.

ii) Health visiting interventions – Emotional strain relating to wifehood

By focusing on the diagnosis of emotional strain relating to wifehood, it can be seen that the recognition of relevant cultural factors is essential if diagnostic precision and integrity is to be realized. Without cultural insight into Punjabi marital and kinship dynamics, there is no certainty that a health visitor would accurately, and with relative ease, determine relevant cultural factors pertaining to the wife's situation. However, as diagnostic accuracy is essential to the anticipation of effective health visiting interventions, the need to take into account the wife's cultural traditions, and as they relate to her own particular circumstance, becomes essential, both diagnostically and in regard to health visitor interventions.

Having made a culturally based health visiting diagnosis of emotional strain relating to one, or more, of the above predisposing factors, the health visitor moves from the diagnostic process to health visiting intervention. Here again,

she draws on her previous health visiting knowledge and experience (pre-encounter influences) pertaining to the community, as well as data relating to the wife's individual situation. Thus, the findings not only represent pre-encounter influences in regard to forming a diagnosis but also to shaping subsequent interventions. In this sub-section, two factors which relate to the provision of culturally sensitive and culturally appropriate health visiting interventions, and which draw on both the findings and the fieldwork experience, are discussed:

mode of health visiting intervention,
referrals to other health care professionals.

a) Mode of health visiting intervention

Counselling is one dominant mode of health visiting intervention relevant to helping a wife cope with emotional strain. As previously noted, the purpose of counselling is to assist clients in making their own decisions from amongst the choices available to them. Therefore, helping a wife to identify and talk through issues that are culturally relevant is an important aspect of health visiting intervention as well as diagnosis. However, if a health visitor is to guide a wife's thoughts and conversation along appropriate channels in inter-cultural situations, cultural insight and understanding becomes essential. Cultural insight is also essential if goals and objectives (Christensen 1986:170) are to be appropriate to the wife's individual circumstance and to the way in which she views and upholds her cultural traditions and values.

In Chapter One, it was seen that, educationally, health visitors are more prepared for using an 'individualist' than a 'collectivist' (or group-oriented)

mode of health visiting intervention. The advantage of the individualist approach is that it provides the wife with someone who cares to understand how she feels and thinks as an individual, and with whom the wife can talk in confidence and alone. In fact, one wife was referred to me partly in the hope that I would be someone with time to listen to her family problems and, in some measure, reduce the emotional strain she was experiencing as the health visitor did not have the time to visit her frequently.

Whilst an individualist approach may be a suitable approach for counselling and advising a wife (whether Punjabi or non-Punjabi) living in a nuclear household, the findings and the fieldwork experience indicate that it may be neither a feasible nor a suitable approach for a Punjabi wife in a joint family household. In particular, the presence of a husband or a mother-in-law may make it difficult for the health visitor to find opportunities to talk with a wife alone. Indeed, she may have to observe subtle cues (such as the tone of the wife's voice and her facial expressions) if she is to detect a wife's unhappiness at all. Even then, having recognized that a wife is unhappy, it may be very difficult, and demand skilful engineering, to arrange to visit at a time when the mother-in-law (and/or husband) is expected to be out of the house. Such situations arose in the course of the fieldwork. However, the need to engineer such visits would be unusual in homes of the dominant culture, except possibly in areas of high unemployment where the husband might be at home most of the day. Therefore, and because of the corporate nature of the joint Punjabi family, a collectivist approach to practice (that is, a group-oriented approach whereby the health visitor worked with other members of the family as well as with the wife) might be a more appropriate approach. By using a collectivist approach to help reduce the emotional strain that the wife is experiencing, the wider family group is counselled and supported rather than the wife alone.

To work successfully within a collectivist approach with a Punjabi family, it is suggested that the health visitor needs to win the family's trust in her as someone actively interested in understanding the nuances of Punjabi family life and marriage customs. And, if her practice is to lessen, rather than to increase, the difficulties that the wife is experiencing, then it is also essential that she recognizes the delicacy of the Punjabi wife's status *vis-à-vis* other family members. Even then, it may be an unusual, and possibly an unwelcome, experience for a joint Punjabi family to have a health visitor helping them (#7). Indeed, because of the sensitive nature of family *izzat* in Punjabi culture, a collectivist approach might be viewed as an unacceptable intrusion into family matters and hence need skilful negotiation. Nevertheless, it can be envisaged that family members would be willing to share their difficulties with a health visitor who had demonstrated that she was a culturally caring and knowledgeable practitioner in whom they could place their trust and receive beneficial and culturally attuned guidance and support.

Whilst health visitors who participated in the research study occasionally referred families to me who were experiencing serious family and marital dissension, they never spoke of having received formal preparation for counselling South Asian families about family and marital problems. Indeed, lack of confidence in marital guidance in multi-cultural situations may have accounted for the reluctance of one health visitor to refer a mother to me who was experiencing serious marital dissension. However, health visitors did speak of drawing upon the help of community workers from organizations specifically geared to help ethnic minority families who are faced with serious family problems.

b) Referral to other health care professionals

Because of the pressures of their caseloads, most health visitors are unlikely to have time for in-depth marital and family counselling, even if they feel competent in this area of health visiting. Yet, if the wife is pregnant and/or has small children, the health visitor must ensure, as best she can, that a tense marital situation is eased. This she does to promote as secure an environment as possible within which the child may grow and develop satisfactorily. As already noted, the *biraderi* endeavours to help where it can in serious marital and family problems. In addition, in various towns and cities countrywide, community based organizations exist that are geared specifically to help ethnic minority families with family problems. In the city where the families lived, the caring attention that was provided by community workers from such an organization might be summed up in one Muslim mother's words: 'she is like a sister to me' (#1). Often belonging to the same ethnic group as the families they visit, and usually speaking the same language that the families speak, these community workers have a culturally attuned cognitive map that allows them to provide a culturally relevant service with ease. Even so, the service that they offer is distinct from health visiting and does not (and, I suggest, should not) be seen as a substitute in a multi-cultural society for the provision of a culturally relevant health visiting service.

Where the family, the *biraderi*, the community worker and the health visitor are all unable to provide the help a wife needs, the health visitor encourages the wife to consider consulting another health professional. The findings, however, indicate that the wife might prefer to turn to traditional health workers. Certainly the foregoing discussion (sub-sections [i] [a-d]) highlights the fact that any referral should be made with full regard to the wife's need for

culturally attuned care. With regard to locating a health professional of the Western medical tradition in a town or city with a small ethnic minority population (such as the one where the study was undertaken), the wife/health visitor might have difficulty locating one who is able to provide culturally sensitive and relevant marital guidance to a Punjabi couple. Then, more than ever, the health visitor needs to have abilities in counselling and advising the couple within culturally acceptable parameters, that is, if she is to provide a culturally responsible service to the wife, to the husband, and to the unborn/newborn child.

A few instances from the fieldwork illustrate difficulties that might interfere with a Punjabi wife with marital problems receiving appropriate help from a health professional. For example, I discovered that the local branch of one national organization who provide a phone-in counselling service for psycho-social problems had little experience in helping members of Punjabi families. Also, a Sikh mother (a fluent anglophone) recalled being assigned specifically to an Indian psychiatrist who neither spoke her Indian language nor had an adequate command of English for her to converse easily with him in English. Even when a health professional is of the same ethnic group and religion as a Punjabi client, there still may be difficulties in understanding. An example of this is when there is a distinct difference in social status between doctor and client, an observation made by the one Asian general practitioner interviewed during the fieldwork. It is also possible that some wives may prefer to confide in someone for whom the notion of *izzat* does not exist in its Punjabi sense (#7). Although these diverse difficulties are ones over which a health visitor may feel she has little control, this depends on how she delimits the horizons of her health promotive role. Not only may a health visitor act as an advocate for a Punjabi wife with young children if adequate marital guidance

does not seem forthcoming, but, through professional channels, press for the provision of more culturally relevant health services.

iii) Conclusion

In this section, the practice of health visiting has been discussed in regard to diagnosing emotional strain relating to wifhood in the Punjabi community studied, or a similar Punjabi community, drawing on the findings in so doing. Whilst emotional strain may be linked to various (individual or combined), non-culture specific factors relating to being newly wed, living in a new locality, adjusting to a new socio-emotional support system, and severe marital discord, these factors were seen to be shaped by various Punjabi traditions. Hence, cultural understanding becomes a fundamental prerequisite to a health visitor diagnosing and, thereafter, helping the Punjabi wife cope with emotional strain relating to wifhood. If, however, the health visitor is to use her limited time to the best advantage in regard to the wife's (and, thereby, also the infant's) needs, and to the discharge of her own composite health visiting responsibilities, she must be proficient in culturally attuned practice.

D) BEING PREGNANT IN THE PUNJABI COMMUNITY

In this section, important findings which relate to the pregnant Punjabi mother from the community studied are presented in abbreviated form. These findings are additional to, yet should be envisaged as being interwoven with, findings relating to wifhood. As pre-encounter influences, the health visitor views them as dynamic entities which may vary according to the context and the circumstance of the mother's situation. The important findings relating to the antenatal Punjabi mother are:

1. The increase in status that pregnancy provides the wife within the affinal family (p. 318). In one sense, the baby belongs to the joint affinal family as a whole and not to the parents alone (note pp. 319–320). For the *Bhatra* wife, male progeny provide greater status than do female progeny (p. 318).
2. The importance of religio-cultural beliefs and practices to conception (particularly to bear a son) and to the safeguarding of pregnancy (p. 319). Traditional health practitioners (e.g. a *hakim*, a *devi*, or a *babu*) and Western scientific health practitioners may be consulted for similar concerns (p. 319).
3. The acceptance of Western scientific health care with regard to pregnancy and confinement. Most Sikh mothers recall attending for initial antenatal examinations during the first trimester of pregnancy, and earlier than the Muslim mothers remember attending (p. 321).
4. A view of pregnancy (especially amongst the *Bhatra* community) as a time of increased vulnerability to harmful forces which can both harm the unborn child and cause the pregnant mother to miscarry (pp. 319,323). Culturally defined measures are used to counteract these forces (p. 319).
5. The maintenance of an interrelated 'hot-cold' (*garam-thanda*) foods and bodily conditions belief system (pp. 325–326). In particular, this system is upheld by the *Bhatra* mothers. Dietary cravings of pregnancy frequently relate to Indo-Pakistani foods (p. 324).

6. The minimal uptake of formal antenatal classes by pregnant mothers. This finding relates to towns and cities countrywide (pp. 321–322). Antenatal guidance and support is provided traditionally by female relatives (p. 323).

E) HEALTH VISITING THE ANTENATAL PUNJABI MOTHER

In this section, the findings are discussed with regard to health visiting practice and, specifically, in relation to a hypothetical pregnant Punjabi mother from the community studied, or from a similar Punjabi community. In so doing, three health visiting diagnoses are considered: 'preparedness for confinement', 'preparedness for the *puerperium*' (the six to eight weeks following parturition when the mother physically and emotionally recuperates from childbirth), and 'preparedness for motherhood of a newborn infant'. Both cognitive and affective components are acknowledged in using the term 'preparedness'. In putting forward these diagnoses, it is recognized that they are ones which health visiting shares with midwifery, all three being amenable to midwifery as well as health visiting intervention. Where inadequate preparedness (whether for confinement, the *puerperium*, or motherhood) is diagnosed, health education is seen as an important mode of intervention, the intent being to help the mother avoid, avert, reduce and/or cope with any potential and actual health related problems. One important reason for intervention is to ensure as low a perinatal/infant mortality and morbidity rate as possible.

i) Diagnosis – Preparedness for confinement

To diagnose whether or not the pregnant mother is adequately prepared for confinement, the health visitor must discover whether or not the mother

demonstrates a deficit in three predisposing, non-culture specific factors:

sense of security relating to giving birth to a healthy, viable infant,
knowledge relating to childbirth in hospital,
knowledge relating to coping with hospitalization.

a) A sense of security relating to giving birth to a healthy, viable infant

To diagnose a pregnant mother's 'preparedness for confinement', the health visitor must consider whether or not the mother has an adequate 'sense of security relating to giving birth to a healthy, viable infant'. With the dominant culture being secular in nature, there is no certainty that a unicultural health visitor will consider the comfort and assurance that religio-cultural beliefs and practices can provide for a pregnant mother in regard to the safekeeping of her pregnancy, and to the delivery of a healthy, viable infant. Indeed, the health visiting literature gives scant consideration to religio-cultural beliefs and practices as they relate to providing the pregnant mother with a sense of security relating to giving birth to a healthy, viable infant. For the most part, pregnant mothers of the dominant secular culture are envisaged as placing their trust predominantly in the expertise of Western scientific health professionals in regard to the well-being of the unborn child and to giving birth to a healthy, viable infant.

The findings, however, indicate that religio-cultural beliefs and practices relating to pregnancy and the well-being of the unborn child are maintained by many of the mothers, particularly amongst the *Bhatra* families. These beliefs and practices (whether relating to religious beliefs [e.g. belief in *Sher-vali*, and

in Allah's supremacy over life events] or to powerful forces of a non-religious nature [e.g. the evil eye, also the avoidance of women who have had a recent miscarriage (p. 323)] are held in conjunction with an acceptance of Western scientific health care practices relating to pregnancy and confinement. Hence, those mothers who uphold religio-cultural practices to ensure the well-being of their pregnancies do so while concurrently accepting the monitoring of their pregnancies by Western health professionals (for example, by routine blood pressures readings, fundal height measurements, and urinalysis).

Therefore, to make an accurate health visiting diagnosis of a Punjabi mother's preparedness for confinement, the health visitor needs to include an explicit data search as to what religio-cultural beliefs and practices the individual mother upholds, and to what extent these provide her with a sense of security relating to giving birth to a viable and healthy infant. Indeed, if subsequent health visiting interventions (e.g. providing reassurance relating to the progress of pregnancy, to delivery, and to the condition of the newborn child) are to be culturally attuned, then the diagnosis of preparedness for confinement must take full cognizance of the Punjabi mother's belief system.

b) Knowledge relating to childbirth in hospital

As a diagnostician concerned with the antenatal mother's preparedness for confinement, the health visitor must determine whether or not the mother has a deficit of 'knowledge relating to childbirth in hospital'. By and large, the transition from pregnancy to motherhood in contemporary Britain occurs in hospital. Indeed, all the mothers who formed the sample group were delivered in hospital for all their confinements in the United Kingdom. Although many of the mothers recalled attending their initial antenatal examination during the first

trimester of pregnancy, only three of the twenty-six mothers who were asked if they had attended antenatal classes had done so. Even then, only one mother recalled attending more than two classes of one series of classes (p. 322). Several mothers also spoke of being minimally prepared for childbirth (p. 327).

Amongst other reasons, antenatal classes are organized with the intent that pregnant mothers should become acquainted with the hospital setting. In addition, various features of childbirth, such as the process of labour and delivery, possible complications of childbirth, and obstetrical interferences (e.g. epidural anaesthetics, forceps deliveries) that may be employed, are discussed during each series of classes. The mother is thus prepared to deport herself during labour and delivery in a manner which helps her to give birth without becoming unduly exhausted (emotionally and physically) and with a clearer understanding of the process of birth. In some measure, it is hoped that if the mother is more knowledgeable about childbirth, the hazards of childbirth may be reduced, so helping to ensure as low a perinatal infant mortality rate as possible.

Because of workload pressures, health visitors (and midwives) depend on pregnant mothers attending antenatal classes in order to become better acquainted with the process of labour and delivery. It is therefore very likely that the mothers who did not attend antenatal classes received minimal preparation for confinement from health professionals. Indeed, it can be speculated that most of the knowledge that these mothers received would have been provided by their own informal, lay advisory-support systems (e.g. their mothers and/or mothers-in-law). Whilst both the use of informal, lay advisory-support systems and non-attendance at antenatal classes is non-culture specific, the literature indicates a low attendance rate for pregnant

South Asian mothers at antenatal classes (e.g. Jones and Dougherty 1982:288). Therefore, in order to diagnose with accuracy, the health visitor needs to discover what knowledge concerning childbirth the mother is receiving from her informal advisory-support systems as well as from professional sources. If this is as minimal as the findings and the literature suggest, the health visitor needs to consider appropriate intervention.

As this intervention, for the most part, would be in the form of health education, consideration needs to be given to why formal antenatal classes do not attract the pregnant Punjabi mother. To an extent, the lack of interest in antenatal classes may have been because the mothers received (and, possibly, preferred) antenatal guidance from female family members and friends, guidance which would be more in accord with Punjabi customs (p. 323). In addition, with it being usual for a midwife (a *dai*) in the Sub-continent to prepare a pregnant mother for childbirth only when it is close to the time for confinement (note Gideon 1962:1223), it is possible that many mothers may view antenatal classes as providing information at a culturally premature time. Another possible reason may relate to the mother's religious beliefs. For example, Lipson and Meleis (1983:859 - although discussing Islamic values in regard to preparation for birth in the Middle East) note that Muslim mothers believe in leaving events 'in God's hands until the moment when they occur'. Classes may also be seen as infringing on the mother-in-law's 'terrain'. Nevertheless, and despite one mother claiming that women give birth satisfactorily without ever attending antenatal classes (p. 322), several mothers considered that they had been prepared insufficiently for the reality of childbirth (p. 327).

c) Knowledge relating to coping with hospitalization

In diagnosing preparedness for confinement, the health visitor must discover whether or not the mother's 'knowledge relating to coping with hospitalization' is adequate. Whilst the findings illustrate the maintenance of Punjabi cultural traditions, they also indicate that cultural norms are sometimes modified to blend as smoothly as possible into non-Punjabi settings (e.g. *Bhatra* wives modifying their custom of veiling before male affines [pp. 311-312]). However, if a Punjabi woman is to maintain Punjabi traditions in non-Punjabi settings over a more extensive period of time, as she would when hospitalized for confinement, she may encounter difficulties. Difficulties of this type which were brought to light in the findings include the maintenance of the Punjabi codes of hygiene and sexual propriety as well as the maintenance of religious dietary proscriptions.

Several mothers spoke of ways in which they coped with maintaining the Punjabi code of hygiene in hospital. Even so, whilst one mother's use of a bidet (p. 329) for cleansing the perineum after using the lavatory permitted both the Punjabi and Western obstetrical codes of hygiene to be upheld, the use of a jug that is used for measuring urine (note p. 329) would be unacceptable to the Western obstetrical code of hygiene. Yet, if Punjabi mothers are not openly and respectfully recognized by hospital staff as following culture-specific codes of hygiene, they may be reluctant to request a jug for their personal use. Hence, if hospitalization for childbirth is to be as untraumatic an experience as possible (both emotionally and physically), then the Punjabi mother needs to be prepared adequately to maintain, or adapt, cultural traditions that are important to her.

Planned in accord with Western nutritional food beliefs, hospital diet may pose difficulties for a Punjabi mother wishing to maintain 'hot-cold' dietary beliefs as well as religious dietary proscriptions. Although mothers spoke of upholding religious dietary proscriptions by selecting carefully from the hospital menu, the findings highlight the fact that a number of families, especially amongst the *Bhatra* Sikh community, uphold the 'hot-cold' foods and bodily conditions belief system. As well as being relevant to pregnancy, these beliefs are important in regard to the mother regaining her strength post-natally (pp. 326,339). Although families were seen to enjoy non-Punjabi as well Punjabi cuisine, the extent to which the mothers understood the nutritional belief system of the dominant culture was not determined. Therefore, not only does the health visitor need to elicit what nutritional belief system the mother upholds, but whether she views non-Punjabi cuisine within the Western or the 'hot-cold' nutritional belief systems. Whilst the literature describes the use of 'hot-cold' food and bodily conditions belief system both in Britain (e.g. Homans 1983) and in the Sub-continent (e.g. McGilvray 1982:55-57), and the Health Education Council (e.g. 1982) literature aligns pictorially Punjabi foods with information relating to the Western nutritional belief system, Henley (1979:129-130) provides one of the few contributions which helps to link the one belief system to the other.

Another factor relating to possible difficulties in coping with hospitalization is the sense of 'de-personalization' (Homans 1982:242) that pelvic examinations can cause women to feel. Although this factor is non-culture specific, the importance accorded to sexual propriety within Punjabi culture can make vaginal examinations by male doctors, and irrespective of the doctor's personal attitude, especially disconcerting for Punjabi mothers (note p. 321). With child bearing in Punjabi culture being an exclusively female domain (certainly in the

Sub-continent [note Gideon 1962:1224; cf. McGilvray 1982:57-58]), and with the cultural emphasis on sexual modesty, the Punjabi mother may find it emotionally difficult to adjust to the dominant culture's childbirth custom of men being involved in childbirth. Should this be so, then it is a concern that the mother needs to be encouraged to discuss (especially with the hospital staff) if she is to cope adequately at an emotional level with hospitalization.

Thus, to diagnose a possible deficit in the mother's knowledge relating to coping with hospitalization, the health visitor needs to know what cultural norms the mother envisages having difficulty maintaining in the non-Punjabi setting of a hospital, and to what extent she would be distressed if she was unable to maintain them. Where the mother envisages being distressed, the health visitor needs to be able to recommend ways in which the mother might avoid or overcome these difficulties.

ii) Diagnosis - Preparedness for the *puerperium*.

To diagnose the adequacy of a pregnant mother's 'preparedness for the *puerperium*', the health visitor must discover how the mother envisages recuperating from the activity of childbirth once she has returned home from hospital. Whilst recuperating from childbirth involves both emotional and physical aspects for all mothers, the findings indicate that there are culture-specific ways in which this time of recuperation is managed in the Punjabi community studied. In fact, the findings highlight a culturally defined dimension which focuses on the diminution of cultural pollution throughout the *chalia* (or *sawa maheena*), the customary forty day post-natal period. During the *chalia*, not only does the mother become culturally purer but, by tradition, she recovers from the physical experience of childbirth with the support of

female relatives. Proscribed behaviour relating to this time includes ritual baths as well as ritual distancing, for example, from holy texts such as the *Qur'an*. As the mother's most culturally polluted time occurs during childbirth and the immediate post-partum period, hospital delivery eases the concern that a family may have in accomodating this time of increased cultural pollution in the home.

Informal post-natal support systems were seen to vary, particularly in relation to whether the mother was a Muslim or a Sikh, to whether she lived in a nuclear or a joint family household, and to the distance the mother lived from her natal and affinal kin (pp. 328,335) For instance, mothers in nuclear households were especially prone to being without the customary post-natal support from female relatives. Indeed, in nuclear households, a husband may find it necessary to take on traditional post-natal caring responsibilities, thus contravening usual cultural norms. Although similar difficulties are experienced by mothers of the dominant culture who live in nuclear households, it is well-accepted culturally for husbands to arrange to take time from their work to support their wives after childbirth.

Whilst post-natal support may follow more traditional lines in Punjabi joint family households, even then, this support may depend on whether the newly delivered mother is well-accepted by her mother-in-law. In addition, certain family members may be precluded from providing direct post-natal support. For instance, the *Bhatra* mother is precluded from turning to her own natal family (except in very unusual circumstances) lest the *izzat* of her natal family, and of her affinal family, is injured in so doing. This finding, however, is in contrast with Gideon's (1962:1222-1223) description of childbirth in the Ludhiana area of the Indian Punjab in which the typical Sikh wife (possibly from

a different sub-caste group) is depicted as returning to her natal home to deliver her firstborn. Whilst this disparity may be due to sub-caste differences, it nevertheless underlines the importance of health visitors utilizing pre-encounter influences with caution lest stereotyping occurs.

Although traditional customs help a newly delivered Punjabi mother through an important transition period of her life, the health visiting literature provides minimal reference to cultural variations in post-natal practices. Yet, to make a diagnosis regarding the Punjabi mother's preparedness for the *puerperium*, the above discussion highlights not only the relevance of cultural information, but the necessity of cultural traditions being modified in accord with the demands of the mother's circumstance. To an extent, the contingency plans that the mothers resorted to when unable to maintain traditional Punjabi post-natal practices may have differed little from plans that a mother of the dominant culture might have made. Nevertheless, the health visitor needs to be alert to the differences between Punjabi and the dominant cultural norms relating to the *puerperium* (e.g. the preclusion of certain family members from providing post-natal help) in order that interventions are based on culturally accurate diagnoses and are culturally acceptable in themselves.

The findings also indicate that, in diagnosing the mother's preparedness for the *puerperium*, the health visitor needs to discover how the mother defines a nutritious post-natal diet, both in regard to the mother's recovery and to the promotion of successful lactation. As previously noted, the mother (especially the *Bhatra* mother) may uphold dietary beliefs that differ considerably from those of the dominant culture. For the unicultural health visitor visiting a mother of the dominant culture, dietary beliefs based on Western nutritional principles would be mutually understood. Certainly advice given within the

Western nutritional belief system would be acceptable to most mothers of the dominant culture. However, a unicultural health visitor visiting the *Bhatra* mother would need to recognize that her advice may need to relate to the 'hot-cold' food and bodily conditions belief system and, in particular, to how these beliefs relate to the mother's recuperation during the *puerperium* and to the promotion of successful lactation.

iii) Diagnosis – Preparedness for motherhood of a newborn infant

During her antenatal visits, the health visitor also diagnoses whether the mother's (especially a *primagravid* mother's) 'preparedness for motherhood of a newborn infant'. One factor predisposing to inadequate preparedness for motherhood of a newborn infant is a knowledge deficit relating to infant nutrition. However, as the health visitor seldom makes her initial post-natal visit before the tenth day post-partum, she therefore needs to act on such knowledge deficits antenatally. To a great extent, health visiting intervention regarding infant nutrition is informative and health educative in nature, the health visitor helping the mother make an informed decision which is both appropriate to the mother's way of life and to the promotion of her infant's health and well-being.

Whilst breast-feeding may not necessarily be the method chosen by the majority of newly delivered mothers in the United Kingdom, it is well-promoted by the health visiting profession as the ideal form of infant nutrition. To an extent, cultural factors, in addition to personal preference, were seen to have relevance as to whether a mother in this community breast-fed her baby. For instance, the *chalia* was noted as a time when the mother was 'at home all [the] while' (p. 337) and when a mother in a joint family household could

breast-feed in the knowledge that her household duties were being cared for by other family members. Bearing in mind that sons are particularly desired in Punjabi society, it is possible that breast-feeding is held in regard (even if not chosen) by the mothers interviewed, in that male infants and very 'precious' babies were the only infants recalled as being breast-fed for extended periods of time. Whilst this is but a tentative interpretation of this finding, Dosanjh's (1976) study indicates that male infants of South Asian families are more likely to be breast-fed for a longer period of time than female infants are. This possible cultural regard for breast-feeding plus the relaxation that the *chalia* traditionally provides are two cultural factors that a health visitor wishing to encourage the Punjabi mother to breast-feed could emphasize.

When determining the possibility of a knowledge deficit relating to bottle-feeding, the findings suggest that the health visitor needs to consider whether the mother views running water as essential for adequate cleansing. If this is so, then the health visitor would need to promote boiling, rather than using a sterilization unit, as a suitable method for cleansing bottles in a Punjabi home. Whilst the findings only describe one instance of a mother who was reluctant to follow the health visitor's advice about using a sterilization unit, this instance does point to the importance of the health visitor being cognizant of the mother's culturally defined code of hygiene both in regard to diagnosis and to intervention through health education.

**iv) Health visiting interventions – Preparedness for confinement,
the *puerperium*, and motherhood**

As previously discussed, health visitors are concerned that pregnant mothers (especially *primagravidae*) are adequately prepared for the reality of

childbirth and for motherhood of a newborn infant. On the whole, professional preparation is usually provided through formal antenatal classes which frequently are taught by health visitors as well as by midwives. Thus, the teaching provided at antenatal classes may be viewed as one form of health visiting intervention. However, from the findings relating to twenty six of the twenty-nine sample Punjabi mothers, it was apparent that very few of these mothers had ever attended antenatal classes. Indeed, it is suggested that the elicitation of aggregated knowledge such as this is necessary in that it helps the individual health visitor, as well as the health visiting service in the area, to assess the uptake and the relevance of formal antenatal education within cultural dimensions.

Although never stated, the lack of attendance at antenatal classes may have been connected with the cultural inappropriateness (actual or presumed) of advice given at antenatal classes. However, should excessive formality and/or inconvenience to family life have been major factors as to why the pregnant Punjabi mothers did not attend classes, then a home-based approach to antenatal education might be a more suitable alternative. Certainly a home-based approach would allow other family members to participate, members who are supporting the pregnant mother and who usually would not be invited to (and, indeed, may not feel they have the time to) attend institutionally-based antenatal classes. For the Punjabi family more than for the typical family from the dominant culture, there is a sense that the infant belongs to the entire affinal family. Thus, it could be said that there is a 'joint familyhood' (in addition to motherhood and fatherhood) that occurs with the birth of each baby. This reinforces the need, particularly in joint family households, for antenatal health visiting practice to be considered within a 'collectivist' orientation.

One of the findings in the study was that many of the families owned a video-recorder. This finding suggests one possible alternative approach to antenatal education, one in which video-cassettes on various topics relating to child bearing and child rearing could be produced and then loaned to each family with a video-recorder. Cassettes could easily be in both Punjabi and English and, thereby, be of value to those whose command of English is insufficient to benefit from antenatal classes where an interpreter is unavailable. A wide range of topics could be covered, not only topics raised in the above sub-sections, but also others that were not broached at all during the fieldwork interviews. For example, topics such as foetal growth (note McGilvary 1982:56-57) and body image during pregnancy (note Kitzinger 1972; 1977:21) as well as attitudes towards breast-feeding (note Kitzinger 1977:21). In addition to providing information about the onset and process of labour as well as hospital childbirth procedures, these cassettes could address difficulties that a Punjabi mother may have in coping with the maintenance of cultural traditions in hospital, for instance, with regard to dietary beliefs and proscriptions, notions of modesty (e.g with regard to hospital nightgowns [p. 329]) and codes of hygiene. Useful advice might include the mother being encouraged to ask the hospital staff for a clean jug for her personal use or to take her own jug (or *lota*) with her into hospital. Advice might also relate to the selection of suitable items on a hospital menu and include recommendations that overlap Western nutritional beliefs with 'hot-cold' nutritional beliefs.

At subsequent visits, the content of the cassettes could be discussed between the various family members and the health visitor, thus providing an inter-cultural educational experience of a reciprocal nature for both the health visitor and the family. And, if the mother-in-law participated, antenatal education would have reached one of the most influential members of the

family who, thereafter, may guide other daughters-in-law through their pregnancies. In addition, husbands would be able to view the cassettes without public loss of *izzat* from being involved in what is an exclusively woman's domain in Punjabi society. This, then, is one alternative approach to antenatal education amongst Punjabi families which draws on the finding that in many of the homes visited there was a video-recorder. Whilst this approach might be seen as a substitute for formal, institutionally-based antenatal classes, this need not be so. However, more information is needed as to why Punjabi mothers do not attend antenatal classes.

3. THE POST-NATAL MOTHER AND INFANT

A) THE POST-NATAL HEALTH VISITING REMIT

During the *puerperium*, the mother recuperates from the experience of childbirth and adjusts to caring for her newborn infant in addition to her other family responsibilities. Until the tenth day post-partum, the midwife visits the mother and infant as they recuperate from the activity of parturition. Thereafter, the health visitor establishes, or re-establishes, a long-term, health visitor-client relationship through which she aims to promote the health and well-being of both the mother and the infant. She also aims to promote the health and well-being of the father and other family members as well as the adequate functioning of the family as a whole. During her initial visits, the health visitor determines whether there are any health related problems, potential or actual, for which she can provide help and guidance, of either a direct or an anticipatory nature. Not only is she alert to the possibility of child abuse, but, by encouraging and helping the family to provide as secure and as loving a home environment as possible, she hopes that the infant's potential

for optimal health and well-being may be fully maximized.

Throughout the ensuing five years until the child enters school, the health visitor is concerned with the promotion of optimal infant and pre-school growth and development. During home visits and at child health clinics, she provides the mother (or whoever is caring for the child) with information and advice relating to sound child health practices. Such advice includes encouraging the mother to avail her infant of routine immunization programmes and routine child developmental assessments with the intent that avoidable diseases may be prevented and developmental delays and disabilities detected promptly.

B) THE POST-NATAL PUNJABI MOTHER AND INFANT

In this section, important findings which relate to the post-natal mother and newborn infant from the community studied are presented in abbreviated form. These findings should be viewed as interwoven with findings relating to wifehood. As pre-encounter influences, the health visitor considers them to be dynamic entities which are subject to revision in accord with the context and circumstance of the family's situation. The important findings relating to the post-natal Punjabi mother and infant are:

1. The maintenance of an approximately forty-day, customary post-natal period known as the *chalia* (or *sawa maheena*) when the mother is considered to be in a culturally polluted condition (pp. 329-335). For the *Bhatra* mother and infant, this cultural pollution is reduced through a series of ritual baths taken at decreed times by both the mother and the infant (pp. 330-333). On the fortieth day, the *Bhatra* mother and infant

take their final ritual baths and present themselves at the *gurdwara* for the *mata takon* when they are reincorporated formally into the *Bhatra* community.

2. The maintenance of culturally defined post-natal dietary beliefs. In particular, *garam* foods (especially *punjeeri/dabra* [pp. 326–327]), nutritious liquids and softened foods are recommended (p. 339). Lactating mothers avoid a variety of foods which may adversely affect the infant's digestive system (p. 339).
3. The maintenance of religio-culturally defined ceremonies for infants. Not only is the *azan* recited into each ear of the newborn Muslim infant (p. 341), but the infant's head is tonsured and nails clipped in early infancy (pp. 340–341). Circumcision is performed routinely on all male Muslim infants/children (p. 341). Many Sikh infants receive the initial letter for their name from a randomly opened page of the *Guru Granth Sahib* during the *mata takon* (p. 340).
4. The protection of *Bhatra* infants (especially male infants [p. 354]) from harmful forces through the maintenance of culturally defined practices. These include the maintenance of a strict *chalia* for the infant (p. 331), placing a black mark on the infant's forehead (p. 356), tying a *thaga* on the infant (p. 355), and by hanging the *schree* across a number of door lintels in the home (p. 355).
5. A preference for bottle-feeding, certainly after the infant is eight weeks of age (pp. 336,338). Reasons provided for the discontinuation of breast-feeding are varied (pp. 337–338).

6. The acceptance of routine child developmental assessments (p. 349). Mothers appear to have minimal awareness of the purpose of specific developmental testing procedures (pp. 349,351).
7. The acceptance of routine immunization for infants/pre-schoolers (pp. 346-347). Many mothers appear to have minimal awareness of the diseases against which their infants are being protected.

C) HEALTH VISITING THE POST-NATAL PUNJABI MOTHER AND INFANT

In this section, the findings are discussed in regard to health visiting practice and, specifically, in relation to a hypothetical post-natal Punjabi mother and her infant from the community studied. In so doing, two diagnoses are considered: 'management of the transition to motherhood of a newborn infant' and 'management of infant health promotion'. As health visiting diagnoses, they are seen in regard to the long-term (certainly until the child has reached school age) as well as the short-term promotion of the health and well-being of the mother and her infant. The use of the term 'management' is envisaged as encompassing the idea of skilfully handling the course of, as well as the idea of coping with the hurdles and difficulties of, transition to motherhood and the promotion of infant health.

i) Diagnosis - Management of the transition to motherhood of a newborn infant

When diagnosing maternal 'management of the transition to motherhood of a newborn infant', the health visitor is concerned whether the mother is managing this transition adequately or inadequately. For the *primiparous*

mother, childbirth assumes a definite developmental stage. Although each subsequent birth may involve many adjustments, never again is the mother a novice parent. For the *primagravid* Punjabi wife, this transition into motherhood invariably is in combination with wifeness. Similarly, the first-time Punjabi father invariably makes a transition from husbandhood to a combined role of fatherhood and husbandhood. Although the husband's adjustments are not addressed in the following discussion, and motherhood rather than the more encompassing concept of parenthood focused upon, this is not to relegate fatherhood to a level of unimportance. Whilst Indian fathers, as noted by Kakar (1978:126,130), himself a Punjabi-speaking Indian, traditionally have little involvement in child care until the child reaches about four years of age, the findings illustrate the reality of Punjabi fathers demonstrating warm paternal involvement in child nurturance.

In forming a diagnosis of adequate, or inadequate, maternal management of the transition into motherhood of a newborn infant, the health visitor considers physical and emotional factors that are involved in this transition. As well as indicating that cultural knowledge is important in regard to physical and emotional factors, the findings indicate that religio-cultural beliefs and practices (such as the diminution of cultural impurity and the concern for danger and vulnerability of a cultural nature) are also integral to the Punjabi mother's transition into motherhood of a newborn infant. The following discussion considers three factors which, in addition to being considered relevant to the post-natal Punjabi mother's management of the transition to motherhood of a newborn infant, are also considered to be non-culture specific:

religio-cultural factors,
physical factors,
emotional factors.

a) Religio-cultural factors

Not only are religio-cultural beliefs and practices important to the Punjabi mother antenatally, but also to the totality of both the post-natal mother's and the infant's well-being. 'Religio-cultural factors' are therefore factors that the health visitor must take into consideration when diagnosing management of motherhood of a newborn infant.

With childbirth being a time of cultural defilement for the Punjabi mother and infant, religio-cultural practices are important to the reduction of this cultural impurity and are upheld throughout the *chalia* or *sawa maheena*. For the *Bhatra* mother and infant, it was seen that the practice of ritual bathing is maintained at designated times throughout the *chalia*. Over the forty days, the *Bhatra* mother resumes her household, family and marital responsibilities. For example, kitchen work is resumed after the *chaunka chalia*. On the fortieth day, the *Bhatra* mother and infant present themselves at the *gurdwara* for the *mata takon*. At this ceremony, the initial of the infant's name may be selected and announced. Thus, before the *Guru Granth Sahib* and in front of the congregation, the mother and her infant are reincorporated symbolically into the *Bhatra* community. Thereafter, they may visit, and be visited, without the same concern for cultural impurity and vulnerability. Mothers in nuclear households, however, may have to modify, possibly even abandon, certain religio-cultural post-natal practices because of lack of personal support in the home. Hence, in forming her diagnosis, the health visitor needs to determine

what practices the mother is unable, as well as able, to uphold, and whether the inability to uphold certain practices is seen as a cause for concern.

The maternal management of the transition into motherhood of a newborn infant may also be considered to encompass a concern for the maintenance of appropriate religio-cultural practices in regard to the infant's transition into infancy. It was seen that, for the Punjabi infant, these practices are supervised and/or performed by other members of the family or sub-caste (e.g. the mother-in-law, the husband, a daughter of the clan) as well as by the mother. In addition to the purificatory baths, post-natal customs for the *Bhatra* infant include tying a *thaga* around the infant's waist, ankles and/or wrists, and hanging the *schree* when a son is born; both customs affording the infant protection from cultural harm. Religio-cultural practices relevant to the Muslim infant's transition into infancy were noted to include the recitation of the *azan* shortly after birth and the nail clipping and tonsuring ceremony during early infancy. Due to circumstances in the United Kingdom, circumcision for male offspring may have to be delayed until pre-school age.

The health visitor who is prepared educationally for inter-cultural practice recognizes that the maintenance of culturally defined and sanctioned traditions helps to give meaning and direction to many transitional periods in life (note Homans 1982:244). However, with the 'churking of women' following childbirth seldom being practised by post-natal mothers of the dominant, secular culture of contemporary Britain (Staton 1981; also 1982:personal communication), the unicultural health visitor is unlikely to consider the importance of religio-cultural practices to the post-natal Punjabi mother's overall transition to motherhood. Yet, for the Punjabi mother and infant, especially in the *Bhatra* community, religio-cultural practices are important

cultural components of the mother's and the infant's transition into motherhood and infancy which the health visitor must consider if she is to make an accurate diagnosis relating to the Punjabi mother's management of the transition to motherhood of a newborn infant.

b) Physical factors

In forming her diagnosis of maternal management of the transition to motherhood of a newborn infant, the health visitor also considers 'physical factors'. Such factors include those relating to the mother's physical recovery from childbirth, such as the avoidance of stressful and physically tiring tasks as well as the need for a nutritious post-natal diet. The findings, however, indicate that these factors are viewed within Punjabi cultural parameters, and, as such, are likely to remain unrecognized by the unicultural health visitor. Culturally defined notions of what a post-natal Punjabi mother should avoid doing during the *sawa maheena* were reported to include the avoidance of knitting, sewing and reading. In so doing, the mother prevents undue stress on her body at a time when she is recognized as being 'weaker' (p. 334). And, should the *Bhatra* mother be considered insufficiently recovered from childbirth to resume kitchen work, then the *chaunka chalia* may be postponed. It was also noted that certain foods are culturally defined as being particularly suitable for helping the post-natal mother regain her strength. For example, *garam* foods such as *punjeeri* or *dabra* (thus in accord with the 'hot-cold' food belief system) as well as foods of a defined consistency are especially recommended.

Diagnostic considerations also relate to the adequacy of perineal healing and to family planning intentions. With regard to both considerations, the health visitor needs to be cognizant of the culturally defined notions within

which the mother views her body as well as the Punjabi code of hygiene which defines how she performs perineal cleansing. For instance, any advice regarding perineal care must take into account the Punjabi notion of only the left hand being used for perineal cleansing, the right hand being considered symbolically clean. This practice also has relevance to the choice of family planning methods, in that it is difficult to insert a diaphragm or cap with the left hand only. As the *Bhatra* mother may also view her body as being more culturally polluted below than above the waist, culturally appropriate advice concerning perineal care for the *Bhatra* mother needs to take both these beliefs into account. Thus, the health visitor would suggest the use of a detachable shower unit or a jug douche rather than tub bathing, in that the former methods of cleansing (and soothing) ensure that the water flows from the part of the body that is least, to the part that is more, culturally polluted. Whilst such advice upholds the Punjabi code of hygiene, it also allows both the Punjabi and the Western obstetrical codes of hygiene to be upheld simultaneously.

c) Emotional factors

In diagnosing whether a mother is managing adequately the transition into motherhood of a newborn infant, the health visitor also considers relevant 'emotional factors', her concern being for the mother's and, indirectly, for the infant's well-being. With the intent of providing judiciously timed counselling and/or early referral to other health professionals, the health visitor aims to identify emotional strain and/or post-natal depression as early as possible.

With the emphasis on fecundity needing to be demonstrated early in marriage, emotional strain relating to wifedom may be a factor impeding the

smoothness of the post-natal Punjabi mother's transition into motherhood of a newborn infant. Whilst the demonstration of fecundity early in marriage is not culture-specific, Homans' (1982:235) findings, which relate to 'Asian' (predominantly Punjabi) and 'British' women in a Midlands city, suggest that 'the Asian women . . . were far more likely to conceive soon after marriage' than were the 'British' women.

By custom, a supportive female relative (frequently the mother-in-law or mother) guides the *primiparous* Punjabi mother into the art of mothercraft. Where this is so, mothercraft is learnt in a mentorship situation and is a feature of Punjabi culture which can help to provide a strength-oriented diagnosis. In several nuclear Muslim households, husbands were noted as being involved directly in day to day aspects of child care. Even so, for the Punjabi mother who is distant from her natal kin, the *puerperium* may be a time when she feels the rift particularly acutely, thus adding to her vulnerability to post-natal depression. Although post-natal mothers from the dominant culture may also be distant from their natal kin, the notion of *izzat* and the custom of arranged marriages are cultural factors that help to increase the possibility of geographical separation being a reality amongst post-natal Punjabi mothers in this community.

For the early identification of emotional strain and/or post-natal depression to be achieved, the health visitor needs to be alert to subtle, as well as overt, clues as to the post-natal Punjabi mother's emotional well-being. Such observations involve visualizing the mother as a cultural being. For instance, when observing changes in the mother's appearance, the health visitor needs to be aware of the way in which the mother usually expresses her ethnic identity. Hence, cultural information relating to clothing, jewellery, cosmetics

and colours hold importance. In addition, the health visitor must be aware of the underlying cultural values which shape and govern the mother's actions and decisions, yet recognizing that these may vary intra-culturally and even be contravened. For example, although Punjabi families invariably maintain an outward expression of patriarchal dominance, in regard to the everyday politics of family life the mother-in-law may be the most powerful person in the home. The health visitor also needs to remember that, because of her junior position in the affinal household, an emotionally distressed mother, post-natally as well as antenatally, may hesitate to voice her feelings. Hence, the health visitor not only needs to detect subtle clues relating to emotional well-being, but find suitable opportunities to help the mother in as culturally acceptable a manner as possible.

ii) Diagnosis – Management of infant health promotion

In this section, three predisposing factors relating to maternal 'management of infant health promotion' are discussed. This diagnosis encapsulates the notion of the mother's responsibility for promoting her infant's health and well-being. This is not to say that she is alone in assuming this responsibility. In the nuclear family-oriented, dominant culture, the husband usually is the other important person who shares this responsibility. As the health visitor only visits intermittently, she is envisaged in a helping role, providing the mother with health related information, advice, support and guidance as required. Three factors relating to this diagnosis, which are both highlighted in the findings and considered to be non-culture specific, are:

knowledge relating to infant growth and development,
knowledge relating to infant and pre-school immunization,
knowledge relating to infant nutrition.

Whilst important, knowledge relating to infant nutrition has been discussed in regard to the diagnosis of 'preparedness for the *puerperium*'. Therefore, only the first two factors will be discussed in this section. In making this diagnosis, the mother is envisaged as having either adequate knowledge or a knowledge deficit in regard to these factors.

a) Knowledge relating to infant growth and development

In forming the diagnosis of adequate, or inadequate, maternal management of infant health promotion, the health visitor must discover whether or not the mother has a deficit of 'knowledge relating to infant growth and development'. From the findings, the mother-in-law emerged as a particularly important person, especially amongst the *Bhatra* families, in regard to guiding a new mother in infant management.

With the intent of monitoring the growth and development of each infant and pre-schooler, routine child developmental assessments are offered at child health clinics countrywide. Many health visitors also undertake these assessments during home visits. As well as aiming to identify developmental delays and disabilities, infant and pre-school developmental assessments are useful educational tools for helping mothers maximize their child's potential for growth and development. Indeed, Wills (1978:2084) recommends structured developmental assessments as ideal opportunities to provide nutrition counselling in a 'game atmosphere'. Bryant et al. (1979:362) and Robertson

(1984:21) also emphasize the educational possibilities of developmental assessments for health visiting practice. Although the findings indicate that the majority of the mothers interviewed attended child health clinics and availed their infants and pre-schoolers of child developmental assessments, most of the mothers did not have a precise understanding of the various developmental procedures employed. Thus, most mothers demonstrated a knowledge deficit relating to infant growth and developmental assessment procedures. Even so, the extent to which the mothers had been provided with explanations and anticipatory guidance of a structured nature (by health visitors and/or doctors) in regard to infant and pre-school growth and development was unknown. Whilst Kakar (1978:81) suggests that 'the Indian mother' adopts a *laissez faire* approach to child development (e.g. in regard to a toddler mastering the skills of 'walking, talking and dressing himself'), and follows rather than leads when 'dealing with her child's inclinations', nevertheless the health visitor would be concerned about, and seek to rectify, a knowledge deficit relating to infant health growth and development.

Although health visitors routinely maintain a surveillance of the growth and developmental progress of the infant and pre-school population of the United Kingdom, there has been no comprehensive evaluation of the effectiveness of this surveillance (note Jennings 1984:62). Yet, it would seem that if the educational achievement of pre-schoolers in contemporary Britain's multi-cultural society is to be promoted, not only is there a need for health visiting data which relate to the growth and development of Britain's under five year old population, but, specifically, to ethnic grouping. And, if health visitors are to provide parents with guidance on child development with full regard to the child's ethnic identity, then cultural knowledge is essential for so doing. Whilst ideas such as those put forward by Glass (1975) – in an article in the

Teacher's World entitled 'Multicultural wendy house' - help to increase teachers' awareness of how knowledge of South Asian cultures can be used to develop a pre-schooler's use of language, imagination and social interaction, there appears to be a lack of a similar sharing of ideas within the health visiting literature. Although this is a relatively unexplored area of cultural knowledge, it is one that a health visitor who has diagnosed a deficit of knowledge relating to infant growth and development in a Punjabi family would need to draw upon if she is to promote the infant's health with full regard to his, or her, ethnic identity.

b) Knowledge relating to infant and pre-school immunization

In diagnosing maternal management of infant health promotion, the health visitor needs to discover whether or not the mother has a deficit of 'knowledge relating to infant and pre-school immunization'. During the fieldwork, mothers verbalized a general acceptance of routine infant and pre-school immunization. Although the mothers' verbalized acceptance of such programmes was not verified (e.g. child health records were not scrutinized), nevertheless, the findings indicate that infant and pre-school immunization was viewed by most of the mothers as beneficial to the promotion of their child's health. However, there was little awareness of the individual diseases against which the children were being immunized. In addition, there was no spontaneous mention of the pertussis controversy that had occurred prior to the time of the fieldwork (i.e. pre-1980). Indeed, the confidence in immunization that most of the Punjabi mothers verbalized contrasts with the reduced confidence in infant and pre-school immunization that occurred throughout the United Kingdom as a consequence of the pertussis controversy in the mid-1970s (note Robertson 1984:4-9). Although the controversy brought to light the need to review the

safety of the pertussis vaccine, not only has a disease that was almost extinct in Britain in the 1970s returned to cause fatalities once again, but this controversy resulted in a worrying reduction nationwide in all routine infant and pre-school immunization.

iii) Health visiting interventions – Management of the transition to motherhood of a newborn infant, and management of infant health promotion

In visiting the post-natal mother and infant throughout the ensuing five years, the health visitor's role in health promotion inevitably assumes a variety of forms. These include counselling, developmental surveillance, and health education as well as the provision of information, advice and anticipatory guidance. In regard to all these forms of health visiting intervention, it can be anticipated that health visiting energies will be dissipated, possibly negated, if they do not take into account the client's cultural traditions and values. In this section, the relevance of cultural knowledge in relation to aspects of health education and infant illness prevention will be focused upon, drawing upon the findings and the literature in so doing.

Most health visitors have the opportunity to be involved in health educational activities, including those focusing on topics relating to the post-natal mother and infant. These may include clinic display work and the production of health educational literature. The findings, however, show that, if health messages are to be conveyed as intended to a Punjabi clientele, care needs to be exercised in regard to culture-specific symbolism. It was seen, for instance, that colours, and colour combinations, may assume culturally defined connotations. Hence, display work utilizing saffron and vivid blue can be

anticipated as assuming religious connotations to a Sikh clientele. And, if the health message relates to sinister realities (e.g. road accident fatalities), red needs to be used cautiously in that it bears culturally defined connotations of happiness and fertility for Punjabi families. Other forms of symbolism which also need to be used with care in regard to a Punjabi clientele, such as the community studied, include the pictorial representation of the left hand for culturally 'unclean' activities (e.g. the insertion of vaginal contraceptives) and the right hand for culturally 'clean' activities (e.g. eating and gift-giving), as well as the relevance of the upper and lower parts of the body in relation to their assumed degree of cultural pollution. Also, the importance accorded to the opinions of senior family members should be acknowledged where relevant (e.g. in regard to decisions relating to sterilization).

With regard to child development being promoted with full thought to the child's ethnic identity, health visiting interventions must take into account the cultural value system into which the child is being socialized. For the Punjabi child, learning to feed himself correctly involves learning to use the right hand only, whereas toilet training involves learning to use the left hand for cleansing after defecation. And, although the toys observed during the fieldwork visits did not appear to the researcher as being noticeably different from toys that many children from the dominant culture might have, the imagination and fantasy that would be involved in playing with them might well have been very culture-specific. Punjabi children in this community also grow up learning to live in two differing cultural worlds. Indeed, the findings highlighted the presence of biculturalism. For instance, both Punjabi and non-Punjabi cuisine was seen to be enjoyed in several homes, and older children were noted to be bilingual.

Although beliefs relating to the 'hot-cold' foods and bodily conditions were not explored during the fieldwork in regard to the prevention of infant illness, research findings suggest their relevance (Lozoff et al. (1975:355). These findings, which relate to South India, indicate that infant diarrhoea and infant dehydration are based on two conceptually different belief systems. Whilst infant diarrhoea was found to relate to the presence of too much 'heat' in the body from the ingestion of 'hot' foods, either by the child or, if the child is being breast-fed, by the mother, infant dehydration was found to relate to the presence of cultural impurity. The same article suggests honey (a 'cold' food) and water, rather than the usual sugar (a 'hot' food) and water, as a more culturally acceptable treatment for infant diarrhoea. Whilst it is helpful to draw on knowledge relating to other South Asian cultures, whether in the Sub-continent or in the United Kingdom, caution nevertheless needs to be exercised. Although there may be similarities, and fruitful data searches may result if channelled along such avenues, findings applying to one group of South Asians in the United Kingdom do not necessarily apply to another. Nevertheless, in considering what advice to give a lactating, or a non-lactating, mother whose infant is having loose bowel motions, Lozoff et al.'s findings suggest a possible directed data search, that of discovering whether the infant's complaint is viewed within the 'hot-cold' food and bodily belief system. Indeed, it is possible that the mother who discontinued breast-feeding because of her infant's and her own loose bowel motions (p. 337) may have done so in accord with similar ideas, in that she made this decision on the advice of her mother-in-law in Pakistan.

4. DISCUSSION

In this chapter, several diagnoses relating to health visiting's maternal and child health remit have been presented as a basis for the discussion of the findings and their relevance to health visiting practice. In forming her diagnosis, the health visitor has been envisaged as drawing upon a meld of cultural knowledge. This meld combines knowledge that she has acquired through professional and personal experiences and education with knowledge concerning the Punjabi community to which the client belongs, or a similar Punjabi community. As both health visiting related cultural knowledge and pre-encounter influences, the findings have been demonstrated in this chapter as intrinsic to the formation of complete and accurate health visiting diagnoses, whether strength- or problem-oriented. As diagnostic accuracy is a prerequisite to relevant and sound health visiting interventions, not only is such cultural knowledge seen to be an essential diagnostic ingredient, but also essential to the subsequent formation and implementation of effective, client-oriented health visiting interventions.

In demonstrating the relevance of cultural knowledge to diagnostic accuracy and completeness when caring for the Punjabi mother and infant, and to the cultural appropriateness of subsequent health visiting interventions, the discussion in this chapter has also highlighted the need for health visitors to be alert to intra-cultural variations. Both religious and sub-caste differences were seen to have diagnostic importance. In addition, it was seen that Punjabi cultural traditions and values may be modified and/or emphasized according to the context and circumstance of the mother's situation – Punjabi culture having,

as do all cultures, a dynamic quality. Hence, the health visitor must be proficient in her everyday field practice in discovering and analyzing data relating to the Punjabi mother's ethnic identity and background.

The acquisition of expertise in cultural discovery for diagnostic purposes involves, however, the continual development and refining of a cerebral library of health visiting related cultural knowledge. Indeed, to recognize a width of diagnostic possibilities and alternative avenues for directed data searches, not only does the health visitor need a cognitive map for the elicitation of cultural knowledge, but also a fund of knowledge relating to cultural groups similar to, and different from, the cultural group for whom she is providing care. In this chapter, typical cultural norms of both the dominant culture of the United Kingdom and other Punjabi and South Asian communities (in the Sub-continent and the United Kingdom) have been brought into the discussion.

It has been seen that the anticipation of effective health visiting interventions (e.g. counselling, health education) depends on the alignment of health visiting interventions to the Punjabi traditions and values upheld by the mother and her family. Thus, in caring for the Punjabi mother and infant, whether antenatally or post-natally, the health visitor needs to be proficient in practising creatively within cultural parameters other than her own. To provide care that is oriented and tailored to her client's needs in inter-cultural health visiting situations, the health visitor needs both to emancipate herself from her own cultural view and to visualize cognitively her client's cultural world. In this thesis, this world has been that of the Punjabi mother and child.

Fundamental to health visitors achieving their health promotive goal in what, frequently, is a guest capacity, their practice must be seen by the client

as relevant and meaningful to her, or his, needs. Throughout this chapter, the health visitor has been envisaged as a culturally conscious diagnostician, blending together cultural knowledge relating to the client's way of life with knowledge relating to health visiting practice. Thus, she has been viewed as articulating two cognitive maps: the one map relating to the boundaries and scope of health visiting practice, the other providing her with a guide for the elicitation of cultural knowledge. Indeed, the emergence of culturally relevant health visiting practice can be viewed as being dependent on the integration and consonance of data relating to both cognitive maps.

Whilst it has been seen that proficiency in culturally relevant practice allows the health visitor to diagnose more accurately when visiting the Punjabi mother and child, it can also be reasonably assumed that this same proficiency will allow her to practise in a culturally astute and sensitive manner with other client groups (e.g. the elderly, the school child, the bereaved) in the same Punjabi community. And, in addition, the cognitive map that acts as a guide for cultural discovery when the health visitor is diagnosing the Punjabi client can also be envisaged as guiding her practice in other inter-cultural situations as well as increasing her awareness of her own cultural traditions and values in intra-cultural health visiting situations.

Although the hypothetical health visitor in this chapter has been presented as being alert to culturally relevant cues when forming her diagnosis, the discussion has also emphasized the likelihood of the unicultural health visitor missing diagnostically important cues for lack of a cognitive map to guide her in cultural discovery. Indeed, educationally prepared within the dominant cultural ethos and, in many instances, belonging to the dominant culture, there is no certainty that the unicultural health visitor has developed the necessary

skills and abilities for forming culturally relevant and accurate diagnoses from which to plan and implement culturally appropriate interventions. Lacking a cognitive map to guide her in the elicitation of cultural knowledge in multi-cultural situations, the unicultural health visitor's ability to help the Punjabi mother and child maximize their potential to achieve optimal health and well-being with full regard to their cultural traditions and values is limited seriously. It can also be reasonably inferred that because the unicultural health visitor's practice is attuned to the perspective of the dominant culture, it will be far from adequate in other multi-cultural situations.

In contrast to the unicultural health visitor, the transcultural health visitor has been prepared educationally during qualifying health visitor education, or subsequently, to provide culturally sensitive and attuned care. Thus, she is able routinely to base both her diagnoses and her subsequent interventions on knowledge relating to her client's ethnic identity and background. Through educational preparation, she has developed expertise in looking beyond her own cultural perspective and in affirmatively bridging and transcending cultural differences within health visitor-client relationships. Hence, she is able to avoid spending unnecessary time, both the client's and her own, pursuing culturally inappropriate avenues of inquiry and offering culturally inappropriate advice. And, as demonstrated in this chapter, because of her ability to discover and creatively utilize data relating to her client's cultural traditions and values, the transcultural health visitor is able to fulfil her health promotive role to the Punjabi mother and child, antenatally and post-natally, in a more culturally sensitive, appropriate, and effective manner than the unicultural health visitor is able to achieve. She is also supported organizationally in so doing.

Transcultural health visiting practice is hall-marked by the practitioner's ability both to affirmatively bridge and transcend cultural differences and to ensure that the client's cultural traditions and values are acknowledged, respected, and included in the provision of care. Whilst many Punjabi traditions may be alien to the transcultural health visitor's own cultural world view, she has been prepared educationally to recognize that other cultural traditions and value systems have coherence and meaning to those who uphold them. And, because the the notion of 'transcultural reciprocity' is central to transcultural health visiting, the transcultural health visitor is proficient in conveying to her client her respect for, and concern to understand and promote health within, the client's cultural traditions and values. She both initiates, and thereafter assumes the onus for the maintenance of, transcultural reciprocity. As empathy is recognized as occurring more easily when there is a similarity between the client and the practitioner, transcultural health visiting education prepares the health visitor to expand her 'empathic boundaries' (Travelbee 1971:203) when practising in multi-cultural situations. Thus, the ideology that governs transcultural health visiting practice increases the likelihood of the Punjabi mother and child receiving culturally relevant and effective health visiting care on a continuing basis, thus differing from unicultural health visiting practice.

Whilst cultural knowledge has been seen in this chapter as essential to diagnostic precision and completeness in regard to three hypothetical Punjabi clients, the feasibility of health visitors discovering similar cultural knowledge in everyday field practice is an important factor in regard to the viability of the transcultural perspective at field level. As previously noted, the fieldwork visits paralleled conventional health visiting practice in nature and content. For instance, the visits were planned explicitly to discover cultural knowledge

relevant to the provision of maternal and child health visiting care in the Punjabi community studied. The knowledge gleaned during the fieldwork visits was envisaged as 'cultural knowledge for use', thus, 'pre-encounter influences' with regard to the diagnostic process of health visiting. As the researcher visited in the capacity of a non-practising health visitor, the fieldwork visits differed from actual health visiting practice in that they were not planned with the intent to promote the respondents' health. However, as clients are usually aware of the serial nature of health visiting, it is likely that Punjabi mothers would proffer more, rather than less, cultural information to a practising health visitor educationally prepared to elicit cultural knowledge than to a non-practising health visitor/researcher, as in the research study.

Many of the visits to the sample families were approximately one hour in duration. In this respect they were similar to many of the routine home visits, which included initial and subsequent assessment visits, made to the original thirty-one families by the health visitors who participated in Clark's (1985b:59,100,245) study (see Chapter Two). The timing (i.e. between 10 a.m. and 5 p.m., Monday to Friday) of the fieldwork visits also paralleled conventional health visiting practice. Although the researcher had never received formal transcultural health visitor/nurse education prior to the initial fieldwork, it is suggested that her previous experience in the promotion of health in inter-cultural situations (although not amongst a Punjabi clientele), combined with knowledge relating to both Punjabi culture and the use of ethnographic insights and approaches to cultural discovery, as described in Chapter Four, would be similar in many ways to the educational preparation and field experience of a transcultural health visitor. It is therefore suggested that knowledge similar to that gleaned during the fieldwork through ethnographic approaches to cultural discovery could be elicited by health

visitors in everyday field practice, given that they had been prepared educationally to so do. This being so, and with the findings being demonstrated as relevant to hypothetical health visiting practice, it can be posited that ethnographic methods used in an attenuated form are both feasible approaches for health visitors to use and suitable and productive approaches to the discovery of health visiting related cultural knowledge in everyday field practice (note Dobson 1986 – see Appendix Five).

It should also be noted that the mothers visited during the fieldwork belonged to a small, widely dispersed Punjabi community in a city with a small ethnic minority population. Therefore, in demonstrating the relevance of the findings to diagnostic accuracy, the need for all health visitors to be prepared educationally to provide culturally relevant care in areas with small, as well as large, ethnic minority populations is highlighted. As health visitors are concerned with the promotion of socio-emotional as well as physical health and well-being, and collect data for both future and immediate diagnostic and intervention purposes, the cultural knowledge that each health visitor needs to glean, utilize, and store in her cerebral library is wide-ranging. Hence, for health visitors nationwide to be able to provide culturally attuned care, the cognitive map which guides each health visitor's discovery of cultural knowledge must be both comprehensive and non-culture-specific.

In formulating the diagnoses presented in this chapter, the North American 'Classification of Nursing Diagnoses' (see Frey et al. 1986; Risner 1986:153) has been drawn upon as a basis for ideas, the notion of 'diagnosis' having received scant consideration by health visitors. However, a diagnosis in accord with Clark's (1985b:293) systems-based model is viewed as 'an actual or potential imbalance in the health equilibrium, ie. a health problem'. In regard to

subsequent health visiting interventions, Clark (1985b:293) notes that 'the definition of the problem in turn directs the plan'. Interventions that Clark (1985b:295; 1986:103) enumerates include 'specific health teaching (eg. parentcraft)', 'anticipatory guidance (eg. antenatal classes)', and 'supportive counselling'. As seen in this chapter, these are health visiting interventions which, with regard to the Punjabi mother and child, must be based on culturally relevant diagnoses. Therefore, for Clark's model to be relevant to the practice of culturally attuned health visiting in the Punjabi community studied and, as suggested, by inference also in other multi-cultural situations, Clark's model needs to address more explicitly the cultural dimension of health visiting practice. As previously observed, Clark links neither her model nor the records that she has devised for documentation purposes explicitly to the practice of health visiting in a multi-cultural society. It is therefore suggested that Clark's model would be strengthened by the inclusion of features relating to the transcultural perspective of health visiting, such as: the routine discovery of data relating to the client's ethnic identity and background, and the notion of 'transcultural reciprocity' within inter-cultural health visitor-client relationships.

In conclusion, the relevance of the findings, and thus the importance of cultural knowledge, to the anticipation of effective, client-oriented health visiting practice relating to the Punjabi mother and child has emerged clearly in this chapter in regard to the formation of accurate and culturally sound health visiting diagnoses. It has been seen that the transcultural health visitor is able to fulfil her health promotive role in a more culturally sensitive and attuned manner than the unicultural health visitor is when caring for the Punjabi family. And, because it can be reasonably inferred that the transcultural health visitor's increased ability to promote health in a culturally appropriate manner will occur in other multi-cultural situations, it is suggested that the transcultural

perspective has the potential to ensure that all health visitors nationwide are able to fulfil their health promotive role in multi-cultural situations. By practising within the transcultural perspective, health visitors are thus able to uphold routinely the code of professional conduct for health visitors which considers that, in her practice, each registered health visitor should take into account her client's 'customs, values and spiritual beliefs' (U.K.C.C. 1984:2).

CHAPTER NINE

CONCLUSIONS

1. **Conclusions**
2. *Quo Vadis?*

1. CONCLUSIONS

In this thesis, the cultural dimension to health visiting practice has been the focus of concern. With the multi-cultural composition of contemporary British society well-acknowledged in the health visiting literature, the health promotive role of the health visitor needs to be viewed explicitly in relation to a multi-cultural clientele. Yet, in Chapters One and Two, it was shown that the health visiting service at United Kingdom health visiting policy level has paid little attention to ensuring that all its practitioners receive educational preparation in, and organizational support for, the nationwide provision of culturally sensitive and relevant care. As presented in the literature, the health visiting service currently operates within a unicultural perspective wherein the primacy of the dominant culture is upheld at all levels, with only peripheral recognition being given to other cultures. Viewed as an inappropriate perspective for the nationwide delivery of a culturally relevant health visiting service with a multi-cultural clientele, the transcultural perspective was presented in Chapter Three as an alternative perspective for health visiting.

Within this alternative perspective, which is characterized by specific educational preparation and organizational support for transcultural practice, all health visitors aim routinely to provide culturally attuned care to clients of all cultural traditions throughout the United Kingdom. However, for the transcultural perspective to be considered as a viable alternative, the feasibility of health visitors discovering and utilizing health visiting related cultural knowledge in their everyday field practice, and the relevance of such knowledge to the increased effectiveness of their practice, needed to be demonstrated. To achieve this, the findings of a study which aimed to discover

health visiting related cultural knowledge pertaining to a small Punjabi community in one British city was utilized. This study considered various aspects of Punjabi life in relation to both the antenatal and the post-natal Punjabi mother and child. Not only were ethnographic insights and approaches, particularly observation, interviewing and participation, utilized in this study to elicit cultural knowledge, but the study was undertaken by a non-practising health visitor who was well-accustomed to promoting health in inter-cultural, community-based nursing situations. This study was described, and the findings presented, in Chapters Four to Seven.

In Chapter Eight, the findings of this study were demonstrated as essential to diagnostic accuracy and completeness in regard to three hypothetical clients from the same, or a similar, Punjabi community. The findings were also demonstrated as essential to the effectiveness and cultural relevance of subsequent health visiting interventions. Although the notion of 'diagnosis' is not in common usage in health visiting practice at the present time, the diagnoses presented in Chapter Eight focused on potential concerns that health visitors consider routinely in relation to their maternal and child health remit. With the fieldwork situation paralleling actual health visiting practice (particularly home visiting) in regard to nature, content and timing, the possibility of health visitors in actual field practice discovering similar cultural information through the utilization of ethnographic insights and approaches to cultural discovery is considered to be eminently feasible, given that they have received educational preparation in so doing during their qualifying health visiting education, or subsequently.

With the transcultural perspective characterized by the educational preparation of all its practitioners in the routine discovery and utilization of

data relating to their clients' ethnic identity and background, it is suggested that this perspective should be given serious consideration for its potential as a viable and appropriate cultural perspective for health visiting in contemporary multi-cultural Britain. This perspective accords emphasis to the importance of respect and understanding for the client's cultural traditions and values as well as to the emancipation of the health visitor from her own cultural view. The transcultural health visitor affirmatively aims to bridge and transcend cultural differences between herself and her client in all inter-cultural health visiting situations. However, with her enhanced awareness of the relevance of cultural traditions and values to diagnostic integrity, and educationally prepared to utilize a cognitive map to guide her in the discovery of cultural knowledge, it is also suggested that the transcultural health visitor is more likely to have increased insight into intra-cultural situations than the unicultural health visitor. Indeed, it is visualized that the educational preparation that the transcultural health visitor receives provides her with the proficiency to practise with increased cultural accuracy, appropriateness and creativity in intra- as well as inter-cultural situations.

2. *QUO VADIS?*

In considering the cultural dimension of health visiting practice, the researcher has looked at an area that has received little consideration at United Kingdom health visiting policy level. In this study, the cultural dimension of care has been explored specifically in relation to health visiting the Punjabi mother and child. Other explorations are needed, including a consideration of the abilities and resources that health visitor educators, both college tutors and fieldwork teachers, need if appropriate educational preparation in transcultural health visiting practice is to be realized. More also needs to be known about

other cultural groups as well as other client groups within the British Punjabi population. For instance, there is scant health visiting related cultural knowledge regarding Britain's Chinese population, an ethnic minority group which lives in small as well as larger sized communities and which is ubiquitous throughout the United Kingdom. Other Punjabi client groups which need focusing upon are the elderly and the adolescent Punjabi populations. In addition, with four National Boards for Nursing, Midwifery and Health Visiting now in existence, more health visiting knowledge needs to be known about the various cultural groups within the four separate nations: England, Northern Ireland, Scotland and Wales.

Although health visitors were interviewed during the research fieldwork (several introducing the researcher to their Punjabi clients) and several child health clinics were attended, most of the data relating to the ethnic identity and background of the mothers in the study sample was gleaned during the researcher's independent visits to the families' homes and at the *gurdwara*. Therefore, a study is required to demonstrate the feasibility of health visitors discovering and utilizing, in everyday field practice, data relating to their clients' ethnic identity and background. Such a study might be one in which a group of health visitors received educational preparation in transcultural practice, including the use of ethnographic insights and approaches to the discovery of health visiting related cultural knowledge.

In this thesis, cultural knowledge relating to the client's ethnic identity and background has been demonstrated as intrinsic to accurate, appropriate and effective health visiting practice. Without such knowledge, the health visitor is unable to maintain professional standards in accordance with the code of professional conduct for health visitors. In contemporary Britain's

multi-cultural society, all clients of all cultural traditions nationwide should receive care that is sensitively attuned to their cultural traditions and values by health visitors proficient in so doing. However, for this aim to be achieved, an alternative to the unicultural perspective within which health visitors currently operate is required. This alternative perspective needs to be one in which the expertise of others outwith the health visiting service (e.g. anthropologists) is drawn upon. It also must be one in which health visitors at all levels, practice, educational, research and organizational, are encouraged affirmatively to develop expertise in, and knowledge pertaining to, the provision of culturally attuned health visiting care. The transcultural perspective is presented as such an alternative.

APPENDIX ONE

GLOSSARY

In compiling this glossary, the following sources have been drawn upon in addition to those stated:

- 1) Anwar 1979
- 2) Cragg 1978
- 3) Jeffery 1979
- 4) Nesbitt 1980
- 5) Saifullah-Khan 1974
- 6) Singh A. 1981
- 7) Singh Bhai M. 1895
- 8) Sykes 1976
- 9) Wilber 1964

The transliteration used in this appendix has been considered as acceptable by several members of the families who took part in the research study. Alternative spellings are bracketed.

ADI GRANTH

Lit. 'first collection'.

Granth – religious book or code, collection of religious writings.

The *Adi Granth* forms the first scriptures of the Sikhs. Compiled in 1604, the *Adi Granth* is written in *Gurmukhi*, a medieval Punjabi script. The *Dasam Granth* forms a subsequent collection compiled during the time of Guru Gobind Singh. Together they form the *Guru Granth Sahib*.

AKALI

Lit. 'a worshipper of the Timeless God' (Cole and Sambhi 1978:xviii). A strictly devout group of Sikh adherents who frequently wear the colours of Sikhism

(a vivid blue and saffron) and are to be seen protecting *gurdwaras* in India.

AMRIT

Lit. 'the water of life' or 'nectar'. Sanctified water used since the inauguration of the *Khalsa* in 1699 to initiate Sikh adherents into the faith. Stirred symbolically with a steel sword.

ARAIN (Rain)

A Muslim sub-caste. Traditionally employed in gardening or cultivating land for the production of vegetables. With increased affluence, some have become landowners (see Chapter Five).

AZAN (adhan)

Muslim call to prayer:

Come alive to prayer, come alive to good.
Better than to sleep is to pray.

The usual public summons from a mosque alerting the local population to read the *namaz*. Also the first words a newborn Muslim infant should hear – first into the right ear and then into the left – usually spoken by a male Muslim (see Ikramullah n.d. [1947–54]:54) and preferably a *hajji* or someone who has learnt the *Qur'an* by heart (a *hafiz*).

BABA

Honorific title. Used as a term of respect for Guru Nanak and for the *Guru Granth Sahib*. Also accorded to men of the Sikh faith who are considered to possess God-given powers of healing (faith healers).

BABA DA CUMRA

Meaning 'The Room of the Guru'. The room in which the Sikh congregational services are held. During these services, the *Guru Granth Sahib* is read – the Holy Scriptures being installed on a *palki* (stand) in front of the congregation.

BAISAKHI

Beginning of the Punjabi agricultural year when both the spring harvest and the festivities celebrating the new agricultural year take place. For the Sikhs, this is also the day when, in 1699, the *Khalsa* was inaugurated by Guru Gobind Singh. *Baisakh* is the first month of the Indian lunar calendar.

BETAK (bathaik)

The front room or parlour. The room in a home which is kept for receiving visitors for business or pleasure, especially for the use of the menfolk.

BHAJI

A gift, a present.

BHATRA

The name of a Punjabi sub-caste. One of the first South Asian groups to settle in the United Kingdom (see Chapter Five).

BINDI

A small circle – usually red-coloured – placed centrally on the forehead and only worn by married women (but not widows).

BIRADERI

A brotherhood – also fraternity, kindred. Usually composed of relatives who are outside the nuclear family and amongst whom a ‘brotherly’ sentiment, or a system of mutual relationships, is supposed to exist. Its boundaries tend to be imprecise. It may also extend to non-kin.

BRAHMAN

The priestly caste which ranks highest and is considered the purest of the classical four-fold Hindu *varna* (caste) system.

BRAJ BHASA

Bhasa – a dialect, language.

Braj Bhasa – A dialect of Hindu that was incorporated into the language that is known as *Urdu*.

BURQA

An over-garment which Muslim women wear to provide a more complete form of bodily protection in public places.

CHADDAR

A large shawl. A mantle.

CHALIA

Lit. 'the fortieth'. Used to denote the forty-day post-partum period kept by Sikh women. Alternatively known as the *sawa maheena* by Muslim mothers (see Chapter Seven). Also used for other forty-day periods when customary restrictions are imposed.

CHAPATTI

Unleavened bread baked (usually on a griddle) as a thin flat, round cake. Used to scoop up vegetables and stews.

CHAUNKA CHALIA

The ceremony which signifies that, and the time when, the post-partum woman is ritually clean enough to return to house and kitchen work again.

Chaunka – the area for cooking; kitchen work.

CHAURI

Flywhisk. Those used in Sikh religious services are wafted above the *Guru Granth Sahib* in a fashion similar to that accorded to Indian kings. The *chauri* usually consists of white hairs from the yak (or other animal).

CHULA (chul)

A cooking hearth. In the Sub-continent, each Punjabi household within the joint family compound will be referred to as a 'hearth'.

CHUNNI

A gauzy scarf worn with the *salwar-kameez* by Punjabi women and girls. Draped across the upper part of the body and over the head as a form of modesty when socially required. Also known as a *dupatta*.

CONGEE

A traditional Chinese weaning food specially prepared by boiling rice in a large quantity of watery meat broth (Tann and Wheeler 1980:22).

DABRA

A food specially prepared for the newly delivered mother during the post-partum period (see Chapter Seven).

DAHL

The split pea of the gram (or pulse) which is used frequently in making stews.

DAI

A Punjabi midwife (or nurse). From the Persian word *dayah*.

DEVANAGRI

Indian script which is used in the eastern part of the Punjab.

DEVI

Goddess. Title given to women of the Sikh faith who are considered to possess God-given powers of healing (faith healers). Also used by some Sikh women and girls instead of the title *Kaur*, if more euphonic to do so.

DIWALI

Festival of Lights. Held by Hindus on the day of the new moon of *Kartik* (i.e. Scorpio – thus during November) when the streets are illuminated and there is much rejoicing. Also celebrated by Sikhs as the day when Guru Hargobind (the sixth Guru) was released from Gwalior gaol.

DOAB

Lit. 'Two waters' (Persian). Intra-fluvial tracts of land (e.g. between the Beas and the Sutlej rivers).

DUPATTA

Chiffon or muslin scarf used by women to veil themselves. Same as *chunni*.

DURBAR SAHIB

'The Court of God' or 'The Lord's Service'. A Sikh religious gathering/assembly held in God's presence and before the *Guru Granth Sahib*. The *Guru Granth Sahib* was decreed by the last Guru, Gobind Singh, to become the eternal Guru, the everlasting embodiment of the 'Living Spirit' of the Gurus themselves, and is revered but not worshipped. *Durbar Sahib* is also used as an appellation for the Sikh temple at Amritsar.

EID

Islamic festival or holy day. *Eid-ul-fitr* marks the end of *Ramadan*. *Eid-ul-azha* (*Bakr-eid*) commemorates Abraham's (*Ibrahim's*) willingness to sacrifice his son Isaac (*Ishmael*). (See Jeffery 1976:183).

GARAM

Hot or heating. May be used to describe the weather, bodily conditions and food, but, regarding the latter, it does not include spiciness for which the term *masala* is used.

GARARA

A type of flared *salwar* (trousers) worn by Muslim women and girls on special occasions. Made of brocade or other expensive materials and based on Moghul court dress.

GHEE

Butter clarified by boiling.

GON

A song. May be used to describe a gathering where there is singing and celebration. Used for the all-female party given during the seventh (usually) or ninth month of pregnancy when *punjeeeri* is made specially and is given to the pregnant *Bhatra* woman by the guests (see Chapter Seven).

GORA

Lit. 'fair-skinned' (see Parry 1979:325). Punjabis use this adjective to refer to 'white' individuals/people.

GULABI

Lit. 'rose-coloured water' or 'rosewater'. The name of the ancestor of the *Landa* clan of the *Bhatra* Sikhs.

GUR

Juice of the sugar-cane, condensed into unrefined brown sugar.

GURDWARA

Lit. 'The place of the Guru'. The building in which the *Guru Granth Sahib* is installed and where congregational Sikh worship takes place. In Britain, this may be either a purpose-built or an adapted building. It is unacceptable for there to be a room directly above the room in which the *Guru Granth Sahib* is kept. Sikhs may use 'temple' or 'church' as English translations.

GURMUKHI

Lit. 'Proceeding from the mouth of the Guru'. A medieval script written from left to right, said to be a development of both the Devanagari script of Sanskrit and Hindi. Introduced by Guru Angad (the second Guru), it is the script in which the Sikh Scriptures originally were written.

GURU

A teacher, religious guide or leader, a revered man, a master. Title given to the ten founding fathers of the Sikh religion. Also used for 'God' (*Waheguru*) as well as for the Sikh Scriptures.

GURU GRANTH SAHIB

The Sikh Scriptures. (See *ADI GRANTH*).

HAJJ

Pilgrimage to Mecca and Medina. One of the five 'pillars', or duties, of Islam.

HAJJI

A male Muslim who has made the Islamic pilgrimage to Mecca and has thus performed *hajj*. A female Muslim who has performed *hajj* is known as a *hajjan*.

HAKIM

A physician – usually one who practises *Unani* medicine.

HALAL

Lawful, legitimate, having religious sanction. Used to describe meat that is from an animal which has been slaughtered according to Islamic prescription.

IMAM

Muslim religious leader.

IMBELI

The tamarind tree and the fruit of the same (*Tamarindus Indica* [L.]).

INUIT

Lit. 'the people'. The name by which the indigenous people of the Canadian arctic regions are known amongst themselves.

IZZAT (ijjat)

Honour, prestige, status.

JALLEE

A small net such as used by a Sikh boy to cover his hair when it is wound into a 'top-knot'. Also to cover a woman's hair when worn as a bun.

JAT

Use in reference to an endogamous sub-caste in Punjabi society. Because this term also assumes more fluid connotations (e.g in reference to clan, caste, tribe, nation), its usage may only become clear within the context of the conversation (Parry 1979:131).

KA'ABA

The cube-shaped holy shrine of Islam in Mecca towards which all Muslims face when they read the *namaz*.

KACHHA (Kachera)

Mid-thigh or knee-length shorts worn as undergarments by orthodox Sikhs as part of the five 'K's, or 'articles', of the Sikh faith. They were intended to replace the looser wrap-around garment (*dhoti*) and are said to be symbolic of sexual restraint.

KALIMAH

Word derived from '*kalam-allah*' meaning 'the word/speech of God'. Used for the proclamation of the Islamic faith:

La ilaha illallah Muhammad rasul allah.
There is no god but God (Allah) and Muhammad is his prophet.

KARA

Bracelet – usually of steel – worn on the right wrist as one of the five 'K's, or 'articles', of the Sikh faith.

KARELA

A bitter vegetable (*Mormodica Charantia*, Nat. Ord. *Cucurbitaccae* [L.]) – somewhat like a roughened cucumber in appearance.

KAUR

Princess. Appellation used by Sikh women and girls. Said to provide practical emphasis to the idea of distinctions of birth ceasing to have any value within Sikhism (Cole and Sambhi 1978:114).

KEDGEREE

Green *moong* beans and rice cooked together with butter – specially made for happy occasions.

KES

Uncut hair. One of the five 'K's, or 'articles', of the Sikh faith, both for men and for women.

KHALSA

Lit. 'The pure'. Name given to an individual Sikh who has been initiated into the faith, and who observes the rules laid down by Guru Gobind Singh – also the name used for the worldwide body of Sikhs.

KHANDA

A broad, straight, two-edged sword. Used in the symbol of Sikhism and worn by the *Akalis*.

KHANGA

A comb – usually wooden – worn in the hair by orthodox Sikhs as one of the five 'K's, or 'articles', of the Sikh faith.

KHATRI

Punjabi sub-caste (*jat*) to which all the Sikh Gurus belonged. Is within the *Kshatriya varna* or warrior caste. (See McLeod 1976:88–90).

KIRPAN

Curved sword worn by orthodox Sikh adherents as one of the five 'K's, or 'articles', of the Sikh faith. Sometimes a miniature replica will be worn, perhaps in the form of a religious necklet.

KOL (*Kajal*)

From the Hindi word *koela* meaning charcoal, coal. A type of black eye cosmetic – according to Ikramullah (n.d. [1947–54]:35), *kol (kajal)* is made from lamp soot which is prepared by burning specially perfumed oils, covering the flame with an earthen cup, from which the moist soot is then removed. Although similar to *surma*, *kol* glistens and is considered to be more alluring.

LANGAR

The corporate vegetarian meal that is provided free in the dining rooms at the Sikh *gurdwaras*. Started by Guru Amar Das (the third Guru) to remove caste and colour distinctions at a religious level. Also used as a term for the *gurdwara* dining room itself.

LOHRI

An Indian festival held in January (at the beginning of the Indian month of *Mag*) – kept particularly by families to whom a son has been born in the preceding year. Signifies the beginning of the Indian calendrical year.

LOTA

An earthen or metal vessel with a spout. Used for ablutions and personal hygiene.

LUNGI

A loose, wrap-around skirt-like garment worn by Punjabi men.

MATA DEVI

Mother Goddess. *Mata* (Mother) is a title of respect given to a *Devi* (Goddess).

MATA TAKON

The act of bowing before someone to whom one accords respect. As a term, it is used for:

- the act of bowing before the *Guru Granth Sahib* which all Sikhs who attend the congregational services at the *gurdwara* perform before taking their place in the congregation.

- the act of bowing before the *Guru Granth Sahib* by the post-partum *Bhatra* mother at the next service at the *gurdwara* following the fortieth day after childbirth. At this service, the post-partum mother is re-incorporated formally and publicly into the Sikh community.

- the act of bowing which married women, male children and menfolk perform before their elders as a token of respect. Married Sikh women bow before their affinal elders.

MAWLY (*mauli*)

Intertwined red and white threads which are used to tie the *schree* together, that is, the bundles of leaves which are hung across the door lintels in Sikh homes after the birth of a son. These threads are considered efficacious in

keeping away evil forces and may also be used on other joyful occasions.

NAMAZ

Prayer – especially the formalized prayers which are offered orthodoxly by Muslims five times a day and are one of the five ‘pillars’, or duties, of Islam.

PAKORA

A spicy eatable made of the flour of gram and fried in oil.

PANJ-AB

Panj – five. *ab* – waters. Lit. ‘The land of the five waters’. Geographical area in the north-west of the Indian Sub-continent between the rivers Indus and Sutlej.

PANJ PYARES

Lit. ‘five beloved ones’. First five Sikhs who were instituted into the *Khalsa* by Guru Gobind Singh on *Baisakhi* Day in 1699, having demonstrated their unconditional obedience and hence known as ‘saint-soldiers’. Also used for the five ‘pure Sikhs’ who initiate a candidate into the Sikh faith with *amrit*.

PANTH

A path, a way, a religious society or denomination. Also used for the worldwide body of Sikh believers.

PARANDIAN

Black or coloured threads, often with tassels, used to thicken or decorate the single long plait of hair worn by Punjabi women.

PARDA

Lit. curtain, screen, anything that conceals; privacy, modesty (Persian). The institution of purdah in which women’s social interaction with certain men is restricted by a multiplicity of means, e.g. separate living quarters, veiling the face (see Chapter Five).

PERCHAAVA

A shadow. Also to cast a shadow.

POORI

A thin round cake made of *chapatti* flour and fried in *ghee*.

PRASAD

Also known as *karah prasad*. The sacramental food that is blessed during the Sikh religious service and distributed by hand to the congregation. A sweet doughy mixture made of semolina, sugar and *ghee*. It is prepared in an iron bowl (*karah*) and cut with a *kirpan* during the concluding prayers.

PUNJEERI

A food specially prepared for post-partum mothers. Alternatively known as *dabra*. Recipes provided in Chapter Seven.

PURNMASHI

A fast held by Sikh wives in honour of their husbands with the intent of seeking sustained marital happiness – also in the hope of male progeny.

PUTKA

A piece of cloth that is worn by Sikh men and boys to cover their hair when it is wound into a 'top-knot' – may be worn under a turban.

PYJAMA

Slimmer version of the *salwar* (trousers) worn by Punjabi women and men.

QUOM

A tribe, nation, a sect, a caste (Arabic). Alternative word for *jat*. A term which is used in certain areas in the Punjab and usually with regard to sub-caste.

QUR'AN

Lit. 'recitation'. The sacred book of Islam. The written collection of the 'words' of Allah, as revealed to Muhammad in the seventh century and which form the doctrinal basis of Islam.

RAKHTI

Punjabi/Hindu festival held on the day of the full moon in the month of *Sawan* (i.e. Leo – thus during August) when sisters tie ornamental bracelets of

religio-cultural significance on the right wrists of their brothers. If sent by post (as happens in the United Kingdom), and should a sister or another female member of the natal family not be available, a daughter of the clan (see *'THEE-THIANI'* below) will be the one to do this. This practice emphasizes the life-long protection that brothers are expected to provide for their sisters.

RAJ

A kingdom, government, rule, dominion.

RAMADAN

The ninth month of the Islamic calendar which is organized around lunar months of about twenty-nine or thirty days, and thus shifts each year in relation to the solar calendar. This is the month when the prophet Muhammad is said to have received the first revelation and the month when Muslims will fast during the daylight hours.

ROTI

Unleavened bread (same as *chapatti*), sustenance, any substantial meal where *chapattis* are an essential part.

ROZA

Fasting, especially abstinence from eating, drinking, smoking and sexual intercourse between sunrise and sunset during *Ramadan*. One of the five 'pillars', or duties of, Islam.

RUCHYA

Amulet usually worn on a black thread.

SAKTI (shakti)

Power, ability, strength. Used as a cultic term for the worship of the Mother Goddess *Devi*, *Siva's* consort (otherwise known as *Parvati*, *Durga* or *Kali*).

SALWAR-KAMEEZ

Trousers (*salwar*) and tunic (*kameez*) worn as traditional Punjabi attire by women, men and children. In Britain, this outfit is often called a 'suit'.

SANT

A devotional tradition in India (to which Kabir belonged) which repudiated caste distinctions and idol worship. It is thought by certain scholars to have influenced Guru Nanak's teaching.

SAWA MAHEENA

Sawa – one and a quarter, or a quarter over the number immediately following.

Maheena – a lunar month.

Lit. 'one and a quarter lunar months' and, thereby, approximately thirty-seven days. Name given to the post-partum period by Muslim Punjabi women (see Chapter Seven).

SCHREE

Bundles of leaves hung across the door lintels of a Sikh home as a form of cultural protection, and announcement, when a son is born. These are hung across the lintel of the outside door of the home and of the door to the room where the infant is kept. Leaves used in the Punjab are said to be those of the *sarin* or siris tree (*Acacia speciosa* or *sirissa* [L.] – Nesbitt 1980:219). In the Beas basin in the Punjab, this tree is known as the *shiri* and, on the Punjabi Plains generally, as the *siris* or *siri* (Stewart 1869:55). In Britain, the *Bhatra* Sikhs use the leaves of the *Acuba japonica* (L.) and, although these leaves are unlike those of the acacia, they are plentiful, available and evergreen.

SHARIA

The Islamic judicial system.

SHARM

Shame, modesty, bashfulness. Often family and kinship honour depends on women (especially) maintaining this sense of *sharm*.

SHER-VALI

Sher – lion, tiger.

vali – belonging to

Lit. 'She who belongs to the tiger'. A goddess of the Hindu pantheon who is believed to be powerfully able to help those women who long to conceive a child/son, and/or those men and women who particularly seek continued health.

SHIA

One of the branches/sects of Islam which accepts Ali as the rightful successor to Muhammad, insomuch that he was his son-in-law, and which rejects the first three Caliphs: Abu Bakr, Omar and Usman. Approximately one tenth of the Muslims in Pakistan are *Shiites*.

SHISH

Lit. a learner, disciple (Sanskrit). The derivation of the word 'Sikh'. A follower of the religious movement created by Guru Nanak and the successive Gurus of Sikhism.

SINGH

A lion – metaphorically, a brave man. Name used by Sikh males since the inauguration of the *Khalsa* – said to give practical effect to the idea of distinctions of birth ceasing to have any value (Cole and Sambhi 1978:114).

SIVA

One of the supreme deities of Hinduism whose consort is known as *Parvati* (and, in her other forms of manifestation, as *Durga* and *Kali*).

SUBALA

Punjabi bridegroom's young male attendant – frequently a younger brother or another male relative. Rides on the horse with the groom during the wedding festivities.

SUNDH

Ginger.

SUNNI

Major branch of Islam to which most of the Muslims in Pakistan belong and who differ from the adherents of the *Shia* branch of Islam in that they believe that the Caliphate should be awarded on merit rather than genealogical closeness to Muhammad. Thus, they accept the first three Caliphs of Islam.

SURA

Chapter – as in the *Qur'an*.

SURMA

Black ter sulphide of antimony used to beautify the eyes – also to strengthen the nerves of the eyes and preserve sight. May be confused with sulphide of lead. Similar to *kol*.

SWAG PHAG

Swag (suhaag) – the happy state of marriage. Also the name given to ornaments that wives wear, but only when their husbands are alive.

Swag Phag is a fast sometimes kept by Sikh wives during either October or November (four days after the full moon of the Indian month of *Auso*) to ensure matrimonial bliss for their husbands.

THAGA

A thread. Black threads may be tied ceremonially round the wrists, ankles and/or waist of small children to provide cultural protection.

THEE-THIANI

'Daughter of the clan'. Term used by *Bhatra* Sikhs (see Chapter Six). Although on marriage a *Bhatra* Sikh woman joins the clan of her husband's family, she continues to be recognized as a daughter of her natal, patrilineal clan. As a daughter of the clan, she may be called upon to perform certain rituals (e.g. to hang the *schree*).

THANDA

Cold, cooling, mild. May be used regarding temperature, temperament or bodily condition.

THORIA

Also known as *okra* or lady's fingers. Tall malvaceous plant with mucilagenous seed pods. Used as a vegetable and for thickening stews.

THURGARAM

Tepid.

THURI

A streak of colour – invariably red – that is placed along the hair partings of married women.

TIKA

Lit. spot or blemish. A mark or spot, usually red-coloured, painted or placed on the centre of their forehead by married women. Also a jewelled pendant which hangs over the forehead and is worn by brides at their weddings and on other very special occasions.

UNANI

Lit. 'Greek'. Refers to the system of medicine traditionally associated with Muslims in India.

URDU

Lit. 'army' (Turkish). A hybrid language developed during the Mughal empire. Written from right to left in the Arabo-Persian script, it is the national language of Pakistan.

VARNA

Lit. 'colour'. A category within the four-fold hierarchical caste system which has been in existence in the Sub-continent since Aryan times. These castes are unilineal, endogamous descent groups which invariably are patrilineal. A belief in ritual purity pervades this system which is followed by Hindu

adherents. The four categories are:

Brahman – priestly caste

Kshatriya – warrior caste

Vaishya – mercantile caste

Sudra – cultivator caste.

VARTAN BHANJI

Bhaji – a gift, present. *Vartan* – dealing.

Lit. 'dealing in gifts'. A reciprocal gift exchange system (see Chapter Five).

VICHOLA

A go-between, an intermediary – for instance, for match-making purposes.

Usually a woman but may be a man.

VODI

A bride.

VURTH

A fast.

ZAKAT

Compulsory almsgiving – one of the five 'pillars', or duties, of Islam.

ZENANA

The part of a house reserved for the womenfolk (the women's quarters) which offers seclusion from the menfolk in compliance with the need to maintain purdah.

APPENDIX TWO

LIST OF SAMPLE MOTHERS AND OTHER INDIVIDUALS

AND FAMILIES INTERVIEWED

**LIST OF SAMPLE MOTHERS AND OTHER INDIVIDUALS
AND FAMILIES INTERVIEWED**

(All mothers are married and living with their husbands unless otherwise stated. Number of children refers to living children).

1) SAMPLE MOTHERS

Number	Relevant information
# 1.	23 year old Muslim mother with 2 children
# 2.	25 year old Muslim mother with 1 child
# 3.	29 year old Muslim mother with 1 child
# 4.	28 year old Muslim mother with 5 children
# 5.	23 year old Sikh mother with 2 children
# 6.	28 year old Muslim mother with 2 children
# 7.	29 year old Sikh mother with 3 children
# 8.	37 year old Sikh mother with 7 children
# 9.	26 year old Muslim mother with 2 children
# 10.	20 year old Sikh mother with 2 children
# 11.	18 year old Sikh mother with 1 child
# 12.	24 year old Muslim mother with 1 child
# 13.	36 year old Muslim mother with 5 children
# 14.	37 year old Muslim mother with 4 children
# 15.	27 year old Muslim mother with 3 children
# 16.	20 year old Sikh mother with 2 children
# 17.	24 year old Muslim mother with 2 children

1) SAMPLE MOTHERS CONTINUED

Number	Relevant information
# 18.	24 year old Muslim mother with 1 child
# 19.	20 year old Muslim mother with 1 child
# 20.	36 year old Muslim mother with 3 children
# 21.	27 year old Sikh mother with 4 children
# 22.	32 year old Sikh mother with 4 children
# 23.	23 year old Muslim mother with 3 children
# 24.	18 year old Muslim mother with 1 child
# 25.	27 year old Muslim mother with 2 children
# 26.	19 year old Muslim mother with 1 child
# 27.	40 year old Muslim mother with 2 children
# 28.	22 year old Muslim mother with 2 children
# 29.	24 year old Sikh mother with 3 children

2) OTHER INDIVIDUALS AND FAMILIES

Letter	
# A.	31 year old Sikh mother with 4 children
# B.	27 year old Sikh mother with 2 children
# C.	Young, separated Muslim mother with 1 child and living with older relatives
# D.	Young, divorced Muslim woman living with older relative
# E.	Long-established Muslim family
# F.	Middle-aged Muslim mother
# G.	32 year old Sikh mother with 2 children

2) OTHER INDIVIDUALS AND FAMILIES CONTINUED

Letter	Relevant information
# H.	Muslim family with 4 children
# I.	Muslim family with 1 child
# J.	Muslim mother with 2 children
# K.	Muslim father - also a religious leader
# L.	Asian female member of a community relations organization
# M.	Young Muslim woman from a long-established family
# N.	Separated, young Muslim wife living with another Muslim family

APPENDIX THREE

INTERVIEW SCHEDULE

Date _____

Number _____

Mother's age _____

country of birth _____

(if not Great Britain, how many years in Great Britain? _____)

Language ability

<u>Husband</u>				<u>Wife</u>		
<u>Spoken</u>	<u>Understood</u>	<u>Read</u>		<u>Spoken</u>	<u>Understood</u>	<u>Read</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Punjabi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urdu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bengali	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hindi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Does the husband like to be at home when the Health Visitor visits?

- Yes, always
- Yes, if he can
- Does not matter

Who makes decisions about:

Changes in the child's feeding? _____

If the child should go to the doctor or clinic?

Can you tell me a little about when and where your children were born?

	<u>Age</u>	<u>Boy/Girl</u>	<u>Place of birth Hospital/Home</u>	<u>Town/village Country</u>	<u>Comments</u>
1.					
2.					
3.					
4.					
5.					
6.					
7.					

2.

How do you feel about having your children immunized?

Whom would you talk with before having your children immunized?

Other members of the family	<input type="checkbox"/>
Friend	<input type="checkbox"/>
Health Visitor	<input type="checkbox"/>
G.P.	<input type="checkbox"/>
Hospital Doctor	<input type="checkbox"/>
Other person	<input type="checkbox"/>

Do you keep a written record of your children's immunization?

Yes, for all the children	<input type="checkbox"/>
Yes, for some of the children	<input type="checkbox"/>
No record kept	<input type="checkbox"/>

What diseases are you interested in having your youngest child immunized against?

Diphtheria	<input type="checkbox"/>
Tetanus	<input type="checkbox"/>
Whooping Cough	<input type="checkbox"/>
Polio	<input type="checkbox"/>
Measles	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>
Other	<input type="checkbox"/>
All offered	<input type="checkbox"/>

3.

How do you like to feed your babies?

Bottle	<input type="checkbox"/>
Breast	<input type="checkbox"/>
Both	<input type="checkbox"/>

How did you feed each baby and for how long a time?

	Bottle	Breast
1.	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>

Vitamins

Do/did you give vitamins?

Yes No

What kind and how often?

How old was your youngest child when you started giving him/her food?

What foods did you start with?

In what order is it usual for your family to eat?

Do you share the cooking with:

- no one else
- other members of the extended family
- landlord
- other

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

When a woman is pregnant, what foods would you suggest:

are good for her to eat? _____

she shouldn't eat? _____

If a mother wants to breast feed:

what foods would you suggest she eats? _____

why _____

what foods should she avoid taking? _____

why? _____

If a woman is pregnant, when do you feel is a good time to tell a doctor that she is pregnant? _____

why? _____

Which person in your family helped you most in caring for:

your first baby? _____

your last baby? _____

Do you ever go to anyone outside the family for advice on looking after your child's health?

- G.P.
- Hospital Doctor
- Doctor at the Health Clinic
- Health Visitor
- Chemist
- Friend
- Community worker
- Hakim
- Other

If you have been to antenatal classes, were they helpful?

5.

Has your youngest child had any check ups at the child health clinic/surgery?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

What sort of things did they check up on? _____

Has this child had a hearing test yet?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

Have you been asked about this child's eye-sight?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

After the baby is born and during the next year, are there any special ceremonies for the child or the mother that knowing about would help a Health Visitor to understand about special times that are important to the family?

Do you have any ideas about how we can offer better help to Asian people, especially parents who have young children or who are expecting a baby?

What is your religion? _____

What is your husband's work? _____

APPENDIX FOUR

LIST OF FOODS

LIST OF FOODS ACCORDING TO 'HOT-TEPID-COLD'/'

'GARAM-THURGARAM-THANDA' CLASSIFICATION

(As defined by families #7 and #29).

FAMILY #7

FAMILY #29

HOT/ THANDA

Pigeon meat
Crab
Nuts (esp. almonds
and pistachios)
Tea (hot or cold)
Ginger
Garlic

Eggs
Fish
Cauliflower
Peas
Lentils
Aubergine
Mango
Semolina

TEPID/ THURGARAM

Lamb
Chicken
Pork
Dahl
Rice (brown/white)
Minced meat

Almonds
Thoria (okra)

DRY

Peanuts
Cashew nuts

COLD/ THANDA

Yoghurt
Unsalted butter (*ghee*)
Roti/chapatti
Gram (pulses and flour)

Blackgram pepper
Chickpea
Tomato
Lettuce
Cabbage
Red beans
Chapatti flour
Butter
Peas
Green Pepper
Vegetable oil
Margarine

Pear
Cherry
Lemon
Grapes
Orange
Apple
Milk
Cheese
Rice

APPENDIX FIVE

JOURNAL PUBLICATIONS

Bringing culture into care

Susan Dobson explains why nurses should have a sound understanding of the concept of culture now that they are caring for the health needs of various ethnic groups in Britain

ASPECTS of care relating to ethnic minority groups are increasingly being included in British nursing textbooks. It is, however, important for us to remember that ethnic groups, whether minority or majority groups, are also culture-bearing groups. Nurses caring for patients and clients from various ethnic groups find themselves with the challenge of caring for and advising people whose beliefs, values and lifestyles may vary considerably from their own.

Together with various articles in the nursing press, Henley¹, and more recently Sampson and Mares^{2,3} have specifically provided us with a wealth of ethnic and cultural information that is of value to different aspects of nursing practice.

Even so, while our understanding and appreciation of details of cultural diversity have been greatly increased, there has been little focus on the underlying concept of culture. Yet, without a sound understanding of this concept, it can be all too easy to slip into the practice of compartmentalising areas of differences such as food, dress and religion, without seeking to understand how these areas relate to, even dovetail into, each other to form an integrated, composite and meaningful whole.

Essentially, the way we visualise the idea and meaning of 'culture', our own and others', is of fundamental importance to our practice of nursing care and our involvement in health education.

DEFINING 'CULTURE'

The term 'culture' has several meanings, but, as a concept relating to mankind, it has been defined and redefined, mainly by anthropologists. Concerned with the study of man and mankind in the widest sense, that is, both through time and throughout the world, anthropologists have offered succinct as well as more elaborate definitions.

One concise definition of culture is 'a blueprint for social living'⁴, but the



Photographs: Mike Abrahams/Network

meaning of culture is probably more clearly understood as:

'... the sum of *learned* knowledge and skills ... that distinguishes one community from another and which, subject to the vagaries of innovation and change, passes on in a recognisable form from generation to generation'⁵.

This definition reminds us that a culture must be viewed not only as dynamic, but also as socially inherited. From infancy onwards we learn to think, act and react in certain ways, and without realising it we develop an understanding of, and are socialised into, behaving in culturally appropriate ways.

Our culture can be viewed as our 'way of life'⁶, and as such it encompasses both the major and the minor aspects of

life. 'The small intimate habits of everyday life, such as the way of preparing and eating food, or of hushing a child to sleep'⁷ are as much a part of our culture as our language, our moral values, our political practices and the beliefs we hold relating to health and illness.

If a patient suffers from a condition such as diabetes mellitus, we may readily think to ask about cultural dietary norms, for instance, what foods are generally eaten and how foods are classified. Does the person follow one of the various 'hot' and 'cold' systems of food classification that are used in certain parts of the world?

There are, however, other factors such as our understanding and use of spatial distances, time and even colours,

which are all culturally learnt and are often just as significant in relation to how we feel and the way we live. As an example, for many Indians white is a colour frequently worn by widows, and to be sick in a ward where nursing staff wear white uniforms may be as disturbing for them as it would be for many other patients in Britain to be cared for by nurses wearing black uniforms.

Although we may readily acknowledge the fact that other people will view 'their world' differently from the way we view our own, we may not really be conscious of what these differences are. If we were



asked to describe and discuss our own culture we would probably find it easy enough to explain part of it, the part of which we are conscious and which we can make explicit to others

It is the 'hidden' aspects, those areas of which we are not so aware but which are still important, that are difficult to convey to others, because in fact we seldom realise that we are constantly thinking, behaving and reacting in what are almost automatic yet culturally determined ways.

THE CULTURAL DIMENSION

The importance of cultural understanding to sound and relevant nursing care and advice has long been acknowledged. In 1894, when talking about health teaching, Florence Nightingale pointed out that:

'It is a truism to say that the women who teach in India must know the language, the religions, superstitions, and customs of the women to be taught in India. It ought to be a truism to say the

very same for England'⁸.

The cultural dimension to nursing practice, however, has been and often is largely ignored. Sometimes, I suggest, it is because the person we are caring for is from the same cultural background as our own, and we *assume* our 'ways of life' to be very similar; at other times it is because we *presume* that a person from another cultural background will understand and accept the importance of the nursing goals we have decided upon, and our plans for achieving them.

For the most part, I feel that many nurses only narrowly understand the concept of culture and, as they are unsure of how to collect, piece together and use cultural information, it is easier to recoil from and even to ignore altogether this dimension to nursing practice.

Another possible reason why the culture concept has generally been resisted is that it 'throws doubts on many established beliefs'⁹. Anthropologists have frequently pointed out that by studying and learning from other cultural groups we become more conscious of our own culture, and for many people this can be an unsettling experience.

As nurses, we are frequently involved in promoting change in a patient's or a client's behaviour, and it is sometimes hard to accept that our culturally rooted ideas are not necessarily seen as being quite so ideal as we may think they are by others whose backgrounds are culturally different from our own.

Many nurses working in Britain have moved from place to place and many have lived in other parts of the world. They know what it is like to learn to adjust to certain areas of the culture which belongs to their chosen place of work, but nevertheless they find themselves retaining many of their own cultural ways and values, invariably because it feels very uncomfortable to do otherwise.

This can often be a useful experience, for while we may find ourselves recognising that there are many equally satisfactory and satisfying ways of rearing children, organising family life, expressing sexuality, preparing and cooking food and so forth, we may still have no wish to change all our own ways, which indeed seem to serve us well.

By being interested and actively involved in discovering more about the concept of culture, and developing cultural awareness in our work as



nurses, we can widen our appreciation of broad patterns of human behaviour and also focus on more specific areas of cultural knowledge.

We might choose to focus our attention on how different cultural groups care for their sick members, or perhaps explore what beliefs and ideas other cultures—or even our own—have about the parts of our body and the functions they serve. To discover the ideas held by members of our own family can be a revelation in itself!

Exploring and making discoveries about cultural beliefs, ideas and activities is a fascinating occupation; but it is more than that, for it can help us to look afresh at our work and perhaps question and refashion our nursing philosophies as well as our practical goals.

PLANNING CULTURALLY RELEVANT CARE

Nurses have many opportunities to learn about the cultural backgrounds of the people they care for, whether the work is in a hospital or in other areas of a



community. Gradually, by asking relevant questions, listening and watching, we can piece together information which helps us to see a little more clearly what life is like and what it means to the person we are trying to help.

Developing cultural insight does not necessarily involve more nursing time with patients or clients, but it does mean that we need to use our time constructively.

Greater understanding of the cultural aspects of difficulties that the person may be facing should increase rather than detract from our ability to plan appropriate care. Even if we are unable to alter the care we are offering, being able to discuss problems with cultural understanding can help in itself to put a distressed mind more at ease.

Not only are people individuals within their own culture, but cultures themselves also vary and change, and to rely on standard descriptions of different cultures found in various texts, though helpful, may at times be misleading. Nurses need to be able to acquire this

cultural knowledge themselves, and it is this ability that the nursing profession needs to encourage in all fields of practice.

It would be interesting to know just how much use we make of the various departments of anthropology that are located throughout the country, and which are centres of expertise in developing in others a deeper and broader understanding of the concept of culture as well as cross-cultural interviewing and observational skills.

Brownlee's text¹⁰ is one of the few that offers practical advice to health workers, nurses included, on how to acquire relevant cultural information. It has been written so that it can be used by nurses working in cross-cultural situations, whether in their own countries or elsewhere, as well as by those wishing to gain greater insight into aspects of their own culture.

CONCLUSION

Having developed an understanding of the concept of culture and mastered

skills in cultural assessment, we then need to take up the challenge of pursuing ways of tailoring nursing care and advice to try and make it as culturally relevant and acceptable as possible. Such a blending of cultural factors into care is vitally important if we are to bring greater quality to our nursing practice: quality that would indirectly reveal itself through care studies published in British nursing journals.

To date, published studies demonstrating warmly and vividly how cultural, particularly minority ethno-cultural, factors can be woven into nursing care and advice are few in number.

Nurses already conversant with this type of approach to their work have possibly been reticent in sharing their experiences and nursing practices with others in print; but, more seriously, I believe this paucity of cross-cultural nursing care studies reflects a more fundamental omission of the cultural dimension in nursing educational curricula which urgently needs to be rectified. **NT**

REFERENCES

- ¹Henley, A. *Asian Patients in Hospital and at Home*. London: King Edward's Hospital Fund for London.
- ²Sampson, C. *The Neglected Ethic: Religious and cultural factors in the care of patients*. London: McGraw-Hill Book Co (UK) Ltd., 1982.
- ³Mares, P. *The Vietnamese in Britain: a handbook for health workers*. Health Education Council and the National Extension College, Cambridge, 1982.
- ⁴Paul, B. The role of beliefs and customs in sanitation programs. *American Journal of Public Health*, 1958; 48:11, 1502-1506. Also in: Landy, D. (ed) *Culture, Disease and Healing: Studies in medical anthropology*. New York: Macmillan Publishing Co. Inc., 1977, 233.
- ⁵Lewis, I. M. *Social Anthropology in Perspective*. Harmondsworth: Penguin Books, 1976, 17.
- ⁶Eliot, T. S. *Notes Towards the Definition of Culture*. London: Faber and Faber, 1948, 41.
- ⁷Mead, M. *Cultural Patterns and Technological Change*. Paris: UNESCO, 1953, 9-10.
- ⁸Nightingale, F. Health teaching in towns and villages. Rural hygiene. In: *Selected Writings of Florence Nightingale*. Seymour, L. R. (compiler). New York: The Macmillan Publishing Co. Inc., 1954, 379.
- ⁹Hall, E. *The Silent Language*. Connecticut: Fawcett Publications Inc., 1959, 50.
- ¹⁰Brownlee, A. T. *Community, Culture and Care—a cross-cultural guide for health workers*. St Louis: C. V. Mosby Co., 1978.

BIBLIOGRAPHY

- Kitzinger, S. Body fantasies. *New Society* 1972; 21: 510, 12-13.
- Leininger, M. *Nursing and Anthropology: Two worlds to blend*. New York: John Wiley and Sons Inc., 1970.
- Paul, B. (ed) *Health, Culture and Community*. New York: Russell Sage Foundation, 1955.
- Spradley, J. P. *Participant Observation*. New York: Holt, Rinehart, and Winston, 1980.

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Under a Punjabi sky

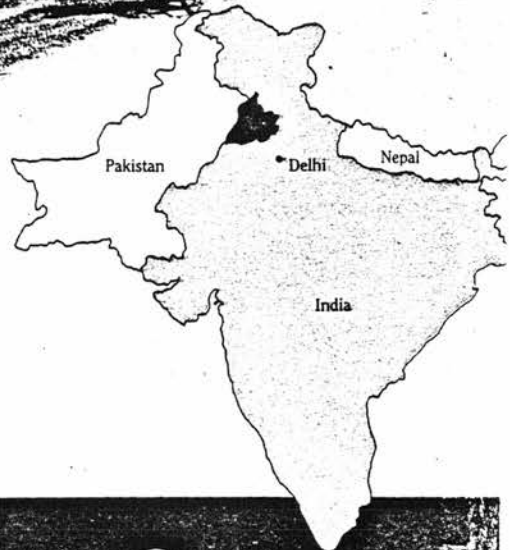
In a multiracial society, it is essential that community nurses develop a greater understanding of the health needs of cultural minority groups. Susan Dobson travelled to India and Pakistan to learn more about Punjabi culture



View of the countryside near Sialkot Pakistan



A village fair on Baisakhi day near Ludhiana, India



Colourful foodstore in Old Lahore, Pakistan



Punjabi lady lighting the hearth to make tea — Lahore

BREAKING BARRIERS

OUTSIDE, brightly-clad Sikh men and women are beginning to travel along to the nearby *gurdwara* or Sikh temple, some cycling or walking in groups, others on tractor-drawn wagons. Baisakhi* day has begun and even the birds as they sing their morning chorus seem to know rejoicing is in the air. This is rural India and it is harvest time on the Punjabi plains. All around, the wheatfields glow golden in the sun and one has a sense of being in the very lap of nature.

Two weeks previously, in another Punjabi village, a group of traditional midwives or *dais* were attending a programme which aimed to develop their skills and knowledge. I listened as they exchanged ideas and experiences. With the help of a hospital-trained midwife they were considering alternative ways of coping with the various problems of village midwifery. This time I was in Pakistan.

Geographically, the Punjab or 'the land of the five rivers' spans the Indo-Pakistani border. It is a vast, fertile plain which, over the centuries, has received the initial brunt of numerous armies seeking to conquer the subcontinent. It is here that the Punjabi culture has evolved, its people learning to be both resilient and adaptable.

My study in Britain looks at the role of the health visitor in multicultural situations, focusing specifically on Punjabi mothers and children. Over half of the Indians and Pakistanis in Britain are Punjabis² and, though religious adherence is a divisive factor, a similar underlying social structure exists, uniting the two groups in many ways.

Having visited Punjabi families in Britain, both Muslim and Sikh, I felt that they related to three cultural dimensions: the Punjabi culture of the subcontinent, the 'British' culture and also an Anglo-Punjabi culture, a synthesis of the first two dimensions. While I was familiar with the 'British' culture and also increasingly with the Anglo-Punjabi culture, I realised that I knew very little about the Punjabi culture, and that a visit to the Punjab would help me analyse my research findings more confidently.

As 'family guests'³ among ethnic minority groups, health visitors and

other community nurses have unique opportunities to learn about other ways of life and to develop culturally appropriate forms of care⁴. Language difficulties are frequently cited as barriers to understanding but, even when they are not present, it is all too easy for us, as nurses, to remain ethnocentric in our approach. That is, without necessarily meaning to do so, we may rate other people's cultural ways less favourably than our own, an attitude which inevitably influences our judgements and decisions.

Our culture represents a 'shared system of meanings'⁵. We learn, revise, maintain and define them, initially unconsciously and later in life more consciously, as we interact with others in both formal and informal situations. When one cultural group comes into contact with another and develops a degree of interdependence, certain cultural elements are often changed; temporarily or even permanently.

Adjustments may be made to certain cultural features, for instance, clothing and diet, while others, such as deeply cherished values, may be carefully insulated from modification and confrontation⁶. In this way, cross-cultural interaction is achieved without undue disruption, allowing a cultural equilibrium to be maintained.

I chose an ethnographic approach for my research study as I felt it would enable me to gain greater cultural insight into aspects such as diet, hygiene and the care of the pregnant woman, as well as into how these aspects fuse into one another and become parts of a cultural whole. This approach to nursing research is one where we seek to discover through interviewing and participant-observation the other person's '... point of view, his relation to life, to realise his vision of his world.'⁷

In this way, we do more than study people; we in fact learn from them, not only how they structure their lives and what hopes they have, but also what cultural restrictions may influence their health care, as well as the type of advice that may be counter-productive. Subsequently, we can discover more about the relevance of our nursing care and advice.

It has been said about India and her peoples that: '... it is not enough to read about it in books, or see it on the cinema screen, or hear someone talk

about it. It has to be a personal experience...'⁸

As an adjunct to my study, this visit was planned to be a 'living' insight into physical, social and economic environments from which Punjabi families in Britain have come and to which they still relate. I was particularly interested in learning about the minutiae of family life, such as cooking, home-keeping, childbearing and health care, in both urban and rural settings. I also wanted to know more about the varying ways in which religion is expressed in daily life. Certainly in most of the homes I have visited, both Muslim and Sikh, a religious script or picture hangs on the wall, and in Pakistan each day begins with the sound of the call to prayer from a nearby mosque.

Most casual visitors to the subcontinent see only the man's world. The lives of the womenfolk, in which I am interested, are less readily visible. In a society where women are socially secluded, a female researcher from another country may be allowed, as an outsider, to mix with the menfolk and yet also be allowed to join in the women's world⁹. While I have found this to be so, people have often made a point of finding me a female travelling 'companion' and, interestingly, when I have been encouraged to take an afternoon rest during visits to various villages, an older lady has come to watch over me. In a part of the world where women do not usually travel alone, I have felt more appropriately dressed in the *salwar-kameez*, the tunic and trouser outfits that, together with the *dupatta* or scarf, are the traditional dress worn by Punjabi women.

On the whole, I have stayed in hostels belonging either to the YWCA or to mission hospitals which, being both reputable and relatively inexpensive, have proved ideal for my needs. At the end of a hot and busy day, I was able to find the peace and tranquillity needed to reflect on the day's activities.

A microcassette tape recorder has been invaluable. As it is readily portable, I have used it both to dictate my impressions and to record conversations. Not only has it reduced the amount of time I would have spent making notes, but it has allowed me to record mothers singing cradle songs, sounds of the countryside and religious singing and chanting in churches and *gurdwaras*.

As a visual record, photographs offer

* Baisakhi day celebrates the beginning of the first month of the Punjabi farming calendar as well as being of particular significance to the Sikh faith¹.

BREAKING BARRIERS

additional opportunities to reconsider aspects of daily life and to make further comparisons between lifestyles and environments¹⁰. As people have been so eager to be photographed, my seemingly adequate photographic supplies have been far from sufficient! Photography, together with tape recording, permits visual and auditory impressions to add greater realism to the overall cultural picture of life that is being 'painted'.

My visit began in March. I arrived in Delhi at seven o'clock in the morning; the city had woken up and people were beginning to make their devotions at the various temples and gurdwaras. I made my way to the offices of the YWCA of India where the staff helped me both to reconsider my itinerary in the light of the political disturbances in the Indian Punjab and to settle into life in a subtropical climate.

Delhi has a large Punjabi community and here, as in other urban and rural locations, I have met a variety of people who have shared their time, thoughts and ideas with me, speaking either in English or through people willing to interpret. My research study in Britain was almost entirely among English-speaking Punjabi families, and the fact that I am not conversant with any of the languages of the subcontinent has been a frequent source of frustration. On the other hand, it has meant that I have concentrated even more carefully on non-verbal communication as well as surrounding environmental features which I might otherwise have missed.

From Delhi I flew to Lahore, a city dating back to the 15th century which used to be the administrative capital of the Punjab before Partition in 1947. The old city still preserves many of its traditional values, and time spent looking around the colourful bazaar is ideal for observing economic aspects of people's daily lives at close quarters.

I spent several days visiting homes in a poorer district of the city with the staff of a mother-and-child health centre. This proved a valuable opportunity to learn about the types of care available for pregnant mothers and families with young children, as well as the unmet needs of many disabled people. I was later able to add to this knowledge in and around Sialkot and Ludhiana.

The greater part of the Punjabi population lives in the villages. Here, as in towns and cities, people can turn to a

IN PUNJABI HOSPITALS, IT IS USUAL FOR A FAMILY MEMBER TO STAY WITH A PATIENT MOST OF THE DAY AND NIGHT

variety of health care practitioners. 'Western' as well as various traditional forms of health care, such as Ayurveda and Unani, are readily available. In addition, a variety of hospital-based community health care programmes take preventive and curative health care into the very heart of the countryside. Community health workers, nurses and medical interns have taken me with them as they have visited from house to house, and several village leaders including a Pakistani Christian pastor have shown me around their villages. In Pakistan, Christianity is a minority faith, most hospitals having a mosque rather than a chapel for patients and staff to use.

Discussions with nursing and medical personnel have covered topics such as infant bonding, maternal mortality, prenatal nutrition and medical education in community health. I have spent time reflecting on the ways in which nursing practice in both hospital and the community is culturally determined. In Punjabi hospitals, it is usual for a family member to stay with a patient most of the day and night, and nurses are well accustomed to their presence. What tremendous opportunities there are for encouraging family interest and participation in health care practices!

In Pakistan, to conform to rules of female modesty, nurses wear the *salwar-kameez*. Though less acceptable as a style of uniform in British hospitals, I could not help but feel that they not only looked feminine, but the style seemed eminently practical for nursing activities.

A five-week visit offers but a glimpse into Punjabi life. I shall be taking away with me a vast kaleidoscope of memories and impressions ranging from a newborn baby letting the world know it is alive, to discussions on the status of women in a strongly patriarchal society.

Ethnic minorities have been part of British society for a long time¹¹, yet only in recent years has the nursing profession begun to take an active interest in the cultural aspects of its service and in offering nurse learners a sound understanding of the relevance of culture to nursing care.

I believe the ethnographic approach to research is one that nurses, who are continually observers and interviewers in their professional working lives, would find both valuable and easy to comprehend, and particularly useful for those interested in developing greater understanding of the health needs of cultural minority groups.

While my visit has been specifically to enhance and enrich my research data, adding greater personal confidence to the analysis of my findings, I feel that visits similar to mine, if encouraged more by nurse educators and others, would help to build up greater international understanding within the nursing profession, and might bring a wider range of innovative ideas to nursing.

NT

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REFERENCES

- ¹ Eglar, Z. *A Punjabi Village in Pakistan*. New York: Columbia University Press, 1960, 203.
- ² Singh, R. Punjabi culture in Britain. *The Asian* 1980; 3: 6/7, 3.
- ³ Karsenas, P. The health visitor — family guest and host. In: Rees, C. (ed) *The Health Needs of Ethnic Groups*. Report of a symposium. University Hospital of Wales, Cardiff, September 11, 1980, 1.
- ⁴ Dobson, S.M. Bringing culture into care. *Nursing Times* 1983; 79: 6, 57.
- ⁵ Spradley, J.P. *The Ethnographic Interview*. New York: Holt, Rinehart and Winston, 1979, 6.
- ⁶ Barth, F. (ed) *Ethnic Groups and Boundaries — The Social Organization of Culture Difference*. London: George Allen and Unwin, 1969, 16.
- ⁷ Malinowski, B. *Argonauts of the Western Pacific*. London: Routledge and Kegan Paul, 1922, 25.
- ⁸ Singh K. *I Shall Not Hear the Nightingale*. London: John Calder Ltd., 1959, 101.
- ⁹ Papanek, H. The woman field worker in a purdah society. *Human Organization* 1964; 23: 160.
- ¹⁰ Collier, J. *Visual Anthropology: Photography as a Research Method*. New York: Holt, Rinehart and Winston, 1967, 5.
- ¹¹ Eyles, J. Black and British. *The Geographical Magazine* 1982; 54: 5: 282-283.

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Ethnography: a tool for learning

Susan Dobson

Although the question of including ethnographic studies in nursing curricula is seldom discussed in the British nursing literature, the need for such perspectives is recognised. Developed and used imaginatively, small-scale projects based on ethnographic research methods can help to provide the experience needed for developing cultural awareness and sensitivity amongst nurse learners. A wealth of texts, mostly in the field of social anthropology, exist which provide insight into this approach to cultural discovery.

While ethnic diversity has been an accepted feature of society in the UK throughout the 20th century, it is only in the 1980s that the British nursing profession has begun to recognise that skills in discovering and blending cultural knowledge with patient care are essential to nursing practice. Since then, not only has the nursing literature increasingly considered the lifestyles of Britain's various ethno-cultural groups (e.g. Sampson 1982), but nursing institutions have begun to include multi-cultural 'approaches to learning' (Sharman 1985) in their curricula. Even so, very little discussion as to how cultural understanding is being taught, or of the exchange of such ideas and experiences, is to be found in British nursing journals or textbooks. Ideas put forward by Burrows (1983), who advocates the need for 'ethnographic perspectives', and Calery (1984) are among the few.

ETHNOGRAPHY

What is ethnography and how might it be usefully adapted as a tool for learning? As a

term, ethnography is used to describe both the activity of cultural data collecting and the description of the cultures themselves (Ellen 1984). A well-established approach to gaining cultural knowledge and understanding, ethnography traditionally involves long-term immersion in a cultural setting. Basic to anthropology, and more recently to sociology, participant observation and ethnographic interviewing are methods central to this type of research fieldwork.

Rather than studying people, ethnographers *learn* from people (Spradley 1979) and, dependent on what aspect of a culture is being focused upon, those who are most able to provide relevant knowledge are selected. No one part of a culture, for instance child-rearing practices, is alienated from the whole; the wider cultural context always needs to be considered. Indeed, not only may the 'part' never be entirely divorced from the 'whole', but the overall structure of a culture is frequently found mirrored in the very minutiae of life. With the accent on gathering the 'richest data possible' (Lofland 1984), ethnographers use various modes of participation, observation and interviewing either independently or concurrently. However, because ethnography is rooted in everyday living, various circumstantial limitations (e.g. sampling frames)

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inevitably occur and have to be accepted; the attributes and shortcomings of this approach to cultural discovery are well summarised by Robertson and Boyle (1984).

While observation, participation and interviewing are skills which are central to nursing care, as ethnographic methods they take on a cultural emphasis. How then are these three methods defined by ethnographers? Briefly, ethnographic participation involves attending cultural functions and interacting with the people whose culture is under observation. Observational activities, however, focus both on the behaviour of the members of the cultural group chosen and the settings and circumstances in which such behaviours take place. Finally, because it is important that a respondent should express his or her ideas with ease, ethnographic interviewing assumes a style that is flexible and informal. Even so, an interview schedule is frequently used to guide certain conversations as well as to record baseline data, such as age, parity and religious affiliation.

Not only does the use of photography, maps, life histories, tape recordings and the collection of relevant artifacts add to the understanding of a culture through audio-visual and biographical approaches, but also, such an eclectic approach to cultural discovery allows scope for ingenuity and creativity (Collier 1967; Crane and Angrosino 1974; Leininger 1985). Thus cradle songs may be recorded and photographs may provide a visual record and act as a conversational focus to promote further discussion. In addition, maps and plans may help to substantiate other cultural information, such as why certain health-care facilities seem to be used more by some families than others and how rooms in a home are apportioned and their use by individual family members.

How a cultural group visualises their 'world' is also intimately linked to how they describe it. For example, through a series of ethnographic interviews, Rousseau (1983) was able to explore what foods a group of Scottish schoolchildren rated as either a snack (colloquially, a 'playpiece') or a meal, and why. The emergent idea that eating must not interfere

with playing highlighted how different the child's view of food consumption may be from that of an adult. Such an approach to eliciting a linguistically based cultural analysis can be used to discover a wide range of cultural data and is well explained by Spradley (1979).

MINI-ETHNOGRAPHY

The inclusion of a mini- or small-scale ethnography which allowed sufficient insight without being too unwieldy is one possible approach to developing cultural awareness and sensitivity in nursing and health visiting education. Whether such a project is undertaken by an individual student or as a group project (Baker & Mayer 1982), the student nurse or health visitor should have the opportunity to develop in-depth understanding, not only in collecting cultural data but also in becoming adept at making culturally sensitive nursing decisions and in offering guidance that is culturally acceptable. As a project during health visitor training, this might conceivably become one of the mandatory field studies.

By its very nature, nursing offers its practitioners numerous opportunities to learn about their clients' and patients' lifestyles. In the home visiting component of their work, health visitors (and other community-based nurses) have ideal opportunities to develop a store of cultural knowledge, that is, given insight into what types of observations and discussions will reap the greatest rewards within the setting of their culture. Brownlee's (1978) text, which follows a 'What-Why-How' format, provides a fund of ideas on health-related topics to draw upon for planning cultural observations and interviews. In my own fieldwork amongst Punjabi mothers in a British city (in which I considered the maternal and child health remit of the health visitor), ethnographic approaches provided me with both knowledge and a rapport that would have been invaluable had I been the families' health visitor.

Although a small-scale study will only provide a narrowly focused appreciation of a cultural lifestyle, to an extent 'a common cul-

ture is reflected in practically every person, event and artifact belonging to a common system' (Hongmann 1970). Thus, even at a research level, a mini-ethnography (Leininger 1985) can be justified as being culturally significant. However, as an educational tool for in-depth cultural discovery, a mini-ethnography would combine a practical experience in understanding cultural diversity with an appreciation for qualitative research methods.

While most ethnographic texts consider large-scale research studies, adapting ethnographic methods to small-scale dimensions involves a similar chain of activities but with a limited focus of inquiry, a smaller number of respondents and a shorter time span. A useful guide is offered by Spradley & McCurdy (1972):

1. *Acquiring conceptual tools* This involves understanding the concept of 'culture' and becoming acquainted with some of the field methods.
2. *Entering the field* A cultural setting and focus are chosen. Possible informants are then identified and approached.
3. *Doing fieldwork* Cultural data is collected, recorded and considered.
4. *Describing the culture* The total data is analysed and a cultural description is produced.

While each student would work through each phase, the type of data that they would collect would depend on whether they were part of a group project or working alone. In a group project, different students could each concentrate on collecting a different and selected type of data. Thus, if the project focused on child-rearing practices, one student might collect information regarding infant feeding practices, while another might take photographs of the various ways in which children are handled and played with (cf. Mead & MacGregor 1978). For a project undertaken by an individual student, an in-depth study of the cultural lifestyle of one patient or client, whether in hospital or at home, might be considered. This could be based on a series of ethnographic interviews.

PROJECT CONSIDERATIONS

Ethnography should not be viewed only as a means by which members of a majority culture can discover the ways of a minority culture. Ethnographic methods and techniques are in no way culture-specific. However, it is helpful in developing cultural awareness, to study a cultural lifestyle that is sufficiently dissimilar from one's own; the eye and mind more readily perceiving the differences between cultures than the similarities. Certainly this is usually so until one is accustomed to perceiving what cultural features are salient and how these might be covertly as well overtly expressed in everyday situations.

The need for cultural understanding in British nursing practice is often linked with the need for racial understanding. Invariably this focuses on white-majority nurses needing to consider the ethnocentricity of their professional values and approaches to practice when caring for black-minority patients and clients. However, the nursing profession itself is both multi-racial and multi-cultural. Both black nurses and white nurses care for patients and clients from all racial and ethno-cultural backgrounds. Hence, cultural understanding requires a multi-directional perspective and cultural inclusion in nursing curricula should be planned with no one racio-cultural direction in mind. Programmes initiated to develop cultural understanding should be targetted such that racial differences are not a prime feature but consequent on the choice of cultural group selected for projects within the programme. Nevertheless, the opportunity to encourage both racial and cultural understanding can be usefully combined.

With sufficient cultural diversity existing within both white and black racial groups in Britain, the wide choice of cultural groups make a mini-ethnography a feasible project for student nurses and health visitors throughout the country. Numerous choices also exist regarding the focus of inquiry, allowing the student to pursue his or her own line of interest. Baker

& Mayer (1982), for instance, provide a succinct list of topics, relating them to 'meeting man's basic human needs'. Mares *et al.* (1985) offer another which specifically relates to the ethnic minority communities in Britain. Thus, the scope on which to base mini-ethnographic projects is extensive, both culturally and thematically.

CONCLUSION

While the importance of cultural understanding in nursing care is accepted nationally, how is this being encouraged and achieved? The British nursing literature certainly has not been a forum for this type of discussion. Ethnographic perspectives have been recommended, but how can they be learnt and become part of a qualified nurse's repertoire of approaches to practice? Used imaginatively, I suggest ethnography can be developed as a tool for learning. Indeed, small-scale ethnographic projects could provide nurse learners with direct experience both in gaining health-related cultural knowledge and in becoming sensitive to cultural cues. Students of all cultural heritages would have the opportunity to be purposefully involved in cultural discovery. At the same time, a much needed store of nursing-related cultural knowledge would be generated.

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References

- Baker C G, Mayer G G 1982 One approach to teaching cultural similarities and differences. *Journal of Nursing Education* 121 (4): 17-22
- Brownlee A T 1978 Community, culture, and care: a cross-cultural guide for health workers. CV Mosby, St Louis
- Burrows A 1983 Patient-centred nursing care in a multi-racial society: the relevance of ethnographic perspectives in nursing curricula. *Journal of Advanced Nursing* 8 (6): 477-485
- Callery P 1984 Communication across the cultures - a learning unit. *Nurse Education Today* 3 (5): 118-119
- Collier J 1967 Visual anthropology: photography as a research method. Holt, Rinehart and Winston, New York
- Crane J G, Angrosino M V 1974 Field projects in anthropology: A student handbook. General Learning Press, Morristown, New Jersey
- Ellen R F (ed) 1984 Ethnographic research: a guide to general conduct, ASA research methods in social anthropology 1. Academic Press, London
- Honigsmann J J 1970 Sampling in ethnographic field work. In: Naroll R, Cohen R (eds) A handbook of method in cultural anthropology. Columbia University Press, New York
- Leininger M (ed) 1985 Qualitative research methods in nursing. Grune and Stratton, Orlando, Florida
- Lofland J, Lofland L H 1984 Analyzing social settings: A guide to qualitative observation and analysis. Wadsworth Publishing Company, Belmont, California
- Mares P, Henley A et al 1985 Health care in multiracial Britain. Health Education Council/National Extension College, Cambridge
- Mead M, MacGregor F C 1978 Growth and culture: A photographic study of Balinese childhood (conclusions). In: Polhemus T (ed) Social aspects of the human body. Penguin Books, Harmondsworth, 37-50
- Robertson M H B, Boyle J S 1984 Ethnography: contributions to nursing research. *Journal of Advanced Nursing* 9 (1): 43-49
- Rousseau N 1983 Give us a playpiece, please; not lectures! *The Journal of the Royal Society of Health* 103 (3): 104-111
- Sampson A C 1982 The neglected ethic: cultural and religious factors in the care of patients. McGraw-Hill Book Company (UK), Maidenhead
- Sharman R L 1985 Ethnic minority groups: a discussion paper on curriculum development in health visiting. English National Board for Nursing, Midwifery and Health Visiting, London
- Spradley J P 1979 The ethnographic interview. Holt, Rinehart and Winston, New York
- Spradley J P, McCurdy D W 1972 The cultural experience: ethnography in complex society. Science Research Associates, Chicago

Cultural Value Awareness: Glimpses into a Punjabi Mother's World

SUSAN DOBSON

Summary

Drawing upon findings of a descriptive study of 29 Punjabi mothers in a British city, cultural values are discussed with regard to the health visitor's maternal and child health remit. It is advocated that cultural value awareness should be an essential component of health visiting education and practice.

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Introduction

'The effective professional is the one who is equipped with knowledge and appreciation of diversity in values and beliefs . . . who can use this awareness to look critically at her own cultural values.'¹ For health visiting to consider itself a truly responsive service, the need to consider cultural values

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would seem to be mandatory. Yet, despite being fundamental to the practice of health visiting, cultural value awareness is a topic that has received surprisingly little discussion in the health visiting literature.

Cultural values can be defined as 'enduring beliefs'², abstract ideals which are accepted, implicitly or explicitly, by members of a social group and which subsequently become determinants of the group members' behaviour³. Such values become integrated into coherent value systems with ranking of values within these systems. Conceptually, values imply a sense of worth and are set apart from non-enduring beliefs, in that we choose our values from alternatives, cherish them and are willing to act upon them publicly^{4,5}. Most of us, however, seldom reflect on what we are valuing or why we consider one value, whether cultural, professional or personal, to be more important than another.

Ostensibly, the health visiting service seeks to help others to find culturally satisfying levels of health and well-being at a

personal and family level, as well as at a societal level. This being so, cultural value awareness should not be viewed as a dominant cultural group considering the ways and values of an ethnic minority group but, instead, it should take on a more multi-directional perspective, acknowledging the fact that the health visiting profession is multi-cultural itself. Thus, cultural value awareness becomes a basic prerequisite for practice, not only in areas with sizeable ethnic minority communities, but also countrywide.

An ethnographic study

In choosing to study a small group of Punjabi families, my intent was to understand more about the health visitor's maternal and child health remit in multi-cultural situations. By utilising an ethnographic approach to data collection and analysis, I was able to paint a picture of a Punjabi mother's child bearing and child rearing career, looking at the initial concern for fecundity and various aspects of pregnancy

and childbirth, as well as factors relating to child rearing in a Punjabi home. My aim was not only to elicit cultural features relating to aspects of maternal and child health, but also to look further into how these unfolded and intertwined within the wider cultural scene.

In reality, a Punjabi cultural lifestyle not only shapes the Punjabi mother's world, but is maintained within the social expectations of the dominant non-Punjabi society, with a certain blending and alignment of the two, often differing, approaches to life. In analysing my findings, it was possible to draw out cultural values that subsumed the various stages within a Punjabi mother's reproductive career. These predominantly relate to authority (senior-junior), gender (male-female), cultural purity (pure-impure) and concern for cultural danger and vulnerability.

Altogether, I visited a total of 47 homes in a city with a widely dispersed Punjabi population. These included 29 families with at least one child under five years of age, as well as other families and individuals. As I chose to interview English speaking Punjabi families, I seldom needed the assistance of an interpreter. Thus, my findings can be seen to have general relevance for situations where linguistic barriers can no longer be claimed to impede inter-cultural understanding.

The families belonged to both Islamic and Sikh faiths, with religious artifacts visible in every home. While the Sikh families were mostly from the *Bhatra* sub-caste, the Muslim families varied. In both these communities, sub-castes are not connected with the Hindu notion of a hierarchy based on levels of cultural purity but, nevertheless, do carry importance with regard to group loyalty and marital alliances.

Underlying cultural values: male-female

Basically, Punjabi society is patriarchal, that is, male authority dominates and a prevailing notion of male *izzat* (honour) encompasses both the idea of dominance within the family (whether joint or nuclear) and the ability to protect and provide for their female kin. The importance of male progeny for maintaining such a system means that the birth of a son is especially welcomed and, indeed, actively sought after. For instance, as well as offering their initial prayers to the Sikh gurus, on the day of the full moon of the month when the birthday of the founder of the Sikh faith is celebrated, many *Bhatra* families keep the fast of *Purnmashi* (often for a whole year) in the hope of being blessed with a son. Whenever a son is born, the *schree* (bunches of leaves from the *Acuba japonica*) are hung over the doorways.

Together with the notion of *izzat*, a parallel idea of *sharm* (a sense of shame or modesty) permeates the Punjabi social fabric. For instance, in order that no doubt should be cast on either paternity or the possibility of female sexual impropriety, women are enjoined to uphold varying forms and degrees of modesty. Thus, sex-

ually discreet clothing is preferred, as are various forms of sexual segregation, both within the home and in public. Yet, while adhering to such rules of female modesty may raise the family's status in the eyes of the Punjabi community, it may also evoke unnecessary loneliness, the wider non-Punjabi society not being attuned to such a lifestyle. Even where preferred levels are relaxed in public settings, such as health clinics and maternity hospitals, this may still be a cause for unease. The same value accounts for the reason why acceptance of a male health visitor is unusual, particularly as far as home visiting is concerned.

Approximately half of the babies born to the 29 mothers in my study had been breast-fed for a varying period of time, declining over the first six to eight weeks post-partum. Thereafter, only male infants and those born to a mother with a traumatic obstetric history were breast-fed. While my findings remain tentative, being based on recall as well as relating to a relatively small sample of mothers, Dosanjh⁶ also found that male infants were breast-fed for a longer period of time than were female infants in his study amongst Punjabi mothers in Nottingham and Derby.

Underlying cultural values: senior-junior

Authority within the family usually runs parallel with seniority. While the most senior woman in the family invariably will be subordinate to a male member of the family, young wives (particularly in joint family households) are subject to the authority of their mothers-in-law. While such a system provides a known structure on which to rely in time of need, it can also be the cause of dissension and unhappiness. However, it is worth remembering that although dissatisfactions may be more readily voiced, intergenerational love and caring are often less openly or powerfully stated.

During pregnancy, a Punjabi wife hopes to be able to turn to her mother-in-law for guidance and, if she is not available, an expectant mother may feel bereft. Indeed, as the mother-in-law is often seen as carrying the responsibility of ensuring that a daughter-in-law's pregnancy proceeds satisfactorily, health visitors would need to understand more about the beliefs and practices held by the more senior women-folk and, in fact, work within these ideas.

Amongst the *Bhatra* families, *punjeeri* (also known as *dabra*) is a food that mothers-in-law make for their pregnant daughters-in-law during either the seventh or the ninth month of pregnancy (never the eighth, as this is considered inauspicious). Although recipes for *punjeeri* vary, the basic ingredients tend to consist of *ghee* (clarified butter), sugar, *chapatti* flour and various nuts, such as almonds and pistachios. An all-female party (*a gon*), to which married and unmarried women are invited, is held, the mother-in-law being responsible for both organising and financ-

ing the party. During the *gon*, each guest places a portion of *punjeeri* into the expectant mother's *dupatta* (chiffon head covering) which she holds out in her lap in readiness. According to Punjabi food categories, which draw upon traditional Hindu (Ayurvedic) beliefs, food substances are recognised as having 'hot' and 'cold' qualities, which relate to the effects they have on the body, rather than the temperature or taste of the food itself. As pregnancy is considered a culturally 'hot' bodily condition, 'hot' food substances are only taken in moderation lest they 'overheat' the body and so disturb the pregnancy⁸. Being a culturally 'hot' food substance, very little *punjeeri* is eaten until after the baby is born, when it is considered to help a post-partum mother to regain her strength.

Only Muslim wives speak of turning to their own mothers for help after childbirth. Amongst the *Bhatra* families, a newly delivered mother would never consider returning to her natal home, as this would bring *sharm* to her natal kin. Consequently, she is even more dependent on the advice of her in-laws, both antenatally and post-natally. Once the mother has returned home after the birth, a *Bhatra* mother-in-law initially is expected to sleep in the same room as her daughter-in-law, in order to help her care for the baby. Generally, reliance on knowledge imparted from female family members would appear to be held in high regard. Indeed, this may account for why only three of these Punjabi mothers had ever attended antenatal classes, not only in the British city in which my study was based, but in the eight other towns and cities throughout the country where these mothers lived during their various pregnancies.

Underlying cultural values: pure-impure

The *chalia* (the customary 40-day post-partum period, also known by the Muslim families as the *sawa maheena*) is kept by the mothers if at all possible. This is a time when a newly delivered mother is considered to be culturally 'unclean' or 'impure'. Although one young Muslim mother laughingly commented that she did not know anyone who had kept the *sawa maheena*, many families (including all the *Bhatra* families) recognise the cultural need to take ritual baths at differing times throughout this time. With all births taking place in hospital, the most ritually impure time no longer occurs in the home.

In addition to baths or showers taken for physical cleanliness, ritual baths are taken by the *Bhatra* mothers. The baby also receives ritual baths, with both mother and baby progressively becoming culturally 'purer' with each ritual bath. Once the mother is considered to be physically strong enough to return to work in the house and kitchen again, the ritual bath known as the *chaunka chalia* is taken, often on the thirteenth or twenty-first day post-partum. On the fortieth day, the last ritual bath is taken and both the mother and the baby attend

the *gurdwara* (the Sikh temple) to present themselves publicly before God and thus become actively incorporated into the Sikh community once again.

Amongst the Muslim families, during the *sawa maheena* (literally, 'one and a quarter lunar months'), the post-partum mother is forbidden to touch the *Qur'an*, although she may listen to it being read. Nor may she read the *namaz*, the formalised prayers which orthodox Muslims offer five times a day. Although few women attend the mosque, it is considered acceptable for a post-partum mother to do so once she has stopped bleeding vaginally and if she has bathed beforehand. For a Muslim baby, the scalp hair will be shaved on approximately the seventh day, having become culturally 'unclean' or polluted during the process of childbirth. While in Britain this hair is then thrown away, in the Punjab it will be placed somewhere that is considered to be culturally 'clean', such as in the rafters of the home or in a river. Thus, childbirth is considered an impure time in a woman's life, and various ceremonies must be performed to reduce this cultural impurity for both the mother and the baby.

Concern for cultural danger and vulnerability

A strong awareness of the notion of cultural danger and vulnerability is threaded throughout much of Punjabi life, being especially important with regard to pregnancy, childbirth and infancy. The powers of extraneous influences such as the 'evil' or 'powerful' eye are included in the various influences which families with a newborn infant should be concerned about. While no one in my study imparted a sense of fear or dread with regard to such influences, many did consider that a degree of caution is necessary to ensure that adequate protection is provided.

In the Indian sub-continent, eyes (including the 'third eye' which is considered to be located in the centre of the forehead) are believed to be able to 'transmit various emotions and functions of the mind', including envy and malice⁹. Various methods are recognised as being potent enough to divert such powers, including the use of the colour red. Infants are known to be par-

ticularly vulnerable and, because of this, *Bhatta* mothers will ensure that their newborn babies keep the *chulla* (the 40 day post-partum period) more strictly than they do for themselves. Likewise, a fetus is also vulnerable and, during pregnancy, a pregnant mother will endeavour to ensure that she keeps away from anyone who has recently miscarried, lest cultural harm should adversely affect the pregnancy.

Not only does the *schree* (the bunches of leaves hung across the doorways) act as a form of announcement that a male Sikh infant has been born, but it is also a form of protection which helps to cast away any evil. The leaves are tied together with orange-red threads and hung over the door to the room where the baby is being cared for, as well as over the main door of the house. While some families may not be unduly concerned about protecting a baby from danger of this type, should misfortune occur, a mother will often reflect on and possibly attribute such misfortune to failing to take adequate care. However, the contravention of customs is considered (as one mother described it) as being 'spiteful to the family with the baby'.

Clarifying our values

While intriguing in itself, gaining knowledge about various cultural groups and their lifestyles may have little effect on our practice if such information is 'interpreted in the light of old beliefs'¹⁰. Understandably, looking beyond our own ethnocentric outlook is always difficult to achieve. Yet, if we are to offer a culturally relevant and economically viable health visiting service, it would seem to be an important and necessary asset.

By aligning various Punjabi practices regarding pregnancy and childbirth with the values that pervade a Punjabi cultural lifestyle, I hope to have emphasised that such an approach offers greater insight on which health visiting decisions and guidance can be more realistically made. However, the very activity of considering the values of another cultural group invariably brings us face to face with our own values.

As well as being a salutary experience in itself, I believe that, as health visitors, we need to clarify our values more frequently,

that is, on a more structured basis and certainly during health visitor training. What values are we employed to uphold and why? What cultural values do we hold as individuals and how do they influence the way in which we practise or intend to practise professionally? Can we be flexible and really consider how other cultural groups view what they consider to be important in life and subsequently discuss their views sympathetically? Are our own views in fact fettered by our inability, possibly unwillingness, to accept other cultural lifestyles as both meaningful and coherent? Standing back and looking anew at both our own cultural values and those of other cultural groups is surely fundamental to health visiting practice and, I suggest, should therefore be more openly considered and included in basic and post-basic health visitor education.

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References

1. Mares P *et al.* Health Care in Multiracial Britain. Health Education Council/National Extension College, Cambridge, 1985.
2. Rokeach M. The Nature of Human Values. The Free Press, New York, 1973.
3. Bock K. Modern Cultural Anthropology. Alfred A Knopf, New York, 1974.
4. Rath L E *et al.* Values and Teaching: Working with Values in the Classroom. Charles E Merrill Publishing Company, Columbus, Ohio, 1978.
5. McFarlane J. Nursing values and nursing action. *Nursing Times*, Occasional Papers, vol 78, no 28: 109-112.
6. Dosanjh J S. A Comparative Study of Punjabi and English Child Rearing Practices with Special Reference to Lower Juniors (7-9 years). Unpublished PhD thesis, University of Nottingham, 1976.
7. Homans H. A Question of Balance: Asian and British Women's Perceptions of Food during Pregnancy. In Murrill A (ed) *The Sociology of Food and Eating*. Gower Publishing Company Ltd, Aldershot, 1983.
8. Nichter M, Nichter M. The Ethnophysiology and Folk Diets of Pregnancy: A Case Study from South India. *Human Organisation*, vol 42, no 3, 235-246.
9. Maloney C (ed). *The Evil Eye*. Columbia University Press, New York, 1976.
10. Jaffe Ruiz M C. Open-Closed Mindedness, Intolerance of Ambiguity and Nursing Faculty Attitudes toward Culturally Different Patients. *Nursing Research*, 1981, vol 30, no 3, 177-181.

REFERENCES

- ABBAS Valerie 1981 *A Theoretical Examination of the Factors involved in Health Education with Ethnic Minority Groups*, Unpublished dissertation for the Diploma in Health Education, University of Leeds, England.
- ABRAHAM Rachel 1982 'Some Observations on Gujarati Diet and Pregnancy', *Health Visitor*, Vol. 55, No. 8, pp. 421,423,426.
- ADORNO T.W.
FRENKEL-BRUNSWIK Else
LEVINSON Daniel J.
SANFORD R. Nevitt 1950 *The Authoritarian Personality*, Harper and Row, New York.
- AFFONSO Dyanne D. 1984 'Postpartum depression', in *Perinatal Nursing*, Recent Advances in Nursing, Vol. 8, pp. 146-177, Ed. P. Field, Churchill Livingstone, Edinburgh.
- AGAR Michael H. 1980 *The Professional Stranger : An Informal Introduction to Ethnography*, Academic Press, New York.
- AGGLETON Peter
CHALMERS Helen 1984 'Models and Theories', *Nursing Times*, Vol. 80, No. 36, pp. 24-28.
- AICHLMAYER Rita H. 1969 'Cultural Understanding : A Key to Acceptance', *Nursing Outlook*, Vol. 17, No. 7, pp. 20-23.
- ALEXANDER Brenda 1974 'Help for immigrant families', *Nursing Times*, Vol.70, No. 17, pp. 632-636.
- ALEXANDER Effie P. 1983 'A health visitor's study of a mother and baby using the model for nursing', in *Using a model for Nursing*, pp. 52-67, Eds. N. Roper, W. Logan and A. Tierney, Churchill Livingstone, Edinburgh.
- ANDERSON Gwen
TIGHE Bridget 1973 'Gypsy Culture and Health Care', *American Journal of Nursing*, Vol. 73, No. 2, pp. 282-285.
- ANONYMOUS 1980 Personal communication – Health professional.
- 1986 Personal communication – Female Punjabi living in Britain.

- ANTONOVSKY Aaron 1979 *Health, Stress, and Coping*,
First edition, Jossey-Bass Publishers,
San Francisco, CA, U.S.A..
- ANWAR Muhammad 1979 *The Myth of Return : Pakistanis in Britain*,
Heinemann Educational Books, London.
- ARDENER Shirley 1984 'Gender orientations in fieldwork',
in *Ethnographic Research : A Guide to
General Conduct, A.S.A. Research Methods
in Social Anthropology -1*, pp. 118-129,
Ed. R. F. Ellen, Academic Press, London.
- ATKINSON Jean 1971 *Handbook for Interviewers*,
Office of Population Censuses and Surveys
Social Survey Division, H.M.S.O., London.
- ATTARIWALA Rajinder 1977 'Asian children and school meals in the UK -
a question of choice',
Journal of Human Nutrition, Vol. 31, No. 4,
pp. 251-255.
- AULD Margaret G. 1979 'Nursing in a changing society',
Journal of Advanced Nursing, Vol. 4, No. 3,
pp. 287-298.
- AURORA G.S. 1967 *The New Frontiersmen : A Sociological Study
of Indian Immigrants in the United Kingdom*,
Popular Prakashan, Bombay, India.
- BAHL Veena 1981 'Stop Rickets Campaign',
Nutrition and Food Science, No. 70, pp. 2-5.
- BAKER Alma W.
COOK Gwen S. 1983 'Stress, Adaptation, and the Black Individual:
Implications for Nursing Education',
Journal of Nursing Education, Vol. 22, No. 6,
pp. 237-242.
- BALLARD Roger 1972 'Family Organisation among the Sikhs in
Britain',
New Community, Vol. 2, No. 1, pp. 12-24.
- 1979 'Ethnic Minorities and the Social Services',
in *Minority Families in Britain : Support and
Stress*, pp. 147-164, Ed. V. Saifullah-Khan,
The Macmillan Press Ltd., London.
- 1983 'The context and consequences of migration
: Jullundur and Mirpur compared',
New Community, Vol. 11, Nos. 1/2,
pp. 117-136.
- [1983] *The Implications of Cultural Diversity for
Medical Practice : an Anthropological
Perspective*,
Mimeograph, Leeds.

- BALLARD Roger
BALLARD Catherine 1977 'The Sikhs : The Development of South Asian Settlements in Britain',
in *Between Two Cultures : Migrants and Minorities in Britain*, pp. 21-56,
Ed. J. L. Watson, Basil Blackwell, Oxford.
- BALY Monica E. 1984 *Professional Responsibility*,
Second edition,
John Wiley and Sons, Chichester, England.
- BARNARD Alan
GOOD Anthony 1984 *Research Practices in the Study of Kinship*,
Academic Press, London.
- BARTH Fredrik 1969 'Introduction',
in *Ethnic Groups and Boundaries : The Social Organization of Culture Difference*, pp. 9-38,
Ed. F. Barth, Scandinavian University Books, Oslo, Norway.
- BARTHOLET Mary N. 1968 'Effects of Color on the Dynamics of Patient Care',
Nursing Outlook, Vol. 16, No. 10, pp. 51-53.
- BATESON Gregory 1958 *Naven*,
Second edition, Stanford University Press,
Stanford, CA, U.S.A..
- BEARD Patricia 1982 'Contraception in Ethnic Minority Groups in Bedford',
Health Visitor, Vol. 55, No. 8, pp. 417,420-421.
- BELL Roger T. 1968 'The Indian Background',
in *New Backgrounds : The Immigrant Child at Home and at School*, pp. 51-69,
Ed. R. Oakley, Oxford University Press,
London.
- BENDER Donald R. 1967 'A Refinement of the Concept of Household : Families, Co-residence, and Domestic Functions',
American Anthropologist, Vol. 69, No. 5,
pp. 493-504.
- BENNER Patricia 1984 *From Novice to Expert : Excellence and Power in Clinical Nursing Practice*,
Addison-Wesley Publishing Company, Menlo Park, CA, U.S.A.
- BERREMAN Gerald D. 1962 *Behind Many Masks : Ethnography and Impression Management in a Himalayan Village*,
Monograph No. 4, The Society for Applied Anthropology, Ithaca, NY, U.S.A..

- BÉTEILLE André 1975 'The Tribulations of Fieldwork',
in *Encounter and Experience : Personal
Accounts of Fieldwork*, pp. 99-113,
Ed. A. Beteille and T. Madan, Vikas
Publishing House P.V.T. Ltd., Delhi, India.
- BHADURI Reba 1979 'A family's sorrow',
Nursing Times, Vol. 75, No. 15, pp. 638-639.
- BHANUMATHI Patinhara 1977 'Nurses' Conceptions of "Sick Role" and
"Good Patient" Behaviour : a Cross-Cultural
Comparison',
International Nursing Review, Vol. 24, No. 1,
pp. 20-24.
- BIRREN Faber 1978 *Color and Human Response*,
Van Nostrand Reinhold Company, New York.
- BOCK Philip K. 1974 *Modern Cultural Anthropology : An
Introduction*,
Second edition, Alfred A. Knopf, New York.
- BOISSEVAIN Jeremy 1974 *Friends of Friends : Networks, Manipulators
and Coalitions*,
Basil Blackwell, Oxford.
- BONAPARTE Beverly H. 1979 'Ego Defensiveness, Open-Closed
Mindedness, and Nurses' Attitude toward
Culturally Different Patients',
Nursing Research, Vol. 28, No. 3,
pp. 166-172.
- BOOTH Charles
(ed.) 1892 *Life and Labour of the People in London*,
Vols. 1-3, Macmillan and Co., London.
- BOTT Elizabeth 1957 *Family and Social Network*,
Tavistock Publications Ltd., London.
- BOWER Fay L. 1982 *The Process of Planning Nursing Care :
Nursing Practice Models*,
Third edition, The C.V. Mosby Company,
St Louis, MO, U.S.A..
- BRAIN Jean
MARTIN Molly D. 1983 *Child Care and Health for Nursery Nurses*,
Second edition, Hulton Educational,
Amersham, England.
- 1985 *An Examination Guide for Nursery Nurses*,
Hulton Educational, Amersham, England.
- BRANCH Marie F.
PAXTON Phyllis P.
(eds.) 1976 *Providing Safe Nursing Care for Ethnic
People of Color*,
Appleton-Century-Crofts, New York.

- BRANDL M.
TILLEY E. 1981 'Marching to a different drum : The uses of anthropology in the Belyuen Health Centre, Northern Territory of Australia', *The Australasian Nurses Journal*, Vol. 10, No. 9, pp. 24-31.
- BRENT
(BRENT COMMUNITY HEALTH COUNCIL) 1981 *Black People and the Health Service*, Brent Community Health Council, London.
- BRIGGS Jean L. 1970 *Never in Anger : Portrait of an Eskimo Family*, Harvard University Press, Cambridge, MA, U.S.A..
- BRIM John A.
SPAIN David H. 1974 *Research Design in Anthropology : Paradigms and Pragmatics in the Testing of Hypotheses*, Holt, Rinehart and Winston, New York.
- BRINK Pamela J.
(ed.) 1976 *Transcultural Nursing : A Book of Readings*, Prentice-Hall, Inc., Englewood Cliffs, NJ, U.S.A..
- BRODIE Alex 1984a 'Pakistan to devalue its women', *The Guardian*, Saturday, 28th July, p. 6.
1984b 'Women "will not suffer in Islamic law"', *The Guardian*, Monday, 30th July, p. 6.
- BROWN Alison 1981 'Planning for blacks in Britain', *Town and Country Planning*, Vol. 50, No. 2, pp. 48-51.
- BROWN Esther L. 1948 *Nursing for the Future*, Russell Sage Foundation, New York, U.S.A..
1964 *Newer Dimensions of Patient Care : Patients as People (Part 3)*, Russell Sage Foundation, New York, U.S.A..
- BROWN John 1970 *The Un-Melting Pot : An English Town and its Immigrants*, Macmillan, London.
- BROWN Roger 1965 *Social Psychology*, The Free Press, New York.
- BROWNLEE Ann T. 1978 *Community, Culture, and Care : A Cross-Cultural Guide for Health Workers*, The C.V. Mosby Company, St Louis, MO, U.S.A..

- BRUBAKER Beryl H. 1983 'Health Promotion : A Linguistic Analysis',
Advances in Nursing Science,
Vol. 5, No. 3, pp. 1-14.
- BRYANT Gillian M.
DAVIES Kathleen J.
NEWCOMBE Robert G. 1979 'Standardisation of the Denver
Developmental Screening Test for Cardiff
Children',
*Developmental Medicine and Child
Neurology*, Vol. 21, No. 3, pp. 353-364.
- BULMER Martin 1980 'On the feasibility of identifying "race" and
"ethnicity" in censuses and surveys',
New Community, Vol. 8, Nos. 1/2, pp. 3-16.
- BUNTING Anne 1984 'Asian women and contraception',
Senior Nurse, Vol. 1, No. 29, pp. 12,14,16.
- BURGEST David R.
(ed.) 1982 *Social Work Practice with Minorities*,
The Scarecrow Press, Inc., Metuchen, NJ,
U.S.A..
- BURRELL-DAVIS Leila
WILLIAMS W.M. 1984 'Health Visitor Manpower Survey 1979-1981',
Health Visitor, Vol. 57, No. 1, pp. 9-14.
- BURROWS Alison 1983 'Patient-centred nursing care in a
multi-racial society : the relevance of
ethnographic perspectives in nursing
curricula',
Journal of Advanced Nursing, Vol. 8, No. 6,
pp. 477-485.
- BURTONWOOD Neil 1984 'Multicultural education : education for a
multicultural society or multicultural
individuals?',
New Community, Vol. 11, No. 3, pp. 278-279.
- BUSH Helen A. 1979 'Models for Nursing',
Advances in Nursing Science,
Vol. 1, No. 2, pp. 13-21.
- BUSHNELL Jeanette M. 1982 'Beliefs about Pregnancy and Childbirth of
Quinault Indian Women',
in *Proceedings of the Seventh Annual
Transcultural Nursing Conference*,
held in Seattle in 1981,
pp. 22-28, Eds. C. and J. Uhl,
The Transcultural Nursing Society, University
of Utah, Salt Lake City, UT, U.S.A..

- BYERLY Elizabeth Lee 1976 'The Nurse-Researcher as Participant-Observer in a Nursing Setting', in *Transcultural Nursing : A Book of Readings*, pp. 143-162, Ed. P. Brink, Prentice-Hall, Englewood Cliffs, NJ, U.S.A..
- BYRNE Marjorie L.
THOMPSON Lida F. 1978 *Key Concepts for the Study and Practice of Nursing*, Second Edition, The C.V. Mosby Company, St Louis, MO, U.S.A..
- CAPEL Lesley M. 1978 'Health Visiting : where do we go from here?', *Nursing Mirror*, Vol. 147, No. 8, pp. 36-38.
- CARNEVALI Doris L. 1983 *Nursing Care Planning : Diagnosis and Management*, Third Edition, J.B. Lippincott Company, Philadelphia, PA, U.S.A..
- 1984 'The Diagnostic Reasoning Process', in *Diagnostic Reasoning in Nursing*, pp. 25-56, Eds. D.Carnevali, P. Mitchell, N. Woods and C. Tanner, J.B. Lippincott Company, Philadelphia, PA, U.S.A..
- CARPIO Barbara 1981 'The Adolescent Immigrant', *The Canadian Nurse*, Vol. 77, No. 3, pp. 27,30-31.
- C.E.T.H.V.
(COUNCIL FOR THE EDUCATION AND TRAINING OF HEALTH VISITORS)
- [1973] *The Function of the Health Visitor*, Pamphlet published by C.E.T.H.V., London.
- 1977 *An Investigation into the Principles of Health Visiting*, C.E.T.H.V., London.
- 1980 *The Investigation Debate : A Commentary on An Investigation into the Principles of Health Visiting*, C.E.T.H.V., London.
- 1981 *Report of the Working Party on Curriculum Development*, C.E.T.H.V., London.

C.E.T.H.V.

(COUNCIL FOR THE EDUCATION AND TRAINING OF HEALTH VISITORS)

[1982a] *Health Visiting - Working towards health in the community*,
Pamphlet published by the C.E.T.H.V., London.

[1982b] *What Do Health Visitors Do?*
Pamphlet published by the C.E.T.H.V., London.

CHAPMAN Christine M.

1972 'Clarify the Concepts!',
Nursing Times, Vol. 68, No. 25, pp. 775-776.

1976a 'The Use of Sociological Theories and Models in Nursing',
Journal of Advanced Nursing, Vol. 1, No. 2, pp. 111-127.

1976b 'Constructing Theories in Nursing',
Paper published in the Report of the fourth Open Conference of the Association of Integrated and Degree Courses in Nursing, entitled: *Developing a Theory of Nursing*, held at the University of Hull, England, 9-11th July 1976, pp. 2-8.

1980 'The Rights and Responsibilities of Nurses and Patients',
Journal of Advanced Nursing, Vol. 5, No. 2, pp. 127-134.

1985 *Theory of Nursing : Practical Application*,
Harper and Row, London.

CHARSLEY Simon

1985 'Marriage Rites in one's own Society : The Problem of Meaning',
Paper presented at the A.S.A. Conference entitled: *Anthropology at Home*, held at the University of Keele, England on 26th March 1985.

CHILDREN AND YOUNG PERSONS ACT

1932 22 and 23, George 5, Chapter 46.

1933 23, George 5, Chapter 12.

CHIN Robert

1961 'The Utility of System Models and Developmental Models for Practitioners',
in *The Planning of Change : Readings in the Applied Behavioral Sciences*, pp. 201-214,
Eds. W. Bennis, K. Benne and R. Chin,
Holt, Rinehart and Winston, New York.

- CHRISMAN Noel J. 1982 'Anthropology in Nursing : An exploration of adaptation',
in *Clinically Applied Anthropology : Anthropologists in Health Science Settings*, pp. 117-140,
Eds. N. Chrisman and T. Maretzki,
D. Reidel Publishing Company, Dordrecht, Holland.
- CHRISTENSEN Paula J. 1986 'Planning: Priorities, Goals, and Objectives',
in *Nursing Process : Application of Theories, Frameworks, and Models*, pp. 169-182,
Eds. J. Griffith-Kenney and P. Christensen,
The C.V. Mosby Company, St Louis, MO, U.S.A..
- CLARK June 1972 '1. What DO Health Visitors Do?',
Nursing Times, Occasional Papers, Vol. 68, No. 30, pp. 117-119.
- 1973 *A Family Visitor : A Descriptive Analysis of Health Visiting in Berkshire*,
Royal College of Nursing, London.
- 1980a 'A Framework for Health Visiting : A Systems Approach - Part 1 : The Application of Systems Theory to Health Visiting',
Health Visitor, Vol. 53, No. 10, pp. 418-420.
- 1980b 'A Framework for Health Visiting : A Systems Approach - Part 2 : The Nature of Health Visiting Activity',
Health Visitor, Vol. 53, No. 11, pp. 487,489.
- 1980c 'A Framework for Health Visiting : A Systems Approach - Part 3 : The Environment and the Time Dimension',
Health Visitor, Vol 53, No. 12, pp. 533,535.
- 1981 *What Do Health Visitors Do? : A Review of the Research 1960-1980*,
Royal College of Nursing, London.
- 1982 'Development of models and theories on the concept of nursing',
Journal of Advanced Nursing, Vol. 7, No. 2, pp. 129-134.
- 1984 'Mothers' Perceptions of Health Visiting',
Health Visitor, Vol. 57, No. 9, pp. 265-268.
- 1985a 'Delivering the goods',
Community Outlook, January, pp. 23-24,26-28.
in *Nursing Times*, Vol. 81, No. 2.

- CLARK June
1985b *The Process of Health Visiting*,
Unpublished Ph.D. thesis,
Council for National Academic Awards,
Polytechnic of the South Bank, London.
- 1986 'A Model for Health Visiting',
in *Models for Nursing*, pp. 97-109,
Eds. B. Kershaw and J. Salvage,
John Wiley and Sons, Chichester, England.
- CLARK June
HENDERSON Jill
(eds.)
1983 *Community Health*,
Churchill Livingstone, Edinburgh.
- CLEMENTS Imelda W.
ROBERTS Florence B.
(eds.)
1983 *Family Health : A Theoretical Approach to
Nursing Care*,
John Wiley and Sons, New York.
- CLODE Drew
1978 'Of Primary Concern . . .',
Health and Social Service Journal,
Vol. 88, No. 4591, pp. 538-540.
- C.N.A.
(CANADIAN NURSES ASSOCIATION)
1980 *A Definition of Nursing Practice : Standards
for Nursing Practice*,
Canadian Nurses Association,
Ottawa, Canada.
- COHEN Florence S.
1982 'Transcultural Nursing : Benefits for the
Nurse',
Nursing Leadership, Vol. 5, No. 1, pp. 10-14.
- COLE W. Owen
SAMBHI Piara Singh
1978 *The Sikhs : Their Religious Beliefs and
Practices*,
Routledge and Kegan Paul, London.
- COLLIER John
1967 *Visual Anthropology : Photography as a
Research Method*,
Holt, Rinehart and Winston, New York.
- COLLINS Sheila
PARKER Edith
1983 *An Introduction to Nursing*,
Macmillan Press, London.
- COMMONWEALTH IMMIGRANTS ACT
1962 10 and 11, Elizabeth 2, Chapter 21,
H.M.S.O., London.

- CONSTANTINIDES Pamela 1977 "'Ill at Ease and Sick at Heart" : Symbolic Behaviour in a Sudanese Healing Cult', in *Symbols and Sentiments : Cross-cultural Studies in Symbolism*, pp. 61-84, Ed. I. Lewis, Academic Press, London.
- COOMBE Vivienne 1976 'Health and Social Services and Minority Ethnic Groups', *The Journal of the Royal Society of Health*, Vol. 96, No. 1, pp. 34-38.
- COPCUTT Lynn 1983 *Case studies and objective test questions for student nurses*, Pastest Service, Hemel Hempstead, England.
- CORMACK Desmond 1976 *Psychiatric Nursing Observed*, Royal College of Nursing, London.
- CRAGG Kenneth 1978 *Islam and the Muslim*, Man's Religious Quest, Course AD 208, Units 20-21, The Open University Press, Milton Keynes, England.
- CRANE Julia G.
ANGROSINO Michael V. 1974 *Field Projects in Anthropology : A Student Handbook*, General Learning Press, Morristown, NJ, U.S.A..
- CROW Jean 1977 *The Nursing Process*, Macmillan Journals Ltd., London.
- DAHYA Badr 1972 'Pakistanis in England', *New Community*, Vol. 2, No. 1, pp. 25-33.
- 1974 'The Nature of Pakistani Ethnicity in Industrial Cities in Britain', in *Urban Ethnicity*, A.S.A. Monograph No. 12, pp. 77-118, Ed. A. Cohen, Tavistock Publications, London.
- DAHYA Zaynab 1965 'Pakistani Wives in Britain', *Race*, Vol. 6, No. 4, pp. 311-321.
- DAVIE Emma 1979 'The Cultural Dimension', *Community Care*, No. 264, May 17th, pp. 36-39.
- DAVITZ Lois L.
DAVITZ Joel R.
HIGUCHI Yasuko 1977a 'Cross-cultural inferences of physical pain and psychological distress -1', *Nursing Times*, Vol. 73, No. 15, pp. 521-523.
- 1977b 'Cross-cultural inferences of physical pain and psychological distress -2', *Nursing Times*, Vol. 73, No. 16, pp. 556-558.

- DAWAR Anne 1979 'Food for thought in work with immigrants',
Nursing Mirror, Vol. 149, No. 16, pp. 27-30.
- DAWOOD N.J.
(Translator) 1974 *The Koran*,
Fourth revised edition, Penguin Books,
Harmondsworth, England.
- DESAI Rashmi 1963 *Indian Immigrants in Britain*,
Oxford University Press, London.
- DHANJAL Beryl 1976 'Sikh Women in Southall',
New Community, Vol. 5, Nos. 1/2,
pp. 109-114.
- D.H.S.S.
(DEPARTMENT OF HEALTH AND SOCIAL SECURITY)
- 1976 *Prevention and Health : Everybody's
Business*,
H.M.S.O., London.
- 1984 *Services for Under Fives from Ethnic
Minority Communities*,
Report of a Sub-Group on Provision of
Services for Under Fives from Ethnic
Minority Communities,
Inter Departmental Consultative Group on
Provision for Under Fives, H.M.S.O., London.
- D.H.S.S. et al.
(DEPARTMENT OF HEALTH AND SOCIAL SECURITY
SCOTTISH HOME AND HEALTH DEPARTMENT
WELSH OFFICE)
- 1969 *Report of Working Party on Management
Structure in the Local Authority Nursing
Services*,
Chairman - E.L. Mayston,
Department of Health and Social Security,
Scottish Home and Health Department, and
Welsh Office, London.
- DICK George 1978 *Immunisation*,
Update Books, London.
- DICKOFF James
JAMES Patricia 1968 'A theory of theories : A position paper',
Nursing Research, Vol. 17, No. 3,
pp. 197-203.

- DINGWALL Robert
- 1974 *The Social Organisation of Health Visitor Training*,
Unpublished Ph.D. thesis, University of Aberdeen, Scotland.
- 1976a 'The Social Organisation of Health Visitor Training - 1. The social theories of health visitors',
Nursing Times, Occasional Papers, Vol. 72, No. 7, pp. 25-28.
- 1976b 'The Social Organisation of Health Visitor Training - 3. Health Visiting as an Occupation',
Nursing Times, Occasional Papers, Vol. 72, No. 9, pp. 33-36.
- 1976c 'The Social Organisation of Health Visitor Training - 4. Method in Nursing Research',
Nursing Times, Occasional Papers, Vol. 72, No. 10, pp. 37-40.
- 1977 *The Social Organisation of Health Visitor Training*,
Croom Helm, London.
- DIXON Norman
- 1976 *On the Psychology of Military Incompetence*,
Jonathan Cape, London.
- DOBSON Susan
- 1985 'Under a Punjabi Sky',
Nursing Times, Vol. 81, No. 7, pp. 44-46.
- 1986 'Ethnography : a tool for learning',
Nurse Education Today,
Vol. 6, No. 2, pp. 76-79.
- DODGE J.S.
(ed.)
- 1969 *The Field Worker in Immigrant Health*,
Staples Press, London.
- DOSANJH J.S.
- 1976 *A Comparative Study of Punjabi and English Child Rearing Practices with Special Reference to Lower Juniors (7-9 years)*,
Unpublished Ph.D. thesis, University of Nottingham, England.
- DOUGHERTY Cynthia M.
- 1985 'The Nursing Diagnosis of Decreased Cardiac Output',
The Nursing Clinics of North America,
Vol. 20, No. 4, pp. 787-799.
- DOUGHERTY Molly C.
TRIPP-REIMER Toni
- 1985 'The Interface of Nursing and Anthropology',
Annual Review of Anthropology,
Vol. 14, pp. 219-241.

- DOUGLAS Mary 1966 *Purity and Danger : An Analysis of Concepts of Pollution and Taboo*, Routledge and Kegan Paul, London.
- 1968 'Pollution', in *International Encyclopaedia of the Social Sciences*, Vol. 12, pp. 336-342, Ed. D.L. Sills, The Macmillan Company and The Free Press, U.S.A..
- 1975 *Implicit Meanings : Essays in Anthropology*, Routledge and Kegan Paul, London.
- DRAPER Peter 1986 'Any use for an American import?', *Nursing Times*, Vol. 82, No. 2, pp. 37-39.
- DUBE Leela 1975 'Woman's Worlds - Three Encounters', in *Encounter and Experience : Personal Accounts of Fieldwork*, pp. 157-177, Eds. A. Béteille and T. Madan, Vikas Publishing House P.V.T. Ltd., Delhi, India.
- DUBE S.C. 1963 'Men's and women's roles in India : A Sociological Review', in *Women in the New Asia*, pp. 174-203, Ed. B. Ward, U.N.E.S.C.O., Paris.
- DUNNIGAN Matthew 1981 'Measure of success', *Nursing Mirror*, Vol. 152, No. 3, pp. 18-19.
- DWIVEDI Kedar N. 1980 'Indian Notions in Counselling Situations', *Counselling News*, Issue No. 32, May, pp. 10-14.
- EASTERDAY Lois
PAPADEMAS Diana
SCHORR Laura
VALENTINE Catherine 1982 'The Making of a Female Researcher : Role Problems in Fieldwork', in *Field Research : A Sourcebook and Field Manual*, pp. 62-67, Ed. R. G. Burgess, George Allen and Unwin, London.
- EGLAR Zekiye 1960 *A Punjabi Village in Pakistan*, Columbia University Press, New York.
- ELAHI Karam 1967 *Some Aspects of Social Adaptation of Pakistani Immigrants in Glasgow*, Unpublished M.A. (Hons.) dissertation, Dept. of Social Anthropology, University of Edinburgh, Scotland.

- ELIOT T.S. 1948 *Notes towards the Definition of Culture*,
Faber and Faber Limited, London.
- EVANS N.
WALPOLE I.R.
QURESHI M.U.
MEMON M.H.
EVERLEY JONES H.W. 1976 'Lack of breast feeding and early weaning in
infants of Asian immigrants to
Wolverhampton',
Archives of Disease in Childhood, Vol. 51,
No. 8, pp. 608-612.
- EVANS-PRITCHARD E.E. 1940 *The Nuer*,
First edition, Oxford University Press, London.
- EYLES John 1982 'Black and British',
The Geographical Magazine,
Vol. 14, No. 5, pp. 277-283.
- FAWCETT Jacqueline 1984 *Analysis and evaluation of conceptual
models of nursing*,
F.A. Davis Company, Philadelphia, PA, U.S.A..
- FIELD Peggy A. 1983 'An ethnography : four public health nurses'
perspectives of nursing',
Journal of Advanced Nursing, Vol. 8, No. 1,
pp. 3-12.
- FIELD Susan
DRAPER Juliet
KERR Marion
HARE Michael 1982 'A Consumer View of the Health Visiting
Service',
Health Visitor, Vol. 55, No. 6, pp. 299-301.
- FISCHER Ann 1970 'Field Work in Five Cultures',
in *Women in the Field : Anthropological
Experiences*, pp. 265-289,
Ed. P. Golde, Aldine Publishing Company,
Chicago, IL, U.S.A..
- FITZPATRICK Joyce J.
WHALL Ann L. 1983 *Conceptual Models of Nursing : Analysis and
Application*,
Robert J. Brady Co., Bowie, MD, U.S.A..
- FLASKERUD Jacquelyn H.
HALLORAN Edward J. 1980 'Areas of Agreement in Nursing Theory
Development',
Advances in Nursing Science,
Vol. 3, No. 1, pp. 1-7.

- FOX A. Mervyn 1974 *"They get this training but they don't really know how you feel",*
National Fund for Research into Crippling Diseases, Horsham, England.
- FOXMAN Ruth
MOSS Peter
BOLLAND Gill
OWEN Charles 1982 'A Consumer View of the Health Visitor at Six Weeks Postpartum',
Health Visitor, Vol. 55, No. 6,
pp. 302,304,305,308.
- FRAKE Charles O. 1977 'Plying Frames can be Dangerous : Some Reflections on Methodology in Cognitive Anthropology',
The Quarterly Newsletter of the Institute for Comparative Human Development,
Vol. 1, No. 3, pp. 1-7.
- FREY Velma C.
HOCKETT Christine
MOIST Gerri 1986 *Nursing Diagnosis - Care Plans*,
Williams and Wilkins, Baltimore, MD, U.S.A..
- GARDEE M.R. 1979 *The Health of Asian Communities - Three Reports of Studies in Johannesburg and Glasgow*,
Unpublished submission for Part II Examination for M.F.C.M., Faculty of Community Medicine, London.
Also available at Greater Glasgow Health Board, Glasgow.
- GASKELL P. Gordon 1969 'The local problem in general-practice research',
Journal of the Royal College of General Practitioners, Vol. 17, No. 81, pp. 219-222.
- GEBBIE Kristine
LAVIN Mary Ann 1974 'Classifying Nursing Diagnoses',
American Journal of Nursing,
Vol. 74, No. 2, pp. 250-253.
- GENNEP Arnold van 1960 *The Rites of Passage*,
Routledge and Kegan Paul, London.
- GHUMAN P.A.S. 1980 'Bhattra Sikhs in Cardiff : family and kinship organisation',
New Community, Vol. 8, No. 3, pp. 308-316.

- GIDEON Helen 1962 'A Baby in Born in the Punjab',
American Anthropologist, Vol. 64, No. 6,
pp. 1220-1234.
- GLASS Valerie 1975 'Multiculture wendy house',
Teacher's World, No. 3415, 2nd May, p. 19.
- GLASSER Melvin A. 1958 'A study of the public's acceptance of the
Salk vaccine program',
American Journal of Public Health, Vol. 48,
No. 2, pp. 141-146.
- GOEL K.M. [1981] *Growth of Immigrant Children in Glasgow*,
Oxfam, Oxford.
- GOEL K.M.
HOUSE F.
SHANKS R.A. 1978 'Infant-feeding practices among immigrants
in Glasgow',
British Medical Journal, Vol. 2, No. 6146,
pp. 1181-1183.
- GOLD Raymond L. 1958 'Roles in Sociological Field Observations',
Social Forces, Vol. 36, No. 3, pp. 217-223.
- GOOD Mary-Jo D. 1980 'Of Blood and Babies : The relationship of
popular Islamic physiology to fertility',
Social Science and Medicine, Vol. 14B, No. 3,
pp. 147-156.
- GOODALL John 1968 'The Pakistani Background',
in *New Backgrounds : The Immigrant Child at
Home and at School*, pp. 70-92,
Ed. R. Oakley, Oxford University Press,
London.
- GOODE William J. 1982 *The Family*,
Second edition, Prentice-Hall, Englewood
Cliffs, NJ, U.S.A..
- GORDON Marjory 1982 *Nursing Diagnosis : Process and Application*,
McGraw-Hill Book Company, New York,
U.S.A..
- GOULDNER Alvin W. 1960 'The Norm of Reciprocity : A Preliminary
Statement',
American Sociological Review,
Vol. 25, No. 2, pp. 161-178.
- GRAHAM Sarah 1972 "'Excuse me, Professor, but have you seen
my patient?'" ,
Nursing Times, Vol. 68, No. 14, pp. 408-409.

- GRAY Judith
BROWNING Waltrant 1980 'Cultural bridge building',
Health and Social Service Journal, Vol. 90,
8th August, pp. 1042-1043.
- GRIFFIN Anne M. 1972 'Understanding the immigrant worker',
Occupational Health, Vol. 24, No. 4,
pp. 121-127.
- GRIFFITH-KENNEY Janet 1986 'Overview of Selected Theoretical
Approaches',
in *Nursing Process : Application of Theories,
Frameworks, and Models*, pp. 17-54,
Eds. J. Griffith-Kenney and P. Christensen,
Second edition, The C.V. Mosby Company,
St Louis, MO, U.S.A..
- GRIFFITHS Kathleen 1983 'Child-rearing practices in West Indian, Indian
and Pakistani communities',
New Community, Vol. 10, No. 3, pp. 393-409.
- GROSSMANN-SCHULZ Mary
FEELEY Nancy 1984 'A Working Model of Support',
The Canadian Nurse, Vol. 80, No. 2,
pp. 42-46.
- HAGEY Rebecca
BULLER Ed 1983 'Drumming and Dancing : A new rhythm in
nursing care',
The Canadian Nurse, Vol. 79, No. 4,
pp. 28-31.
- HAHLO K.G. 1980 'Profile of a Gujarati community in Bolton',
New Community, Vol. 8, No. 3, pp. 295-307.
- HAMMERSLEY Martyn
ATKINSON Paul 1983 *Ethnography : Principles in Practice*,
Tavistock Publications, London.
- HANDY Charles B. 1985 *Understanding Organizations*,
Third edition, Penguin Books,
Harmondsworth, England.
- HARDY Leslie K. 1986 'Identifying the place of theoretical
frameworks in an evolving discipline',
Journal of Advanced Nursing,
Vol. 11, No. 1, pp. 103-107.
- HARDY Margaret E. 1978 'Perspectives on Nursing Theory',
Advances in Nursing Science,
Vol. 1, No. 1, pp. 37-48.

HEALTH EDUCATION COUNCIL

- 1974 *Health Education and Measles Vaccination : A Study of a Vaccination Campaign in Bristol, March 1973*,
Unpublished report No. 110,
Health Education Council (Medical Research Division), Bristol, England.
- 1980 *Feeding your child from one to five years old*,
Pamphlet published by the Health Education Council, London.
- 1982 *A Healthy Pregnancy : Some helpful advice*,
Pamphlet published by the Health Education Council, London.

HEALY M.A.
ASLAM M.

- 1984 'Identification of Lead in Asian Cosmetics - A Test for Use by Health Visitors',
Public Health, Vol. 98, No. 6, pp. 361-366.

HELMAN Cecil

- 1981 'Disease versus illness in general practice',
Journal of the Royal College of General Practitioners, Vol. 31, No. 230, pp. 548-552.
- 1984 *Culture, Health and Illness : An Introduction for Health Professionals*,
John Wright and Sons, Bristol, England.

HENLEY Alix

- 1979 *Asian Patients in Hospital and at Home*,
King Edward's Hospital Fund for London, London.
- 1983 'Monocultural services in a multicultural society',
in *Community Health*, pp. 83-89,
Eds. J. Clark and J. Henderson,
Churchill Livingstone, Edinburgh.

HENLEY Marylyn

- 1986 'The health visiting process',
Senior Nurse, Vol. 4, No. 4, pp. 24-26.

HERSHMAN Paul

- 1974 'Hair, Sex and Dirt',
Man (N.S.), Vol. 9, No. 2, pp. 274-298.
- 1977 'Virgin and Mother',
in *Symbols and Sentiments : Cross-cultural Studies in Symbolism*, pp. 269-292,
Ed. I. Lewis, Academic Press, London.

- HEWITT Margaret 1968 'Family',
in *A Dictionary of Sociology*, pp. 76-78,
Ed. G.D. Mitchell,
Routledge and Kegan Paul, London.
- HICKS Donald 1976 *Primary Health Care : A Review*,
H.M.S.O., London.
- HILGER M. Inez 1966 *Field Guide to the Ethnological Study of
Child Life*,
Behavior Science Field Guides, Vol. 1,
Second edition, Human Relations Area Files
Press, New Haven, NJ, U.S.A..
- HILL Pauline 1980 'Southall Abnormal Births Survey',
Health Visitor, Vol. 53, No. 2, pp. 47-48.
- 1982 'Personality Variables and Personality Testing
in Health Visitor Selection',
Health Visitor, Vol. 55, No. 6, pp. 286,288,289.
- HIRO Dilip 1971 *Black British, White British*,
Eyre and Spottiswoode, London.
- HOBBS Patricia 1973 *Aptitude or Environment : A Study of the
Group Teaching Activities of Health Visitors*,
Royal College of Nursing, London.
- HOFSTEDE Geert 1980 *Culture's Consequences : International
Differences in Work-Related Values*,
Sage Publications, Beverly Hills, CA, U.S.A..
- HOMANS Hilary 1980 *Pregnant in Britain : A Sociological Approach
to Asian and British Women's Experiences*,
Unpublished Ph.D. thesis, University of
Warwick, England.
- 1982 'Pregnancy and Birth as Rites of Passage for
two groups of Women in Britain',
in *Ethnography of Fertility and Birth*,
pp. 231-268, Ed. C. MacCormack,
Academic Press, London.
- 1983 'A Question of Balance : Asian and British
Women's Perceptions of Food during
Pregnancy',
in *The Sociology of Food and Eating*,
pp. 73-83, Ed. A. Murcott,
Gower Publishing Company Ltd., Aldershot,
England.
- HONIGMANN John J. 1970 'Sampling in Ethnographic Field Work',
in *A Handbook of Method in Cultural
Anthropology*, pp. 266-281,
Eds. R. Naroll and R. Cohen,
Columbia University Press, New York.

- HORN Beverly M. 1975 *An Ethnoscience Study to determine Social and Cultural factors affecting native American Indian Women during Pregnancy*, Unpublished doctoral dissertation, The University of Washington, Seattle, WA, U.S.A..
- HORNE Alexander D. 1978 *A Study of ante-natal care uptake amongst Asians in Bradford*, Report based on an unpublished M.B.Ch.B. elective dissertation, University of Aberdeen, Bradford Health Education Unit, Bradford, West Yorkshire.
- HOROWITZ B.
KISHWAR Madhu 1982 'Family Life - The Unequal Deal : Women's Condition and Family Life among Agricultural Labourers and Small Farmers in a Punjab Village', *Manushi* (Delhi), No. 11, pp. 2-18.
- HUDDERSFIELD CORPORATION ACT
1906 6, Edward 7, Chapter 84, Section 73.
- HULL E.J.
ISAACS B.J. 1982 *Do-it-yourself revision for nurses - 4*, Second edition, Bailliere Tindall, London.
- HUNT Maura 1972 'The Dilemma of Identity in Health Visiting 1', *Nursing Times*, Occasional Papers, Vol. 68, No. 5, pp. 17-20.
- HUNT Sandra P. [1976] 'Nutritional advice to Asians', *In Touch, Nutrition News from the Gerber Baby Council*, No. 8, pp. 1-3, Gerber, Esher, Surrey, England.
- H.V.A.
(HEALTH VISITORS' ASSOCIATION)
1981 *Health Visiting in the 80s*, H.V.A., London.
Also as supplement in *Health Visitor*, Vol. 54, No. 2.
- IBBETSON Denzil C.J. 1883 *Report on the Census of the Panjab, Taken on the 17th of February 1881*, Vol. 1, The Superintendent of Government Printing, Calcutta, India.
- I.C.N.
(INTERNATIONAL COUNCIL OF NURSES)
1977 *The Nurse's Dilemma : Ethical Considerations in Nursing Practice*, Project Director - B.L. Tate, International Council of Nurses, Florence Nightingale International Foundation, Geneva, Switzerland.

- IKRAMULLAH Shaista S. n.d. *Behind the Veil*,
[1947–1954] Pakistan Publications, Karachi, Pakistan.
- ILLING Margaret
DONOVAN Brian 1981 *District Nursing*,
Baillière Tindall, London.
- IMMIGRATION ACT 1971 Chapter 77,
H.M.S.O., London.
- INDIAN EXPRESS 1984 'Dowry death alleged',
Indian Express, 8th April, p. 6.
Chandigarh, India.
- JACOBSON Doranne 1982 'Purdah and the Hindu Family in Central
India',
in *Separate Worlds : Studies of Purdah in
South Asia*, pp. 81–109,
Eds. H. Papanek and G. Minault, Chanakya
Publications, Delhi, India.
- JACOX Ada 1974 'Theory Construction in Nursing : An
overview',
Nursing Research, Vol. 23, No. 1,
pp. 4–13.
- JAFFE RUIZ Marilyn C. 1981 'Open-Closed Mindedness, Intolerance of
Ambiguity and Nursing Faculty Attitudes
toward Culturally Different Patients',
Nursing Research, Vol. 30, No. 3,
pp. 177–181.
- JEFFERY Patricia 1976 *Migrants and Refugees : Muslim and
Christian Pakistani families in Bristol*,
Cambridge University Press, Cambridge,
England.
- 1979 *Frogs in a Well : Indian Women in Purdah*,
Zed Press, London.
- 1980 Personal communication,
Lecturer, Department of Sociology, University
of Edinburgh.
- JEFFERYS Margot 1965 *An Anatomy of Social Welfare Services*,
Michael Joseph, London.
- JENNINGS Kathleen 1984 'The Role of the Health Visitor',
in *Screening for Children with Special Needs
: Multidisciplinary Approaches*,
Ed. G. Lindsay, pp. 43–62,
Croom Helm, London.

- JIVANI S.K.M. 1978 'The practice of infant feeding among Asian immigrants',
Archives of Disease in Childhood, Vol. 53,
No. 1, pp. 69-73.
- JOINT TUBERCULOSIS COMMITTEE
1978 'Tuberculosis among immigrants in Britain',
British Medical Journal, Vol. 1, No. 6119,
pp. 1038-1040.
- JONES A.D.
DOUGHERTY C. 1982 'Childbirth in a Scientific and Industrial
Society',
in *Ethnography of Fertility and Birth*,
Ed. C. MacCormack, pp. 269-290,
Academic Press, London.
- JONES Philippa
BARNES Daphne 1985 'Health visitors as group leaders',
*Midwife, Health Visitor and Community
Nurse*, Vol. 21, No. 11, pp. 396,404.
- JUNKER Buford H. 1960 *Field Work : An Introduction to the Social
Sciences*,
The University of Chicago Press, Chicago, IL,
U.S.A..
- JYOTI Surinder K. 1983 *Marriage Practices of the Sikhs : A study of
intergenerational differences*,
Deep and Deep Publications, New Delhi,
India.
- KAKAR Sudhir 1978 *The Inner World : A Psycho-analytic Study of
Childhood and Society in India*,
Oxford University Press, Delhi, India.
- KARSERAS Patience 1981 'The Health Visitor - Family Guest and Host',
in *The Health Needs of Ethnic Groups*,
Report of a Symposium held in Sept. 1980 at
the University Hospital of Wales, Cardiff,
pp. 1-9, Ed. C. Rees,
South Glamorgan Health Authority
(Teaching).
- KASL Stanislav V.
COBB Sidney 1966 'Health behavior, illness behavior, and sick
role behavior',
Archives of Environmental Health, Vol. 12,
No. 2, pp. 246-266.
- KAUR Ranjit 1974 'Pulmonary tuberculosis complicated by
constrictive pericarditis',
Nursing Times, Vol. 70, No. 31,
pp. 1186-1189.

- KAY Margarita A. 1982 'Writing an Ethnography of Birth',
in *Anthropology of Human Birth*, pp. 1-24,
Ed. M.A. Kay,
F.A. Davis Company, Philadelphia, PA, U.S.A..
- KEESING Roger M. 1975 *Kin Groups and Social Structure*,
Holt, Rinehart and Winston, New York.
- KELLER Marjorie J. 1981 'Toward a definition of health',
Advances in Nursing Science,
Vol. 4, No. 1, pp. 43-64.
- KERR Margaret 1983 'Special Areas of Work',
in *Health Visiting*, pp. 249-270,
Second edition, Ed. G. Owen,
Baillière Tindall, London.
- KHOGALI M. 1979 'Tuberculosis among immigrants in the
United Kingdom : the role of occupational
health services',
*Journal of Epidemiology and Community
Health*, Vol. 33, No. 2, pp. 134-137.
- KING Imogene M. 1971 *Toward a Theory for Nursing*,
John Wiley and Sons, New York.
- 1981 *A Theory for Nursing : Systems, Concepts,
Process*,
John Wiley and Sons, New York.
- 1984 *Overview*,
Presentation given on May 2nd at the *Nurse
Theorist Conference*, Edmonton Convention
Centre, Edmonton,
Audio-tape No. 3, Kennedy Recordings,
Edmonton, Alberta, Canada.
- KITZINGER Sheila 1972 'Body Fantasies',
New Society, Vol. 21, No. 510, pp. 12-13.
- 1977 'Challenges in antenatal education :
1. Immigrant women in childbirth -
an anthropologist's view',
Nursing Mirror, Vol. 144, No. 25, pp. 19-22.
- KNIGHT Lindsay 1979 'Eastern promise in the East End?',
Nursing Mirror, Vol. 149, No. 17, pp. 35-37.
- KRATZ Charlotte R. 1974 *Problems of Care of the Long-term Sick in
the Community with particular reference to
patients with stroke*,
Unpublished Ph.D. thesis, University of
Manchester, England.
- KRAUSZ Ernest
MILLER Stephen H. 1974 *Social Research Design*,
Longman, London.

- KROEBER A.L. 1948 *Anthropology : Race, Language, Culture, Psychology, Prehistory*, Revised Edition, Harcourt, Brace and Company, New York.
- KUMARI Radha 1984 Personal communication, Secretary Adult Education, Y.W.C.A. of India, New Delhi, India.
- LACKEY Carolyn J. 1978 'Pica : A nutritional anthropology concern', in *The Anthropology of Health*, pp. 121-129, Ed. E. Bauwens, The C.V. Mosby Company, St Louis, MO, U.S.A..
- LANCASTER Wade
LANCASTER Jeanette 1981 'Models and Model Building in Nursing', *Advances in Nursing Science*, Vol. 3, No. 3, pp. 31-42.
- LANE-CLAYPON Janet E. 1920 *The Child Welfare Movement*, G. Bell and Sons Ltd., London.
- LANNOY Richard 1971 *The Speaking Tree : A Study of Indian Culture and Society*, Oxford University Press, London.
- LEACH Edmund 1976 *Culture and Communication*, Cambridge University Press, Cambridge, England.
- 1982 *Social Anthropology*, Fontana Paperbacks, [London].
- LEDDY Susan
PEPPER J. Mae 1985 *Conceptual Bases of Professional Nursing*, J.B. Lippincott Company, Philadelphia, PA, U.S.A..
- LEE Everett S. 1969 'A Theory of Migration', in *Migration*, pp. 282-297, Ed. J.A. Jackson, Cambridge University Press, London.
- LEININGER Madeleine 1970 *Nursing and Anthropology : Two Worlds to Blend*, John Wiley and Sons, New York.
- 1978 *Transcultural Nursing : Concepts, Theories, and Practices*, John Wiley and Sons, New York.

- LEININGER Madeleine 1981 'The Phenomenon of Caring : Importance, Research Questions and Theoretical Considerations',
in *Caring : An Essential Human Need, The Proceedings of the Three National Caring Conferences : 1978-1980*, pp. 3-15, Ed. M. Leininger, Charles B. Slack, Inc., Thorofare, NJ, U.S.A..
- 1984 'Transcultural Interviewing and Health Assessment',
in *Mental Health Services : The Cross-Cultural Context*, pp. 109-133, Eds. P. Pedersen, N. Sartorius and A. Marsella,
Sage Publications, Beverly Hills, CA, U.S.A..
- 1985a 'Transcultural care - Diversity and Universality : A Theory of Nursing',
Nursing and Health Care,
Vol. 6, No. 4, pp. 208-212.
- LEININGER Madeleine
(ed.) 1979 *Transcultural Nursing*,
Masson International Nursing Publications,
New York.
- 1985b *Qualitative Research Methods in Nursing*,
Grune and Stratton, Inc., Orlando, FL, U.S.A..
- LEMU B. Aisha
HEEREN Fatima 1978 *Woman in Islam*,
Islamic Council of Europe,
Prepared under the auspices of The Islamic
Foundation, Leicester, England.
- LEWIS I.M. 1976 *Social Anthropology in Perspective*,
Penguin Books, Harmondsworth, England.
- LIPSON Juliene G.
MELEIS Afaf I. 1983 'Issues in Health Care of Middle Eastern
Patients',
The Western Journal of Medicine,
Vol. 139, No. 6, pp. 854-861.
- LOBO Edwin de H. 1978 *Children of Immigrants to Britain : Their
Health and Social Problems*,
Hodder and Stoughton, London.
- LOFLAND John 1971 *Analyzing Social Settings : A Guide to
Qualitative Observation and Analysis*,
Wadsworth Publishing Company Inc.,
Belmont, CA, U.S.A..

- LOVELAND Marion K. 1971 'The Work of Health Visitors in an Urban and a County Area', *Nursing Times*, Occasional Papers, Vol. 67, No. 22, pp. 85-87.
- LOYNES A.P. 1979 'Working with families from Bangladesh', *Midwife, Health Visitor and Community Nurse*, Vol. 15, No. 12, pp. 501,504-505.
- LOZOFF Betsy
KAMATH K.R.
FELDMAN R.A. 1975 'Infection and Disease in South Indian Families : Beliefs about Childhood Diarrhea', *Human Organization*, Vol. 34, No. 4, pp. 353-358.
- LUKER Karen A. 1979 'A framework for the nursing process : problem-oriented recordings', *Nursing Times*, Vol. 75, No. 35, pp. 1488-1490.
- 1980 *Health Visiting and the Elderly : An experimental study to evaluate the effects of focused health visitor intervention on elderly women living alone at home*, Unpublished Ph.D. thesis, University of Edinburgh.
- 1982 *Evaluating Health Visiting Practice*, Royal College of Nursing, London.
- 1985 'Evaluating health visiting practice', in *Health Visiting*, pp. 121-153, Eds. K. Luker and J. Orr, Blackwell Scientific Publications, Oxford.
- LUMB K.M.
CONGDON P.J.
LEALMAN G.T. 1981 'A comparative review of Asian and British-born maternity patients in Bradford, 1974-8', *Journal of Epidemiology and Community Health*, Vol. 35, No. 2, pp. 106-109.
- McCLEARY G.F. 1933 *The Early History of the Infant Welfare Movement*, H.K. Lewis and Co. Ltd., London.
- 1935 *The Maternity and Child Welfare Movement*, P.S. King and Son Ltd., London.
- McCLYMONT Alison 1980 *Teaching for Reality*, Council for the Education and Training of Health Visitors, London.
- MacCORMACK Geoffrey 1976 'Reciprocity', *Man (N.S.)*, Vol. 11, No. 1, pp. 89-103.

- McDONALD Ann 1978 'Mystical seven',
Nursing Times, Vol. 74, No. 24,
pp. 1019-1021.
- McFARLANE Jean 1976 'The role of research and the development of
nursing theory',
Journal of Advanced Nursing,
Vol. 1, No. 6, pp. 443-451.
- 1982 'Nursing values and nursing action',
Nursing Times, Occasional Papers,
Vol. 78, No. 28, pp. 109-112,
- McFARLANE [Jean]
CASTLEDINE George 1982 *A Guide to the Practice of Nursing using the
Nursing Process*,
The C.V. Mosby Company, London.
- McGILVRAY D.B. 1982 'Sexual Power and Fertility in Sri Lanka :
Batticaloa Tamils and Moors',
in *Ethnography of Fertility and Birth*,
pp. 25-73, Ed. C. MacCormack,
Academic Press, London.
- McLEOD W.H. 1976 *The Evolution of the Sikh Community*,
Clarendon Press, Oxford.
- McLEOD W.H.
(trans. and ed.) 1984 *Textual Sources for the Study of Sikhism*,
Manchester University Press,
Manchester, England.
- MacQUEEN Ian A. 1962 'From Carbolic Powder to Social Counsel',
Nursing Times, Vol. 58, No. 27, pp. 866-868.
- MACGREGOR Frances C. 1960 *Social Science in Nursing*,
Russell Sage Foundation, New York.
- MADGE John 1953 *The Tools of Social Science*,
Longmans, Green and Co., London.
- MAIR Lucy 1977 *Marriage*,
The Scholar Press, London.
- MALINOWSKI Bronislaw 1922 *Argonauts of the Western Pacific*,
Routledge and Kegan Paul, London.
- MALONEY Clarence 1976 'Don't say "Pretty Baby" lest you zap it with
your eye - The Evil Eye in South Asia',
in *The Evil Eye*, pp. 102-148,
Ed. C. Maloney, Columbia University Press,
New York.

MANCHESTER

(MANCHESTER HEALTH EDUCATION DEPARTMENT AND MANCHESTER INDUSTRIAL LANGUAGE TRAINING UNIT)

- 1981 *Asian Communities in Manchester : A Handbook for Health Workers*, Manchester Health Education Dept. and Manchester Industrial Language Training Unit, Manchester, England.
- MARES Penny 1982 *The Vietnamese in Britain : A Handbook for Health Workers*, Health Education Council and the National Extension College, Cambridge, England.
- MARES Penny
HENLEY Alix
BAXTER Carol 1985 *Health Care in Multiracial Britain*, Health Education Council and the National Extension College, Cambridge, England.
- MARKS Jenny 1979 'Infant feeding across cultures', *Health Visitor*, Vol. 52, No. 7, pp. 271-274,276.
- MAYER Adrian C. 1959 *A Report on the East Indian Community in Vancouver*, Institute of Social and Economic Research, University of British Columbia, Canada.
- MAYOR Vina 1984 'Pregnancy, childbirth and child care', *Nursing Times*, Vol. 80, No. 24, pp. 57-58.
- MEAD Margaret 1969 'Research with Human Beings : A Model derived from Anthropological Field Practice', *Daedalus*, Vol. 68, No. 2, pp. 361-386.
- 1970 'The Art and Technology of Field Work', in *A Handbook of Method in Cultural Anthropology*, pp. 246-265, Eds. R. Naroll and R. Cohen, Columbia University Press, New York.
- MEAD Margaret (ed.) 1953 *Cultural Patterns and Technical Change*, World Federation for Mental Health, U.N.E.S.C.O., Paris.
- MELEIS Afaf I. 1985 *Theoretical Nursing : Development and Progress*, J.B. Lippincott Company, Philadelphia, PA, U.S.A..
- MELIA Kath M. 1981 *Student Nurses' Account of their Work and Training : a Qualitative Analysis*, Unpublished Ph.D. thesis, University of Edinburgh.

- MIDDLETON D. 1983 *Nursing 1 – Multiple Choice Questions*, Blackwell Scientific Publications, Oxford.
- MINISTRY OF HEALTH et al.
(MINISTRY OF HEALTH
DEPARTMENT OF HEALTH FOR SCOTLAND
MINISTRY OF EDUCATION)
- 1956 *An Inquiry into Health Visiting*,
Chairman – W. Jameson,
Her Majesty's Stationery Office, London.
- MORGAN Barbara S. 1983 'Selected correlates of white nursing students' attitudes toward black American patients',
International Journal of Nursing Studies,
Vol. 20, No. 2, pp. 109-121.
- MOSER Claus
KALTON Graham 1971 *Survey Methods in Social Investigation*,
Second edition, Heinemann Educational
Books, London.
- NAIR Kusum 1961 *Blossoms in the Dust : The Human Element
in Indian Development*,
Gerald Duckworth and Co. Ltd., London.
- NATH Jharna 1970 *Some Aspects of the Life of Indians and
Pakistanis in Newcastle with Special
Reference to Women*,
Unpublished M.A. thesis, University of
Durham, England.
- NATIONAL HEALTH SERVICE ACT
1946 9 and 10, George 6, Chapter 81,
H.M.S.O., London.
- NATIONAL HEALTH SERVICE REORGANISATION ACT
1973 Chapter 32,
H.M.S.O., London.
- N.D.C.G.
(THE NURSING DEVELOPMENT CONFERENCE GROUP)
- 1973 *Concept Formalization in Nursing : Process
and Product*,
First edition, Little, Brown and Company,
Boston, MA, U.S.A..
- NEHRING Virginia
GEACH Barbara 1973 'Patients' Evaluation of their Care – Why they
don't complain',
Nursing Outlook, Vol. 21, No. 5, pp. 317-321.
- NESBITT Eleanor M. 1980 *Aspects of Sikh Tradition in Nottingham*,
Unpublished M. Phil thesis, University of
Nottingham, England.

- NEUMAN Betty 1982 'The Neuman Health-Care Systems Model : A Total Approach to Client Care', in *The Neuman Systems Model : Application to Nursing Education and Practice*, pp. 8-29, Appleton-Century-Crofts, New York.
- 1985 'The Neuman systems model', *Senior Nurse*, Vol. 3, No. 3, pp. 20-23.
- NEUMAN Betty M.
YOUNG Rae J. 1972 'A Model for Teaching Total Person Approach to Patient Problems', *Nursing Research*, Vol. 21, No. 3, pp. 264-269.
- NEWMAN Margaret A. 1972 'Nursing's Theoretical Evolution', *Nursing Outlook*, Vol. 20, No. 7, pp. 449-453.
- NEWSON John
NEWSON Elizabeth 1963 *Infant Care in an Urban Community*, George Allen and Unwin Ltd., London.
- NICHTER Mark
NICHTER Mimi 1983 'The Ethnophysiology and Folk Dietetics of Pregnancy : A Case Study from South India', *Human Organization*, Vol. 42, No. 3, pp. 235-246.
- NIGHTINGALE Florence 1860 *Notes on Nursing : What it is, and what it is not*, Harrison, London.
- NORRIS Catherine M.
(ed.) 1982 *Concept Clarification in Nursing*, Aspen Systems Corporation, Rockville, MD, U.S.A..
- NOTIFICATION OF BIRTHS (EXTENSION) ACT 1915 5 and 6, George 5, Chapter 64.
- NURSE Gaynor 1980 *Counselling and the Nurse : An Introduction*, Second edition, HM+M Publishers, Aylesbury, England.
- NURSES, MIDWIVES AND HEALTH VISITORS ACT 1979 Chapter 36, H.M.S.O., London.
- NYROP Richard
BENDERLY Beryl L.
CONN Cary C.
COVER William W.
CUTTER Melissa J.
PARKER Newton B. 1975 *Area Handbook for Pakistan*, Fourth edition, American University, Washington, DC, U.S.A.

- O'BRIEN R. Barry 1979 'Moslem leaders fight to save faith in Britain',
The Daily Telegraph, 26th February, p. 8.
- O'CONNELL Patricia E. 1978 *Health Visitor Education at University*,
Royal College of Nursing, London.
- OFFICE OF HEALTH ECONOMICS
1963 *The Price of Poliomyelitis*,
Office of Health Economics, London.
- OREM Dorothea E. 1985 *Nursing : Concepts of Practice*,
Third edition,
McGraw-Hill Book Company, New York.
- ORQUE Modesta S. 1983 'Orque's Ethnic/Cultural System : a
framework for ethnic nursing care',
in *Ethnic Nursing Care : A Multicultural
Approach*, pp. 5-48,
Eds. M. Orque, B. Bloch and L. Monrroy,
The C.V. Mosby Company, St Louis, MO,
U.S.A..
- ORQUE Modesta S.
BLOCH Bobbie
MONRROY Lidia S. 1983 *Ethnic Nursing Care : A Multicultural
Approach*,
The C.V. Mosby Company, St Louis, MO,
U.S.A..
- ORR Jean 1980 *Health Visiting in Focus : A Consumer View
of Health Visiting in Northern Ireland*,
Royal College of Nursing, London.
- 1985a 'The Community Dimension',
in *Health Visiting*, pp. 1-31,
Eds. K. Luker and J. Orr,
Blackwell Scientific Publications, Oxford.
- 1985b 'Assessing Individual and Family Health
Needs',
in *Health Visiting*, pp. 67-120,
Eds. K. Luker and J. Orr,
Blackwell Scientific Publications, Oxford.
- OWEN Grace M. 1983a 'The Health Visitor Today',
in *Health Visiting*, pp. 33-51,
Second edition, Ed. G. Owen,
Baillière Tindall, London.
- 1983b 'The Sociological Perspective',
in *Health Visiting*, pp. 105-126,
Second edition, Ed. G. Owen,
Baillière Tindall, London.
- PAKISTAN ACT 1973 Chapter 48,
H.M.S.O., London.

- PAPANNEK Hanna 1964 'The Woman Field Worker in a Purdah Society',
Human Organization, Vol. 23, No. 2,
pp. 160-163.
- 1982a 'Purdah : Separate Worlds and Symbolic Shelter',
in *Separate Worlds : Studies of Purdah in South Asia*, pp. 3-53,
Ed. H. Papanek and G. Minault,
Chanakya Publications, Delhi, India.
- 1982b 'Purdah in Pakistan : Seclusion and Modern Occupations for Women',
in *Separate Worlds : Studies of Purdah in South Asia*, pp. 190-216,
Ed. H. Papanek and G. Minault,
Chanakya Publications, Delhi, India.
- PARMAR Pratibha 1982 'Gender, race and class : Asian women in resistance',
in *The Empire Strikes Back : Race and Racism in 70s Britain*, pp. 236-275,
Hutchinson, London - in association with
Centre for Contemporary Cultural Studies,
University of Birmingham, England.
- PARRY Jonathan P. 1979 *Caste and kinship in Kangra*,
Routledge and Kegan Paul, London.
- PAUL Benjamin D.
(ed.) 1955 *Health, Culture and Community : Case Studies of Public Reactions to Health Programs*,
Russell Sage Foundation, New York.
- PAYNE Stanley L. 1951 *The Art of Asking Questions*,
Princeton University Press, Princeton, NJ,
U.S.A..
- PEARSALL Marion 1965 'Participant Observation as Role and Method in Behavioral Research',
Nursing Research, Vol. 14, No. 1, pp. 37-42.
- PEARSON Maggie 1986 Personal communication - June 1986.
Lecturer in Medical Sociology, University of
Liverpool, England.
- PELTO Pertti J.
PELTO Gretel H. 1978 *Anthropological Research : The Structure of Inquiry*,
Second edition, Cambridge University Press,
New York.

- PORTER Tom
MIKELLIDES Byron 1976 *Colour for Architecture*,
Cassell and Collier, Macmillan Publishers Ltd.,
London.
- POWDERMAKER Hortense 1967 *Stranger and Friend : The Way of an
Anthropologist*,
Secker and Warburg, London.
- QURESHI Bashir 1985 'Family Planning and Culture',
Journal of the Royal Society of Health,
Vol. 105, No. 1, pp. 11-14.
- RACK Philip H. 1978 'Immigrant Families and the Health Service',
in *Off to a Good Start*, pp. 31-39,
Report of the 65th Annual Conference of the
National Association for Maternal and Child
Welfare - held on 29th June 1978 at the
University of Leeds, England.
- RAGUCCI Antoinette T. 1971 *Generational Continuity and Change in
Concepts of Health, Curing Practices, and
Ritual expressions of the Women of an
Italian-American Enclave*,
Unpublished Ph.D. dissertation, Boston
University Graduate School, Boston, MA,
U.S.A..

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(A COMMITTEE OF THE ROYAL ANTHROPOLOGICAL INSTITUTE OF
GREAT BRITAIN AND IRELAND)

- 1951 *Notes and Queries on Anthropology*,
Sixth edition, Routledge and Kegan Paul Ltd.,
London.

- RAYMOND Elizabeth 1983a 'Into the Community',
in *Community Health*, pp. 3-10,
Eds. J. Clark and J. Henderson,
Churchill Livingstone, Edinburgh.
- 1983b 'The Skills of Health Visiting',
in *Health Visiting*, pp. 220-231,
Second edition, Ed. G. Owen,
Baillière Tindall, London.

R.C.N.

(ROYAL COLLEGE OF NURSING)

- 1971 *The Role of the Health Visitor - Report of
the Working Party on the Role of the Health
Visitor now and in a changing National
Health Service*,
Royal College of Nursing and the National
Council of Nurses of the United Kingdom,
London.

- R.C.N.
(ROYAL COLLEGE OF NURSING)
- 1983 *Thinking about Health Visiting*,
A discussion document produced by the Rcn
Health Visitors' Advisory Group,
Society of Primary Health Care Nursing,
Royal College of Nursing of the United
Kingdom, London.
- REES Colin
(ed.)
- 1981 *The Health Needs of Ethnic Groups*,
Report of a Symposium held in Sept. 1980,
at the University Hospital of Wales, Cardiff.
South Glamorgan Health Authority
(Teaching).
- REPORT OF THE COMMITTEE ON NURSING,
- 1972 Chairman-A. Briggs,
Command 5115, H.M.S.O., London.
- RHODES Hazel
- 1985a 'From Alipor to Batley',
Community Outlook, June, pp. 39-40,43-44.
- 1985b 'From Batley to Alipor',
Community Outlook, July, pp. 8,11-12,14.
- RIEHL Joan P.
ROY Callista
- 1980 'A Unified Model of Nursing',
in *Conceptual Models for Nursing Practice*,
pp. 399-403,
Eds. J. Riehl and C. Roy, Second edition,
Appleton-Century-Crofts, New York.
- RISNER Phyllis B.
- 1986 'Diagnosis : Diagnostic Statements',
in *Nursing Process : Application of Theories,
Frameworks, and Models*, pp. 151-168,
Eds. J. Griffith-Kenney and P. Christensen,
The C.V. Mosby Company, St Louis, MO,
U.S.A..
- ROBERTSON Carol
- 1981 'What does the health visitor do?',
Community Outlook, March, p. 111,
in *Nursing Times* Vol. 77, No. 11.
- 1984 'Preventive health care for infants',
in *Maternal and Infant Health Care*, pp. 3-25,
Ed. M. Houston,
Churchill Livingstone, Edinburgh.

- ROBERTSON Iris
GLEKIN B.M.
HENDERSON Janet B.
McINTOSH W.B.
LAKHANI A.
DUNNIGAN M.G.
- 1982 'Nutritional deficiencies among ethnic minorities in the United Kingdom', *Proceedings of the Nutrition Society*, Vol. 41, No. 2, pp. 243-256.
- ROBERTSON Mildred H.B.
BOYLE Joyceen S.
- 1984 'Ethnography : contributions to nursing research', *Journal of Advanced Nursing*, Vol. 9, No. 1, pp. 43-49.
- ROBINSON Jane
- 1982 *An Evaluation of Health Visiting*, C.E.T.H.V., London.
- ROBINSON Kathleen
- 1985a 'Knowledge and its Relationship to Health Visiting', in *Health Visiting*, pp. 154-184, Eds. K. Luker and J. Orr, Blackwell Scientific Publications, Oxford.
- ROBINSON Jane
- 1985b 'Health Visiting and Health', in *Political Issues in Nursing : Past, Present and Future*, Vol. 1, pp. 67-86, Ed. R. White, John Wiley and Sons, Chichester, England.
- ROGERS Martha E.
- 1970 *An Introduction to the theoretical basis of nursing*, F.A. Davis Company, Philadelphia, PA, U.S.A..
- 1984 *Overview*, Presentation given on May 3rd at the *Nurse Theorist Conference*, Edmonton Convention Centre, Edmonton, Audio-tape No. 6, Kennedy Recordings, Edmonton, Alberta, Canada.
- RONALDS Clare
VAUGHAN J.P.
SPRACKLING P.
- 1977 'Asian mothers' use of general-practitioner and maternal/child welfare services', *Journal of the Royal College of General Practitioners*, Vol. 27, No. 178, pp. 281-284.
- ROPER Nancy
- 1982 *Principles of Nursing*, Third edition, Churchill Livingstone, Edinburgh.

- ROPER Nancy
LOGAN Winifred
TIERNEY Alison
- 1985a *The Elements of Nursing*,
Second edition, Churchill Livingstone,
Edinburgh.
- 1985b 'The Roper/Logan/Tierney model',
Senior Nurse, Vol. 3, No. 2, pp. 20-26.
- 1986 'Nursing Models : A Process of Construction
and Refinement',
in *Models for Nursing*, pp. 25-38.
Eds. B. Kershaw and J. Salvage,
John Wiley and Sons, Chichester, England.
- ROPER Nancy
LOGAN Winifred W.
TIERNEY Alison J.
(eds.)
- 1983 *Using a Model for Nursing*,
Churchill Livingstone, Edinburgh.
- ROSE H.A.
(compiler)
- 1911 *A Glossary of the Tribes and Castes of the
Punjab and North-West Frontier Province*,
Vol. 2 (A - K),
Civil and Military Gazette Press, Lahore.
- ROSS Aileen D.
- 1961 *The Hindu Family in its Urban Setting*,
University of Toronto Press, Toronto, Ont.,
Canada.
- ROUSSEAU Nicole
- 1983a *In Bites and Pieces : A Study of Food
Consumption of Edinburgh Primary School
Children*,
Unpublished Ph.D. thesis, University of
Edinburgh.
- 1983b 'Give us a playpiece, please; not lectures!',
The Journal of the Royal Society of Health,
Vol. 103, No. 3, pp. 104-111.
- ROWELL V.R.
RACK Philip H.
- 1979 'Health Education Needs of a Minority Ethnic
Group',
Journal of the Institute of Health Education,
Vol. 17, No. 4, pp. 3-19.
- ROWLEY Gwyn
TIPPLE Graham
- 1974 'Coloured Immigrants within the City : An
Analysis of Housing and Travel Preferences',
Urban Studies, Vol. 11, pp. 81-89.
- ROWNTREE B. Seebohm
- 1901 *Poverty : A Study of Town Life*,
First edition, Macmillan and Co. Ltd., London.

- RUDNER Richard S. 1966 *Philosophy of Social Science*,
Prentice-Hall, Inc., Englewood Cliffs, NJ,
U.S.A..
- RUNNYMEDE TRUST
(RUNNYMEDE TRUST AND THE RADICAL STATISTICS RACE GROUP)
1980 *Britain's Black Population*,
Heinemann Educational Books, London.
- SAHLINS Marshall 1972 *Stone Age Economics*,
Aldine-Atherton, Inc., Chicago, IL, U.S.A..
- SAIFULLAH-KHAN Verity 1974 *Pakistani Villagers in a British City : The
World of the Mirpuri villager in Bradford and
in his Village of Origin*,
Unpublished Ph.D. thesis, University of
Bradford, England.
- 1976 'Pakistani women in Britain',
New Community, Vol. 5, Nos. 1/2, pp. 99-108.
- 1977 'The Pakistanis : Mirpuri Villagers at Home
and in Bradford',
in *Between Two Cultures : Migrants and
Minorities in Britain*, pp. 57-89,
Ed. J. L. Watson, Basil Blackwell, Oxford.
- 1979 'Work and Network : South Asian women in
South London',
in *Ethnicity at Work*, pp. 115-133,
Ed. S. Wallman, The Macmillan Press Ltd.,
London.
- SALTER Joseph 1873 *The Asiatic in England - Sketches of Sixteen
Years' work among Orientals*,
Seeley, Jackson, and Halliday, London.
- SAMPSON A. Chris 1982 *The Neglected Ethic : Cultural and Religious
Factors in the Care of Patients*,
McGraw-Hill Book Company (UK) Ltd.,
Maidenhead, England.
- SATZ Karen J. 1982 'Integrating Navajo Tradition into
Maternal-Child Nursing',
Image - Journal of Nursing Scholarship,
Vol. 14, No. 3, pp. 89-91.
- SCHATZMAN Leonard
STRAUSS Anselm L. 1973 *Field Research : Strategies for a Natural
Sociology*,
Prentice-Hall, Englewood Cliffs, NJ, U.S.A..
- SCHUTZ Alfred 1964 'The Stranger',
in *Collected Papers II : Studies in Social
Theory*, pp. 91-105, Ed. A. Brodersen,
Martinus Nijhoff, The Hague, Holland.

S.C.R.H.V.E.T.C.

(STANDING CONFERENCE OF REPRESENTATIVES OF HEALTH VISITOR
EDUCATION AND TRAINING CENTRES)

- 1980 *Time to Learn*,
Unpublished Report of Standing Conference
of Representatives of Health Visitor
Education and Training Centres' Working
Group on the Content and Length of the
Health Visitor Course, March 1980,
[North East London Polytechnic, London].
- SELIG Naomi A. 1981 *Asians and Psychiatry*,
Unpublished dissertation for M.Sc. Clinical
Psychology, University of Leeds, England.
- SHARMA Ursula M. 1978 'Women and their Affines : The Veil as a
Symbol of Separation',
Man (N.S.), Vol. 13, No. 2, pp. 218-233.
- 1980 *Women, Work, and Property in North-West
India*,
Tavistock Publications, London.
- SHARMAN Ruth L. 1985 *Ethnic Minority Groups : A Discussion Paper
on Curriculum Development in Health
Visiting*,
English National Board for Nursing, Midwifery
and Health Visiting, London.
- 1986a Personal communication - May 1986.
Education Officer (Health Visiting),
English National Board for Nursing, Midwifery
and Health Visiting, London.
- 1986b Personal communication - August 1986.
- SHEPHERD Eric 1984 'Values into Practice : The Implementation
and Implications of Human Awareness
Training',
The Police Journal, Vol. 57, No. 3,
pp. 286-300.
- SHUKLA Kiran 1980 'Diet and Culture',
Nursing (U.K.), 1st Series, April, pp. 523-525.
- S.I.
(STATUTORY INSTRUMENTS)
- 1965 *The National Health Service (Qualifications of
Health Visitors) (Scotland) Regulations*,
No. 1490, (S. 80), H.M.S.O., London.
- 1972 *The National Health Service (Qualifications of
Health Visitors) Regulations*,
No. 1822 (England and Wales),
H.M.S.O., London.

S.I.

(STATUTORY INSTRUMENTS)

- 1983a *The Nurses, Midwives and Health Visitors (Parts of the Register) Order 1983*, No. 667, H.M.S.O., London.
- 1983b *The Nurses, Midwives and Health Visitors Act 1979 (Commencement No. 4) Order 1983*, No. 668 (C20), H.M.S.O., London.
- SIMMEL Georg 1908 'The Stranger', in *Georg Simmel : On Individuality and Social Forms*, pp. 143-149, Ed. D. N. Levine, edition dated 1971, The University of Chicago Press, Chicago, IL, U.S.A..
- SINGH Arjan K. 1981 'Sikhism', in *East meets West : a Background to some Asian Faiths*, pp. 79-106, Ed. M. Iqbal, Third edition, Commission for Racial Equality, London.
- SINGH Bhai Maya (comp. and ed.) 1895 *The Panjabi Dictionary*, Munshi Gulab Singh and Sons, Lahore.
- SINGH Hindbalraj 1977 *Bhatra Sikhs in Bristol : Development of an Ethnic Community*, Unpublished dissertation as part of B.Sc. degree, Department of Sociology, University of Bristol, England.
- SINGH Indera P. 1958 'A Sikh Village', *Journal of American Folklore*, Vol. 71, No. 281, pp. 479-503.
- SINGH Khushwant 1953 *The Sikhs*, George Allen and Unwin Ltd., London.
- 1963 *A History of the Sikhs : Vol. 1 : 1469 - 1839*, Princeton University Press, Princeton, NJ, U.S.A..
- SINGH Ramindar 1980 'Punjabi culture in Britain', *The Asian*, Vol. 3, No. 6/7, pp. 3-6.

- SKINNER Carolynne K. 1979 *Asian Immigrants and their use of the Family Planning Services*,
Report based on an unpublished dissertation for the M.Sc. degree in Medical Demography, University of London – lodged at the Centre for Population Studies, London School of Hygiene and Tropical Medicine, London. Also available at International Planned Parenthood Federation, London.
- SLACK Patricia A. 1978 *School Nursing*,
Bailliere Tindall, London.
- 1981 'Some Aspects of Health Service Planning for Children of Cultural Minorities',
in *Social and Community Work in a Multi-racial Society*, pp. 59-66,
Eds. J. Cheetham, W. James, M. Loney, B. Mayor and W. Prescott,
Harper and Row, London.
- SMITH James P. 1979 'The challenge of health education for nurses in the 1980s',
Journal of Advanced Nursing, Vol. 4, No. 5,
pp. 531-543.
- SMITH Marian W. 1960 'Social Structure in the Punjab',
in *India's Villages*, pp. 161-179,
Ed. M.N. Srinivas, Second edition,
J.K. Publishers, London.
- SMITH Susan R. 1981 'Sound off! 'Oremization', the curse of nursing',
R.N. (Medical Economics), Vol. 44,
No. 10, p. 83, Oradell, NJ, U.S.A..
- SOCIAL INSURANCE AND ALLIED SERVICES
1942 Report by William Beveridge, November 1942,
Command 6404, H.M.S.O., London.
- SOHIER Raphella 1976 'Gaining Awareness of Cultural Difference :
A Case Example',
in *Transcultural Health Care Issues and Conditions, Health Care Dimensions*,
pp. 67-81,
Ed. M. Leininger, F.A. Davis Company,
Philadelphia, PA, U.S.A..
- SPRADLEY Barbara W. 1981 *Community Health Nursing : Concepts and Practice*,
Little, Brown and Company, Boston, MA,
U.S.A..

- SPRADLEY Barbara W.
(ed.) 1982 *Readings in Community Health Nursing*,
Second edition, Little, Brown and Company,
Boston, MA, U.S.A..
- SPRADLEY James P. 1979 *The Ethnographic Interview*,
Holt, Rinehart and Winston, New York.
- 1980 *Participant Observation*,
Holt, Rinehart and Winston, New York.
- SRIVASTAVA Sheela R. 1975 *The Asian Community in Glasgow*,
Unpublished Ph.D. thesis, University of
Glasgow, Scotland.
- STATON M.W. 1980 *The Rite of Churching : A Sociological
Analysis, with Special Reference to an Urban
Area in Newcastle upon Tyne*,
Unpublished M.A. thesis, University of
Newcastle upon Tyne, England.
- STATON Maurice 1981 'Churching - Past and Present',
Contact, [Journal of Pastoral Studies],
No. 72, pp. 10-17.
- 1982 Personal communication,
Methodist Minister, Consett, Durham,
England.
- STEVENS Barbara J. 1984 *Nursing Theory : Analysis, Application,
Evaluation*,
Second edition, Little, Brown and Company,
Boston, MA, U.S.A..
- STEWART J.L. 1869 *Punjab Plants*,
Government Press, Lahore.
- SUTHERLAND Anne 1975 *Gypsies : The Hidden Americans*,
Tavistock Publications, London.
- SYKES J.B.
(ed.) 1976 *The Concise Oxford Dictionary of Current
English*,
Sixth edition, Clarendon Press, Oxford.
- TAGORE Rabindranath 1920 'The Indian Ideal of Marriage',
in *The Book of Marriage*, pp. 98-122,
Ed. H. Keyserling, Blue Ribbon Books, New
York.
- TANN Swee Poh
WHEELER Erica F. 1980 'Food intakes and growth of young Chinese
children in London',
Community Medicine, Vol. 2, No. 1,
pp. 20-24.

- TAYLOR J.H. 1976 *The Half-Way Generation : A Study of Asian Youths in Newcastle upon Tyne*, N.F.E.R. Publishing Company Ltd., Windsor, England.
- TAYLOR Monica J. 1981 *Caught Between : A Review of Research into the Education of Pupils of West Indian Origin*, N.F.E.R. - Nelson, Windsor, England.
- TENNYSON Alfred 1842 'Ulysses', in *The Early Poems of Alfred Lord Tennyson*, Ed. J.C. Collins, edition dated 1900, Methuen and Co., London.
- THEODORSON George A.
THEODORSON Achilles 1970 *A Modern Dictionary of Sociology*, Methuen and Co. Ltd., London.
- THOMAS D.A.T.
GHUMAN P.A.S. 1976 *A Survey of Social and Religious Attitudes among Sikhs in Cardiff*, Open University in Wales, Cardiff, Wales.
- THOMPSON Thomas W. 1922 'The Uncleanness of Women among English Gypsies', *Journal of the Gypsy Lore Society*, Third Series, Vol. 1, No. 1, pp. 15-43.
- TIERNEY Alison 1986 Personal communication, Director, Nursing Research Unit, University of Edinburgh, Scotland.
- TISDALL W. StClair 1911 *A Conversation-Grammar of the Hindustani Language*, Julius Groos, Heidelberg.
- TOLSTAYA N.I. 1981 *The Panjabi Language - A Descriptive Grammar*, First published in Moscow in 1960, Translated into English by G.L.Campbell, Routledge and Kegan Paul, London.
- TOMLINSON Sally 1981 'The Educational Performance of Ethnic Minority Children', in *The School in the Multicultural Society*, pp. 119 - 146, Eds. A. James and R. Jeffcoate, Harper and Row, London.
- TOWELL David 1975 *Understanding Psychiatric Nursing*, Royal College of Nursing, London.
- TRAVELBEE Joyce 1971 *Interpersonal Aspects of Nursing*, Second edition, F.A. Davis Company, Philadelphia, PA, U.S.A..

- TRIPP-REIMER Toni 1983 'Retention of a Folk-Healing Practice (*Matiasma*) among Four Generations of Urban Greek Immigrants', *Nursing Research*, Vol. 32, No. 2, pp. 97-101.
- 1984a 'Reconceptualizing the Construct of Health : Integrating Emic and Etic Perspectives', *Research in Nursing and Health*, Vol. 7, No. 2, pp. 101-109.
- 1984b 'Research in Cultural Diversity : Directions for Future Research', *Western Journal of Nursing Research*, Vol. 6, No. 2, pp. 253-255.
- TRIPP-REIMER Toni
BRINK Pamela J.
SAUNDERS Judith M. 1984 'Cultural Assessment : Content and Process', *Nursing Outlook*, Vol. 32, No. 2, pp. 78-82.
- TURRELL Sally 1985 'Asian expectations', *Nursing Times*, Vol. 81, No. 18, pp. 44-46.
- TYLOR Edward B. 1871 *Primitive Culture : Researches into the Development of Mythology, Philosophy, Religion, Art, and Custom*, Vol. 1, John Murray, London.
- UBEROI Narindar 1964 'Sikh women in Southall', *Race*, Vol. 6, No. 1, pp. 34-40.
- U.K.C.C.
(UNITED KINGDOM CENTRAL COUNCIL FOR NURSING, MIDWIFERY AND
HEALTH VISITING) 1983 *Code of Professional Conduct for Nurses, Midwives and Health Visitors (based on ethical concepts)*, First edition, U.K.C.C., London.
- 1984 *Code of Professional Conduct for the Nurse, Midwife and Health Visitor*, Second edition, U.K.C.C., London.
- UNIVERSITY OF MANCHESTER 1981 *Health care provision for the Asian Community*, A National Administrative Training Scheme Group Project - 1978 Intake, Working Paper No. 45, May 1981, Health Services Management Unit, Dept. of Social Administration, University of Manchester, Manchester, England.

- VATUK Sylvia 1982 'Purdah Revisited : A Comparison of Hindu and Muslim Interpretations of the Cultural Meaning of Purdah in South Asia', in *Separate Worlds : Studies of Purdah in South Asia*, pp. 54-78. Ed. H. Papanek and G. Minault, Chanakya Publications, Delhi, India.
- VIRDI Parmjit K. 1984 'Talking the same language', *Nursing Mirror*, Vol. 158, No. 7, pp. 47-49.
- VISINTAINER Madelon A. 1986 'The Nature of Knowledge and Theory in Nursing', *Image, Journal of Nursing Scholarship*, Vol. 18, No. 2, pp. 32-38.
- WAKIL Parvez A. 1970 'Explorations into the Kin-networks of the Punjabi Society : A Preliminary Statement', *Journal of Marriage and the Family*, Vol. 32, No. 4, pp. 700-707.
- WALKER Lorraine O.
AVANT Kay C. 1983 *Strategies for Theory Construction in Nursing*, Appleton-Century-Crofts, Norwalk, CT, U.S.A..
- WANDSWORTH
(WANDSWORTH AND EAST MERTON HEALTH DISTRICT [TEACHING])
1979 *Ethnic Minorities and the Health Service*, Report of the Working Party on the Provision of Health Services to Ethnic Minorities living in the Wandsworth and East Merton District, Wandsworth and East Merton Health District, London.
- WARNER Una 1984 'Achieving Goals', *Community Outlook*, July, pp. 242,244, in *Nursing Times*, Vol. 80, No. 27.
- WATSON James L.
(ed.) 1977 *Between Two Cultures - Migrants and Minorities in Britain*, Basil Blackwell, Oxford.
- WEBB Penny 1981 'Health Problems of London's Asian and Afro-Caribbeans', *Health Visitor*, Vol. 54, No. 4, pp. 141,144,145,147.
- WEBB Sidney
WEBB Beatrice 1932 *Methods of Social Study*, Longmans, Green and Co., London.

- WENGER Anna F. 1985 'Learning to do a Mini Ethnonursing Research Study : A Doctoral Student's Experience', in *Qualitative Research Methods in Nursing*, pp. 283-316, Ed. M. Leininger, Grune and Stratton, Inc., Orlando, FL, U.S.A..
- WERBNER Pnina 1979 *Ritual and Social Networks : A Study of Pakistani Immigrants in Manchester*, Unpublished Ph.D. thesis, University of Manchester, England.
- 1980 'From rags to riches : Manchester Pakistanis in the textile trade', *New Community*, Vol. 8, Nos. 1/2, pp. 84-95.
- 1981 'Manchester Pakistanis : life styles, ritual and the making of social distinctions', *New Community*, Vol. 9, No. 2, pp. 216-229.
- WHILE Alison 1986 'The uptake of prophylactic care during infancy', in *Research in Preventive Community Nursing Care : Fifteen Studies in Health Visiting*, pp. 53-66, Ed. A. While, John Wiley and Sons, Chichester, England.
- WHILE Alison E.
GODFREY Mary 1984 'Health Visitor Knowledge of Asian Cultures', *Health Visitor*, Vol. 57, No. 10, pp. 297-298.
- WHITE Earnestine H. 1977 'Giving Health Care to Minority Patients', *Nursing Clinics of North America*, Vol. 12, No. 1, pp. 27-40.
- WHITE Geraldine 1986 Personal communication - September 1986. Professional Officer (Primary Health Care), Welsh National Board for Nursing, Midwifery and Health Visiting.
- WHITETHREAD Mary 1981 'Ostomists : a world of difference', *Journal of Community Nursing*, Vol. 5, No. 2, pp. 4-5,10.
- WILBER Donald N. 1964 *Pakistan : Yesterday and Today*, Holt, Rinehart and Winston Inc., New York.
- WILKIE Elaine 1979 *A History of the Council for the Education and Training of Health Visitors : An Account of its Establishment and Field of Activities, 1962-1975*, George Allen and Unwin, London.

- WILKINSON Sharon 1986 'Why there are no accidents in Thika',
Nursing Times, Vol. 82, No. 18, pp. 49-51.
- WILLIAMSON Janet A. 1981 'Mutual Interaction : A Model of Nursing
Practice',
Nursing Outlook, Vol. 29, No. 2, pp. 104-107.
- WILLS Betty B. 1978 'Food becomes fun for children',
American Journal of Nursing,
Vol. 78, No. 12, pp. 2082-2085.
- WILSON Amrit 1978 *Finding a Voice : Asian Women in Britain*,
Virago, London.
- WISEMAN Joyce 1980 *Health Visiting - The Allocation Problem*,
*A research study to determine an approach
for an allocation plan*,
Unpublished M.Sc. dissertation,
University of Lancaster, England.
- WRIGHT Steve 1986 'Developing and Using a Nursing Model',
in *Models for Nursing*, pp. 39-46,
Eds. B. Kershaw and J. Salvage,
John Wiley and Sons, Chichester, England.
- YOUNG Ken
CONNELLY Naomi 1981 *Policy and Practice in the Multi-racial City*,
Policy Studies Institute, London.
- ZAKLAMA M.S. 1984 'The Asian Community in Leicester and the
Family Planning Services',
Biology and Society, Vol. 1, No. 2, pp. 63-69.