

Reproducing Home: Arab Women's Experiences of Canada

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Birth is more than physical reproduction; through reproductive traditions and birthing processes, social reproduction is manifested. In other words, these traditions and ceremonies highlight the values of social life. Migration to a new country may affect the ability of women and their families to perform reproductive rituals; hence, examination of women's birth stories may demonstrate the tensions between the challenges and benefits of migration. This shifting ground of multiple identities in turn contextualizes the process of acculturation as migrants strive to adapt to their new country while maintaining cultural and ethnic identities. In this article, we study experiences of reproduction to examine how Arab immigrant women shape their Canadian identities while balancing connections with their families "back home" and their ethnic/cultural identities.

Introduction

Childbirth is more than the physical reproduction of the family, for it also functions as social production, in the reproduction of cultural values and belief systems (Franklin & Ragoné, 1998; Jordan, 1993). As such, the rituals associated with pregnancy, birth and the post-partum period symbolize ideologies of gender, healing, and religion as well as forming individual and group identities.

We suggest that the process of reproduction may also be fertile ground for the study of the interplay between acculturation and maintenance of migrants' traditions and belief systems. Acculturation is defined here as the process whereby immigrants who are members of minority communities incorporate and practice traditions of the dominant group (Berry, 1980; Snowden & Hines, 1999). Of course this process is mitigated by actual and perceived opportunities for integration, as well as inter-group heterogeneity (e.g. variations based on individual behaviors, characteristics, etc.), with respect to both the migrant and dominant cultures and communities (Rudmin & Ahmadzadeh, 2001; Vega & Rumbaut, 1991). Furthermore, the process of acculturation is not unilateral, for migrant communities also influence and contribute to the dominant group's socio-cultural beliefs and practices (Phillips, 2005).

Migration can be a stressful process, especially for women who give birth to children in a new cultural context, and who do not have the means or knowledge to fulfill their obligations to arrange for traditional rites and rituals (Deitrick, 2002; Groleau, Soulière & Kirmayer, 2006). On the other hand, immigrant women may welcome the opportunity to participate in "new" reproduc-

tive technologies, and the diminished responsibilities of celebrating birth as a social event that was weighed down with "old", unnecessary traditions.

This article will compare and contrast Arab women's reproductive experiences in their home countries with those in Canada, as well as examine the factors that shape women's abilities and desires to participate in traditional pregnancies, birthing processes, and post-partum practices. To add historical depth to this discussion, comparisons are made between the experiences of recent and non-recent migrants. The examination of the sociocultural framework of reproduction and immigrant women's experiences of the reproductive process highlights both challenges and opportunities associated with migration and living in Canada.

Methodology

This study was conducted in a large city in Western Canada with a population of approximately one million. According to the most recent 2001 census, 17.8% of this city's population consists of immigrants and 14.6% of visible minorities. The Arab community makes up 6.7% of this visible minority population (Statistics Canada, 2001). The results presented here are part of a larger study examining adult women's migration experiences. Both recent immigrants who have been residing in Canada for less than ten years and non-recent immigrants who have been residing in Canada for more than ten years were recruited, in order to compare changes over time in immigrant women's experiences. A female Arab research assistant assisted with recruitment of participants, translation when required during the interview process, and transcription of interviews.

This study was designed to be community-based, and has been conducted in collaboration with a local community organization composed of immigrant women from various countries. It was with the help of this organization that we located research assistants (one from each participating community), who were also instrumental in the development of the research design (e.g. defining appropriate questions and how to best phrase them). One goal of the study is to be able to provide this community organization, and other interested parties, with information that can be used for advocacy, and in the development of culturally appropriate health education programs (e.g. food prescriptions/proscriptions, traditional knowledge and care of mothers' postpartum that could be incorporated into medical practices) both for participating communities and health providers.

Six focus group interviews were conducted, three with recent and three with non-recent immigrants. This number of focus group interviews was found to be

adequate for saturation (Glasser & Strauss, 1967; Morgan, 1997). Each focus group consisted of five to eight women. Discussions were elicited easily; therefore, groups of this size were adequate for collecting a range of opinions, as well as allowing all the participating women to be heard. Thirty-six Arab women participated. In conjunction with these interviews, demographic information was collected, and acculturation and body image measurements were administered. The findings from these focus group interviews are the focus of this article.

All women gave informed consent prior to participation in the focus group interviews, and they had the option of ceasing participation at any point, requesting that their comments not be utilized after it was over, or of not participating in a particular portion of the focus group interview. Interviews were conducted in women's homes or community centers, and took approximately two and a half hours to complete. Helen Vallianatos and a research assistant were present at all interviews; the former took notes and asked probing questions and the latter facilitated the discussion, using predetermined interview questions. The Human Research Ethics Committee of the Department of Anthropology, Faculty of Arts at the University of Alberta approved the study.

Interviews were audio taped, translated into English where required, and transcribed. Data analysis from the interviews was content-based (DeVault, 1990). In other words, the data were examined for patterns in what women said, rather than doing a narrative analysis of the content. This method is useful in exploring themes. Qualitative data were coded by reviewing all cases. Codes were formulated through a line-by-line analysis of concepts that were identified in the data. Comparative analysis led to the development of categories. This level of analysis examined how women used the codes defined in the first stage. Themes were developed from the categories that emerged from the data, and by comparing these concepts to those reported in the literature. Helen Vallianatos conducted the data analysis.

Findings

Characteristics of Participants

A description of the characteristics of the study's participants is provided in order to contextualize their experiences of migration and reproduction. A total of fifteen non-recent and twenty-one recent Arab women participated in the focus group interviews. The non-recent immigrant women had been in Canada for an average of twenty-three years, whereas the recent participants had lived in Canada for an average of three and a half years.

Compared with the recent immigrant women, non-recent migrants were about a decade older on average (32 and 41 years respectively). All of the women were, or had been married; three were divorced. Household size varied from two (among those who were married without children) to seven members. Household income was variable, although just over half of the participants were living in low-income households. In Canada, a poverty line per se does not exist. Instead, low-income households are defined according to community and household size. Part of the financial difficulties faced by immigrants is the lack of recognition of foreign credentials, resulting in underemployment. According to various Arab informants, "We [in our city] have the most educated cab drivers," a statement that reveals the extent of underemployment in this immigrant community.

All of the participants were Muslim except one, and all self-identified as Arab. Their countries of origin were diverse: Egypt, Iraq, Syria, Jordan, Palestine, but the majority were from Lebanon. The majority of participants had come to Canada on family reunification visas. In order to have some measure of assessing their various degrees of acculturation, an acculturation scale measuring language usage patterns was used. This four-item questionnaire, where responses are scored on a 5-point scale, was modified from one previously used among Spanish-speaking immigrants (Norris, Ford & Bova, 1996; Wallen, Feldman & Anliker, 2002). Unquestionably, language use alone does not measure all degrees and varieties of acculturation: previous research has found that language preference and use can be used to provide an appropriate estimate of acculturation (Marin, Sabogal, Marin, Otero-Sabogal & Perez-Stable, 1987; Norris, Ford & Bova, 1996; Wallen, Feldman & Anliker, 2002). Non-recent immigrants scored higher on this scale, indicating greater ease with, and frequency of English in everyday life. This suggests that non-recent immigrant women felt relatively more comfortable interacting with non-Arab Canadians.

Comparisons of Reproductive Rituals between Canada and "Home"

In this section, we compare and contrast reproductive rituals practiced in Canada with what those women recalled from their home countries. All women could recount traditions associated with pregnancy, birth and the post-partum period, even if they had only experienced pregnancy and birth in Canada. However, most women could contrast their own personal experiences of reproduction both in Canada and at home, having had some of their children before migrating to Canada. Three interrelated themes on women's reproductive experiences emerged from the interviews, labeled as follows: 1) social support networks; 2) medical technology and per-

sonnel; and, 3) feeding the mother. As each of these themes is discussed, the viewpoints of recent and non-recent migrants are compared.

Theme 1: Social Support Networks

Many of the discussions concerning women's lives during pregnancy and the post-partum period focused on the traditions of social support evident throughout women's reproductive experiences. This was especially emphasized in the conversations with non-recent immigrants, one of whom explained, "You treat yourself, everyone around you treats you". Women recalled being pampered throughout pregnancy, demonstrated not only by the amount of food offered to them, but also by receiving special foods or foods that they craved. Extended family networks ensured that mothers were well cared for and helped first time expectant mothers prepare for birth. This continued into the post-partum period, when mothers recalled doing nothing but sleeping and caring for their newborn infant for the first couple of weeks, while female family members rallied to ensure domestic tasks were completed.

All women who reminisced about birthing in their home countries pointed out that one of the greatest challenges they faced in Canada was the lack of social support available for mothers, especially during the post-partum period. During these times, the comfort and care provided by families were especially missed. This was a source of the greatest tension, as it highlighted differences in how womanhood and birth are viewed in Canada. Neolocal residence patterns are the norm in Canada, reflecting emphasis on individuality and reliance on self. Families are often dispersed, and are not available to provide much help during the reproductive process due to both time and distance limitations. Birth in Canada is arguably a medical event, occurring primarily under the expert control of medical professionals, and in hospitals where medical technology is readily available for use (Bourgeault, Declercq & Sandall, 2001; Davis-Floyd, 1992; Davis-Floyd & Sargent, 1997; Daviss, 2001; Jordan, 1993; Wrede, Benoit & Sandall, 2001). In contrast, although Arab women reported that medical systems and interventions were commonly used in their home countries, birthing was to a greater degree a social event, marked with celebrations and women, ensconced in supportive social systems, could take at least some time to rest and bond with their infant.

Due to their inability to divide labor, and to lean on the support of others, some women perceived the Canadian birth context as detrimental to their own and their infants' well-being. This is exemplified in the following comparison made by a non-recent immigrant:

In Beirut, my mother-in-law bought me lemons and homemade soup, and she used to make me special foods because I was pregnant and it was good for me and the baby. My first son was born in Lebanon; he was 10 lbs, but my other kids were born smaller, like Hana was one month early and she was 4 lbs. That is because I did not like the food here; even if I found everything [that could be found at home], the food still was not good.

This woman's description of the important support she received from her mother-in-law also highlights the symbolic value of food. The above quotation also suggests that food can demarcate challenges of adjusting to life in Canada. The mother's dislike of the food, even if Arabic food was found and purchased, is symbolic of missing home and everything that home represents. The reliance on others for help in provisioning and preparing special food perceived as a requirement for a healthy pregnancy is further explored below. Before turning to explore in greater depth the care women receive as new mothers, represented by food items and the sharing of food preparation, an investigation into the medicalization of birth in women's home countries is in order.

Theme 2: Medical Technology and Personnel

In the past two decades, much research has been conducted on the medicalization of reproduction, including childbirth. This process of medicalization may be explained as when language and ideology of scientific medicine come to predominate in explanations of human behavior and biology. In relation to childbirth, emphasis is focused on increasing usage of technology in birthing, of "operationalizing" childbirth, of treating it as a "disease" to be fixed (Davis-Floyd, 1992). This process of medicalization of women's reproduction is commonplace in North America, thus birth in Canada can be categorized as a medical event (Davis-Floyd & Sargent, 1997; Daviss, 2001). However, it is a mistake to conceptualize reproduction and childbirth as either a medical or social event. Both, to varying degrees, are important in formulating women's experiences; they are not mutually exclusive. This is especially clear when discussing birth with recent immigrants.

Recent immigrant women further contextualized the meaning of birth in their discussions concerning medical and social aspects of reproduction in Canada and their home countries. Having more recently experienced birth in their home countries, they pointed out that medical interventions in the birthing process are global. However, both positive and negative contrasts can be made, as shown in the following exchange:

Woman 1: I was more comfortable during my pregnancy in Lebanon. Here I was tired all the time. But during delivery, here is much better because here you can have your

mother or sister beside you in the delivery room, but back home, no one is allowed in the room with you. No, here is much better to have the baby, really.

Woman 2: But the doctors and doctor visits, the doctors' care is much better there.

Woman 1: Yeah, that's true.

Woman 2: Like when you're pregnant back home you go to the doctor right away, you don't need to make any appointment and wait, and the same doctor you go to is the same doctor who does the ultrasound. The machines are in the same office as the checkup and everything.

Woman 3: Generally being pregnant there is more comfortable, but here it's much better at the time of delivery.

Woman 2: Well I'm pregnant right now and I feel tired a lot too.

Woman 4: Like for the delivery, the nurses back home are not as nice as the nurses here. They yell at you if you're in pain, Wallah, they really do.

Note in this exchange that being tired was associated with living in Canada. As mentioned in the previous section, this reflects the fact that women have smaller social networks in Canada, hence they have fewer people on whom they could count on to help on a daily basis — a pattern that has previously been reported for Iranian and other immigrant communities (Ali, 2002; Dossa, 2004; Lock, 1991). This is exacerbated by the relatively fast pace of the Canadian lifestyle, where long work hours are required to stay financially solvent, let alone to get ahead and rise in socioeconomic status (Vallianatos & Raine, 2005; Vallianatos, Ramos-Salas & Raine, 2005). Constant work further impedes women's abilities to find others who have the time to help, so the pampering during pregnancy and the postpartum period experienced in home countries are idealized in immigrant women's imaginations. Furthermore, hospital stays for routine births are a day or two, so women must return to their homes and their household duties, with no one to help.

The above exchange also highlights a major difference in medical practices and interactions with medical personnel. Access and ongoing care were described as being better at "home" since women could see their care-provider whenever they wished, and were ensured that the same provider who was advising them throughout their pregnancy would be present at the birth. Building a personal relationship with one's care provider fosters trust, and in turn helps to make women's reproductive experiences more positive. This is usually not the case in recent years in Canada. Instead, the obstetrician on call attends the birth, and it is becoming common for obstetrical practices to consist of a group of doctors. For women this means that even for routine visits during pregnancy, they may see whichever partner is available, consequently not developing a strong personal connection with one doctor.

The next section examines the reproductive process as a whole, and food practices in particular, to develop an understanding of the social significance of reproduction.

Theme 3: Feeding the Mother

"When people know you're pregnant, they all want to feed you." (Non-recent Immigrant Woman) As this quote shows, women recalled pregnancy as being a special time back home, where they were sheltered, given special food, and encouraged to rest and take care of themselves. In contrast, because of lifestyle pressures in Canada, immigrant women often felt lonely, and missed the care provided by extended family members and friends in their home country. Recent migrants in particular spoke of these differences, as exemplified by this quotation: "They make the food for you, and you are always resting. Friends and family make you soup and other food. Here you have to do everything yourself, it's much harder."

Food cravings are a common experience shared by pregnant women around the world (e.g. Coronios-Vargas, Toma, Tuveson & Schutz, 1992; Demissie, Muroki & Kogi-Makau, 1998; Vallianatos, 2006). Folk knowledge often emphasizes the importance of satisfying cravings, for if not met, it is believed that something may happen to the fetus. An example of this is shown in the following exchange:

Woman 4: One advantage is that because here everything is available, when a woman craves it's easy to find whatever she wants. Back home, if you crave watermelon in winter, you can't find it.

Researcher: So what happens if you can't meet your cravings?

Woman 1: You wait until you find it and eat it, you just keep craving.

Woman 6: We believe if you don't get what you craved for, the shape of the food you craved will be on the baby's body.

In the above exchange, it is also clear that there are benefits to living in Canada while pregnant. Seasonality has little impact on food availability, as food items from around the world are imported, although food purchased out of season may be more expensive. Nevertheless, the plethora of products available in grocery stores from around the world ensures that cravings may be satisfied.

The study's participants also reported food prescriptions for the post-partum period. These dietary practices are believed to enhance breastfeeding by ensuring that adequate quantities of high-quality breast milk were produced. These foods included 'hot' foods, necessary for bringing the body back into equilibrium. Non-recent immigrants recalled:

Woman 1: After you have the baby, they give you a lot of milk and hot stuff to drink so the milk will come. Here the first thing they bring you in the hospitals is cold water! It was weird, back home they give you hot drinks.

{Aside as group discusses why they would be given cold items in Canada; no one knew}

Woman 2: We give her eggs with garlic and cumin after she delivers, for the milk to come.

Woman 3: Also chicken soup for one month.

Woman 2: And *sawdah* (liver) which is good for the blood.

The discussion of the necessity of giving new mothers 'hot' items seems to be folk knowledge based on traditional Islamic medical procedures. Islamic medicine is a humoral medical system, in which health is defined as the balance of humors. Imbalance can result from an individual's activities, including dietary and physical activity patterns, and must be corrected in order to maintain health. Also shaping the balance of humors are environmental factors, such as the seasons of the year, and individual characteristics, such as personality and different stages in life, including pregnancy, birth, and lactation (Ullmann, 1978). Pregnancy is considered a 'hot' condition, and birth releases this heat from women's bodies. Consequently, women must be given 'hot' foods or drinks that are strengthening, and protect against illness caused by being too 'cold'. Giving 'hot' foods also ensures that adequate milk will be produced, and that the breast milk will be of good quality. Although women did not have a deep understanding of humoral medical systems, it does seem to have permeated folk wisdom, demonstrated by the conversation above. In this context, it is surprising that women in Canada are given cold items during labor and after birth.

Breast-feeding has been shown to be a common practice; most of the women studied breast-fed for at least a few months, and often for two years. Social support was provided to mothers in their home countries, in order to successfully initiate and to encourage continuation of breastfeeding, as reported by one recent immigrant woman: "Back home, they all try to help you to breast-feed as long as possible. They try to make everything comfortable for you to breast-feed, and they make all the foods that bring more milk." Breast-feeding is a skill that takes time to learn, and even for multiparous women, time is required to develop the relationships with their new infant. The lack of a large support network in Canada means that women often feel harried to meet all their household tasks, leaving only a day or two to recover from birth and establish a routine. This lack of social space for breast-feeding, in conjunction with difficulties mothers face in implementing post-partum traditions, has been reported to negatively affect breastfeeding initiation and continuation rates

among immigrant women (Groleau, Soulière & Kirmayer, 2006).

Therefore, immigrant Arab women's remembrances of the reproductive process in their home countries emphasized the quality and extent of care they received. This was symbolized in the provision of special foods that ensured their own, and their infants' well-being. The importance of taking care of new mothers was also represented by the time they were given to recover from birth, and to settle into a new routine with their infants. Women received the most help with activities concerning food, as female relatives and friends took over food provisioning not just in providing special foods for the new mother, but also helped meet the dietary needs of the family as a whole.

Discussion

Reproduction is a rite of passage experienced by the vast majority of women who participated in this study. Not only is this a physical event women experience, but it is shaped by cultural values, affecting women's expectations and views of their reproductive experiences. The process of reproduction is also a social one, as it propagates not only new community members, but social values as well. In other words, the rituals associated with the reproduction process demonstrate fundamental societal worldviews. The suggestion being made is that because the reproductive process is intimately linked with sociocultural values and worldviews, an investigation comparing and contrasting immigrant women's reproductive experiences in their new and home countries is useful in highlighting tensions that are frequently part of the migration process.

Analysis of focus group interviews conducted with recent and non-recent Arab immigrant women showed this tension in the challenges they faced in birthing in Canada. The most common element missing in the Canadian context was a large support network composed of friends and family who would look after pregnant and lactating mothers, especially in the weeks following the birth event. Women recalled being vetted in their home countries while pregnant and lactating. This treatment was symbolized by the provisioning of food, in particular special foods. This was often not the case in Canada, where lifestyle changes resulted in fewer opportunities for socialization. The negative impact of the faster pace of life on women's abilities to perform traditional customs was exacerbated by financial constraints. Nevertheless, the study's participants spoke of the importance of continuing these traditions, not only because these practices shaped women's well-being, but also as a means of connecting with their homeland and living according to their ethnic and cultural identi-

ty. To participate in these traditions was a way of reproducing "home".

Challenges faced by immigrant women were balanced with benefits perceived to come with living in Canada. The medical system in Canada was overall highly regarded. Despite the complaint of lack of personal relationships with doctors, women appreciated the public health system and the consequent accessibility of care. Hospitals were clean and friendly, and staff were helpful and accommodating (e.g. religious dietary prescriptions were respected), allowing women to feel comfortable in this environment. Furthermore, for a small number of women, moving to Canada meant escaping the responsibilities that come with social reproduction, and they welcomed the opportunity to not participate in traditional reproductive rituals and ceremonies.

In sum, women's role as mothers is in large part manifested in reproduction, in their endeavors of reproducing children and society. Moving to a country where they are a visible minority group is accompanied by a variety of social, economic, and political stresses. These tensions may negatively affect their coping abilities of adjusting to life in Canada, and adversely affect their health and well-being (e.g. Dossa, 2004; Stewart et al., 2006; Vallianatos & Raine, 2005). Reproducing "home" through continuance of traditions may help to alleviate some anxieties, but in addition, efforts to address the issues female migrants face need further investigation and action (cf. Stewart et al., 2006). Advocacy with medical and governmental bureaucracies to increase awareness of Arab immigrant women's needs and development of culturally appropriate ways to help these women cope with the challenges they face in Canada are required. In addition, the education of medical and governmental administrators and staff members in the diverse cultural interpretations of health and reproduction is also necessary in order to provide culturally appropriate care.

Endnotes

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