THE CHILD-RELATED HEALTH CARE PERCEPTIONS AND BEHAVIOUR OF THE PUNJABI SPEAKING PEOPLE IN MANITOBA

BY

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ABSTRACT

This study describes health and child caring perceptions and behaviour of the Punjabi people of Manitoba. The unfamiliarity of the health practices and behaviour of different ethnocultural communities to mainstream health service providers may create a gap in the health status of these communities. The study population rated their health significantly lower than the average of the Canadians as reported in Canada's Health Promotion Survey (1990). Some barriers to accessing health care are related to Punjabi perceptions of the effectiveness of Western medicine and cultural beliefs and social behaviour during pregnancy. Poor nutritional knowledge and lack of prenatal care might be contributing to many health complications, including low birth- weight babies in this community. Language can be a barrier to accessing health care if Punjabi speaking medical doctors are not available. A need for better communication in the patient-doctor relationship is the major finding of the study. Better communication with this community will undoubtedly help them to take better preventive actions. Health promotion programs should also take into account the cultural practices, beliefs and disease patterns. Understanding historical and social relationships in the Punjabi circumstances are particularly important in order to understand Punjabi perceptions of health and illness. A feeling of alienation from mainstream society might also be impeding development opportunities of the children of this community. The study was based upon exploratory open-ended interviews and survey of 87 Punjabi households. The study is particularly important to health educators and planners and can be used as a guideline in initiating programs with social and cultural sensitivity relative to a particular ethnic community.

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1. INTRODUCTION

The purpose of this study is to describe the health-related child caring perceptions and behaviour of the Punjabi speaking people in Manitoba. The study also compares some health-related behaviours of the Punjabi people with those of the mainstream society as described in Canada's Health Promotion Survey (1990). The rationale for this study is summarised under six main headings:

a. Multiculturalism

b. Health Promotion Programs

c. Immigration, Culture and Social relationships

d. Punjabi Health Beliefs

e. Culture and Disease

f. Historical and Cultural background of the Punjabi people

1.1 Multiculturalism: Multiculturalism has become a fundamental characteristic of Canada's fast changing society. The health care providers of Canada are challenged with the varying health care needs of different ethnic groups. They often find many ethnic expressions of diseases which are quite unique, requiring a deeper understanding of traditions, beliefs and cultural behaviours of different ethnic groups (Krause 1989). This study is an endeavour to familiarize health care providers with Punjabi perceptions for child caring and health-related behaviour. This familiarity is necessary because in Manitoba the majority of Punjabi speaking people are still first generation immigrants, although the

Punjabi settlement in other parts of Canada started in the beginning of this century (Morrison et al. 1990, Singh 1983).

Manitoba's multiculturalism policy promotes preservation of cultures of all ethnic groups and addresses the issue of ethnic disparities, social justice and equality in achieving health by all, by making services and programs more sensitive to cultural values and traditions of every ethnic group (Manitoba's Policy for a Multicultural Society 1990). This policy is a reflection of an egalitarian democratic political system of Canada. In such a liberal democratic system, it becomes an issue of human rights to preserve the culture of disadvantaged groups against the intrusions by the majority or mass cultures (Gutmann 1992). Charles Taylor (1992) in his essay on *The Politics of Recognition* advocates for due recognition to every culture as a vital human need, and suggests that withholding of recognition can be a form of oppression. Taylor asks the questions: "Can a democratic society treat all of its members equally?" or "How far can differences, diversity and pluralism be accommodated?" He asserts that freedom and equality should be accorded to every one with mutual respect for reasonable intellectual, political and cultural differences. In accordance with this concept of multiculturalism, this study was designed to explain the Punjabi health behaviour within their historical, traditional and cultural values, social and economic status, family structures and other health-related and culturally patterned behaviour.

1.2 <u>Health Promotion Programs</u>: Health promotion involves an understanding of

cultural values, beliefs and practices of a community and creating a supportive environment, access to information, life skill and opportunities and resources for making healthy choices (Ottawa Charter 1986). The Ottawa Charter (1986) focuses on equity in health, and defines health promotion as the process of enabling people to increase control over, and to improve, their health. Concepts such as these can be further corroborated by studies conducted on multiethnic communities with respect to accessing information on their cultural and social behaviour.

The philosophy of health promotion has a strong historical basis in Canada. Both Lalonde (1974) and Epp (1986) recognized that disadvantaged groups had significantly lower life expectancy, poorer health and a higher prevalence of disability than the average Canadian. A further stimulus in this area was provided by many international conferences and conventions. Some important milestones in this field are; the Alma Ata conference and the UNESCO "declaration of experts" in rejecting the claim that health is not merely a biological problem (Johnson 1984). Particularly the Alma Ata declaration expressing that psychological and cultural factors have a bearing on health, and the more recent finding that the "Asian low birth weight syndrome" disappears as maternal and child health improve (ibid.), also encouraged various studies related to immigrant and refugee health. The famous Black report of the UK entitled "Inequalities in Health" describes inequalities in health and in the use of health services according to class, place of residence, age and sex (Donovan 1984). It reported that the lower socioeconomic class had poorer health, and a higher mortality, than their fellow citizens in the more affluent classes. The

literature on the "health belief model" suggests that "good health" is a goal more or less common to all. Differences in health behaviour are due to differences in perceptions that impinge on the individual's motivations to engage in action. Social networks and socio-economic status were also found to be related to personal health behaviour (Langlie 1977).

1.3 Immigration, Culture and Social Relationships: One of the main issues related to immigrant health is social status. Feelings of powerlessness, hopelessness, social isolation and the resulting alienation may be strong barriers to the utilization of preventive services for a recently immigrated community (Beiser et al. 1988). Beiser et al. (1988) also reported that moving from one country and culture to another, inevitably entails stress. The Western medical delivery system particularly its institutional arrangements, appointments and referral systems might inhibit many immigrant communities from accessing health care services (Magnusson and Aurelius 1980). Studies have consistently shown that the cultural beliefs of health and illness and perceptions of guilt and shame, usually placed on immigrants by the social structure of a mass culture, affect accessibility to the health care system (Beiser et al. 1983, Helman 1990). Western physicians often find themselves practising at an "invisible border" separating them from foreign-born patients (Kraut 1990). Such invisible borders might become an impediment to a Western physician's ability to gain cooperation with prescribed therapy while interacting with an immigrant population.

Some reports describe indirect costs such as child care, time off work, and transportation as possible barriers to accessing health and social services by immigrants and refugees (Nyman 1992). Nyman (1992) examined a specific list of 30 likely barriers immigrants may eventually face in order to access mental health services. Some of them, such as lack of information about the availability of services, language barriers, problems with transportation, and administrative problems (e.g. culturally insensitive staff) may be particularly relevant to the Punjabi speaking people.

The social relationships of Punjabi people are also relevant in forming cultural perceptions. Though Sikhs are religiously opposed to the caste system, there still prevails a widespread support for this system in practice (Henley 1983). *Jat Sikhs* (land owners) perceive themselves to be superior than *chamar* - the lowest caste treated as untouchable (Krause 1989). Land ownership in Punjab is a dominant force (Ballard 1983). Social hierarchy is often based on achieved status (Pettigrew 1972). Powerful administrative positions, positions in the army or police force and acquired wealth give higher status in society. Many Sikhs find migration a remedy from social suppression by the higher status groups (Ballard 1983). Such social discriminations and hierarchies may prevent Punjabis from healthy social interactions which are an essential element for their social well-being.

1.4 <u>Punjabi Health Beliefs</u>: Some factors such as the health practices of India may have profound influence on the outlook of the Punjabis towards Western medicine. The traditional Ayurvedic system of medicine may constitute a framework for the expression

of Punjabi ideas about illness and treatment (Krause 1989). The Ayurvedic system promotes a connection between human life and the universe, and it establishes a relationship between the body and the mind.

Both the Unani and the Ayurvedic systems place a heavy emphasis on the disturbance and rectification of the "hot and cold" equilibrium (Bhopal 1986). Foods are generally classified as hot and cold in symbolic terms (Morrison et al. 1990, Helman 1990, Bhopal 1986, Henley 1983). An excess of any of these could cause sickness. Various Punjabi expressions, such as, *Bhye Bhaddi*- a symptom that could cause flatulence, indigestion and abdominal distension, and "sinking heart"- an illness in which physical sensation in the heart is experienced, are typical cultural expressions of illnesses which are not found in the Western parlance (Krause 1989, Bhopal 1986). Pregnancy is believed to be a "hot" stage (Morrison et al. 1990). After the delivery the body becomes "cold" therefore, hot substances such as ginger, ghee (purified butter) and *Panjiree*, a flour mixture especially made by mixing flour, ghee, almonds and various types of nuts are preferred. The constitution of food (hot ,cold, wet and dry) is transformed in the body during the consumption process into three humours: wind, bile and phlegm. An excess of any of these humours is thought to cause illness (Islam 1994, Krause 1989). Homeopathic medicine also has some influence on the Punjabi people (Helman 1990). In addition to these established systems, there also exist many local healers and home remedies. Local healers often believe in super-natural powers. They offer a special "CHARM" to people which would keep the evil spirit in abeyance. *Kajal* is used as one of the devices to keep the bad

spirit away from the child (Aslam et al. 1979). Many of these belief systems need to be elaborated to understand the Punjabi perceptions towards health care.

1.5 Culture and Disease: There is a lack of literature specific to the Punjabi community in Canada but some research done in the United Kingdom is described here to establish the need to study the epidemiology of disease in ethocultural communities.

Several studies in Britain (Stephens et al. 1981; Ford et al. 1973; Goel et al. 1976) reported vitamin D deficiency, neonatal rickets and osteomalacia in the Asian population. Some studies also reported a higher prevalence of diabetes compared to the English population (McKeigue et al. 1991; Gillam et al. 1989, Ramaiya et al. 1991). Gillam et al. (1989) described asthma, respiratory diseases and tuberculosis as being prevalent in Asian groups. Balarajan et al.(1984) and Donaldson & Clayton (1984) found that Punjabi men settled in Britain died more often from cerebrovascular diseases, mental disorder and cirrhosis of the liver as compared to the English population and the total number of cancer cases in Asians was significantly higher when age was taken into account.

Aslam et al.(1979) described the existence of some heavy metals in some of the Asian medicines and cosmetics. Some studies (McKeigue 1991, Williams et al.1993) reported that South Asians were shorter and broader and more overweight (women) compared to the general population. The pulse rates of Asians were also reported as higher than expected and men had a higher diastolic blood pressure; women had low FEV1 (Forced

Expiratory Volume in 1 second) in relation to their vital capacity and had asthma.

The health gap is also found to be higher between genders of Asian population. Ineichen (1990) reported that the Asian culture poorly understands mental illnesses. Many studies (Gillam et al. 1989, Beiser et al. 1988, Potter et al.1984) reported that immigrants had low physician consultation rates. Balarajan et al. (1989) reported that Indians in the UK consulted doctors more at ages 45-64 followed by 0-15 in contrast to the white males who consulted most at ages 0-15 years followed by 45-65, and while females consulted most at ages 16-44 years followed by 45-65. The same study reported that chronic conditions such as hypertension, heart disease, stroke, and diabetes were more common in South Asians than in the mainstream population.

This brief review demonstrates that we should not assume that our expectation about mainstream Canadian health status and behaviour will be relevant to the members of different ethnocultural communities. Understanding health-related perceptions and behaviour should be a prerequisite for designing health promotion and education policies.

1.6 <u>Historical and Cultural background of the Punjabi people</u>: In order to understand the contemporary context of Punjabi customs, it is necessary to review the history of the Sikh migration from Punjab to Canada. This would also help us to understand the historical circumstances and events that have an influence upon intra and inter family relationships. Past experiences shape aspirations and hopes, fears and anxiety,

and have some bearing in shaping present belief systems and behaviour.

The word Sikh is believed to be drawn from the Sanskrit word *Shishya* meaning disciple and therefore, Sikhism literally means disciple-hood (Singh 1988). Sikhs have tremendous devotion to their masters and the holy book *Gurugranth Sahib.* The broad philosophical meaning of *Gurugranth Sahib* is the illumination of the Master's work and his guided ultimate path of enlightenment (Henley 1983). Literally, *Guru* could mean both Master and teacher. The *Guru* is some one who is enlightened, the one who knows his path of the "ultimate truth" and who can guide the disciple on the same path. A *Guru* is omnipresent, omniscient and omnipotent; *Granth* means holy book and *Sahib* means reverence. The *Gurugranth Sahib* consists of 1948 pages including 7,000 hymns (Singh 1988).

Guru Nanak was born in the year 1429 in the Indian village of *Talawandi* near Lahore now in Pakistan (Singh 1988). Historians have a difference of opinion about the social situations at the time Nanak was born, but it is evident that India was passing through a period of disintegration besides facing a domination under the Muslim rulers (McMullen 1989). The Hindu religion also faced criticism for over-emphasizing the rituals and making its people complacent and passive even at the time of an invasion. A case in point is the Mahamud of Ghzni (Afghanistan) who was successful in attacking and looting the wealth of India in the year 997, despite his being less powerful than the mighty kings of India. Superstition and fanaticism were apparently wide-spread at that time. The social situations paved the way to give rise to a charismatic person. Guru Nanak was one such

charismatic leader (McMullen 1989). He declared the fallacy of the blind faith and superstitions and taught the inner piety as a "true religion". Nanak was believed to be influenced by Sufi and Bhakti movements which had already produced many religious leaders such as Kabir and Ravidas, and all of them were "accepted" within a larger context of the Hindu society. But no other saint of the Bhakti movement could institutionalize his religion as strongly as did the Sikhs in India.

It is pertinent to point out that Sikhism was a reform of Hinduism when it was initiated by Nanak (McLeod 1984). Through the passage of time, it changed much of its context and developed a separate identity from the mainstream Hindu society (McMullen 1989). Such a different identification might have caused a feeling of alienation from the mainstream society. The sense of minority for a longer period of time might have made Sikhs more self-adjusting even in the new social situations, and these adjustments might be making Sikh migration and overseas settlement easier as compared to the migration of other Indian communities.

Guru Nanak died in 1539 but Sikhism continued (Singh 1988). Between the year 1552 and 1574 Guru Amar Das, the third Guru, started *Langar* or the common kitchen system which had a profound impact on the social system of Sikhs at a later stage. Sikhs started living in communes. Collective thinking and community living became a way of life.

The fourth Guru Ram Das (1574-81) established the concept of pilgrimage (Singh 1988).

He built the *Amrit Sarowor* at Amristar where the Sikhs most revered temple *Harmander Sahib* is now located. *Amrit* literally means elixir of life and *sarowar* means pond or lake. Devotees take a plunge into this pond to wash away the sins of their lives. Sikhism was institutionalizing its own system of rituals and traditions. The fifth guru Arjan Das (1581-1606) built the four doors of this temple symbolically, meaning that all four castes of Hindus are allowed in the temple, a practice which is forbidden in the traditional Hindu religion (McLeod 1984, Henley 1983).

A conflict with the Emperor Jehangir, the muslim ruler, started when Jehangir's son Khusro was turning rebellious against Jehangir and was believed to be in close contact with Guru Arjan Das, the fifth Guru (Singh 1988). Guru Arjan Das was tortured to death by Jahangir. A sense of martyrdom, a sense of injustice and feeling of insecurity were predominant sentiments amongst the Sikhs, which grew stronger with passing time.

Guru Hargobind (1606-44) the sixth guru and the son of Guru Arjan Das was compelled to maintain an army. This set the stage for a trend to militancy in Sikhism which grew out of the necessity to protect their religion from the invaders. Jahangir's son Shah Jahan sent an army to kill Guru Hargobind. Guru Hargobind was the object of constant hostility and aggression by the Muslim ruler. He left Amritsar and lived in Kartarpur until his death. Sikhs in general were on the move, generating support and founding new towns and military bases to fight against the Muslim Emperor.

The ninth guru Tegh Bahadur (1664-75) faced major aggression from the Muslim Emperor (Singh 1988). Amritsar itself was attacked. Sikhism was in danger of being destroyed. Guru Tegh Bahadur was executed and once again Sikhs were seen facing new challenges to protect their religion. Sikhs were also seen moving from one place to another to protect themselves.

A new form of Sikhism appeared when the tenth and the last guru Gobind Singh (1675-1708) became the Head of this religion. Sikhs were running and hiding to save themselves and their children and women. A strong enmity between Sikhs and Muslims had become widespread. It was difficult to distinguish between Sikhs and non-Sikhs. Guru Gobind Singh then baptized them and called them *Khalsa* (the pure ones), and for the purpose of distinguishing them the guru decreed that they should wear five "K" s. They were *Kesh* (long hair), *Kanga* (comb), *Kara* (Steel wristband), *Kirpan* (short sword) and *Kaccha* (short breeches).

" Guru Gobind Singh's own life was, in a sense, a series of sudden attacks and strategic retreats. It was a life spent in the saddle and on the move, to such an extent that he was not even once able to visit the holy city of Amristar, or the hallowed Harmandir" (Singh 1988 : 66).

Guru Gobind Singh's two sons were killed in battle and the other two were tortured to

death. At that time (during the middle of the seventeen century) the Governor of Punjab set a price of Rs 50 for each head of a Sikh alive or dead (Singh 1988). Sikhs faced a holocaust probably unparalleled in the history of mankind.

These historical conditions have produced four prominent influences on Sikh social norms:

1. A turn to more militancy from the original path of soul searching; they were now soul protecting.
2. Increased mobility which may in part explain an increased desire to emigrate overseas.
3. A strong preference for community oriented social life. Collectiveness mattered more than individual preferences. This is reflected in child care practices and seeking advice from friends or acquaintance in the initial period of illness.
4. A strong value on male protection of women. A clear distinction was being made between the "protector" and the "protected". A line of control and authority was established which divided male and female. The preference for male children and differential treatment of men and women probably are the outcome of such values.

A further description of history after English occupation is also relevant. In brief, there was a rebellion in 1857 against the British rule and it is believed Punjabis did not take a serious part in it (Ballard 1983). During the first and second World Wars the British required more and more soldiers in their army. Sikhs proved to be good fighters and they were recruited in large numbers. Sikhs were sent to Singapore, Burma and other countries

to fight wars for the British. Many Sikhs were decorated with the Victoria Cross, the highest army decoration for valour in the British Army.

After the Wars, the economy was booming and the British needed more people to work in their factories. The Sikhs started settling in the UK, and also as farm labourers in California and in lumber industries in British Columbia (Morrison et al. 1990).

Ballard (1983) reports that migration always has its own dynamics. This is evident from the fact that at the end of the World Wars, Sikhs settled in Singapore and Hong Kong as night watchmen or as small traders. When the U.K. later excluded many of them from entering into the UK by enacting restrictive immigration laws, the Sikhs tried to settle in Germany, Hong Kong and Australia. When industrialized nations were in deep recession, Punjabis turned to the construction sites of Saudi Arabia and other Gulf countries.

In order to survive the recession of the 30's and also because of their military skills, Sikhs in India were forced to abandon their agricultural past and rely on jobs with the army or police. Migration to provide income became a usual practice. Some even tried to work in factories or to drive long distance trucks which many other ethnic communities avoided doing in India. This hard working attitude, movement and adaptation gave them a prosperity over other ethnic communities in India. At the same time it weakened the family fabric as men tended to be away from the family to earn money and the child caring burden was often left solely on the mother. After migration to Canada, further changes

have occurred when mothers were required to join the work force. This made it necessary for families to depend on community child care.

From this historical background it is clear that Sikhs in general believe in more collective decision making as opposed to the typical individualistic way of decision making in Western society. Their higher level of consultation with friends and family members in the matter of child care is also derived from this historical background. Their faith on *Langar* - eating together in temples, frequently visiting temples and friends and a higher level of consultation for home remedies are clearly derived from historical experience.

2. DESIGN AND METHODS

The study is descriptive in nature. The focus of the study is to describe Punjabi health knowledge in general, and attitudes and practices in relation to child caring in particular, and to explore if these are in any way a barrier to participating in health promotion or accessing medical care in Canada. It was thought pertinent to describe Punjabi cultural beliefs and perceptions towards health, Western medicines, home remedies, intra and inter family relationships and their outlook towards the mainstream society that may be shaping present as well as future health actions. It was also felt that what the society at large perceives as a barrier to health may not be regarded as one by the respondents.

The study followed a two-stage design. To more fully understand health perceptions and behaviour of Punjabi parents, the first stage involved in-depth interviews of five sets of Punjabi parents. Interviews were done with both parents together and the differences in attitude and health perceptions were noted.

Although there were many similarities in their response in the interviews, differences did exist about health perceptions and behaviour among the respondents. It was felt that these differences might be partially explained by fundamental differences in the background of the respondents. In order to further explore these differences a survey was designed to describe the distribution of beliefs and behaviour throughout the Punjabi community, and to associate these differences with social and demographic variables.

The in- depth interviews served as the framework for the development of survey questions which were subsequently pre-tested with an additional ten families. In the survey questionnaire a series of core questions were reproduced from Canada's Health Promotion Survey -1990. Some questions are also reproduced from an infant care questionnaire - a study being conducted to investigate the sudden infant death syndrome (Moffatt 1994), and from the "National Longitudinal Survey of Children" to be initiated by the Government of Canada in 1994. These questions served to provide a framework for understanding Punjabi health behaviour in comparison with that of the mainstream society.

Although the questionnaire became very lengthy and some respondents complained during the pre- test, it was thought appropriate to continue with it as there was no other way to explore a wide range of subjects. The questionnaire was divided into seven sections. The first section contained general socio-demographic questions such as education, occupation etc. The second section was designed to elicit attitudes about the accessibility of medical care. Questions pertaining to cost of medicine and satisfaction with Western medicine are investigated in this section. The third section was designed to record health behaviour and perceptions (eg. smoking and alcohol use etc.) The purpose of the fourth section was to understand family relationships and the child caring experience in Canada. Questions such as: "Do your children play in the neighbourhood?" and their experience of day care were included. The fifth section elicited information about general cultural beliefs about foods. The sixth section was to understand attitudes about social relationships and health behaviours such as the role of Punjabi husbands and their

preference for male children etc. The last section was to describe the Punjabi beliefs such as the use of *Kajal*, oil massage etc.

2.1 Sampling: The study is confined to the Punjabi speaking population of Winnipeg. Though there are some Punjabi speaking people who live in other cities and towns of Manitoba, their number is not large enough to make a significant impact on the study.

Only respondents with children below the age of five were included. Children after five years of age start going to school which could have an unpredictable effect on both children's and parental health behaviour. Secondly, many parenting behaviours such as the disciplining of the children, home -remedies used, compliance with recommended medical treatments, etc could be tested only up to a certain minimum age after which parents may not be able to remember the past practices accurately.

There is no accurate population list available of the Punjabi speaking people in Manitoba. Four possible ways were identified to compile the list of the total population of Punjabi speaking people in Manitoba. First, to take the list of members of various *Gurudwaras* (temples). This option would not meet the requirement of statistical randomness in sample selection, a basic prerequisite for this type of study, because the Punjabi people are often divided among different *Gurudwaras* according to their faith and beliefs in political systems. There was also a possibility that some recent Punjabi immigrants might not have joined any *Gurdwara* because of the financial constraints new arrivals are faced with. The

second option was to obtain the list of names from the hospitals of Winnipeg for all the women who gave birth in preceding years and select the Punjabi names from the list. There were many practical problems associated with this option. As well as being expensive (requiring hospital staff to compile lists), this option would have encountered complex ethical problems related to the release of names. The third option was to get a list from the Immigration Department; that because of regulations regarding privacy accessing such lists was not possible.

The only plausible option was to compile a list of names and addresses from the telephone directory, since Punjabi names are easily recognizable to someone else from the culture. While discussing this option with many local Punjabi leaders it was generally felt that most Punjabi people, including recent arrivals, had a telephone, albeit sharing one telephone among many members. Some studies in the UK also found no problems in taking Punjabi names from the telephone directory as chances of missing names will be statistically insignificant (Nicoll et al. 1986, Ecob & Williams 1991, Williams et al. 1993).

The Punjabi language is spoken by Sikhs, and Hindus and some Muslims who migrated from the Punjab states of India and Pakistan respectively. Sikhs and Hindus were included in the study population while Muslims were excluded primarily because it is hard to differentiate between the Punjabi speaking and Urdu speaking Muslims by their names. In Manitoba, the population of the Pakistani Punjabi speaking people is also very limited as compared to the Indian Punjabi speaking people. The inclusion of such diverse groups in

the study would have made generalization very difficult without a substantive increase in sample size.

I commissioned a local senior person from the Punjabi community to select the names from the telephone directory. I selected the names from the telephone directory as well. After comparing both the lists and inserting the missing names, the list of 555 Punjabi respondents was finalized. How many of them have children under the age of five is not known.

2.2 Survey Administration: Individuals were selected for enrollment in the study by telephone contact using a random numbers table. If the person did not have a child under five years of age or if he declined to participate in the study, the second random number was selected. If there were two eligible families in the same household, preference was given to the one with more recent immigration background.

My wife and I visited almost all the respondents to deliver the questionnaire forms. This was our first face-to- face contact with the respondents. This helped in building trust with the respondents which was crucial as many distrust such surveys particularly when various personal and lengthy questions are asked.

Many respondents at the first meeting were suspicious and showed reluctance to participate, indicating that they thought that the study pertained to some government

interest.

In spite of our personal contact with each respondent it was very difficult to get the questionnaire filled out by respondents. In- depth interviews over the telephone or filling out all the questions by ourselves in their homes was not possible because many Punjabi women are working mothers and have limited time to spend for such studies. Most of them have to complete many household jobs such as cleaning, cooking, washing and other similar tasks before they go to work. Secondly, if the interview is taken in their residences, their mothers-in- law or other members of the family sit together with the respondents which makes mothers uncomfortable to answer any question related to family matters.

Often when the questionnaires were not properly completed, I contacted respondents over the phone to get their response. Most replied negatively saying the questions were left unanswered deliberately. They could not be further persuaded to answer for ethical reasons.

Given the situation, it was very difficult to collect the required number of respondents based on the random numbers table. I was only successful in enrolling 55 respondents out of 100 contacted using the random number table. In order to achieve the intended sample size of 100 respondents, I solicited referrals to other households from agreeable respondents. In Punjabi culture referrals from other family members or friends are often

the only way to establish trust with a stranger. A total of 32 respondents were obtained from such referral connections providing a total sample of 87 respondents. A low participation rate is one of the limitations of the study. However, since the first 55 respondents were selected from the random numbers, and they belonged from a varied socioeconomic, educational and income levels, it is likely that their referrals also belonged to the varied backgrounds as themselves. Statistically non-significant difference between the responses of both groups do indicate the randomness of the sample.

2.3 Sample Size: There are approximately 4000 Punjabi speaking people living in Manitoba (Telephone confirmation by Statistics Canada). A list of 555 households was identified from the telephone directory, 87 of which have participated in the study. It is not known how many of the 555 households have children under the age of 5.

Out of 87 participants, 79 participants were Sikh and eight were Hindus. Therefore, the study attempts to describe more of the Sikhs' traditions, which otherwise, are almost similar to the traditions of the Hindus from the Punjab states of India.

In a descriptive study like this one, part of the analysis will be to estimate the proportion of the sample exhibiting certain characteristics. A 95% confidence interval defining limits of variability about the estimated proportion is given by:

Interval $= 1.96 \sqrt{P(1-P)/N}$, where P is the proportion and N is the sample size. This interval is a maximum at P= 0.5. Therefore, with my sample size of 87 the interval about this proportion can be estimated to be:

$$= 1.96 \sqrt{0.5\ (0.5)/87}$$

$$= .1126$$

The significance of the statistical results should be judged with the margin of error equal to $\mp$ 11.26%.

2.4 Analysis: The purpose of qualitative analysis is to explore, describe and explain the background information and the social conditions of the Punjabi speaking people in Manitoba. These conditions have contributed to developing specific perceptions, and have influenced Punjabi child caring behaviour. Many social conditions and health practices of India were also found to influence Punjabi health care behaviour; those factors were explored and reported. Other conditions such as, the change in the role of the family members and the deprivation of other family members in Canada, which have an impact on the Punjabi child caring behaviour, were described. Direct quotations from the respondents' comments and literature references were used to support particular themes where appropriate.

In the analysis of the survey, both univariate and multi-variate analysis were performed to test the relationships of the socio-economic factors with the barriers as explained in the questionnaire. To describe socioeconomic and demographic factors, simple frequency

tables, basic statistical measures of central tendency and dispersion were utilized.

Many health practices reported by Canada's Health Promotion Survey (1990) were also compared with those of the Punjabi people and statistical significance was reported by the Chi-square values.

Before the analysis began, a two-by-two table as outlined here below as table 1, was constructed to test the relationships among the socioeconomic variables by using the Chi-square analysis. Probability levels of less than .05 indicate a significant relationship. They also indicate that those factors may have a confounding effect if tested together in the statistical analysis.

The following factors are tested in Table 1.

1. The length of stay of the female respondents (Wife stay) if less than or equal to eight years and above eight years.
2. The length of stay of the male respondents (Husband stay) if less than or equal to eight years and above eight years.
3. The income level of the household if less than or equal to $25,000 annual and above $25,000.
4. The education level of the female respondents (Wife education) if less than or equal to 12 grades or above 12 grades.

5. The education level of the male respondents (Husband education) if less than or equal to 12 grades and above 12 grades.

TABLE 1. Association among the Socioeconomic and Demographic Factors

	Husband stay <8 >8	Wife educ <12 >12	Husband educ <12 >12	Income <25 >25
Wife stay				
<8 years	33 18	26 25	27 24	36 15
>8 years	18 18	26 10	18 18	27 9
	(P=.17)	(p=.05)	(p=.79)	(p=.65)
Husband stay				
< 8 years		32 19	24 27	41 10
> 8 years		20 16	21 15	22 14
		(p=.50)	(p=.30)	(p=.05)
Wife educ				
<=12 grades			31 21	35 17
>12 grades			14 21	28 7
			(p=.07)	(p=.19)
Husband educ				
<=12 grades				34 11
> 12 grades				29 13
				(p=.50)

The above table indicates that the length of time of the female respondents are associated with their education level whereas the length of stay of the male respondents is associated with their income level. It would appear that Punjabi men may put effort into increasing their income with the passing years of their stay in Canada. It also appears that more educated women are coming to Canada in more recent years.

The statistical significance of various barriers to accessing health care was tested with the above specified socio-economic characteristics. The Fisher's Exact Test was used to find the statistical significance if the number of the respondents fell below five in any cell.

2.5 Limitations and Strengths: The study such as this one which is based on a particular ethnic group has its own limitations. A high non-response rate was one of the major hurdles to complete this study. The cultural barriers in explaining certain questions to Punjabi women were also a major problem experienced in this study. Some problems were related to the cultural difficulties in women's responding to certain questions such as breast-feeding practices etc. particularly, when other senior members of their family were present during the interviews. The influence of husbands on wives might have created some biases in their response on the family values and relationships. The role of many Punjabi women in Manitoba as bread-winners, child care-takers, and house wives engaged in the complete set of house-hold jobs such as cleaning, washing and cooking, have left them with no time for the extensive study like this one which required 2 to 3 hours for filling out the questionnaire forms. These were the major difficulties and limitations of the

study. However, the study has other strengths. Since I am aware of the Punjabi culture and social norms I was able to interpret their responses with accuracy. Whenever I sensed biases in their responses because of the presence of the other members of the family I tried to solicit the right response by either arranging further appointments or confirming through telephone if that was possible. My wife also helped me in making follow-up calls. Studies such as this are normally done on a referral basis (e.g. as recently done in Vancouver to study the Hispanic health status. See Palacios 1992) rather than on the random sample basis. This study, however, is based on 55 respondents selected randomly from a comprehensive population list and a further 32 referred respondents who do not appear different in any significant way. This represents a major methodological advance over previous Canadian studies.

3.0 RESULTS FROM THE QUALITATIVE INTERVIEWS:

The findings of the five exploratory interviews can be summarised under the five main headings as follows:

a. Family and social relationships

b. Community orientedness

c. Role of elders

d. Child rearing

e. Impact of the Indian medical system

3.1 Family and Social Relationships:

The Punjabi speaking people in general and Sikhs in particular as reported in the literature are a male dominated patriarchal society (Dobson 1986). Such gender domination may contribute to the desire for having more male children in the family. It was reflected in the interviews that Punjabi mothers often became more religious during pregnancy, hoping that their wishes for a male child would be granted. Some of them even became vegetarians because meat was perceived to be an impious food on the path of devotion to God as pointed out by one woman respondent:

" I did prayer everyday (during pregnancy) so I thought I should restrict to vegetarian foods."

It was found that a male child in the Punjabi families would bring joy and celebration whereas the birth of a female child was considered to be a let down and the mother was often blamed for it. A woman's position in the family was seriously undermined if she had a number of female children and did not produce a male child who would carry the family name into the next generation. These ideas were elaborated by an informant as follows:

" You know how much a male child is preferred in our community. My husband has changed but in-laws are old people, they will never change."

As the girl child grew older, her mother and the grandmother would train her for the female type household jobs, such as cooking, cleaning and washing. All girls having learnt the above tasks should continue the same throughout their married life. As one respondent stated:

" Since early childhood, as far as I remember from 10 or 12 years of my age, my grand mother and my mother taught me how to roll the chapati ----- they thought it was one of the basic qualities of womanhood."

The women respondents also indicated that from early childhood on they were trained so that they can shoulder the responsibilities of their future families after the marriage. To make their marriage successful they were also trained to eat only after everyone has eaten,

to be responsible for taking care of other children and senior members of the family. They were constantly reminded that the parental house was not their house and they belonged somewhere else. Although, legally, women are entitled in India to lay claims to their parental property, in practice, only the men are expected to inherit properties. Sons are thought to be providing financial care and other supports to the family. After the marriage, sons remain in their parent's house and raise their children there.

A girl child was allowed in India to play outside up to a certain age after which she was trained for household jobs. There was a dress code for girls which became more strict once they were married. They were not supposed to be seen by the father-in-law or brother -in-law without *chunni*, a piece of shawl used to cover their heads and wrapped around the front portion. Wearing a pair of slacks was considered immodest as they define a woman's body. Women felt comfortable wearing *salwar-kameej,* a loose-fitting Punjabi dress.

Young Punjabi men generally saw their mothers as the role model for their wives. The hard working and caring mothers had a strong bond with their children. Those daughters-in-law who could not measure up to the set standard of subservient behaviour, were considered out of place in the family by their husbands. In such extended families where the husband always tends to support his mothers' role model for his wife, the relationship between the mother-in-law and the daughter-in-law is often found to be tense and unfriendly. This was reflected when some of the female respondents described the "odd

behaviour" of the extended family members. Such family tension might have resulted in a negative approach towards the joint family system for some of the female respondents. As one respondent stated in English in front of her mother-in-law who did not understand what was being said:

"------- I don't want to criticize any one but even other members of the family should understand how difficult it is to work 10-12 hours every day and also listen to everyone in the family." (This woman was indicating her in-laws)

Another respondent stated:

" -----they are important but they should try to change their attitudes once they are in a new country; too many restrictions can spoil family life."

Seniority in the family was reported to be based on the relationship rather than difference in ages. For example if the younger brother's wife was older than the wife of an older brother, the older woman (the younger brothers' wife) was still treated as a junior in the family hierarchy .

Most of the respondents of the interviews were *Jat Shikhs* (land-owners). Questions were raised as to why they had immigrated to Canada if they had sufficient land back in their home country? They explained that brothers tended to divide the agricultural land and other properties if they separated from the extended family. Even those who did not work

on the parental land still had their entitlement to that. Some of them even sold their share of land to a third party. Land was being fragmented due to such divisions and because of constant population growth. Pettigrew (1972) has indicated that educated Punjabi men feel humiliated working in village agriculture and this was confirmed by the majority of the respondents. Migration could be a result of such social behaviour.

In the villages of Punjab, education probably had a different meaning. Girls were often educated to get a rich husband, and boys to get an influential job such as a job with the army. Often beauty and education were two important attributes of a girl for getting a good husband. As confirmed by a respondent:

" We never studied to do a job ------if you don't study you don't get a good husband, particularly in village."

In spite of these values, marriage is a sacrament as well as social ceremony and highly valued. By and large, the respondents placed a great deal of trust in the institution of marriage and, women, in particular, show a tremendous amount of *izzat* (veneration) towards their husbands. After migration to Canada, the family relationship, in general, remained very cohesive.

3.2 Community Orientedness: Village life of India was reported to be open and children were expected to interact within the community at large in a disciplined manner. The youngsters were not only supposed to respect their own family but also other seniors of the village. Community interaction and decisions had more influence on the family decision making process. The elderly were respected and were regarded by the family members with due reverence. There was no concept of "old people's home". The extended family system therefore, is preferred for such reasons. To quote one of the respondents view:

" Extended family system creates certain bonds within family members. This gives emotional support."

In Punjab, children were allowed to play anywhere in the village. Parents would know almost everyone. One of the respondent described the situation as:

" There in India children go anywhere and parents are not scared at all as everyone in the neighbourhood knows everyone else, but in Canada you cannot even trust your neighbour."

3.3 Role of Elders: The role of elders is to look after the grand children and prepare home remedies besides making all major decisions in the family. They tend to know herbal and traditional medicines. Neo-natal and post-natal care are some of the specific

responsibilities of the mother or the mother-in-law

As one of the respondents stated:

" ---you should ask this question to my mother-in-law because she knows all about the home remedies. I know only a few basic remedies such as giving fennel seeds with milk etc."

When I asked the mother-in-law of the respondents about the traditional medicines she told me that she is reluctant to use the Indian home-remedies because she feared that their use might be illegal in Canada.

3.4 Child Rearing:

The health of the infant was judged by the tone of its crying(e.g. if the baby keeps on crying or changes the tone of the crying that would indicate possible bad health). If the child has constant fever, running nose or cries unusually for a long period of time, parents indicated they would take them to doctors. There is no prevailing rule as to when a child would be taken to a doctor. In the case of cold and fever, some will immediately start home remedies such as giving the child a mixture of honey and ginger and if it did not help they would see a doctor next day or a day after that. In the case of slight stomach pain, some of them might start with home remedies such as giving a spoon of soup of fennel seed and go to a doctor if the pain persists. There is not a common or a standard practice for these and other treatments.

A conviction that children should be properly and strictly disciplined was prevalent among all parents. Some of the problems reported by the parents for child rearing were related to the fear of crime in the neighbourhood, particularly in the downtown area. This concern results in the restriction of the children from playing outside the home yard.

3.5 Common Health Practices in India: The health practices of India have had a profound influence on the outlook of the Punjabis towards Western medicine. Some of these unique factors are described here:

Patient - doctor relationships in India are reported to be different from those in North America. There, doctors played a very authoritative role in deciding what the patients should or should not do, what food they should eat, and how they should behave, among other things. Patients were completely at the mercy of doctors who were looked upon with great reverence and trepidation.

Most Punjabi medical practitioners in India probably placed themselves in a distinctive position and in a higher status than other professionals. They were reported to be communicating among themselves in English - a language not commonly understood by the general public; they seemed to be describing diseases as they do elsewhere, in its generic term, which sounded disconcerting to those who were unfamiliar with the jargon. In many Indian hospitals the patient looked after by a particular doctor will not be further attended by another even if his condition worsens. These orthodox attitudes were reported

to be still prevalent in many parts of India creating fear, anxiety and barriers in accessing the Western style health care system. To point out a respondent story:

" *My mother was hospitalized in India. She was in the serious condition but in the ward no other doctor would check her except the one who admitted her. When doctors come to a ward all visitors are asked to wait outside. Other doctors did not even look at her even when she was experiencing severe pain. There was no way I could have approached to any other doctor. They are Gods*" (The respondents was seemingly very angry at that moment)

Another respondent stated: " *In India doctors are more authoritative and they are looked upon as powerful people--"*

Indian doctors were described as being more direct in their response. Patients often inquired about various things, perhaps uncommon to many Western doctors. For example a patient's general questions might include: What food is good for me? Can milk be allowed?; if yes, how many times a day ? Is yoghurt harmful if taken with medicine? Can the patient take a bath?; and when can he take a bath ? Is patient allowed to eat rice or only bread ? Is a patient allowed to go out in the fresh air? How should medicines be taken- with hot or cold water? Is a patient allowed to eat vegetables or should he/ she take only eggs and how should he/she take eggs; fried,or boiled?.

The respondents stated that often they were confused with the response of the mainstream doctors whenever they replied saying that they didn't know the answer. They may have never heard a doctor admit a lack of knowledge on a subject. They treat doctors as superior human beings, knowledgeable about every subject and the savers of life. As an illustration, during the testing of my questionnaire I asked a Canadian physician about the use of fennel seeds in reducing or curing gastric problems. He replied that he did not know anything about that. However, one of my respondents told me that his East Indian doctor recommended to take fennel seeds for gastric problems. Another respondent reported that his East Indian doctor had forbidden any home-remedies including the use of fennel seeds. It is interesting to note that whatever the East Indian doctors answered, they always answered either in "yes" or "no", but never in "don't know".

A common perception was that an efficient doctor could cure the diseases quickly. This perception may be a reflection of the behaviour of many physicians or other medical practitioners of India as they often prescribed only a strong dose of antibiotics for quick results. Many pharmacists of India are reported to be selling strong antibiotics to patients without consulting the doctors. In India, all medicines are available over the counter. Patients who can read and write buy the same antibiotics without even consulting a physician if the illness returned.

Most of these experiences were still evident in Punjabi community in Winnipeg. They felt comfortable with the physician who was willing to communicate with them more openly,

and advise them in an unambiguous way either in "yes" or"no".

Unfamiliarity between ethnocultural communities and the mainstream health providers has not only created a distance but also a distrust between them.

A Punjabi man narrated an interesting story. His child was burnt by a hot press. The man rushed the child to a walk-in clinic. He thought that he was being suspected of child abuse. Not being sure of the medicine prescribed, he again went to an Indian doctor for medical advice.

The health practices during pregnancy differed among educated and uneducated respondents. Many beliefs such as "women should not travel much during pregnancy", and "they should be checked by only female physicians" were found to be common irrespective of education background. There was also a particular belief about bathing after the delivery.

These interviews were helpful in clarifying many complex issues related to the child-caring of the Punjabi speaking people in Manitoba. The unique background information, beliefs and cultural practices emanating from these interviews indicated many aspects of their family and social relationships which had a direct impact on their child caring practices, specifically when the role of their family in general, and the role of Punjabi women in particular, were constantly changing in Canada. However, some variations in

Punjabi health behaviours were noticed. Such variations could only be statistically confirmed if a large sample were included in the study. Accordingly, a survey questionnaire was designed based on the information of these qualitative interviews and variation was examined in a sample of 87 people.

4.0 RESULTS OF THE SURVEY:

Prior to analyzing the survey data, a comparison between randomly selected and referred respondents was done. Altogether four questions were analyzed:

1. The weight of the first-born child
2. Income level
3. Self rated health
4. The language constraint

None of these variables were found to be significantly different from the variance of random response (Table 2). The T value of weight is 0.18 (p=.85). The Mann-Whitney non parametric test was used to test the income. The Chi-square tests were done for comparing the "self rated health" and the "language constraint". The non significant Z values of 0.2 for the income; X^2 values of 4.91 and 3.0 with df=4 and 1 for the "self rated health" and the "language constraints" respectively confirmed that both randomly selected and the referred samples did not differ statistically.

In spite of such a non-significant variation in the responses of the randomly selected sample and the referral sample, the final results should be interpreted cautiously because of the limited participation in the study.

TABLE 2. Comparison of Random and Referred sample

Factors	Referral Mean (N=32)	Non-referral Mean (N= 55)	Test	Probability
Weight	6.8 lb	6.77 lb	T = 0.18	0.85
Income (Median)	25,000	25,000	Z = 0.2	0.84
Self-rated health	2.87 level	2.81 level	$X^2 = 4.91$	0.30
Language (Percent reporting "important" factor)	67.8%	75.8%	$X^2 = 3$	0.22

The analysis of survey was done using the computer software Number Cruncher (NCSS). The results from the survey describe eight major areas:

1. Socioeconomic and demographic characteristics
2. Personal health practices
3. Disease and accident prevention
4. Child caring behaviour, practices and problems
5. Health related beliefs and attitudes
6. Family relationships
7. Health status
8. Accessibility and barriers

4.1 Social Characteristics: The average length of time that the Punjabi female respondents have lived in Canada is 8.23 years with 95% confidence limits of 7.12 to 9.33 years. The male respondents have lived here 8.78 years with 95% confidence limits of 7.58 to 9.98 years.

The mean age of female and male respondents are 28.96 and 32.24 years respectively.

The education level of the respondents is quite high. On an average both male and female respondents have 12 grades of schooling. About 8.2 % of the female respondents have a Master's degree while only 7.1% have less than five grades of schooling. Most education was obtained before emigration to Canada; a total of nine women reported having

completed some form of Canadian secondary education or higher degrees. Certificates and short term diplomas were not included in this category.

The average yearly family income of the sample population is about $ 25,000. About 72.4% of the sample population reported earning less than $ 26,000 per year which is considered below the poverty line.

The average household size is found to be 5.51 members with 95% confidence limits of 5.08 and 5.94, but the range is 3 persons to 15 persons in different households. This figure in fact underestimates household size because parents who shift residence amongst their sons were often omitted when household size was reported (Table 3).

TABLE 3. Socio-economic and Demographic Characteristics

Sample size= 87

Characteristics	Mean	Range
Length of time:		
Female	8.23 years	2 to 20 years
Male	8.78 years	1 to 23 years
Age:		
Female	28.96 years	21 to 40 years
Male	32.24 years	23 to 46 years
Education:		
Female	12 grades	5th to Masters
Male	12 grades	0 to Masters
Income	$25,000 yearly	<$10,000 to> $60,000
Marital status:		---
Married	100%	
Household size	5.51 members	3 to 15 members

4.1.2 Employment Status: About 61% of the Punjabi female respondents reported being employed. Many of these women indicated they worked in garment factories. Some reported poor and hard working conditions. Asthma, back pain and constant headache were mentioned as problems during interviews.

Out of 88.6% employed Punjabi males, the majority (59.8%) confirmed working over five days a week (Table 4). Most of the Punjabi women reported in the interviews that the child caring responsibilities were largely left on women in spite of many of them working outside of home.

TABLE 4. Employment Status of the Respondents

Employment status	Female %	Male %
Five days a week	40 (46.0)	22 (25.3)
Less than 5 days a week	9 (10.3)	3 (3.5)
Over 5 days a week	4 (4.6)	52 (59.8)
Unemployed	30 (34.5)	5 (5.7)
Not answered	4 (4.6)	5 (5.7)
Total	87 (100)	87 (100)

4.2.0 Personal Health Practices

4.2.1 Alcohol Use: On the question of alcohol use, a total of 81% confirmed the use of it and only 19% said they had not drunk at all in the past 12 months (Table 5). Among drinkers, 44.8% drank about twice a month or less, about 48.2% drank weekly and 6.9% daily. In comparison with Canadian averages this is not statistically different (X^2=0.32, df=2, p> .05).

TABLE 5. Comparison of Punjabi and Canadian Alcohol Use

Alcohol use	Punjabi %	Canadian %
Twice or less than twice per month	44.8	48
Once or 2-3 times per week	48.2	46
Daily	6.9	7

4.2.2 Medication: On the use of different types of medication in the past 12 months, three respondents reported using one or the other kinds of medicines, mostly ASA or other pain relievers. Only three reported using sleeping pills, one woman each reported using

demerol, anti-depressants, stimulants and tranquilizers. The number is very small and statistically insignificant as compared to the Canadian average.

4.2.3 Smoking: Only 6.9% of the respondents reported smoking on a regular basis. This in comparison with the Canadian average number of smokers (29%) is a significantly low number ($p<.001$).

4.2.4 Breast-feeding Practices: About 30% of the Punjabi women did not breast feed at all, and 17 % breast fed for less than 3 months. The mean average for the breast feeding to the male child was 3.93 months whereas for female it was 3.26. Avoiding breast-feeding could be a major cultural shift in the Punjabi health practices.

4.2.5 Priorities for Healthy Life: In the Canada's Health Promotion Survey (1990), Canadians have expressed that three lifestyle changes- quitting smoking, learning to relax more, and becoming more physically active, together with a more secure income and spending more time with family and friends will improve their health and well being. These results provide an insight for designing health promotion programs for different ethnic groups. The same question was asked in this study and a comparison was made to find out the differences in the perceptions between the mainstream society and the Punjabi population (Table 6).

TABLE 6. Comparison of Punjabi And Canadian Perspectives on Changes in Health Behaviour.

Factors	Canadian %	Punjabi %		
		Yes	No/Don't know	Not Applicable
Stop smoking	81	10.4	3.4	86.2
Relax more	69	44.8	49.4	5.7
Exercise more	65	47.1	42.5	10.3
More secure income	45	26.4	35.6	37.9
More family time	45	39.1	28.7	32.2
Lose weight	42	29.9	52.9	17.2
Better dental care	27	19.5	54.0	26.4
Change job	22	21.8	34.5	43.7
Reduce drinking	16	10.3	47.1	42.5
Move	14	12.6	42.5	46.0

The above questioning about changes in health behaviour were selected by a few Punjabis only; most of the Punjabis replied that these questions were "not applicable". It appears that these behaviour changes do not have any immediate relevance or any connection to the Punjabis' day-to-day life. However, the low priority given to the exercise and the relaxation as compared to the Canadian average might be cause for concern for health care providers. Since most of Punjabis do not smoke, the low priority given to stop smoking is understandable.

This ranking also indicates that the health promotion strategy needs to be more ethnic oriented for providing more information to different ethnic groups on health risks and benefits.

4.2.6 Actions Taken for Healthy Life: In response to the question if Punjabis did anything to improve their health in the past 12 months, only 29 persons (33.3%) said yes which is significantly lower than the Canadian average of 48% (Table 7).

TABLE 7. Comparison of Changes in Punjabi and Canadian Health Behaviour

	Punjabi %	Canadian %
Improving health during the last 12 months (Chi Square= 4.68, p<.05)	33.3%	48%

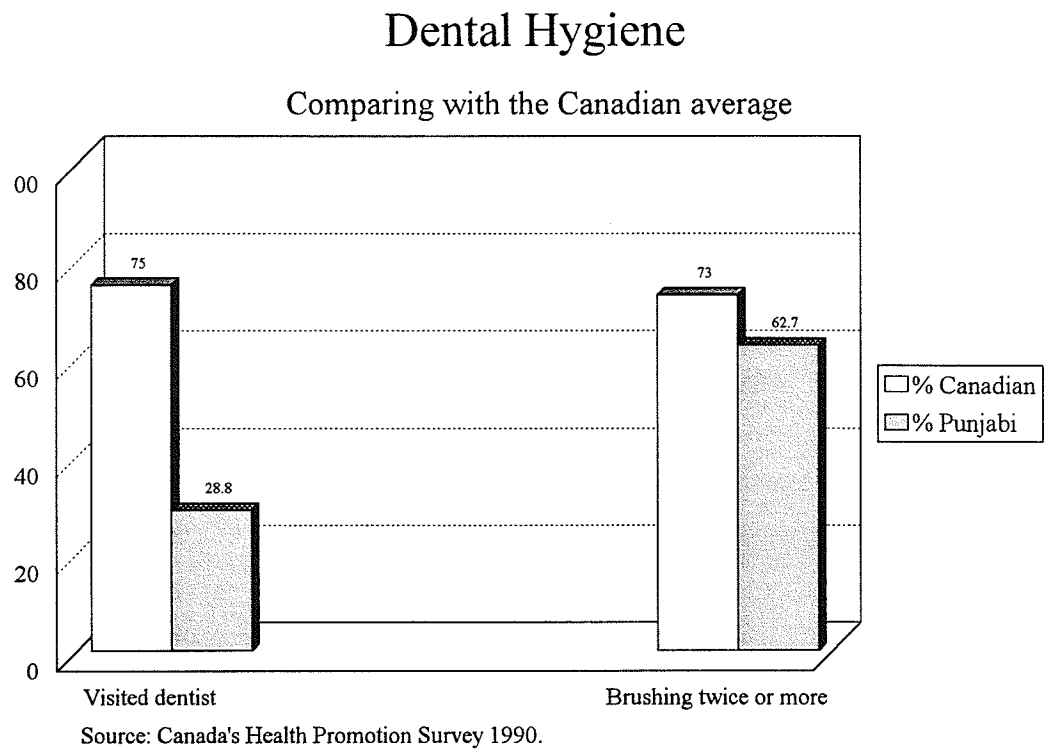
It is interesting to note here that although Punjabis feel exercise and diet improve health status, the majority of respondents do not make these changes in their health behaviour. This could be of great concern to health providers especially if such attitudes are compared to Canadian averages.

In contrast to Canadians, generally Punjabis do not regard smoking, alcohol use and STD, dental hygiene, physical environment and medication, as their health problems.

4.3.0 Disease and Accident Prevention

4.3.1 Dental Hygiene: It is a matter of some concern that most of the respondents have not given due care to dental hygiene. In the past 12 months only 28.8 % of the respondents had visited the dentists. Only 62.7% reported brushing twice or more during the day compared to 73% of Canadians (Figure 1).

FIGURE 1.



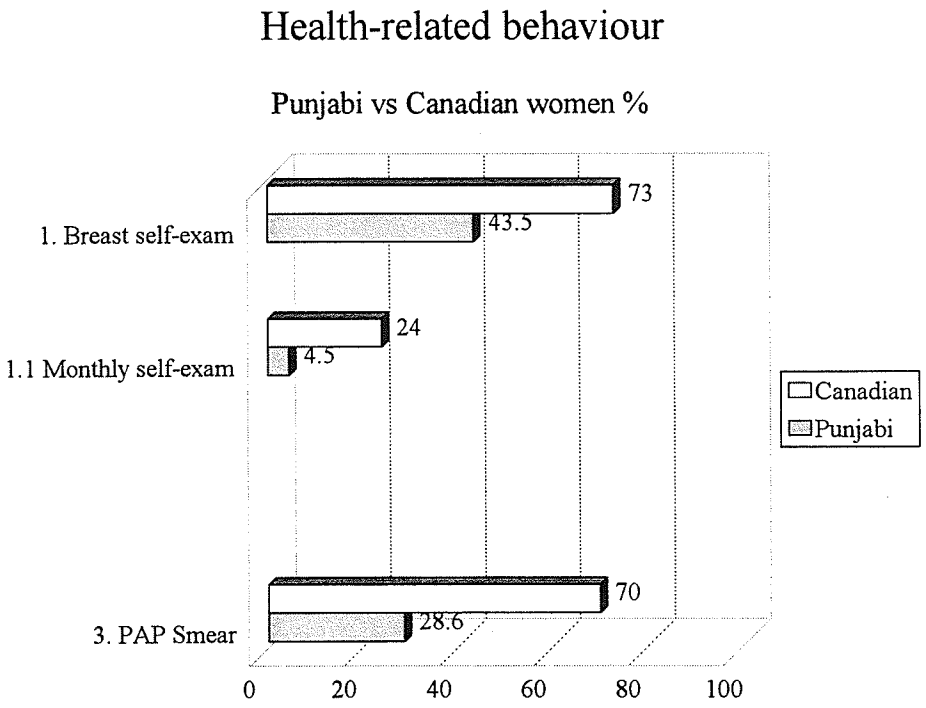
Source: Canada's Health Promotion Survey 1990.

4.3.2 Mammogram: As reported in Canada's Health Promotion Survey (1990) only 22% of Canadian women under the age of 40 years have had a mammogram. However, in this study only 16.9% reported having a mammogram done in their life. Though this figure is not statistically significant while comparing with the Canadian women, it should be interpreted cautiously because many Punjabi women also said that they had mammogram done only when their physicians suspected some breast problems e.g. breast cancer, which may not be true with all Canadian women who went through the mammogram.

4.3.3 Breast Self-Exam: About 73% of Canadian women are reported to be involved in breast self-examination (Canada's Health Promotion Survey 1990) as compared to only 43.5% of Punjabi women population and only 4.5% do the monthly self -exam as compared to the national 27% (Figure 2).

4.3.4 PAP Smear: Only 28.6% of Punjabi women had pap smear test as compared to 70% national average.

FIGURE 2.



Source: Canada's Health Promotion Survey 1990.

4.3.5 Smoke Detectors: Altogether 28.7% of respondents reported as not having or not proper functioning of smoke detectors in their house. This number is significantly higher as compared to the Canadian average of 13%.

4.4.0 Child Caring Behaviour, Practices and Problems

4.4.1 Sleeping Position : Sleeping infants on their stomachs was confirmed by 30.8% of the respondents; 24.4% preferred to lay infants on their back, and 44.9% on the side. Respondents indicated infants were found the following positions after sleep: 33.9% on the stomach, 35.5 on the back, and 30.6% on the side. On being asked as to who advised them on sleeping position their replies were:

-14.6% by the family members

- 4.9% by friends

- 46.3% by nurse and

- 34.1% by the doctors.

In open-ended responses to this question respondents indicated that there were common beliefs that the male child should lie on its stomach and the girl on its side. This would presumably result in boys ending up with broad shoulders and chest whereas, girls will be endowed with narrow waists and larger breasts.

4.4.2 Application of Kajal: *Kajal* is applied to the eye, for medical purposes, and has

the appearance of mascara. The various published reports indicate excessive lead in *Kajal* (Aslam et al. 1979). However, 44.9% of the respondents confirmed applying it to the eyes of the children on daily basis. There was no consensus among the respondents about the standard age of the children when the application of *Kajal* should be stopped.

4.4.3 Oil Massaging: Oil massaging of a child was confirmed by 80% of the respondents.

4.4.4 Reaction to Children Illness: In answer to this question, 70.8% reported they would immediately go to a doctor, 12.7% mentioned that they would wait for a day; 7% would start home remedies and 8.5% would ask for help from their family members and friends.

4.4.5 Check Up: A total of 49.4% of the respondents reported taking a child to a doctor only when the child was sick, as compared to 50.6 % who reported taking a child to a doctor for a regular check up.

4.4.6 Child Rearing Problems: Through the exploratory interviews, seven problems relating to child rearing in Canada were identified. The questions asked were not specific for the children under the age of five. The reason for not limiting the questions to a specific age group was to get the broader perspective of the problems related to the child caring. Therefore, these responses included the respondent's perspectives for all children including those under the age of five. The most outstanding one as reported in Table 8

was television. Television shows were considered pornographic and violent. Shielding children from such adverse moral influence was felt to be a difficult task by the parents. A second problem reported was the inability of parents to send children to play outside of the home. The third problem described was that society as a whole is becoming more violent and crime oriented. The fourth problem was the lack of discipline among teenagers. The fifth was not having grand parents residing in Canada. The non-availability of herbal and homeopathic medicines were the sixth and seventh problems respectively.

TABLE 8. General Difficulties in Child Rearing in Canada.

Sample size=87

General difficulties	Very significant or significant	Not so significant
T.V. shows	79 (90.8)	8 (9.2)
Playing outside	71 (81.6)	16 (18.4)
Violent society	71 (81.6)	16 (18.4)
Teenage discipline	64 (73.6)	23 (26.4)
No grandparents	41 (47.1)	46 (52.9)**
No herbal medicines	21 (24.1)	66 (75.9)
No Homeopathic medicines	13 (14.9)	74 (85.1)

**Includes people who have grandparents residing in Canada.

4.4.7 Children Playing in the Neighbourhood: Many women reported that they were apprehensive about Canadian society in general and their neighbours in particular causing their children harm. Such fear was the underlying cause for 36.8% of Punjabis reporting that they confined their young children within their own homes. The reasons for confining children to the home are provided in table 9.

TABLE 9. Reasons for Children Not Playing in the Neighbourhood.

1. Don't know the neighbours	4 (12.5)
2. Think that neighbours will not like it	3 (9.3)
3. Don't like children playing out	4 (12.5)
4. Don't trust neighbour	2 (6.3)
5. Don't think it is proper to send child out	2 (6.3)
6. Other reasons*	17 (53.1)
Total:	32 (100)

*The details of other reasons are not reported by many respondents. Some of them explained the other reasons as the child being very small to go out to play and general crime in the neighbourhood.

4.4.8 Disciplining : How would they discipline their children? Fifty one percent would

first speak to them to point out their mistakes. If the child still did not change his attitude they would be physically punished. The physical punishment was considered necessary up to a certain age by 29.4% of the respondents; Four percent of the respondents would not do anything because of a concern that in the Canadian society one might lose the child, and 15.7% of respondents do other things which are not recorded in the questionnaire. These responses are again not confined to the age under the five only. The responses are applicable to all children.

4.4.9 Child Birth Services in Canada: The majority (90.4%) were fully satisfied with the existing child birth services in Manitoba.

4.4.10 Racial Discrimination: Respondents were also asked if they felt any racial discrimination during hospitalization at the time of delivery. The vast majority (92.7%) said no and only 7.3% reported some discrimination. Two major areas of discrimination were reported, namely, slow response, and abrupt and impolite behaviour of staff. No one reported any problems with the facilities or hospital foods. Some examples of their negative experience are listed below:

* A Punjabi woman went to a hospital at midnight for her delivery. No doctor was available. The baby was delivered by the nurses who were apparently confused and uncertain. She heard the nurses talking in confusion. After the delivery, the knife and thread and other equipment were left right beside the baby.

* A Punjabi man complained about the lack of care in a hospital. His father was discharged one evening in spite of his condition having worsened. He requested that his father be kept in the hospital for further investigation. The staff were reluctant. Ultimately, he had to take him home only to readmit him the next morning because his condition had deteriorated overnight.

4.4.11 Day Care: Forty one persons out of 87 had no experience of day care in Canada as their children were very small. Out of 46 persons who sent their children to day care 17 persons (40%) indicated that day cares are good. Eleven persons (24%) said they experienced some problems. The remaining 18 persons (36%) did not reply to this question. Those who experienced some problems indicated that the day cares generally did not provide the same level of care as the children would receive at home. Some respondents also indicated that food and language were problems.

4.5.0 Health Related Beliefs and Attitudes

4.5.1 Prevalent Home Remedies: The most commonly used home-remedies in Punjabi families are:

1. Honey for cold and cough
2. Fennel seeds for gastric problems
3. Caraway for stomach pain

4. Digestive tablets "Hazmola" for indigestion (produced in India, this product is available in most Indian grocery stores).

5. Brandy for cold, cough and for sound sleep.

6. Some women reported that they avoid giving milk and milk products to a child if the child is suffering from a common cold or has diarrhea.

7. Some women reported that they became vegetarians during pregnancy as they could not digest meat, eggs etc. When asked how they knew they could not digest, they replied they did not feel good after eating. Some felt "hot" and some had diarrhea.

4.5.1 Factors Considered to Affect Illness: The literature related to Punjabi health describes the following factors as Punjabi beliefs about the causation of illness.

1. Imbalance in hot and cold temperatures.

2. Imbalance in hot and cold foods.

3. Mental attitude.

4. Predetermination factors.

5. Divine retribution.

As evident from Table 10, only the first two of these factors, namely, 1. imbalance in hot and cold temperatures and, 2. imbalance in hot and cold foods, are still considered by the Punjabi community in Winnipeg as important causal factors for illness. Other factors are not perceived as important by the majority of the respondents. However, a few respondents did believe that an illness was predetermined or was meted out by God as a

form of punishment.

TABLE 10. Beliefs about Causation of Illness

Sample Size=87

Beliefs	True (%)	False (%)
Imbalance in hot and cold temperature	79 (90.8)	8 (9.2)
Imbalance in hot and cold food	61 (70.1)	26 (29.9)
Because of wrong thinking and doing	22 (25.3)	65 (74.7)
It is predetermined	7 (8)	80 (92)
It is a punishment from God	16 (18.4)	71 (81.6)

4.5.3 Bathing After Child birth: It is generally considered inappropriate for the mother to bathe within thirteen days of delivery in Punjab (Gordon et al. 1965). However, in this study, 52.1% respondents reported that they didn't mind taking a bath immediately after the delivery, although 26.8% said that they avoided doing so because of their exposure to practices in India. The remainder (21.1%) were confused about it. Some 16.7% in fact

took a bath immediately after the delivery and another 54.2% bathed one day after the delivery; 20.8% bathed after 2 days and remainder 8.3% within 3 days of the delivery.

4.5.4 Preference for Warm Food: The majority (57.5%) preferred hot (warm) food after the delivery and 32.9 % did not care whether their food was hot or cold. Nine point six percent of the respondents preferred cold food.

4.5.5 Vegetarian Food: During hospitalization, 35.2% of the Punjabi women indicated that they preferred vegetarian food and 8.5% preferred non-vegetarian food. The majority (56.3%) had no preference. Avoiding meat and eggs during pregnancy was not found to be a common practice. The majority (59.4%) of the respondents did not avoid these foods during pregnancy; 18.8% avoided them while 21.9% did not respond to the question.

4.5.6 Seclusion after Delivery : Punjabi women consider that after delivery they should be secluded from the family for about 40 days. This study shows that 48.4% of the women believed that seclusion strengthened their bodies; 37.6% of the women did not seclude themselves as they considered this practice to be relevant only in India, and not in Canada because of the economic necessity for women to work out of their home.

4.5.7 Preference for the Dress: The majority of women(54.4%) preferred not to wear their "*salwar kamiz*" (a dress of Punjabi women) during a hospital stay; only 29.4% prefer wearing it. This finding was also different from what was specified about the preferences

of *"Salwar Kamiz"* in the literature of Punjabi health.

4.5.8 Preference for Hospital Delivery: Nearly all respondents (93.4%) prefer their babies to be born in hospitals.

4.6.0 Family Relationships:

4.6.1 The Changed role of the Punjabi Mothers: Changes in the mother's child caring role was addressed by asking a question as to who looked after the child among Punjabi families in Canada. Seventy seven point nine percent of respondents reported that the mothers were solely responsible for looking after the children in Canada. Only 17.6% of respondents said that the mother-in-laws were helping them. In India, the majority indicated that they would have been supported by mothers-in-law or other family members. Moreover, in India, they would not have been working outside of their homes.

A subsequent question was then asked, if it made any difference in the growth of the child if mothers were not involved full time in looking after the children in Canada. The majority (45.2%) replied yes, 12.2% said "don't know" and 42.5% said "no". Those who said "no" appeared to be normally those who had other family members to take care of the child.

A further question was asked: Is an extended family system an absolute necessity for child care? The majority (63.2%) said it was, 25% said "not much" and 11.8% said "no".

4.6.2 The Role of Husbands: The role of Punjabi husbands has changed tremendously as compared to what it was in India. As reported by the respondents; in India, 68.4% of the males would have considered child birth a woman's exclusively responsibility. The husbands participated only in the case of emergency. However, in Canada, 80.6% of the Punjabi males stated that child birth was a joint responsibility of both husband and wife.

4.6.3 Family Values : Some respondents did not wish to reply to questions related to family relationships (indicated in a separate category in table 11). Eighty six point two percent reported that at a time of crisis they relied on each other for support; 81.2% said that individuals in the family were accepted without reservation, and 82.7% indicated they confided easily to each other. Eighty point five percent said they were able to make decisions and resolve family problems as they arose. About 33.3% were reluctant to discuss their fears and concerns with the other members of the family and 13.8% had bad feelings in their family. This response should be interpreted cautiously as the family biases or the husband's influences on the wife's response can not be ruled out, in spite of many precautions taken during the interviews.

TABLE 11. Family Relationships

Sample Size=87

Factors	Agree or strongly agree	Disagree or strongly disagree	Not answered
Family support during crisis	75 (86.2)	0.0	12 (13.8)
Acceptance of individual	71 (81.6)	4 (4.6)	12 (13.8)
Confide to each other	72 (82.7)	4 (4.7)	11 (12.6)
Avoid discussing fears	29 (33.3)	45 (51.8)	13 (14.9)
Bad feelings	13 (13.8)	62 (71.4)	12 (13.8)
Able to solve problems	70 (80.5)	5 (5.7)	12 (13.8)

4.6.4 Preference for male child: Do they have preference for a son? Almost half of the respondents answered in affirmative, and 40% indicated no preference.

4.6.5 Relationships with Children: Relationships with children were determined by assessing the degree to which respondents engaged in the following practices:

1. Tolerance of tantrums of children

2. Eating as prescribed

3. Fixed bed time

4. Physical punishment

5. Complying with children's request

6. Staying late at night

As indicated in Table 12, 86.2% of the respondents tolerated tantrums of their children; 81.6% demanded that their children eat all the food they were served; 82.8% thought that it was important to have a fixed bed time; 33.3% considered physical punishment to be the best way to deal with the children's bad behaviour; and 14.9% required their children's compliance with all their requests. Only 5.7% suggested that children had the right to choose to stay up late occasionally. The above findings suggest that within this community parental authority is quite rigid.

TABLE 12. Relationships with Children

Sample Size=87

Factors	Agree or strongly agree	Disagree or strongly disagree	Not answered
Tolerate temper	75 (86.2)	0	12 (13.8)
Must eat	71 (81.6)	4 (4.6)	12 (13.8)
Fixed bed time	72 (82.8)	4 (4.6)	11 (12.6)
Physical punishment	29 (33.3)	45 (51.7)	13 (15)
Must comply	13 (14.9)	62 (71.3)	12 (13.8)
Stay late night	5 (5.7)	70 (80.5)	12 (13.8)

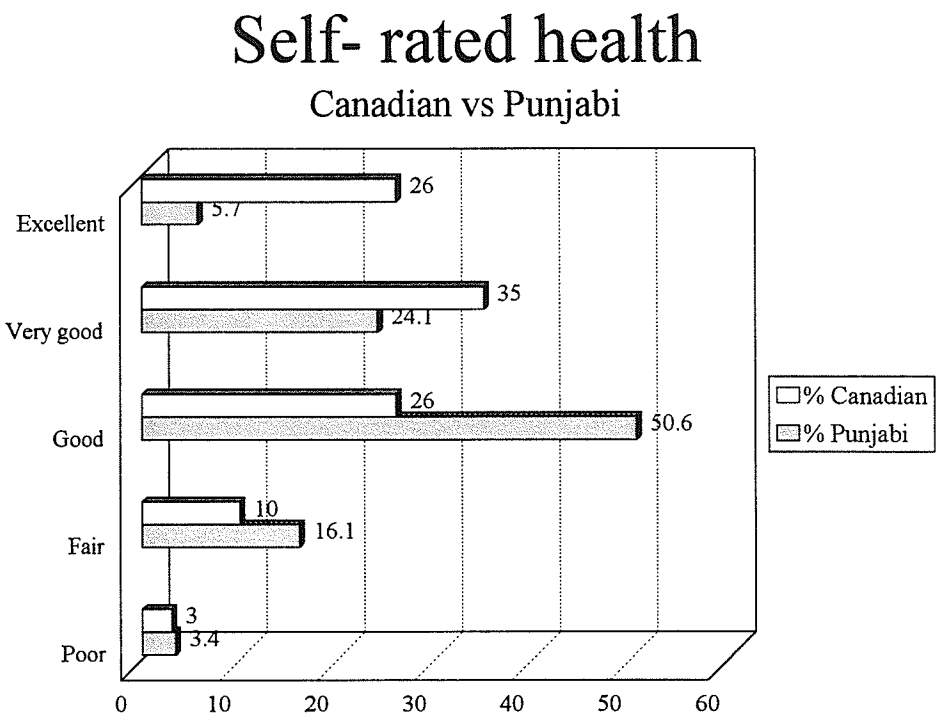
A question was asked as to who disciplined the child in the household. Fifty eight percent answered that both the parents were responsible; 32% said it was the mother's domain and 10 % said that it was exclusively the father's.

4.7.0 <u>Health Status</u>:

4.7.1 Perceived Health Status: In Canada's Health Promotion Survey (1990)the self-

rated health status is described as highly correlated with the presence of specific health problems and also to be a predictor of both health care utilization and mortality. The self-rated health status of the Punjabi respondents has been compared with the Canadian averages in Figure 3. Only 5.7% Punjabi perceived their health as excellent as compared to 26% of Canadians; 24.1% of Punjabis perceived it to be "very good" compared to 35% of Canadians; 50.6% said "good" compared to 26% of Canadians; 16.1% considered it "fair" compared to 10% of Canadians and 3.4% said it was poor compared to 3% of Canadians. The statistical significance of the self-rated health indicates that the Punjabi speaking respondents perceive their health status as significantly worse than [χ^2= 40.5($p<.001$)] Canadians in general.

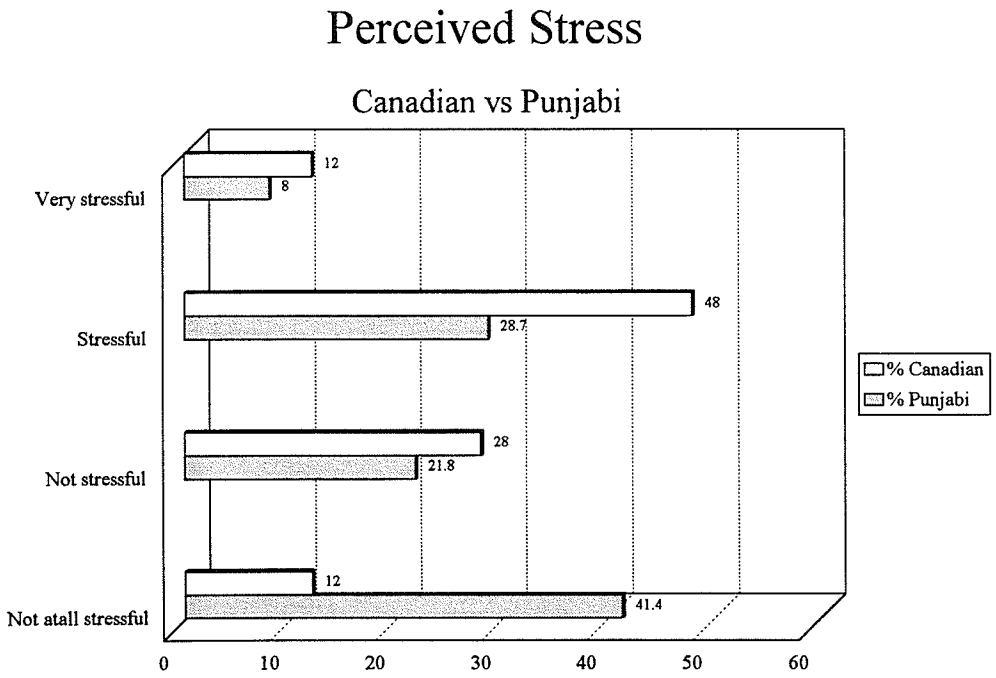
FIGURE 3.



Source: Canada's Health Promotion Survey 1990.

4.7.2 Stress Level: Stress in a person was measured by asking direct question as to how stressful a person was. The response was rated in four categories, from the "very stressful" to the "not at all stressful". The responses were compared with those of the mainstream society as specified in Canada's Health Promotion Survey (1990). The Punjabi respondents perceived their stress level significantly lower than that of the average Canadians [X^2=69.8,p<.001] (Figure 4).

FIGURE 4.



Source: Canada's Health Promotion Survey 1990.

4.7.3 Rated Health of Children: The health of the Punjabi children was rated as "excellent" by only 23.8% of the respondents; 27.6% rated "very good"; 35.6% as "fair" and 13.8% rated it as "poor". There is no data available to compare with average Canadian perception towards the health of their children. Since nearly half of the respondents rated the health of their children as fair or poor, an examination of Punjabi perspectives on child health is warranted. On the positive side, the fact that only 5.7% of the Punjabi people perceived their health as "excellent" while 23.8% of the respondents rated their children's health as "excellent" signifies a change in perception for their children.

This question was further tested with the socioeconomic and demographic factors (Table 13). It is interesting to note that the recent Punjabi immigrants rate the health of their children poorer than those who lived here for more than eight years (X^2 =7.68, df= 3 and P= .05). It reflects a positive side of settlement of the Punjabi people in Canada.

TABLE 13. Differences in the Rated Health of the Children

Rated Health	< 8 Years of Stay	> 8 Years of Stay
Excellent	8	12
Very Good	12	12
Good	21	10
Fair	10	2
Total Number of Respondents	51	36

4.7.4 Child Birth and Weight: The percentage of the first, the second and the third child born in Canada is 84.6%, 96.1 %, 92.6 % respectively; the rest were born in India or elsewhere.

Respondents were asked to remember the birth weight of their children, and they had little difficulty providing a precise answer. The mean weight at birth of the first child was reported to be 6.77 pounds with 95% confidence limits of 6.57 to 6.96. Four twin births were also reported in the study, which were omitted when calculating the mean weight of the first child. This study does not record any gestational age. It would appear however, that the birth weights of the Punjabi children are lower than the average Canadian, which is reported to be about 7.9 pounds for 50 percentile singleton female babies and for male children of the same percentile about 8.4 pounds (Arbuckle et al. 1993). The birth weight of the second child was reported to be 7.12 pounds with confidence limits of 6.82 to 7.42.

There could be several factors contributing to the lower birth weights of Punjabi babies. Many Punjabi women were unaware of prenatal classes. Only a few recalled having received any advice from their physicians during pregnancy to improve the nutritional quality of their daily diets, but they remembered nothing specific about advice on resting and physical fitness. Even the advice for diet improvement, in all likelihood, was not taken seriously by many Punjabi women because of the limited nutritional knowledge they expressed during the exploratory interviews.

Although these data suggest problems in intra-partem care for Punjabi women, they must be interpreted cautiously for methodological reasons.

4.7.5 Child Development: The Punjabi perspective as regards to the developmental problems for their children in Canada was asked, and the answer was recorded separately for each of the physical, mental and spiritual developments of the children. Only 34% of respondents felt the development was a problem. It seemed that the question was not considered very important or their awareness about the development of children was different. Out of those who responded positively, 10% indicated that there was a lack of normal physical development and 16.7% listed problems with adequate spiritual advancement. Only 3.3% suggested the environment (sufficiently conducive) was not for mental growth. Seventy percent said they did not know. A sense of confusion about the prospects of a new society was evident from such answers.

TABLE 14. Missing Factors in Child's Development

1. Physical growth	3 (3.4%)
2. Mental growth	1 (1.2%)
3. Spiritual growth	5 (5.8%)
4. Don't know	21 (24.1%)
5. No-response	57 (65.5%)
Total	87 (100%)

4.8.0 Accessibility and Barriers

4.8.1 Health Utilization: Nearly all of the respondents reported having a family physician. A small minority reported using a walk-in clinic (Table 15).

TABLE 15. Accessing Physicians by Punjabi People

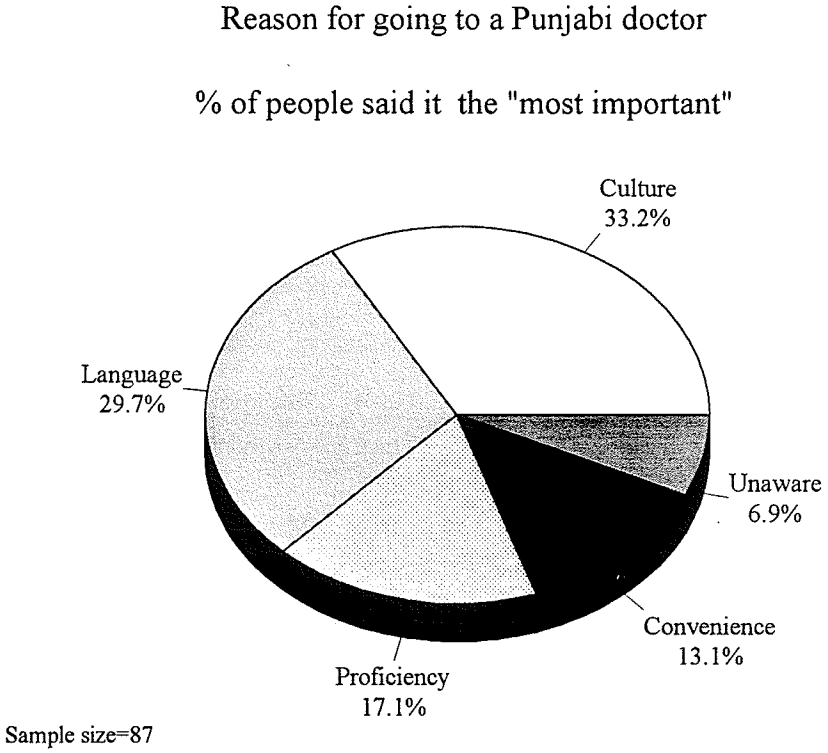
Accessing physicians	Number	Percent
Family physician	77	88.5
Walk-in clinic	9	10.3
Neither	1	1.2
Total	87	100

Eighty five percent of Punjabi speaking people went to a Punjabi doctor or a doctor of East Indian origin. Some factors which were thought to influence the selection of Punjabi physicians were: language (fluency in English), culture, proficiency of doctors, convenience and, the unawareness of any other physician. Out of these factors, the first two factors i.e. language and culture were significant factors as supported by the majority of respondents (Figure 5). However, for selecting a Western physician the "proficiency" of that physician was the most important reason ($X^2 = 17.07$, df=1).

Culture was translated as *apara* (belonging to us) in Punjabi. Many doctors whom they called *apara* are not necessarily from Punjab. Some of them speak Hindi which is widely understood by Punjabis and some speak Urdu which is similar to Hindi. Some respondents felt more comfortable going to the *"apara"* doctors because they were more accessible for

consultation by phone as well as during emergencies. Generally, *"Apara"* doctors do not require appointments- this appears to be a distinct attraction. There is also a strong sense of loyalty in Punjabi people towards physicians as they are held in high regards in the Punjabi society.

FIGURE 5.



4.8.2 Testing Presumptions: Five other attributes of a physician that might attract Punjabis to a physician, as outlined below, were tested in the survey. These attributes were:

* Directness in communication
* Calling patient regularly
* Advising what food to eat
* More thorough physical examination
* Giving stronger dose of medication

Questions were asked in the survey if these attributes were significant to respondents when choosing among physicians.

Except for directness in communication which was translated as "do you think Punjabi doctors give a straightforward reply?", no other hypothesis specified in the literature on Punjabi health was supported by a majority of respondents in this study.

TABLE 16. Prevalence of Some Assumptions about Punjabi Culture

Sample size=87

Attributes	True %	False %
Directness	46 (52.9)	41 (47.1)
Regularity	18 (20.7)	69 (79.3)
Advising foods	22 (25.3)	65 (74.7)
Examining carefully	16 (18.4)	71 (81.6)
Stronger dose	14 (16.1)	73 (83.9)

4.8.3 Cultural and Economic Barriers: From the exploratory interviews, six factors were identified as possible barriers in preventing the Punjabi people from going to a doctor in Canada. These barriers were:

1. Not driving or not having a car
2. Believing that Western medicines have side effects
3. Being unaware of physician services
4. Finding medicines expensive in Canada
5. Having fear of side effects
6. Practicing home remedies.

Not driving or not having a car has been reported as a problem by as many as 18.4% of the respondents (Table 17). This problem is however, not associated with any socio-economic or demographic factors such as the length of stay, education and income of the Punjabi families. Since the majority of the respondents are in the taxi business, it appears that at their time of actual need a relative or a friend will always help them.

TABLE 17. Socio-economic and Cultural Barriers

Sample size =87

Barriers	Yes %	No %
Driving	16 (18.4)	71 (81.6)
Western medicine is not effective	7 (8)	80 (92)
Unawareness of Physician services	10 (11.5)	77 (88.5)
Medicines are expensive	13 (14.9)	74 (85.1)
Side effects	11 (12.6)	76 (87.4)
Home remedies	8 (9.2)	79 (90.8)

The only cultural barrier found to be statistically significant in relation to socioeconomic factors is the belief that the Western medicine is not effective.

All people with this belief are Punjabi women at their initial stage of arrival to Canada i.e. less than 8 years of arrival. Such beliefs may be a barrier in accessing health care facilities.

TABLE 18. Belief that Western medicine is Not Effective and Socio-economic Factors

Sample size=87

	Wife stay <=8 >8	Husband stay <=8 >8	Income <=25>25k	Wife educt <=12 >12	Husband educt <=12 >12
No	44 36	47 33	58 22	47 33	42 38
Yes	7 0	4 3	5 2	5 2	3 4
p level	0.02	0.93	0.95	0.51	0.62

4.8.4 Difficulties Faced When One of the Parents is Not Available: A question was asked as to who took the child to see a doctor. Almost 11% said that it was the father, 17% said usually mothers, 9% said that it was always the mothers and 65% said that both parents were involved. A subsequent question was then asked if it became a barrier if the

usual person was not available. Twenty four persons indicated this would be a difficulty.

Out of those who answered in the affirmative, the following reasons were specified:

a. Eleven persons said that only one of the parents was deeply aware of the child's medical needs because the other parent was working too hard to meet the family's financial needs. This was tested against socio-economic factors and was not found significant with any of them.

b. Four persons said that only one of them could communicate with doctors.

c. Eight persons mentioned driving being a problem. However, it is not significant when tested with socio-economic factors.

d. One person named shortage of money as a problem.

4.8.5. Preference for Doctors: Regarding their preference for care givers during childbirth, the majority of Punjabi women (88.7%) preferred female doctors (either Punjabi or Western), only a few (11.3%) preferred male doctors during delivery.

4.8.6 Avoiding Doctors During Pregnancy: By far, the majority (88.5%) of the respondents visited their doctors during pregnancy. A few (10 persons i.e.11.5%), who

avoided going to a doctor did so for a reason: The following reasons were given for avoiding doctors during pregnancy:

1. It's not required
2. Baby in the womb should not be disturbed
3. Too much travelling is unhealthy, and
4. Visiting male doctors is not culturally correct

4.8.7 Compliance. In the survey response only 52% reported that the full course of the prescribed medicines was always administered. A total of 37% of the population reported not giving the full course of the medicine "sometimes" and about 11% not giving the full course "often".

5.0 DISCUSSION:

The Punjabi population is comparatively new in Manitoba. Traditionally, they used to be more concentrated in the cities of British Columbia and Ontario. Now they have started to settle in Manitoba because of the present economic situation of Canada. Their preferred jobs in manufacturing and lumber mills are scarce in British Columbia and Ontario. In Winnipeg, most of the men drive taxicabs. Even for the new immigrants who are qualified and skilled, driving taxi has become a more convenient source of income. They have found this niche after having failed to obtain suitable employment in spite of the fact that many of them have degrees in law and some have advanced degrees (e.g. Masters and Ph.D.'s in many diverse fields).

Based on the survey data which indicated that the majority of the women gave birth to their first child at the initial stage of their arrival. At this early adjustment period they went through hard physical and economic constraints together with various problems of settling in a new country. Many pregnant women did not have resources and/or knowledge about nutritious food and proper dietary intake as indicated during interviews. The low birth weight babies could very well be the result of such resource constraints. The evidence suggests that the second child is comparatively healthier than the first one.

The majority of the Punjabi mothers reported that they had not received any prenatal advice from the health services. A few who received such advice reported that they only

learnt a little bit about available nutritional foods. It is unlikely that they have made any major changes in their food system even after such advice. The common practice of advising patients for such cases was clearly found to be unsatisfactory as most of them reported to have received only some printed brochures written in English. The validity of such brochures in transferring the required knowledge to effect a change in behaviour is questionable. This is also evident from the fact that except for one respondent, no one else in the entire sample population ever attended the prenatal class. Proper communication between doctor and patient is desirable especially when this community regards doctors as powerful figures. Prenatal education from sources such as radio and television could also be helpful (Kendall 1983).

The role of the Punjabi doctor is becoming more important with the influx of immigrants. Qualitative interviews indicated that these physicians command a respectable and powerful status in the community, it is important that they become more communicative with recent immigrants. A stereo typical doctor - patient relationship is not enough for serving many ethno-cultural communities as indicated by this study. Although there could be other demands on the physician's expertise, it is equally important to acknowledge that unless beliefs and values are modified, new arrivals will constantly demand health care services without improving their health status.

The common belief that there is a barrier in making health care accessible to all new immigrants is not corroborated by this study. On the contrary, it is established that the

majority of the Punjabi speaking people have their own family physicians beginning at the initial stage of their arrival. A small delay of a day or two might occur for a minor sickness such as cold or gastric trouble, but if the condition gets worse they would go to see a doctor.

Language is the principal reason why Punjabi speaking people feel more comfortable visiting the doctors of East Indian ancestry. Western physicians seem to make limited conversation with new immigrants, especially with visible minorities, concerned that the immigrants might not understand the language, as indicated by some Punjabis. This, however, creates further distance between them. Encouraging new immigrants to ask questions about foods and all aspects of the medical regimen might prove useful in bridging the gap.

Punjabi people are patriarchal by cultural tradition. In such a system, respect and loyalty is accorded to the higher hierarchial position of the society. Many parents reported that they go to a particular doctor because they have been going to him for many years and they feel that switching to another doctor even if they are not satisfied with the present one would be disloyal. It is inherently believed that whatever a doctor says is always right and the relevance of a physician's advice is never questioned. The proficiency of a doctor and the convenience in accessing him are not of consequence to many Punjabi immigrants. Other factors such as East Indian doctors providing more careful examination, giving a stronger dose of medicine and advising what food to eat etc. were found to be

insignificant. Therefore, the correlates in decisions to see a particular doctor are only culture and language and a feeling of loyalty towards the doctors.

Smoking is forbidden by the Sikh religion but drinking is widely accepted in the society. Conversely among Hindus, smoking is accepted to some extent but not drinking. These enduring religious beliefs have not changed much in their adopted country, Canada.

Some beliefs are altered quickly while others remain static for a long period of time. Many interacting forces bring about such changes. These forces might be economic, educational or social and could be modifying, enabling and transforming perceptions into the beliefs of enduring or non-enduring nature. Some old practices might not be based on enduring beliefs. The enduring health beliefs could have both "positive" health effects as established by the Western medical system or be regarded as "negative" because their effects are still untested by medical research. Both positive and negative are obviously culture based terms.

Punjabi perception of foods as "hot" and "cold" were found to be an enduring belief which has not changed even after a long stay in Canada or with a university degree or a higher level of income, whereas breast feeding practices proved to be an unenduring belief which is changing dramatically after immigration to Canada. The modifying factor most probably is economic as many Punjabi mothers are forced to become bread-winners; a role they rarely practiced in India.

The perception of some female respondents about losing body weight appears to be of greater importance than any exercise to improve health. However, in the male respondents, the opposite is true. For many, exercise is believed to be a body building activity only appropriate to men. The concept of exercise for better health is almost non-existence in this community. Women who don't work outside the home usually spend their days at home watching Hindi movies. In most Hindi movies, the actresses are not depicted as slim as in Western movies. In Hindi as well as Punjabi movies, portly women are highly glorified and celebrated. I also found that most of the Punjabi women believe that being slim is not a healthy status. Some slim women reported their health status as only "good" or "fair" instead of "very good" or "excellent", although they looked perfectly healthy and did not report any health related problems.

For raising children, two most critical problems faced by the Punjabi people are related to the discipline and feelings of being a stranger in a new society. T.V. shows in general are believed to be very violent and pornographic. These T.V. shows are perceived as a barrier in child rearing in Canada. The children of the mainstream in general are not perceived to be disciplined as compared to immigrant children. Prevalent laws are often criticized for lack of discipline. Punjabis, in general, find it hard to let their children play in the neighbourhood. The perception of the Indian village community is reflected in this. Those who live in the core area of the city list neighbours, traffic, and crime as the main reasons why they would not allow their children to play in the neighbourhood. The children in such areas are confined within the premises of the house and spend most of their time

outside the school hours watching Hindi movies or playing in a small, crowded living area. If parents could be convinced to take children out to community centres or open parks, especially during summer, that would be highly desirable for improving their health.

Except for a few exceptional cases, child birth services provided by hospitals were found to be quite satisfactory. Some hospitals rated higher than others but not many cases of racial discriminations were reported. Some women even went on record to say that nurses in Winnipeg hospitals were as efficient and caring as they ever experienced in any other places.

Family relationships in general were found to be excellent with tremendous confidence expressed in each other and the ability to make decisions together. There were hardly any bad feelings found in the family. Extended family, in general, was supported.(However, it should be remembered that the responses were given in the presence of other members of the family, and therefore, they could be biased) Some daughters-in-law felt differently and became critical of the concept of the extended family system. They said that they felt no freedom to express themselves. These, however, were the minority cases and not the general finding. A word of caution. There are cases where women are so dominated that family violence is possible. Family life educators should be aware of such facts and necessary education should be given to prevent family violence. If it does happen the woman should know where to go for shelter or how to get legal help.

The Punjabi believe that illness is caused by imbalances of hot and cold temperature and foods. Exposing oneself immediately after a bath to open air, or going out with wet hair or not covering oneself properly when going out are considered likely causes of illness. A child is always covered properly, or at times, over protected in fear of cold temperature. An infant is taken outside for the first time when it is 40 days old. On the 40th day the mother along with the child go to the temple to purify themselves. During the first three months of post-partum care, foods such as rice, yoghurt, fruits and some vegetables are considered "cold" foods for the mother but if these foods are taken with extra garlic, onion and gingers they may protect the body from the various potential illnesses. The concept of food system is their enduring belief and is practiced in almost all families. Some believe that their illnesses are predetermined and are a punishment from God, although such beliefs are slowly being abandoned in favour of modern health care beliefs.

The practice of not taking a bath immediately after delivery is also changing. Many are now taking a bath immediately. However, the majority of women still prefer hot foods such as hot milk or tea after delivery. The hot foods such as meat and eggs are not avoided by the majority of Punjabi women during pregnancy hoping for a male child. Vegetarian food was however, preferred to avoid complications suffered during previous pregnancies.

In India, a woman would rest completely for 40 days after delivery, but economic necessities are forcing women to go to work much earlier. No significant adverse effects

on health have been reported as a result of starting work sooner.

The changed role of husbands are appreciated by many women. Many of them find Punjabi husbands more caring in Canada than they were in India. Many men said that in India they were not allowed to go to see their wives in hospital wards during delivery. In India, that would be a culturally inappropriate thing to do. In Canada, however, the Punjabi men prefer to be near their wives during the process of delivery in the hospital. Here, the modifying factors responsible for change in behaviour could be cultural differences between India and Canada, but could be also due to the fact that they do not have female family members to look after their wives during hospitalization, as they had in India.

Some old beliefs such as during pregnancy one should not undergo internal medical examination are not found to be relevant in this study. The majority of women reported that they regularly went to see a doctor for a check -up during pregnancy. However, too much travelling is still believed to be harmful for pregnant women. The majority of Punjabi women felt more comfortable with a female doctor than a male doctor.

Some old behaviours such as not giving a full course of medicine to sick children is still prevalent in this community. They do not seem to realize the importance of giving a full course of medicine. They do not see the benefit of continuing with the medication when it becomes obvious that the child is no longer sick. Again, a proper doctor- patient relationship is required to instill the compliance behaviour in these patients.

The role of health care provider is immense in making Punjabi people more oriented towards preventive health practices as they are not familiar with the concept of preventive practices such as breast self examination, mammogram and Pap smear.

The importance of breast feeding was deep rooted in their culture and widely practiced in India as reported by many women. This important practice is increasingly being avoided or shortened after they come to Canada. Advertisements and the pressure to return to work might be changing mothers' behaviour regarding breast feeding. The general reason given during interviews for not continuing with breast feeding appears to be a concern that the infant may not drink other milk if it is not encouraged to do so soon after delivery. A wrong perception is prevalent that formula milk is equivalent to breast milk; if Western women can have healthy babies by bottle feeding why can't Punjabi women as well. Proper education again will play an important role in changing such behaviour.

There is a large gap in the health practices between the Punjabi population and those of the average Canadian population. Except for the alcohol consumption rate, which is the same, other preventive practices are different in both populations. Pap smear, breast self exam, dental hygiene and self rated health are lower in the Punjabi population. However, the Punjabi smoking rate is lower which might protect them from many potential diseases.

Finally, although these immigrant women are living a hard life, their reported level of stress is below the Canadian average, which indicates a positive attitude towards life and a

healthy outlook towards family values.

6. CONCLUSION AND RECOMMENDATIONS

The study finds that the concept of health in Punjabis is embedded in their cultural, social and historical context. The prevalent social situations and the institutions in Canada have also influenced changing Punjabi health care practices. The study recognizes such changes which have ensued after their settlement in Canada. The study also points to the need for specific examinations in the areas where the gap in the health care practices between the Punjabis and the Canadian average is significantly different.

The study finds that the Punjabi speaking people have no barriers in accessing the services of physicians, irrespective of their length of stay in Canada, their education or income levels. The supporting factors for such utilizations, as reported in the qualitative interviews, are the availability of many physicians of the East Indian background, and also because of the no up-front service charges in the existing health care system in Canada. In spite of such accessibility, most of the Punjabis rated their health lower than the Canadian average. Such assertion needs further validation through specific studies.

However, some cultural parameters need to be evaluated. Firstly, most of the Punjabi believe that the healthy state of the body is when the "cold" and "hot" conditions and the three humours (viz. wind, bile and phlegm) are in balance. Excess of any of them may be felt as an illness, and the treatment for it , as reported in this study, often start with home-remedies. For example, if an infant cries excessively, it might be treated with the soup of

fennel seeds with an assumption of a gastric problem- a problem considered to occur by the excess of the "wind" in the body. Such imbalance may affect anyone frequently due to changed food system, eating habits, climate and working conditions, causing one to believe that he or she is not in good health. The second parameter is about the perception of health itself. Only those with a properly built- up bodies are considered by many Punjabis in the interviews as healthy persons; slimness is generally considered an unhealthy state of the body. Such perceptions may contributed to their perception of themselves as less healthy when interviewed. For such cultural reasons the data on self-rated health status should be interpreted cautiously.

Similar to the self-rated health status question, Punjabis have also rated their stress levels significantly lower than the Canadian average. Such lower rating of perceived stress could also be a cultural expression. As stated in response to open-ended questions many Punjabis felt that, health is a state when disease is absent. The definition of health as quoted by WHO as "physical, mental and social well-being" is not a common consideration for many of them. Especially, mental health may be misjudged as merely a physical disease and the treatment is confined to only those symptoms which are somatically expressed by the patient. For example, distress from a social failure may be treated as a symptom of "sinking heart" and the treatment may start with serving the "cold" foods. The interpretation of the social well-being for many new Punjabi immigrants has a different dimension. For them, it may be confined to their socializing with only relatives, Punjabi friends or with the limited Punjabi community members. Cross-

community socialization is normally not very common as reported in the interviews. Therefore, any social comparisons of oneself with others or other status comparison factors which may cause stress to some persons, may not be a substantive cause for the frustration or stress to many of these new comers. Sometimes social well-being or social malaise both are considered not directly connected with health status, as reported in the interviews. This may be the reason why their stress levels are reported to be so low. Again an exclusive study may be useful to scientifically explain the low perception of social stress in the Punjabi community in Manitoba.

Punjabis who have been living in Canada for more than eight years stated in their survey response that they rate their children's health comparatively higher than those who lived here less than eight years. This represents a positive finding for immigrant resettlement; however, it requires further examination to substantiate this finding.

The first birth occurs within a short period of the Punjabi immigrant's arrival in Canada as reported in the interviews. The first born children have lower birth weights as compared to the Canadian average. However, the second born appear to have higher birth weights indicating that the gain in birth weights might be due to environmental rather than genetic factors. The study recommends that the prenatal advice is immensely important. Particularly, advice to the pregnant women about nutritional supplements, exercise and resting should be given a higher priority by the health care providers.

The lower utilization of many health preventions and practices such as the use of smoke detectors, breast self- examinations, medical compliance rates and prenatal care by the Punjabis needs to be rectified by strong doctor-patient relationships and by making health education and promotion more culturally appropriate. The prenatal advice and classes should be culturally suitable and not difficult to comprehend. Communications and promotion materials need to be revised. Health education programs should also monitor the nutritional deficiency and supplement requirements based on the food and eating systems of these ethnocultural groups.

Some health promotion strategies which are often stereo-typical middle class oriented behaviours such as exercising by playing tennis are not appropriate for many Punjabi women of Manitoba. Such health promotion and education plans should incorporate and address such diversities in multi ethnic perceptions.

The study also suggests that health resource allocation, particularly at the time when the Government is talking about reform and restructuring, should be based on the health needs of various ethno-cultural communities. For example, the risk of AIDS may not be a problem of the same magnitude to the Punjabis of Manitoba as to other groups. However, the need for nutritional knowledge, prenatal care or other issues of child caring and social adjustments warrant immediate attention.

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APPENDIX

QUESTIONNAIRE

This section can be filled out by any one of the parents who has already indicated his/her name at the beginning in the "Important Note " section.

SECTION A: INTRODUCTION

Q A1. When did you immigrate to Canada?
(Please write the year)

.....

When did your spouse

wife
husband } (Please circle correct one)
immigrate to Canada?
---------(give year)

Q A2. Do any of the following live with you in this house?
(Please check(√) all those family members living with you)

Mother------Mother-in-law----Father------Father-in- law--- -- Brother-in-law----Sister-in-law----Brother---- Sister--- others--- ---------- (specify)

Total number (including children)---

Q A3. What is the month and year of your and your spouse's birth?
(Please specify both)

Month ------ Year------You
Month------- Year------Wife/Husband

Q A4. What was the highest grade or level of education you and your spouse have completed?

(Please mark only one)

YOU	From where
◯ No schooling	
◯ Upto 5th grade	-------
◯ Upto 10 grade	-------
◯ Up to 12 Grade	-------
◯ B.A., B.Sc.,B.Com. technical courses,and equivalant	-------
◯ M.A.,M.Sc.,Ph.D. and equivalent	-------

Your spouse	From where
◯ No schooling	
◯ Upto 5th grade	------
◯ Upto 10th grade	------
◯ Upto 12th grade	------
◯ B.A., B.Sc.,B.Com., technical courses and equivalent	------
◯ M.A.,M.Sc.,Ph.D.and equivalent	-----

QA5. Are you currently employed outside the home?

(Please specify for both)

Wife-----yes/no
Husband-- yes/no

QA6. What are your present occupations and how long have you been in these occupations?
(Please write the type of work you do)

Wife's Occupation--------
Since when----------

Husband,s Occupation---------
Since When ----------

QA7. Which of the following best describe the hours you and your spouse work at your jobs?

(Please circle all that applicable to both of you, F=father and M= mother)

F/M- Regular daytime schedule of shift
F/M-Regular evening shift
F/M-Regular night shift
F/M-Regular shift
F/M-Split shift
F/M-On call

QA8. How many days a week do you usually work?
(Please circle for both of you)
You -- less than 5 days, 5days ,6days , 7days
Spouse--- less than 5 days, 5days ,6days , 7days

QA9. What is your best estimate of the total income of all household members from all sources in 1993 before taxes and deduction? Was the total household income...
(Please mark one)
◯ less than 10,000
◯ about 10,000
◯ about 15,000
◯ about 20,000
◯ about 25,000
◯ about 30,000
◯ about 35,000
◯ about 40,000
◯ about50,000
◯ about 60,000
◯ 60,000 or more

CHILD'S MEDICAL HISTORY

QA10. For each child, please fill in the chart.

s.no.	year of birth	male/ female	country of birth	weight at birth	weight after 1 year
child1					
2					
3					

QA11. Do any of your children not have any of the following immunizations?
(Please check only if he does not have any)

	Child number
DPT	-------
POLIO	-------
MEASLES	-------
GERMAN MEASLES	-------
MUMPS	-------

QA12. Do or did any of your children have any conditions they were born with that involved any of the following:

(Please check only if it applies to you)

HEART	(--)
EYES	(--)
MOUTH OR THROAT	(--)
STOMACH OR INTESTINES	(--)
KIDNEYS OR URINARY SYSTEM	(--)
MUSCLES, BONES	(--)
BRAIN OR NERVOUS SYSTEM	(--)

QA13. Does any of your children have any chronic disease?

Child number	Disease
---	---
---	---
---	- ---

Section B: Accessibility and barriers

(This section can be filled out by one of the parents who has already indicated his/her name at the beginning in the "Important Note" section)

QB1. Do you have a family physician or do you visit a particular Walk-in clinic ?
(Please check one)

Family Physician-----

Walk-in Clinic-------

Neither --------

If your answer is "Yes", is your physician Punjabi or East Indian by origin?

Yes------ No------

If yes, please select the following on the basis of importance for your choosing to go to this doctor.

1= most important, 2=important, 3=least important

(a) Culture: Because we share common culture **(1)(2)(3)**

(b) Language: Easy to understand him **(1)(2)(3)**

(c) Proficiency :He/She is better than others in treatment **(1)(2)(3)**

(d) Convenience in accessing **(1)(2)(3)**

(e)I don't know anybody else **(1)(2)(3)**

Besides the points mentioned above do you find any other differences between Punjabi speaking/East Indian physicians and English speaking physicians?
(Please mark as true or false for these statements)

(1) East Indian doctors are more direct
true/false

(2) East Indian doctors call you regularly for further check ups
true/false

(3) East Indian doctors tell you what food to eat others don't
true/false

(4) East Indian doctors examine you more carefully and they tell you about those examination while others don't
true/false

(5) East Indian doctors give you a stronger dose which cures you quickly while others take a long time
true/false

QB2. Do any of the following problems make it difficult for you to go to a doctor?
(Please mark the relevant/s one/s)

a. You don't know how to drive and no one else is available to take you to a Physician/Walk-in clinic--- **yes/no**

b. Because you think Western medicine is not that effective for the type of sickness of your child **yes/no**

c. You don't know any good physicians **yes/no**

d. Because medicines are expensive here **yes/no**

e. Because the Western medicines can cause side effects
yes/no

f. Because you are trying home remedies or other medicines.
yes/no

g. Because of any other reason (specify)----------

QB3. Who takes the children to the doctor?
(Please check one)

Usuallyfather------Always father-------Usually mother---
Always mother----Both------
Others(specify) --------

QB4. Does it become barrier in visiting the doctor when the person named above is not available then?

(Please check one)
Usually yes....., Sometimes.....,Never....., I don't know...

How does it become the barrier?
(Please circle all that apply to you)

a. Only he/she knows about the child

b. Only he/she can communicate with doctors

c. Only he/ she knows driving

d. Only he/she has the money to pay for medicines

e. Any other(specify)----------

SECTION C: Perception of the parents
(To be filled out by any one of the parents who has already indicated his/her name at the beginning in the "important note" section.)

QC1. Did you do something to improve your health in the past 12 months?

Yes---, No---

If your answer is yes, what is the single most important change you have made in the past 12 months to improve your health?
(Please mark all that apply to you)

a. Increased exercise , sports or physical activity
b. Lost weight
c. Changed diet or eating habits
d. Quite smoking/reduced amount smoked
e. Reduced drug/medication use
f. Drank less alcohal
g. Managed or reduced blood pressure
h. Managed or reduced stress
i. Changed physical environment
j. Recieved medical treatment
k. Changed sexual behaviour or reduced risk of STD
l. Improved dental hygiene
m. Other(specify)----------

If your answer is excersise (By exercise we mean vigourous activities such as aerobics, jogging, racquet sports, team sports, dance classes or brisk walking, Yoga or any other activities you feel appropriate) specify how many times per week, on average, do you exercise?
(Please circle one)

a. Daily
b. 5-6 times a week
c 3-4 times a week
d. 1-2 times a week
e. Less than once a week
f. Never
g. Don't know

QC2. In general, compared to other people your age, would you say your health is..
(Please circle one)

a. Excellent
b. Very good
c. Good
d. Fair
e. Poor

QC3. What about your children's health?... as compared to the same age of other children , would you say their health is ...
(Please circle one)

a. Excellent
b. Very good
c. Good
d. Fair
e. Poor

QC4.Have you ever told by a doctor, nurse or other health professional that you have high blood pressure (for the mother except when she was pregnant)
(Please check for both)

Father: yes---, no--, don't know---

Mother: yes---, no--, don't know----

QC5. When did you last have your blood pressure checked
(Please mark one)

a. Within the last 6 months

b. 7-12 months

c. 13-24 months

d. More than 2 years

e. Don't know

f. Never

QC6. Do you believe any of the following would help you to improve your health and well-being? (Mark all that apply)

	yes	no don't know	not app lica ble
a. A more secure income			
b.Moving to another neighbourhood or community			
c. A change in job or business			
d.Spending more time with family or close friends			
e.Exercising more or being more physically active			
f. Losing weight			
g. Stop smoking			
h. Cut down on drinking			
i. Reduce drug use or medication			
j. Taking better care of teeth			
k.Learning to relax more and worry less			

QC7. Do you or father of the child smoke cigarettes every day?

yes----how many per day----,no----

QC8. In the past 12 months , have you or the father of the child have taken a drink? by drink we mean:

a. one bottle of beer or glass of draft
b. one small glass of wine
c.one shot of mixed drink with hard liquor

yes----no-----

QC9. In the past 12 months, how often on average did you/father of the child drink alcohol? was it--

a. Every day
b. 4-6 times a day
c. 2-3 times a week
d. Once a week
e. Once or twice a month
f. Less often than once a month

Thinking back over the last 7 days , starting with yesterday, how many drinks did you have on each day?
(Please write the number after the day)

Monday -----
Tuesday -----
Wednesday -----
Thursday -----
Friday ----
Saturday -----
Sunday -----

QC10. In the past 12 months have you used
(Mark all that apply)

a. Tranquilizers such as Valium
b. Diet pills or stimulants
c. Anti-depressants
d. Codeine, demerol or morphine
e. Sleeping pills
f. ASA or other pain reliever

QC11. Have you seen a dentist in the past 12 months

yes--- no--- don't know.....

QC12. How often do you usually brush you teeth

a. Twice or more a day/after every meal
b. Once a day
c. A few times a week
d. Once a week

QC13. How often do you feel lonely or remote from other people

Very often----------Not so often-------Never-------

QC14. Would you describe your life as---
(Mark only that apply to you)

a. Very stressful
b. Somewhat stressful
c. Not very stressful
d. Not at all stressful

SECTION D: Social relationship and child rearing experience.

(This section is to be filled out by the mother only)

QD1. Who is more involved in looking after the children

You -----
Your mother-in-law ----
Some body else -----

QD2. Had you been in India who would have looked after your children?

You -----
Your mother-in-law -----
Somebody else -----

QD3. If you are not involved full -time caring for your child is that making a difference in his development?

Yes ---- No ---- I don't know ----
(Please check the appropriate box)

QD4. Is the extended family absolutely necessary in Canadian circumstances for you?
(Pleases check one)

Yes------, Not much-------, No-------

QD5. What specific difficulties do you face in rearing your child in Canada as compared to India?

Please **circle** the following options on the basis of importance (Number 1 is the most important and number 3 the least: **1=is the most important,2= is the important, 3=not so important)**

a. Child can't play in the neighbourhood
1 2 3
b. Herbal medicines are not available
1 2 3
c. Homeopathic medicines is not available
1 2 3
d. The Grandparents are not here
1 2 3
e. Other children are not disciplined
1 2 3
f. T.V. shows too much violence and sex
1 2 3
g. This society is not disciplined
1 2 3

QD6. Are you satisfied with the childbirth services provided to you when you were last pregnant?
Yes----,Not very ----, No -----

QD7. Did you experience any racial discrimination against you during your hospitalization for child birth?
Yes-------, No --------

If yes , did one of the following happen?

(Please mark relevent one/s)
a. Respondent slowly for your request
b. Abrupt or cold behaviour
c. Impolite to you
d. Did not provide facilities requested
e. Did not provide food requested
f. Other (Specify)----------

QD8. Do your children play outside your house in the neighbourhood?

Yes ----- No ------

If no, please specify all that apply to you

a. You don't know your neighbours.
b. You think your neighbour will not like it.
c. You don't like them to play outside.
d. You don't trust your neighbours.
e. You think it is not proper to send your child outside to play.
f. Any other reason(specify)----------

QD9. What is missing in your child' development?
(Please check all that apply to you)

Physical growth ----------
Mental growth ----------
Spiritual growth ----------
Don't know ----------

QD10. What is your experience of day care ?
(Mark all that apply)
1. I don't know
2. They are good
3. Their food is a problem
4. Language is a problem
5. They don't care as much as our people care for the child

QD11. Who does the baby sitting for you?

1. One of your family member
2. A Punjabi friend or neighbour
3. Some body from the neighbourhood who is not Punjabi
4. No body

If your answer is 3.Are you satisfied with your baby-sitter.

Yes----No-----Don't know------

QD12. How often do you take your children to your temple?
(Please mark the relevant box)

a. More than once a week once a week
b. More than twice in a month
c. Once in a month

QD13. The following statements are about families and family relationships. Please rank your preference for the question number D13 and D14 on a scale of 1 to 4 with **1 being strongly agree, 2 - agree, 3-disagree and 4- strongly disagree.**

1. In times of crisis you can turn to each other for support
1 2 3 4
2. Individuals (in the family) are accepted for what they are
1 2 3 4
3. You confide to each other
1 2 3 4
4. You avoid discussing your fears or concerns
1 2 3 4
5. There are lots of bad feeling in your family
1 2 3 4
6. Your are able to make decisions about how to solve problems.

1 2 3 4

QD14. The next statements focus on the way you relate to you children.

1. You don't tolerate temper tantrums form the children
1 2 3 4
2. Your children must try every food you serve
1 2 3 4
3. It is important to have a fixed bedtime
1 2 3 4
4. Physical punishment is the only way to deal with some of children's misbehaviour.
1 2 3 4
5. You think they should comply all you requests
1 2 3 4
6. The children should have the right to chose to stay up late occasionally.
1 2 3 4

QD 15. Who usually disciplines the children?
(Mark one only)

1. Mother
2. Father
3. Both
4. Other family member
5. Don't know

SECTION E: Beliefs
(This section to be filled out by the mother only)

QE1. What minor ailments of your child can you cure by your home remedies and you will not go to a doctor unless it becomes severe?
(**Please specify the treatment,** approximately how many **days** you would continue such treatment and will not go to a doctor.)

TREATMENT(specify) FOR HOW MANY DAYS(specify)

Days

a. common cold
---------- -----
treatment

b. slight fever
---------- -----
treatment

c. slight stomach pain

---------- -----
treatment

d. watery stool
---------- ----
treatment

e. constipation
---------- ----
treatment

f. not sleeping properly

---------- ----
treatment

g. not eating properly
---------- ----
treatment
h. pain when he is teething
---------- ----
treatment

i. slight pain in ears
---------- -----
treatment

j. others(specify)
---------- -----
treatment

QE2. How does a person become ill?
(Please mark as true or false)

(a)Imbalance of hot and cold temperature **true/false**

(b)Imbalance of hot and cold food **true/false**

(c)Because of his wrong thinking and doing **true/false**

(d)It is predetermined **true/false**

(e)It is a punishment from God **true/false**

QE3. Do you prefer not to take bath(except cleaning dirty parts of body) immediately after delivery because it may cause you arthritis and related diseases?
(Please check one)

Yes....No....Don't know.....

After how may days did you take bath after delivery?
(Please circle one)

immediately, one day, two days, three days

QE4. Do you prefer hot (warm) foods after the deliver?
(Please check one)

Yes----No-----Don't know---

QE5. Do you prefer vegetarian foods after the deliver?
(Please check one)

Yes---No----Doesn't matter------

When do you give fennel seeds, honey, Hazmola, ginger, carraway and other seeds to your children:
(Please specify)
1.----------For What Reason----------
2.----------For What Reason----------
3.---------- For What Reason----------

QE6. Do you avoid hot foods such as meat, eggs during the first trimester of your pregnancy as they might cause miscarriage or premature delivery?
(Please check one)

Yes....No...Don't Know

QE7. Are you secluded about 40 days after your delivery because you are supposedly week and most susceptible to backaches etc.

Yes---No-----Don't know----

If your answer is no, did that make any difference in your health?

Yes-----, No----Don,t know---

SECTION F: ATTITUDE

(To be filled out by the mother of the child)

QF1. Do you take your child to a doctor for a regular check up or only when he is sick?
(Please check one)

Only when he is sick -------
Regular checkups --------

QF2. How often do you not give the full course of medicines as directed by the physicians?
(Please check one)
Often------- Sometimes------Never------

QF3. Do the Punjabi husbands consider child birth a women's business and husbands participate only in so far as they stay near the house in case of emergency?
(Please check both a and b)

a.Back in India -Yes----,No----

b.In Canada- Yes----,No---.

QF4. Do you prefer to wear your traditional dress "Salwar Kamiz" to the extend possible during your stay in hospital because Canadian hospital gowns leave the legs bare or have a low neckline?
(Please check one)

Yes....No.....Don't Know.....

QF5. Do you avoid seeing doctors regularly during pregnancy?

Yes....No...Don't Know
If your answer is "Yes" please specify all those relevant to you:

a. It 's not required
b. Baby in the womb should not be disturbed
c. Too much of travelling is unhealthy
d. Because your doctor is a male doctor
e. Others

QF6. If you notice your child was sick what would be your first step in his/her treatment?
(Please mark all that apply to you)

a. Wait for another one day for the symptoms to be grown completely.

b. Wait for another day and start home remedies

c. Go to a doctor

d. Ask your family members/friends for help

QF7. Do you have a preference for son?

Yes---No---I don/t know---

QF8. Which of the following best describe you approach to disciplining children?
(Please mark only the statement that describe your approach)

a. First advising them to correct themselves and if they still insist on doing wrong you may physically punish them.

b. By not doing anything

c. Not doing anything because this society is such that you might loose your child

d. Physical punishment is necessary till certain age of the child
e. Other---------- (specify)

QF9. Would you prefer to have your baby born at home rather going to hospital?

Yes----No-----Don't know----

QF10. What is your preference for care givers to deliver your baby?
(Please check one)

Male Western Doctor----
Female Western Doctor----
Male Punjabi Doctor----
Female Punjabi Doctor---
Western Midwife----
Punjabi Midwife-----

QF 11. Do you have time to take your children to an open park or play ground or other recreation centres to play?
(Please check the appropriate box)

I don't have time----------
I don't like the idea------
I don't have the resources to take them------
Its not required ----------
Don't know------

SECTION G: Behaviour
(To be filled out by the mother of the child)

QG1. Do you use "kajal" on your child/ren's eyes
Yes----No-----

QG2. Do you give oil massage to your infant baby regularly?

Yes--No---I don't know---

QG3 At what age did you start feeding each child milk from a bottle?
(Please write age in month)

Child 1 ----
Child 2 ----
Child 3 ----
Child 4 ----
Child 5 ----

QG4. What kind of milk did you mostly use in bottle?
(Please mark one)

1. Dairy milk
2. Baby formula(Specify the brand name) ----------
3. Commercial prepared milk

QG5. What food did you give to child?(Please specify for one child only)
TYPE OF FOODS

one month----------
two month----------
three month----------
four month----------
five month----------
six month----------
seventh month----------
eight month----------

QG6. When did you stop breast feeding?
(Please write for both male and female children ,if you have both)
Age

male child --------
female child --------

QG7. How do you usually position your infant baby for sleep?
(Check one only)

------on stomach-----on back----on side

QG8. What position do you usually find your infant baby in after sleep?

-----on stomach-----on back----on side

QG9. Did anyone advise you about sleeping position for infant?
------yes -----no

If yes, who advised you and what did they suggest?
-- --family members
-----friends outside family
---- nurse
---- doctor

if doctor advised you, was there a medical problem--yes ----no
If yes what problem----------

QG10. Where does your infant baby most often sleep?
(Please mark one)
a. in a crib, basinet or cot:

1. in your own bed room
2. in the separate room

b. in bed with you

c. in bed with other children
d. in bed with grandparents

e. other(specify)------

QG11. How often do you use child car seat while driving your child?

Always-------, Sometimes--------, Never--------

QG12. Do you have smoke-detectors in your house?

Yes--------, No --------

QG13. How often do you perform breast self-examination?
(Please mark one)

a. At least once a month
b. Once every 2-3 months
c. Less often
d. Never

QG14. Have you ever had a mammogram, that is, a breast X-ray
(Please check one)
Yes -----No----Don't know------

QG15. Have you ever had a PAP smear?
(Please check one)
Yes--No-- Don't know---

QG 16. Please specify if you have any medical problem in last 12 months.
