CONSTRAINED SPACES OF PRENATAL CARE: SOUTH ASIAN IMMIGRANT WOMEN IN NEW YORK CITY

BY

RANJANA CHAKRABARTI

DISSERTATION

Submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Geography in the Graduate College of the University of Illinois at Urbana-Champaign, 2009

Urbana, Illinois

Doctoral Committee:

Professor Sara McLafferty, Chair
Professor David Wilson
Associate Professor Ezekiel Kalipeni
Associate Professor Zsuzsa Gille
Abstract

The aim of this research is to examine use of prenatal care by South Asian immigrant women in New York City, focusing not only on barriers to care but also women’s reliance on multi-scalar, place-based social networks and resources. Recently, public health analysts have raised concern about low utilization of prenatal care by South Asian women who are much less likely than US-born women to receive early and adequate prenatal care.

I use a mix of quantitative and qualitative methods to examine spatial variation in use of prenatal care for South Asian women in New York City and to understand experiences of pregnancy care for a specific sub-group of South Asian immigrant women. In the quantitative section, GIS and statistical methods are employed to identify risk factors and areas where use of prenatal care is especially low. The qualitative section comprises in-depth interviews with women from Bangladesh and Bengali women from India to understand their formal as well as informal pregnancy care experiences. I seek to examine the social, cultural and geographical barriers these women face in gaining access to prenatal care and explore how women create and draw upon resources at different geographical scales to maintain health and well-being during pregnancy.

Results from the quantitative section show that Bangladeshi and Pakistani women are at higher risk of receiving less than adequate prenatal care especially in specific areas such as in South Central Brooklyn. Education and employment emerges as significant risk factor for Pakistani and Bangladeshi women’s low use of prenatal care. Results from the qualitative section highlight South Asian women’s situatedness in local and
transnational networks and the role of such networks in enabling women to use both formal and informal pregnancy care.

Situated within the theoretical framework of a ‘new’ medical geography this research makes several contributions to the emerging body of work untangling the linkages between health and place. Home emerged as important as a space for care as well as strenuous labor for pregnant South Asian women. Everyday places such as neighborhood parks, temples emerged as important spaces with physical as well as social therapeutic qualities. ‘Social therapeutic networks’, operating at multiple geographical scales were important in shaping women’s place-based experiences of pregnancy care. As these networks unfolded, places were recreated and/or transformed making them therapeutic and healthy places. Therapeutic qualities of informal conversations and of sights and sounds surfaced in women’s narratives, further enriching the notion of therapeutic landscapes. Identifications of everyday locales as therapeutic as well as use of social therapeutic networks differed based on differences in class, religion and country of origin.

The research has several policy implications. Issues raised by the women, such as long waiting times and too many tests, need to be addressed. By highlighting within group diversity amongst South Asian women, this research emphasizes the need to fine-tune prenatal care policies to cater to the needs of diverse sub-groups of women masked under a broad label. By highlighting the importance of place in South Asian women’s use of pregnancy care, this research emphasizes the need to focus not only on barriers to care but also on women’s reliance on multi-scalar, place-based social networks and resources.
To my Mother and to my Father
To my brothers,
Rajib and Sanjib
To Diptarko, my son,
and
Dipayan, my husband
Acknowledgement

I extend my heartfelt and loving thanks to my advisor, Prof. Sara McLafferty for her support, encouragement and fine mentorship all through these years. Through her excellent mentorship skills Sara gave her insights whenever it was necessary and helped shape the research in important ways. Her excellent writing skill has had a deep imprint on me, which I feel I will retain all my life. Sara has also been very understanding on the event of any setbacks. She gave the much-needed support and also endured with me through several life events and episodes. Her encouraging words helped a lot to recuperate and get back to work. Thanks from the bottom of my heart to my advisor for guiding me and helping me with patience and endurance all these years.

I extend my heartfelt thanks to my committee members, David Wilson, Ezekiel Kalipeni and Zsuzsa Gille for their friendly and encouraging words and guidance and support whenever necessary. I will always remember Zsuzsa’s supportive and cheering attitude and great liking for my work. Thanks to all the faculty members both within and outside the department for their kind and encouraging words all through my stay in UIUC. Special thanks to Jane Domier and Mu, Lan for their helpful comments on the GIS maps. Special thanks to Steven Brechin and Zsuzsa Gille and for their encouraging words and inputs on the qualitative section of the research. I especially remember Scott Isard for his encouragement and support during the initial years as graduate student in UIUC.

At this moment I would also like to express my heartfelt thanks to fellow graduate students for providing a fun, exciting and friendly work environment and kind and cheerful words. A note of special thanks to Jeessun and Francis for helping me whenever I needed it most. Special thanks to Brad for helping with the GIS maps.

My heartfelt thanks to the staff of our Geography office, specially Barbara, Chris and Susan for taking care of umpteen official matters and timely reminders. I especially thank Chris and Susan, for being so up to date and knowledgeable about requirements, procedures and deadlines.

I would like to gratefully and sincerely thank the Society of Woman Geographers for awarding the Evelyn L. Pruitt National Fellowship for Dissertation Research 2004-2005, to support this research. Sincere thanks to the Graduate College, University of Illinois-Urbana Champaign for funding my fieldwork through a Dissertation Travel Grant, 2003-2004. Also, special thanks to the Department of Geography, University of Illinois-Urbana Champaign for awarding me the second Charles S. Alexander Graduate Fellowship for Women, 2003-2004, and enabling me to pursue my research full-time.

This research would not have been possible without the generosity of the women who participated in the study. Even though setting out time for interview was not easy amidst routines of everyday life, the women in this study gave plenty of time for detailed discussion and enabled the interview process to be conducted comfortably, in a homely setting. I will remain indebted to all the women for whom this research could be conducted and completed. Special thanks to Rupna, Jyotsna di and Nahar di for helping me gain access to women in the initial phase of fieldwork and to the Bangladesh Hindu Mandir and the Ramakrishna Vivekananda Center and storeowners and storekeepers in the various neighborhoods, especially Anwar ji and Seema di for giving access to and enabling contact with prospective research participants.
At this moment I fondly remember my first year (Fall 2000-Spring 2001) as a doctoral student at Hunter College, City University of New York. A note of special thanks to Marianna Pavlovskaya for being so inspiring and to Sue Grady for her guidance and help.

I would also like to express my special thanks to Jayasree De, my teacher in M.S. University of Baroda, India, for introducing me to Health Geography and still inspiring me to pursue a career in this field.

I would not have reached this point without the love, support and wishes of my parents and family members. Very special thanks from the bottom of my heart to my mother, my father, my elder brothers, Rajib and Sanjib for their wholehearted support, positive words and encouragement for everything I wanted to pursue. Baba, I earnestly wish you were with me to share this moment of joy. I feel your presence every moment of my life; your honesty, simplicity, determination and undying spirit of endurance guide me in every step I take. Ma, your principles, simplicity and sweetness guide me in everything I do. I wish you will always be with us. Rajib, I have always admired the breadth and depth of your knowledge and tried to follow your footsteps. Sanjib, you have always encouraged me to dream and helped me to think ahead and remain focused; your generosity touches me deeply in all my endeavors. I consider myself to be blessed to have you as my brothers; to be surrounded by your unconditional love and guidance since my first day on the earth.

My heartfelt thanks to my father-in-law and mother-in-law for their support and encouragement during a crucial phase. During the few months after my son was born both my father-in-law and my mother-in-law took upon themselves the project of helping me continue with my writing. My father-in-law is not with us anymore; I fondly remember his charming and friendly manners and sincerity and imagine that he is sharing my joy from wherever he is now.

Without my husband’s love, support and patience life would not have been so meaningful as a doctoral student. Dipayan, without you this would not have been possible; you have inspired me to dream, you have supported me to pursue my dreams and you have always provided me with mental support. I will always remain grateful to you for your patience and understanding during the times when I had to be away from you to complete my on-campus requirements in Urbana-Champaign. Thanks for being with me through thick and thin and providing me with love and companionship.

My life as a doctoral student has been made complete by the arrival of my son, Diptarko! Dear son, you have given all meaning to my life and enriched every moment of my doctoral pursuits. It was through becoming your mother, that everything made new sense, there were profound realizations and I could pursue my research and writing with renewed vigor in spite of all the challenges. Your presence makes life evermore meaningful and joyous.

Last, but not the least my sincere thanks to all my friends, relatives and well-wishers here in the U.S. and back in India who keep me in their prayers and wish me the very best in everything I do.
Table of Contents

List of Tables ........................................................................................................... viii

List of Figures .......................................................................................................... ix

Chapter 1: Introduction .......................................................................................... 1

Chapter 2: Review of Literature ............................................................................ 13

Chapter 3: Data and Methods .............................................................................. 66

Chapter 4: Visualizing Variation: Quantitative Analysis
of South Asian Immigrant Women’s Use of Formal Prenatal Care ..................... 96

Chapter 5: Use and Experience of Formal Pregnancy Care in Spaces of Everyday Life ............................................................................................................. 131

Chapter 6: Therapeutic Places and Networks of Informal Care During Pregnancy ............................................................................................................. 177

Chapter 7: Conclusion ........................................................................................... 235

Bibliography .......................................................................................................... 254

Appendix: Interview Questionnaire ........................................................................ 266
List of Tables

Table 3.1: Percent increase of South Asian population in New York City .................92
Table 3.2: Description of variables used in the models ...........................................93
Table 3.3: Sample questions asked in in-depth interviews .........................................94
Table 3.4: Number of women interviewed in different neighborhoods in New York City ..........................................................95
Table 4.1: Number of live births by foreign-born South Asian women in New York City, 1999 .................................................................115
Table 4.2: Use of prenatal care by foreign-born South Asian women in New York City, 1999 .................................................................115
Table 4.3: Sources of birth-related health care expenses for foreign-born South Asian women in New York City, 1999 ...........................................116
Table 4.4: Selected sociodemographic characteristics of foreign-born South Asian women who gave birth in New York City, 1999 ...........................................117
Table 4.5: Logistic regression: variables affecting use of prenatal care among South Asian immigrant women ......................................................118
Table 4.6: Logistic regression: variables affecting use of prenatal care among South Asian immigrant women by country of origin .........................118
Table 5.1: Sociodemographic characteristics of the research participants ..................173
List of Figures

Fig.2.1: A diagrammatic representation of the conceptual framework ..................62

Fig.2.2: Defining place, culture and gender for South Asian immigrant women:
   A few examples ................................................................. 63

Fig.2.3: Place, gender and culture in creating South Asian women’s
   care environment during pregnancy: Some illustrative examples ................. 64

Fig.2.3a: Home as site of care for pregnant South Asian women ...................... 64

Fig.2.3b: Neighborhood as site of care for pregnant South Asian women .......... 64

Fig.2.3c: Workplace as site of care for pregnant South Asian women ............... 65

Fig.3.1: New York City zip code areas ............................................. 91

Fig.4.1: Residential distribution of foreign-born South Asian women
   who gave birth in New York City, 1999 ........................................ 119

Fig.4.2: Residential distribution of foreign-born Indian women
   who gave birth in New York City, 1999 ........................................ 120

Fig.4.3: Residential distribution of foreign-born Bangladeshi women
   who gave birth in New York City, 1999 ........................................ 121

Fig.4.4: Residential distribution of foreign-born Pakistani women
   who gave birth in New York City, 1999 ........................................ 122

Fig.4.5: Percentage of foreign-born South Asian women in New York City
   with late or no prenatal care, 1999 .............................................. 123

Fig.4.6: Percentage of foreign-born Indian women in New York City
   with late or no prenatal care, 1999 .............................................. 124

Fig.4.7: Percentage of foreign-born Bangladeshi women in New York City
   with late or no prenatal care, 1999 .............................................. 125

Fig.4.8: Percentage of foreign-born Pakistani women in New York City
   with late or no prenatal care, 1999 .............................................. 126

Fig.4.9: Percentage of foreign-born South Asian women in New York City
   on Medicaid, 1999 ............................................................... 127
Fig. 4.10: Percentage of foreign-born Indian women in New York City on Medicaid, 1999 ................................................................. 128

Fig. 4.11: Percentage of foreign-born Bangladeshi women in New York City on Medicaid, 1999 ...................................................... 129

Fig. 4.12: Percentage of foreign-born Pakistani women in New York City on Medicaid, 1999 .............................................................. 130

Fig. 5.1: Journey from home to prenatal care facility: mediating factors ................. 174

Fig. 5.2: Elmhurst hospital, a major prenatal care facility for South Asian women in New York City ......................................................... 174

Fig. 5.3: South Asian women arriving at Elmhurst hospital with kid and baby in stroller .................................................................... 175

Fig. 5.4: Welcome sign in Bengali in Elmhurst hospital, New York City ................. 175

Fig. 5.5: Signs giving direction to Medicaid office, Bellevue hospital, New York City ............................................................................. 176

Fig. 6.1: Women from Bangladesh attending ‘puja’ in Divya Dham temple, New York City ................................................................. 232

Fig. 6.2: Bangladesh Hindu Temple, New York City, a therapeutic space for Bengali women ................................................................. 232

Fig. 6.3: A local park in Woodside, New York City: space enabling informal conversations ........................................................................ 233

Fig. 6.4: A public school in Brooklyn: space enabling informal talks ..................... 233

Fig. 6.5: A shop in Jackson Heights, New York City, with Bengali signage ............ 234

Fig. 6.6: A shopping plaza in Jackson Heights, New York City .............................. 234
Chapter 1
Introduction

The care women receive during pregnancy is a very important component of women’s health care in general and reproductive health care in particular. It is referred to as ‘prenatal care’ in medical terminology and ‘pregnancy care’ in wider literature. It consists of care and services that help women carry a healthy baby as well as maintain their own health and well-being. Health care research provides extensive evidence linking improved birth outcomes with receipt of prenatal care (Alexander & Kotelchuck, 2001; Healthy People Objectives, 2000, 2010; Institute of Medicine, 1985; Lia-Hoagberg, Rode, Skovholt, Oberg, Berg, Mullet et al., 1990; McDonald & Coburn, 1988). The sooner women start receiving medical care during pregnancy, the better are the chances of ensuring their own health and that of their babies. Low birth weight and other adverse outcomes of pregnancy are often associated with inadequate use of prenatal care (Alexander & Kotelchuck, 2002; Institute of Medicine, 1985; Kieffer, Alexander & Mor, 1992). Despite widespread recognition of the value of prenatal care, however, use of regular and adequate prenatal care is far from universal. A large percentage of women in the US do not utilize adequate prenatal care. A significant portion of these women are women of color and immigrant women.

Research Objectives:

The aim of this research is to examine use of prenatal care by South Asian immigrant women in New York City, focusing not only on barriers to care but also women’s reliance on multi-scalar, place-based social networks and resources. The main
objective is to understand the role of place, culture and gender in shaping pregnancy care experiences of Bengali immigrant women, a fast growing immigrant group in New York City. I employ a mix of quantitative and qualitative methodologies, first, to examine spatial variation in use of prenatal care by South Asian women and identify socioeconomic risk variables and second, to understand in depth how a distinctive group of South Asian women in New York City, namely Bengali immigrant women, use and experience pregnancy care. I engage with recent developments in health geography and situate my research within a theoretical and conceptual framework that seeks to understand immigrant women’s health care experiences through rigorous and careful untwisting of the linkages between health and place.

The research is carried out in two phases. In the first phase, I examine patterns of prenatal care use by Indian, Bangladeshi and Pakistani immigrant women, the three major groups of South Asian immigrant women in New York City, using aggregate quantitative data on prenatal care use. I employ GIS and statistical methods to analyze disparities and associated risk variables of prenatal care use for South Asian women and to identify neighborhoods where prenatal care use by South Asian women is especially low. The second phase of the project comprises a more focused, qualitative study of Bengali immigrant women’s pregnancy care experiences. Based on in-depth interviews, I examine the social, cultural and geographical barriers these women face in gaining access to prenatal care and explore how women create and draw upon resources at different geographical scales to maintain health and well-being during pregnancy.

The site of this research is New York City, one of the major destinations of immigrant women from South Asia (The Newest New Yorkers, 1996, 2004). I investigate
the patterns and trends of prenatal care use amongst South Asian immigrant women who gave birth in New York City. I then attempt to understand in depth the use and experience of health care during pregnancy by Bengali immigrant women in selected neighborhoods in New York City.

The research participants in the qualitative study are women from Bangladesh and Bengali women from India, two neighboring countries with common linguistic and historical ties. These women speak the same language, Bengali, but differ in many respects such as religion, culture, socioeconomic background as well as migration trajectories resulting in their embeddedness in different socio-spatial settings in New York City.

**Research Questions:**

This proposed study will address the following research questions:

- How and why does prenatal care use by South Asian Immigrant women vary within New York City?
- How do South Asian women gain access to prenatal care services?
- How does the experience of place mediate the prenatal care experiences of these women? How do these women relate to and gain knowledge from the formal and informal prenatal care resources in their local environment? What geographical, economic and cultural barriers do they face?
- Is there an influence of culture in pregnancy care experiences of these women? Do they use or follow any culturally specific prenatal care practices and advice? Are such practices place-based and at what scale?
How do South Asian women create and utilize place based social networks at the local, national or transnational scales to gain access to formal and informal pregnancy care resources, services and advice?

**Background:**

Use of early and regular prenatal care is widely recognized as an essential preventive medical service for pregnant women, because a number of adverse birth outcomes has been associated with non or inadequate use of prenatal care. High incidences of pre-term and low birth weight babies have been associated with low and non-use of prenatal care in numerous studies (Alexander & Kotelchuck, 2001; Institute of Medicine, 1985). Such adverse birth outcomes can lead to infant mortality, a critical public health issue in the US (Institute of Medicine, 1985). Pre-term and low birthweight infants also face a higher risk of adverse health outcomes both in infancy and later in life. Early diagnosis and intervention through prenatal care can not only reduce such adverse birth outcomes and but also reduce maternal morbidity as well as mortality resulting from specific risk conditions (Alexander & Kotelchuck, 2001).

Unfortunately, women marginalized due to race, ethnicity, socioeconomic and migrant status continue to be at high risk of receiving less than adequate prenatal care. Trends in the timing of prenatal care in the US from 1980-1994 based on birth certificate data indicate that very few groups of women reached the Healthy People Objective 2000 target of 90% women starting prenatal care in the first trimester. (The pregnancy period is typically divided into three, 3-month long trimesters.) The percentage of mothers initiating prenatal care early was very low among non-Hispanic black (67%), Puerto Rican (67%) and American Indian women (68%) (Lewis, Mathews, & Heuser, 1996).
More recent national estimates of the trimester in which women began prenatal care show that in the year 2004, 11.4% of non-Hispanic black, 11.2% of American Indian, 11% of Hispanic women initiated prenatal care in the 3rd trimester or did not receive any care compared to 6.2% for women of all races and 4.5% for white women (Martin, Hamilton, Sutton, Ventura, Menacker, & Kirmeyer, 2006).

Recently, public health analysts have raised concern about low utilization of prenatal care by certain immigrant groups. Among the groups cited are South Asian women who are much less likely than US-born women to receive early and adequate prenatal care (Coalition for Asian American Children and Families, 2000; South Asian Public Health Association, 2002). In particular women from Bangladesh and Pakistan, are seen to have very low levels of prenatal care use. For instance in New York City in 2005 the rate of late or no prenatal care was 10% for Bangladeshi women and 11.6% for Pakistani women compared to 5.7% for the city as a whole (Summary of Vital Statistics, 2006).

The links between pregnancy care and reproductive health outcomes for South Asian immigrant women are complex and poorly understood. Recent public health data indicate South Asian women at high risk of delivering low birth weight babies, which may be related to their lower rates of early prenatal care use. However, health outcomes are not consistently better among South Asian women who do start prenatal care early in their pregnancies. For example, women who have immigrated to the US from India are more likely to deliver low birth weight babies than white women, even though the Indian women receive first trimester prenatal care at the same rate as white women (Gould,
Madan, Qin, & Chavez, 2003; South Asian Public Health Association, 2002). This ‘epidemiological paradox’ has only recently begun to be examined.

Very little is known about the complexity of circumstances that leads to low or inadequate utilization of formal prenatal care by specific groups of South Asian immigrant women. Many unanswered questions remain. What kinds of social, cultural, economic and geographical barriers do South Asian women face in obtaining prenatal care? Do women substitute informal services and advice for services provided through the formal health care sector? Is such informal care place-based and at what scales?

Low use of formal prenatal care by certain immigrant women groups become critical in view of the rapidly growing immigrant population in the US. The foreign-born population in the United States increased from 19.8 million in 1990 to 31.1 million in 2000, an increase of 57% within a decade (Malone, Baluja, Costanzo, & Davis, 2003). A quarter of this flow is comprised of individuals from Asia (Malone et al., 2003). The growth rate of Asian population in the U.S. between 1990 and 2000 was higher than the total population (Barnes et al., 2002). South Asian immigrants contribute to a growing and an increasingly diverse share of Asian immigrants in the US (Reeves & Bennett, 2004; South Asian Americans Leading Together, 2005).

New York City continues to be one of the top immigrant rich metropolitan areas in the US. In the year 2000, 45% of adult population in New York City was foreign-born (Rosen, Weiler, & Pereira, 2005). A key characteristic of New York City’s immigrant population is their recent arrivals, attributed by high rates of population turnover each year. Forty three percent of the city’s foreign-born population at present had arrived during the 1990’s (The Newest New Yorkers, 2004). South Asian immigrants comprise a
high percentage of the ‘Newest New Yorkers’. India, Pakistan and Bangladesh were together ranked 6th among the top eleven source countries or group of countries of New York City’s immigrants (Rosen et al., 2005). The South Asian immigrant group exemplifies the heterogeneity of immigrant population in the U.S. Immigrants from South Asia differ in many respects including national origin, socio-economic background, religion, culture and linguistic characteristics.

Another feature of the 1990 immigration wave in New York City is higher percentage of women in all except two (Mexico, India) major immigrant groups (Rosen et al., 2005). The relatively young age profile of immigrants in the City (Rosen et al., 2005) means that there is a growing need for accessible and culturally sensitive reproductive health care services for immigrant women.

In 2001 foreign-born women accounted for more than 50% of all live births in New York City (Boschert, 2004). The New York City data indicate that immigrant women are much less likely than native-born women to receive first trimester prenatal care. Although foreign-born women had better birth outcomes than US born women from 1992-2001, the outcomes varied considerably among immigrant groups. Jamaican women, for instance had much poorer birth outcomes compared to Chinese women (Boschert, 2004).

It is also important to note that most research on prenatal care focuses on use of formal prenatal care; the medical care received by women in prenatal care facilities such as hospitals and clinics. The trimester when women start using prenatal care and the number of visits constitute prime measures of use in majority of studies on formal prenatal care. Relatively less is known about quality of care women receive. Women
experience prenatal care in different types of facilities and the standard of care is not the same in all types of facilities. Moreover, immigrant women are likely to face different types of barriers such as language barriers and differences in cultural beliefs and practices, which may constrain full and satisfactory use of formal prenatal care. A small body of research centering on such issues is emerging in the public health literature. More research is needed to understand the experiences of formal prenatal care for immigrant women from diverse backgrounds living in diverse settings.

More importantly, informal pregnancy care – care received outside of formal settings through everyday interactions and networks -- remains a neglected area of study in public health and social science research. What knowledge and resources do women use outside prenatal care facilities to maintain their health and well-being? How does use of such resources vary based on class, cultural beliefs and practices and migrant status? Such questions are particularly important for immigrant women who are likely to be situated disadvantageously with respect to societal, institutional and cultural environments of the host country. I argue that a fuller understanding of immigrant women’s use of health care during pregnancy requires in-depth examination of their use of informal resources and care to maintain health and well-being during pregnancy.

**Significance:**

This research aims to fill this gap by exploring the roles of place, culture and gender in shaping pregnancy care experiences for Bengali immigrant women in New York City. I seek to explore women’s experience of formal as well as informal care to understand their overall experience of health care during pregnancy. Using a mixed methodology I seek to understand how women’s situatedness in dynamic local and
transnational social and geographical networks constrains access to prenatal care and how women draw on such networks in creating new spaces of prenatal care access. Gaining knowledge about the geographical contexts of Bengali immigrant women’s everyday lives in New York City and the strategies these women use at different geographical scales to meet their pregnancy care requirements constitutes the key essence of this research.

The research is significant in several ways:

It focuses on an important and neglected population – South Asian immigrant women – and investigates spatial and social disparities in these women’s use of formal prenatal care services. GIS mapping and statistical analysis of aggregate quantitative data on prenatal care use allow for visualization and examination of geographical disparities in prenatal care use by South Asian immigrant women in New York City. By investigating use of both formal and informal pregnancy care by Bengali immigrant women in New York City, this research provides a comprehensive account of immigrant women’s experiences of care during pregnancy. Examination of within group differences based on class, religion, culture, country of origin and length of residence highlights the diversity of immigrant experiences and the ways in which place, class and culture intersect in shaping women’s health care strategies and experiences.

More generally, this research provides empirical evidence to support emerging theoretical constructs about health and place linkages in a ‘reformed’ and renamed ‘post-medical’ health geography. Detailed understandings of health care seeking experiences and strategies by immigrant women during pregnancy reveal the importance of place-based resources and networks at multiple geographical scales. Situated within an
interpretative framework of ‘therapeutic landscapes’, this research shows how women and their families actively create therapeutic spaces and networks of pregnancy care at multiple scales.

This research also illuminates the benefits of using mixed methodologies. Quantitative analysis using aggregate data helped to portray the contours and patterns of prenatal care use by South Asian immigrant women and to identify areas with low levels of use. In-depth interviews helped to create a fuller understanding of use and experience of pregnancy care by a distinctive group of South Asian immigrant women situated in particular socio-geographical contexts. Qualitative research tools helped to unearth the multiple and complex factors operating at different geographical scales, spanning from the local to the transnational, that shaped Bengali immigrant’s women’s experiences of care during pregnancy.

**Organization:**

The research is presented in several chapters each covering different topics related to the broader research questions: Chapter 2 consists of three interrelated sections: a review of literature relevant to women’s access to prenatal care, a discussion of the theoretical construct guiding the study, and finally presentation of the conceptual framework within which the research is nested. In the first section, major themes of research relating to social and racial disparities in prenatal care are discussed focusing on barriers to use of early and adequate prenatal care. In the second section, the major discourses in understanding health and place linkage within an emerging ‘new’ medical geography are highlighted and the interrelationships among place, health, gender and
culture in shaping immigrant women’s health and health care experiences are discussed. Finally the conceptual framework guiding the research is portrayed.

Chapter 3 discusses data and methods used in the research. The first section focuses on the quantitative data and methods; whereas the second section describes the qualitative methods. Selection and recruitment of research participants, major themes of interview, usefulness and challenges of conducting the qualitative part of the research is discussed.

Chapter 4, 5 and 6 describe the results and findings of the research. Quantitative analysis of prenatal care use by South Asian women in New York City and the variation in use by class, insurance coverage and geographic location are presented in Chapter 4. Descriptive statistics on use of prenatal care by South Asian women are included along with a series of GIS maps showing spatial variation in use of prenatal care and insurance coverage among the major groups of South Asian women in New York City. Finally, logistic regression models are estimated to explore the effects of traditional social, economic and demographic maternal risk factors on prenatal care use by South Asian women in New York City.

Chapters 5 and 6 focus on findings emerging from in-depth interviews with a sample of Bengali immigrant women in New York City. Chapter 5 discusses use and experience of formal prenatal care by Bengali immigrant women in New York City, focusing on barriers women face in accessing and using prenatal care. Chapter 6 is a discussion of use and experience of informal pregnancy care by Bengali immigrant women in New York City, focusing on the link between place, culture and gender in
influencing women’s efforts to maintain health and well-being during pregnancy. Chapter 7 summarizes the main conclusions and describes directions for future research.

----------*----------
Chapter 2
Review of Literature

This chapter lays out the background on which the research is set. It consists of three interrelated sections: a review of literature relevant to women’s access to prenatal care, a discussion of the theoretical construct guiding the research and development of the conceptual framework within which the research is nested. In the first section, major themes of research relating to social and racial disparities in prenatal care are discussed focusing on barriers to use of early and adequate prenatal care. In the second section, the major discourses in understanding health and place linkage within an emerging ‘new’ medical geography are highlighted. An emerging body of research on immigrant women’s use of health care and health maintaining practices is discussed. This section is based on an understanding of place as a lived reality shaped by local and global processes and an understanding of culture as expressions of everyday life. Gaps in the literature are pointed out and the importance of investigating immigrant women’s access to pregnancy care within a theoretical framework that recognizes the importance of place, culture and gender is emphasized. Finally, the conceptual framework for addressing the major research questions based on the aforementioned theoretical construct is described.

Prenatal care is the care women receive during pregnancy to help her maintain health and well-being and carry and deliver a healthy baby. It consists of a range of services designed to monitor and assess the growth and development of the fetus in the womb and ascertain any medical risk that may affect the baby and the mother. Medical advice and counseling specially related to diet and exercise and abstinence from risk
behaviors such as substance abuse forms an important component of prenatal care. Recent approaches to delineating the content of prenatal care emphasize instillation of healthy life style and behaviors that will continue to exist in post-natal period and later stages of women’s life.

The health care women receive during pregnancy may be broadly categorized into formal care and informal care. The former consists of aforementioned care women receive in prenatal care facilities from trained and professional doctors, midwives and nurses. Doctors recommend that pregnant women begin using formal prenatal care in the first trimester of pregnancy. Women whose first contact with formal prenatal care occurs after the first trimester are considered to have received ‘late’ prenatal care and face a higher risk of pregnancy complications and adverse outcomes. In contrast women who start using prenatal care during the first trimester and keep all the recommended visits during the entire pregnancy period are considered to receive adequate prenatal care.

Informal prenatal care consists of care, advice and support women receive outside of prenatal care facilities, at home and elsewhere from family, friends, relatives and neighbors. This informal care is essential to women’s efforts to maintain health and well-being during pregnancy as well as to access and use formal prenatal care. Most literature on prenatal care focuses on formal care received by women in prenatal care facilities. Very little is known about pregnant women’s use of informal resources and care.

In this study Bengali immigrant women’s use of formal as well as informal care during pregnancy has been examined to understand their overall experience of health care during pregnancy. The care and support received outside of biomedical facilities have
been described interchangeably as informal prenatal care or informal pregnancy care in the text.

**Social Disparities in Prenatal Care Use:**

A large number of risk factors for non-utilization of prenatal care have been identified in previous studies. Inadequate use of prenatal care is strongly related to socio-economic disadvantage. Studies show that low-income women and ‘women of color’ are over represented among women who have low rates of prenatal care use. In addition, women who are younger than 20, unmarried, multiparous and those who have less than 12 years of education are more likely than other women to initiate prenatal care at a late date or not to receive prenatal care at all (Institute of Medicine, 1985; Lia-Hoagberg et al., 1990; McDonald & Coburn, 1988; York, 1996).

Sociodemographic determinants of prenatal care use have been well investigated in previous studies. Regardless of ethnic background, women of young age, low education and single marital status have been identified as under utilizers of prenatal care (Alexander et al., 2002). However, race and ethnicity form a major ‘axis of difference’ in prenatal care use (Kogan, Alexander, Mor, & Kieffer, 1998; Yu, Alexander, Schwalberg, & Kogan, 2001). Non-use of prenatal care has been found to be significantly high among blacks, Hispanic and American Indian women (Byrd, Mullen, Selwyn, & Lorimor, 1996; Clarke, Bono, Miller, & Malone, 1995; Frisbie, Echevarria & Hummer, 2001; LaVeist, Keith, & Gutierrez, 1995; Lia-Hoagberg et al., 1990). Studies have reported third trimester or no prenatal care for 10% of black mothers and 12.3% of American Indian mothers, compared to 5% of white mothers (Lia-Hoagberg et al., 1990). Black women have been found to be much less likely to receive early and adequate
prenatal care or to go for as many total prenatal care visits as white women (Kogan, Kotelchuck, & Johnson, 1993; LaVeist et al., 1995).

Much of this racial and ethnic variation remains unexplained by socioeconomic factors. Even after controlling for important sociodemographic factors such as age, marital status, education and parity, significant differences have been found in rates of prenatal care use among different ethnic groups (Alexander et al., 2002; Kogan et al., 1998). Kogan et al. (1993), for instance, examined racial disparities in the use of prenatal care by analyzing data obtained from the Massachusetts Prenatal Care Survey, a follow back study of 2587 postpartum women. It was seen that black women reported significantly less visits than white women in the last trimester and this racial difference remained even after controlling for gestational age, sociodemographic factors, barriers to care, insurance status and access to care.

Financial difficulties, language barriers and cultural beliefs have been indicated as major constraints faced by ethnic minority women in accessing prenatal care in many studies (Yu et al., 2006). Lack of access to facilities such as transportation and childcare services coupled with unhelpful partner and inconvenient office hours also limit minority women’s use of prenatal care (Byrd et al., 1996; Kogan et al., 1998; Yu et al., 2006; Zambrana, Scrimshaw, Collins, & Dunkel-Schetter, 1991). Several studies have pointed out the importance of cultural barriers and content and quality of prenatal care in explaining racial disparities in prenatal care use (Misra & Guyer, 1998). However very little is known about how culture and women’s perception of the quality of care influence differential use of prenatal care among minority groups.
Earlier investigations on racial disparities in prenatal care use have focused mostly on black-white differences. More recently researchers are trying to understand low use of prenatal care among other minority groups. In a recent study aimed at explaining differentials in prenatal care use in a nationally representative sample of non-Hispanic White, African American and Mexican American women, the risk of Mexican American women receiving inadequate prenatal care (odds ratio=1.93) was found to be greater than that of African American women (odds ratio=1.46) (Frisbie et al., 2001). Racial and ethnic variation was strongly associated with women’s perception of barriers, their marital status and participation in prenatal care programs. Perceptions of obstacles to use of prenatal care doubled the risk of receiving inadequate prenatal care among the sample women. However, these factors did not fully explain observed racial differences (Frisbie et al., 2001).

More recently researchers are paying increasing attention to patterns and predictors of prenatal care use among Asian American women. Yu et al. (2001) investigated the patterns of prenatal care use among US resident mothers of Chinese, Japanese, Korean and Vietnamese ancestry. The study revealed significant variability in prenatal care use among these different groups. Korean Americans and Vietnamese Americans exhibited the lowest levels of prenatal care use. Young or single motherhood, high parity for age, and low educational attainment were singled out as major factors for low use (Yu et al., 2001). In an earlier study examining the differences in prenatal health among nine Asian ethnic subgroups, Asians were not only more likely than whites to receive prenatal care after the first trimester but also exhibited significant within group differences in prenatal care use (Morrow et al., 1994). In a study by Kieffer et al. (1992),
among Caucasian, Hawaiian, Filipino, Japanese, Samoan, Black and other Asian mothers in Hawaii, Samoan women and women with high parity for age had higher levels of inadequate use of prenatal care (Kieffer et al., 1992).

Differences in prenatal care use have also been noted between US born and foreign-born women belonging to certain ethnic groups. In a study investigating the birth outcomes of Japanese women, US born women were found to be more likely than foreign-born women to use early and adequate prenatal care (Alexander, Mor, Kogan, Leland, & Keiffer, 1996). During the period 1995-1997, of all live births in California, US born blacks and foreign-born Mexican women received much lower levels of prenatal care in terms of number of visits and early initiation of care compared to whites. On the other hand foreign-born Asian Indian women received relatively early and adequate prenatal care (Gould et al., 2003).

**Barriers to Prenatal Care:**

These ethnic, racial and socio-economic disparities in prenatal care use reflect women’s experiences and barriers in accessing prenatal care. In addition to socio-demographic barriers mentioned above, women face structural as well as psychological barriers in using prenatal care. Major structural barriers to use of prenatal care include: lack of financial resources, insufficient capacity of prenatal care facilities, under funded public health departments, and lack of transportation (Brown, 1988; York, 1996). Financial constraints are a major impediment to gaining access to prenatal care in the US. Approximately 26% of childbearing women in the US do not have any insurance at the beginning of pregnancy and 15% are without insurance at the time of delivery (York, 1996). Recent data show that one in five women of childbearing age in the US do not
have any insurance. Nineteen and half percent of women aged 15-44 did not have insurance in 1999 (March of Dimes, 2000). Policies regarding insurance coverage vary from state to state, and thus the proportion of pregnant women lacking insurance coverage varies by state. For instance, the percentage varied from 30% in New Mexico to 10% in Minnesota (March of Dimes, 2000).

Medicaid, the federal-state health insurance program for low-income individuals and families, covers prenatal health care for many low-income pregnant women. Medicaid policies differ greatly among states, and in many states, immigrant women are not covered, even if they have low incomes. Poor women who do not have Medicaid coverage are less likely than other women to receive adequate prenatal care. Even with Medicaid coverage, several studies indicate that women may not use adequate prenatal care (Aved, Irwin, Cummings, & Findeisen, 1993; McDonald & Coburn, 1988; St. Clair, Smeriglio, Alexander, & Celentano, 1989). The failure to find a physician willing to accept low-income women and women covered by Medicaid has been identified as an important barrier to obtaining prenatal care (Aved et al., 1993). In the above study, physicians mentioned administrative complexities and low reimbursement levels of Medicaid-plus as barriers to caring for low-income women.

Lack of convenient and affordable transportation has been found to be a major barrier in accessing prenatal care in many studies (Byrd et al., 1996; Lia-Hoagberg et al., 1990). One study found that lack of transportation was cited as a top barrier by women who never tried to obtain care (Aved et al., 1993). A recent study on the role of para-transit in providing transportation to a prenatal care facility for low income women in Detroit Michigan provides convincing evidence that monetary cost of transportation,
unreliable scheduling of buses, and a shortage of direct bus routes to healthcare facilities prevented or discouraged women from obtaining prenatal care (McCray, 2000). Spatial analysis of bus stops and routes in relation to where the study participants lived showed that they had to take at least two buses to get to the prenatal care facility of their choice which restricted women’s use of prenatal care (McCray, 2000).

Many studies emphasize the importance of the capacity of prenatal care facilities and quality and content of care in influencing women’s decisions to access and use regular prenatal care (Brown, 1988; LaVeist et al., 1995; McDonald et al., 1988). Many low-income women face long waiting times in overcrowded prenatal clinics thus creating a deterrent to regular prenatal care use. A study of low-income Hispanic women indicates extended waiting times, uncomfortable physical check-ups, and lack of transportation as perceived barriers to early entry to prenatal care (Byrd et al., 1996). One of the recommendations of the authors based on the above study is to make the clinic waiting areas big enough for family members and to allow patients to bring their children with them (Byrd et al., 1996). In a recent study of attitudinal and psychological determinants of prenatal care among Black women of low socio-economic status, women who started prenatal care late spoke about insensitive behavior of clinic staff as a perceived barrier (Daniels, Fuji Noe, & Mayberry, 2006).

In addition to sociodemographic and structural barriers to care, attitudinal and psychological barriers have received a lot of attention in studies of prenatal care use. Attitudes towards pregnancy, personal beliefs and lifestyle and psychological dispositions have important effects on prenatal care utilization. Women who experience psychological stress as a result of poverty, racial discrimination and unemployment are less likely to
receive adequate prenatal care. A qualitative study on the psychological reasons for non-use of prenatal care indicated four categories of reasons: the women’s lifestyles were different from the mainstream society; the women believed prenatal care was important, but worrisome events in their life came in the way of using prenatal care; the women endeavored to receive care but were not encouraged, accepted or given adequate information by service delivery personnel; and the women did not want to have a baby (Bedics, 1994).

While sociodemographic, structural and psychological barriers to prenatal care use have been well investigated, very few studies have examined the effects of place on women’s access to prenatal care. Place refers to the areas and spaces in which women conduct their everyday activities. In a few studies, area of residence has been identified as a risk factor for inadequate use of prenatal care. Rural areas and non-metropolitan communities characterized by poverty, inadequate transportation and lack of prenatal care facilities have been identified as areas with relatively low prenatal care use. McDonald et al. (1988) in their study of prenatal care use among a sample of mothers in Maine concluded that where one lived was a significant predictor of the adequacy of prenatal care use irrespective of factors such as age, education, income, travel time and receipt of Medicaid. Rural residents were much less likely than urban and suburban residents to receive adequate prenatal care.

Clarke et al. (1995) examined national level data on prenatal care use among African American, White and Hispanic women who gave birth in 1988. Their study concludes that non-metropolitan residents were less likely to receive early and regular prenatal care and Hispanic residents exhibited the lowest rate of adequate prenatal care.
use. Factors such lack of prenatal care providers, higher rates of poverty and lack of insurance were indicated as risk factors resulting in differences in prenatal care use among metropolitan and non-metropolitan residents.

Kieffer et al. (1992) attempted to explain geographic variation in the use of prenatal care services in Hawaii. The authors identified census tracts in Hawaii with inadequate use of prenatal care. Actual and predicted percentages of prenatal care use were used to create maps and identify areas with high and low use of prenatal care. Socio-economic status, environmental conditions and pregnancy-related risk characteristics were included as measures of census tract characteristics. Environmental condition was however narrowly defined in the study to include characteristics of the total community environment assessed by such social indicators as levels of education. It was seen that in comparison to poverty, overcrowded housing and unemployment, levels of education and ethnic characteristics of the census tracts explained major variation in prenatal care use. Higher percentage of Japanese mothers and black mothers and adults with more than high school education were positively correlated with low percentage of inadequate use of prenatal care. On the other hand high percentage of Samoan mothers and women with high parity were positively correlated with high percentage of inadequate use of prenatal care. In the case of black women, their access to Army prenatal care services as wives of military personnel helped explain their higher levels of prenatal care use. On the other hand, Samoan women’s participation in community based, non-medical pregnancy care explained to some extent their inadequate use of prenatal care. These findings were significant in pointing out important factors beyond traditional
risk variables in explaining differences in levels of prenatal care use among ethnically diverse areas.

**The Role of Context: Looking Beyond Individual Risk Factors:**

The above-mentioned risk factors create important barriers in women’s use of prenatal care. More importantly they act together in affecting women’s use of prenatal care. Low income and minority women face multiple barriers to using prenatal care, which are linked to the spatial and social contexts of their everyday lives.

Lia-Hoagberg et al. (1990) identified and compared the major barriers and motivators to prenatal care among low income white women and women of color. Interviews were conducted in five hospitals in a mid-west US city with representative sample of women who lived in low-income census tracts, focusing on women’s perceptions of problems in obtaining prenatal care and getting to appointments. Quantitative analysis and data interpretation indicated a high degree of complexity in prenatal care participation. Psychological, structural and sociodemographic factors emerged as major barriers to accessing prenatal care while mother’s attitudes, beliefs and support systems emerged as major motivators.

Significant findings in the above study point out multiple interrelated problems of stress, depression, childcare, transportation and other hassles of daily living resulting in negotiated and place-driven decisions regarding prenatal care utilization (Lia-Hoagberg et al., 1990). Barriers to care were found to be inseparably tied to the “experience of being poor” and living in poor neighborhoods (Lia-Hoagberg et al., 1990, p. 493). In the words of the authors, “in the process of putting food in the table, caring for other children, coping with everyday stresses of being poor, and dealing with the worries
engendered by pregnancy, significant numbers of women found it difficult to give high
priority to prenatal care.” (Lia-Hoagberg et al., 1990, p. 493).

Other researchers have emphasized the importance of adopting a ‘socio-
ecological’ approach to understand the barriers low-income women face in using
adequate prenatal care. By reviewing and evaluating the literature on barriers to prenatal
care, Sword (1999) points to the complexity of the problem and recommends health care
practitioners and researchers to acknowledge multiple factors influencing prenatal care
use. The concept of barrier to use of prenatal care in previous literature is criticized and a
call is made for a broader orientation in understanding limited use of prenatal care by low
income and minority women. Studies focusing on barriers often emphasize individual
factors stripped off from the socio-structural contexts of women’s lives. Thus, failing to
consider multiple influences on prenatal care use, only a partial view of women’s
difficulties in gaining access to prenatal care is gained. In conclusion the author stresses
the importance of making community level programs and services more tuned to the
needs of disadvantaged women by adopting a socio-ecological approach in understanding
what will make it possible for them to make adequate use of such services.

Similarly, by putting place, context and differences in the center of explanation
adherents of social model of women’s health argue that without accounting for the
sociospatial context of women’s lives a full understanding of their health care experience
cannot be gained. As emphasized by McLafferty & Tempalski (1995, p.311), “poverty,
substance abuse and access to prenatal care do not occur in a vacuum but are inextricably
linked to the societies and communities in which women live and work.” In a recent
Employment status, number of workplaces, and gendered workspaces were found to influence how women deal with everyday stresses during pregnancy. Women employed in low-paid, part-time multiple jobs in gender-neutral workspaces were more likely to experience negative pregnancy health and adverse birth-outcomes (Lindsay, 2004). A large section of immigrant women are likely to be disadvantaged in their living and working environments because of their low socio-economic status and are thus likely to experience difficulties in caring for themselves during pregnancy.

**What Facilitates Women’s Use of Prenatal Care?**

It is important to identify barriers women face in using prenatal care. However, in order to implement services and programs to assist women in making effective use of prenatal care, it is also necessary to understand what factors facilitate and motivate women to make adequate use of available prenatal care services. Social support has been identified as an important motivator; enabling low-income women to get to prenatal care appointments (Lia-Hoagberg et al., 1990). Research on minority women reinforces the importance of support from social networks in facilitating women’s use of prenatal care (Giblin, 1990; Sable, Stockbauer, Schramm, & Land, 1990).

A term first coined by J.A. Barnes in 1954, social network refers to a structure of connections between individuals and organizations. The individuals and organizations are referred to as nodes, and the nodes are connected through relations ranging from simple acquaintance to close familial bonds. Friedson was one of the earliest researchers who attempted to systematically analyze the relationship between social network structure and health care utilization (Freidson, 1961, 1962, cited in St. Clair et al., 1989, p. 824). Social networks play an important role in shaping peoples’ experiences of health and health
care. Help and support received from networks of friends, relatives and acquaintances is a resource that influences how people experience health and care in everyday life. This is especially true for immigrants who rely to a great extent on social networks for knowledge, information and access to health care. A good majority of immigrants come from countries with very different social and institutional life, speak different languages and have different cultural beliefs and practices. Everyday life in the US is difficult for these migrants because of their placement in a socially and culturally remote environment. Access to and use of health care seems complex in a private health care setting with a seemingly incomprehensible insurance system. Social networks play a key role in providing support and help to migrants in overcoming these constraints and adapting to a new health care system and culture. Extended family members, friends, neighbors belonging to a similar social, economic and cultural background provide a familiar environment and setting wherein immigrants feel relatively more at ease seeking for and asking for help, advice and knowledge related to health and health care.

Support provided by social networks can be of various types: emotional support in the form of love and affection from family members, close friends and relatives, informational support in the form of advice and guidance, tangible support such as such as help with childcare (Dunkel-Schetter, Sagrestano, Feldman, & Killingsworth, 1996; Harley & Eskenazi, 2006; St. Clair et al., 1989). Each of these can help a pregnant woman in her health seeking behavior and practices. There are also many ways of measuring the amounts of help received from social networks. Researchers have distinguished between structural and functional measures of social support. The former relates to the size and density of social networks while the later refers to the actual help
Researchers have tried to assess the importance of social support in women’s use of formal prenatal care. St Clair et al.’s (1989) study examined whether structural characteristics of social networks in a sample of 185 low-income, single, inner city women influenced their prenatal care use. The authors found a strong influence of social networks on women’s use of prenatal care. Results indicated that women were more likely to underutilize prenatal care if they had strong emotional ties with immediate relatives who lived close by, whereas women with more diverse networks composed mainly of friends with less intense emotional ties were likely to use adequate prenatal care.

In another study involving a much larger sample of primarily low-income, black, non-Hispanic women, Sable et al. (1990) found that social support had an important mediating influence on use of prenatal care. Face to face survey interviews with 1,454 women in postpartum units in three hospitals in Missouri during 1987-88 revealed that women in the adequate care group had much higher rates of social support compared to women in the inadequate care group. Similar findings were reported in a study conducted with 300 postpartum, low income, black women in Detroit, Michigan. Presence of social support, abstinence from smoking and drinking and parity accounted for twenty-two percent of variation in the use of prenatal care (Giblin, 1990).

The role of social support in reducing barriers to use of early and regular prenatal care is particularly important for immigrant women belonging to different ethnic backgrounds (Dunkel-Schetter et al., 1996). Lack of health insurance to cover the cost of
care, lack of access to transportation, difficulties in getting leave from work – these barriers can be mediated and reduced through reliance on social networks, especially for low income, ethnic and immigrant women (Dunkel-Schetter et al., 1996). Hence, it is hypothesized that social support can help lessen women’s difficulties in using early and regular prenatal care by ameliorating difficulties women face in accessing prenatal care. However, very few empirical studies have been done on immigrant groups belonging to diverse cultural and social backgrounds to examine in-depth the role of social support in prenatal care use.

The role of the spouse has been shown to be particularly important in influencing women’s use of prenatal care (Giblin, 1990; Sable et al., 1990; Zambrana, Dunkel-Schetter, & Scrimshaw, 1991). Being single and not receiving support from the baby’s father has been found to be a significant barrier in initiating and using prenatal care among low-income African-American women and women of Mexican descent. In a study of 107 black, Mexican-American and recent Mexican immigrant women, Zambrana et al. (1991) found that a positive relationship with the baby’s father was associated with early initiation of prenatal care. This was true in case of all the three groups of women. In Giblin’s (1990) study, both tangible and emotional support received from the baby’s father was significant in predicting initiation of prenatal care. In the study by Sable et al. (1990), support from baby’s father was found to be a stronger predictor of prenatal care use compared to support from others.

Mixed findings are reported about the role of family and friends in predicting prenatal care use in these studies; however, it is difficult to generalize these findings to other ethnic immigrant groups that differ in cultural and socio-structural and economic
backgrounds. One challenge in analyzing the relationship between social support and use of prenatal care is the difficulty of measuring social support. Since receiving and perceiving help and advice from social networks as positive support is a very subjective phenomenon it is difficult to estimate the influence of such support in prenatal care use. Hence quantitative analysis of survey data, even if for a large sample size, may not be useful in assessing the role of social support in helping women access formal prenatal care. More importantly, it is difficult to generalize about other immigrant and ethnic groups from such studies, because use of social networks is likely to be culturally- and ethnically-specific. Immigrants are likely to vary widely in their reliance on social networks in accessing and using formal prenatal care.

**Role of Informal Care in Birth Outcomes for Immigrant Women:**

The above section is a brief review of important strands of research concerning women’s use of formal prenatal care. Little is known about women’s use of informal resources that help them to stay healthy, physically as well as emotionally during pregnancy and how use of such resources varies among women belonging to different socio-economic, ethnic and cultural groups. Women have access to different sources of care and support and how they benefit from these different sources shapes their experience of pregnancy and influences birth outcomes. Recent studies of the ‘Mexican immigrant paradox’ – the existence of favorable birth outcomes among Mexican immigrants despite their low utilization of formal prenatal care -- has brought to the forefront the importance of informal resources and health-related behaviors which are tied to socio-cultural beliefs, values and practices.
The Mexican immigrant paradox provides an opportunity for investigating the role of culture, behavior and social support in birth outcomes. Detailed social and ethnographic research has been conducted on these topics for Mexican immigrant women in the US. Studies indicate that “protective cultural behaviors” and social support networks benefit immigrant Mexican women during pregnancy (Sherraden & Barrera, 1996b; Zambrana, Scrimshaw & Dunkel-Schetter, 1997, p.1022). These women have been found to eat healthier foods and are less addicted to alcohol and substance use (Harley & Eskenazi, 2006; Zambrana et al., 1997). Their experience of pregnancy and health care practices are closely linked to their embeddedness in family and extended family networks, which provide an environment that helps to nurture, and nourish pregnant women and their babies. Religiosity is another important factor that has been shown to make their overall experience of pregnancy healthy and positive (Magana & Clark, 1995).

Many studies have enunciated the role of support received from social networks in helping pregnant women maintain their health and well-being. Social support acts as a ‘buffer’ against stresses of everyday life, which can influence health related behaviors during pregnancy (Dunkel-Schetter et al., 1996; Zambrana et al., 1997). Low social support has been shown to be associated with prenatal stress resulting in preterm delivery in Mexican American and long-term Mexican immigrant women (Zambrana et al., 1997). Social support has been shown to be a key protective factor explaining better birth outcomes in a sample of Mexican immigrant women (Sherraden & Barrera, 1996a). A recent study on social support and health related behavior during pregnancy among women of Mexican descent shows that high social support is related to better diet quality,
intake of prenatal vitamins and reduced smoking among Mexican immigrant women (Harley & Eskenazi, 2006).

The roles of the women’s mother and the baby’s father have been found to be especially important in health seeking behavior during pregnancy. In Zambrana et al. ‘s (1997) study, among a large sample of Mexican-American and Mexican immigrant women, women with higher support from the baby’s father had less negative attitudes toward pregnancy, started formal prenatal care early and used fewer substances. On the other hand women with less support from the baby’s father reported negative attitudes towards pregnancy, used more substances and were medically at higher risk. In an in-depth qualitative study focusing on maternal support and cultural influences among 41 Mexican immigrant mothers living in Chicago, Sherraden et al. (1996b), found that the women’s mothers played a very important role in reinforcing healthy behaviors during pregnancy. In the absence of the mother, women sought guidance and help from other elderly or experienced female family members or relatives such as the mother-in-law, sister, sister-in-law or very close friends.

It is important to note, however, that all immigrants don’t have equal access to social support. The age at which women migrate and their lengths of stay in the host country have also been identified as important in creating differences in the extent of social networks and the amount of help received. Studies have shown low levels of social support among recent immigrants (Harley & Eskenazi, 2006). Social support during pregnancy has been found to be lowest among recent Mexican immigrants and highest among others including those who migrated at a younger age and US-born women of Mexican descent (Harley & Eskenazi, 2006). At the same time, women who migrate to
the US at a young age have a higher risk of negative health behaviors such as smoking and drinking, and thus have a higher risk of adverse health outcomes. For other immigrants, however, a longer time of residence in the US is typically associated with more dense and extensive social networks and healthier lifestyles during pregnancy. Harley & Eskenazi (2006) found high social support to be associated with improved diet quality during pregnancy among low-income Mexican immigrant women irrespective of age at which women migrated to the US.

In this body of work on the role of informal support during pregnancy in improving birth outcomes amongst immigrant women, however, the roles of place, culture and gender in immigrant women’s use and experience of pregnancy care has not been looked at. Place, as a site of everyday life but constituted by a mixture of local as well as global processes, is particularly ignored in research concerning women’s use of pregnancy care in health and social science literature. Researchers interested in Mexican women’s health practices and behaviors during pregnancy have underscored the importance of culture in investigating women’s pregnancy-related health care decisions and behavior. However, little is known about the interrelationship of culture, place and gender in creating socio-spatial constraints in immigrant women’s prenatal care use. Several axes of difference marginalize immigrant women coming from different places with different social, cultural and formal and informal care environments and are likely to constrain their access to prenatal care. This research aims to fill this gap by understanding use of pregnancy care by an important group of South Asian immigrant women in New York City, emphasizing their embeddedness in a set of socio-spatial relations carved out and delineated by interaction between place, culture and gender.
‘Place’ and ‘Health’: Towards a New Understanding:

The theoretical framework that informs this study is based on recent emphasis in medical geography to unearth the links between health and place. During the last decade there has been a conscious move to shift the disciplinary focus of medical geography from a biomedical and spatial perspective towards careful untying of the links between health and place (Kearns, 1993, 1995; McLafferty & Tempalski, 1995). To reflect this shift medical geography in recent years is being described as ‘new’ medical geography. Reflecting a conscious effort to focus on health rather than illness medical geography has been renamed to health geography.

This ‘new’ medical geography involves explicit incorporation of social theory in the sub-discipline and engagement with associated developments in the conceptualization of ‘space’ and ‘place’ in human geography (Jones & Moon, 1993, Kearns, 1993, Kearns & Joseph, 1993; Litva & Eyles, 1995; Moon, 1997). It calls into question an uncritical use of space and place in examining issues pertaining to health and health care. This change has been brought about by attempts to understand the role of place, not as a passive stage where people act out their lives but as a dynamic force with power to shape people’s health and health care experiences (Dyck, 1995b; Kearns, 1991, 1993). The proponents of a new medical geography have pointed out the importance of place in people’s everyday lives and its relation to use and experience of health and health care. Insightful and stimulating arguments have been forwarded in favor of a health and health care research agenda where ‘place’ is taken seriously (Dyck, 1999; Kearns, 1994). The appeal is to undertake closer examination of the processes that connect health and place (Dyck, 1995a, 1995b; Kearns 1993).
Space and place are two different concepts used in analyzing the world from a geographical perspective (Kearns & Joseph, 1993). Social theorists in the field of geography and other sister disciplines have variously tried to conceptualize space and place. The socio-spatial view of space sees space both as the medium and outcome of social relations (Dear & Wolch, 1989; Soja, 1985; cited in Kearns & Joseph, 1993, p. 712). The understanding of social construction of space and the multifaceted nature of its penetration in people’s lives has opened up new avenues of enquiring into the relationship between health, ill health and provision of health care (Dyck, 1995a).

While the concept of space is more objective and is somewhat detached from people’s day-to-day lives, place is “…anchored in the world of human experience” (Kearns & Joseph, 1993, p. 712). In the words of Gesler (1991, p. 165) “… place is studied with an eye to its meanings for people”. A place is constituted by the lived experiences of people. The meanings, the connections, that people form of and have with places constitutes their place-based experiences. Holding on to this view, place refers to “spaces which are occupied, used and given meaning to in the course of interaction in social life” and penetrates people’s experiences of health and illness (Dyck, 1995a, p. 308).

Kearns (1993) emphasizes the necessity of going beyond investigating how place is perceived and bringing in the idea of how place is experienced in relation to health care services. In his study of Hokianga medical area, Kearns shows how the presence of a community health clinic can enhance the experience of place for the people it serves (Kearns 1991). The clinic in a special medical area in New Zealand, not only provides health care services but also helps to improve the health of the community by serving as a
gathering place for local residents where they can share and exchange information. Thus provision of health care catering to the community contributes to health of people and places in much broader ways; more than just diagnosis and treatment of medical illnesses (Kearns, 1991).

The reintroduction of place in the understanding of health and health care experiences of people has been advanced by critiques of the spatial analytic viewpoint in medical geography that likened place with location (Kearns, 1993; Kearns & Joseph, 1993). Spatial analysts paid little attention to the understanding of space and place from the perspective of people who live, experience and give meanings to places. Contemporary medical geographers have also invoked aspects of social theory such as the structure and agency debate. Drawing on the structuration theory of Giddens (1984) the ‘new’ medical geographers have argued that although socioeconomic and political structures are instrumental in generating options and restraining opportunities, the way people experience and construct meaning about these opportunities influences their health and health care experiences and practices. The emphasis is on how people’s lives are experienced and how people actively construct their everyday lives in specific place environments.

Dyck’s works extend and enrich this conceptualization of place. In her study of the everyday lives of women with multiple sclerosis in the Greater Vancouver area of British Columbia, Canada, she shows that their experience of place with physically impaired body is closely tied to the interrelationship of space and gender (Dyck 1995a). While physical impairment delineated their everyday lives and spaces, an essential strategy adopted by the women to cope with their illness involved rearranging their home,
refiguring the ways they moved around in the neighborhood and public spaces, and reorganizing their personal relationships. Such restructuring of everyday spaces and relations contributed to and constituted their experience of place (Dyck, 1995a).

An essential element of theorized conceptions of place is differences produced by structural processes and power relations. This precept allows for appreciating the diversity amongst places lived by differentially positioned people by highlighting the links and the interconnections between the local and the non-local. According to Dyck, “Place is understood as dynamic, constituted and reconstituted through the operation of uneven distributions of power over space, with individuals interacting and experiencing place in different ways as they engage in various sets of social relations” (Dyck, 1995b, p. 248). Such an understanding of place allows for linking people’s experiences with wider sets of social relations (Dyck, 1995b). With such a focus it becomes possible to understand health care experiences and practices in local environments and the influence of broader social processes that result in unequal access to knowledge, resources, and services for people placed in diverse settings.

‘Therapeutic Landscapes’: Places of Healing in Everyday Life:

The emergence of a ‘new’ medical geography is going hand in hand with the development of the concept of ‘therapeutic landscapes’. This is a key theoretical concept that is helping to establish the links between health and place. The idea of therapeutic landscapes describes how health, healing and well-being intersect in and characterize places. Given its importance in conceptualizing people’s place-based health and health care experiences the development of the concept and research directions and contributions are discussed in detail below.
The term ‘therapeutic landscapes’ was first introduced by Wil Gesler in 1991 in his book ‘The Cultural Geography of Health and Health Care’. Since then health geographers have contributed to widening and strengthening both the theoretical and empirical foundations of the concept. Gesler (1993, p. 171) defined therapeutic landscape as places with “an enduring reputation for achieving physical, mental and spiritual healing.” A therapeutic landscape, according to Gesler (1996, p. 96), “arises when physical and built environments, social conditions and human perceptions combine to produce an atmosphere which is conducive to healing.”

The power of this concept and its promise in enriching the notion of ‘place’ and its relation to health lies in its rootedness in contemporary developments in social theory and cultural geography. Gesler (1991) adopted a humanistic perspective and embraced the idea of ‘sense of place’ developed by cultural geographers in building up the concept of therapeutic landscape. He argues that environmental, individual and societal factors come together in creating healing landscapes (Gesler, 1993). As such, both the humanistic perspective emphasizing the subjective experience of people and the structuralist perspective emphasizing the importance of social structures and forces are considered important in understanding the therapeutic qualities of places.

Gesler’s empirical research on therapeutic landscapes has centered around specific places renowned for healing, such as Bath (Gesler, 1998), Lourdes (Gesler, 1996) and Epidauros, Greece (Gesler, 1993). However, Gesler’s theorization of healing landscapes also touches upon subtly the potential of everyday landscapes of people’s lives to become therapeutic. As the published literature on ‘therapeutic landscapes’ show, during the last one and a half decades, medical geographers have contributed to a rich
body of work that attest to the immense scope of the concept in ascertaining the links between health and place. In the book ‘Therapeutic Landscapes: The Dynamic Between Place and Wellness’ (Williams, 1999), Williams compiled three important strands of research on therapeutic landscapes during the 90’s: “therapeutic landscape as healing places”, “therapeutic environments and the marginalized” and “symbolic landscapes in health care systems” (Williams, 1999, p. 5). In addition to these, other important works during the decade include studies on non-western healing landscapes (Dobbs, 1997), indigenous health care systems (Madge, 1998) and ‘landscapes of fear’ and mental health in Chile (Frazier & Scarpaci, 1998). In more recent works, researchers are examining the concept of therapeutic landscape more critically and important questions are being raised about engaging with only positive connotations of the term.

In the aforementioned book and through her research focusing on health-promoting effects of place identity of home care nurses, Williams (1999, 2002) extended the definition of therapeutic landscapes to include places that enhance ‘health and well-being’. A significant step forward, this phase saw a rich collection of research emphasizing the qualities of places that help to maintain physical, mental and spiritual well-being. Similar to Gesler’s research on places noted for healing, researchers have attempted to understand the therapeutic qualities of physical environments and natural surroundings including national parks and summer camps (Bell, 1999; Kearns & Collins, 2000; Palka, 1999; Thurber & Malinowski, 1999). The mentally ill and homeless have received attention in works by Geores & Gesler (1999), Parr (1999) and Bridgman (1999). This subset of work takes a critical approach in trying to understand how ‘marginalized’ people in society try to create therapeutic spaces within the everyday
spaces of their lives and brings forth the struggles, politics and negotiations at the societal and policy level in providing a humane environment for these people. The broader therapeutic landscapes in communities trying to reclaim ‘healthy’ lives in post war and post revolutionary societies are examined by Frazier & Scarpaci (1998) and Scarpaci (1999).

The symbolic dimensions of therapeutic landscapes, explicated by Gesler (1991), have been used by health geographers as interpretative framework in understanding the politics of marketing in naming health-promoting places and health care centers. Symbols can be used in positive ways to facilitate healing and also in more negative ways to control people and place in therapeutic settings (Gesler, 1991; Kearns, 1999). Geores (1999) and Kearns (1999) show how metaphors and symbols are used to make places profitable. Geores’ (1999) study, based on a historical site, shows how the metaphor equating hot springs and health, helped to sell a sacred Native-American water site as a ‘healing landscape’ to the white Americans. Kearns (1999) study of a modern children’s hospital in Auckland named ‘Starship’ shows how a healing place epitomizes the commodification of health care.

As can be seen in the above discussion, most studies on therapeutic landscapes so far had been on healing landscape on western settings. The few exceptions are Dobbs’ (1997), Clare Madge’s (1998) and Kathleen Wilson’s (2003) studies. Madge’s (1998) research highlighted the importance of place and culture in understanding health care beliefs and practices. In discussing the links between indigenous and biomedicine in the Jola, The Gambia, the author emphasized the necessity to understand ‘therapeutic landscapes’ in the light of global power relations in the arena of medicine and health care.
Kathleen Wilson’s (2003) research on therapeutic landscapes of First Nations Peoples specifically stated omissions in earlier research. She emphasized the importance of understanding the everyday lives and activities of people and appreciating the role of cultural beliefs in creating ‘therapeutic effect’ in daily life. ‘Anishinbek’ people’s relation with land was examined to understand how people created meaningful health-maintaining beliefs. Williams’ (1998) also stressed the importance of understanding non-western healing landscapes in examining holistic medicinal practices in relation to humanistic concepts.

More recent literature on therapeutic landscape reveals an increasing uneasiness in adopting an unproblematic perspective in adopting the concept of therapeutic landscapes as a theoretical framework. Researchers are pointing to different ways in which therapeutic landscapes can be interpreted and experienced. In particular attention is being paid to how people construct therapeutic landscapes and also negotiate such spaces in everyday life. Wakefield & Mcmullan’s (2005) research on the ‘health-affirming’ and ‘health-denying’ images of Hamilton, Ontario is a significant step in this direction. Their research shows that perception of therapeutic landscape is determined by the physical and social context of people’s lives and is ‘negotiated’ at multiple scales. The city’s image as epitomizing the negative effects of industrialization, such as, unhygienic, unhealthful, is being de-emphasized by local residents, who try to find therapeutic qualities in the run-down city, and by policy makers who try to portray positive images of the city. Milligan & Bingley (2006) explore the positive as well the negative effects of woodland on the mental well being of adults in the UK. Similarly, Martin, Nancarrow, Parker, Phelps, & Regen’s (2005) and Wilton & DeVerteuil’s (2006) research on rehabilitation centers and
alcohol recovery programs shows how ‘therapeutic places’ and ‘therapeutic programs’ are places of conflict and contestation.

A common thread that links this emerging body of work is the complex and contradictory character of therapeutic landscapes. A landscape is not inherently therapeutic; if at all, and the degree to which an individual can avail of therapeutic gains from a given landscape depends on how s/he is positioned, relates to and is empowered to gain from multiple aspects of such an environment. A place can have different levels of therapeutic effect on different people; a place perceived as non-therapeutic by some people could be therapeutic for others.

Understanding how people perceive, experience and relate to therapeutic qualities in everyday life in everyday places is beginning to be examined. Extending beyond healing places of reputation, beyond healing properties of nature-endowed places frequented by people for relaxation and rejuvenation, researchers are trying to understand therapeutic as well as non-therapeutic properties of lived, everyday places (Cattell, Dines, Gesler & Curtis, 2008; English, Wilson, & Keller-Olaman, 2008; Williams, 2002; Wilson, 2001, 2003). Everyday places are settings and environments where people carry out routine day-to-day activities such as the home, workplaces, markets and sites of recreation. Maintenance of health and well-being is closely tied to such everyday places; not just to the characteristics of such places, but also the networks and interactions that constitute such places (Cattell et al., 2008). The role of public spaces in shaping people’s sense of well-being is well investigated in Cattell et al.’s (2008) study in a multi-ethnic setting in East London. This study reveals the importance of local parks, streets and ethnic market areas in enabling intra- as well as inter-ethnic social interaction, and in
sustaining a sense of community and wellness. The authors point to the need to resist the demolition of such sites under the pressure of urban renewal schemes. Through in-depth interviews with women surviving from breast cancer, English et al. (2008) demonstrate that the women’s strategies to heal their minds and bodies are implemented at multiple scales including the body, the home, the community, and everyday as well as extraordinary natural sites and settings. Friends, family and community-based activities were crucial in their journey towards recovery.

While the interconnection between everyday places and well-being is well explained in these studies, the gendered and culturally specific dimensions of everyday healing places has not received enough attention in the therapeutic landscape literature (see Wilson, 2001). Research needs to be undertaken to understand how immigrant women in their efforts to maintain health and well-being, make use of place-based resources and gain benefit from the therapeutic qualities everyday places. For immigrant women, the diverse ways in which such places are created and experienced at geographical scales crossing national boundaries is critically important. Emerging studies in this direction emphasize the importance of home as sites of prayer, food preparation and blending of traditional and western bio-medicinal knowledge, engaged in by immigrant women with diverse backgrounds. I return to this in the next section on place, culture gender and immigrant women’s use and experience of health and health care.

**Place, Culture, Gender and Immigrant Women’s Health:**

An emerging body of work that has gone hand in hand with the ‘new’ medical geography centers around women’s health and health care issues (Dyck, Lewis & McLafferty, 2001; Mathews, 1995). The publication of the book ‘Geographies of
Women’s Health’ (Dyck et al., 2001) marked an important step in this direction. A key objective of this book was to critically address issues related to conceptualizing and theorizing how diverse women experience health and health care differently in different places. Minority women’s health and health care issues were particularly emphasized in laying out a framework for understanding geographies of women’s health.

The inclusion of gender as an explanatory variable in understanding how women’s lives are placed and structured differently from men through social codification of differential roles for men and women based on biological distinctions was initiated with concerted and painstaking effort by feminist scholars (McDowell, 1999). Shifting from an early focus on ‘women’, in more recent years feminist scholars are emphasizing the need to go beyond simple distinctions between men and women’s roles in society and embracing a more critical understanding of gender as social construct that infiltrates people’s lives at multiple levels (McDowell 1999). Feminist geographers have added the roles of space and place as indispensable in understanding gendered constructions of place and identity (Massey, 1994; McDowell, 1999).

Recent developments in social and cultural geography, centering on renewed understanding of space and place, and feminist concerns about how and why diverse women living in different places experience health and health care differently has strongly shaped the research agenda for geographies of women’s health. The places where women live are constituted by social constructions of race and gender that translate into everyday living, giving minority women a less advantaged position in maps of health and health care use and access. Feminist geographers emphasize that the gendered
construction of health and health care has largely been invisible in theoretical debates concerning the link between health and place.

However, within this emerging body of research on women’s health, knowledge about immigrant women’s health and health care experience is relatively limited. Except for a small body of work, immigrant women still remain the ‘other’ among the ‘Other’ in literature on women’s health and health care use. Women immigrants are engaged in unique place-making endeavors in their attempts to carry out their reproductive, productive and care-giving roles in material and social settings very different from those in their home countries. For relatively recent immigrants home is more than a remembered place; it pervades their whole self. Women immigrant’s agency is particularly challenged in maintaining the health and well-being of themselves and their families with resources that seem to be socially and culturally remote.

An important body of work is growing around this concern, attempting to bring immigrant women in focus in conceptualizing and theorizing the connection between health, place and culture in producing healthy or less than healthy spaces (see Dyck, 1990, 1995b, 2006; Dyck & Dossa, 2007). Place is experienced by immigrant women in unique ways different from women who have not been displaced from familiar social, cultural and institutional settings. The ways in which place intervenes health maintaining and health care seeking beliefs and practices of immigrant women are tied to the present circumstances of their lives; lives that are devoid of the meaningful routines, activities and social interactions of the home country but reset within the confines of new socio-spatial settings. Again, in the process of adjusting to the newly placed life, immigrant
women actively seek knowledge and access resources from local surroundings and also from the home country to meet health and health care requirements.

In her work focusing on how first generation Chinese and South Asian women in Vancouver, Canada managed and lived with chronic illness Dyck (1995b) shows that their illness managing strategies are closely tied to the place where they live and the local and global processes that shape the context of their everyday lives. Social networks and non-medical resources coupled with barriers to use of biomedical resources shaped their health care practices in important ways. Narratives of ongoing negotiation between biomedical and culturally specific health care knowledge mirrored the complex interactions between place, culture and women immigrant’s agency. Immigrant women in the study opted for remedies that worked best for them in their current life circumstances.

In a more recent study Dyck (2006), unravels the illness-management and health maintaining strategies of South Asian immigrant women in British Columbia, Canada by reflecting on the fine balance women try to achieve in negotiating the tension between western biomedicine and indigenous cures in deciding on the most appropriate remedy for common illnesses. A multiplicity of renewed placed-based interactions and experiences emanating from setting their foot in a new country and setting up home in a new setting shaped their everyday decisions related to health and ill-health. While work responsibilities at home and workplace, shaped by reinforced gender roles, put majority of women’s health at risk, home was the site where knowledge about healthy food and safe and effective remedies were put into practice. Women’s everyday routines shaped by their material circumstances as well as interaction in and with places, such as visit to
the local South Asian store to procure healthy foods and ingredients for home remedies shaped their experiences and practices of health and healing. The role of social networks in helping women gain or confirm knowledge about healthy food and traditional remedies as well as in forming meanings about new knowledge gained in host country is particularly emphasized. Their efforts to negotiate health knowledge(s) to come up with an effective blend that could be put into practice within the socio-spatial dynamics of everyday life, highlights the complex ways in which immigrant women’s health and their efforts to maintain the health of their family is shaped by place, gender and culture.

In their most recent work on South Asian Punjabi and Afghan refugee women living in Vancouver, Canada, Dyck and Dossa (2007) highlight how these women constructed healthy homes through routine practices of food preparation, home remedies and daily religious or spiritual observances. The situational context of the two groups of women differed because of different migration paths resulting in differential access to place-based social and economic resources. South Asian Punjabi women for instance were situated favorably amidst a close-knit community with ready access to social networks and South Asian stores and markets. However, inspite of such differences both group of women’s health practices were closely tied to place, through for instance efforts to prepare food that take into account dominant knowledge about healthy food in Canada, especially for the sake of children growing up in Canada and knowledge and experience relating to traditional cooking and home remedies. This research is particularly important as it connects to the theorization of therapeutic places and brings into focus the healing qualities of everyday spaces and routine activities such as prayers, a profoundly
important but neglected aspect of women’s everyday health-maintaining activities in the ‘therapeutic landscapes’ literature.

A focus into immigrant women’s health keeping and health care seeking behavior and strategies immediately brings into attention their cultural beliefs and practices, the most visible axis of difference from the mainstream society. Culture, as a way of life is important in shaping immigrant women’s health-related experiences and practices. Attempts to understand this necessitate stripping culture off its negative connotation in describing ‘other’ women’s health care practices and instead understanding culture as essential in immigrant women’s efforts to maintain health and well-being. Dyck’s (1990, 1995b) critique of culturalist explanation of immigrant women’s health care practices provides a rich ground for understanding how the life circumstances of immigrant women shape and influence their health care practices. Often in the biomedical literature, the beliefs and values of immigrant women are cited as reasons for not following recommended treatment regimes and lifestyles. Dyck proposes to go beyond this constricted conceptualization of culture and understanding the interrelationship between place, context and culture in developing in-depth understanding of immigrant women’s health care needs and help-seeking pathways (Dyck, 1990).

Culture as a way of life holds a lot of meaning for immigrants trying to settle down and adjust to a new life in a new country. The value of culture as a form of social capital is enhanced in the process of adjusting to the host country. The “nurturing qualities of culture” have been shown to be helpful in negotiating the host society. (Ahmad, 1993, cited in Dyck, 1995b, p.257.). Culture thus helps immigrants to continue living a meaningful life in the host society. Dyck’s work on immigrant women’s
experiences related to health and health care attests to the importance of culture in creating healthy homes and providing a repertoire of healing knowledge(s) (Dyck 2006; Dyck & Dossa, 2007). Other works in geography of health and health care also show that collective cultural identities help communities contest dominant forms of knowledge about health and health care practices and to gain access to health services (Dyck & Kearns, 1995; Kearns, 1991).

In attempts to understand how immigrant women’s culture shapes their health and health care experiences, the changing nature of culture has been especially highlighted (Dyck, 1990, 1995b). The way migrant women live their culture is shaped by the situational context of their life, which is structured by local and global processes. Their lived culture, enmeshed in the routine activity of everyday life, is adaptable, allowing for change in response to what works best to live a meaningful and healthy life. This understanding of culture brings into light the interrelationship between place, culture and health. The acknowledgement that place influences how culture is lived indicates that cultural beliefs and practices are negotiated in everyday interactions with the host society in efforts to create healthy living environments (Dyck, 1990, 1995b).

The local context in the case of immigrant women operates in new settings and environments. Changes in home, neighborhood and work environments characterize the local context of displaced women. This altered context and migrant women’s placement in changed social relations are likely to have greater power than traditional beliefs in shaping their health care experiences and practices (Elliot & Gilles, 1998). Through qualitative analysis of the of links between health and migration experiences of South Asian Fijian women in British Columbia Elliot and Gilles (1998) found that their
experiences were closely tied to the context of everyday life as migrants. It emerged from in-depth interviews that most women had a more holistic view of health. The experience of migration and greater work pressure in daily life were pointed out as reasons for health problems such as fatigue and stress and distress of separation from family in home country emerged as important concerns affecting health. These were exacerbated by the distance and prohibitive cost of travel to the home country (Elliot & Gilles, 1998).

‘Transnational Networks’ and Immigrant Women’s Health:

Transnationalism, a term used to describe the ties and interactions that people situated in a ‘diaspora’ space usually maintain with their home country is increasingly gaining grounds as an optic to understand immigrant women’s everyday life. The experience of place for immigrants is not only localized, but operates at various scales ranging from the local to the global on one hand and as Mahler and Pessar describe, “operates simultaneously at multiple spatial, social and cultural scales” (Mahler and Pessar, 2006, p. 42). Contemporary studies on transnationality have brought to the forefront the increasingly transnational nature of immigrant lives (Levitt & Jaworsky, 2007; Portes, Guarnizo, & Landolt, 1999; Vertovec, 1999). Migrants in today’s world retain important relationships cross nationally through “complex networks across space” (Mitchell, 2003, p. 77).

An important dimension of immigrant women’s experience of health and health care is their placement in transnational networks and connections. Immigrant women are likely to seek out, explore and rely on cultural knowledge and secure support system from their home country to maintain health and well-being (Dyck, 1995b, 2006; Dyck & Dossa, 2007; Menjivar, 2002). Globalization and the increasing access to modern means
of communication have significant implications in how immigrant women’s places of health and health care are constituted by crossnational networks. Through telephone, email and visits, immigrant women have options to draw on the knowledge and support provided by family and friends in the home country, even as they create and maintain new networks and connections in the host country. Thus social networks for immigrant women operate at many different scales – local, regional and transnational. Little knowledge exists about the characteristics of such networks and how immigrant women draw upon such networks in maintaining health and well-being and in gaining access to health care.

Menjivar’s (2002) research on indigenous and non-indigenous Guatemalan immigrant women’s healing networks in Los Angeles, employing in-depth interviews and participant observations, shows how social networks, both local and transnational help these women procure treatment for themselves and their families. To make up for the limitations of choices they face within the health care setting in the US these women relied on friends, families and acquaintances to gain access to medical advice, traditional remedies and biomedicines more informally. Reliance on local and transnational connections emerged as critical in immigrant women’s health care seeking strategies in the study establishing evidence about help seeking and help receiving component of women centered networks and the influence of gender relations in shaping such informal ties in immigrant and minority populations (see for instance, Hondagneu-Sotelo, 1995; cited in Menjivar, 2002 p. 439). Menjivar (2002) also particularly emphasizes the negotiable characteristics of such informal networks and exchanges by highlighting the
tensions and conflicts in the help seeking process inherent within the general and broader supportive components and characteristics of such ties.

Gender plays a critical role in shaping everyday context of transnational subjects. The importance of gender relations and gender as a process in setting out the conditions under which women migrate and the context of their lives in the host society are slowly seeping in migration studies, especially through contributions from feminist scholars across various disciplines (Donato, Gabaccia, Holdaway, Manalansan, & Pessar, 2006; Mahler & Pessar, 2006; Silvey, 2006). Gendered geographies of power (GGP), a framework laid out to conceptualize how gender operates at multiple socio-spatial scales at multiple sites for immigrants marks a significant stepping stone in theorizing gender relations in migration studies (Mahler & Pessar, 2006, 2001; Pessar & Mahler, 2003). As pointed out by the Mahler and Pessar (2006), a bunch of unanswered or partially addressed issues remain. Are transnational contexts sites of reinforced gender roles or do location in transnational networks initiates and helps to break traditional gender roles? Even as existing research points to unequal gains for men and women, the degree and extent of changed gender identities and relations and their variation across a diverse group of immigrants are yet to be studied. In understanding immigrant women’s attempts to maintain health and well-being as transnational subjects it is important to look at the gendered context of their everyday life, as they are nested in networks at multiple scales and the fluidity of their changing gendered identities.

Situating my research within this emerging body of work on place, gender and health, especially in the context of migration, I adhere to a relational view of place. Place has often been defined in terms of social relations and networks. In putting forth the
notion of ‘a global sense of place’, Massey defined places as “articulated moments in networks of social relations and understandings” (Massey, 1994, p. 154). In applying these ideas to everyday lives, one is immediately struck by the complexity of how people make sense of and form meanings of places as ‘unbounded’ and ‘open’. The situated nature of everyday human practices and experiences is a key to unravelling this complexity. Feld and Basso (1996, p. 7) uphold the importance of “cultural processes and practices through which places are rendered meaningful”. Recent body of work in health geography upholds a subjective view of place, filled with meanings and experiences (Gesler, 1991; Kearns, 1993). Consistent with these works, I refer to place as the settings and environments where women live their daily lives. The settings of everyday life are given meaning through routine activities and experiences. The social relations in which women’s lives are nested form an important component of place, giving shape to and enabling women to negotiate and create livable, healthy and meaningful spaces for themselves. For immigrant women, transnational relations and connections contribute to blurring the boundaries of places creating complex, multiscalar networks that are meaningful for health and health care. The study is based on an understanding of ‘culture’ as a lived experience and ‘gender’ as socially constructed, both intervened in complex ways by place. I adhere to the notion of culture as a way of life; not static and given, but continuously changing in response to life’s situation. I specifically seek to understand aspects of culture that helps South Asian immigrant women to live a healthy pregnancy, e.g. visiting a temple, or sending home-cooked food to pregnant women. Understanding of the gendered nature of women’s everyday life is crucial in understanding the effects of place and culture in South Asian women’s experience of
pregnancy care. Gender structures women’s everyday lives and infiltrates women’s experience of place. For immigrant women, changing meanings of gender in the host as well as home societies complicates the relation between gender, place and health.

It is very important to recognize the diversity as well as similarities in immigrant women’s use and experience of health care. Even amongst women originating from similar places, significant within group differences are expected to result based on differences in class, social circumstances, cultural beliefs and practices and institutional settings. In an in-depth study aimed at understanding factors influencing Sonoran women’s decisions to temporarily cross border and seek prenatal care in the US, Pope (2001) highlights differences in their experiences based on the composition, extent and location of social support networks, past encounters with health services in the US, viability in terms of cost and expenses and anticipation of impacts on chances of immigration. Many other factors such as differences in culture, socio-economic background, prominent social, cultural and political discourses-increasingly dominated by global mass media-on healthy living will shape immigrant women’s agency in seeking health and health care differently.

This emerging theoretical construct linking place, culture, gender and health provides a fertile ground for investigating the geographies of the health and health care experiences of immigrant women. Even though propositions have been forwarded emphasizing this direction, little empirical research has been undertaken. This research aims to fills this gap by seeking to understand South Asian immigrant women’s use and experience of health care during pregnancy. I aim to reinforce as well as substantiate the theoretical keystone of the ‘new’ medical geography by seeking to unearth how gender
and culture makes the relation between health and place complex for South Asian immigrant women.

**Situating South Asian Immigrant Women’s Use and Experience of Pregnancy Care**

**A Conceptual Framework:**

The conceptual framework for this research is based on the above-mentioned theoretical construct. It is based on the assumption that to gain a fuller and deeper understanding of pregnancy care experiences of South Asian immigrant women it is necessary to consider place, culture, and gender and their complex interrelationship in everyday life.

A majority of South Asian women come to the US as spouses, their ‘placement’ as migrants, the work they do at home and outside and their living and work environments, being shaped by their entry in the US as spouses of migrant husbands, struggling to make a viable economic living. They also come with distinct beliefs, ideas and practices and how they live their culture is shaped by the material and place based context of their lives in the US. This is true of their health and health care experiences as well since health care practices are not separated from the routines of daily life.

This research seeks to understand the interplay of these multiple factors in shaping the circumstances that affect South Asian immigrant women’s care seeking experiences and strategies during pregnancy. I focus on both formal and informal care to gain fuller understanding of their overall experience of health care during pregnancy. A diagrammatic representation of the conceptual framework is given in Fig. 2.1.

Culture, religion and tradition form a very important part of South Asian women’s everyday life. The ensuing paragraphs provide a glimpse of the cultural context of South
Asian women’s lives. I particularly emphasize the cultural and traditional beliefs and practices that shape South Asian women’s role and status in family and delineate her work and caring responsibilities. I then return to conceptualizing their use of prenatal care as immigrant women on the basis of an understanding of South Asian culture as an essential ingredient of their everyday lives.

South Asian women refer to a very diverse group of women belonging to different religious, linguistic, cultural and socio-economic backgrounds. One common thread that binds these women together is a very gendered construction of women’s identity (Bhopal, 1997; Clark, 1993). Patriarchy is the dominant form of family life. Men have the primary responsibility of earning for the family while women has the primary responsibility of home keeping and child rearing (Bhalla, 2008; Sharma, 2003). Men are expected to venture out in public spaces while women are expected to spend most of their time in the private space of home. Even though women have to work hard to raise and maintain a family their unpaid labor does not give equal status with men. Women’s roles as daughter, wife, daughter-in-law and mother are expected to center round the welfare of the home and family and a woman’s status in society is determined by how well and how appreciably she performs her roles.

Arranged marriage is the predominant form of matrimonial alliance which gives very little choice to women in deciding about their future husbands. It is the parents who find a suitable match based on several criteria such as caste and socioeconomic status. In a majority of such marriages women get to know their husbands only after marriage and forming a emotional and functional relationship with the husband and his family members forms a key aspect of everyday life as a new wife. Upon marriage women leave
the home of their parents and go to their husband’s home. The bride takes up the surname of her husband and legally becomes a member of her husband’s family. As wife, daughter-in-law and sister-in-law she is expected to strive for the welfare of her husband’s family. She is expected to share household and childcare with other female members of the family and gradually take up major responsibility of domestic work by giving relief to mother-in-law or elderly sister-in-laws. Her needs, wants and desires are expected to take a backseat so that she can perform her roles dutifully and sincerely.

However, in recent decades significant changes have occurred in age-old norms, values and ideologies that determined the life course of South Asian women through the centuries. A shift in gender roles is taking place slowly and steadily. Women are coming forward in every walk of life and working side by side with men. As more and more women are participating in workforce traditional gender roles are breaking (Bhalla, 2008; Bhopal, 1997). Many men are sharing household and childcare responsibilities with spouses. However, this change is not taking place smoothly and easily. The shift towards more equal gender roles is resulting in sites of contestation (Bhalla, 2008). Women have to struggle everyday and play an active role in enforcing equal and justifiable division of labor. For instance, it is still expected that the woman will make tea for her spouse after returning from work even though she might come back home equally tired and equally wanting to rest. Also, shifts in gender roles are not taking place equally among all South Asian women. These shifts are more visible among working women in urban areas, well educated women, and women whose lives have been touched by realizations of equality, justice and awareness of countless ways in which women have been subordinated and denied basic human rights.
The aforementioned gendered construction of everyday life affects South Asian women’s efforts to maintain health and well-being in everyday life and to seek and use health care resources (Fig. 2.2). South Asian women tend to overlook their own health and health care needs in their pursuit to look after home, children and family (Bottorf et al., 2000). Household and childcare responsibilities take away most of her time and she is left with little energy and strength to care of herself. In addition, religious norms and ideologies often reinforce women’s gendered roles. This should be read with caution however, since religion and spiritualism often give women valuable and treasured ways of keeping happy, well-balanced and healthy by engaging with a more holistic way of living.

Previous research has shown that in health care settings South Asian immigrant women face stereotyping and discrimination since they hold on to cultural and religious beliefs and practices (Bowler, 1993). In health care encounters a South Asian women who is educated can speak fluent English and wears western dress is likely to face less stereotyping than another women who is less educated, cannot speak English fluently and wears traditional dress.

Becoming pregnant and giving birth is a very important phase of a woman’s life cycle and South Asian women are no exception. A South Asian woman’s status is elevated in the eyes of the society when she becomes a mother, especially in the case of the first child and in many cases, if it is a boy. A woman can expect to get a lot of attention and care even in her in-law’s place when she is pregnant. However, exceptions are not uncommon and dynamics of relations with in-laws and husbands often determine everyday care during pregnancy. Nonetheless, women usually can expect to get a lot of
help and support from the social support structure consisting of family, friends and relatives who live close by and are readily available to help. It is a common tradition for a South Asian woman to go to her parents’ place during pregnancy and spend the majority of time there. This creates a sense of well-being in receiving help and enjoying the care and attention of mother and siblings.

The above description of South Asian women’s role and status in family and society, her engagement with religious and cultural beliefs and practices, the importance of social support structure in her everyday life and significant shifts that are taking place in traditional gender roles, gives a starting point to understand how immigrant South Asian women experience health and health care during pregnancy.

When South Asian women come to the US they come with their cultural beliefs and values and health and health care experiences gained from their home country. However, in the host society they become situated in a challenging contextual setting that structure their everyday lives including their health care practices and decisions. The challenge to cope with the new ‘place’ is made difficult due to separation from family members, close friends, removal from previously available social support systems and also financial difficulties including lack of basic resources such as health insurance coverage. Women go through a painful process of adjustment and readjustment with their current life situation as immigrants.

How easy is it for South Asian women, marginalized due to migration and having to constantly meet challenges of adjusting to a new ‘place’, to access and use formal prenatal care? The lack of the social support system that was so easily available at home country through extended family networks and friends, the need to adjust with new
family members including the husband (especially in the case of arranged marriage), stress and strain in accomplishing work responsibilities in new and unfamiliar environment inside and outside home, fulfilling culturally prescribed gender roles, all these can circumscribe her experience of pregnancy. To maintain a healthy body, to use regular prenatal care, and to make the experience of pregnancy healthy and satisfying she will need to adopt strategies that her life situation allows. Such strategies are likely to be shaped by the close interaction of place, gender and culture.

Like other immigrant groups South Asian immigrant women are likely to reside in ethnic neighborhoods. Previous studies have shown that such neighborhoods may be deprived of quality and culturally sensitive health care and other facilities. In a metropolis like New York City, traveling to remotely located services and facilities may be very difficult because of distance and time constraints. At the same time other culturally specific resources available in such neighborhoods, such as community shopping areas and religious centers, may add positively to their health care and health care experiences (Dyck & Dossa, 2007). The availability of social support systems and social networks with people from similar cultural and linguistic backgrounds can be crucial in accessing and using formal and informal prenatal care.

While unequal gender roles may sometimes make it more difficult for immigrant women to maintain health, other aspects of culture and religion provide women with positive environment to heal the mind, body and self (Fig. 2.3). Creating and sustaining a soothing place to live during pregnancy becomes vital for immigrant women who are adapting to a painful process of distance and physical separation from family, relatives and friends. Pregnancy, in itself being a very rewarding and satisfying experience in
anticipation of having a baby and becoming a mother is sought to be lived in a comforting surrounding. South Asian women are likely to hold on to their religious and spiritual beliefs and practices to create therapeutic environment for their pregnant body and self. This would be shaped by place and context in important ways. For instance the presence of a temple in close proximity could be of profound benefit to many women. On the other hand household and childcare responsibilities could prohibit women from visiting such therapeutic spaces more often.

South Asian women’s traditional confinement to the private space of home and venturing out in public mostly in the accompaniment of other women or men underlines the importance of home in everyday life. Having been relegated to the confines of home South Asian women have through the centuries strived to make home a place of haven. In efforts to take care of children and family she has sought out to draw on cultural knowledge and practices to create a healthy place where healthy bodies and healthy minds can be raised and nurtured. South Asian women, in general, are likely to strive to live and put into practice the positive and health maintaining aspects of culture at home, set in a new setting in the US. Mothers and grandmothers are likely to be especially important in providing cultural knowledge and imbibe healthy beliefs and practices.

Home as a site of prayer and worshipping is expected to be of vital importance for most South Asian pregnant women. It is common for a South Asian Hindu woman to have an altar at home with pictures or miniature statues of deities where she performs her daily prayer and meditation. For South Asian Muslim women home forms the key site for daily prayer and performing ‘namaz’. Do South Asian immigrant women desire to pray more during pregnancy asking for a healthy baby? Are they able to perform their daily
prayers and rituals amidst household chores and responsibilities? How do they negotiate their need for prayer and worshipping in the context of their current living and working conditions? Attempts to answer such questions will help to get a closer look at South Asian women’s overall experience of health care, including caring for the mind, body and soul, during pregnancy.

Other types of places such as the local neighborhood and workplace have similarly complex associations with South Asian immigrant women’s health care experiences during pregnancy (Fig. 2.3). These associations emerge from the interplay between culturally proscribed gender roles, household needs and opportunities, local resources and constraints, and women’s agency in maintaining health and well-being in the context of dis-placement due to migration.

The conceptual framework of this study assumes that place, culture and gender affect the beliefs as well as everyday practices related to health care during pregnancy of South Asian immigrant women. The way they experience and form meaning about the formal and informal prenatal care available to them is closely tied to the material context of their lives and is shaped by the interaction of place, context and culture. Gender, shaped in significant ways by context and culture forms a crucial element in forming the place where women live, work and seek care during pregnancy. The conceptual framework aims for an ‘open reading’ of the everyday lives of South Asian immigrant women. By adopting such an approach, a deeper understanding of the complexity of circumstances and situations shaping the prenatal care experiences of South Asian immigrant women is sought for.
Use of health care during pregnancy: The roles of place, culture and gender
Fig. 2.2: Defining place, culture and gender for South Asian immigrant women: A few examples

PLACE
Place experienced by immigrant women centers around home, neighborhood including park, school, local social networks, community center, religious center, health care facilities, local and ethnic shopping centers, contact and connections with home country.

GENDER
Unequal gender roles, shouldering major responsibility of household work including domestic and childcare responsibilities, segmentation in part-time, low wage jobs to supplement family income.

CULTURE
Performing prayer or worshipping at home or religious center, buying ethnic food-stuff, cooking South Asian recipes, engaging with South Asian culture of welcoming and inviting friends and relatives informally and for special lunch or dinner, considered as a duty and religious act.
Fig. 2.3: Place, gender and culture in creating South Asian women’s care environment during pregnancy: Some illustrative examples

**Fig. 2.3a: Home as site of care for pregnant South Asian women**

- **Home (Place)**
  - Site of prayer and worship (**Culture**)
  - Greater work responsibility (**Gender roles**)
  - Healthy place of care during pregnancy
  - Unhealthy place of care during pregnancy

**Fig. 2.3b: Neighborhood as site of care for pregnant South Asian women**

- **Neighborhood (Place)**
  - Rich ethnic resources (**Culture**)
  - Crowded and congested (**Place context**)
  - Healthy place of care during pregnancy
  - Unhealthy place of care during pregnancy
Fig. 2.3c: Workplace as site of care for pregnant South Asian women
Chapter 3

Data and Methods

This research uses a mix of quantitative and qualitative data to examine and understand the use and experience of pregnancy care by South Asian immigrant women in New York City. The purpose of using a mixed methodology was twofold: first, to examine the broad contours of formal prenatal care use by South Asian immigrant women in New York City through preliminary understanding of their use of prenatal care in relation to residential location and making sense of variation in use and; second, carrying out a more detailed in-depth study in select neighborhoods to gain thorough understanding of use and experience of pregnancy care by a specific group of South Asian immigrant women. The quantitative methods uses aggregate data on South Asian immigrant women’s use of prenatal care during one particular year and include descriptive analysis and GIS mapping of prenatal care and Medicaid use and a series of logistic regression models estimated to explore the effects of sociodemographic and economic risk factors on prenatal care use by immigrant women from South Asia. The qualitative methodology comprises in-depth interviews with a sample of Bengali immigrant women in different neighborhoods in New York City.

Study Area:

This research is based in New York City. New York is an immigrant rich city, with a diverse and multicultural population base. It is the largest metropolitan city in the US with a total population in 8,008,278 according to US Census 2000, of which a high percentage is immigrants. Geographically, it consists of five boroughs namely, Bronx,
Manhattan, Queens, Brooklyn and Staten Island. Among the boroughs Queens and Brooklyn have the largest immigrant population residing in culturally and ethnically diverse neighborhoods.

New York City is a city of immigrants. About 32.95% of the city’s total population is foreign born. A notable characteristic of New York City demographics is the rapid rate of growth of its foreign-born population. The foreign-born population increased from 2.1 million in 1990 to 2.9 million in 2000, an increase of 37.8 percent. Of this total number, 43% immigrated to the US in the preceding 10 years (US Census Bureau, 2000). The three major South Asian countries, India, Bangladesh and Pakistan, form a major source region of immigrants in New York City. According to the Census 2000 figures, some of the most rapid growth in the Asian population has occurred among South Asians, with growth rates from 1990-2000 ranging from 78.5% for the Pakistani population to 286.4% for the Bangladeshi population (Table.3.1). Immigration has played a major role in the growth of these communities. The number of immigrants from India, Bangladesh and Pakistan increased from 67,000 in 1990 to 146,000 in 2000 (US Census Bureau, 2000).

The socioeconomic and demographic characteristics of these newly arrived immigrants contrast sharply with those of the South Asian community of the 1960’s and 1970’s. The earlier immigration stream comprised mostly high skilled professionals such as doctors and engineers. In contrast, the recent South Asian immigrants, especially during the last decade, are mostly young, working class and less likely to speak English. A very high percentage of Bangladeshi and Pakistani immigrants in New York City
belong to low-income, working class community and live in low-income neighborhoods. To earn a living they drive taxis, sell newspapers, man stalls in the subway stations and run small businesses in the city as well as in the ethnic neighborhoods (South Asian Network, 2004). This recent trend of immigration means that a more vulnerable, low-income group of South Asian women is settling in the city. South Asian women especially women from Bangladesh, Pakistan as well as a section of women from India mostly migrate to the US as dependents. They usually follow their husbands who are typically engaged in low-paid jobs, struggling to make a living and trying to save from a limited income to start a family. Thus for a majority of South Asian immigrant women, the new life in the US is structured by a socio-economic setting that makes her susceptible to constrained material and social conditions. This vulnerable, low-income group of women is likely to face barriers in accessing and using adequate health care during pregnancy because of socio-economic constraints as well as language and cultural barriers.

In this research I use a mix of quantitative and qualitative methods to understand South Asian immigrant women’s use and experience of prenatal care in New York City. The research begins with quantitative mapping and statistical analysis of the births data: examining spatial variation and use of prenatal care for South Asian immigrant women in relation to selected socio-demographic variables. The results of this analysis are used to design a focused qualitative study of Bengali immigrant women’s use and experience of pregnancy care in selected neighborhoods in New York City. The neighborhoods were chosen based on the quantitative analysis of data to represent different place contexts for
South Asian women and different spatial clusters of South Asian women in New York City.

Quantitative Analysis of Prenatal Care Use:

Quantitative Data

The quantitative data on prenatal care use by South Asian immigrant women come from the Births Master File, collected from the Office of Vital Statistics, New York City Department of Health. The Births Master File is a comprehensive dataset generated from the birth certificates of babies born to mothers who live in New York City. The data include information about the mother’s place of residence by zipcode, mother’s birthplace and ethnicity and several sociodemographic attributes such as education, age, health insurance coverage and marital status. The data also provide information about the mother’s use of prenatal care – if the mother used prenatal care or not, and which trimester she started using prenatal care. The nine-month pregnancy period is divided into three trimesters (3-month periods). Medical guidelines recommend that pregnant women begin receiving prenatal care during the first trimester, so the trimester divisions provide a useful way of measuring prenatal care use (Institute of Medicine, 1985).

The quantitative part of this research focuses on South Asian immigrant women from India, Pakistan and Bangladesh. These countries are the major sources of South Asian immigrant women in the US. The reason for exclusion of women from other South Asian countries is their relatively very smaller numbers. From the Births Master file, information on zipcode of residence, prenatal care use, insurance coverage and socio-demographic attributes were extracted for all women whose birthplace was mentioned as
either India or Pakistan or Bangladesh. The resulting dataset was used for quantitative analysis of South Asian immigrant women’s use of prenatal care.

The Births Master File data is a fairly complete dataset on women giving birth to babies in New York City. However, there are some limitations of the data. For a small percentage of women the zip code of their residence is unknown and has been designated as 88888. This could be either because they are from outside New York City, or they did not mention their zipcode in the birth certificates. A total of 228 women were not included in analysis because of missing zipcodes. As is expected, there are some missing values for almost all the variables used in the quantitative analysis.

A final limitation of the birth data concerns how the variables are measured. Some of the variables are not very useful for analysis. For instance, the categories defined for different types of occupation are ambiguous and do not give accurate information about the actual occupations of the mothers. The categories for occupation include: 1) Homemaker, housewife, at home, HW, Mother, on Welfare, Domestic Engineer. 2) Student. 3) Never worked, none, unemployed, disabled, unknown, prisoner, dead. 4) Retired (only if no occupation and no business or industry is given), volunteer. 5) Occupation not listed above or entry in business or industry. 9) Blank. Such categorization is unlikely to elicit correct information about women’s occupation. A housewife for instance may be confused whether to check 1 or 3 as she may also have never worked before or regards herself as unemployed. Again many immigrant women are primarily housewives but work in part-time jobs. The above categories do not give the option to mention this. It would have been more useful to have information about
whether women were full-time homemakers or were homemakers and employed in part-time jobs, or were employed in full time jobs.

The geographical unit used for analysis of quantitative data and sampling of neighborhoods for depth interviews are zip code boundaries (Fig.3.1). The 5 digit Zip Code Tabulation Areas (ZCTAs) 2000 for New York City are used as the base map for spatial analysis of the data, since the mother’s address is reported at the the zip code level. The shape file of zip code boundaries was downloaded from the Maps and Mapping resources in the US Census Bureau website.

There are several limitations of using zipcodes for creating GIS maps to depict health care use and related statistics (Cromley & McLafferty, 2002). Zipcode boundaries often do not coincide with administrative boundaries such as census tracts. Thus there is little scope of overlaying and integrating zipcode level data with related data available for other geographical units. A zipcode in large metropolitan cities may consist of neighborhoods with very different socio-economic characteristics, thus rendering any average of health statistics for the zipcode a biased value which does not correctly represent the underlying differences in socio-economic status of people residing in the zipcode (Cromley & McLafferty, 2002).

Despite limitations of zipcodes, they are the smallest areas for which births data are readily available. Hence, spatial resolution used for depicting prenatal care use by South Asian immigrant women in the quantitative section of this research is zip code boundaries.
Quantitative Methods

A range of quantitative methods was used to analyze spatial variation in use of prenatal care for South Asian immigrant women in New York City. The methods include descriptive statistics, GIS mapping and logistic regression models.

Descriptive statistics

Descriptive statistics were used to describe the use of prenatal care, source of finance to cover prenatal care costs and several socio demographic attributes of South Asian women in New York City. They were also used to analyze differences among women from the 3 countries of origin.

GIS mapping

A Geographical Information System (GIS) was used to examine the spatial variation in the use of prenatal care by South Asian immigrant women in New York City. GIS maps were created to describe the pattern of prenatal care use by South Asian women and to analyze the variation in their use of prenatal care by zipcode of residence in New York City and by the mother’s place of birth. Maps were also created to show geographic variation in Medicaid coverage for South Asian women.

The generation of GIS maps involved the following steps:

1. The 5 digit Zip Code Tabulation Areas (ZCTAs) 2000 for New York were downloaded from the Maps and Mapping resources in the US Census Bureau website.

2. The shapefile of the New York City area, covering five boroughs, was clipped from the original downloaded shapefile of New York State.
3. Tables were created in Excel and saved as dbf files for all South Asian women and separately for women from India, Bangladesh and Pakistan. The tables included information on prenatal care use and Medicaid coverage of each mother by zipcode, taken from the Births Master File data. The raw data was categorized as dummy variables assigning 1 if the women used late or no prenatal care and 1 if she was on Medicaid. The final value was obtained by adding the number of women in each zipcode.

4. The attribute tables for the maps were created by adding up all the women in each zipcode using the ‘Summarize’ function in ArcGIS attribute table. The percent of total women in each zipcode with late or no prenatal care and on Medicaid were calculated.

5. There were several zipcodes in New York City with less than 30 South Asian women who gave birth in the year of analysis. Rates of prenatal care use and use of Medicaid were not calculated for these low-population areas. Hence, in the maps depicting prenatal care use and Medicaid coverage only zipcodes with more than 30 women are shown. The reason for exclusion of these zipcodes was their relatively small size and the problems of exaggerated representation of late or no use of prenatal care and Medicaid coverage. For instance in many of the zipcodes with very few women the percentage of women with late or no prenatal care is 90-100% which distorts the actual reality in terms of the number of women. The number 30 was therefore selected as a dividing line to ensure accurate representation of the data.
6. The ‘Join and Relate’ function in ArcGIS was used to join the attribute tables to the base map to create maps of spatial distribution and variation in the use of prenatal care and Medicaid for all South Asian women and separately for women belonging to the three groups.

The resulting GIS maps helped to explore the distribution of South Asian women in New York City and examine and analyze the spatial variation in their distribution, use of prenatal care and use of Medicaid.

**Logistic regression models**

A series of logistic regression models were estimated for all South Asian women and separately for women from India, Pakistan and Bangladesh to explore the effects of traditional maternal level risk factors on their use of prenatal care. The dependent variable in the models is late or no use of prenatal care. It is set up as a dummy variable in which 1 is assigned to late or no prenatal care and 0 to early use of prenatal care. The use of prenatal care was defined on the basis of when the woman started receiving prenatal care. Women who started prenatal care in the second or third trimester have been defined as women using late prenatal care.

In the biomedical literature a regular nine-month pregnancy is divided into three trimesters, each continuing for 3 months (Institute of Medicine, 1985). The trimester at which women initiate prenatal care is recognized in public health literature as a useful way of assessing adequacy of prenatal care use (Institute of Medicine, 1985). Women starting care in the first trimester and going for a recommended number of visits during the entire pregnancy are considered to use adequate prenatal care, and are more likely to enjoy healthy pregnancy and deliver a healthy baby. On the contrary women who start
receiving prenatal care after the first trimester, in the second or as late as third trimester are considered to receive late and inadequate prenatal care. The New York City community health profiles published by the New York City Department of Health, for instance adopts this definition (New York City Community Health Profiles, 2003). Some studies adopt a different definition of late prenatal care categorizing only women receiving care in the third trimester as receiving late prenatal care. In this study, I selected the former definition (Late = initiating care in the second or third trimester) since there is universal agreement that women starting care after the first trimester are at higher risk of poor birth outcomes such as low birthweight and infant mortality (Institute of Medicine 1973, 1985; Gortmaker, 1979).

The independent variables in the models are: age, education, employment status, insurance coverage, marital status and parity. These were set up as dummy variables as follows: age, 1 if < 20 yrs, 0 if else; education, 1 if < 12 yrs of education, 0 if else; employment status, 1 if not employed during pregnancy, 0 if else; Medicaid, 1 if the women received Medicaid, 0 if else; self-pay, 1 if the women paid for prenatal care out of pocket, 0 if else; marital status, 1 if not married, 0 if else; parity, 1 if the women had 3-8 children, 0 if else.

The logistic regression equation for the models is:

\[
Z = a + b_1X_1 + b_2X_2 + \ldots + b_kX_k
\]

Where:

\[
Z = \ln(p/(1-p))
\]

\[
p = \text{probability of late or no use of prenatal care}
\]
The $b$ values are regression coefficients that describe the association between an independent variable and late or no use of prenatal care.

A series of hypotheses guided the inclusion of the variables in the model and their expected relationship to late or no use of prenatal care (Table 3.2). The variables were chosen to represent socio-economic determinants of prenatal care use, such as education, employment and insurance coverage, which have been identified in previous research. Specifically, women who are less than 20 yrs and women with less than 12 yrs of education are expected to be at greater risk of late or non-use of prenatal care. Women employed during pregnancy are expected to have higher risk of late or non-use of prenatal care, as are women on Medicaid and women in the self-pay group. I also expect social and cultural factors to be important. Women who are not married and women who have high parity are expected to be more likely to receive late or no prenatal care. In summary, the logistic regression models helped to shed light on the extent to which factors like education, employment and lack of insurance coverage account for South Asian women’s low use of prenatal care.

**Qualitative Analysis of Use of Pregnancy Care:**

**Qualitative Method and Research Participants**

Recent efforts to de-medicalise health geography have been accompanied by serious endeavor to engage with social theories and debates in social and cultural geography and feminist geographies. In attempts to theorize and reconceptualise health
geographies, researchers are increasingly emphasizing the importance of qualitative research (Dyck, 1999; Elliot, 1999; Kearns, 1991; Wilton, 1999).

The qualitative methods used in this research include in-depth interviews. Although the original plan was to interview women from all the three major South Asian countries -- India, Pakistan and Bangladesh -- it quickly became apparent that the South Asian population is too large and diverse to be examined in a single qualitative study. Women from these three major source countries of South Asian immigrants in the US speak different languages and come from different cultural and socioeconomic backgrounds. India, for instance, is a multilingual country with women in different states speaking different languages and varying widely in social and cultural beliefs and practices. Even though a predominantly Hindu nation, women living in different regions practice Hinduism differently. A good percentage of Indian Hindu women practice Sikhism, Buddhism or Jainism, which are different sects of Hinduism and a significant portion of Indian women belong to other religion such as Islam and Christianity. Again, from some states of India such as Punjab, women migrate to the US or Canada from urban as well as rural areas while from some states such as West Bengal women migrate mostly from urban areas. The representativeness of this diverse group of women in in-depth understanding of issues pertaining to their experience of pregnancy care is likely to be compromised and problematic in a study focusing on all South Asian women. In health geography literature, qualitative research on South Asian immigrant women often focuses on specific communities such as the Sikh community (see Dyck, 2006).

This is a problem for women from Pakistan and Bangladesh also. Even though majority of women from Bangladesh and Pakistan belong to the same religious group,
namely Islam, language and culture forms major axes of difference between women from the two countries. Pakistani women speak mostly Urdu or Punjabi whereas women from Bangladesh speak Bengali. Again Hindu minority women from the two countries form a significant percentage of South Asian immigrants in the US. Having faced years of discrimination in their home countries, many Hindu immigrants from Bangladesh or Pakistan hesitate to interact with South Asian Muslim immigrants in the US.

Apart from differences in terms of class, South Asian immigrant women in New York City, therefore, differ considerably in social, cultural and religious ideas, beliefs and practices. Understanding and adequately representing these differences within the larger South Asian community in use and experience of pregnancy care would be very problematic in a single study. Hence, I argue that understanding of pregnancy care experiences of each South Asian immigrant group deserves a separate in-depth study. At the same time, in-depth understanding of pregnancy care experience of one major group of South Asian women would provide substantial knowledge and directions to lay a foundation for future research on pregnancy care use in particular and health care use in general for other groups of South Asian immigrant women. Based on these arguments the qualitative part of my research focuses on a one particular group of South Asian immigrant women in New York City.

The focus of this research is on Bengali immigrant women in New York City consisting of women from Bangladesh and Bengali women from India. These women share a common language and are connected by historical ties. They originate from countries that were once part of the greater undivided British India. The divide and rule policy of the British empire, culminated in a decision to transfer political power to Indian
leaders in lieu of division of the country into a predominantly Hindu nation, India and a predominantly Muslim nation, Pakistan. Pakistan was formed by bringing under one administrative power two geographically, linguistically and culturally separate regions located in Northwestern India and Eastern India. Soon after independence of India and division of the country into India and Pakistan in 1947, conflicts started between West and East Pakistan centering on differences in language and culture. Mass uprising took place in East Pakistan, resulting in the Bengali Language Movement (Bhasa Andolon) in 1950-51, the Bangladesh War of Revolution in 1971, and ultimately the creation of the independent country of Bangladesh.

Religious beliefs and practices form the main axis of difference between women from Bangladesh and women from West Bengal. Majority of women from Bangladesh are Muslims whereas majority of women from West Bengal are Hindus. There is also a significant number of Hindu immigrant women from Bangladesh – a minority group in the country - who form a distinct community in New York City. The common thread binding these culturally diverse groups of Bengali immigrant women is their spoken language. These women speak Bengali or one of the many dialects of Bengali depending on the region from where they have immigrated.

In this research women from Bangladesh comprise majority of research participants. A majority of women from Bangladesh in the sample are low-income, as is typical of the Bangladeshi immigrant population in New York City. Relatively smaller numbers of research participants are Bengali women from India. All except one Indian Bengali women are high-income, thus representing a section of immigrants described as ‘model minority’ in terms of their high levels of educational and professional
achievements. The aim is to get a perspective of differences in use and experience of pregnancy care based on differences in religion and socio-economic status.

The following section summarizes the criteria that guided the selection of Bengali immigrant women for in-depth study:

First, quantitative data suggest that Bengali women face difficulties in accessing prenatal care. The rate of late prenatal care is high for Bangladeshi immigrant women in New York City. Analysis of Births Master File data for the year 1999 indicates that among South Asian immigrant women, Bangladeshi women are most likely to start prenatal care late, in the second or third trimester. The rate of non-use of prenatal care is also high for Bangladeshi women, next only to women from Pakistan. It is, however, impossible to estimate the rate of late or no prenatal care use among Bengali women from India since the Births Master File data does not provide information about the region the women come from in their country of origin.

Secondly, women from Bangladesh form a growing segment of South Asian immigrant women in New York City (The Newest New Yorkers, 2004). The number and percentage of Bangladeshi women in New York City and other major cities in the US is increasing rapidly. Being low-income and vulnerable as far as access to health care and related resources is concerned, attention needs to be focused on their use and experience of pregnancy care as immigrant women and understanding barriers they face in accessing health care resources during pregnancy.

Thirdly, Bengali immigrant women are also of interest because of the socioeconomic diversity of the Bengali population in New York City. Women from Bangladesh belong mostly to low-income group whereas majority of Bengali women
from India have a better socio-economic condition. This difference allows for analyzing class differences among Bengali women and focusing on barriers to prenatal care use for low-income immigrant women.

Fourthly, this sub-group of South Asian immigrant women in New York City provide a rich sample population by virtue of their origin in two different countries with marked social, cultural and economic differences but at the same time having threads of similarity in a common history and a common language. The economic and cultural differences play out distinctly in the city among low-income Bengali women, who are mostly from Bangladesh, and the relatively higher income women from India. The cultural difference based on two different religions – Islam and Hinduism – is marked, and Bengali women in the city form distinct enclaves of social, cultural and religious life. Bengali immigrant women display a strong tendency to recreate their social and cultural life here with strong links to their home-country and a significant percentage of women feel safe living in a secure cultural and ethnic enclave.

Fifthly, women from Bangladesh migrate to the US from urban, semi-urban as well as rural areas while Indian Bengali women migrate mostly from urban centers. This adds to the intra-group diversity among Bengali immigrant women and makes it an interesting immigrant group for in-depth study.

Finally, Bengali immigrant women in New York City speak Bengali or one of its several dialects. Bengali, being my mother tongue, has given me an added advantage to speak with Bengali immigrant women. For doing in-depth study it is crucial that the researcher in the field is fluent and understands really well the spoken language of the research participants. It is best when research participants are interviewed in their mother
tongue in interviews that progress through conversations, providing an environment to speak freely. Though high-income Bengali women in New York City and women with high educational backgrounds can understand and speak English well, most women, especially in the low-income group, cannot speak English fluently. Keeping in mind the difficulty of speaking in English and the comfort and easiness of conversing in Bengali for most Bengali immigrant women, I conducted the interviews in Bengali. The aim was to gain maximum understanding of their pregnancy care experiences through in depth conversations.

Interviews

The purpose of the in-depth interviews was to understand the pregnancy care experiences of Bengali women in New York City. The interviews focused on the overall pregnancy care experience of the women including their experience of formal prenatal care and informal help, support and advice received from social networks comprising friends, relatives and neighbors to maintain health and well-being during pregnancy. The primary goal was to understand the interacting roles of place, culture and gender in shaping Bengali immigrant women’s use and experience of health care during pregnancy. The interviews focused on understanding the types of barriers women faced in using formal prenatal care services and how women utilized social networks, both locally and transnationally to gain knowledge and receive advice and support during pregnancy. The in-depth interviews explored a wide range of issues including use of formal and informal prenatal care services and resources, the experience of the place(s) where women lived during pregnancy, the everyday spaces that circumscribed women’s prenatal care experiences and practices, the strategies for gaining access to prenatal care knowledge
and resources, barriers and time-space constraints faced in using prenatal care services and relevant experiences as immigrant women. I also asked about social networks and contacts in relation to use of prenatal care and the scale, characteristics and locations of these networks. Women’s situational context as immigrants was included as a key reference point for understanding their experience of pregnancy care.

The interviews were semi-structured. A set of topics was discussed with the interviewees with the aid of questions that guided and initiated the conversation. A section on sociodemographic information was included in the questionnaire to obtain selected sociodemographic attributes of the women. Each interview lasted for several hours, ranging from one and half hour to three hours. A sample of topics and sample questions asked in the interview is shown in Table 3.3. A full version of the interview questions is included in the Appendix.

A pilot study was conducted in Urbana-Champaign, Illinois prior to actual fieldwork in New York City. Interviews were done with a small sample of pregnant South Asian women in the community to pretest the format and questions for the in-depth interviews. A total of 6 women, 2 from Bangladesh and 4 from India were interviewed in a time period of one and a half months. The interviews included questions on use of formal and informal prenatal care, the place where the women lived and experience as immigrant women. Place-based social networks emerged as important in the prenatal care experiences of the women. Friends, neighbors and families formed networks of support in the place where the women lived and in their home country in accessing formal and informal care. The women were found to actively seek advice and suggestions, both in formal as well as informal care setting to make the experience of pregnancy as positive
and fulfilling as possible. Based on that experience, a detailed set of interview questions was formulated.

The main qualitative phase of the project was conducted in two phases in New York City. The first phase began in February 2004 and lasted for 6-8 months. The second phase started in January 2005 and lasted for 1 year.

The Institutional Review Board of the University of Illinois-Urbana Champaign granted permission for the in-depth study in December 2003. The interviews were conducted with due cognizance to the ethical standards of qualitative research (Dowling, 2005). All necessary measures were taken to comply with ethical standards and requirements recommended for qualitative research. Women were interviewed based on their willingness to participate in the study. A brief statement of the study, the information requested and the time required was communicated to the prospective research participants before the interview. Before starting the interview women were asked to sign a consent form that contained the above information and spelled out their rights as research participants. The participants were briefed about their ‘rights’ as respondents before the interview. The interview environment was made as comfortable and homely as is possible. The women were given the opportunity to respond to the questions in depth and reflect on the issue or question posed. They could interrupt the interviewer or ask any question they had any time during the interview. All interviews were audio taped with due consent from the research participants. All necessary measures were adopted to protect the anonymity of the research participants and the confidentiality of the data collected. The names of all the respondents were changed for use in the dissertation.
All interviews took place in the home of the research participants through prior appointments. The interviews went very well as far as the questions were concerned. Most of the participants did not have any problem in understanding the questions. In some cases probing helped women to give more detailed accounts of their experiences. The participants did not refuse to answer any of the questions. In almost all the interviews the participants were happy to converse about their experiences during pregnancy. During the first phase of the interviews, the conversations sometimes tended to become a little too lengthy. Considering the fact that many women especially with children had multiple work responsibilities at home and sometimes outside, efforts were made to ensure that women’s daily routine was not affected. After the first set of interviews I rephrased some of the questions and combined some of the themes to be able to get more information in relatively shorter time without compromising on the breadth and depth of the topics. This helped in keeping the interview manageable and also in obtaining more useful information from the participants. As the researcher I kept my time frame flexible so as to allow research participants to participate in the research without feeling pressurized and constrained. Women were asked to attend to any important work that needed to be done right away and take breaks if needed during the interview process. This was especially important for women with babies and toddlers needing continuous attention and for whom household work got stretched all through the day. Effort was always made to make the interviewees feel that it was a conversation and discussion rather than collecting responses to specific questions.

The qualitative data was analyzed using ethnographic methods. The methods involved careful listening of the interviews, transcribing interview conversations and
analyzing interview data using a grounded theory approach (Cope, 2005; Strauss & Corbin, 1998). Through repeated interpretative reading of the transcribed interviews, major themes related to Bengali immigrant women’s use and experience of pregnancy care were identified. Select sections from each interview were translated from Bengali to English and used as excerpts in the text. Identifying similarities and differences among the Muslim and Hindu women from Bangladesh and comparing their use and experience of pregnancy care with Bengali women from India formed a key part of interview data interpretation.

Sampling and recruiting research participants

The sample women for depth interviews were chosen to reflect the geographical, economical and cultural diversity of Bengali immigrant women in New York City. Based on the quantitative GIS analysis, place-based stratification was employed to identify neighborhoods for carrying out the interviews. The identification of the neighborhoods was done on the basis of the concentration of Bengali immigrant women, the rate of late or no prenatal care and the rate of Medicaid use in the neighborhoods. Attempt was made to interview women from the Muslim as well as Hindu community, and to get a representative sample of women belonging to different income groups.

The initial research participants were contacted through non-governmental organizations working for immigrant South Asian women such as Andolon, a group that supports the interests of domestic workers. The majority of research participants were, however, recruited through informal networks and social gatherings in New York City. Additional research participants were contacted through the initial participants using a snowball-sampling procedure (Bradshaw and Stratford, 2005). It was not very easy to
find women for interviewing in the initial phase. Gaining access to participants was attempted through South Asian organizations and activists with limited results because of the issue of privacy and confidentiality of their clients. The informal contacts formed a more reliable source to establish contacts with prospective participants. After two months of interviewing, I initiated a more active process of finding informants. I contacted local stores in ethnic neighborhoods where South Asian women visit frequently, went to the neighborhood parks and schools where women take their kids and walked around and spent time in the neighborhoods. The Bangladesh Hindu Mandir and the Ramakrishna-Vivekananda Center of New York formed primary sites for recruiting Hindu women from Bangladesh and Indian Bengali women respectively. Spending time in community spaces and neighborhood sites where Bengali immigrant women visit regularly was a very good way to find women for interviews.

The number of women who participated in this research is 40. Out of this total number, 23 respondents were Muslim women from Bangladesh, 11 respondents were Hindu women from Bangladesh and 6 were Indian Bengali women. All Indian Bengali women were Hindus (Table.3.4). The sample was designed to represent the Bengali immigrant women group in New York City. The sample fairly represents Muslim as well as Hindu women from Bangladesh based on an educated guess of their population size in the city. No data is available about the number or percentages of Muslim and Hindu immigrants from Bangladesh residing in New York City. Field observations, discussions with members of Bangladeshi community and general literature on trends of immigration from Bangladesh indicated the existence of a significant percentage of Hindu immigrants from Bangladesh. The number of Muslim and Hindu women from Bangladesh, therefore,
seems representative of the general composition of the Bangladeshi immigrant women group in New York City. A total of 6 women were interviewed from the Indian Bengali community. A relatively smaller number of women were interviewed from the Indian Bengali immigrant women group in New York City because of their smaller size and since they belong mostly to middle and higher income groups. The percentage of low and non-use of prenatal care is also much lower among Indian women compared to women from Bangladesh. Since the interviews were in-depth a sample of 40 was a good size to be able to conduct the interviews and analyze and understand the data. It is also large enough to permit basic comparisons between groups of Bengali women, for example, Hindu and Muslim women.

One of the criteria adopted in sampling was to adequately represent women from low income, middle income and high-income neighborhoods. This criterion was met to some extent. However, because of the constraints of finding women for interviews in some of the neighborhoods, the number of women interviewed from each neighborhood is not the same. Also, the Bengali population is not equally represented in these income groups, so differences in the sample partly reflect differences in the underlying population. Despite this, attempt was made to have at least some representation of women from the different income groups. By and large the majority of women in the sample are low-income and a smaller percentage is middle or high-income.

Interviews were conducted with women who were currently living in either Queens or Brooklyn (Table 3.4). In most cases these women had spent their pregnancy in either of these boroughs. It was difficult to recruit Indian Bengali women for interviews from just Queens and Brooklyn since a large percentage of Indian Bengali community
live in more affluent neighborhoods in Long Island or Staten Island. I therefore interviewed two Indian Bengali women currently living in Long Island. However, both these women used to live in Queens during initial years after migration and had spent their pregnancies in Queens.

Use of qualitative methods in this research has helped to gain in-depth understanding of pregnancy care use by an important group of South Asian immigrant women in New York City. Like any qualitative research, finding research participants, setting up time for interviews, working with participants’ time schedules and convenience, agreeing and later refusing to participate were major challenges in timely completion of the interviews. Overall however, going into the field, placing myself amongst Bengali women who sought or are seeking pregnancy care, walking around and observing the neighborhoods where women lived helped me gain a better and thorough understanding of the locales and environments where Bengali immigrant women use and experience pregnancy care in New York City. The interview process itself was very satisfying especially since women felt empowered in relating their experiences and strongly felt that it was important to hear what they had to say. Most women felt that it was an important topic to investigate and more research needs to be done on immigrant women’s experience of accessing and using health care.

Conclusion:

In this chapter I have described the data and methods used in this study. A mixed methodological approach has been adopted in this research and attempt has been made to effectively combine quantitative techniques and qualitative methods to understand pregnancy care experiences of South Asian immigrant women in New York City. Quantitative techniques such as descriptive statistics, GIS mapping and logistic
regression models were employed to explore, analyze and make sense of the spatial
distribution and variation in the use of prenatal care by the three major groups of South
Asian immigrant women in New York City. The results and findings from the
quantitative analysis provided the background and foundation for a detailed qualitative
study consisting of in-depth interviews with Bengali immigrant women in New York
City. The main goal of the in-depth study was to get nuanced accounts of pregnancy care
experiences of one particular group of South Asian immigrant women in New York City.
Bengali immigrant women do not represent all South Asian immigrant women, but as one
of the major South Asian groups and a group exhibiting low use of formal prenatal care,
this population is an important one for detailed investigation. In-depth interviews helped
to gain thorough understanding of pregnancy care needs, expectations and experiences of
a distinct and varied group of immigrant women in New York City.
Figures and Tables:

Fig. 3.1: New York City zip code areas
Table 3.1: Percent increase of South Asian population in New York City

<table>
<thead>
<tr>
<th>Nativity/Countries Of origin</th>
<th>1990</th>
<th>2000</th>
<th>Percent change</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>94,590</td>
<td>170,899</td>
<td>80.7</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>4,955</td>
<td>19,148</td>
<td>286.4</td>
</tr>
<tr>
<td>Pakistan</td>
<td>13,501</td>
<td>24,099</td>
<td>78.5</td>
</tr>
</tbody>
</table>

Source: US Census Bureau
Table 3.2: Description of variables used in the models

<table>
<thead>
<tr>
<th>Variables</th>
<th>Definition (value=1)</th>
<th>Direction of expected relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>&lt;20 years</td>
<td>positive relation-if less than 20 years more likely to receive late or no prenatal care</td>
</tr>
<tr>
<td>Education</td>
<td>&lt;12 years of education</td>
<td>positive relation - if less than 12 yrs of education more likely to receive late or no prenatal care</td>
</tr>
<tr>
<td>Employment</td>
<td>If not employed during pregnancy</td>
<td>negative relation - if employed during pregnancy more likely to receive late or no prenatal care</td>
</tr>
<tr>
<td>Medicaid</td>
<td>If on Medicaid</td>
<td>positive relation - if on Medicaid, more likely to receive late or no prenatal care</td>
</tr>
<tr>
<td>Selfpay</td>
<td>If paid for prenatal care out-of-pocket</td>
<td>positive relation - if in self-pay group, more likely to receive late or no prenatal care</td>
</tr>
<tr>
<td>Marital status</td>
<td>If unmarried</td>
<td>positive relation - if unmarried, more likely to receive late or no prenatal care</td>
</tr>
<tr>
<td>Parity*</td>
<td>If more than 3 children</td>
<td>positive relation - if high parity, more likely to receive late or no prenatal care</td>
</tr>
</tbody>
</table>

* In this study having more than 3 children was defined as high parity
Table 3.3: Sample questions asked in in-depth interviews

<table>
<thead>
<tr>
<th>Topics that guided the interviews</th>
<th>Sample questions asked to discuss the topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of formal prenatal care</td>
<td>Did you visit a doctor during pregnancy? If yes, what type of facility did you visit?</td>
</tr>
<tr>
<td>Use of informal prenatal care</td>
<td>Did you receive any advice/care from family members and relatives? If yes, where did they live? How did you communicate with them?</td>
</tr>
<tr>
<td>The place where the women lived during pregnancy</td>
<td>How long did it take you to reach the prenatal care clinic? What prenatal care resources such as community centers, library did you use in your neighborhood?</td>
</tr>
<tr>
<td>Time-space constraints</td>
<td>What work responsibilities did you have at home such as cooking, cleaning, laundry?</td>
</tr>
<tr>
<td>Experience as immigrant women</td>
<td>Did you experience any barriers in accessing prenatal care such as making appointments, communicating with the clinic staff and doctors? How did your experience of prenatal care differ from what it could have been in your home country?</td>
</tr>
<tr>
<td>Socioeconomic context</td>
<td>How did you cover the cost of prenatal care?</td>
</tr>
<tr>
<td>Culturally prescribed gender roles and practices</td>
<td>Were you free to travel alone during pregnancy? Was there any work at home that was solely your responsibility? If yes, how did you manage those works during pregnancy?</td>
</tr>
</tbody>
</table>
Table 3.4: Number of women interviewed in different neighborhoods in New York City

<table>
<thead>
<tr>
<th>Borough</th>
<th>Neighborhoods</th>
<th>Number of women</th>
<th>Bangladeshi Muslim women</th>
<th>Bangladeshi Hindu women</th>
<th>Indian Bengali women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queens</td>
<td>Astoria</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queens</td>
<td>Woodside</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Queens</td>
<td>Jamaica</td>
<td>8</td>
<td>7</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Queens</td>
<td>Corona</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Queens</td>
<td>Elmhurst</td>
<td>2</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Queens</td>
<td>Long Island City</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queens</td>
<td>flushing</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Queens</td>
<td>Sunnyside</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Brooklyn</td>
<td>Borough Park</td>
<td>8</td>
<td>7</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Brooklyn</td>
<td>Sunset Park</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Queens</td>
<td>Queens Village</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Queens</td>
<td>Floral Park</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Brooklyn</td>
<td>Richmond Hills</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Brooklyn</td>
<td>Williamsburg</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Long Island</td>
<td>Westbury, Long Island</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Long Island</td>
<td>Woodbury, Long Island</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>40</td>
<td>23</td>
<td>11</td>
<td>6</td>
</tr>
</tbody>
</table>
Chapter 4
Visualizing Variation: Quantitative Analysis
of South Asian Immigrant Women’s Use of Formal Prenatal Care

This chapter presents a quantitative analysis of prenatal care use by South Asian immigrant women in New York City and the variation in use by class, insurance coverage and geographic location. The chapter is divided into three sections, each section focusing on different aspects of prenatal care use. The first section includes descriptive analysis of formal prenatal care use and source/s of finance to cover the prenatal care expenses for South Asian immigrant women in New York City. Also included is a description of the sociodemographic characteristics of the women. The second section includes GIS maps created to examine the residential distribution of South Asian women in New York City and detailed analysis of spatial variation in use of prenatal care for the women based on visualization. The third section includes analysis of the results of logistic regression models estimated to explore the effects of traditional social, economic and demographic maternal risk factors on prenatal care use for South Asian immigrant women in New York City. The models were estimated for all South Asian women as well as separately for women from India, Bangladesh and Pakistan.

The data for this study come from the New York City Department of Health (NYCDOH) and were extracted from records of all women who gave birth in New York City for the year 1999. The data provides detailed information about these women including their use of prenatal care, insurance coverage and certain sociodemographic attributes. Records were extracted for all South Asian women who gave birth in New
York City during the year 1999 and then the data was further filtered into separate sets for women from India, Bangladesh and Pakistan.

**Use of Prenatal Care and Insurance Coverage:**

South Asian immigrant women represent a significant and growing fraction of all women giving birth in New York City. In 1999, a total of 4325 immigrant South Asian women gave birth in New York City (Table 4.1). The trend is visible in more recent years as well. Each year there is a 2 to 3% increase in the number of immigrant South Asian women giving birth in New York City. For instance, the total number of women from India, Bangladesh and Pakistan who gave birth in New York City increased from 4673 in 2001 to 4813 in 2002. According to recent estimates, this number has increased to 4850 in 2006 (Summary of Vital Statistics, 2002, 2003, 2006). At the time of initiation of this study I had detailed individual level data for the year 1999, so that year is the focus of this study.

In 1999, South Asian women who gave birth in New York City came from the three major source countries of South Asian immigrants in the US, namely, India, Pakistan and Bangladesh. Women from India contributed to the larger percentage of births, followed closely by Bangladesh and India (Table 4.1).

**Use of Prenatal Care**

The percent of South Asian women who received at least some prenatal care is very high, almost 90 percent. However, more than a quarter of South Asian women started prenatal care late and one-tenth of the women did not use any formal prenatal care (Table 4.2). The percent of women who started prenatal care late is very similar among women from India, Bangladesh and Pakistan but women from Bangladesh have a slightly...
higher percentage. The number of women with no prenatal care is exceptionally high among Pakistani women (23%) compared to Bangladeshi (6.4%) and Indian (4.9%) women. These data suggest that the problem of poor access to and use of prenatal care is especially serious for Pakistani and Bangladeshi women.

Source of Finance

South Asian women in New York City used different sources of finance to cover the cost of birth-related health care (Table.4.3). A majority of the women used Medicaid, which provides public funding of health care services for low-income populations. A smaller percentage of women paid for care out of pocket. These women are the most vulnerable being unable to buy insurance or to avail of Medicaid. Only one fifth of the women had 3rd party health insurance and very few were covered by health maintenance organizations (HMO). The source of finance used by South Asian women differed among the three groups. Bangladeshi women were the largest users of Medicaid followed closely by Pakistani women. More than 70% of women from Bangladesh and Pakistan were on Medicaid. The use of Medicaid was lower among Indian women who had higher percentages of HMO and 3rd party insurance. Selfpay was approximately similar among the three groups, with a slightly higher percentage for Pakistani women.

Selected Sociodemographic Characteristics:

Attributes such as age, education, employment, marital status and parity are known to have significant influence on women’s use of prenatal care. (Brown, 1988). The following descriptions provide a glimpse of the sociodemographic background of South Asian immigrant women in this study.
Age

The majority of South Asian immigrant women who delivered during the year 1999 were in the age group 21-34 years (Table.4.4). The percentages were approximately similar for the three groups of women with a slightly higher percentage for Indian women. A very small percentage of the women were less than 20 years. This percentage was higher among Bangladeshi women than among Indian and Pakistani women, but still small in comparison to the percentage of teen women in the whole city.

Education

A large percentage of South Asian women in this study, approximately 20 percent, had less than 12 years of education (Table.4.4). However, the percentage of women with 12 years of education and more than 12 years of education was higher. About two fifth of the women had more than 12 years of education. The number of years of education differed notably among the three groups of women. Sixty percent of the Indian women had more than 12 years of education and very few had less than 12 years of education. Less than 30% of Bangladeshi and Pakistani women had education beyond high school, the percentage being lowest for Bangladeshi women.

Employment

A majority of South Asian women in this study were homemakers (Table.4.4). Less than one fifth of the women listed their occupation as some form of business, industry or other profession. Interestingly a very small percent were unemployed. Although these data suggest that a minority of South Asian women work outside the home, the data may be flawed. Women who reported themselves as homemakers in the birth certificate application, may be employed in part time jobs or may be looking for
jobs and cannot be designated as unemployed. The percent of homemakers was highest among Pakistani women followed closely by Bangladeshi women. The percent of homemakers was lowest among Indian women who had a relatively higher percentage of women in business, industry or other professions. Compared to Indian and Pakistani women a higher percent of Bangladeshi women were unemployed.

Marital Status

The majority of South Asian immigrant women giving birth in New York City were married (Table.4.4). However, 15.1% of the women were not married. Pakistani women were most likely to be married followed by Indian and Bangladeshi women. Bangladeshi women had the highest percentage of unmarried women among the three groups.

Parity

Parity refers to the number of children women have. In this study parity includes the most recent live birth. Overall, parity was low among South Asian immigrant women who gave birth in New York City in 1999. However, a little less than one fifth of the women in all the three groups had 3 to 4 children. A small percentage of women had 5–8 children.

The percentages differed somewhat among the three groups. Having 3-4 children was more common among Bangladeshi and Pakistani women. Pakistani women were most likely to have a large number of children, 5 or more. The percentage, however, was small (Table.4.4). More children at home normally entail more caring responsibilities for the mother and have significant implications for use of essential health care services.
Visualizing Spatial Patterns of Prenatal Care Use:

A geographical information system (GIS) was used to map spatial variation in the distribution of South Asian immigrant women who gave birth in New York City during the year 1999 and visualize variation in their use of prenatal care and use of Medicaid. GIS maps were created for all South Asian women and separately for women from India, Bangladesh and Pakistan to examine differences in spatial variation in use of prenatal care and Medicaid coverage among the three groups of immigrant women. Based on detailed and comprehensive examination of the maps a description of spatial patterns of their distribution, use of prenatal care and Medicaid is laid out in the following subsection.

South Asian immigrant women are spatially concentrated in several areas in New York City. The residential distribution of women who gave birth in 1999 shows marked spatial concentration in specific neighborhoods (Fig.4.1). While most of the zipcodes have some South Asian women, specific neighborhoods in Queens and Brooklyn have very dense concentrations. These boroughs are the largest among the five boroughs in New York City and are characterized by ethnically diverse population. South-central Brooklyn, western, central and south-east Queens and northern Bronx shows visible clusters of immigrant women from South Asia (Fig.4.1). There are moderate concentrations of South Asian women in Bronx and Staten Island as well. Very few South Asian women live in the most densely populated borough of Manhattan -- the economic hub of New York City.

The composition of South Asian immigrant women in the different ethnic clusters varies by country of origin. Indian and Bangladeshi women are mostly concentrated in
Queens, with dense clusters mainly in west, central and south-east Queens (Fig.4.2, Fig.4.3). Bangladeshi women, however, form spatial clusters in Brooklyn and Bronx as well. One particular zipcode in south-central Brooklyn has very high concentration of Bangladeshi women. There is a modest concentration of Bangladeshi women in central and south-east Bronx. There are fewer clusters of Pakistani women in Queens (Fig.4.4). Pakistani women are mostly concentrated in Brooklyn forming dense concentration in central and south Brooklyn. There are modest concentrations of Pakistani women in a few zip codes in central and southeast Queens. The percentage of Indian women living in Staten Island, a relatively high-income borough, is much higher compared to those of Bangladeshi and Pakistani women. Overall, Bangladeshi women seem to be most spatially clustered relative to Pakistani and Indian women. Five zipcodes have very dense concentration of Bangladeshi women compared to two zipcodes each in case of Pakistani and Indian women.

Use of late or non-use of prenatal care shows noticeable variation among South Asian immigrant women living in different zipcodes of the city. Fifty to as high as 83% of women residing in south-central Brooklyn and one zipcode in north-west Queens initiated prenatal care late or did not use prenatal care. Except for a few zipcodes in south-east Queens, in most of the zipcodes in Queens and Brooklyn with moderate concentration of South Asian women, the percentage of women using late or no prenatal care ranged from 26-50% (Fig.4.5). In south-east Queens and in Bronx this percentage was much lower.

When mapped separately, Indian, Bangladeshi and Indian women are seen to contribute differently to the overall spatial pattern of prenatal care use in the city. The
highest percentage of late or no prenatal care use in case of Indian women is much less (50-54%) compared to all South Asian women. These women are mostly concentrated in west and south-east Queens (Fig. 4.6). The rates of late or no prenatal care use for Indian women are low in other parts of Queens and Staten Island, and overall Indian women are less likely than the other two groups to receive late or no prenatal care.

Bangladeshi immigrant women who used late or no prenatal care shows thick concentrations in relatively few zip codes (Fig. 4.7). The highest concentrations, ranging from 50-54%, are found in west Queens and in central Brooklyn. The percentage is lower in east Brooklyn, and central Bronx. The lowest percentages occur in east-central Queens.

Among the three groups, Pakistani women have the highest percentages of women using late or no prenatal care, and in several zip codes over three-fourths of Pakistani women initiated prenatal care late or did not receive any prenatal care (Fig. 4.8). In the Coney Island-Sheepshead Bay area of Brooklyn, 88% of Pakistani women had late or no prenatal care and in Borough Park the percentage is 79%. The percentage is lower in other neighborhoods, but still they are substantially higher than the corresponding percentages for Bangladeshi and Indian women.

In summary, the percentage of South Asian immigrant women with late or no prenatal care varies significantly across New York City and the patterns differ among the three major groups of women. Specific neighborhoods in the city are visibly disadvantaged in terms of access to prenatal care. Poor access to prenatal care is a foremost concern for immigrant women from Pakistan and Bangladesh living in south-central Brooklyn. The reasons for this unusually high concentration of women receiving
late or no prenatal care are unclear. They may include, lack of knowledge about resources and facilities, hesitation, unwillingness and fear in visiting a hospital or clinic because of language barriers and cultural differences, time space constraints in everyday life, some of the factors known to create barriers in immigrant women’s efforts to use health care services (Bottorf et al., 2001; Bowler, 1993). Lack of prenatal care facilities is also of prime concern in this area. In a recent study McLafferty and Grady (2005) found poor geographic access to prenatal care clinics provided by public and voluntary agencies for Pakistani and Bangladeshi immigrant women in Brooklyn, New York. The density of clinics in and near the residential location of these women was found to be low relative to other immigrant and US born women in the area, inspite of their high needs for adequate prenatal care (McLafferty & Grady, 2005). Low use of prenatal care by Bangladeshi and Pakistani women in specific neighborhoods in New York City possibly results from a combination of these constraints. The qualitative part of this research aims to explore and understand these reasons in depth.

Use of Medicaid was high among South Asian immigrant women who gave birth in New York City in 1999 and shows distinct spatial variation. Medicaid is a public assistance program for low-income people, so high Medicaid coverage is an indicator that a high percentage of South Asian women have low incomes. The percentage of women on Medicaid was high in several zip codes in west, central and southeast Queens, central and south central Brooklyn and in central Bronx (Fig.4.9). Interestingly, all the neighborhoods in Brooklyn with high use of Medicaid are also areas with high percentage of women receiving late or no prenatal care. The same is, however, not true in
Queens where many of the neighborhoods with high use of Medicaid have lower percentages of women using late or no prenatal care. This pattern is also seen in Bronx.

The percentage of women using Medicaid is seen to differ considerably among the three groups of women. The percent of women on Medicaid is noticeably much less amongst Indian women compared to women from Bangladesh and Pakistan. Higher percentages of Indian women on Medicaid are concentrated mostly in west Queens and in several zip codes in South east Queens (Fig.4.10). Use of Medicaid is most prevalent among Bangladeshi women with 70 to 90% of the women on Medicaid. High rates of Medicaid coverage are seen in virtually all the spatial clusters of Bangladeshi women, in Queens, Brooklyn and Bronx (Fig.4.11). Use of Medicaid is also high among Pakistani women, ranging from 54% to as high as 88% in few areas. The highest concentration is seen in and around south central Brooklyn (Fig.4.12).

**Exploring Variables Influencing South Asian Women’s Use of Prenatal Care:**

To explore the effects of traditional economic, social and demographic maternal risk factors on prenatal care use, a series of logistic regression models was estimated for South Asian women from India, Bangladesh and Pakistan who delivered in New York City in the year 1999. Models were created for all South Asian women and then separately for women from each country of origin. The dependent variable is no or late use of prenatal care. The independent variables are: age, education, employment status, insurance coverage, marital status and parity.

The model for all South Asian women (Table.4.5) indicates that the selected independent variables explain some of the variation (Nagelkarke $R^2 = .149$) in the use of prenatal care. The model is statistically significant based on a Chi Square test, and it
correctly predicts 63.4% of late or no prenatal care use for South Asian women. Thus the model represents a good fit to the data, especially in relation to the large sample size.

Education, employment, Medicaid and self-pay emerged as significant variables (< .05 significance level) affecting South Asian women’s use of prenatal care, as is expected from previous studies on maternal risk factors affecting use of prenatal care. The results attest to importance of these factors indicated in numerous studies on barriers to and predictors of low prenatal care use among low-income and minority women (Brown, 1988; Lia-Hoagberg et al., 1990; McDonald et al., 1988; York, 1996). South Asian women who are less educated, are employed, use Medicaid or belong to the self-pay category are more likely to receive late or no prenatal care.

Education is positively related with South Asian women’s use of prenatal care indicating that women with less than 12 yrs of education are more likely (exp(B) = 2.2) to receive late or no prenatal care. This corroborates existing research findings on affect of low education levels on use of formal prenatal care.

Employment is negatively related with South Asian women’s nonuse of prenatal care indicating that women who are employed during pregnancy are more likely to receive late or no prenatal care. This indicates that being employed during pregnancy inhibits South Asian women’s use of early and regular use of prenatal care. This contradicts evidence of better health and greater use of preventative measures among employed women in researches on the ‘healthy worker effect’ (Dahl, 1993; Romito, 1989; cited in Lindsay, 2004, p.37). The difference can be explained to some extent by the type of employment. The experience of prenatal care is expected to differ among those who are employed in full-time, well-paid jobs and those who are employed to low-
paying part-time jobs. Unskilled workers, trainees, students and housewives, for instance, were identified to be at risk of receiving inadequate prenatal care in a study analyzing perinatal database in the German state of Baden-Wuerttemberg (Simoes, Kunz, Munnich, & Schmahl 2006). The type of job women hold has been found to be critical in influencing women’s use of prenatal care and family planning services among Filipino women (Estrin, 1999; Miles & Brewster, 1998). Women employed in low-paying jobs, labor-intensive jobs with little say in delineating time, hours and pace of work have been found to be much less likely than women employed in white-collar jobs to use early and regular prenatal care (Miles & Brewster, 1998). Many South Asian women work in low-paid part time jobs to supplement family income. They also bear the major responsibility of household work and childcare. The resulting time space constraints due to their significant responsibilities at home as well as in the work place is likely to prevent them from using early and regular prenatal care.

Medicaid and self-pay emerged as very significant variables affecting South Asian women’s use of prenatal care. Both are positively related to late or non-use of prenatal care. Women who received Medicaid were more likely to receive late or no prenatal care. Women on Medicaid were twice (exp (B) = 2.4) as likely to receive late or no prenatal care as compared to women with other kinds of health insurance. This supports findings from previous studies that receipt of Medicaid may not always ensure early use of prenatal care and other constraints resulting from poverty such as time space constraints may be more important in determining early use of prenatal care (Aved, 1993; McDonald, 1988). Intuitively, removal of financial obstacles is of prime importance in ensuring access to prenatal care among low-income women. This has led to expansion of
Medicaid coverage among pregnant women to cover their prenatal care expenses and not just delivery expenses during the 1990’s. However, in spite of expanding coverage and drawing a large section of previously ineligible women in Medicaid enrollment, several factors still impede women’s use of early and regular prenatal care. Some women may receive Medicaid coverage late in their pregnancy and then start prenatal care. So they gain Medicaid coverage late which then results in late prenatal care initiation.

South Asian women who had no insurance coverage and belonged to the self-pay category were most likely to receive late or no prenatal care. These women were thrice (exp (B) = 3.5) as likely to receive late or no prenatal care than women who have insurance coverage indicating that women who must pay for prenatal care out of pocket are most vulnerable among women across all income levels. Undocumented immigrants may be a significant portion of women in this category. Even though Medicaid has been expanded to cover any pregnant women with eligible income levels irrespective of their migrant status, in 1999 many women still hesitated to avail of such public funding entailing application and paperwork.

Age and marital status did not emerge as significant factors affecting South Asian women’s use of prenatal care. This may be because of very low percentage of women in the teen and adolescent group and also in the unmarried group. Parity, however, was statistically significant (< .05 significance level) and negatively related to South Asian women’s use of prenatal care. Women with more than 3 children were more likely to get early prenatal care than were women with fewer children. This contradicts findings of previous studies wherein high parity was seen to result in time space constraints in routines of everyday life affecting women’s use of prenatal care (Brown, 1988; Lia-
Hoagberg et al., 1990). In the case of South Asian women, having more children may facilitate early and regular prenatal care use due to women’s familiarity with the prenatal care system from earlier pregnancies, and their belonging to older age group and high risk category.

In the models estimated separately for the three major groups of South Asian women, the results are somewhat similar, but there are a few marked differences. The model for Bangladeshi women (Table 4.6) has the lowest predictive power (correct prediction = 60%). The selected variables explain only a modest fraction of the variation in the use of prenatal care. Education, employment, Medicaid and self-pay emerged as significant variables in the model (< .05 significance level) whereas age, marital status and parity were not statistically significant. Education, Medicaid and self-pay were positively related to the use of late or no prenatal care by Bangladeshi women, whereas employment was negatively related. Bangladeshi women with less than 12 yrs of education, who were employed during pregnancy and who used Medicaid or had to pay on their own for prenatal care, were more likely to receive late or no prenatal care. The odds ratio for employment is quite large for Bangladeshi women, the highest among the three groups of women. This indicates that Bangladeshi women who work outside home are less likely to get early and adequate prenatal care. As mentioned in the case of South Asian women in general, the reason could be that these women are employed in part time, low paying jobs. The nature of such jobs characterized by inconvenient hours, meager hourly wage, limited say in the type and amount of work is likely to deter Bangladeshi immigrant women from using early and regular prenatal care. Again, since women working in part-time jobs also shoulder the major responsibility of domestic
work, employment creates additional burden of work responsibilities not accompanied by significant positive upliftment of self and status that can give greater control over one’s own life and well-being. Overburdened with work at home and outside Bangladeshi women may have to start prenatal care late or miss appointments.

In relative terms, the model for Indian women has greater predictive power than that for Bangladeshi women. This model correctly predicts 66.5% of variation in the use of prenatal care. Employment, Medicaid and self-pay emerged as significant variables (< .05 significance level) in the model. A significant difference with the other models is that education did not emerge as an important variable affecting the use of prenatal care. Less educated Indian women were not at risk of receiving late or no prenatal care and used early and regular care at the same rate as women with more than 12 years of education. A probable explanation may be that women from India are more familiar with formal health care services than women from Bangladesh and Pakistan and are more aware of the need to use early prenatal care. Rigorous public campaigns in India emphasizing the benefits of family planning and getting medical advice during pregnancy and generally more positive attitude towards western bio-medical care could be a reasons for education not emerging as a significant variable in case of Indian women. However, since such campaigns are in place in other South Asian countries as well, further research is needed to understand the reason likely to explain this difference. Indian women who had to pay on their own for prenatal care were slightly less likely to use late or no prenatal care compared to Bangladeshi and Pakistani women. One reason could be that Indian women had higher incomes and were able to afford for prenatal care although the reason for not buying insurance remains explained. It may be that the self-pay group consists of newly
arrived women who became pregnant during the first few months but did not have insurance by then.

The model for Pakistani women (Table 4.6) has the highest predictive power among the three groups of women (correct prediction = 67.2%). A Nagelkerke R² of .201 indicates that the model predicts a good amount of variation in the use of prenatal care by Pakistani women. Education, employment, Medicaid and self-pay emerged as significant variables (< .05 significance level). Especially, the effect of education and self-pay in Pakistani women’s use of prenatal care is striking. Pakistani women with less than 12 yrs of education were about four times more likely (exp (B) = 3.9) to receive late or no prenatal care compared to women with more education. Also women who had to pay on their own for prenatal care were five times more likely than women with insurance or Medicaid (exp (B) = 4.8) to receive late or no prenatal care. This rate is highest among the three groups of South Asian women indicating that Pakistani women are at a very high risk of receiving late or no prenatal care if they do not have financial support to cover the cost of prenatal care.

The logistic models show that South Asian immigrant women’s use of prenatal care can be explained to some extent based on traditional maternal risk factors. However it cannot be understood solely in the light of these factors. All the models had relatively modest predictive power. The inclusion of few independent variables in the models due to limited availability of data may be a reason for the moderate predictive power of the models. Also the models do not capture within group differences. The results emphasize the need to go beyond traditional maternal risk factors in attempts to understand the constraints and barriers in the use of prenatal care use by South Asian women.
Conclusion:

The aim of this chapter was to present a quantitative analysis of aggregate data on South Asian immigrant women’s use of prenatal care. Descriptive statistics, GIS mapping and logistic regression models were used to examine spatial variation of prenatal care use among South Asian women and explore variables that can explain some of the observed variation. Among South Asian immigrant women who gave birth in New York City in 1999, a majority of women used some prenatal care, but more than 30% initiated prenatal care only in the 2nd or 3rd trimester. A higher percentage of women from India started prenatal care early while an exceptionally high percentage of Pakistani women did not use any prenatal care.

Visual interpretations of the maps show that a majority of South Asian immigrant women in New York City are concentrated in visible spatial clusters, mostly in Queens and Brooklyn. The residential distribution varied according to country of origin. Indian and Bangladeshi women are concentrated mostly in Queens whereas Pakistani women form dense spatial clusters in south and central Brooklyn. The pattern of late or no prenatal care use differed by place of birth and also by place of residence. About three fourths of Pakistani women used late or no prenatal care and the highest percentages were concentrated in Brooklyn. The rate of late prenatal care use was also high among Bangladeshi women. One distinctive characteristic of Bangladeshi women who received late prenatal care was their location in multiple and dispersed spatial clusters.

To cover the cost of prenatal care South Asian immigrant women relied heavily on Medicaid. The use of Medicaid was very high amongst Bangladeshi and Pakistani women and relatively less among Indian women. Many areas with high rates of Medicaid
exhibited low use of prenatal care, reinforcing findings from previous studies that use of Medicaid may not always ensure early and adequate use of prenatal care. Medicaid and self pay, however, emerged as the two most significant variables in the logistic regression models estimated to predict South Asian immigrant women’s use of late or no prenatal care. Women who paid for prenatal care out of pocket and also women on Medicaid were least likely to receive early and regular prenatal care, across all the three groups. The significance of these variables differed somewhat among the three groups but overall emerged as important risk variables.

Thus class is the single most important factor determining South Asian immigrant women’s early use of prenatal care. In tune with existing knowledge about barriers to use of prenatal care, women with low incomes and less education were found to be more likely to start prenatal care late or not receive prenatal care. Mixed findings on the influence of education for Indian women underline the importance of informal education, general awareness about benefits of preventive medical care during pregnancy from mass media and public health campaigns in home country for certain section of the immigrant women groups. However, since such campaigns are in place in other South Asian countries as well, further research is needed to understand the reason likely to explain this difference. A significant finding was the emergence of employment as a barrier to South Asian immigrant women’s, especially Bangladeshi women’s early use of prenatal care. The results indicate Bangladeshi immigrant women’s employment in low-paying, part-time jobs makes it difficult to balance work and home responsibilities creating significant time space constraints in everyday life. Without giving women the benefits of self-autonomy, control over life and well-being and ability to take firm decisions related to

113
health and health care use, employment in part-time jobs does not contribute to enabling
Bangladeshi immigrant women to seek early prenatal care.

To sum up, aggregate quantitative analysis of prenatal care use for South Asian
immigrant women in New York City reveals diversity in use amongst women from India,
Pakistan and Bangladesh. The logistic regression results indicate that traditional risk
factors such as poverty create significant barriers to early prenatal care for many South
Asian women and these barriers differ among the three groups of women. The overall
spatial and geographical pattern opens up the possibilities for a more in-depth qualitative
study to understand the geographies of pregnancy care use by South Asian immigrant
women in New York City.
Figures and Tables:

Table 4.1: Number of live births by foreign-born South Asian women in New York City, 1999

<table>
<thead>
<tr>
<th>Mother’s country of origin</th>
<th>No. of births</th>
<th>% of births</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>1622</td>
<td>37.5</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>1391</td>
<td>32.2</td>
</tr>
<tr>
<td>Pakistan</td>
<td>1312</td>
<td>30.3</td>
</tr>
<tr>
<td>Total</td>
<td>4325</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Births Master File, NYCDOH, 1999

Table 4.2: Use of prenatal care by foreign-born South Asian women in New York City, 1999

<table>
<thead>
<tr>
<th>Mother’s place of birth</th>
<th>Early prenatal care use %</th>
<th>Late prenatal care use %</th>
<th>No prenatal care use %</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Asia</td>
<td>44.1</td>
<td>32.2</td>
<td>10.9</td>
</tr>
<tr>
<td>India</td>
<td>53.0</td>
<td>30.3</td>
<td>4.9</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>44.8</td>
<td>35.2</td>
<td>6.4</td>
</tr>
<tr>
<td>Pakistan</td>
<td>32.4</td>
<td>31.3</td>
<td>23.0</td>
</tr>
</tbody>
</table>

Source: Births Master File, NYCDOH, 1999
Table 4.3: Sources of birth-related health care expenses for foreign-born South Asian women in New York City, 1999

<table>
<thead>
<tr>
<th>Sources of finance</th>
<th>% of South Asian women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>62.2%</td>
</tr>
<tr>
<td>HMO</td>
<td>9.7%</td>
</tr>
<tr>
<td>3rd Party</td>
<td>21.9%</td>
</tr>
<tr>
<td>Self</td>
<td>5.0%</td>
</tr>
<tr>
<td>Unknown</td>
<td>1.2%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Births Master File, NYCDOH, 1999
Table 4.4: Selected sociodemographic characteristics of foreign-born South Asian women who gave birth in New York City, 1999

<table>
<thead>
<tr>
<th></th>
<th>South Asian</th>
<th>Indian</th>
<th>Bangladeshi</th>
<th>Pakistani</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-20 yrs</td>
<td>5.3%</td>
<td>2.8%</td>
<td>8.1%</td>
<td>5.4%</td>
</tr>
<tr>
<td>21-34 yrs</td>
<td>82.3%</td>
<td>84.7%</td>
<td>82.8%</td>
<td>78.9%</td>
</tr>
<tr>
<td>35-46 yrs</td>
<td>12.3%</td>
<td>12.5%</td>
<td>9.1%</td>
<td>15.7%</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;12 yrs</td>
<td>21.5%</td>
<td>9.8%</td>
<td>25.3%</td>
<td>32.0%</td>
</tr>
<tr>
<td>12 yrs</td>
<td>29.8%</td>
<td>23.1%</td>
<td>34.9%</td>
<td>32.5%</td>
</tr>
<tr>
<td>&gt;12 yrs</td>
<td>38.8%</td>
<td>60%</td>
<td>23.8%</td>
<td>28.7%</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homemaker</td>
<td>70.9%</td>
<td>54.7%</td>
<td>75.5%</td>
<td>86.1%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>9.8%</td>
<td>7.7%</td>
<td>16.0%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Business/Industry/</td>
<td>16.8%</td>
<td>34.6%</td>
<td>6.0%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Other occupation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td>2.1%</td>
<td>2.5%</td>
<td>2.2%</td>
<td>1.4%</td>
</tr>
<tr>
<td><strong>Employment during pregnancy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>15.4%</td>
<td>32.5%</td>
<td>5.1%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Not employed</td>
<td>84.5%</td>
<td>67.3%</td>
<td>94.9%</td>
<td>94.6%</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>84.9%</td>
<td>88.0%</td>
<td>77.1%</td>
<td>89.4%</td>
</tr>
<tr>
<td>Not married</td>
<td>15.1%</td>
<td>12.0%</td>
<td>22.9%</td>
<td>10.6%</td>
</tr>
<tr>
<td><strong>Parity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Including most recent birth)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-2 children</td>
<td>78.9%</td>
<td>82.1%</td>
<td>77.7%</td>
<td>76.1%</td>
</tr>
<tr>
<td>3-4 children</td>
<td>17.9%</td>
<td>16.3%</td>
<td>19.0%</td>
<td>18.8%</td>
</tr>
<tr>
<td>5-8 children</td>
<td>3.2%</td>
<td>1.6%</td>
<td>3.3%</td>
<td>5.1%</td>
</tr>
</tbody>
</table>

Source: Births Master File, NYCDOH, 1999
Table 4.5: Logistic regression: variables affecting use of prenatal care among South Asian immigrant women

<table>
<thead>
<tr>
<th></th>
<th>South Asian immigrant women</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
</tr>
<tr>
<td>Mother’s age (&lt;20 yrs of age)</td>
<td>-.055</td>
</tr>
<tr>
<td>Mother’s education (&lt; 12 yrs of edn)</td>
<td>.801</td>
</tr>
<tr>
<td>If employed during pregnancy</td>
<td>-.435</td>
</tr>
<tr>
<td>Medicaid</td>
<td>.881</td>
</tr>
<tr>
<td>Selfpay</td>
<td>1.260</td>
</tr>
<tr>
<td>Marital status</td>
<td>.045</td>
</tr>
<tr>
<td>Parity (3-8 children)</td>
<td>-.164</td>
</tr>
<tr>
<td>Constant</td>
<td>-.809</td>
</tr>
</tbody>
</table>
| Nagelkerke R² | -.149, correct prediction-63.4 %

Table 4.6: Logistic regression: variables affecting use of prenatal care among South Asian immigrant women by country of origin

<table>
<thead>
<tr>
<th></th>
<th>Bangladeshi immigrant women</th>
<th>Indian immigrant women</th>
<th>Pakistani immigrant women</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Sig.</td>
<td>Exp (B)</td>
</tr>
<tr>
<td>Mother’s age (&lt;20 yrs of age)</td>
<td>-.169</td>
<td>.467</td>
<td>.845</td>
</tr>
<tr>
<td>Mother’s education (&lt; 12 yrs of edn)</td>
<td>.536</td>
<td>.000</td>
<td>1.708</td>
</tr>
<tr>
<td>If employed during pregnancy</td>
<td>-.701</td>
<td>.043</td>
<td>.496</td>
</tr>
<tr>
<td>Medicaid</td>
<td>.783</td>
<td>.000</td>
<td>2.187</td>
</tr>
<tr>
<td>Selfpay</td>
<td>1.103</td>
<td>.002</td>
<td>3.014</td>
</tr>
<tr>
<td>Marital status</td>
<td>.101</td>
<td>.557</td>
<td>1.107</td>
</tr>
<tr>
<td>Parity (3-8 children)</td>
<td>-.216</td>
<td>.177</td>
<td>.806</td>
</tr>
<tr>
<td>Constant</td>
<td>-.971</td>
<td>.000</td>
<td>.379</td>
</tr>
<tr>
<td>Nagelkerke R²</td>
<td>-.074, correct prediction-60.0 %</td>
<td>Nagelkerke R²</td>
<td>-.128, correct prediction-66.5 %</td>
</tr>
</tbody>
</table>
Fig. 4.1: Residential distribution of foreign-born South Asian women who gave birth in New York City, 1999.

Fig. 4.2: Residential distribution of foreign-born Indian women who gave birth in New York City, 1999

Indian mothers in New York City, 1999

Number of mothers in each zipcode

Source: New York City Dept. of Health, Births Master File, 1999
Fig. 4.3: Residential distribution of foreign-born Bangladeshi women who gave birth in New York City, 1999

Bangladeshi mothers in New York City, 1999

Number of mothers in each zipcode

- 0
- 1 - 30
- 31 - 82
- 63 - 140

Source: New York City Dept of Health, Births Master File, 1999
Fig. 4.4: Residential distribution of foreign-born Pakistani women who gave birth in New York City, 1999

Source: New York City Dept of Health, Births Master File, 1999
Fig. 4.5: Percentage of foreign-born South Asian women in New York City with late or no prenatal care, 1999

Percentage of South Asian mothers in New York City with late or no prenatal care, 1999

Source: New York City Dept of Health, Births Master File, 1999
Fig. 4.6: Percentage of foreign-born Indian women in New York City with late or no prenatal care, 1999

Source: New York City Dept. of Health, Births Master File, 1999
Fig. 4.7: Percentage of foreign-born Bangladeshi women in New York City with late or no prenatal care, 1999
Fig. 4.8: Percentage of foreign-born Pakistani women in New York City with late or no prenatal care, 1999

Percentage of Pakistani mothers in New York City using late or no prenatal care

Source: New York City Dept. of Health, Births Master File, 1999
Fig. 4.9: Percentage of foreign-born South Asian women in New York City on Medicaid, 1999

Percentage of South Asian mothers in New York City on medicaid, 1999

Source: New York City Dept of Health, Births Master File, 1999
Fig. 4.10: Percentage of foreign-born Indian women in New York City on Medicaid, 1999

Source: New York City Dept of Health, Births Master File, 1999
Fig. 4.11: Percentage of foreign-born Bangladeshi women in New York City on Medicaid, 1999

Source: New York City Dept of Health, Births Master File, 1999
Fig. 4.12: Percentage of foreign-born Pakistani women in New York City on Medicaid, 1999

Source: New York City Dept of Health, Births Master File, 1999
Chapter 5

Use and Experience of Formal Pregnancy Care

in Spaces of Everyday Life

The aim of this chapter is to present the results of qualitative in-depth interviews conducted with Bengali immigrant women in New York City about their experience of accessing and using formal care during pregnancy. The sample of Bengali immigrant women interviewed comprised of Muslim as well as Hindu women from Bangladesh and Hindu Bengali women from India. These women from neighboring countries in South Asia speak the same language and have common historical ties, but live in diverse settings in New York City resulting from differences in socioeconomic status, migration trajectories, religion and culture.

Through depth interviews attempt was made to understand the role of place, culture and gender in shaping Bengali immigrant women’s experiences of formal prenatal care. Women’s productive and reproductive roles in everyday life were explored to gain understanding of their experience of prenatal care in relation to the geographies of their everyday lives. I examined the nuances of Bengali immigrant women’s experiences of prenatal care by reflecting on similarities and differences among the sub-groups in the larger Bengali community.

The qualitative findings presented in the chapter are based on an interpretative approach to data collection and analysis (Cope, 2005; Dunn, 2005). The main aim of conducting in-depth interviews and interpreting the interviews was to extract important themes related to Bengali immigrant women’s use of formal prenatal care services such
as prenatal clinics and physician visits. The findings have been organized according to a set of emergent themes, which include themes related to health insurance coverage and access to and utilization of prenatal clinic and medical services. The chapter consists of two broad sections followed by summary and conclusion. The first section is a description of the socioeconomic background of the women interviewed. The second section consists of themes related to the role of place, culture and gender in shaping Bengali immigrant women’s use and experience of formal prenatal care. It consists of two sub-sections: the first focuses on Bangladeshi women and the second focuses on Indian Bengali women.

**Socioeconomic Background of Research Participants:**

**Household Income**

The majority of the women in the sample belong to low-income group. The median household income of women from Bangladesh is $30,600. Only one Hindu woman and 3 Muslim women from Bangladesh have an annual income over $80,000. The median household income of Bengali women from India on the other hand is $92,500. The median monthly income of women from Bangladesh is $2,550 and that of women from India is $7,708. Thus, the women from India in the sample are much more well-off than those from Bangladesh. Bangladeshi women’s household incomes are close to the poverty line, indicating high levels of economic disadvantage.

It may be noted that the income statistics are based on the current household income of the research participants. In most cases they were not able to provide their income when they were pregnant and when they accessed prenatal care. However, current
income is likely to be slightly higher than income while pregnant thus indicating greater economic disadvantage when women were pregnant.

**Occupation**

A majority of women in my sample are housewives. At the time of interview 53% of women from Bangladesh were housewives and 41% were doing part time low wage jobs mostly in stores, laundry facilities or fast food joints. Two women were working full time, 8 hrs a day in factory laundry facilities. Fifty-five percent of Hindu women were housewives and 52% of Muslim women were housewives. Of the research participants from India, 3 were employed in full time, 2 were doing part time jobs and 1 was a housewife.

The picture was, however, different during the time when the women were pregnant for both Hindu and Muslim women from Bangladesh. Seventy percent (16 women) of Bengali Muslim women were housewives during pregnancy and 26% (6 women) were doing part-time low wage jobs in stores and fast food joints and one woman was doing a full time job in a laundry facility. Eighty-two percent (9 women) of Bengali Hindu women were housewives during pregnancy; only one woman was doing a part time job during her 2nd pregnancy in a store and one woman was doing a full time job in a laundry facility. In many cases women quit their jobs immediately or a few months after conceiving and then started working again when they could make arrangements for childcare or when the kids started going to pre-k or school.

**Husband’s Occupation**

The husbands of women from Bangladesh were mostly employed in low wage jobs in restaurants, stores, delis, and warehouses. Several were cab drivers or had their
own small business of which leasing and manning stalls in the subway stations or on the streets was most common. Only two were in the corporate sector and others worked in middle-income jobs in banks, city agencies, unions, post office and as traffic police. Two were students. Among husbands of Bengali women from India all were employed in the corporate sector, in high paying jobs in government agencies or were professionals.

**Age**

The median age of women from Bangladesh at the time of interview was 31 years and that of women from India was 39 years. The women from Bangladesh ranged in age from 22 to 41 years and majority of the women were above 25 years of age while the majority of women from India were above 30 years of age. The median age at which women became pregnant in the US was 26 years for women from Bangladesh, both for Hindu and Muslim women and 30 years for the women from India.

**Education**

Thirty-eight percent of women from Bangladesh had intermediate or high school education, 38% had finished college before coming to the US and 18% had completed a Master’s degree in Bangladesh. One woman had completed MBBS (Bachelor of Medicine/Bachelor of Surgery) and was doing residency before arriving in the US. Among the Bengali women from India 50% had come to the US with a college level education and 50% had completed a Master’s degree in India.

**Length of Residence**

The women had been living in the US for different periods of time and the median length of residence at the time of interview was 8 yrs for women from Bangladesh and 10 years for Bengali women from India. The vast majority (74%) of women from
Bangladesh immigrated to the US during the last 10 years. In general the husbands arrived earlier and brought their spouses and children later. The median length of residence of husbands of women from Bangladesh at the time of interview was 13 years. Many of the women (38%) had arrived more than 6 years after their husbands, 29% had arrived between 1 and 5 years and only 18% of the women came together with their husbands.

**Number of Years Within which Women Became Pregnant after Immigration**

A majority of women from Bangladesh were relatively recent immigrants when they became pregnant with their first baby in the US. Thirty-eight percent of the women became pregnant within the first year after coming to the US and 68% became pregnant within the first 3 years of stay in the US, so almost all became pregnant shortly after arrival in the US. A similar pattern exists for Bengali women from India: 33% became pregnant within the first year of immigration while 50% became pregnant within the first 3 years.

**Use of Formal Care During Pregnancy:**

**Women from Bangladesh**

The women interviewed received formal medical care from doctors, nurses or midwives during their pregnancy in prenatal care facilities such as in hospitals, clinics or doctor’s office. In this section I discuss their experiences of seeking, receiving and using prenatal care amidst the routines of everyday life. The influence of space, place and time in accessing formal prenatal care is explored in terms of what spatial and temporal constraints women face, how they deal with such constraints and how they manage to use regular formal prenatal care. The section focuses first on Muslim and Hindu women from...
Bangladesh and then Indian Bengali women who used formal prenatal care and gave birth in New York City.

**Accessing formal prenatal care**

In general, the use of formal prenatal care amongst Hindu as well as Muslim women from Bangladesh began early during pregnancy. Thirty-six percent of Bangladeshi Hindu women started prenatal care during the 1st month, 36% during the 2nd month and 18% during the 3rd month, all during the first trimester. Only one woman started going to the hospital at the end of her 5th month since she arrived in the US 5 months pregnant. Of the 23 Muslim women from Bangladesh, almost all started using prenatal care in the first trimester-26% during the 1st month, 70% during the 2nd month and only 4% during the 3rd month. Three Bengali Muslim women however started prenatal care late during subsequent pregnancies, one during the 4th month and two during their 6th month. Once the women started using prenatal care, they mostly made regular prenatal visits and went for all the appointments.

One woman, however, missed a few appointments during the 6th and 7th month as she felt it was not necessary and it was also difficult as she had a 1 year and 5 month old to take care of:

“..I went to most of the appointments..I think I just missed 2-3 appointments during the 6th and 7th month. Actually they give a lot of appointments during the later stage to check if everything is ok..I did not go when I felt things were fine..they used to ask me why I missed my appointment..I used to tell that I was tied up with work..but when I felt there could be some problem or there was an ultrasound scheduled I always went for the appointments..”—Naaz (Muslim-high-income)

Another woman missed an appointment as she went to the emergency room instead of to her regular prenatal care provider. This occurred because of a
miscommunication or language problem, which is an important and largely unresolved issue in health care encounters of immigrant women.

“I missed an appointment since I mistakenly went to the emergency instead of my regular doctor. The doctor had asked me to go to the emergency if I had a problem. I realized this only when I got a letter from the hospital.”—Reba (Hindu)

Though the use of formal care was mostly regular and adequate, many women mentioned that long waiting times in the hospital or clinic and too many tests were reasons why they might consider starting prenatal care much later during future pregnancies. They questioned the need for so many tests and expressed dissatisfaction at being made to wait almost the whole day during regular appointments. This was especially true in public hospitals, but was not uncommon in non-profit hospitals. Some women were discouraged by other recent or long term immigrant women to go to the hospital immediately after conceiving to avoid waiting for long hours and spending the whole day in the hospital. They were advised to get a pregnancy test done to confirm their pregnancy and then wait for a few more months before starting regular prenatal care. The women did mention, however, that they would make regular prenatal care visits later in the pregnancy, but that the long waiting times and frequent medical tests were discouraging factors.

“...the quality of care is good here but when they started doing frequent ultrasounds from the 2nd trimester I wondered if there was a need to do so many ultrasounds. From 7 months they did ultrasounds very frequently.”—Misti (Hindu)

“I heard from many people that they give a lot of appointments. I went to the hospital later (3rd month) to avoid going there frequently. If I have another baby I might start prenatal care only after 5 months (smiles).”—Noini (Hindu)
“..the major problem here is the waiting time..in the public hospitals the waiting time is much longer than in private hospitals..the very thought of hospital reminds me of the long waiting time..since we are Medicaid recipients we have to go to public hospitals..there is no alternative..if I have another baby I won’t go to the hospital at 5 months..I will go around 8 months (smiles).”—Payel (Hindu)

“I get tired waiting in the hospital..I have to wait there for almost 3 hours..first go to the registration, then keep waiting for the nurse..after going inside I give my urine sample and again keep waiting for the doctor..after taking leave from the doctor again I have to wait in the registration area to fix next day’s appointment.”—Rabia (Muslim)

“I received good treatment in the hospital but they are very slow..I used to go in the morning and return in the evening.”—Ayesha (Muslim)

“..the waiting time was very long in the public hospital I went to during my first 2 pregnancies..but during my 3rd pregnancy we had moved to Borough Park and I went to the nearby private hospital and it was much better there..if my appointment was at 10 A.M. I used to go at around 9 A.M and return by 11A.M or 12 P.M. But in the other hospital if I had an appointment at 10 A.M I could not return before 3 or 4 P.M...”—Sakeena (Muslim)

As mentioned before three Bengali Muslim women actually started using prenatal care late during their 2nd pregnancy, for different reasons. Aamira wanted to keep fasting during the month of Ramadan and did not go to the hospital in case the doctor would insists that she break the ‘roja’, the Bengali word for ‘swam’, the fourth pillar of Islam that prescribes fasting for 29/30 days. Fatima on the other hand had a 1 1/2 year-old baby and was not keeping well, so she didn’t have the time and was not physically fit to make the regular trips to the hospital. Sakeena was not keeping well and used to have frequent black outs and since they had moved to a different neighborhood located far from the public hospital she went to during her first pregnancy, traveling to and from the hospital was difficult for her.

“..I went to the same hospital but I went a little late..I became pregnant within 1 year after the previous baby was born..the baby was not keeping
well, I had other children to take care of..I was also very sick with severe nausea and vomiting..so I couldn’t go the hospital early..”—Fatima (Muslim)

“..actually when we go to the hospital after conceiving they do a lot of tests and then we have to go to the hospital many times..I did not feel well during the first few months and going all the way to the hospital was difficult and then the long waiting time..so during my 2nd pregnancy I went to the hospital at around 6 months..”—Sakeena (Muslim)

Choice of prenatal care facility

Public hospitals were very important sites for prenatal care for the women interviewed. Of the 11 Bengali Hindu women only one woman went to a non-profit hospital and 2 went to doctor’s offices. About 43% of Bengali Muslim women went to public hospitals, 30% of the women visited non-profit hospitals and 22% went to doctor’s office. The importance of public hospitals is a result of economic and geographic considerations: public hospitals typically serve low-income patients who cannot afford care at private and non-profit hospitals, and public hospitals are located near the areas where many Bengali women live. Women who visited non-profit, teaching hospitals were living in a neighborhood with non-profit hospitals nearby. Relatives and friends also assured these women that the non-profit hospitals accepted Medicaid patients. Nearness to the facility and acceptance of Medicaid were mentioned as prime criteria for visiting a particular hospital or clinic. Advice from friends and relatives also played an important role in helping women finalize their decisions. Another important reason, which made women feel comfortable about visiting a particular facility, is that it is visited by a lot of other Bengali women.

Elmhurst Hospital (Fig.5.2) located in Elmhurst, Queens was used most frequently by the sample women interviewed: 32.35 % of the women interviewed went to
Elmhurst hospital. About 60% of the sample women living in northwest Queens in Elmhurst, Woodside, Sunnyside and Corona went to Elmhurst hospital for prenatal care. Elmhust is located either within walking distance or within a 10-20 minute subway or bus ride from the above neighborhoods.

“...I used to live in Astoria then and Elmhurst is closeby from there...and I had heard from friends and neighbors that many Bengali women go to Elmhurst hospital...”—Rita (Hindu)

“...One of our aunt who lives in Astoria, she has 2 children who were born here, she advised me to go to Elmhurst hospital...”—Payel (Hindu)

“...during my 2nd pregnancy I went to Elmhurst hospital...it was closeby from our house and also most Bengalis who live around here go to this hospital...”—Mrinmoyi (Hindu)

“...I went to Elmhurst hospital during my 1st pregnancy because it was the closest from our previous apartment and it is a city hospital...there are other hospitals such as Mt Sinai in Queens Boulevard but we didn’t know much about those...”—Indira (Hindu)

“...we went to Elmhusrst hospital because it was closeby...we didn’t have a car then and you know during pregnancy most women want to go to a hospital which is nearby, where there is good communication...since I live in Sunnyside Elmhurst was a good choice for me...I could easily go there by 7 train or by bus...that is why my husband took me there, so that during subsequent visits I can go there alone...”—Alisha (Muslim)

Among other women living in these neighborhoods, three went to Bellevue, North Central Bronx and Woodhull respectively; all public hospitals but requiring longer travel times. Women used these hospitals because of strong recommendations from relatives and friends or husband’s familiarity with the hospital. During later pregnancies after a few months, however, they shifted to nearby hospitals: one went to Elmhurst, one went to Bellevue and one went to Maimonides. Interestingly these women and some Muslim women living in north east Queens avoided going to Elmhurst Hospital because of overcrowding and long waiting times. Those who went there did so because they had no
other choice. The other research participants who lived in the above neighborhoods, but did not visit Elmhurst Hospital, went to doctor’s office located closeby or within manageable distance because of good reputation of the doctor. They either had private insurance or the doctor accepted Medicaid and was affiliated to the hospital of their choice where they wanted to have their delivery done.

“..during my first pregnancy I went to North Central Bronx hospital..my husband used to live in Bronx before, he used to go to this hospital..he said it was a good hospital, so I went there..but when I was 6-7 months pregnant we transferred to Bellevue hospital because this was very far you know, I had to change two trains to get there..”—Roma (Hindu)

“..during my 2nd pregnancy I went to Bellevue hospital all through..it is better than North Central Bronx hospital..my husband’s friends’ advised us to go to Bellevue hospital..and it is nearer..it is easier to go to Manhattan from Queens than to go to the Bronx..I could have gone to Elmhurst, it is close from our apartment but I didn’t go there because I had heard that the waiting time is very long in Elmhurst..”—Roma (Hindu)

“..for my first baby I didn’t have Medicaid, so I went to Elmhurst hospital which is a public hospital. I went there for 4 months then when I got my Medicaid card I transferred to Lenox Hill hospital..it is a private hospital and I had heard from my relatives that it is a good hospital..this hospital is in Manhattan you know, it took 45 mins to get there by subway..I used to go there alone most of the time..I used to go to school you know, I was active, so it was not a problem..”—Aamira (Muslim)

“..during my 1st pregnancy I went to Bellevue hospital..you know we had just arrived from Bangladesh and did not know anything here..our relatives who live here used to go to Bellevue hospital, so they suggested me to go there..that is why I went there you know even though it was far..”—Zaina (Muslim)

“..during my 2nd pregnancy I went to Elmhurst hospital from the beginning..it was not out of choice..for my first delivery the ambulance took us to Elmhurst saying that we don’t have enough time to go to Bellevue..since I had delivered there I continued with my son’s care there and also when I conceived again..but I liked Bellevue hospital more you know..I used to take my appointments in the morning and they saw me always in time..their treatment, facilities and behavior of the doctors and nurse is much better than Elmhurst..it is too busy here (in Elmhurst)..but still I continued in Elmhurst since I had other kids, one of them went to
school and I had to pick him up and since I cannot drive it was difficult to take the younger one all the way to Manhattan by subway and bus.”—Zaina (Muslim)

“I visited a doctor in Queens hospital whom my husband knew from before. I had also seen her a couple of times before and we both liked her, so we decided that even though the hospital is a little far we will go there and we have car so the commute was easy and this hospital is less crowded you know, the treatment is also good so we went there.”—Rokeya (Muslim)

Among the Bengali women living in Jamaica in north-east Queens, two went to Queens hospital, a public hospital, one woman with private insurance went to New York hospital of Queens and the others went to doctor’s offices. In southern Brooklyn, of the women interviewed in and around Borough Park the majority went to Maimonides Hospital mainly because the hospital was close-by and also accepted Medicaid and one went to Coney Island community hospital since she lived there at the beginning of her pregnancy. Proximity was the most important factor affecting hospital choice. In addition to proximity, another important reason cited by most of these women was the availability of female doctors or midwives.

“I go to Queens General hospital…it is very near from our apartment, a few stops you know since I have to go alone to the hospital we have selected this one. We have seen few other hospitals as well like the Mary Immaculate hospital, but they transfer you to St. John’s hospital which is very far it is not possible for me to go there alone by bus now. The Queens hospital is just 5-10 mins bus ride from here and I can easily go there alone my husband cannot accompany me you know since he is busy during the day.”—Tuhina (Muslim)

“I went to Maimonides hospital. The hospital is very close from our house. I could walk to the hospital I didn’t have to take anyone’s help taking me to the hospital and while coming back I went there alone and also you know they have women doctors you know the midwives if you go there you will be checked by a woman doctor or midwife and the delivery is also done by woman doctor that is why I like it there very much.”—Fatima (Muslim)
“..I went to Maimonides hospital during my pregnancies..you know it is closeby from here and most of our acquaintances went to this hospital..they have midwives you know, so my friends and relatives advised me to go there..”—Aana (Muslim)

“..I went to Maimonides hospital when I was pregnant.. I didn’t know anything around here at that time..so I asked my neighbors and acquaintances and they suggested Maimonides because it was near..some advised me to go to Coney Island hospital but said it was far..since Maimonides was near and I could go there alone if needed I decided to go there..”—Shabana (Muslim)

The private doctor that two Bengali Hindu women visited is a Bengali Muslim woman from Bangladesh, a renowned gynecologist, who has been practicing in the city for many years. For Bengali Muslim women who opted to visit a doctor’s office the choices varied from a Pakistani to an African American doctor.

For the few high-income women, the insurance policy determined to a great extent the selection of doctor. In addition to knowledge about the reputation of the doctor gained from social networks, women and their husbands sought to know beforehand the hospital or hospitals the doctor is affiliated with and where the doctor’s patients are usually sent for delivery.

“..I came to know about this doctor from my neighbor and also from our friends and acquaintances in the temple..she is a very renowned doctor..has been practicing in New York city for the last 20 years..”—Misti (Hindu)

“..after coming here I heard about this doctor from many people..she is a Bangladeshi doctor originally from Dhaka..she has been practicing here for many years..very good doctor..”—Nira (Hindu)

“..the doctor I usually visit here referred me to a Pakistani doctor who has her clinic in Jamaica..she is a well known doctor and is affiliated to the North Shore Jewish hospital where I went for delivery..”—Nazma (Muslim)
Journey from home to prenatal care

As women started using prenatal care, getting from home to the prenatal care facility involved making arrangements in the routines of everyday life. The spatial and temporal aspects of daily life intersected and shaped how women experienced the visits to the clinic, including the trip from home to the clinic and back again, and the arrangements made to accommodate everyday routines and responsibilities.

The distance women traveled to get to the hospital ranged from a few blocks to a few miles. If the facility was close by, women usually walked to get there, otherwise they used the subway and bus, called a cab or were dropped off by their husband either in their own car or in husband’s cab if he was a cab driver. Very few women interviewed had a car of their own. Most of the time the women interviewed went to the hospital alone except for the first or second visit and during the later stages of pregnancy. Sometimes women were dropped off by a neighbor or accompanied by a family member or a relative.

In general, proximity of the hospital was always an advantage for the women. Most of the women who went to a hospital or clinic close-by walked to get there. They felt happy doing that since it relieved them from the hassles of arranging for transportation and also helped them to get some exercise, which is good for the mother and the baby and helps in having a normal delivery. Walking became a challenge, however, during later phase of pregnancy, especially for women with kids and babies who had to be carried in strollers (Fig.5.3). Women who went to facilities not within walking distance used the subway or bus or a combination of subway, bus and walking and found the commute manageable if the weather was good, if they didn’t have to carry
a child in stroller and if they were in the early stages of pregnancy. Many women complained of having difficulty in climbing stairs in the subways during later stages of their pregnancy and also difficulty of pushing a stroller, especially during winter months. Climbing up and down the icy, slippery and long, winding and narrow subway stairs in many of the stations was difficult and unsafe for these women. Some women called a cab to ensure a safer commute but it was difficult for many to afford a cab and they opted to take the bus instead of subway.

“..I used to walk to the hospital, it was just 10-15 mins walk from here and most of the time I used to take the older daughter with me in a stroller, but when I was 8 months pregnant it used to be difficult for me to push the stroller..I used to leave my daughter with my husband or my nephew or my friend in the building and go to the hospital alone.”—Gita (Hindu)

“..during the first few months I used to take the subway but later I took the bus more often..sometimes I used to call a cab, but cab used to be expensive..it took 15-20 mins in subway and about 30 mins in a bus..but I suffered from queasiness and it used to be difficult for me to climb up and down the stairs in the subway stations..and during the last months I wanted to avoid the subway stairs because it was winter, it used to snow and the stairs were slippery..so I used to mostly take the bus to the hospital..”—Alisha (Muslim)

“..I used to go to a clinic in Astoria which is affiliated to Elmhurst hospital..sometimes when I felt better I used to take the train to get there, otherwise I used to call the cab because if I took the subway I had to again walk for a while to get to the clinic..later I was transferred to Elmhurst when I tested positive for sugar and I realized that it was a much easier commute for me..many Bengali women who live here go to Elmhurst ..initially I used to call the cab, I avoided the subway because I did not feel comfortable climbing up and down the long and crowded stairways.. but later my friends and neighbors suggested me to take the bus and it was convenient for me, I didn’t have to pay so much and could avoid climbing the stairs..”—Jahanara (Muslim)

“..the hospital is closeby, this is 41st ave and the hospital is on 48th ave, just 7 blocks, so I could easily walk to the hospital..if the weather was bad anyday I used to call a cab otherwise I always walked, it was not very far you know..”—Fatima (Muslim)
For women who traveled to hospitals far away in other boroughs or in the same borough, the experience depended on several factors. If the woman liked the care in the hospital she didn’t mind the long commute. It was a trade-off between longer commute and getting good care from hospital of their own choice. However, when women had another child to take care of, the longer commute became a challenge producing mental and physical strain and eventually they decided to go to hospital nearby irrespective of whether they liked the service there. In some cases other factors were also important such as subway routes, the surroundings of the hospital and where it was located in relation to husband’s workplace. Roma, living in Woodside, for instance transferred from North Central Bronx Hospital to Bellevue Hospital after 6-7 months of her first pregnancy and continued to seek prenatal care there during her 2nd pregnancy. Bellevue Hospital was also far from her house but she preferred traveling to Manhattan than Bronx, specially because of frequent and better subway service, location of the hospital in a nicer area, and because it was easier for her husband, a cab driver in the borough to drop her off or pick her up from the hospital.

“...during my first pregnancy we used to live near Greenpoint in north west Brooklyn, so I went to Woodhull hospital which was closeby..then we moved to Borough park which is farther south, but during my 2nd pregnancy I went to Woodhull again since I was familiar with the hospital and knew how things work there..but you know Woodhull is very far from here, it took almost an hour..I had to change two trains you know , I had to climb a lot of stairs to get into the 2nd train..so during my 3rd pregnancy I started going to Maimonides hospital which is close by..”—Sakeena (Muslim)

Some women took a cab to the hospital to ensure a hassle-free travel specially when the hospital was not very far and the cab fare was affordable. Most of the time these women were relatively recent immigrants and were not very familiar with the subway
and bus routes or they could afford cab fare. Also as mentioned before, sometimes husbands who were cab drivers dropped off or picked up their wives if the appointment timings matched with their working hours and their area of service.

“..I don’t know the subway routes very well..once or twice I went to the hospital by subway with my husband, otherwise I took a cab most of the time..”—Rita (Hindu)

“..I was new to this place then, I did not know the roads and subways very well and I was scared to go out alone..my husband drives yellow cab..so he used to drop me to the hospital in his cab..”—Payel (Muslim)

“..I used to take the cab to the hospital..you know my pregnancy was not planned and I had this 11 month baby with me..my husband used to be at work, so he couldn’t accompany me..so I used to call a cab..”—Faizia (Muslim)

A majority of the women went to the hospital alone for most visits. Husbands usually accompanied their wives during the first few visits and during the last weeks of pregnancy. In between they either accompanied or dropped off or picked the women from the hospital or clinic whenever possible. Husbands could accompany their wife only if the time of appointments was not during their working hours or if they had an understanding employer so that they could come back early from work. Many husbands, however, couldn’t afford to lose wages by taking off from work early except when it was an emergency. Very few women had their own car and very few were fortunate to have their husbands take them regularly to all the visits by car.

“..the clinic was a little far from our house..it was 20 mins by highway, in Flushing..but I usually didn’t have any problem because my husband used to go with me and we used to go in our car..his office is very good, his boss is very good, whenever I had an appointment, and I usually took appointments during the evening say  from 6-8 P.M., my husband used to come back home a little early and take me..I never had any problem..sometimes there used to be tests and ultrasounds during the day, my husband used to take leave from office then or go to the office after the visit..”—Misti (Hindu)
“..the first day my husband went with me to the hospital..I was new to this place, I didn’t know where to go, whom to talk to in the hospital..and I couldn’t explain things clearly in English then..so I took my husband with me..but after that I have been going to the hospital alone..”—Rabia (Muslim)

“..my husband went with me to the hospital regularly during the last few appointments..he used to leave early from work and come..he used to think that I was new to the place and I used to be a little scared also because my English was also not very good..now I can communicate in English much better, but then it used to be a problem..so my husband used to take leave from work and come even if it was difficult for him..and I used to take the appointments during afternoon at about 3 PM..he used to work for 7-8 hours and then came back home to take me to the hospital..usually he used to work for 10-12 hours, during my appointments he used to do 1-2 hours less work and return early..”—Aana (Muslim)

“..I used to go to the hospital alone because it was difficult for us to lose wage hours..my husband was the sole earner in the family, so we couldn’t afford to do that..sometimes during my 3rd pregnancy when it was difficult for me to take both the kids with me he used to stay back home to look after them..”—Sakeena (Muslim)

Sometimes neighbors or other family members and relatives living closeby accompanied women to the hospital or clinic.

“..during my first pregnancy I did not know anyone whom I could ask for help and I couldn’t go out without my husband..but during my 2nd pregnancy I got help from a room-mate of ours who is also from Bangladesh, he used to rent a room in our apartment..one day it was snowing a lot since morning and I was getting tensed, how I will go to the hospital in this bad weather, it will be difficult to get a cab also..my husband has already left for work, it will be difficult for me to go alone..then I noticed that our roommate was going out for work, so I asked him if he could kindly drop me to the hospital, he readily agreed..once or twice he dropped me to the hospital..”—Mrinmoyi (Hindu)

“..yeah, when I went for prenatal care my mother-in-law used to accompany me to the doctor’s office regularly..I did not know driving then and my sister-in-law was also pregnant at the same time..so many a times when if we had appointments on the same day she used to drop her drop me and then pick both of us..she really helped a lot with this, anytime I requested her she readily went with me..”—Naaz (Muslim-high-income)
“..my grandmother and mother lives closeby and I received a lot of help from them..during the later stage of my pregnancy when I couldn’t drive, my mother used to drive me to the hospital..”—Mehar (Muslim-high-income)

Reliance on social networks emerged as crucial in Bengali immigrant women’s use of formal prenatal care. For keeping the prenatal care appointments women relied on social networks especially for help with childcare. Seventy one percent of all women interviewed had 1 or more children to take care of during their pregnancy in the US. These women usually asked for help from neighbors or friends who lived nearby. The type of help depended on the age of the child. In the case of a pre-school baby, the woman would either take him or her to the hospital or leave the child in the care of a family member or relative. If the child was older and in school, the woman would drop the child to school and go to the hospital and request a friend or neighbor to pick the child from school and look after the child until she returned. Oftentimes neighbors also helped to drop off the child to school. It was common to receive such help from the parents of the child’s friend from school.

“..when I went for regular prenatal care appointments I took my son along with me..sometimes when I had to go for tests my son would be in school..so it was not a problem..”—Misti (Hindu)

“..I received a lot of help from my neighbor who lives upstairs..I came to know her after coming here, she is not my relative or anything but she helped a lot..I could leave my daughter with her when I went to the hospital..”—Gita (Hindu)

“..I used to take my daughter to the school in the morning and then I used to take the bus and then transfer to the subway to go to the hospital..I used to try to come back in time to pick up my daughter from school..but in case I couldn’t make it in time I used to ask my Indian neighbor to pick her up from school..but most of the time I used to come back early..my doctor knew I have another baby, so she used try to leave me early..”—Indira (Hindu)
“..it was difficult at times..when I was pregnant with my youngest son, my daughter used to go to school..but I had to take my younger son with me in a stroller..sometimes I used to leave him with my sister-in-law who was living with us then..during the last 2 weeks my mother- in-law came from Bangladesh and I could leave the baby with her.”—Salima (Muslim)

“..sometimes when I had some tests like the one to test diabetes I had to go empty stomach and wait till 10 A.M. in the hospital..it was difficult for me to take the baby with me then, I was very weak and used to be scared that I may become senseless when they draw blood..so I used to request my landlady (also Bangladeshi, an elderly couple living with their daughter) to keep the baby till I came back.”—Faizia (Muslim)

“..during my 2nd pregnancy whenever I went for appointment my grandmother-in-law used to come and take care of the older baby..it was a great help you know..”—Naaz (Muslim-high-income)

Making these arrangements with neighbors, friends and relatives seemed to depend on how comfortable women felt in asking for help. Some women were fortunate to have neighbors willing to help women during their pregnancy and since their children went to the same school the parents happily offered this help. But sometimes women felt uncomfortable in asking for help and tried not to bother friends and neighbors and do as much as possible on their own.

The availability of help and support based on such social networks depended not only on the number of years the women had lived in a particular neighborhood but also which area of the neighborhood she resided. Women living in areas with dense concentration of Bengalis had much closer social networks than women living in areas with relatively sparse concentration of Bengalis. Also apartment complexes formed important sites where many Bengali families living in the same building interacted in ways similar to what is found in their home country, mingling with neighbors as close friends and relatives. Women living in these neighborhoods and apartment complexes received greater help and support from neighbors and friends.
“..when I did not feel very well I used to ask my neighbors to pick up my son from school. I used to accompany him downstairs in front of the apartment complex and send him to school with his class-mate’s parents. The father of my son’s class mate who live in the next building used to help me regularly with this when I was pregnant with my 2nd son.”—Zaina (Muslim)

“I have a lot of friends in the neighborhood, but I relied on the friend who lives in the 2nd floor. She was in the same building so that was an advantage. I used to fix the appointments in such a way so that my eldest daughter or my husband was there so that they can look after the younger children. So I did not require a lot of help, but my friends used to always ask me to tell them anytime I needed any help.”—Fatima (Muslim)

“..there is one thing I want to say about help from neighbors, many a times they want to help me but they cannot...because most of them work outside...this is the reality in America...people are not available at home during the day...sometimes when I wanted to leave my baby with someone I would find that there is nobody at home, the kids are in school and the elders are out to work...so many a times I did not get help when I needed it most...”—Misti (Hindu)

“..when I was pregnant with my daughter, I used to take my younger son with me to the hospital. It took a long time in the hospital, so I didn’t feel like bothering friends and neighbors. I used to drop the elder son to school and take the younger one with me...it used to be difficult but I did not have any other option you know...”—Zaina (Muslim)

However, for women who became pregnant immediately after coming to the US there was no ready help available with childcare. These women did not have any neighbor close enough whom they could ask for help in keeping their baby, which sometimes made their prenatal visits very challenging and difficult. Ayesha, for instance, who had a 3-year-old baby and became pregnant within a year after coming to New York City, had a difficult time managing her child during prenatal visits in the hospital.

“I had to wait in the hospital for long hours and my son used to throw tantrums...he used to feel hungry and cry...I took his food along with me but sometimes when the waiting time was longer the food used to be over...it was very difficult to keep my son calm and I used to have a tough time...he
used to become very tired and sick when we got back home..” –Ayesha (Muslim)

Most of the women interviewed were housewives during their pregnancy and did the majority of household work such as cooking, cleaning and laundry. Prenatal care visits often-required complex changes to the routines of daily life, changes that created a significant burden for some women. Some women did mention that they received a lot of help from their husbands that helped to ease time space constraints. However, in most cases husbands could not help because of their long working hours outside home. For most women, prenatal care visits required significant adjustments to everyday routines. Most of the time women found it convenient to go to the hospital during mid-hours of the day. Unfortunately that was the time that maternity and infant care departments in the hospitals were the busiest. If the husband accompanied or dropped the woman to the clinic it was also important to consider husband’s working days and shifts in fixing the appointments.

“..I used to do a lot of physical work, I worked almost non-stop, I did most of the shopping as well..my husband did not have time to help me out with household work..and Elmhusrt hospital is very far from here..used to take me an hour and 15 mins to reach there by bus and subway..and I had to drop my daughter to her school and try to come back in time to pick her up..so my time was very limited ..”—Indira (Hindu)

“..I had to take care of my son and also do all the household work..when I had my appointments I had to leave a lot of work unfinished and rush to the hospital..”—Ayesha (Muslim)

Some of the women worked outside the home during pregnancy, which made it even more complicated to arrange prenatal visits. Of the Bengali Hindu women, three worked outside the home during pregnancy: one during her first pregnancy, one during her second pregnancy and another for the first few months of pregnancy, mostly in part-
time jobs. Among Bengali Muslim women, one worked full time in a laundry facility till the last month of pregnancy, one was working in a store, two were part-time students and did part-time jobs in college and one worked part-time during the first few months of pregnancy. For these women, it was challenging to balance household and childcare responsibilities with paid employment to maintain regular prenatal care visits. In addition, they had to select the time of appointment strategically so that it synchronized with the multiple duties at home and outside.

“..I used to work in the same place I work now during my pregnancy..it is a laundry facility in Long Island city, I had to take the subway and then walk..I used to work for 8 hrs, 5 days a week, then I did all the household work myself, my husband was there but he was too busy..so I went to the hospital and did everything alone..”—Reba (Hindu)

Quality of prenatal care

In actual health care encounters in the hospital or clinic, most of the women interviewed commented positively on the quality of care received. Their prenatal care experience here, always weighed in relation to prenatal care in the home country, was overall very good.

“..I received very good care here..I don’t know about other hospitals but Elmhurst hospital is very different from public hospitals in my country..they have taken good care of me and my baby here..”—Rita (Hindu)

“..here the health care is actually much more advanced than in our own country..the very first day they do a lot of tests here..and this continues throughout the pregnancy..”—Gita (Hindu)

“..I think the prenatal care is good here, you remain under a doctor’s care all through pregnancy, then you get get good nutrition, all the supplements..I think health care wise it is good here..”—Rokeya (Muslim)

In discussing quality of care, the women often compared the care received in New York City with that in their home country. In developing countries like Bangladesh where
the health care system is characterized by increasing inequality and privatization and lack of adequate facilities in public hospitals or clinics, low-income and middle-income people are often deprived of quality health care. The best medical facilities, in select private hospitals in these countries, are exceptionally expensive, and health insurance to cover the costs is unavailable. Consequently, only the rich people can dream of and afford high-quality and advanced health care in countries like India and Bangladesh. In their home countries, the women would have had to seek care in public hospitals or from private doctors where overcrowding and lack of facilities would have been impediments to receiving adequate and good prenatal care. Women who lived in rural villages in Bangladesh during previous pregnancies had little or no access to formal prenatal care facilities. In contrast, in New York, women appreciated the standardized and generally good quality of care even in public hospitals. The only problems mentioned by the women as stated before were long waiting times, ‘too many tests’, and communication difficulties; the first being rather unexpected. These women had an idyllic view about the health care system in this country before coming here. Facing these problems in public hospitals came as a surprise to them. Nonetheless, most of the women perceived and experienced the formal prenatal care here as immigrant women, as newcomers in a developed country where everything seems to be perfect compared to conditions in the other side of the world. These women went to the hospital with an appreciating rather than a critical bent of mind. Women’s comments about waiting hours and too many tests however reflected on actual problems they encountered.

“..in our home country we see that pregnant women cannot see a good and renowned doctor because of money..we have to go to public hospital..even if we go to private clinic we cannot go to a big one..whatever care I am getting here, is a lot compared to my home-country, that is why personally
I didn’t think anything critically about the health care I received here.” – Gita (Hindu)

“..I did not feel that way and since I didn’t know anything about the system here, it was all very new to me..and they took good care of me..so I was happy.”—Noini (Hindu)

“..yeah I think the prenatal care I got here was good, since I went for regular check-ups the doctor could tell me if there was any problem, how my baby was doing..but in Bangladesh there are no regular visits like here, sometimes even if we have fever we don’t go to the doctor which may be harmful for the baby..but here it is different.”—Ayesha (Muslim)

“..my experience of prenatal care was better here compared to home country..here the doctor has done check-ups regularly, then I took medicines..in Bangladesh I was in our village house during pregnancy, I did not go for regular check-ups to the doctor..here a pregnant woman gets a lot of attention, the doctor always advised me to eat well, to take care of my health.”—Faizia (Muslim)

“..my first baby was born in Bangladesh, I had a normal delivery, there was no problem..but since we lived in a village you know there weren’t any good facilities for prenatal care closeby, so I couldn’t go to a doctor regularly, if I had was in a town or city may be I could have shown a doctor more regularly..this is like 10-15 years back, now things are changing in urban areas as well as in rural areas, there are many clinics and facilities, it is much better now..but here I could go to the doctor regularly, so it was much better, whenever I asked I got advice from the doctor, then if there is any problem they can detect by doing timely tests..you know prenatal care is much more advanced here..”—Anaan (Muslim)

It should be mentioned here that the views of immigrant women from developing countries, especially recent immigrant women, about the quality of health care in the US differ significantly from the views of American-born women or even long-term immigrant women who are usually more aware about their rights as patients. For instance Aamira, who migrated to the US at the age of 15 with her parents was critical about the short time given to patients by the doctor. Also, Mehar and Naaz who came to the US at a young age were critical about the private doctor they were seeing during their 1st
pregnancies, and during their 2nd pregnancies they went to a different clinic consisting of a group of doctors.

“..here in the hospital the service is good but sometime I feel the doctors don’t give enough time to the patients..you go there, you wait for 1 hour 2 hour and then they see you for 5 minutes you know..that is the bad thing..otherwise may be it is not their fault..they have a lot of patients to see..”—Aamira (Muslim)

“..I have worked in the hospital myself for sometime as a ward manager and I have a vive you know..certain things I am not going to accept from a doctor, and if you have the option to get better service, why should you settle for the bad thing?..”—Mehar (Muslim, high-income)

**Language barrier**

Most of the women interviewed, especially women from Bangladesh did not have very good command over spoken English. This was especially true in case of relatively recent immigrants and women who have been mostly housewives after coming here. Many women mentioned about feeling scared and underconfident to speak with hospital staff and personnel in their initial visits. This constrained feeling definitely came in the way of their experiencing a satisfactory prenatal care service.

Despite these language barriers, most Bengali immigrant women knew some English, being from a former British colony, and they managed to understand and communicate with nurses and doctors. In the public hospitals where most women received care, doctors and nurses were used to interacting with immigrant patients and developed skills to understand and communicate with women not fluent in English. However, as far as the nuances of translation and interpretation, communication between doctors and patients remains a problem that is more often than not taken care of informally. The most common way is to call a Bengali speaking nurse or employee in the hospital to help in communication. Even though several of these hospitals displayed
welcome signs in different languages (Fig.5.4), reflecting the diversity of people served, scarcity of interpreters emerged as an issue in women’s narratives.

Women also relied on friends and family members who were more fluent in English to help with communication. In most cases it was the husband who accompanied his wife to help her communicate with doctor and nurses. But it was not always easy when husbands had to reduce their working hours to go with their wives to the clinic. In some cases, women felt happy if they could visit a Bengali speaking doctor or were seen by an Indian doctor since it relieved them of the restraint experienced due to language barrier.

“..yeah sometimes, sometimes, yeah sometimes..I used to have problems..for instance I couldn’t fully explain where the pain was exactly or how I was feeling..I could say but not so well as I would say in my mother-tongue.. my husband helped me when he was there you know..”—Rita (Hindu)

“..I had specific problems couple of times because of miscommunication..my doctor once told me to go to the ultrasound department to check why my abdomen had suddenly become heavier..I went to the ultrasound doctor but I think my doctor didn’t specify exactly why I needed to get an ultrasound..so I had to go to my doctor again and she wrote in details what needs to be done..they said there was nothing to worry about, it was because of water in the uterus and it would be ok after delivery..”—Rita (Hindu)

“..actually even though I had finished college before coming here, I had difficulty speaking English here..it was not so much a language problem, actually I did not feel very confident, I felt uneasy..if I say something wrong and if they feel bad about it..”—Indira (Hindu)

‘..yeah I had heard that language might be a problem in the hospital..and I had just arrived in this country you know, so it was difficult to understand the English they speak here, specially the accent..but they used to try to explain is as easy a language as possible..sometimes they used to call a nurse may be a Bengali, but many a times they didn’t get a Bengali so they used to call an Indian..so they tried to help you know..and ‘seema appa’ (female relative) used to go with me, so she also used to help in translating ..’”—Inayat (Muslim)
“...yes I do have problem with language, I still don’t understand a lot of things..it is definitely a problem..sometimes I cannot answer when my doctor asks anything even though I may have understood his question, what I am feeling you know or if there is any problem I am experiencing.. for regular questions it is fine like whether the baby is moving or not..but sometimes I just don’t understand what the doctors’ are saying..then they call a Bengali may be someone from amongst the patients to help me explain...”—Rabia (Muslim)

“...from my insurance at work place they asked me to go to Jamaica Hospital but since it was very far from our house they later gave me the address of another doctor which is closeby from here..the doctor was a Bengali female doctor from Chittagong..I did not know she was a Bengali and when we went to her office we were very happy, especially my husband, he kept saying that this will be very good for me since my English is not fluent, I can speak in Bengali and he doesn’t have to accompany me to her office always, I can go alone...”—Jahanara (Muslim)

Financial barriers

Most of the women from Bangladesh had low incomes and thus had limited insurance coverage. They couldn’t afford private insurance and their husband’s insurance from workplace if any did not provide adequate coverage for maternity and infant care. Therefore most women opted for Medicaid, a public health care benefit offered to low-income pregnant women. Ninety-four percent of women from Bangladesh in the sample, applied for and received Medicaid, which covered their expenses of prenatal care as well as childbirth and infant care expenses.

Eighty-seven percent of Muslim women from Bangladesh and 82% percent of Hindu women from Bangladesh used Medicaid. Social networks played an important role in passing on the knowledge about the huge expenses involved in pregnancy-related medical care here and the availability of Medicaid benefits for pregnant women to newly arrived immigrants. In most cases women knew beforehand from friends and relatives
about Medicaid and were also given information in the hospital (Fig. 5.5) about eligibility criteria and procedures of applying for a Medicaid card.

“..I received Medicaid from the hospital..it covered all the expenses..I did not have to pay anything..my husband did part time job then, so we got Medicaid..I think if the income is high they don’t give Medicaid..”—Rita (Hindu)

“..I received Medicaid..I think they give this to all pregnant women..I came to know about it from the hospital and also from friends..”—Reba (Hindu)

“..since my husband is a cab driver we received Medicaid..all our expenses were covered..”—Payel (Hindu)

“..I didn’t have to pay anything in the hospital..when I went to the hospital they asked me if I had Medicaid..they gave me forms to fill up and I got my card, it was not a problem..now I think the application procedure has become more rigorous, they ask for tax papers and many other things..”—Alisha (Muslim)

“..yes, I had Medicaid and it covered the expenses..I think all pregnant women get Medicaid here depending on their income status..Yeah, it was not a problem, they have a office in the hospital, I filled up the form and gave the papers they wanted there and got my card..”—Nusrat (Muslim)

“..one of our neighbors told us about Medicaid..for newly arrived immigrants it is important to have a Medicaid card because health care and insurance is very expensive in this country..there are two things that immigrants need to apply for here, one is Medicaid and the other is Green card..so we applied for Medicaid immediately and received the card in time..all our expenses were covered..we also received food and nutrition supplies under the WIP program..”—Anaan (Muslim)

“..yeah, I received Medicaid to cover my health care expenses during pregnancy..we got full coverage since our income is not very high..I did not face any problem, when I went to the hospital after becoming pregnant they made the card for me..in Woodhull I had to go to a separate office but here in Maimonides they have an office in the hospital itself..”—Sakeena (Muslim)

The knowledge about criteria and procedures for applying for Medicaid was critical in ensuring that women receive their Medicaid card in time so that all the
expenses are fully covered. Noorjahan, for instance, who works in a laundry factory, received her insurance card much later because of negligency on part of her employer who did not send out the required $80 from her pay-check in time to get her card made. She was also not aware that she could apply for regular Medicaid card during pregnancy. She finally applied for Medicaid a few weeks before her delivery and received the benefit card only for the last few months. Her insurance covered only 60% of medical expenses, so she was sent bills for the previous months. Noorjahan didn’t have enough income to pay for the bills and had to make frequent trips to the hospital to request them to give waivers and ended up paying part of the bills herself.

A small number of immigrant women (3 Bengali Muslim and 2 Bengali Hindu women) had private insurance. The coverage of private insurance, however, varied depending on occupation. Most women received coverage from their own workplace or from their husband’s workplace. For these women the use of such insurance resulted in financial constraints that limited their prenatal care choices. Nira (Hindu), for instance, who had Cigna and HIP (Health Insurance Plan of New York) during two pregnancies respectively, mentioned financial constraints in paying for the insurance and paying co-payments at each visit. Rabia (Muslim), who works in a store, has Affinity Health Plan from her workplace, and she couldn’t continue prenatal care in Queens Hospital since they do not accept this insurance. Rabia made regular visits for 2-3 months to Queens Hospital requesting them to accept her as a patient and managed to get some of the initial check-ups and tests done. But the hospital gave her an ultimatum and sadly at her 5th month she was forced to transfer to Mary Immaculate Hospital where they accepted her
insurance. Thus, for low-income women, private insurance coverage resulted in a greater financial burden and more limited choice of services than did Medicaid coverage.

“..we did not apply for Medicaid..I was covered by my husband’s insurance..he has to give $78 per month and the rest is paid by the owner of the restaurant.I had to give $10 copayment at each appointment..even though it sounds reasonable but it was tough for us since I don’t work..it was difficult with only one earning member in the family.”—Nira (Hindu)

“..I really wanted to get prenatal care in Queens hospital but they don’t accept the Affinity Health card that I have from my work..I went there for 2-3 months, they did urine and blood tests and also made a clinic card for me, but they kept saying that if I want to continue care in this hospital I have to apply for Medicaid card, but it will take 6 months and I have to pay out-of pocket till then..so I went to Mary Immaculate hospital ultimately where they accept my insurance.”—Rabia (Muslim)

The wide availability of Medicaid coverage for these immigrant women reflects the expansion of the Medicaid program in New York State during the late 1990s. At that time, the state changed Medicaid eligibility criteria to cover pregnancy-related health care for all pregnant women, including undocumented immigrants, and their children. Medicaid coverage was critically important for these low-income women, most of whom could not afford private health insurance. By removing financial barriers, Medicaid made it possible for women to receive regular prenatal care.

This situation where all immigrant women have Medicaid coverage for prenatal care is not typical in all states. Many other states do not provide Medicaid coverage for immigrant women, specially undocumented immigrants, so those women face huge financial barriers to prenatal care.

Bengali Women from India

The use and experience of formal prenatal care for Indian Bengali women was different from that of the majority of women from Bangladesh since all except one were
in relatively better socio-economic situation and had better insurance coverage. However, for women who were new immigrants and still passing through the phase of hard work and struggling to establish themselves, as well as few long-term immigrants, going to private hospital or clinic for prenatal care was not typical. Proximity to the hospital, the type of insurance coverage, reputation of the hospital or doctor and former acquaintance with the doctor emerged as important factors shaping Indian Bengali women’s decision to visit a particular facility.

Where women lived and the type of insurance mainly determined where Indian Bengali women went for formal prenatal care.

“...actually Elmhurst hospital was the main big hospital close to where we lived in Woodside, that is why we knew about it and went there during my 1st pregnancy..”—Srimonti

In case of Nilima, her selection was based on the choices her insurance offered. She went to the nearest HIP (Health Plan of New York) clinic and was referred to Brookdale hospital during her 1st pregnancy when she lived in Brooklyn, and to Long Island Jewish hospital during later pregnancies when she lived in Queens. Knowledge about good reputation of the doctor, gained from social networks influenced Gayatri’s decision to visit a doctors’s office right next to their apartment building in Flushing during her 1st pregnancy. Having liked the service very much, she went to the same facility even after moving to Queens village during her 2nd pregnancy, requiring a commute time of 45 mins to an hour.

Majority of Indian Bengali women’s husband owned a car. However, women used different types of transportation to get to the clinic or hospital depending on where the facility was located and what worked best in their everyday schedule. If the facility
was very close they walked to get there. Otherwise women went to the clinic in their
husband’s car, drove to the clinic if they had a separate car of their own, or used public
transit such as the bus or subway. Some women went for most appointments with their
husband while some went mostly alone, depending on what was the most convenient
arrangement in day-to-day schedule.

For women employed full time, such as in the case of Laboni, a postdoctoral
research scientist, keeping the appointments involved strategic arrangement to fit in visit
timings with working hours. Laboni’s hospital was enroute the subway she took regularly
to workplace and going to appointments on her way to or from work was convenient.

“..I would sometimes go from home and then come to work or sometimes
go from work and then go back home, so it was sort of in the middle..”—
Laboni

A majority of Indian Bengali women did not rely on social networks to keep
prenatal care appointments. One woman, however, specifically mentioned about relying
on social networks to go for prenatal care appointments.

“..during my first pregnancy if I had appointment during the day one of
our elderly Bengali friend used to accompany me to the doctor’s office,
specially during the later months..she used to live in the same apartment
building.”—Gayatri

“..during my 2nd pregnancy again there is another elderly neighbor here, a
Guyenese American, I used leave my son with her since I had to commute
a long distance then to the doctor’s office, specially when there used to be
a test or a sonogram and I had to spend a long time in doctor’s office..I
took her help a few times..”--Gayatri

All Indian Bengali women were overall happy and satisfied with the quality of
prenatal care they received here. However, women exercised their right of choice when
necessary and did not settle for care or service they did not like. This was possible
because of the greater choices and options of selecting a service they had, unlike majority of women from Bangladesh.

“..during my 2nd pregnancy the test for down syndrome came positive..then we consulted with a few doctor friend of ours, a cardiologist, then a gastroentologist, they advised me to change the doctor..then we went to another doctor..she said there is absolutely no problem, the test was done a little early..then everything was normal, the baby was fine..”—Srimonti

“..I asked for suggestions from a couple of our friends about which doctor to visit.. then I went to an Ob/Gyn but I did not like her office..it was not very clean and seemed a little disorganized..I had been to our dentist’s office and our general practioners office here, those are very neat and clean..then I tried to change and ultimately went to a doctor right next to our apartment building..”—Gayatri

Similarly, Laboni did not continue with her regular Ob/Gyn and switched to Beth Israel shortly after conceiving since she found this doctor ‘cold and unsupportive’. She was in the high risk group because of her age and on recommendation from a close friend who went through a phase of high-risk pregnancy, she went to see an Ob/Gyn in Beth Israel, renowned for taking care of high risk pregnancies. She really liked the doctor, but after a few months with the urge to give natural birth she transferred to the mid-wifery department in the same hospital. She was extremely satisfied and her experience of working with midwives was excellent.

A few women mentioned long waiting times in the hospital but those did not emerge as a major constraining factor. Better socio-economic situation and relatively comfortable work schedule at home may have had the effect of off-setting the time-space constraints posed by waiting times in hospitals or clinics for Indian Bengali women. Women who were working full-time outside home did not face long waiting times in the facilities they visited for prenatal care.
“..I had to wait for the doctor, but I won’t say it was done purposefully because when there are many patients sometimes the doctors take time to finish seeing everyone..or sometimes if the doctor had an emergency visit he or she would reach the clinic late, obviously everything gets delayed then..so it was not intentionally done.”—Nilima

As mentioned before, since most women had insurance coverage, either of their own from work or were covered by their husband’s insurance, they did not face any financial barriers. Only one woman opted for Medicaid and visited the nearest clinic serving low-income patients since her husband was not in a very well paid job and their insurance did not have good coverage for prenatal care and delivery. Another woman mentioned opting for a low option policy before 2nd pregnancy, which was unexpected, and felt some financial constraints as a result.

“..we opted for a low option insurance policy this time since we felt we don’t need a high option policy..then I suddenly conceived our 2nd baby and during each visit I had to pay a $30 co-payment..there are many visits during the later months and had gestational diabetes, so then paying $30 each time seemed a little too much.”—Gayatri

An overwhelming majority of Bengali Indian women knew English well and did not have problems communicating with their prenatal care providers or with other staff or personnel in the hospital or clinic. However, one woman mentioned having difficulties with language initially and also feeling underconfident and restrained while communicating with her prenatal care provider.

“..the doctor I went to was very good and caring..I really liked her..but at that time I used to feel scared you know, I used to be afraid..first of all I had this language problem, I did not go out much here, I did not interact with a lot of people, and even though I am a college graduate and I used to teach in a school before coming here my spoken English was not very good, and I became pregnant soon after coming here, I did not have any experience, I hesitated to ask questions, afraid that I may say something unimportant or irrelevant, basically I was scared..so that was a problem I experienced then.”—Moumita
Summary and Conclusion:

In this chapter I have discussed the use and experience of formal prenatal care by Bengali immigrant women, based on in-depth interviews with sample women living in different parts of New York City. The sample consists of women from Bangladesh and Bengali women from India, two immigrant groups of women from South Asia connected by linguistic and historical ties. In their situational context in New York City, however, they are embedded in diverse settings based on differences in class, religion and culture. The major part of the sample consists of women from Bangladesh and a smaller part consists of women from India. Most research participants from Bangladesh were low-income and all except one Indian Bengali women belonged to high socio-economic strata.

The use and experience of formal prenatal care by Bengali immigrant women in New York City points to the importance of place and gender in circumscribing their geographical, social and economic context of prenatal care use. The place where women lived and their health insurance coverage influenced to a great extent the decision about choice of prenatal care facility. A majority of women lived in areas served by public hospitals, which typically serve low-income people and by non-profit hospitals. These hospitals accept low-income women and provide facilities to apply for Medicaid to help cover their pregnancy care expenses. Hence public and non-profit hospitals formed the main sites of prenatal care for Bengali immigrant women in New York City. Proximity to the hospital or clinic and acceptance of Medicaid, emerged as important criteria in selecting a facility for prenatal care. In the few cases where women sought care in hospitals that required considerable travel for reasons such as past familiarity with the
hospital or high recommendation from relatives or friends, proximity was given prime consideration in choosing a facility to be able to manage going for regular prenatal care visits during the later months of pregnancy or subsequent pregnancies.

In general most women preferred to be seen by a female doctor. However, the preference was flexible and depending on the situation many didn’t mind seeing a male doctor. In some neighborhoods with dense concentration of Bengali women, such as in Borough Park or Sunset Park in Brooklyn, many women mentioned the availability of female doctors and midwives as an added advantage in the hospital they went for prenatal care.

Once women started prenatal care, going for regular appointments involved strategic arrangements in the spacing and scheduling of everyday job centering around the maintenance and welfare of the home and family. Similar findings have been reported in research on South Asian women’s health care concerns and contexts (Bottorf et al., 2001). The bio-medical, societal and cultural need to bear and nurture a healthy baby had to be fulfilled by negotiating the productive and reproductive spaces of everyday life. Most of the women interviewed were housewives during pregnancy, shouldering the majority of household and childcare responsibilities. For these women going for regular prenatal care meant making complex arrangements to complete household jobs before going to the hospital or after coming back. Almost all women endeavored to overcome the temporal and spatial constraints produced by the geographies of household and childrearing responsibilities and keep all the prenatal care appointments.

Long waiting time and overcrowding was critical in exacerbating the time-space constraints faced by most women. Many mentioned appointments taking away major part
of the day and difficulties faced in managing household and domestic work. In some cases childcare and household responsibilities coupled with waiting time kept women from going to the hospital till the 5th or 6th month of pregnancy. Too many tests also emerged as an important reason making some women re-think going for regular prenatal care later on during pregnancy. In one case the need for cultural and religious belief and practice such as keeping a fast during ‘roja’ delayed initiation of formal prenatal care during 2nd pregnancy. Thus instances of actual delay in start of prenatal care and thoughts and possibilities of starting prenatal care late emanated from the gap between women’s work load in everyday life and inadequate infrastructure in public hospitals coupled with biomedically determined need for, check-ups, tests and ultrasounds during pregnancy.

Another important dimension of Bengali immigrant women’s use of prenatal care services was the journey from home to hospital or clinic. Being low-income and not owning a car, made women traverse the urban landscape using public transit and in many cases walking. Most women preferred walking to the hospital if it was close by since it was beneficial for the health of the baby and the mother. Availing of public transportation to get from home to the hospital, on the other hand, meant facing the hassles of traversing crowded streets and waiting for and traveling in crowded buses or subways, which are not easy for a pregnant woman. Reliance on public transit thus added to the time-space constraints faced by women in going for prenatal care appointments. Waiting for buses and climbing up and down the long and winding stairways of New York City subways was difficult for many women. Using public transit was especially risky during winter, when the roads and stairs became wet, slippery and unsafe for pregnant women.
Womens’ views about the quality of care received in the hospital reflected their location as immigrant women amidst experiences, expectations and social discourses centering on health care services they had been accustomed to in the home country and the more advanced health care system they encountered and navigated in the US. A majority of women commented positively on the quality of care they received, always comparing the care to what they would have received in home country. They appreciated the standardized and generally good quality of care even in public hospitals. The only problems mentioned by the women as stated before were long waiting times, too many tests resulting in too many visits and language problems.

Language emerged as critical in restraining women’s full participation and experience of formal prenatal care supporting barriers to health care access for South Asian women in the literature (Bowes & Domokos, 1996; Bowler, 1993). In some cases husbands or relatives accompanied the women to help in communication, but women had to go alone for most visits and had to ask for help with communication from hospital personnel. Hospital staff helped by either asking a Bengali employee to translate or calling an interpreter if available. Availability of interpreters in the hospitals was crucial in helping women with limited language proficiency to be able to communicate with the doctors and nurses and feel satisfied and benefited from the visits, rather than feeling constrained, underconfident and dissatisfied. However, lack of professional interpreters in many hospitals meant that women’s waiting times increased in the process of getting help from Bengali speaking employees who were busy with other work responsibilities.

A majority of the women did not face any major financial barriers in accessing prenatal care as they were eligible for and received Medicaid. Medicaid was important in
enabling women to use regular medical care and receive medical assistance during pregnancy. However, since Medicaid applicants must meet certain eligibility criteria, women had to go through a phase of worry and uncertainty during the time when application was processed. While knowledge about availability of Medicaid gave women peace of mind, the requirements, procedure and duration of the whole application process contributed to anxiety in their overall experience of prenatal care. Nonetheless, by covering the expenses of prenatal care, Medicaid emerged as the single most important factor in enabling and ensuring majority of Bengali immigrant women’s use of formal prenatal care. It also emerged from some women’s narratives that having private insurance with low-option policies, resulted in a greater financial burden and more limited choice of services than did Medicaid coverage.

Place-based social networks constituting women’s everyday life emerged as important in navigating the formal prenatal care system. Only a few women mentioned relying on a friend or neighbor occasionally to get to hospital or clinic. However, knowledge about the prenatal care facilities and benefits for low income women available from social networks played an important role in initiating women’s use of prenatal care. The greatest help from social networks came in the way of childcare during times and days when women could not take children with them for the appointments. Women who had one or more kids to take care of relied on social network to look after the baby if it was small and to drop or pick up kids from school if they were older. Reliance on social networks for help with childcare was critical in enabling women to keep their appointments because most women could not afford day care. For some women with limited social networks such as relatively recent immigrants who were hesitant to ask for
favors, help with childcare was not readily available making it difficult to go for prenatal care visits. Social networks in home country, especially parents, siblings and close relatives also motivated women to use regular formal medical care, especially through phone talks.

The above discussion centers on the experience of majority of Bengali immigrant women interviewed, comprising of low-income women from Bangladesh. In contrast to low-income women from Bangladesh, prenatal care use and experience of high-income women from Bangladesh and Indian Bengali women were much less constrained. High-income women from Bangladesh had better insurance coverage, greater choices of prenatal care facilities, private transportation to go for appointments, flexibility in husband’s work schedule to be able to accompanies or have any other family member or relative to accompany to the hospital or clinic. Most high-income Muslim women from Bangladesh lived amidst networks of family and friends who helped by giving a ride to the hospital or helping with childcare.

The accounts of Indian Bengali women echoed similar experiences, except their lesser reliance on social networks to keep prenatal care appointments and help with childcare. In general, better insurance coverage, greater choices and options in selecting prenatal care service, ability to communicate well in English, time-space flexibility, less pressure of household work, relatively comfortable and regularized routines of daily life contributed to creating more manageable and relaxed places of prenatal care use for Indian Bengali women. Reliance on social networks for formal prenatal care was, however, much less among Indian Bengali women.
To sum up, most women had early and adequate use of formal care. This reflects structural factors – health care coverage through Medicaid and the availability of public hospitals in the neighborhoods where many Bengali immigrants live. It also reflects complex adjustments and negotiations at the individual and household scale that enable women to obtain care and interact effectively with health care providers. For most women, the complex intersections between place, culture, gender and class in the spaces of daily life both facilitated and inhibited use of formal prenatal care services.
## Figures and Tables:

Table 5.1: Sociodemographic characteristics of the research participants

<table>
<thead>
<tr>
<th>Homecountry</th>
<th>Total</th>
<th>Bangladesh</th>
<th>India</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median annual income</td>
<td>$30,600</td>
<td>$33,000</td>
<td>$30,000</td>
</tr>
<tr>
<td>Median monthly income</td>
<td>$2,550</td>
<td>$2,750</td>
<td>$2,500</td>
</tr>
<tr>
<td>Age (Median)</td>
<td>31 yrs</td>
<td>31 yrs</td>
<td>30 yrs</td>
</tr>
<tr>
<td>Age during first pregnancy in the US (Median)</td>
<td>26 yrs</td>
<td>26 yrs</td>
<td>26 yrs</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;=10 years</td>
<td>2(6%)</td>
<td>-</td>
<td>2(9%)</td>
</tr>
<tr>
<td>10-12 years</td>
<td>13 (38%)</td>
<td>3(27%)</td>
<td>10(43%)</td>
</tr>
<tr>
<td>College (13-16 years)</td>
<td>13 (38%)</td>
<td>4(36.5%)</td>
<td>9(39%)</td>
</tr>
<tr>
<td>Graduate (&gt;16 years)</td>
<td>6 (8%)</td>
<td>4(36.5%)</td>
<td>2(9%)</td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housewife</td>
<td>18(53%)</td>
<td>6(55%)</td>
<td>12(52%)</td>
</tr>
<tr>
<td>Part-time job</td>
<td>14(41%)</td>
<td>4(36%)</td>
<td>10(44%)</td>
</tr>
<tr>
<td>Full time job</td>
<td>2(06%)</td>
<td>1(09%)</td>
<td>1(04%)</td>
</tr>
<tr>
<td>Occupation during pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housewife</td>
<td>25(74%)</td>
<td>9 (82%)</td>
<td>16 (70%)</td>
</tr>
<tr>
<td>Part time job</td>
<td>7 (21%)</td>
<td>1 (09 %)</td>
<td>7 (26%)</td>
</tr>
<tr>
<td>Full time job</td>
<td>2 (05%)</td>
<td>1 (09%)</td>
<td>1(04%)</td>
</tr>
<tr>
<td>Length of residence (Median)</td>
<td>8 yrs</td>
<td>8 yrs</td>
<td>8 yrs</td>
</tr>
<tr>
<td>No. of years within which became pregnant after immigration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 yr</td>
<td>13(38%)</td>
<td>3 (27%)</td>
<td>10(43%)</td>
</tr>
<tr>
<td>2 yrs</td>
<td>5</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>3 yrs</td>
<td>5</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>&gt;3yrs</td>
<td>11</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>No. of children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>9(26%)</td>
<td>3(27%)</td>
<td>6* (26%)</td>
</tr>
<tr>
<td>2</td>
<td>18(53%)</td>
<td>8(73%)</td>
<td>10**(43%)</td>
</tr>
<tr>
<td>3</td>
<td>5(15%)</td>
<td>-</td>
<td>5(22%)</td>
</tr>
<tr>
<td>4</td>
<td>2(6%)</td>
<td>-</td>
<td>2(9%)</td>
</tr>
</tbody>
</table>

*Includes 1 woman pregnant with 1st baby

**Includes 1 woman pregnant with 2nd baby
Fig. 5.1: Journey from home to prenatal care facility: mediating factors

![Diagram showing journey from home to prenatal care facility with mediating factors]

- Distance
- Transportation
- Went alone or accompanied by somebody
- Taking care of children
- Managing household work
- Managing outside work commitment

Fig. 5.2: Elmhurst hospital, New York City, a major prenatal care facility for South Asian women
Fig. 5.3: South Asian women arriving at Elmhurst hospital with kid and baby in stroller

Fig. 5.4: Welcome sign in Bengali in Elmhurst hospital, New York City
Fig. 5.5: Signs giving direction to Medicaid office, Bellevue hospital, New York City
This chapter focuses on Bengali immigrant women’s use and experience of informal care during pregnancy. It is based on accounts from in-depth interviews conducted with a sample of Bengali immigrant in New York City. The aim is to explore the role of place, culture and gender in shaping their care environments during pregnancy. The results emanating from interpretative analysis of interview conversations are organized according to a set of emergent themes. The themes center on women’s efforts to seek and use informal care and support during pregnancy to maintain their physical and emotional health and well-being.

The sample of Bengali immigrant women interviewed comprised of Muslim as well as Hindu women from Bangladesh and Hindu Bengali women from India. These women from neighboring countries in South Asia speak the same language and have common historical ties, but live in diverse settings in New York City produced by differences in socioeconomic status, migration trajectories, religion and culture. I examine the nuances of Bengali immigrant women’s experiences of informal prenatal care by reflecting on similarities and differences among sub-groups in the larger Bengali community. The chapter is divided in two broad sections followed by summary and conclusion. The first section consists of themes related to use and experiences of informal pregnancy care for women from Bangladesh and the second section is a description of Indian Bengali women’s experiences of informal pregnancy care.
Use and Experiences of Informal Pregnancy Care:

Women from Bangladesh

Home, place and pregnancy care

The women interviewed received a lot of informal care in the form of advice, support and help from family members, friends, relatives, neighbors, acquaintances and co-workers. In addition to the medical care received in the hospital or clinic, informal care determined to a large extent the overall experience of pregnancy and health care for the women.

Care and support from husband:

Most of the women interviewed received some help from their husband. The amount of help, however, varied depending on several factors such as whether the husband wanted to help; whether he had the skills, know-how, experience and competence to do household chores; and if his job hours and responsibilities left him with the time and energy to effectively take care of his wife and assist with domestic chores.

A few women were fortunate to receive a lot of help from their husband including physical, mental and emotional support. The husband helped by doing a major part of the household work such as cleaning, laundry, taking care of children and even cooking. Relatively flexible working hours and an understanding employer meant that these men could spare the time to be with the wife when she needed him most and be a source of help and support. In some cases, husbands couldn’t help much with domestic chores but they provided a lot of mental and emotional support, for example, regularly enquiring about wife’s health and if she needed anything, trying to bring foods that she wanted to eat, taking her to places she liked to visit. These husbands also helped to ease their wife’s
physical discomfort and pain by, for example, massaging oil in the back and feet, massaging lotion in the belly to prevent stretch marks and helping with putting on shoes during the later stage of pregnancy.

“..I used to vomit a lot..many a times after dinner or lunch I used to feel so nauseated I could not wait till I got to the bathroom..my husband never allowed me to clean it, he used to do that with a smiling face..he used to help me with cooking, cleaning, laundry and never allowed me to do any heavy work..he did so much for me during both the pregnancies, sometimes I used to forget I was staying so far away from my home and my parents.”—Nira (Hindu)

“During my first pregnancy I suffered from a lot of complications..I could not eat anything because of queasiness..my husband helped me as much as he could during that time..he helped me to take showers, to eat, in fact everything that I couldn’t do on my own..sometimes I could not get up from the bed and he would carry me to the bathroom and help me take my shower.”— Indira (Hindu)

“..yes, he did everything that he could..I suffered from serious back pain then..he used to massage the ointment that the doctor had prescribed..he used to remind and give me the vitamin tablets before I went to bed.”— Payel (Hindu)

“..during the last month of my pregnancy it was difficult for me to bend and do any work..my husband used to help me wear my socks and put on my shoes..I think all pregnant women need this help especially during winter when one has to wear sneakers. Also during my pregnancy I used to sleep on the sofa, it was difficult for me to sleep on the bed, and my husband used to sleep near the sofa on the floor so that he can help me if I had any problems.”—Husna (Muslim)

“..actually you know when we are pregnant husbands take a lot of care..that is what I felt..they always ask if there is any problem, they remain concerned..even when my husband was at work he used to call up and see if everything was going well..and he used to help with household chores as well, for example I couldn’t mop the floor then, he used to do that, or may be when I did not feel well he used to do the cooking.”— Sakeena (Muslim)

Many other women, however, did not receive as much help they would want to from their husbands especially with household work requiring physical labor and also
with the care and affection that pregnant women so badly need during pregnancy. In countries like India and Bangladesh, traditional gender roles still have a stronghold in the minds of people, and in general women are expected to do the household work while men are expected to work outside and earn a living for the family. Domestic responsibilities including cooking, cleaning and child-rearing are strongly identified as ‘women’s work’ in typical South Asian families (Rosa 1995). Even if women work outside the home in part time or full time jobs, they have the primary responsibility of managing all the household work. Because of these gender divisions, most Bengali men do not have the experience or competence to do household jobs, and even if they want to they cannot effectively help the women.

Many of the women in the sample spoke of these traditional gender roles and how they impacted the husband’s willingness and ability to help during pregnancy.

“..my husband did not help me with any household work..I had to do everything on my own, cooking, cleaning, laundry, taking care of the older baby..my husband doesn’t even pour a glass of water for himself..I think since he works outside he has this mentality..since I don’t work outside I have the responsibility of all the household chores..I also cooked daily even if I didn’t feel like since he did not want to have previously cooked food..”—Faizia (Muslim)

“..actually in Bangladesh, the husbands usually take the wife to the hospital, buy what she likes to eat, or asks how she was feeling, that’s it, the rest is taken care of by other members of the family..here for example, my husband, he used to do things for me, like going to the hospital, going for walks with me or bringing food I wanted to eat..but there is a cultural gap you know, he has done what he had learned from his culture, I won’t blame him for that..but I didn’t get much help with household work you know, and it is difficult to mop the floor or clean the bathroom during pregnancy..”—Alisha (Muslim)

They also described how the experience of immigration and living in a different place and culture was re-shaping those gender divisions.
“..you know the situation in our country, according to our culture in Bangladesh, women are supposed to do the household work and men are supposed to do outside work, but when married couples come here and the woman starts working outside, the husband has to help..my husband helped by doing some of his work which traditionally I am supposed to do..but not so much with regular household chores.”—Rita (Hindu)

“..most of the time husbands in our home country don’t seem to take special care of the wife during pregnancy because traditionally it is the other female members who take care of pregnant woman..and also men feel that women know the place well and also speak the same language, so she will be able to manage.”--Noini (Hindu)

“..no, you don’t see that in our country, actually the system is different in our country..there are readily available and affordable helpers and maids, and then family members and relatives help a lot..so husbands don’t need to take special care of their wife..”—Mrinmoyi (Hindu)

“..in home country you know there is no question of getting help from husband, we have our parents, our relatives, our own brother and sister, we usually ask them for help, they do most of the things, even taking to the hospital..so most women don’t need help from husband in Bangladesh..but here we need our husband at every step, we need their help in everything we do.”—Rokeya (Muslim)

Gender roles and cultural beliefs and practices structured Bengali immigrant women’s pregnancy care experiences differently for Hindu and Muslim women. It was relatively less common among Muslim women to receive husband’s help in household work and childcare compared to Hindu women. Even fewer mentioned receiving help in caring for themselves. Breaking of traditional gender roles and receiving husband’s care and support was more common among Hindu women.

Beyond traditional gender roles, the responsibilities and time-space constraints associated with earning a living and sustaining the family prevented many husbands from helping even if they wanted to help. Working hours and work schedules determined how much time and energy a husband had after coming back from work. In many cases husbands worked for long hours outside home and did multiple jobs. The majority of
husbands as mentioned before are employed in low-income jobs such as bartenders or waiters in restaurants, as helpers in delis and grocery stores, as cab drivers, as vendors in streets or subway stations. Often times they did multiple jobs to sustain the family and worked for 10-12 hours a day. The work pressure and workload meant that they were so exhausted at the end of the day that they could hardly do anything to help their wife even during her pregnancy when she needed it most. Also, working in low-wage, precarious jobs, many husbands feared taking time off from work or could not afford to take time off to assist their wives.

“..I had to do the household work all by myself..her (pointing to daughter) father was there but he was very busy and couldn’t help me much..he used to work in the restaurant..Friday, Saturday and Sunday he used to work for almost 18 hrs everyday, 11 A.M. to 11 P.M. is normal working hours and when there is a party or something he works for upto 18 hrs and return home at around 2:30-3:00 A.M...”—Reba (Hindu)

“..my husband’s working hours used to drive me crazy..there were days during my 2nd pregnancy when he came back at 4:00 or 5:00 A.M. in the morning and again left within an hour if he had the duty to open the store in the airport..he would come back for an hour just because employees are not allowed or he didn’t feel like sleeping in the airport..there were also days when he came back at 2:00 A.M. and again left at 3:00 A.M...so he hardly got any time to help me..”—Indira (Hindu)

“..no, I wanted to ask for help, but there was no one, no one I could ask for help, I did not know anyone around..my husband was also new to this place, he hesitated to take leave from his work..he took just 2 days off when our daughter was born..”—Ayesha (Muslim)

The ongoing tension between incipient changes in traditional gender roles and the restraining effects imposed by structural forces surfaced clearly in these women’s narratives. Their expectations were not just shaped by the cultural beliefs and practices of their place of origin, but were influenced by gender norms in the host society and the limitations set by their situational context.
“..here? yeah, for example cleaning the oven-top or cleaning the sink, he used to do these during the first 2-3 months..he didn’t let me do it..even the doctor had asked him to help me with these since the chemicals in the cleaners can be harmful for the baby..then after 3 months I used to tell that I will wrap a cloth around my mouth and nose and do it, it will be ok..how much can I ask from him? He also has his work, so after 2-3 months I used to do most of the cleaning..”—Rokeya (Muslim)

“..he always used to tell me not to do any work that is tiring for me but I used to feel bad you know..he works the whole day in two shifts, again he will come and do all these work at home..and he will return from work at 11 P.M. or 12 A.M..so even if I felt tired after cooking, cleaning the fish and all that you know, I used to try to clean the kitchen..I would sit for a while, take some rest and continue with the work, it was very difficult though.. “—Rokeya (Muslim)

“..yes he helped as much as he could..here the main thing is earning money, without income how will be pay our rent and other bills?..he helped as much as he could after coming back from work or taking leaves whenever absolutely necesssary..but outside work is more important for him to do..”—Nusrat (Muslim)

“..you know I conceived after many years of trying, so even though my husband doesn’t help with household work much, but during my pregnany he cooperated as much as possible..first few months when I was advised bed rest he even did the cooking..but still I had to do most of the work..my husband used to wake up at 5 in the morning and leave home at 6 A.M. and again return at 8 in the evening..naturally I had to take care of all the household work..and to tell the truth it is difficult for a person to work 11 hours outside home and then doing household work as well..I did not work outside, so we were dependent on his earning..so he tried but could help me only partially.”—Jahanara (Muslim)

Care and support from other members at home:

Some women had the privilege of having their parents, in-laws or relatives either living in the same house or living close-by, and received a lot of help and support from them. Such support meant that a woman could experience pregnancy in a somewhat similar social setting as in her home country. It definitely provided a stronger and deeper social support then received from newly formed friends and acquaintances after coming here. Living in a traditional joint family or having family members and relatives living
closeby was more common among Bengali Muslim women compared to their Hindu counterparts.

The benefits of living in a joint family are evident in the case of Aamira, a long-term immigrant, who lived with her parent’s family during both her pregnancies and received a lot of help from her mother, father, sister, sister-in-law, brother as well as brother-in-law. She never had to worry about cooking, grocery, cleaning and laundry although she tried to help in domestic work as much as possible. She could continue college during her second pregnancy as her parents and other family members willingly and happily took care of the older baby. In addition to readily available help with household work these women received a lot of mental support, advice and suggestions, as well as help with ride to the hospital.

“..my mother lives here in the same building and same floor, so whenever I felt really bad I used to go and stay in my mother’s house..she also used to come often to see me..whenever I had back pain or any other uneasiness or got concerned about swollen feet or ankle she was always there to ask for advice..she always gave good advice and it was very comforting to have my mother so close-by..”—Rubeina (Muslim)

“..when we first came here we used to live with my husband’s distant cousin and her family..they helped me a lot during my pregnancy..she as well as her parents and husband..they did not let me do any heavy household work..since I had conceived after many years you know they used to take special care of me..”—Inayat (Muslim)

Several women lived with room-mates who also offered their helping hand whenever necessary.

“..we have two room-mates, both are my husband’s friends..I have received a lot of help from them during my pregnancy, they used to help me with cooking specially cutting the vegetables or cleaning and scraping the fish and also with cleaning the house and bathroom, then doing groceries..it was really nice that I got this help..” —Payel (Hindu)
“..my distant brother used to live with us as a room-mate..he helped a lot.. he used to do most of the grocery and also helped with anything I needed..”—Nusrat (Muslim)

However, for a few women, living jointly with relatives or with room-mates meant doing extra work such as cooking for the whole family or for the room-mate and not having the flexibility of taking rest whenever she felt like. Some women mentioned having pre-assigned work responsibilities when they lived in joint families

“..I did all the work, cooking and other work, it was not just for one or two people, we were eight to ten people living together, four members of my sister-in-law’s family, three of us, there was a relative of ours and his mother, we all stayed together, we shared and did all the work together..but sometimes I felt it was too much for me when I was pregnant..”—Rita (Hindu)

“..we used to live jointly with my husband’s brother and sister in law during my pregnancy..but even though they are my relative I did not receive much help from my sister-in-law..we had a routine like if she cooked one day I would cook the next day..the same with other household work like cleaning the bathroom or the floors..during the later stages of pregnancy it was difficult for me to sit and mop the bathroom floor, it was also difficult for me to cook meat or fish..I used to wrap a towel around my face and nose to avoid getting the smell..but since I was living in a joint family I had no other option but to do these work whenever my turn came..my sister-in-law did not offer any help..”—Alisha (Muslim)

“..I have to do all the work myself..there is no one to help me..my husband helps with cooking and laundry during his off days..but otherwise I have to cook everyday because we have a room-mate..”—Rabia (Muslim)

Traditional gender roles and beliefs that define a daughter-in-law’s role in typical Bengali and South Asian joint families also played a role in increasing the burden of work for some women and limiting her space of relaxation, flexibility of scheduling household work according to her own physical comfort. A daughter-in-law is expected to take the major responsibility of household work and give relief to her mother-in-law (Rosa 1995). Some women felt pressure to live up to the expectations of their in-laws.
Women felt guilty taking rest or postponing work for the later part of the day in case their in-laws would look badly upon them.

“..If I go back to bed after dropping my son to his school in the morning my in-laws may feel bad..so I would go to the kitchen and make tea for them..when I am alone at home I can do the chores in my own time and take rest when I feel like..but when my in-laws were here I never used to leave unwashed utensils in the sink in case my mother-in-law thinks that I have left it for her to wash.”—Roma (Hindu)

Women’s relationships with their husbands were also affected. In traditional Bengali culture, it is unusual for husbands to participate in women’s pregnancy care practices and provide her physical and emotional support. It is the women folk who take care of pregnancy and childbirth and men are expected to remain at a distance. Women living in joint families with elderly members were sometimes unable to seek as much help and support from their husbands or even ask husbands to manage their own, regular, self-sustaining work, being apprehensive of what other members would say.

But in general, for most women, living in a joint family or having in-laws visit during pregnancy was an advantage. Whatever help they received from them was always better than not having anyone around to help or give mental support.

*Place-based networks of care:*

Most of the women interviewed received help from friends, neighbors and relatives during pregnancy. The amount of help received however varied depending on the neighborhood the women lived and their length of residence in the US. These factors together largely determined the extent of social networks women had. Long-term immigrants had a greater chance to widen and strengthen their social networks during their course of stay in the U.S. and living in a neighborhood with greater concentration of
Bengali women and women from South Asia in general had a positive effect on the creation and widening of these networks.

The social networks were mostly created and maintained in apartment complexes, on the streets, in stores, in nearby parks, in children’s schools as well as in spaces of social, cultural and religious activities such as the temple. A majority of the women interviewed lived in apartment complexes. These women mentioned other Bengali women living in the apartment building and living closeby as important friends they could seek help from.

“..I got to know them after coming to this country..this is what happens here, other people in the community become like relatives, helping us when we need it..friends help a lot here, people understand each others problems since everyone goes through similar situations..actually I don’t have any close relative here, whatever help I have received is from friends..”—Gita (Hindu)

“..in our home country it is the family members from whom we get support during pregnancy..but here I see that neighbors and people who live close-by, if they see that you are pregnant, you are carrying a baby, then they help you a lot..the support we get from family members back at home is shown and given by neighbors and friends here..”—Indira (Hindu)

“..here Bengalis living in the neighborhood always help each other..you know here your neighbor specially if they are from your homecountry they become like relatives..and there are a lot of Bengalis here, I mean people from Bangladesh, they really help each other a lot..whenever we have any problem they come forward to help..in this neighborhood we don’t have to worry about where we can leave our kids if necessary when we go to the hospital or any other place..and neighbors take good care of other’s kids..you know we have that much of trust on each other..that is why we don’t have to think twice before asking for any help..otherwise it may have been so much difficult..”—Nusrat (Muslim)

As mentioned earlier women with children often relied on place-based social networks for tangible assistance with childcare and sometimes household tasks. Friends and neighbors helped out by looking after children and picking them up or dropping them
to school, when women had to go for prenatal care visits or if she did not feel well. In addition to this, taking care of food aversions and food cravings emerged as a very important support provided by friends, neighbors and relatives. Bengali cuisine is replete with simple but delicious recipes of grandmothers and mothers and most of the women mentioned how badly they missed the food their mother or grandmother prepared at home. Many of these preparations taste good to pregnant women suffering from nausea who cannot stomach very spicy food. Also some women found it difficult to cook and eat foods they wanted because of nausea and quiesness, especially during the first few months of pregnancy. Friends, neighbors and relatives helped much by cooking and sending or bringing food women usually crave to eat at this time and also sometimes cooking and bringing food for the whole family and giving respite from kitchen work.

“..during my 2nd pregnancy there was this Bengali couple living next door..she used to come and see me if I did not feel well..if she found me sleeping because of dizziness or weakness she used to cook and prepare food for me..it was a great help I received from her.”—Mrinmoyi (Hindu)

“..there was another friend in the neighborhood..whenever she used to cook something nice she used to bring for me..and you know how women love to eat what others cook during that time..one day she cooked shrimp with pumpkin leaves, a delicious Bengali side dish.. the pumpkin leaves was from her own house, she had planted it herself..it was so delicious..I will remember it all my life..my good wishes will always be there with her.”—Nira (Hindu)

“..here it is not like home country where my mother used to take care of my food, cook nice dishes for me and also force me to eat healthy foods..but here many of my friends cooks and bring over food that I feel like eating or invites me to their house..the elderly Bengali lady who baby sits my daughter always cooks and sends something everytime I keep my daughter with her.”—Rabia (Muslim-pregnant)

“..I used to go to my friends’ house..during pregnancy they used to cook special dishes and bring food for me..you know during pregnancy women like to eat food cooked by someone else..I used to really wish if I could eat
certain dishes prepared so well by my mother...but she is so far away...” – Salima (Muslim)

“...here other Bengali women living around always asked if I wanted to eat anything special, they often cooked what I felt like eating, or gave me anything special that they made at home...I have seen that Bengali women here, I mean women from Bangladesh really try to give support and help each other during pregnancy...”—Nusrat (Muslim)

“...many of my neighbors cooked and brought food for me...they used to call up and ask what I felt like eating, later they used to cook and bring that for me...here we don’t have anyone, my mother came much later, during my 2nd and 3rd pregnancy there was no one, I was living all alone...so I think this help from neighbors was a lot...to take out some time and cook for me, I think it was really helpful of them...”—Sakeena (Muslim)

Almost all women interviewed mentioned receiving advice and suggestions from neighbors, friends and relatives to live a healthy pregnancy. In general, taking good care of health, eating healthy foods, going for walks, looking and feeling good, keeping the mind stress free and happy were advices that women received in abundance. Some women also mentioned receiving help either with household chores or with some outside work like grocery.

“...here we get a lot of help from Bangladeshi and Indian neighbors...there was a lady who lived in our apartment, she was like my elder sister...she helped me a lot when I was pregnant with my first daughter...she tried to help with my household as well as outside work...”—Gita (Hindu)

“...neighbors used to tell me to eat properly...one need to eat properly at this time...if you eat well your baby will also be healthy...there were 2-3 neighbors who always advised me on eating well, when we met and also over the telephone...”—Rita (Hindu)

“...particularly I remember ‘Shubhra boudi’ in our apartment, she helped me a lot when I was pregnant with my first daughter...she used to give very good advices, like looking and feeling good during pregnancy is very important because it has a positive effect on the baby...I used to feel very nice whenever she came...she used to come almost everyday to enquire if everything was ok and to help me...who does this much in a foreign land for just a neighbor?...”—Nira (Hindu)
“..my husband’s elder brother and his family lives here, closeby, just a few blocks away from here..they also have kids and remain busy, but they helped me as much as possible during my pregnancies..then I have friends here..if I needed something from the market they would buy it and drop it at my place on their way home..”—Salima (Muslim)

The advantage of living amidst networks of family members and relatives is especially evident in the case of the high-income Muslim women living in upscale neighborhood in Hillside, Queens. Having mother, grandmother and aunts close-by meant that help was always readily available. As in the case of Aamira, having immigrated to the US at an early age, these women enjoyed strong family support during pregnancy.

“..lot of my family members live here, my mother is here, my grandmother is here, and me and my brother were basically raised by my grandmother and I was lucky that she was here since everytime I had a question I could call her..even though she is kind of old right now she did her best..”—Mehar (Muslim-high-income)

“..during the later part of my first pregnancy my belly became huge..everybody thought I was carrying a twin you know..and I was worried that may be I will have a C-section..my grandmother then advised me to mop the floors regularly..so I used to regularly mop the bathroom floor upstairs..and she also asked me to sit in squatting position and dust the carpet and walk a lot to help my uterus to open up..I followed all her advice and I had a normal delivery you know..”—Mehar (Muslim-high-income)

“.. my maternal aunt, her husband, my father and my brother, they all live in one house, on Hillside, very close from our house..they always come here and my in-laws also live closeby..so basically we all live in the same neighborhood..my maternal aunt is just like my mother you know..whenevere she came during my pregnancy she would go straight to the kitchen and finish up the cleaning or do some cooking or take care of the older baby..I always feel that she did and still does what my mother would have done if she was there..”—Naaz (Muslim-high-income)

In addition to these local neighborhood networks of support, women also relied on social networks located in other parts of the city. Friends and relatives living at a
distance but within New York City visited some women now and then to help out, give mental support and spend time together. They would often cook and bring foods and give the women a respite from a day or two of cooking. Women also received a lot of advice and mental and emotional support from such friends and relatives over the phone. Reliance on more dispersed social networks for help and support during pregnancy was important for newly arrived immigrants who did not have strong local ties yet. The help received from apartment neighbors and women living close-by, however, was more tangible than that received from more distant, geographically dispersed social networks, which was often, limited to phone calls, advice or occasional visits. Still such help were significant in women’s experience of pregnancy.

“..I was new to this place when I was pregnant, I did not know people in my neighborhood..I used to rely on my husband’s aunt for help and advice..I used to call her and ask for advice anytime I felt uncomfortable or uneasy..she is living here, in Astoria, for a long time..her children were born here, so she knows a lot about this place and is very experienced ..”—Payel (Hindu)

“..yeah my maternal aunt and uncle lives here..then my cousin brother and his wife are there, they have a kid just 1 month older than mine..I used to call her up and tell her about my symptoms and we used to discuss about our pregnancy..she used to advice me to prepare and eat foods that suits my taste, otherwise if I don’t eat well the baby will not grow..she used to also give me recipes of dishes liked by pregnant women..”—Faizia (Muslim)

“..my doctor as well as our friends and relatives used to advice me to eat healthy foods like milk, egg so that the baby becomes healthy.. the wives of my husband’s friends used to tell me always to eat well..they live in different parts of Queens like Astoria, Jackson Heights..”—Suraiya (Muslim)

“..a maternal aunt of mine lives here..she is a little elder to me and she came here before me and had a baby here, so she had an idea of how things work here..she used to advice me about taking care of myself and tell me not to miss any appointments in the hospital..then I have an elder
sister here, she used to tell me to eat well and to take the vitamin and iron supplements regularly.” –Noorjahan (Muslim)

“..and there are a few relatives who lives in other areas in Queens..they used to visit on and off..during the later stages of pregnancy I had swollen feet and ankle..I took leave from my job and stayed at home for 1 and a half months..then they used to come and stay with me..they used to cook and bring over foods and stayed the whole day..so my days used to pass off quickly and nicely talking to them and having them around..”—Noorjahan (Muslim)

Local parks, schools and community centers such as the temple were very important as sites where social networks were created, maintained and reinforced. The temple, for instance, formed an important community space for Bengali Hindu women where they met other Bengali women, made friends and gained acquaintances (Fig.6.1). Most of the Hindu women from Bangladesh regularly visited the Bangladesh Hindu Mandir (temple), located in Elmhurst, Queens (Fig.6.2). In this temple women met for religious and spiritual activities as well as for social, cultural and educational activities catering to their children. As a meeting and gathering place for women from the same religious, cultural and linguistic background, the temple formed a site where women interacted with each other with utmost ease and comfort. For pregnant women it was a place to meet and talk with women who already have had children here and also other pregnant women and ask and receive advice and share and exchange information.

“..during the weekends, friends used to visit us or we used to go to someone’s house, every Saturday and Sunday we used to mingle with our friend circle..Saturday evening we used to go the temple..so we used to meet all our friends there..”—Misti (Hindu)

“..when I was pregnant with my 2nd daughter we used to go to the Bangladesh Hindu temple..there we used get together with all our friends..I used to receive a lot of advice from them like taking care of myself, doing this, doing that, not to catch cold..lots of advices..”—Gita (Hindu)
“...one day I did not feel my baby’s movement the whole day. I went to the temple that evening to attend a ‘puja’ (Bengali term for worshipping), there I related my concern to my husband’s friend’s mother, she asked me to go to the hospital immediately. I went back home, collected the hospital papers and went to the emergency. Although everything was fine, I felt nice that aunty had insisted that I go and get a check-up. The doctor also said if this happens again I should go to the hospital immediately.”—Payel (Hindu)

For most Bengali Muslim women, the mosque did not form an important site for creation of social networks. Only the high-income Muslim women, who belonged to a separate sect of Islam called the Ahmadis, went regularly to the mosque built for their community. They are followers of Mirza Gulam Ahmed of Qadian in India, the founder of Ahmadiyya religious movement with headquarters now based in UK. These women received a lot of advice and support from other members in the mosque and the social gatherings offered a space where pregnant women shared and discussed their experiences during pregnancy.

“...when a woman is pregnant she gets special treatment in the mosque. She is offered chair to sit, the elderly women come and enquire if everything is going alright and give advice and suggestions. I always enjoyed that because to me they were like mother’s advice.”—Mehar (Muslim-high-income)

“...during the breaks and snack times we used to socialize and talk with each other. Elderly women used to give us advice. There were a few other women also pregnant at the same time and we used to talk and discuss about our experience of pregnancy.”—Naaz (Muslim-high-income)

“...my husband had gone to Bangladesh for sometime when I was pregnant. Then everybody from the masjid (mosque) used to call up and ask if I was doing ok, if I needed something, they asked me call up and let them know anytime I needed anything.”—Naaz (Muslim-high-income)

“...I used to suffer from severe back pain during my pregnancy. I mentioned this to the President’s wife in our mosque and she gave me the contact of an Indian ‘dai’, an expert in giving massages to pregnant women. She lived at walking distance from our house and agreed to come to my house regularly. It was such a relief to get her help you know...she
was very strong and knew her stuff really well..I soon got relief from the back aches because of her excellent massages.” —Mehar (Muslim-high-income)

For both Bengali Hindu and Muslim women, local services including neighborhood parks and their childrens’ schools formed important sites for creating and strengthening social networks (Fig.6.3, Fig.6.4) The school and the park offered spaces where parents came together and those from the same linguistic background easily bonded in a keen sense of mutual help and support. The extent of this bonding, rooted primarily in their concern for care for the children, also went beyond that to a more general sense of community well-being and friendship, and helped women a lot during their pregnancy.

“..I made a lot of friends here in the park..we meet a lot of Bengali women there, then may be we exchange phone numbers, then you know paying visits..they are like friends as well as like sisters you know..I mean I have received a lot of help from them during my pregnancies..I also help them in every way possible whenever they need.” —Salima (Muslim)

“.. during my pregnancy I used to go the park here whenever I got time, it is right across the street around the corner..you know a lot of Bengalis go to this park..we used to talk and chat..I made quite a few friends there you know..” —Nusrat (Muslim)

“..our circle is very big here..in the park you will see a huge group of Bengali women..sometimes we jokingly call ourselves the Bangladeshi Women’s Association of Sunnyside..we have met each other in the park and have very good relation with each other..because I had a difficult pregnancy I couldn’t visit the park then but I was in regular touch with everybody over the phone..” —Jahanara (Muslim)

“..I liked living in this neighborhood during my pregnancies specially during the 2nd and 3rd pregnancy..you know the Bengali neighbors I was acquainted with, I used to see them in my kids school regularly..we used to gather and talk about various things.. they used to give me many advice, for instance I need to walk a lot, then what to eat, how to take care of myself..I used to like that you know..” —Aaan (Muslim)
Women who worked outside also received help, advice and support from their co-workers and supervisors. These women mentioned specifically about receiving help from other Bangladeshi and Hispanic co-workers.

“..sometimes when I was pregnant, I did not feel like working, so I used to tell my supervisor that I was not feeling well I want to go home, she used to let me go..or sometime I used call and say I won’t be able to come, they cooperated..I would request a co-worker to work on my shift and someone would help always..”—Mrinmoyi (Hindu)

“I needed help in my workplace..my Spanish supervisor and a Bengali colleague helped me a lot, others helped too but they did a lot for me..they never allowed me to lift any heavy box..you know in workplace we have to do everything, even lifting heavy things..my other Spanish colleagues, both women and men tried to help me in whatever way possible..women especially offered a lot of advice as well, not to do heavy work, not to walk too fast..one of them also gave me rides to the subway stop since it was almost 5 avenues from my work place.’”—Noorjahan (Muslim)

“..at my work place everyone tells me to take rest whenever I get a chance, not to lift heavy things..my manager doesn’t let me lift any heavy things, she brings the boxes for me and asks me to sit and do the work..then when I sit in the cashier sometimes the customers put heavy things in the counter, there is an elderly woman called ‘Lucky appa’, she helps me to lift those..everybody in my work place helps you know..”—Rabia (Muslim)

The extent of help received from social networks was less for relatively recent immigrants compared to more long-term immigrants. Several women mentioned having a difficult time during their first pregnancy in the US compared to later pregnancies as they knew very few people and felt hesitant to ask for help.

“..when I came here for the first time I was already 3-4 months pregnant and I used to miss home terribly..I seldom saw any Bengali or Indian face around..I did not know anyone, there was no one I could talk to..I became very homesick and used to cry most of the time..we had an acquaintance here who lived in Queens and I used to eagerly wait to get an invitation from her to visit her place..I couldn’t just visit her whenever I wanted..then I missed having elderly female members at home who could give me advice and suggestion on pregnancy..I really missed all these help and support during my first pregnancy..”—Mrinmoyi (Hindu)
“...I became pregnant within a year and a half after coming here and I actually faced a lot of difficulty because we did not know how things work here, just to get a pregnancy test we had to go 3 days to the hospital because we didn’t know that in Elmhurst hospital one has to go very early in the morning and be among the first 25 in the queue to get a test done...so we have learned at every step, there was no one to give us advice...I did not have anyone to help me, in the apartment building we lived there were no Bengalis...”—Indira (Hindu)

“...I wanted to ask for help, but there was no one, there was no one I could ask for help, I did not know anyone around...it was difficult you know...there was just one elderly acquaintance whom I used to call up and ask if I had any questions about hospital, such as papers required to apply for Medicaid...”—Ayesha (Muslim)

For other women, in spite of help received from local, place-based social networks, many mentioned that the help was always less than what they would get in their home country. Despite efforts to create supportive spaces of everyday social life, those spaces were always structured by the time space constraints that characterize people’s busy lives in the US. Some women specifically mentioned that they hesitated to ask help from friends and neighbors because they are too busy working both at home and outside. Because of this, local help was often limited, especially compared with the level of help in the home country.

“...I did not get much help from neighbors, not even from friends...even though he has very close friends, they are all busy with their work and after coming back from work they have to do their household work and cook for themselves...it is difficult for them to help me...in Bangladesh there is someone to cook for you when you work outside...so people get time there to help others...”—Roma (Hindu)

“...I received help from my neighbors and friends, from our next-door neighbor, then from the family across the street, their son and my son went to the same school...with others it used to be mainly hi, hello, everybody is busy here you know...we speak over the phone but here we don’t get to visit each other a lot...everybody remains busy, life itself is busy here...”—Rokeya (Muslim)
Bengali immigrant women’s accounts of receiving help and support during pregnancy revealed the influence of memories of home country in forming meanings about care environments provided by local social networks. A majority of women mentioned missing the care and support that would have been available in home country. Women missed the ‘special care’ they would have received from their mother, father, siblings, even in-laws and the ready availability of domestic helpers. Having spent a good part of life in home country, women had to come to terms with the reality here, the absence of the typical family and social support structure they were so used to seeing there. Most women felt that an established social support structure consisting of close family, friends and relatives readily available for help and support would have made their prenatal months less stressful, happier and more enjoyable. Knowing from preconception time that there would be reliable help from close family and relatives would have helped to provide women with a relatively more relaxed environment to live their pregnancy.

A few general differences between help and support available here and in home country emerged from the women’s narratives. First, the amount of help sought and received here was structured by time-space constraints that characterize people’s lives in a big city like New York. Second, here women always thought of help as mutual and felt the need to do something in return, whereas in the home country such help often came without any obligation, so women would ask for help more frequently and freely. Third, sometimes women felt hesitant to ask for help from acquaintances, new neighbors and new-formed friends. These feelings were especially strong for recent immigrants and women who had become pregnant in Bangladesh before coming here or went back for sometime to Bangladesh during pregnancy. For relatively long-term immigrants, with
larger and extended social networks as sources of more regular and systematized informal
support, such feelings were mitigated to some extent.

“..I used to remember my home country a lot during my pregnancy..if I
was in Bangladesh I would have asked my mother to give this or give that
to me, I would have asked my sister to do this to do that for me, then I
would have visited my sister quite often..no matter how much friends or
neighbors you have here no one can replace your mother, father and
siblings..that is what I missed most during pregnancy and since I was in
Bangladesh during first pregnancy I knew what I was missing here..”—
Rita (Hindu)

“..the support during pregnancy from beginning to end, here definitely our
friends and acquaintances have tried to give me advice and support, they
have called up and given me courage or whenever we met..but in
Bangladesh I would have got that physically, physically as well as
mentally..that is the difference you know between here and home
country..”—Indira (Hindu)

“..in Bangladesh I spent a much better time during my pregnancy, I did not
have the sole responsibility of household work, then I did not have another
child to take care..I didn’t have to cook regularly, my mother-in-law, my
sister-in-law, we all used to divide the household work among ourselves,
then we also had helpers at home, but here I am bound to do the regular
chores, even if I did not feel well or felt dizzy I had to go to pick up my
son from school, wake up early in the morning..”—Roma (Hindu)

It was perhaps in the context of remembering and imagining the ‘special care’
from family members and neighbors and readily available help with household chores
that women missed home country most during pregnancy. The amount and type of help
received from the husband and local social networks in the host country often did not
give women respite from regular household chores and childcare responsibilities. Most
women expected a different situation had they spent their pregnancy in Bangladesh with
help and support primarily geared towards lightening the burden of routine domestic
chores. Many women therefore felt lonely during pregnancy and spoke about ‘home in
New York City’ as a site of strenuous labor rather than of comfort and relaxation.
“..here I used to feel lonely at times, it used to feel very alone..I mean there were friends and neighbors but still in Bangladesh my parents, my brothers and sisters would have taken special care of me, I wouldn’t have to worry about anything, cooking, cleaning..and here I used to think that I am carrying my baby and I have to do everything, I don’t have the time to relax and even eat properly..”—Rokeya (Muslim)

“..the difference is, in Bangladesh you have a lot of people to help you when you are pregnant..there are helpers, there are people in your in-laws place, then there are people from your parents family, so we could remain more free or take rest when we felt like..but here this thing is absent, here no matter how sick I felt I had to set out a time within which I had to finish certain work..for instance, when my kid went to school I had to prepare food for him even if I did not feel well..but when I was pregnant in my home country I did not have these responsibilities such as what my husband is going to eat when he gets back or what I am going to eat..in Bangladesh I used to get everything ready, even before I spelled out I used to get what I felt like eating..”—Zaina (Muslim)

“..if I was in Bangladesh I would have had my family members and relatives closeby..here during my pregnancy if I felt like having even a cup of tea I had to make it myself, I had to get up even for a glass of water..but in Bangladesh I never had to worry about these things..”—Jahanara (Muslim)

“I have seen my mother, my aunt, my sisters in Bangladesh, when they were pregnant they got special care from everyone..all the family members used to be very excited and so many things were done that centered solely on the pregnant woman..here my friends have done their best like giving baby shower and other things, but it is so much different there in Bangladesh…I missed being there a lot during my pregnancy..”—Husna (Muslim)

“..in Bangladesh I would have got much more help during pregnancy since I have my parents, my brothers, my sisters, my in-laws, then we have helpers there..I wouldn’t have to do so much of hard work, for example they would have taken care of my kids, I could have taken rest..here even when I didn’t feel well I had to do all these..”—Salima (Muslim)

“..during my pregnancy I often used to think, if I was in Bangladesh my mother would have done this for me, or someone would have helped me, here I have to do everything alone, even if it is very tiring, still I have to do all the household work..then I used to feel sad..”—Sakeena (Muslim)
It was through regular contact maintained with family members back in home country that women’s ‘homesickness’ was relieved to some extent. These routine international calls to family members during pregnancy also gave women access to care, support and knowledge which were useful resources that helped women in their effort to live a healthy pregnancy. Emanating from transnational connections, the emotional sphere of love, affection and concern formed a rich source of informal pregnancy care.

**Transnational networks of pregnancy care**

Most of the women interviewed received advice, help and support during pregnancy from family members back in their home country. Even though situated thousands of miles away, so far that it takes a day-long flight to reach home, modern telecommunication has made it possible for immigrant women to be in regular touch with their home country. Most of the women made frequent phone calls to their parents, siblings, close relatives, and friends and received a lot of mental support, which helped them immensely to maintain their physical, mental and emotional well-being. The use of email was not very common and only a couple of women mentioned using email to communicate with relatives and friends in the home country.

“..I used to call up my family members in Bangladesh every week..I feel nice talking to them over the phone..everyweek I would call up 3-4 times, sometimes even 5 days a week during my pregnancies..”—Salima (Muslim)

“..I call up home regularly..during my pregnancy I used to call almost everyday, sometimes twice a day, morning as well as afternoon..yeah regularly..”—Faizia (Muslim)

Most of the women mentioned how badly they missed their mother during pregnancy. Even hearing the voice of their mother over the phone had a therapeutic effect helping them to cope positively with their pregnancy. Their mother also remained equally
concerned about them on the other side of the globe, feeling sad to be so far away from their daughters and not being able to be with them or help them during such an important phase of their life. Through phone conversations these women situated on opposite sides of the globe, created ‘virtual’ spaces of informal pregnancy care in which advice and mental support were sought and given. The emotional connection between the pregnant daughter and her mother was relived and reestablished in frequent phone conversations that centered on the well-being of the pregnant daughter and her baby. Most of the women made phone calls once every week and some women even called every day or on alternate days. This was true more in the case of relatively recent immigrant women rather than long-term immigrants. For the latter making frequent phone calls became possible during their later pregnancies. International calling rates have become much cheaper compared to previous rates, so today women make longer and more frequent calls back home.

“..yes, I used to call up home regularly..if I had to ask something I used to call my mother mostly and also my mother-in-law..my mother used to tell me some of the things that happen and are expected during pregnancy, comforting me if I got tensed about something..she used to tell me about some of the do’s and don’ts but at the same time she always asked me to discuss any problem with my doctor and do as my doctor suggests..I have been able to talk much more frequently during my second pregnancy..during my first pregnancy I used to call up may be every 7 days or sometimes even every 15 days, but during my second pregnancy I spoke with my mother almost everyday..you know the rates are much lower now and our financial situation has also improved..”—Mrinmoyi (Hindu)

“..during pregnancy I used to yearn for food cooked by my mother..I used to crave for dishes the dishes she prepared so well..I also used to missed talking to her, sitting by her side and just relaxing..this is what you know, I have missed my mother a lot during pregnancy..over the phone my mother used to always tell me to eat this, eat that, to tell my husband to do this or that for me..”—Mrinmoyi (Hindu)
“...I used to speak daily with my mother over the phone...she used to ask me how I was feeling...she had seen me when I was pregnant in Bangladesh...I was so sick I couldn’t get out of my bed...my mother used to remain worried...she used to feel sad that even though I was not feeling well I had to cook, take care of my son...she used to tell me...‘take rest, we are not there beside you, it must be so difficult managing everything...’...my mother used to cry for me and always wait for my phone call.”—Faizia (Muslim)

“...and it is very convenient with the phone cards now...you know I have to call up regularly...If I don’t call up one day my mother calls me up...now international calls have become very cheap, if I buy a card it lasts for about 4-5 days...so I tell her I will call up, you don’t need to...so phone card has become like medicine you know...I call up to hear the voice of my mother and to tell her that I’m doing well...”—Tuhina (Muslim)

Women received a lot of advice from their parents, relatives and friends over the phone such as eating well, not doing heavy household work or lifting heavy things, to be careful moving around and doing regular chores indoor as well as outdoor, relaxing and keeping the mind stress free.

“...yes, I used to call my family in Bangladesh once every 2/3 days, my father would call me if they did not receive my call for some reason...then my elder sister used to call me...they used to advice me to be careful, not to lift heavy things...I always bustled around the house before marriage...so they always advised me to do everything slowly and not to run around too much...”—Rita (Hindu)

“...I used to speak with my family members in Bangladesh regularly over the phone...I used to call up more when I did not feel well, to my mother’s place or my in-law’s house...I used to tell them that I was not feeling well and what should I do...they used to advice me to take rest after cooking...to try to take good care of my elder son, to feed him properly...otherwise not to worry about cooking all the time, to order food from outside when I was not feeling well...”—Zaina (Muslim)

“...my mother used to advise me to eat healthy food so that I can remain physically well...then she used to tell me to remain active and take rest whenever necessary...during the first few months she advised me not to go travel if it was not urgent, then not to do heavy work...during the last months she used to tell me to walk a lot...”—Alisha (Muslim)
“..yeah, I received a lot of advice from my family members and relatives in home country..my sister used to call me up from there or I used to call her..my mother, sister, sister-in-law, they used to remain so concerned about me as if it was their baby..they used to advice me to be very careful since I had conceived after many years of trying..all these gave me a lot of mental support you know..”—Jahanara (Muslim)

“..yeah, whenever I called up home my mother used to advice me to eat well, if I eat well I will keep healthy, my baby will also grow properly..then my friend used to tell me to have vitamins, iron tablets regularly, to take care of myself..”—Salima (Muslim)

Women also received culturally-specific advice from their mother, aunt or grandmother pertaining to specific problems or concerns associated with pregnancy. Some of these can be broadly categorized as ‘mothers’ advice such as massaging oil in the belly to avoid getting stretch marks or to ensure proper positioning of the baby in the womb, having bath in lukewarm water, resting the feet in a pillow while sleeping. Women mostly tried to follow such advices to benefit from the wisdom and experience of elderly and experienced female members in the family.

“..when I was about 5 months pregnant my sister called up and asked me to massage oil in my belly before going to bed in the night..I did not know the benefit so she explained that it will help prevent from getting stretch marks in the belly..I followed her advice and it did help, I did not get any stretch marks in my belly..”—Gita (Hindu)

“..yes I got some of such advices..my mother asked me to massage my belly with oil..it helps in the baby’s movement, it helps to enable the baby to be in a good and comfortable position..it also helps the baby to move downwards during the later stages of pregnancy..”—Roma (Hindu)

“..my mother told me if I feel any pain I should massage my belly very gently with oil.I always benefited by following this advice..my doctor here never told me to do this..I also received other advises which was based on superstition you know like not going out on Saturday evenings, or not eating certain foods such as pineapple..I used my own judgement and followed the ones that were practically feasible here..”—Mrinmoyi (Hindu)
“...mother’s advices are very helpful you know...usually doctor’s don’t discuss so much about these...they won’t ask me if I have a cold or cough...my mother would always warn me not to catch cold, if I sneeze a lot my waterbag may break...then mother would advice to rest the feet on a pillow while sleeping...since this is my last trimester there is a tendency of swollen feet...doctors usually don’t discuss about these things...these are mother’s talk...”—Tuhina (Muslim)

“...you see mothers and grandmothers have already gone through pregnancy, they are more experienced than us, isn’t it? There are many things that we have learned in medical school but in practical situations things may be so different...here you know doctor’s usually say that the baby’s weight is less, my mother would say it is not less, the baby is fine, it is in a curled up position now, its weight is ok. Then if I tell her that the baby will be around 5 lbs before delivery, she would say it is ok, for normal delivery this weight is fine, otherwise you may have difficulties...babies grow fast after delivery...”—Tuhina (Muslim)

A few culturally-specific advice imposed restrictions on women’s diet and mobility. For instance women were told to avoid certain foods such as pineapple, which is traditionally believed to be associated with miscarriage. Women were also recommended not to go out alone in the dark or during certain times and days of the weeks which are considered inauspicious. The extent to which women adhered to these recommendations was a negotiated process. It depended on what was practically feasible here. While most women adhered to the dietary restrictions, none followed any of the mobility restrictions. They used their judgement to evaluate the advices based on the differences in practical utility of such restrictions in the two countries. In countries such as Bangladesh in the busy streets in urban areas as well as in the unlit streets in rural areas the risk of accidents and falls especially among pregnant women is high, hence the restrictions. Here it is relatively safer and easier to move around outside even during the evening and most of the women did go out alone or with their kids in the evening during their pregnancy.
“..my mother advised me not to eat pineapple..we were very friendly with our doctor, so I asked her and she said there was no problem in eating pineapple..but you know I listened to my mother’s advice..but apart from that my mother, relatives and friends advised me to follow what the doctors say here..they used to say you have gone to a foreign country so do what the doctors say there..”—Rokeya (Muslim)

“..yeah, for example my mother advised me not to eat pineapple, there may be a miscarriage if I eat pineapple..and also not to drink coconut water..my doctor did not say any such thing. I did not eat those you know, I was pregnant and did not know so much and I was a little confused, so I thought I will follow my mother’s advice..”—Alisha (Muslim)

“..yeah like in our culture, in our country they say that a pregnant woman should not go out in the evening, but I used to go out, I used to go to the park..then not to eat pineapple, duck meat, then few other things that pregnant women shouldn’t eat. I used to follow some advice but not everything you know..these are what our mother and grandmother believed and followed you know..I used to follow sometimes but not always you know..”—Salima (Muslim)

“..yeah, they used to tell me not to do this, not to do that..they used to tell me for my own good you know..not to go out in the evening..not to eat this not to eat that..to eat well, to sleep in a particular way..they used to say all these things you know..I used to follow as much as I could..”—Inayat (Muslim)

Family members in home country also insisted that women listen to the advice of the doctors, acknowledging the importance of medical assistance. Differences in weather and lifestyle and belief systems in the two countries were especially recognized, which definitely warrant certain things to be done differently.

“..actually the system in our country and the system here is totally different, that is why during my pregnancy here I tried to do everything according to what the doctor’s say here..my aunt and relatives also advised that I do everything according to what pregnant women do here..and the weather here is totally different from the weather in our country..so caring instructions and advises are also different..since I conceived here and was carrying the baby here, I tried to do everything according to what is doable and advisable here..”—Rita (Hindu)
In addition to phone conversations, family members in the home country sent various gifts as well as food items for their pregnant relative in the US with visitors returning from Bangladesh or India. The gifts sent with love and affection by people with whom women connect strongly, mentally and emotionally, and from places filled with endearing memories of pre-immigration years meant a lot to the women. In addition to bringing smiles to the faces of the women, such gifts fulfil parents’ desire to do something for their daughter during her pregnancy. The emotion and nostalgia associated with sending and receiving gifts and other items captures the feeling of living closeby and receiving the warmth of parental love through direct and regular contact. Most of the time mothers sent some food items that women crave to eat but which may not be readily available here, such as home made pickles and sweets to mention a few.

“..I used to miss the milk powder we used to have with tea at home, you know the ‘DANO’ powdered milk..my mother sent it for me with an acquaintance..it was so nice and sweet of her.I haven’t thrown the empty container yet you know, I still have it as a memory..”—Nira (Hindu)

In some cases women had the privilege to experience and receive transnational care in more tangible way. The parents or in-laws of some women visited the US during the pregnancy and provided much needed help and support. However, this was more common during the last stage of pregnancy as in most cases the trips were planned so that the parents could be there to help after delivery.

“..my in-laws visited us during the last month of pregnancy and stayed for about 3 months..my mother-in-law helped me with cooking while she was here and it was definitely a big help..”—Roma (Hindu)

Unfortunately for some women, rules of immigration prevented parents from visiting. Several women mentioned that their parents could not visit even though they wanted to, because their visa was denied, a very common but heart-breaking experience
for the parents as well as their daughter. Economic and social barriers were also important. Many parents couldn’t think of making an overseas trip because of the huge expense or because of duties and responsibilities in home country.

“..I had applied for my mother so that she could come and stay with me, but her visa was declined..even my doctor had asked me to bring my mother if possible because I had some complications..but we don’t know why her visa was declined.”—Faizia (Muslim)

“..my mother wanted to come in tourist visa but my brother is small you know, so my mother couldn’t leave him and come..”—Tuhina (Muslim)

“..no, I would have tried to bring my mother but I have brothers and sisters in Bangladesh and my father is no more, so it would have been difficult for my mother to come..”—Husna (Muslim)

“..my mother couldn’t come because two of my sisters are still at home and she has to look after them..and I also didn’t want her to leave them and come..I have a brother too who is very small..”—Rita (Hindu)

“..my mother couldn’t come because my father is still working and he wouldn’t have been able to come here for such a long time..”—Noini (Hindu)

**Therapeutic spaces of pregnancy care**

The term “therapeutic landscapes” was first introduced by Gesler in his book titled, *The Cultural Geography of Health Care* (Gesler, 1991, p.171). In the ongoing discussion on the links between health and place the concept of ‘therapeutic landscapes’ has been central in understanding how the healing properties of certain places give meaning to how people experience health and health care. Recent shifts in the therapeutic landscape literature underlines the therapeutic qualities of everyday, ordinary spaces and the different ways in which different people perceive such qualities (Cattell et al., 2007) emphasizing recent findings that whether a place is therapeutic or not depends on
people’s experience and ways in which people form meanings about the place (Wakefield & McMullan, 2005).

In this study there were certain places that Bengali women frequented which had a soothing effect on their overall physical and mental well being during pregnancy. For Bengali Hindu women, the temple was a place of peace and solace (Fig.6.2). Regular visit to the temple helped them to relax, to be with themselves, and to spend time thinking and being with the baby in the womb. The temple with its ambiance of peace, silence and serenity formed a therapeuc site for most of the Hindu women interviewed. The smell of the flowers, incense sticks and sandalwood paste in temples fills the air with sacred aroma and women loved to sit there and enjoy the peaceful state of mind.

The most common Hindu way of worshipping is doing ‘puja’ which is a daily ritual involving offering of flowers, water and food and chanting of sacred mantras to a deity representing a particular aspect of the divine. Puja also includes other rituals such as ‘aarti’ in which lighted lamps, ornamented hand-fans, conchshells to mention a few, are waved in front of the deity. At the end of the puja visitors are offered ‘prasad’ or ‘bhog’, the food and water offered to the deity which is considered to be blessed and sacred. The witnessing of puja and aarti, the participation in the chants and prayers and having prasad fills the mind and soul of the devotee with peace and devotion and helps to soothe and uplift their spirit. Bengali Hindu women who visited a temple regularly mentioned how the temple ambiance with such multiple rituals and activities was helpful in soothing their mind during pregnancy.

“...the first thing I would mention is the temple..there was an Indian temple right across our apartment..whenever I felt sad or lonely during my pregnancy I used to go and sit there with closed eyes..I used to feel very
nice and came back home happy and with uplifted spirit.”—Noini (Hindu)

“..during my 2nd pregnancy what I would like to mention specially is our temple (Bangladesh Hindu Mandir). I really liked going to the temple, attending the ‘puja’, listening to the chants and prayers, participating in the ‘kirtan’ (devotional chants and songs). it was really therapeutic for me..”—Mrinmoyi (Hindu)

“..yes, there was one place that I used to like visiting during my pregnancy..it is the ‘temple’..I used to go there whenever there used to be an occasion and also to listen to the ‘kirtans’ in the evening..”—Reba (Hindu)

“..when I was pregnant my husband always tried to take me to places I loved to go..there was a temple called Gita temple near our apartment..I used to enjoy listening to the evening chants there and seeing the ‘aarti’..whenever my husband had time, Monday and Wednesday evenings, we used to go to the Gita temple.. it filled my mind with peace and serenity..”—Nira (Hindu)

The temple, especially the Bangladesh Hindu Mandir (temple), emerged as important also because of its social therapeutic properties. Catering primarily to the Bangladeshi community in the city, the temple provided a mingling space for women from similar linguistic and cultural background. It felt nice to spend time in an ambiance that reminded of similar social and cultural spaces back in home country and gave chance to interact with other Bengali women and share religious and cultural activities.

“..yeah there are many temples here you know, but we go mostly to the Bangladesh Hindu Mandir..when we were in Corona and Woodside we used to go there regularly..the benefit of going to this temple is it feels like our own temple you know, everybody shares the same language, same culture, it feels like a temple in our homecountry..”—Indira (Hindu)

Apart from going to the temple, most women had a sacred space set out at home in the form of an altar, where they performed puja, sat in meditative silence, read holy books or chanted songs and mantras depending on what they personally felt like doing. Women mentioned that they prayed and worshipped more during their pregnancy than in
other times to put their mind at ease and to create a sacred ambiance for the baby in the womb. The health and well being of the baby and a healthy delivery was the biggest concern and women prayed in contemplation so that everything goes well.

While temples, especially the Bangladesh Hindu Mandir formed a therapeutic space for Bengali Hindu women where they regularly visited during pregnancy, visiting a mosque was not very common among Bengali Muslim women. Ninety-nine percent of the Bengali Muslim women interviewed did not go to any mosque on a regular basis. Women mentioned several reasons such as it is not common in Bangladesh for women to go to mosque, absence of separate prayer space for women in the mosques, feeling shy to meet men-folks in pregnant state and also lack of time. For Bengali Muslim women the sacred place at ‘home’ where they did their ‘namaj’ formed the most important therapeutic space in their everyday life during pregnancy. Women mentioned reading ‘namaj’ 5 times a day and praying to Allah with greater devotion and intensity for the well-being of the baby in the womb.

‘Namaj’ is a daily ritual prayer performed 5 times a day between first light and sunrise, after the sun has passed the middle of the sky, between mid-afternoon and sunset, between sunset and the last light of the day and between darkness and mid-night. A Muslim can select any clean space, spread a prayer mat and do their ‘namaj’ which involves reciting verses from the holy book, Quran, and a sequence of movements, standing, bowing, prostrating and sitting. Usually each namaj can be performed in 5 minutes but the length as well as the time of the day is flexible and can be adjusted in special circumstances such as pregnancy. Sometimes if one doesn’t have time to do
Namaj 5 times a day, he or she can do ‘kaja’ that is doing all the missed namaj at one time, may be end of the day before going to bed.

“I did my ‘namaj’ and read the ‘Quran sharif’ regularly during pregnancy..you know I used to always pray for the health and well-being of the baby.I did not go to a mosque here..in Bangladesh we never went to a mosque..here in some mosques women go, but I never went to one..”—Nusrat (Muslim)

“We usually don’t go to mosque..here there are some mosques where women go but I never went..during some auspicious occasion women go to mosque, but I never went..”—Ayesha (Muslim)

“I did the ‘namaj’ everyday during pregnancy, in the morning, at noon, in the afternoon, in the evening and again at night..and during pregnancy you know the more one prays the better it is for the health of the baby as well as the mother ..”—Aanan (Muslim)

“The mosques were not that closeby and after coming back from work I did not feel like going to the mosque..I went to a mosque in Astoria with my husband to attend some religious gathering during my pregnancy, but I felt very shy in front of so many people..after that I stopped going..but I did my ‘namaj’ regularly at home..”—Noorjahan (Muslim)

“We don’t go to mosque here, and in our country I have often seen that they don’t permit women to go to mosque..so I never went to a mosque during pregnancy..but I used to try to do the ‘namaj’ 5 times a day..sometimes I couldn’t because it was difficult to sit during later part of pregnancy..but I always prayed to Allah for the well-being of the baby and offered him my thanks for giving me the baby after years of trying..”—Jahanara (Muslim)

“I used to go to the mosque after coming here, every Friday I used to go the mosque with my husband..there are quite a few mosques here in Jamaica you know..but now that I am pregnant I don’t go anymore, I do my namaj at home. Actually in the mosque the namaj is lengthy and devotees sit up and stand a number of times which is difficult to do during pregnancy..so I do my namaj at home, usually the shorter version..”—Tuhina (Muslim)

One Hindu and one Muslim women, however, mentioned facing time constraints in going to temple or doing the namaj during pregnancy. It was challenging for these women to set out a separate time to visit or spend time in places of prayer and worship.
“...I went to temples a couple of times when I was pregnant, you know the ‘Satyadhham temple’ and the ‘ISKON temple’... my in-laws were also here, they went with me too. We went and had ‘prasad’ and ‘bhog’ and it felt really nice you know. But even though I wanted to go I didn’t get time during my pregnancy to go there as much as I would want to, and my husband didn’t have time to take us to the temples. There was no time you know and on Sundays we had grocery, laundry and cleaning to do. So I went only during some special occasions. But I used to do ‘puja’ at home everyday.”—Roma (Hindu)

“...we are Muslims, so we do ‘namaj’ 5 times a day. And it is good to pray to ‘Allah’ when one is pregnant. But sometimes during my pregnancy specially when I had two older kids to take care of I didn’t get time to do ‘namaj’ during the day. Work comes first you know. I tried to finish my household work first and then later in the night during the last ‘namaj’ I read ‘kaja’ to make up for the ones I couldn’t read during the day.”—Salima (Muslim)

Only the two Bengali Muslim women who were high-income and belonged to the Ahmadi sect of Islam went to their mosque regularly during pregnancy.

“...when I was carrying my son I used to go to the mosque every single day. I used to drive myself and go alone during the initial months and during the last few months I used to go with my husband at least to attend the evening prayer. During my 1st pregnancy I couldn’t go daily but I used to try my best. I mean the number of times I visited every week doubled, I mean normally if I went once or twice I would try to go at least 4-5 times.”—Mehar (Muslim-high-income)

“...our masjid is very close to our house, that is the reason why we have been living here for so many years and did not move you know. I do ‘namaj’ 5 times a day and we are very much involved with the activities in the mosque. We went there everyday when I was pregnant. Only during the later stage of my pregnancy I used to go there for the evening namaj when there were less visitors.”—Naaz (Muslim-high-income)

For most women from Bangladesh, the neighborhood parks were endowed with social therapeutic qualities. As mentioned earlier, parks were important sites where social networks were created and maintained. These neighborhood parks were sites of informal talks, chitchat with other Bengali women, which helped them spend part of the day in a socially familiar and relaxed environment (Fig. 6.3). A park setting gave women a chance
to meet with mothers and other pregnant women who speak the same language, share their experience of pregnancy and seek and receive advice and help. Watching other children or their own children play also helped to relieve stress and strain. The children’s laughter, smiles and cheerful and playful merriment made the women forget the chores of daily life and look forward to the arrival of the new baby.

A few women also went to the bigger parks and lakes during pregnancy with their husband. They mentioned the physical landscape of such parks such as the greenery, the water bodies and the fresh air as important in calming and relaxing their mind. Some women just walked on residential streets and enjoyed watching the gardens in the houses with varied and colorful flowers and trees and enjoyed the early morning breeze if they went out for walks in the morning. Sometimes women would go with their children and walk in front of their building while the kids would ride on their cycles or just play.

“..I remember I used to love going to a lake or a park..and sit by the water..my husband used to take me to Astoria park you know..and I loved eating icecrean..everytime I went to the park I used to sit by one of the lakes and have an ice-cream..every Wednesday my husband used to come back early from work and take me there..I cannot describe in words how much I enjoyed walking there and looking at the water..it was calming and soothing for me..it relieved me of all tensions..”—Nira (Hindu)

“..we have parks and lakes close-by..there was a park right in front of our building..the lake is a little far and we had to go by car there..we used to go to the lake sometimes and every evening I used to go to the park..it was summer time and I loved going to the park either alone or with my elder daughter..”—Gita (Hindu)

“..I was pregnant during summer..I used to love going to Roosevelt Island and also to lakes..there are lovely lakes on the way to Long Island and also Flushing..whenever I got a chance I used to go there with my husband and sit by the water..it felt really nice..”—Noini (Hindu)

“..I used to go out with my son in the afternoon..we used to go to the park and I used to take strolls there..the park is 3 blocks from here..I used to walk for sometime and then sit and watch my son play..it used to be a nice
and relaxing at the end of the day. I did most of the walking after 7 months though. I used to drop my son and pick him up from school in the morning. The morning breeze was very calming and I felt peaceful from inside. “—Rokeya (Muslim)

“I became pregnant during winter, so even if I felt like I couldn’t go out much. During summer I used to go to the parks where my kids loved to go. There is a park right behind our apartment and there is another on 39th st. I used to go to both. Or I used to just walk in front of our apartment building and watch my kids ride on their bicycles. I enjoyed watching them play.”—Zaina (Muslim)

“I used to go to the park sometime, but most of the time I used to prefer walking by quiet and empty residential streets. I used to take long walks on the streets and I used to take one of my kids with me. During summer you can see beautiful gardens in front of many houses. I used to stand in front of the houses for a while or sit somewhere and enjoy looking at the flowers. It was really healing for me after a long day’s work at the laundry factory.”—Noorjahan (Muslim)

“Yeah, I used to go sometimes to a park on Hillside. There is a small bridge over a pond in the park, a very nice little pond you know. I used to go and sit there. I felt relaxed and refreshed after spending some time in the park.”—Nazma (Muslim)

“I like it here, our apartment is on 45th street and the park is on 43rd street. During most of my pregnancy I got summer months, so I used to go to the park everyday. I used to take my kids along with me. There are many Bengalis who go to the park, it feels nice you know. We chat among ourselves while the children enjoy their play. We talk about our home country, about dress. It feels really nice. And during pregnancy it is a nice way of spending time.”—Salima (Muslim)

However, such outdoor spaces of recreation and relaxation were limited and constrained for newly arrived immigrants as they did not know the place very well and did not feel confident venturing out alone. The weather and season also determined how much women could use such spaces. Women who were pregnant during winter, found it difficult to cope with the harsh winter in New York City. They mentioned not being able to take regular walks or go to parks and other open spaces because of the biting cold
which definitely affected their mental and physical well-being. This was especially true for recent immigrants.

“..no, I did not go to parks or any such places..there was no park close to where we lived, so I used to walk in front of our house..during summer, you know it is not possible to take walks here during winter..”—Rita (Hindu)

“..I did not go out for walks because I had just arrived and I was always scared that I may get lost if I go out alone..and my husband used to come home a little late, after he freshened up and had some snacks it used to be late and we did not feel like going out..specially because it was winter..even if we went out I used to slip into a store or shop wearing heavy clothes and shoes..it felt much more comfortable inside than outside..”—Payel (Hindu)

In some cases, sense of safety determined how much women could use neighborhood spaces during pregnancy. One Muslim woman, also a newly-arrived immigrant, living in a relatively secluded part of Borough Park in Brooklyn mentioned that the area surrounding her apartment building was crime prone and she was scared to walk alone in the streets.

“..the area is not that bad but during the nights there used to be random shooting..the boys in the streets used to carry pistols in hand and sometimes used to shoot, very close to our apartment building..so when I was pregnant I did not go to the park or walked on the street alone even though there is a park closeby..”—Ayesha (Muslim)

Ethnic neighborhoods as a therapeutic space:

The neighborhoods where the women resided and the resources available in the area shaped to a great extent how much they could relate to the place and what meanings and associations they formed with such resources during pregnancy. In general women pointed out the advantages of staying in specific neighborhoods such as nearness to the subway and bus stations, schools and other amenities such as parks when they were pregnant.
“..there is everything closeby from where we live..not only hospital but also supermarket, subway station and also laundry..it is like a center, we seldom face any problem here..everything, like bus stop and subway station, supermarket, laundry, hospital, school, everything is close-by..”—Gita (Hindu)

“I like this neighborhood, it is a good location..the subway is closeby, the post-office, the library the shopping center, everything is within reach..then there is a park close-by..during summer I used to take my elder son and sit and relax during the afternoon..then I have some close friends in the building now..so I really like the neighborhood..”—Roma (Hindu)

“I have been living in Sunnyside since I first came to this country..I like it here..the communication is good, the subway station is closeby..I can take the 7 train to go to the hospital or college and it is very frequent..this area is not very good for Bengali grocery, so we usually go to Jackson Heights and it is just a few subway stops from here..”—Alisha (Muslim)

“I think this neighborhood is good because everything is within reach..you will find everything within 5 minutes walk, the library is closeby, the park is closeby, then shops and stores, you know like supermarket and drug store, everything is nearby..”—Jahanara (Muslim)

“.the advantage of this neighborhood is that the subway and bus stops are close by..you know if I had an emergency and our car was not available for some reason I could have used the bus or the subway to go to the hospital..”—Naaz (Muslim-high-income)

In addition to these more general resources, the advantages of living in ‘ethnic neighborhoods’ emerged as critical in how these women experienced pregnancy as immigrant women. They mentioned the advantages of staying in neighborhoods with lots of Bengali people around. It was a delight to see and meet people from their home country. The chance to converse in mother-tongue made women feel at home. Women mentioned the benefits of having Bengali stores and shops all around (Fig.6.6). Living closeby or amidst such familiar surroundings was important in making them feel comfortable. During pregnancy, when women sometimes feel down, frequent trips to the
ethnic streets and shops made them feel happy and less homesick. This was especially true for newly-arrived immigrants.

Neighborhoods with very dense concentrations of Bengali people played a special role in providing an environment similar to home country. Large parts of these areas look like a miniature replica of a neighborhood in a major urban centers in Bangladesh such as in Dhaka or Cox’s Bazaar. In Bangladeshi neighborhoods in New York City such as Jamaica, Borough Park and Jackson Heights, a walk down the street gave women a feeling that they were in a neighborhood in their home country. This catered to their emotional need to be in touch with people and places from pre-immigration phase of life. Restaurants specializing in Bengali cuisines, video stores selling books and cassettes, stores packed with items from Bangladesh such as spices, utensils, sweets, snacks, cosmetics and other items, way-side stalls selling inexpensive phone cards and betel leaves, dot the main streets and their intersections in these neighborhoods. The streets are also dotted with a number of other business units such as real estate offices, financial institutions owned and managed by Bengalis. The signage of each store is in Bengali, which was a delight to the eyes of newly arrived immigrants (Fig.6.5). Listening to people speaking in Bengali most of the time was joy to their ears. Living close by to these neighborhoods helped pregnant women, especially recently arrived immigrants to overcome to a great extent the trauma of separation from the visually familiar surroundings in their home country.

Several women found in such neighborhoods an already established social network and a well-knit community, which made them feel comfortable and relieved to
some extent their concern about being away from family members and relatives in home country during pregnancy.

“..I liked it here during my pregnancies..the previous apartment where we lived is not very far from here, it is closeby..then you know there is everything in this neighborhood..you know our Bengali shops, our Bengali stores, there are two of those..then my daughter’s school is right across the street, then the hospital, everything is nearby..we have everything here..then the communication is also good, the subway station is across the street, our sister-in-law’s house is also closeby on 9th ave, not very far..and there are lot of Bengalis in the neighborhood..when I go to my kid’s school I regularly see and speak to many Bengalis there..”—Salima (Muslim)

“..one advantage of this neighborhood is that there are a lot of Bengalis here..this is one of the major plus point of living in this neighborhood..that is why I did not feel uncomfortable walking in the neighborhood even though I was new to this place..and the hospital is also closeby..”—Inayat (Muslim)

“..during my pregnancies I used to go to the park twice or thrice a week..I used to take my kids with me, they really enjoy going to the park you know..and walking to the park was good for my health..I also used to see other Bengali women there, it felt nice..when I first came here in 1995 there weren’t that many Bengalis in this neighborhood..there were just a few..now you see Bengalis all around..in my building itself I think there are 8-10 Bengali families..”—Anaan (Muslim)

“..I really liked living in this neighborhood during my pregnancy..you know there are people from our homecountry all around and there are many Bengali groceries nearby..the area is very safe too..sometimes I went out during the evening to get something from the market when I was pregnant or went to the park with my kids, I went to the hospital alone, I did not face any problem..the neighborhood is good and the people around are also nice..”—Fatima (Muslim)

“..it would have been better to be in Bangladesh during pregnancy but here since I was in New York City I would say it was not that bad you know..if we was in any other state it would have been really bad..we wouldn’t have our relatives closeby..then you know the Indian and Bangladeshi restaurants here where you can get very good and tasty Indian and Bengali food..and there are so many stores here in Jamaica itself, where we can get everything from our home country such as Hindi movie, tamarind, ‘chanachur’ (snack mix), biriyani..it feels like home here sometime..”—Naaz (Muslim-high-income)
This section focuses on use of informal pregnancy care by Bengali women from India. Because only a small number of women were interviewed, all together six, the conclusions are naturally limited by small sample size. This section describes general trends and patterns, along with similarities and differences in comparison to Bengali immigrant women from Bangladesh.

The informal care used and experienced by Indian Bengali women was broadly similar in many respects to the experiences of women from Bangladesh. Home, local social networks, connection with home country and local as well as transnational resources circumscribed their experience of pregnancy as immigrant women. However, because of differences in socioeconomic status and migration trajectories, reliance on social networks and informal resources during pregnancy was comparatively less. The characteristics of social networks and type of resources used during pregnancy reflected their placement as relatively well-off immigrant group compared to women from Bangladesh.

The role of the husband was central in providing care and support at home for most women. Women received help with household work as well as mental support from their husbands. Only one woman mentioned that her husband was not as supportive and understanding as she would have liked him to be.

“..I would say my husband, he took over the majority of my heavy duty job..”—Gitanjali

“..what we really need here during pregnancy is some help with household work, and I got it..my husband used to help with cleaning the utensils..then doing the laundry, also doing all the grocery since it was not
possible for me to run everytime to the shop for small things then.”—Nilima

“.I actually have less responsibilities than many women because my husband is the main cook..he loves to cook so it’s like it’s great for me..especially when I was pregnant he sort of took it upon himself that I have proper nutrition..his participation was mainly taking care of the home front, and he took it as his jo-b, and s-o like making sure we have enough fo-od, we have stuff that I can bring here, aah when I get home what I’m going to eat, all that stuff was hi-s responsibility.. I’m very lucky with that because aah otherwise I don’t think, I think this would have been that much harder.”—Laboni

Most women received some help from local social networks consisting of neighbors, friends and relatives. The factors that shaped the extent and type of support were similar to those for women from Bangladesh. The amount of help varied, depending on the length of residence, the neighborhood or the apartment building they lived, and their social and professional life. Women who got pregnant soon after coming to the US received little help. However, women whose husbands had lived here for a long time, found themselves amidst an already established social network on arrival. Such networks, in the neighborhood as well in other parts of the city, were good sources of help and support during pregnancy. In contrast to women from Bangladesh, it was more common for Indian women to receive help from American born or non-Bengali and non-South Asian immigrant women and families as well. Also as opposed to women from Bangladesh, the need for help from local social networks was expressed less strongly by some women and some expressed the desire and satisfaction in managing things without help, reflecting their manageable and less stressful everyday jobs and schedules.

“.sometimes my friends used to cook and give food to me so that I don’t have to cook, so when we used to stay in the apartment building in Flushing it was an advantage..if I did not feel well anyday the elderly friend I had used to take my son and look after him so that I can take rest..so that used to be a big help.”—Gayatri
“...in Brooklyn, we were more close to our neighbors...there was an elderly Italian lady living next to our apartment, it was mainly Italian and Jewish neighborhood...she used to give me motherly advice, to do this or not to do that...but during my 2nd pregnancy when I was in Flushing, the neighbors there did not interact much, I mean it was like never interfere or never ask anything...”—Nilima

“...in Woodside I got acquainted with an Indian family...and there was an Italian family next to our apartment, we used to talk...and when we moved to Hillside there we became very close with a Guyanese family...during my 2nd pregnancy they helped me a lot, I mean when I felt tired, specially during the gap after my mother-in-law left and before my parents came, they used to take care of my elder daughter...I have many beautiful memories, they helped me so much...”—Srimonti

Moumita, who did not receive adequate mental support from her husband, relied to a great extent on her sister who lives outside New York for help and support. Her sister made regular phone calls and visits to provide physical as well as emotional support during pregnancy. Her sister’s support, helped to create for her a place of connectedness resembling to some extent the social support readily available in home country.

“...I would mention my elder sister...she has helped me as much as is possible...I remember her help a lot...I did not have friends here, so I relied heavily on her...whenever I felt sad or depressed she used to come over...she used to cook and bring over a lot of food for me...you know we are 3 sisters and we are very close since childhood...I was lucky that my sister is here...I can tell her everything and share with her my worries and concerns...so she always gave a lot of support, a lot...”—Moumita

Women who worked outside the home during pregnancy also received help and support from their co-workers or colleagues. Interestingly, such help was less for women in full-time professional jobs and more in case of women working in part-time jobs. For instance, for Laboni and Gitanjali, a research scientist and a desktop publisher respectively, the support from colleagues was more verbal with promise to help whenever needed, whereas for Gayatri working in a childcare center, her co-workers were more
involved in her experience of pregnancy. Laboni, on the other hand received enormous help and support from her friends from the non-profit organization (Humanist), where she is a full-time member.

“..initially when I got this morning sickness I used to feel sick and restless at work, so my colleagues used to tell me not to worry, that it is a sign that my pregnancy is going well, that my baby is developing properly..and it will go away after a few months..and when I was pregnant with my son a co-worker of mine was also pregnant, so we used to ask each other and talk about how we were feeling ..”—Gayatri

“..big time, big time, I don’t think I could have done it without that, yeah because one of the things also working with the movement for these many years I have friends who are more than family..so my family is these people, an-d they have been really, really, really supportive..”—Laboni

The home country figured prominently in women’s accounts of informal care and support during pregnancy. Like women from Bangladesh, all Indian Bengali women maintained regular connections with home country primarily through phone calls. For most women, the urge to call home and talk to parents, siblings, close relatives and friends intensified during pregnancy. Frequent phone conversations provided women with mental support and advice related to living a healthy pregnancy.

“..my parents used to advice me to eat well, to stay safe, to be careful, not to catch cold..that sort of thing..”—Gayatri

“..yeah, yeah, yeah, my mother, I used to speak with her frequently, our telephone bills used to be like $300, I used to call my mother than my in-laws..s-o ‘ma’ (mother) did put in you know her advice which which I did try and follow..you know the Yoga, the Yoga part of it is from my mother..my mother a-lways told me, throughout pregnancy to do ‘pranayam’ which is the breathing part of it..”—Gitanjali

“..and food, food wise also she would say because I tend to put on weight and during pregnancy I go into binging, you know eating all the wrong kinds of food..that’s another thing she would sa-y don’t eat this, don’t eat that, you know like she used to say not to eat pointy, I don’t know why, like not eating pineapple..and she would always say drink a lot of lot of milk, I always did..”—Gitanjali
A few women experienced a more tangible form of transnational pregnancy care when their parents or in-laws visited all the way from India to help and provide support during pregnancy. Such visits, however, as in the case of women from Bangladesh were mostly during the later phase of pregnancy except for one woman whose mother-in-law was there during the first two trimesters and then her parents came over. So she had readily available help and support from close family members throughout her pregnancy, an uncommon privilege for most Bengali immigrant women.

Indian Bengali women lived in different neighborhoods in New York City. All women interviewed had lived either in Queens or Brooklyn, the two largest ethnic boroughs in the city, during their pregnancies. Most women lived in mixed ethnic neighborhoods in contrast to women from Bangladesh who resided in neighborhoods with dense concentration of Bengalis. The local neighborhoods provided useful resources during pregnancy for some women. For some women areas outside their immediate neighborhoods were important in their experience of pregnancy, where they went regularly for shopping, buying ethnic foodstuffs and for recreation and relaxation.

“..in Woodside we lived in a very small place, but the neighborhood then was very nice..it was very clean, descent, beautiful neighborhood..there was an Indian Chinese restaurant close to our apartment, a few streets away, we used to often go there a lot to eat Manchurian during my first pregnancy..” — Srimonti

“..it was definitely better in Flushing, since there is a large Indian community there, for instance if I felt like eating anything I didn’t have to depend on anyone, I could just walk to the shop and buy it..but here it is different, there are not many Indians here it is mixed neighborhood, and specially there is no Bengali grocery here..in Flushing there were no Bengali groceries as well but atleast I could get the raw vegetables or fish and cook at home..”—Gayatri
“..in both Brooklyn and Flushing the shops and stores were close by from our apartment, so that way it was convenient..in Flushing there were many Indian stores nearby, that was nice..in Brooklyn there weren’t many Indian stores, so we used to come to Jackson Heights in Queens and do a lot of Indian and Bengali grocery..” — Nilima

“..no we did not go much to Jackson Heights because my husband did not like it there, but I like Jackson Heights a lot, specially the saree shops and the jewellery shops, I liked to do shopping there..and in Hillside I used to go to Key foods and there was a Guyanese shop, I used to buy fish from there..”—Srimonti

Almost half of the women mentioned going for walks in the neighborhood streets or parks regularly. Living in nice neighborhoods provided them with clean and safe place to exercise their pregnant bodies. As in the case of women from Bangladesh, harsh winter prevented some women from using neighborhood spaces for physical activity, recreation or relaxation. Some women mentioned going to Manhattan with their husbands, enjoying walking down the avenues and streets, looking around and browsing shops, especially during their first pregnancy when they were relatively new in this country.

“..a lot, my husband and I we’ve always been walkers..every night after dinner we went out for a walk and I kept doing that through the winter .. but walking was very big part of my life..there was a park a little farther away, but there was a school, which had a track, the school was also a little far, sometimes I mean we used to go to different places on different days, because you know in the late afternoon it felt nice to see the beautiful houses while walking..but mostly we would go into that school and walk around the track.”—Gitanjali

“..before delivery my doctor used to advise me to walk, I did not walk a lot then because it was winter and I did not feel like going out in the snow..but I had to sometimes..specially because it was so important for a normal delivery..”— Gayatri

“..I used to go for lo-ng walks, I used to go to the library and come back..we came to the US in the month of September, so winter was very close, so I actually went for walks till December..and in that year there were severe snowstorms since November, so the frequency gradually decreased..my husband was also worried since then an weather emergency was declared because of the snow..so during that period I did not go out
much...my husband used to take me to Manhattan, we used to walk around there, have pizza, do little shopping and then come back home.”—Srimonti

Unlike Hindu women from Bangladesh, none of the Indian Bengali women interviewed visited any one temple on a regular basis. Most of the other Hindu temples in New York City serve the South Asian and Indian community in general. Women mentioned making occasional visits to temples of their choice. After living in New York City for several years when women became acquainted with the larger Bengali community, they got involved in community ‘puja’ and cultural events which enabled closer interaction with other women in the community. Such social gatherings provided a sense of belongingness and networks of support during pregnancy. Some women specifically mentioned experiencing a spiritual upliftment and setting out a time and space at home for spiritual activities during pregnancy.

“..in Flushing there is a temple called Ganesh temple, we used to go there..even during my 2nd pregnancy I went to the temple from here, not regularly but once in a while, may be during a ‘puja’ or during any occasion..”—Gayatri

“..during my 1st pregnancy we went for ‘puja’ organized by Bengali community but I wasn’t an active participant..I used to go, see the ‘puja’ and then come back because I did not know a lot of people then..during 2nd pregnancy I was little involved..but when I was pregnant with my daughter I actively participated in the community ‘puja’..it made me feel good..”—Nilima

“..actually when I was pregnant with my first daughter I was only 26, so I wasn’t that matured, so I really didn’t get to think or do anything religious or spiritual, I don’t think I had a picture of any diety at home..during my 2nd pregnancy I became more spiritual, I used to silently chant “om namah shivaya” all the time, I had become very calm then you know, I noticed a change in myself, so you know I remember that change, may be I got a spiritual streak then..”—Srimonti
In summary, the use and experience of informal pregnancy care by Indian Bengali women is both similar to and different from that for women from Bangladesh. Similarities appear in efforts to create therapeutic spaces in the home, in reliance on local and transnational social networks and in the importance of parks and neighborhood spaces. Differences were primarily tied to class.

The higher-income, more educated Indian Bengali women used fewer resources in their local neighborhoods than in other parts of the city. Visiting a mall or the city center for recreation was more common than among lower-income Bangladeshi women. Owning a car made it easier for many high-income Bengali women to include spaces beyond immediate neighborhood in their attempts to relax and unwind during pregnancy.

Reliance on social networks for informal pregnancy care was much less among Indian Bengali women. Their better financial situation, relatively comfortable and manageable daily routines, higher educational as well as professional levels all seem to make up for the social support missing in this country. This was, however, not the case for women from Bangladesh, even for the few who had relatively high incomes. It was very common for women from Bangladesh to have a close network of family members and relatives living in New York City. In general Indian Bengali women were not embedded in such dense social networks and did not gel together as intensely as Bangladeshi women. Close, dense social networks, therefore, shaped Bangladeshi immigrant women’s pregnancy care experiences differently compared to relatively sparse and more dispersed social networks of high-income Bengali women from India.
Summary and Conclusion:

In this chapter I have discussed Bengali immigrant women’s experience of informal pregnancy care in New York City, based on in-depth interviews conducted with sample women in different neighborhoods. The findings emphasize the complex ways in which place, culture and gender constitute their care environments during pregnancy. The effect of migration with all the stress and strain associated with moving to a new place and the dynamics of settling down was significant in shaping these women’s experiences of pregnancy care. To overcome situational constraints in efforts to live a healthy pregnancy women relied on place-based resources at different scales, ranging from the home and local neighborhood to the home country located thousand of miles away. Efforts were made to immerse in, recreate and reproduce networks of social support resembling what is available in home country to live pregnancy in a secure and familiar setting. The need for social support was greatest for newly arrived women for whom placement in a new setting and simultaneous entry into an important life cycle phase meant greater need to deal with change, discontinuity and distanced links of social networks.

Home formed the central place where women tried to take care of their pregnant mind, body and soul. However, the load of domestic work and childcare responsibilities determined by class and gender made home a less healthy place for living pregnancy for many women. The most important support at home that women had was their husband, but for most low-income women husbands themselves were so busy trying to make a living for the family that it was difficult to provide much needed care and support. Thus
women relied a lot on place-based social networks for help and support during pregnancy.

Bengali immigrant women created and sustained social networks in various neighborhood sites such as parks, schools, stores, streets, apartment complexes and in places of cultural or religious activities such as the temple. These places gave women a chance to interact with other women from the same linguistic and cultural background and provided a space for discussing and talking about pregnancy, the home country, life as immigrants and other related topics. Such talks lightened their heart, comforted their mind and body and served as valuable sources of advice to live a healthy pregnancy and carry and deliver a healthy baby. Friendship, centered a lot on cooking and bringing over food or inviting women for dinner or lunch. Apartment complexes provided a convenient place for such informal, knock at the door visits, a very common way of socializing in South Asian countries.

In addition to home and neighborhood, the home country formed the other important center of Bengali immigrant women’s experience of pregnancy care. Women relied a great deal on family members, relatives and friends in the home country for mental and emotional support mainly through telephone conversations. Even though women missed the tangible assistance from them, just listening to their voices, getting advice and suggestions and being able to relate their experiences and feelings gave courage and strength. These long distance conversations were critical in providing ‘virtual networks’ which constituted therapeutic spaces of care and support for most women. Simply listening to mother’s voice was therapeutic for many women.
Existing research on therapeutic landscapes has mostly emphasized place characteristics. Recent works are emphasizing the need to engage with emotional and relational geographies in understanding healing landscapes (Williams, 2007). Based on Bengali immigrants women’s experiences of informal pregnancy care I argue that social networks constituted in and beyond places where people live are equally important. I use the term ‘social therapeutic networks’ to describe such networks. The term ‘therapeutic networks’ was first used by Smyth (2005) to describe recent works in medical geography centering on the role of informal networks of care and support. She highlighted the increasing importance of these networks in the face of rapid and pervasive health care restructuring.

Women in this study were nested in ‘local’ as well as ‘transnational’ social therapeutic networks, which helped them to live a healthy and meaningful pregnancy. Experiences of receiving care and emotional support from such networks through phone conversations support recent interest in non-physical encounters and interactions in enabling (or limiting) therapeutic experience (Andrews 2004; Davidson & Parr 2007).

Recent work on therapeutic landscapes underlines the therapeutic qualities of everyday, ordinary spaces and the ways in which different people perceive such qualities (Cattell et al., 2007). Highlighting Bengali immigrant women’s agency in absorbing and benefiting from the therapeutic qualities of their everyday environment this study support previous findings that whether a place is therapeutic or not depends on people’s perception and ways in which people form meanings about the place (Wakefield & McMullan, 2005).
Certain places were therapeutic for pregnant Bengali immigrant women. Most women’s accounts highlight their attempts to access and use whatever resources were available within the confines of their everyday settings to uplift their mind and spirit. Home was the primary site for prayer and worship during pregnancy for many Bengali immigrant women. Spiritual and religious practice at home helped women to concentrate and gave strength, courage and confidence to prepare for the new phase of life. For Bengali Hindu women the temple formed an important site where women liked to spend time in the peaceful and serene ambience, a time and space to reflect on the pregnancy and the baby in the womb. For both Hindu as well as Muslim women parks and lakes with greenery and soothing breezes were important in calming and relaxing their mind as well as body. Most women visited such places amidst the chores of everyday life and tried to benefit from the comforting touch of nature.

Finally, for many women, the ethnic resources in the neighborhood where they lived helped a lot in easing their homesickness. In neighborhoods with greater concentration of Bengalis, women got the comfort of being in a place that to some extent captured the essence of familiar settings in the home country. Listening to their mother-tongue, seeing products and shop names in Bengali and having Bengali stores and grocery in the neighborhoods helped women to recover from the sadness of living so far away from familiar visual and social surroundings of home country during pregnancy. Ethnic neighborhoods thus emerged as a therapeutic in the women’s narratives.

Use and experience of networks and spaces of informal pregnancy care differed among Bengali immigrant women based on religion and socioeconomic status. The use of temple by Hindu women from Bangladesh for example was socially and spiritually
therapeutic during pregnancy. Mosques, on the other hand did not emerge as important social space for Bengali Muslim women because of their limited visit to public places of worship. It was more typical of Bengali Muslim women to receive little or no help from husband because of tighter gender norms and religious beliefs. At the same time low-paying, long-hour jobs deterred many husbands to help their pregnant wives irrespective of religious and religious background. Living in joint families was also more common among Muslim women from Bangladesh. The associated benefits as well as disadvantages of spending pregnancy in such settings emerged as more significant for Bengali Muslim women relative to their Hindu counter-parts.

Although it is not easy to generalize about the experience of pregnancy care of all Bengali immigrant women in New York city based on in-depth interviews with a sample women, the above discussion shows how place, culture and gender, re-shaped by the experience of migration, influenced how these women experienced pregnancy and prenatal care in a new place and a new context where they found themselves stripped off from a social support structure readily available in the home country. In particular, the discussion points to the complex ways in which place, culture and gender interact at different scales and give shape to different care environments through differential access to place-based resources and networks for women labeled as ‘South Asian’ immigrant women, but differing in terms of class, culture and religion.
Figures:

Fig.6.1: Women from Bangladesh attending ‘puja’ in Divya Dham temple, New York City

![Image of women attending puja](image1)

Fig.6.2: Bangladesh Hindu Temple, New York City, a therapeutic space for Bengali women

![Image of the temple](image2)
Fig. 6.3: A local park in Woodside, New York City: space enabling informal conversations

Fig. 6.4: A public school in Brooklyn, New York City: space enabling informal talks
Fig. 6.5: A shop in Jackson Heights, New York City, with Bengali signage

Fig. 6.6: A shopping plaza in Jackson Heights, New York City
Chapter 7

Conclusion

The aim of this research is to understand how South Asian immigrant women in New York City use, experience and form meanings about pregnancy care. It is informed by recent work in a ‘new’ and ‘reformed’ medical geography that aims to unearth the links between health and place. The research design was based on a mixed methodological approach. Quantitative methods were used to visualize patterns and explore socio-demographic variables related to use of formal pregnancy care for South Asian immigrant women, providing a foundation for an in-depth qualitative study to understand the use and experience of formal and informal pregnancy care for women from Bangladesh and Indian Bengali women residing in New York City. The study aimed to explore and understand pregnancy care environments for a distinct immigrant group in one of the most ethnically and culturally diverse urban settings in the US, which houses a rapidly increasing immigrant population from South Asia.

Results from the quantitative phase of the research indicate that a high percentage of South Asian immigrant women in New York City initiated prenatal care only after the first trimester. Early use of prenatal care was, however, much less amongst Bangladeshi and Pakistani women relative to Indian women. In tune with emerging research focusing on diversity among and within immigrant groups in health status and health care access (McLafferty & Chakrabarti, 2009; McLafferty & Grady, 2005), this finding points to differences in prenatal care needs and access for South Asian women in New York City.
Maps created to visualize where South Asian mothers lived show visible clustering in specific neighborhoods, specifically in Queens and Brooklyn. Several of these clusters had either a majority of Bangladeshi or of Pakistani women. Some of these zipcodes emerged as areas with particularly low levels of prenatal care use. South-central Brooklyn, for instance, emerges as an area needing special attention to address problems of low prenatal care use for Bangladeshi and Pakistani immigrant women. Variation in the composition of women in the predominantly South Asian neighborhoods and in the levels of prenatal care use characterize these areas as ethnically and culturally specific; pointing to the need for assessing prenatal care needs separately for the different sub-groups of South Asian women living in different neighborhoods in New York City.

A majority of Bangladeshi and Pakistani women used Medicaid indicating very low income levels among these sub-groups of South Asian immigrant women. Use of Medicaid therefore emerges as critical in enabling South Asian immigrant women to access prenatal care. However, low levels of prenatal care in some of the zipcodes in Brooklyn with very high percentage of Medicaid use reinforce findings in previous research about the limitations of simply removing economic barriers to ensure early and adequate use of prenatal care. Efforts need to be made to address poverty-related barriers, such as lack of affordable and reliable transportation, time-space constraints in everyday life, childcare responsibilities, lack of affordable day care, and/or poor geographic access to prenatal care clinics (see McLafferty & Grady, 2005) to enable women in these neighborhoods to use early and adequate prenatal care. Clearly, Bangladeshi and Pakistani immigrant women need special attention in efforts to reduce inequalities in prenatal care use.
Results from logistic regression models estimated for all South Asian women and separately for Indian, Pakistani and Bangladeshi women echoed the existing knowledge of barriers to prenatal care (Brown, 1988) with few interesting differences. Education, employment, Medicaid coverage, self pay and parity emerged as significant variables in the model estimated for all South Asian women. However, results from the sub models indicate that Pakistani women were most affected by the education variable. Pakistani women with less formal education were four times more likely to receive late or no prenatal care than were Pakistani women with more education. Religious beliefs could be a reason deterring Pakistani women and/or their families in initiating early prenatal care.

Results show Bangladeshi women to be most affected by the employment variable. A likely reason is the segmentation of Bangladeshi working women into low-wage, part-time jobs in the lower echelons of the work force. Earning supplemental incomes to raise and maintain a family in expensive New York City gives these women less time and opportunity to access and use adequate prenatal care. This finding highlights the need to assess the health and health care needs of women employed in part-time, low-wage jobs separately from women employed in full-time, well-paid jobs by pointing to the fallacy of a generalized notion of ‘healthy worker effect’ (Lindsay, 2004). Another interesting finding, which contradicts findings in previous research (Lia-Hoagberg et al., 1990), relates to parity: South Asian immigrant women with high parity were less likely to receive late or no prenatal care. It is difficult to explain this counter-intuitive relationship, since more children at home normally entail more caring responsibilities for the mother and have significant implications for use of health care services. Experience and knowledge about the usefulness of prenatal care and/or high-
risk age of pregnant women with high parity may explain this to some extent. Results from the qualitative section of this research indicate that the age and spacing of children is more important than the number of children itself in influencing prenatal care use.

Results from the qualitative section of the research highlight the significance of place in shaping pregnancy care environments for a specific group of South Asian migrant women in New York City. Home, neighborhood and local social networks constituted Bengali immigrant women’s everyday settings and shaped their care environments during pregnancy. Setting out time for prenatal care appointments involved complex arrangements in the spacing and scheduling of work responsibilities centering on the maintenance and welfare of the home and family. Similar findings have been reported in research on South Asian women’s health care concerns and contexts (Bottorf et al., 2001). Help and support from husband was necessary but was often limited because of work demands that characterize low-wage, ‘immigrant-jobs’. The greatest help came from local social networks in the way of childcare during times and days when women could not take children and/or babies with them for prenatal appointments. Social networks also played a significant role in sharing information about prenatal care facilities, and availability of Medicaid for low-income pregnant women in New York City.

A majority of women used public hospitals for formal medical care during pregnancy. The importance of public hospitals is a result of economic and geographic considerations: public hospitals typically serve low-income patients who cannot afford care at private and non-profit hospitals, and public hospitals are located near the areas where many Bengali women live. Non-profit hospitals, which accept Medicaid, also
formed sites of prenatal care for several women. Use of Medicaid emerged as significant in enabling women to use prenatal care. It emerged from some women’s narratives that having private insurance with low-option policies resulted in a greater financial burden and more limited choice of services than did Medicaid coverage.

Even though Medicaid removed economic barriers, women had to negotiate language and cultural barriers inside prenatal care facilities. Long-waiting times, ‘too-many tests’, inability to communicate with non-Bengali speaking staff and shortage of interpreters emerged as important issues characterizing women’s experience of prenatal care visits supporting barriers to health care access for South Asian women in the literature (Bowes & Domokos, 1996; Bowler, 1993).

New York City’s urban landscape delineated women’s experience of traveling to a prenatal care facility. Using public transportation often meant traversing crowded streets, waiting for and traveling in crowded buses or subways, which are not easy for a pregnant woman, especially with kids or baby in stroller. Using public transit was especially risky during winter, when the roads and stairs became wet, slippery and unsafe for pregnant women.

Home and family emerged as central in Bengali immigrant women’s use and experience of informal pregnancy care. Home was the emotional niche and key site of everyday life and activities for a majority of women. However, stress and strain resulting from household and childcare responsibilities often made home a place of strenuous labor than a site of care and comfort for most low-income Bengali women. Having a baby is a happy occasion for the husbands as well, and many husbands tried to help. However,
traditional gender roles reinforced by structural forces that determine the work schedules of immigrant workers gave men little chance to make home a site of care for the women.

It was at multiple geographical scales, ranging from the home to the home country that women’s agency in using informal pregnancy care is best revealed. Women benefited from therapeutic qualities of their everyday localities and surroundings through direct experience as well as through local social networks, reinforcing recent emphasis on the healing aspects of everyday places (Cattell et al., 2007; English et al., 2008). Neighborhood parks emerged as an important therapeutic space for low-income pregnant Bengali women, where women could immerse in the gathering of other South Asian women, as well as relax because of greenery and fresh air. Other important therapeutic spaces were the temple for Hindu women and the sacred space at home for regular prayers for both Hindu and Muslim women. Ethnic neighborhoods were also therapeutic. Such neighborhoods with dense concentration of first and second generation Bengalis gave women a chance to experience the essence of much missed social surroundings of home country. Store and restaurant names in Bengali script and audible conversations in Bengali comforted women suffering from homesickness during pregnancy. Availability of spices used in Bengali and South Asian cooking, sweets and snacks, and restaurants catering to Bengali and other South Asian cuisines were useful resources in efforts to satisfy food cravings typical during pregnancy.

It was women’s situatedness in local and transnational social networks that enabled women to draw on informal pregnancy care knowledge and resources. Local social networks comprised of friends and family helped by providing childcare, by cooking and sending over food, by giving advice and suggestions. Such networks
consisting of Bengali speaking and sometimes South Asian neighbors or friends and extended family members or relatives constituted tangible networks of informal pregnancy care for the women.

Beyond local networks, transnational networks played very important therapeutic role in women’s everyday lives during pregnancy. Regular advice received from parents and other close family members through phone calls helped women take care of themselves and follow the dos and don’ts during pregnancy. Frequent phone conversations helped women satisfy the emotional need to be with family members back in the home country. Such conversations emerged as therapeutic in women’s narratives. Just talking to mother was therapeutic for most women. In the process women created and maintained virtual networks of informal pregnancy care.

I use the term ‘social therapeutic networks’ to describe such multi-scalar networks of pregnancy care. The term ‘therapeutic networks’ was first used by Smyth (2005) to describe informal networks of care and support that operate independently or in conjunction with formal medical care. For the women in this research, such networks of pregnancy care operating at multiple scales, worked in complex ways, reflecting: 1) the situational context of women’s lives, shaped by the temporal (e.g. length of residence) as well place-based (e.g. geographies of residence) aspects of migration, 2) the importance of ‘imaginative aspects’ in shaping the meanings women formed of therapeutic networks and 3) the diverse ways in which women created and sustained these networks, based on class, country of origin, religion and culture.

The above is a summary of pregnancy care use and experience for a majority of sample women. However, several differences were observed based on differences in
income, religion and country of origin. High-income women from Bangladesh and India had better insurance coverage, greater choices of prenatal care facilities, private transportation to go for appointments, flexibility in husband’s work schedule to be able to accompany or have any other family member or relative to accompany to the hospital or clinic.

It was more typical of Bengali Muslim women to be situated in dense social networks comprising family members and relatives living close-by. Such settings were rich sources of reliable help, but often reinforced conventional gender roles. For several Bengali Muslim women, gender and reproductive roles were entrenched in religious beliefs. Reinforced gender roles, and high parity often resulting from religious beliefs as well as the husband’s unwillingness to use protection, resulted in greater childcare responsibilities, which shaped low-income Bengali Muslim women’s use and experience of pregnancy care differently relative to Bengali Hindu women.

For Bengali Hindu women, the temple was very important space where they formed and widened their social networks and gained help and support during pregnancy. Thus their place-making efforts to maintain health and well-being during pregnancy extended beyond their immediate neighborhood, and their social networks were relatively more dispersed. In contrast, Bengali Muslim women did not typically visit a mosque, and consequently their social networks were relatively less dispersed.

Reliance on social networks for formal as well as informal pregnancy care was less among high-income Indian women. In contrast high-income Muslim women from Bangladesh typically lived amidst networks of family and friends and received a lot of help from such networks.
It was more typical of low-income Bengali women to live in ethnic neighborhoods and use a variety of resources in such neighborhoods. In contrast, high-income women from Bangladesh and India, who lived in or near ethnic neighborhoods, used relatively less resources in their neighborhoods than resources in other parts of the city. Owning a car made it easier for Indian Bengali women to include spaces beyond their immediate neighborhoods to relax and unwind during pregnancy.

**Research Contributions:**

Existing research on women immigrant’s health and health care use uphold the complex interrelationship between place, shaped by gender and culture, and women’s health (Dyck, 1995b, 2006; Dyck & Dossa, 2007). In their recent work on South Asian Punjabi women and Afghan refugee women in Canada, Dyck and Dossa (2007) specifically point to the role of routine everyday activities such as food preparation and prayer in women’s efforts to build healthy homes. The situational context of the two groups of women differed because of different migration paths resulting in differential access to place-based social and economic resources. Similarly, this research points to the importance of everyday routines in Bengali immigrant women’s use and experience of pregnancy care. The socio-economic context of women’s lives resulting from migration constrained Bengali immigrant women’s use of pregnancy care. However, women used resources within and beyond the confines of everyday life to live a healthy pregnancy. Access to and use of place-based resources also varied, based on class, religion and country of origin. Reinforcing findings from existing research, this study highlights the role of gender in constraining immigrant women’s health maintaining activities and the
role of culture as an essential ingredient in their care seeking and health maintaining projects.

Like previous studies, this research emphasizes the importance of social networks in health seeking efforts. Bengali immigrant women in New York City rely on local and transnational social networks in their efforts to maintain a healthy pregnancy. This parallels findings by Dyck (2006) and Dyck and Dossa (2007), which show that South Asian immigrant women engage with place locally as well as transnationally.

While supporting the findings of past research, this research also takes a step forward in elucidating and untying the complexity of the place-culture-gender nexus in immigrant women’s use and experience of health and health care.

An important area of contribution is in illuminating the role of the husband in delineating pregnant Bengali women’s care environment at home. Research by Dyck and others focuses on only the women; in this research, conversations with Bengali women reveal the husband as a vital and inseparable part of women’s daily lives which, although constrained by structural forces, contributes to shaping women’s care environments in positive as well as negative ways.

This research also identifies several key aspects of immigrant women’s social networks that have not been adequately addressed in existing research. Although social networks were important to Bengali immigrant women, there was substantial variation among women in the strength and supportiveness of local social networks. Length of residence was important: recent immigrants were much more vulnerable due to the absence of a familiar social setting and the lack of help and support. The composition, extent and spread of local social networks of immigrant women also varied based on
differences in class, country of origin and religion pointing to the necessity of considering such differences in understanding the influence of social networks in immigrant’s women’s use of health care resources.

In addition, inspite of having access to help from social networks, the specificity of Bengali immigrant women’s situation determined what and how much help would be sought. Memories of the home country and of available social support structures there formed the backdrop on which Bengali immigrant women formed meanings of local social networks. The ‘imagined place’ of the home country put immigrant women in a challenging position from which to negotiate ‘how much to ask’ and ‘how much to receive’ from local networks. Research on immigrant women’s care environments needs to take into account the contextual nature of the help seeking process from local social networks and the tension, reciprocity and implicit obligations involved, which make help-seeking a negotiated and subjective process (see Menjivar, 2002).

Even though the transnational nature of immigrant women’s situational context is mentioned in existing research, very little is said about the characteristics of such networks and how women draw upon such networks. This research highlights the importance of relatively inexpensive modern communication, especially phone calls, in intensifying contacts immigrant women maintain with the home country. Reduced international calling rates enable today’s migrant women to be in regular touch with family members, making them virtually present participants in everyday efforts to maintain health and well-being. Recent Bengali immigrant women in this research experienced a much stronger transnational sense of belonging and of regular and
intensified transnational care during pregnancy, relative to long-term Bengali immigrant women in their early years in the US.

Even though frequent, fast and relatively inexpensive flights are cited as reasons contributing to the increasingly transnational experiences of recent immigrants, this study shows that women’s efforts to visit the home country or arrange for family members to visit the US during pregnancy are often forestalled because of the high cost of travel and other social and political barriers. This points to an important difference in the transnational dimension of immigrants from far away countries compared to those from countries that are close-by. Distance still matters for many immigrant women, and the social, economic and cultural context of the home country is very important in delineating transnational experiences of health and health care. Both physical distance and the restrictions and regulations imposed by US immigration policies (e.g. unwillingness to accept pregnancy of a family member as a reason to issue a regular or urgent visa) were cited as barriers to experiencing a desired transnational environment of pregnancy care.

Transnational connections were not only sources of traditional or culturally specific advice; advice from the home country also influenced women’s decision to use formal prenatal care and follow the recommended do’s and don’ts prescribed by prenatal care providers.

Transnational communication relating to pregnancy care was not uniformly strong for all Bengali women interviewed. A few women were reluctant to ask for advice or talk too much about their pregnancy care, because they feared being told to follow culturally-specific advice that they don’t necessarily believe in. Several women avoided
discussing concerns about pregnancy with parents in the home country so as not to make them overly concerned about medical issues that arise during a routine pregnancy.

At the theoretical level this research contributes to empirical foundations of the concept of ‘therapeutic landscapes’ (Gesler 1991, 1993; Williams, 1999, 2007). It adds to understanding of the therapeutic dimension of home and everyday routine activities such as food preparation and prayers, conceived by Dyck and Dossa’s (2007) in their recent work on South Asian immigrant women and Afghan refugee women in British Columbia, Canada. Dyck’s emphasis on the role of gender in the constitution and perception of therapeutic places for immigrant women is particularly reinforced. However, moving beyond ‘home’ this research also emphasizes other therapeutic spaces in immigrant women’s everyday lives. Recent work on therapeutic landscapes underlines the therapeutic qualities of everyday, ordinary spaces and the ways in which different people perceive such qualities (Cattell et al., 2007). Highlighting Bengali immigrant women’s agency in absorbing and benefiting from the therapeutic qualities of their everyday environment this study supports previous findings about the roles of people’s perceptions and meanings in defining therapeutic places (Wakefield & McMullan, 2005). The Bengali immigrant women studied in this dissertation made the neighborhood parks and ethnic stores and streets therapeutic. This research also elucidates the necessity of examining differences in immigrant women’s identifications of everyday locales as therapeutic based on differences in class, religion and country of origin. Within group differences based on class and religion were particularly emphasized.

Existing research on therapeutic landscapes has mostly emphasized place characteristics. Recent works highlight the need to engage with emotional and relational
This research emphasizes the importance of place-based social networks as sources of well-being with the potential to become ‘therapeutic networks’. ‘Social therapeutic networks’, operating at multiple geographical scales, emerged as an essential but neglected constituent in immigrant women’s efforts to create and maintain therapeutic environments for themselves and their families. This research also highlights the therapeutic qualities of informal conversations and of sights and sounds, further enriching the notion of therapeutic landscapes.

This research supports Andrews’ (2004) concerns about the inadequate consideration of memories and ‘imagined’ places in the therapeutic landscape literature. Women’s accounts underscored the importance of beliefs, values and memories in the understanding of left-behind social support structures. Memories were important in several respects: they served as a constructed reference point for understanding experiences of pregnancy care in the host country. For some women, memories of home created spaces of caring that helped in coping with the demands of everyday life and pregnancy in an unfamiliar setting.

**Research Limitations:**

In spite of efforts to make the research as thorough as possible to gain insight into the breadth and depth of issues important in Bengali immigrant women’s experiences of pregnancy care, a few limitations need to be highlighted.

First, the quantitative analysis is based on data for a single year. That year was the most recent one for which individual-level data were available when the research was conducted.
initiated. Inclusion of data for other and more recent years would have helped to analyze trends in use of formal prenatal care for South Asian immigrant women. This limitation is related to the broader issue of difficulty in procuring individual level data from New York City Department of Health because of confidentiality and privacy issues. Second, the data on South Asian immigrant women’s use of prenatal care have been analyzed at the level of zipcodes, the smallest areas for which data were available. Census tract level data could have allowed for more detailed examination and visualization of spatial patterns and variation in use of prenatal care by South Asian immigrant women.

Concerning the qualitative study, time and resource limitations circumscribed the number of research participants included in the study. To keep the research agenda manageable women were interviewed only from Queens and Brooklyn, two of the largest and most ethnically diverse boroughs in New York City. Even though these boroughs have the highest concentrations of South Asian and Bengali immigrant women, other boroughs such as Bronx and Staten Island also have pockets of Bangladeshi and Indian immigrant women. Interviewing more women, covering greater areas of New York City, would have added more breadth of the research. Beyond geographical limitations, although the sample adequately represents women from Bangladesh, especially low-income women who are most likely to be in need of resources, services and support during pregnancy, it does not adequately represent the Indian Bengali immigrant women group in New York City. However, findings from the small group of Indian Bengali women interviewed suggest that this group faces relatively few barriers in accessing pregnancy care. Finally, inclusion of more women who work fulltime in the sample would have enabled a more detailed understanding of pregnancy care and experiences for
Bengali immigrant women who spend many hours outside the home while engaged in paid work.

The transnational dimension of the research needs to be developed in more depth. Except for women’s accounts of topics such as quality of prenatal care experienced in New York City, this research has not dealt in depth with the socio-economic, cultural and health care environments in the women’s home countries and how women negotiated the two worlds in reshaping their expectations and requirements for care during pregnancy.

Nonetheless, despite the above limitations this research is a thorough, in-depth empirical study of South Asian immigrant women’s use and experience of health care in the US. It contributes to strengthening the theoretical and empirical foundations of the ‘new’ medical geography and geographies of women’s health. The research will help provide a base for future research focusing on other groups of South Asian immigrant women in the US as well as other immigrant women groups.

**Future Research Directions:**

Future research employing a mix of quantitative and qualitative methods needs to be undertaken amongst other South Asian immigrant women as well as other immigrant women groups who are at risk of receiving less than adequate prenatal care, such as women from Pakistan. Immigrant women in the US come from very diverse socio-economic and cultural backgrounds and women from the same country and same region are placed in very diverse settings based on their migration trajectories and socio-cultural context. Such intra-group differences are often ignored and remain masked in social science and public health literature. Qualitative research focusing on health care
experiences of immigrant women need to examine such within group differences to better understand the options and constraints that circumscribe their care-seeking environments.

By focusing on South Asian immigrant women this study highlights some of the socio-demographic factors that need to be given more attention in understanding barriers to prenatal care use for certain immigrant women groups. As suggested by this study, it is important to examine why education is more likely to explain Pakistani women’s low use of prenatal care and how employment creates significant barriers to use of prenatal care for Bangladeshi women.

Research on immigrant health also needs to address a diverse range of geographic contexts. For example, there is increasing evidence of Bangladeshi immigrants moving from New York City and settling in smaller cities such as Detroit for economic reasons. Future studies on women from Bangladesh could focus on such migrants and examine differences in pregnancy care experiences between women living in large, diverse metropolises and in relatively smaller and less diverse cities. The latter settings are much less likely to offer the dense ethnic neighborhoods that were shown to provide culturally-specific resources and support for Bangladeshi women in this research.

The lives of women in South Asia and other developing countries are undergoing fast changes. Traditional gender roles are breaking down, giving renewed meaning to women’s lives, roles, aspirations and expectations. Future studies should endeavor to examine how these changing relations of culture and gender filter into experiences of health care during pregnancy for immigrant women. Placed in a setting where women have succeeded to a great extent in breaking traditional gender roles, and experiencing
impulses towards gender equality from the home country, how do immigrant women respond, and what sorts of networks of care do they develop?

To enrich the conceptualization of the place-culture-gender nexus in shaping experience of health care during pregnancy, future studies could be carried out in the home countries of South Asian immigrant women. Such studies would provide a reference point for better understanding immigrant women’s needs, expectations and experience in relation to the health care environments they were accustomed to in their home countries.

By highlighting within group diversity amongst South Asian women, this research emphasizes the need to fine-tune prenatal care policies to cater to the need of diverse subgroups of women masked under a broad label. The spatial and geographical concentration of such groups amidst immigrant ethnic landscapes gives an opportunity to formulate and implement policies and intervention programs sensitive to their experiences and expectations. The emergence of public hospitals such as Elmhurst hospital as a major prenatal care facility for the South Asian women in this study, highlights the need to sensitize staff in the hospital about immigrant women’s specific socio-cultural needs when providing pregnancy care. Especially, issues raised by the women in this research, such as long waiting times and too many tests, need to be addressed. The importance of religious beliefs and needs in decisions about when to initiate prenatal care emphasizes that programs sensitive to immigrant women’s cultural contexts need to be formulated.

Future research on barriers to use of prenatal care should examine factors that help women use adequate care during pregnancy (Brown 1988). This study exemplifies the importance of multiple sources of help and support at multiple scales that help
immigrant women to optimize their efforts to seek care and maintain health and well being during pregnancy. Sensitizing prenatal care policies with such knowledge will help better understand and better serve pregnant immigrant women by providing meaningful recommendations to help them live a healthy pregnancy.

Even though place and people are inseparably tied, and place filters people’s everyday health related experiences, decision-making and activities, place is seldom paid enough attention in the health sciences and in public health policies. By highlighting the importance of place in South Asian women’s use of pregnancy care, this research emphasizes the need to focus not only on barriers to care but also on women’s reliance on multi-scalar, place-based social networks and resources.

----------*----------


Estrin, D.J. (1999). Reproductive behavior is linked to work autonomy, not to employment itself. *International Family Planning Perspectives*, 25(1), 50-51.


between and place and wellness (pp. 123-151). Lanham, MD: University Press of America.


Websites:


--------------*--------------
## Appendix: Questionnaire for research participants

Selected socio-demographic characteristics of the participants

<table>
<thead>
<tr>
<th>Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>Nationality</td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
</tr>
<tr>
<td>Occupation</td>
<td>US:</td>
</tr>
<tr>
<td></td>
<td>Annual Income</td>
</tr>
<tr>
<td>No. of children</td>
<td></td>
</tr>
<tr>
<td>Year and place of birth:</td>
<td>1.</td>
</tr>
<tr>
<td></td>
<td>3.</td>
</tr>
<tr>
<td>Length of residence</td>
<td>In the US</td>
</tr>
<tr>
<td>Spouse’s age</td>
<td></td>
</tr>
<tr>
<td>Spouse’s education</td>
<td></td>
</tr>
<tr>
<td>Spouse’s nationality</td>
<td></td>
</tr>
<tr>
<td>Spouse’s religion</td>
<td></td>
</tr>
<tr>
<td>Spouse’s occupation</td>
<td>US:</td>
</tr>
<tr>
<td>Annual Income</td>
<td>US:</td>
</tr>
<tr>
<td>Length of residence in the US</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>Street: Apt#:</th>
<th>City: State: Zip:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous: (where child was born)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous: (where child was born)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Use of formal prenatal care:

1a. Did you use ‘prenatal care services’ during your pregnancy? (Please see attached sheet for clarifying the meaning of ‘prenatal care’)

1b. If not, why?

1c. If yes, when did you start using prenatal care?

1d. How many visits did you make to your prenatal care provider?

1e. What type of health care facility did you use for prenatal care?
   - doctor’s office
   - clinic
   - hospital
   - others

1f. Was it a private or public health care facility?

1g. Whatever ‘type of service’ you mentioned in 1f. please explain why you chose that?

1h. Was your prenatal care provider a male or a female doctor?

1i. What was his/her racial/cultural background? (e.g. white/black, American/Asian, US/India)

Use of informal prenatal care:

2a. Did you receive any care/advice from family members and relatives during your pregnancy?

2b. If yes, where did those family members and relatives live?

2c. How did you communicate with them? (e.g. telephone, email, visits)

2d. Did you receive any care/advice from friends and acquaintances during your pregnancy?

2e. If yes, where did those friends and acquaintances live?

2f. How did you communicate with them? (e.g. telephone, email, visits)

2g. How frequently did you receive advice from your family members and friends?
2h. Did you receive any culturally specific advice from your family members or friends here or in your home country?

2i. Did you follow any culturally specific advice relating to health care during pregnancy and childbirth?

2j. How strictly could you adhere to those advices?

2k. Did any of the advice you received from your family and friends contradict with any advice received from your formal prenatal care provider?

2l. Did you mention to your formal prenatal care provider about any advice or suggestions you were receiving from your family and friends?

2m. Did your formal prenatal care provider ask whether you were following any advice from your family and friends?

**The place where the mother lives/lived:**

3a. How far was the prenatal care facility from your home?

3b. What means of transport did you use to reach there?

3c. How long did it take you to reach your prenatal care provider?

3d. What ‘social networks’ (help/support from friends, family, neighbors) did you rely on to maintain a regular prenatal care visit? (Please see attached sheet for clarifying the meaning of ‘social networks’.)

3e. Did you use ‘day care’ centers (in case you had another child to take care of)?

3f. Where were the day care center/centers located?

3g. What other prenatal care resources did you use in your neighborhood/community/any other place in the city (eg community centers, public library, ethnic food store)?

3h. Is there anything else that you would like to mention about your neighborhood/community in relation to your experience of prenatal care or pregnancy?

**Time space constraints:**

4a. Did you have any work commitment outside home during your pregnancy?

4b. If yes, for how many hours a day and how many days a week?
4c. What work responsibilities did you have at home such as cooking, cleaning, laundry?

4d. If any, how were they taken care of during your pregnancy?

4e. Did you have another child or anybody else in your family to take care of during your pregnancy?

4f. If yes, how were they taken care of during your pregnancy?

Experience as immigrants:

5a. What was your experience of being pregnant in the US as an immigrant woman?

5b. Did the fact that you are an immigrant/foreign-born women from a different/distinct cultural background affect the quality of prenatal care service you received in any way?

5c. How did your experiences of pregnancy and prenatal care differ here from what they could have been in your home country?

5d. Did you experience any barriers in accessing prenatal care?
   - making appointments
   - contacting your prenatal care provider
   - language problem
   - interacting /communicating with your prenatal care provider

5e. Was there any situation when you felt awkward/uneasy in communicating (speaking) with your prenatal care provider?

5f. Was there any incident or situation that made you feel that your prenatal care provider was not able to understand your cultural beliefs, ideas and needs?

5g. What were your expectations from your formal prenatal care provider?

5h. Were you satisfied with the quality of prenatal care you received?

5i. Is there anything you would have liked to be different?

Socioeconomic context:

6a. How did you cover the cost of prenatal care services (formal as well as informal)?

6b. Did you face any financial constraints/difficulties in using the prenatal care services? (formal/informal)
6c. If you did not have an insurance coverage, how did you manage to pay for the prenatal care services?

**Culturally prescribed gender roles/practices:**

7a. Were you free to travel alone during your pregnancy?

7b. What was your experience of going to any place in your neighborhood and to other places in the city as a pregnant women from a distinct cultural background?

- Did you visit people or places in your neighborhood during your pregnancy?
- Did you visit other places in the city during your pregnancy?
- Was there any incident/situation when you felt awkward or uneasy being a woman from a different cultural background?

7c. Did you wear your traditional dress during any of your visit to your prenatal care provider?

7d. If yes, was there any incident / situation when you felt awkward in the presence of your prenatal care provider or other staff in the clinic or doctor’s office?

7e. Was there any work at home that was solely your responsibility? How did you manage doing those works during your pregnancy?

7f. In your home country/ culture what is normally expected from husbands during their wife’s pregnancy?

7g. How would you describe your husband’s participation in your daily activities and health care during your pregnancy?

7h. How would you describe the participation of other members of your family (e.g. elderly women member) in your daily activities and health care during your pregnancy?

Is there anything else you would like to add to this discussion?
**Formal prenatal care:** Prenatal care is the health care women receive during pregnancy. It consists of regular visits to a doctor, midwife or other health care provider to perform medical screenings and exams to ascertain the well being of the pregnant woman and the fetus. It comprises of sessions where the prenatal care provider discuss with pregnant woman about several things: the way the body works at this special time, health of the mother and the baby, benefits of good nutrition, foods and activities that will help to feel good, foods and activities which should be avoided. In specific cases it may also comprise special diet and nutrition sessions as well as sessions about negative effects of smoking, alcohol and drug use and unsafe sexual behaviors.

At first prenatal care visit, the provider usually:

- gives a general physical check-up
- talks about how the woman is feeling
- asks about health history
- tests blood and urine

At later prenatal care visits, the provider gives information regarding:

- how the baby is growing
- the signs of labor
- what to do when labor starts
- counseling services to help with any problems during the pregnancy period

**Informal prenatal care:** It is the care, advice, help and support received during pregnancy from family members, neighbors, friends and relatives.

**Social networks:** Social networks refer to linkages or relations between individuals. Social networks in this study means ‘informal networks’ of friends, relatives, neighbors, colleagues who live close by in the community or live in the same town or city, and are within reach and available for any help as well as family members, relatives and friends in women’s home countries with whom they maintain regular connection.

---------*---------