Review article

Childbearing traditions of Indian women at home and abroad: An integrative literature review

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A R T I C L E   I N F O

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A B S T R A C T

Background: The percentage of overseas-born mothers giving birth in Australia has increased to 31.5% in 2012 and Indian women represent 10% (the highest proportion). It is important for midwives in Australia to be aware of the childbearing traditions of Indian women and how these influence Indian women birthing in Australia.

Aim: To explore childbearing practices in India and Indian women’s experience of giving birth abroad; and to discuss the relevant findings for midwives working with Indian women in Australia.

Method: An integrative literature review was employed. 32 items, including 18 original research articles were thematically reviewed to identify commonly occurring themes relating to Indian women’s childbearing traditions.

Findings: Five themes relating to traditional childbearing practices of women birthing in India were identified. These themes included diversity and disparity; social context of childbirth and marriage; diet based on Ayurveda; pollution theory and confinement; and finally, rituals and customs.

Conclusion: Indian women giving birth abroad and by implication in Australia experience a transition to motherhood in a new culture. While adjusting to motherhood, they are also negotiating between their old and new cultural identities. To provide culturally safe care, it is essential that midwives reflect on their own culture while exploring what traditions are important for Indian women.

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1. Introduction

This integrative literature review reports on childbearing traditions in India and the effect such traditions may have on Indian women’s birthing experience abroad. The review was guided by two research questions: “What does the literature report about childbearing traditions in India?” and “What does the literature report about Indian women’s experiences giving birth abroad?” with the aim of discussing the findings that are relevant to midwives working with Indian women in Australia.

It is becoming increasingly common for people to settle temporarily or permanently in a foreign country. They may do so out of choice, to further their education or careers or to immigrate. In some cases, it involves a forced displacement due to natural disaster, a war or political oppression. Whatever the reason, their first health encounter is often with the maternity service.

In 2012, 31.5% of birthing women in Australia were born overseas, and of these the highest percentage (10.7%) were from India, surpassing those from New Zealand (10%) and the United Kingdom (UK) (9.7%). This is an increase in Indian women from 5% in 2007. The largest number of permanent migrants in 2012 also came from India, ahead of China and the UK. When midwives working in Australia provide care for these women, it is important that their practice is culturally safe.

Cultural awareness and cultural sensitivity are two important steps towards cultural safety. Cultural awareness means that one becomes aware of differences between one’s own culture and that of others. Cultural sensitivity is demonstrated by the action of respecting the other person’s cultural values. Cultural safety in midwifery practice thus means that a midwife should assess and incorporate the woman’s specific cultural requirements in her care. Having an in-depth knowledge and personal experience of being with women from culturally and linguistically different backgrounds will help midwives provide culturally competent care.
2. Methodology

This study employed an integrative literature review methodology. The five stages expounded by Whittemore and Knaff were utilised, namely, problem identification, literature search, data evaluation, data analysis and presentation.

The CINAHL, EBSCOhost, ProQuest, OVID and SAGE Journals Online databases were utilised to search for journal articles. Key words used with Boolean operator included: India, childbirth, cultural practices, tradition, rituals, Indian women giving birth in Australia. However, when the last key phrase failed to source any article on Indian women’s birthing experiences in Australia, it was changed to ‘giving birth in a foreign country’.

Inclusion criteria were: research articles, both experimental and non-experimental, from peer-reviewed journals as well as books, policies and other relevant literature, which is in line with Whittemore’s rich sampling frame principle. The parameter was set for English language publications of the last ten years to ensure currency for practicing midwives. A total of 339 articles were accessed. After reading the abstracts, 45 articles were selected. Selection of the literature was guided by the two research questions cited above.

A Data Management Form was utilised to store the details of each article, while simultaneously evaluating the article’s validity and relevance to this review. As a result, a further 13 articles were excluded due to lack of relevance or data saturation, leaving 32 articles to be analysed and synthesised.

Various practices of childbearing traditions of Indian women were noted from each article. These practices were analysed, compared, combined or categorised in relation to the following points: How frequently does it get mentioned? What is the belief behind it? Is it unique to India? How does it affect the women? Is it relevant for midwives to be aware of? In accordance with the final step recommended by Whittemore and Knaff, the salient findings were thereafter synthesised under broad, overarching themes.

3. Literature search results

Among the 32 reviewed articles, 12 were from India (Table 1) and 20 from outside India. The 12 articles from India were all original research articles and eight were carried out predominantly among rural populations, two related to urban settings and two analysed national data. This high proportion of studies on the rural population might be related to the facts that in India 74% of the population resides in rural areas and 70% of rural births are at home, assisted by family members or traditional birth helpers. With one exception, all 12 articles mention, if not focus on, the high maternal and neonatal mortality rates in India. This may reflect the Indian Government’s campaign to medicalise birthing: the government argues that home births are a major cause of the high maternal and neonatal mortality rate.

The remaining 20 articles from outside India include six original research studies (Table 2), with one each from New Zealand, Canada, Singapore, and the USA that explored Indian women’s childbearing experiences in relation to the acculturation process. A UK study examined the effect of caseload midwifery practices on a culturally diverse group and one Australian study compared the obstetric intervention rates and birth outcomes between Australian and overseas born. Also included in the review were ten literature reviews (Table 3), one book chapter, and three scholarly, but non-research articles; a clinical paper on the Migrant Health Guide in UK, and a report from the Lancet and

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Table 1

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<thead>
<tr>
<th>Ref. #</th>
<th>Author(s)</th>
<th>Topic</th>
<th>Research type</th>
<th>Aim</th>
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</thead>
<tbody>
<tr>
<td>10</td>
<td>Singh et al.</td>
<td>Determinants of maternity care services utilization among married adolescents in rural India</td>
<td>Quantitative (analysis of national survey 2005–6)</td>
<td>To assess the factors associated with selected maternal healthcare indicators with reference to adolescent mothers in the age group 15–19 years living in rural India.</td>
</tr>
<tr>
<td>11</td>
<td>Corbett and Callister</td>
<td>Giving birth: the voices of women in Tamil Nadu, India</td>
<td>Qualitative (descriptive study) n = 22</td>
<td>To explore the concept of ritual pollution influenced practices after delivery, including during lactation and breastfeeding.</td>
</tr>
<tr>
<td>12</td>
<td>Bandyopadhyay</td>
<td>Impact of ritual pollution on lactation and breastfeeding practices in rural W Bengal, India</td>
<td>Mixed; 402 questionnaire and 30 interviewees</td>
<td>To explore the socio-cultural beliefs and survival practices around the weighing of newborns in Vidihas, Central India.</td>
</tr>
<tr>
<td>13</td>
<td>Bhattacharya et al.</td>
<td>‘To weigh or not to weigh?’: Socio-cultural practice affecting weighing at birth in Vidiha, India</td>
<td>Qualitative (4 FGDs, 6–8 in each group)</td>
<td>To explore the socio-cultural beliefs and survival practices around the weighing of newborns in Vidihas, Central India.</td>
</tr>
<tr>
<td>14</td>
<td>Iyengar et al.</td>
<td>Childbirth practices in rural Rajastha, India: Implications for neonatal health and survival</td>
<td>Qualitative (10 FGDs, 39 interviews, 8 observations)</td>
<td>To explore the socio-cultural beliefs and survival practices around the weighing of newborns in Vidihas, Central India.</td>
</tr>
<tr>
<td>15</td>
<td>Darmstadt et al.</td>
<td>Introduction of community-based skin-to-skin care in rural Uttar Pradesh, India</td>
<td>Quantitative n = 1732 mother–baby pairs</td>
<td>To develop a home-based neonatal care package, using the human resources available in villages in order to reduce neonatal mortality</td>
</tr>
<tr>
<td>16</td>
<td>Bang et al.</td>
<td>Methods and the baseline situation in the field trial of home-based neonatal care in Gadchiroli, India</td>
<td>Quantitative Intervention: 39 villages. Control: 47</td>
<td>To describe the acceptability of STFC (skin to skin care) in rural Uttar Pradesh</td>
</tr>
<tr>
<td>17</td>
<td>Pradhan et al.</td>
<td>Perceived gender role that shape youth sexual behaviour: evidence from rural Orissa, India</td>
<td>Qualitative (cross sectional) n = 20 men, 22 women</td>
<td>To understand the association of perceived gender role with youth sexual behaviour</td>
</tr>
<tr>
<td>18</td>
<td>Singh et al.</td>
<td>Role of TBAs in provision of antenatal &amp; perinatal care at home amongst the urban poor in Delhi, India</td>
<td>Qualitative (cross sectional) n = 29 TBAs</td>
<td>To find out the effect of training of TBAs on maternal and infant mortality</td>
</tr>
<tr>
<td>19</td>
<td>Darmstadt et al.</td>
<td>Traditional practice of oil massage of neonates in Bangladesh</td>
<td>Quantitative n = 322 questionnaire</td>
<td>To find out our epidemiology, practice and perceptions regarding traditional oil massage of Bangladeshi babies</td>
</tr>
<tr>
<td>20</td>
<td>Mohanty</td>
<td>Multiple deprivations and maternal care in India</td>
<td>Quantitative (analysis of national survey 2005–6)</td>
<td>To explore the links between multiple deprivations and use of maternal services</td>
</tr>
<tr>
<td>21</td>
<td>Singh et al.</td>
<td>Socio-economic inequalities in the use of postnatal care in India</td>
<td>Quantitative (analysis of national survey 2007–8)</td>
<td>To compare inequalities in the use of postnatal care between facility births and home births</td>
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</table>
an opinion piece in *Australian Midwifery News* by an Indian midwife.\(^{37}\)

No research article was found specifically exploring Indian women’s childbearing experiences in Australia. Nevertheless, there were three relevant literature reviews from Australia, one on postnatal depression and cultural perspectives,\(^{27}\) one on the importance of cultural safety for Australian midwifery practice\(^{6}\) and a meta-ethnographic study of migrant women’s experiences of breastfeeding in Australia.\(^{34}\)

### 4. Findings

Findings related to traditional practices surrounding childbirth in India are presented under five themes identified in the literature: diversity and disparity; social context of childbirth and marriage; diet based on Ayurveda; pollution theory and confinement; and rituals and customs. This is followed by findings related to Indian women’s experiences of giving birth abroad.

#### 4.1. Traditional cultural practices surrounding childbirth in India

**4.1.1. Diversity and disparity**

India is a multi-cultural society with at least two major religions, more than 20 principal languages and 225 dialects. Diversity among its billion people is undoubtedly the nation’s prominent characteristic.\(^{22}\) Alongside this diversity, significant disparities in maternal and infant health exist depending on the person’s class, place of residence, wealth and education.\(^{10,18,20–22,37}\)

### Table 2

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<thead>
<tr>
<th>Ref. #</th>
<th>Author(s)</th>
<th>Topic</th>
<th>Country</th>
<th>Research type</th>
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</thead>
<tbody>
<tr>
<td>4</td>
<td>Dahlen et al.</td>
<td>Rates of obstetric intervention during birth and selected maternal &amp; perinatal outcomes for low risk women born in Australia compared to those born overseas</td>
<td>Australia</td>
<td>Population based descriptive study. (n=691,738) NSW Midwives Data Collection 2000–2008</td>
<td>To compare the risk profile, rates of intervention and selected maternal and perinatal outcomes for low risk women born in Australia compared to those born overseas</td>
</tr>
<tr>
<td>23</td>
<td>De Souza</td>
<td>Transforming possibilities of care: Goan migrant motherhood in NZ</td>
<td>NZ</td>
<td>Qualitative. (n=7) women</td>
<td>To study the maternity care experiences of women from Goa, India in Auckland, NZ</td>
</tr>
<tr>
<td>24</td>
<td>Grewal et al.</td>
<td>Perinatal beliefs and practices of immigrant Punjabi women living in Canada</td>
<td>Canada</td>
<td>Naturalistic qualitative descriptive. (n=15) women</td>
<td>To describe new immigrant Punjabi women’s experiences and the ways traditional beliefs incorporated into the Canadian health care system</td>
</tr>
<tr>
<td>25</td>
<td>Naser et al.</td>
<td>An exploratory study of traditional birthing practices of Chinese, Malay and Indian women in Singapore</td>
<td>Singapore</td>
<td>Qualitative. (n=30) women (21 Chinese, 5 Malay, 4 Indian)</td>
<td>To explore the traditional birthing practices of Singaporean women</td>
</tr>
<tr>
<td>26</td>
<td>Goyal et al.</td>
<td>Immigrant Asian Indian women and postpartum depression (PPD)</td>
<td>USA</td>
<td>Quantitative descriptive. (n=58) women, 58 survey</td>
<td>To determine the incidence of PPD symptoms in immigrant Asian Indian women</td>
</tr>
<tr>
<td>38</td>
<td>Beake et al.</td>
<td>Caseload midwifery in a multi-ethnic community: the women’s experiences</td>
<td>UK</td>
<td>Qualitative. (n=12) women in each group (Indian women (n=2) in both groups)</td>
<td>To evaluate the outcomes of caseload midwifery practice in a socially deprived and ethnically diverse inner-city area</td>
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### Table 3

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<thead>
<tr>
<th>Ref #</th>
<th>Author(s)</th>
<th>Topic</th>
<th>Country</th>
<th>Item type</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Phiri et al.</td>
<td>Cultural safety and its importance for Australian midwifery practice</td>
<td>Australia</td>
<td>Literature review</td>
<td>To explore the evolution of cultural safety and its application to midwifery practice</td>
</tr>
<tr>
<td>7</td>
<td>Mortensen</td>
<td>The theory and practice of cultural safety in nursing</td>
<td>New Zealand</td>
<td>Literature review</td>
<td>To critically examine if the cultural safety guidelines for nursing practice is effective for CALD groups</td>
</tr>
<tr>
<td>27</td>
<td>Jain and Levy</td>
<td>Conflicting cultural perspectives: experiences of postnatal depression among women in Indian communities</td>
<td>Australia</td>
<td>Literature review</td>
<td>To explore Indian women’s experiences from a cross cultural perspective</td>
</tr>
<tr>
<td>28</td>
<td>Posmontier et al.</td>
<td>Postpartum practices and depression prevalences: technocentric and ethnocentrism cultural perspectives</td>
<td>US</td>
<td>Literature review</td>
<td>To explore the concepts of technocentricism and ethnocentrism and the implications for midwifery care of postnatal women from non-western backgrounds</td>
</tr>
<tr>
<td>29</td>
<td>Requejo et al.</td>
<td>The World Health Organization (WHO) policy on global women’s health</td>
<td>Switzerland</td>
<td>Literature review</td>
<td>To review the WHO policies for the advancement of women’s health</td>
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<tr>
<td>30</td>
<td>Mantle</td>
<td>Developing a culture-specific tool to assess PND in the Indian community</td>
<td>UK</td>
<td>Review</td>
<td>To develop a culture-specific tool to assess PND in the Indian community</td>
</tr>
<tr>
<td>31</td>
<td>Gatrad et al.</td>
<td>Hindu birth customs</td>
<td>UK</td>
<td>Review</td>
<td>To introduce Hindu birth customs to healthcare providers in UK</td>
</tr>
<tr>
<td>32</td>
<td>Dennis et al.</td>
<td>Traditional postpartum practices and rituals: a qualitative systematic review</td>
<td>Canada</td>
<td>Systematic review</td>
<td>To increase the understanding of traditional PN practices in order to provide culturally competent perinatal services</td>
</tr>
<tr>
<td>33</td>
<td>Boerleider et al.</td>
<td>Factor affecting the use of prenatal care by non-western women in industrialized western countries</td>
<td>The Netherlands</td>
<td>Systematic review</td>
<td>To give a systematic review of factors affecting non-western women’s use of prenatal care in industrialised western countries</td>
</tr>
<tr>
<td>34</td>
<td>Schmied et al.</td>
<td>Contradictions and conflict: a meta-ethnographic study of migrant women’s experiences of breastfeeding in a new country</td>
<td>Australia</td>
<td>Literature review</td>
<td>To explore the diversity of migrant and refugee women’s experiences related to breastfeeding in a new country</td>
</tr>
</tbody>
</table>
India is one of 189 countries committed to the Millennium Development Goal of reducing maternal and neonatal mortality rates by 75% during the period 1990–2015. Since 2005, the Indian government has sponsored a cash-incentive scheme to poor and marginalised women to encourage them to give birth in an institution and receive antenatal and postnatal care. However, its level of implementation varies widely among the states. Women in rural areas access healthcare less than those in urban areas. The subjects of a study in rural Rajasthan attributed their reluctance to give birth at a facility to it being an unfamiliar place staffed by nurses and doctors who, unlike the village dai (birth helper), were not known to them. Also, it was easier for them to observe traditional rituals at home.

Paradoxically, while females may be adored and respected within their families, many women are mistreated and disadvantaged in India, which is a male-dominant society. Male-child preference is deeply rooted, for in Hinduism both the family line and performance of funeral rites that ensure safe passage of the soul through purgatory depend on having a son. The high expectation that the next child be a boy places a pregnant woman who already has a daughter under considerable stress.

4.1.2. The social context of childbirth and marriage

Traditionally, having a baby is strictly confined within marriage. Pregnancy outside marriage brings shame and criticism on a woman and her family. Arranged marriage is a common practice, in which the status and reputation of both families play a part. Couples are usually expected to start a family immediately, and when a bride becomes pregnant, this is an event celebrated by the couple’s extended families and neighbours. Becoming a mother elevates a woman’s status within her community and is considered crucial for leading a fulfilling life.

Childbearing traditions reflect community beliefs concerning what is beneficial for the pregnant woman and her unborn baby. Elderly female members have important roles: they are considered the source of knowledge concerning diet, conduct and taboos during pregnancy and the chief supporters of the mother after birth, taking over household chores and baby care so that the new mother can rest.

4.1.3. Diet based on Ayurveda

Ayurvedic medicine practiced by Hindus in India is over 2500 years old. Similar to the humoral medical theory, it emphasises maintaining a proper balance among the various components of a person in order to stay healthy. Since childbirth is seen as a life event that interrupts the balance of doshas (energies), Ayurvedic medicine recommends certain herbs, diet and yoga to restore the balance. One branch of Ayurveda deals with bhut (evil spirit or demon) and some rituals are concerned with this unseen world of spirits. Many taboos on diet are based on the belief that dietary indiscretions by the mother would later cause sickness in the newborn.

The actual food items recommended or prohibited, depending on region and family circumstances, are too numerous to list. However, the general concept underlining dietary prescriptions and taboos is the humoral theory, whereby high protein, acidic and salty foods are considered ‘hot’, and sweet food, vegetable and fruits are considered ‘cold’. The ‘hot’ and ‘cold’ concept of food does not necessarily correlate with the temperature of food. Most of pregnancy is seen as a ‘hot’ state and so ‘hot’ food is to be avoided, but towards the end of pregnancy, ‘hot’ food is recommended to help with birth. The postnatal and lactating mother is in a ‘cold’ state therefore ‘hot’ food is recommended. However, the breastfeeding mother may be advised otherwise, depending on the baby’s condition.

4.1.4. Pollution theory and confinement

The concept of ritual pollution remains strong in contemporary India. Temporary states of impurity may be due to menstruation, birth or death, and people require rituals to revert to a pure state. Traditionally, the umbilical cord and placenta were considered polluted and their disposal was carried out by a certain social caste. A study involving 30 focus group sessions in rural Gadchiroli found that mother and baby were considered polluted and were touched only by the traditional birth attendant, grandmother and mother-in-law. When the cord fell off, a purifying social and religious ceremony was performed; only then was the baby considered pure and dressed in new clothes.

The custom of confinement following childbirth stems from pollution beliefs. Some of the benefits of such a tradition is that it ensures a good rest for the new mother, who is exempted from chores, avoids potential infection from visitors and concentrates on bonding with her baby. This tradition of isolation and mandatory rest for up to 90 days probably originated when life for women was harsh and physical. Although contemporary household chores may not be as demanding, the tradition continues.

4.1.5. Rituals and other customs

Hindu sacraments are part of an ancient Code of Law set up to help individuals to achieve ‘purity’ and ‘perfection’. There are eight sacraments related to the period between pregnancy and the baby’s first birthday, reflecting the importance Hindus ascribe to pregnancy and birth. Each sacrament has its own set of rituals, some of which non-Hindus also observe.

Apart from the washing of the baby immediately after birth, the timing of the ritual bath varies from five to nine days or up to three months. To ward off evil spirits, a black dot is applied to the forehead or elsewhere on the face. An oil massage is a popular practice, believed to improve strength and maintain general health in mothers and their babies. The custom of a pregnant woman going to her natal home around the second trimester and staying for a few weeks postnatally enables the new mother to rest and be pampered by her own family.

A qualitative study in the Vidisha district explored the reasons behind birth weight not being recorded in 71% of cases. This was related in part to the fact that 60% of births in India took place at home but also to mothers not regarding taking the baby’s weight as something important to note down. The study discovered a socio-cultural reluctance among rural women to weigh the baby, as they feared this would not only interfere with the confinement ritual but also expose the baby to the possibility of on-looker casting an ‘evil eye’ on the infant. The concept of ‘evil eye’ was deeply engrained in the community psyche: a baby’s sickness or unwillingness to suckle would be blamed on an ‘evil eye’ cast on the baby.

Breastfeeding is universal throughout India, but the custom of giving ‘pre-lacteal’ feeds to a newborn is prevalent in rural areas, with the exception of Muslim women who put their babies to the breast immediately following birth. Pre-lacteal feeding stems from a belief that colostrum is impure and harmful, hence to be discarded. Babies are given hot water, sugar-water, honey, mustard oil, tea or goat or cow milk to cleanse their system before breastfeeding.

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4.2. Findings related to Indian women’s experiences of giving birth abroad

The following discussion is drawn from research studies on Indian women’s childbearing experiences in Singapore, Canada, New Zealand and the US as well as one research article and one literature review from Australia.
Indian childbearing women who leave their own community imbued with many traditions and resettle abroad face the two-fold challenges of transition to both motherhood and a different childbirth culture. For them, observing the childbirth tradition of their home country is strongly related to their identity in a new culture. Where Indian women may value western maternity care, some traditional beliefs and practices associated with childbirth endure, regardless of their level of acculturation. This may cause the Indian woman to experience conflicts between her belief and advice from health professionals, or sometimes between her belief and that of elder female family members. The reasons Indian mothers in Singapore gave for following traditional practices vary, but can be summarised as showing respect to elders, maintaining family harmony and fear of adverse consequences for themselves and their babies. In New Zealand and Canada, the most frequently mentioned issue while in hospital was the conflict between rest and mobility. The Indian tradition prescribes strict bed rest, whereas western midwifery practice encourages early ambulation and self-care after birthing. Other problematic issues included air conditioning, daily shower and cold drinks and food in the maternity ward; since a new mother is believed to be in a 'cold' state after childbirth and should avoid draughts, water, cold drinks and cold food. In the United States, where the majority of migrant women work, women, their extended family and health care providers was an individual experience.

During the postnatal period, Indian women in New Zealand and Canada reported needing to negotiate between keeping traditional customs and being practical. They become flexible in their expectations and shortened the confinement period if they had to go out, and formed new social networks with other Indian women. When possible, they brought family members from India for support. Where extended family support was lacking, the husband's role was transformed: contrary to norms in India, he became actively involved in domestic responsibilities and child-care. However, as one Indian mother reported, the lack of attentiveness expressed through special food, oil massage, and house chores done by the extended female family members was a painful loss. In India, childbirth was a social process; in her new country it was an individual event. The 'painful loss' described by the Indian woman above may be understood in terms of what Posmontier and Horowitz call the 'ethnokinesis' culture of postnatal care. The term 'ethnokinesis' refers to cultures in which the primary focus is on the social and family support networks during the immediate and later postnatal periods, whereas 'technocentric' refers to cultures such as the Australian, which focus on the use of technology to monitor the well-being of the new mother and baby in the early postnatal days. In some countries, such as among affluent women in India, technocentric culture might dominate during the birthing process whereas ethnokinesis culture takes over during the postnatal period.

Although not based on personal experiences of giving birth, a study by Dahlen et al. provided certain statistical findings, which may constitute useful knowledge for Australian midwives. In the study based on the NSW Midwives Data Collection between 2000 and 2008, among the nine low-risk groups of women, Indian-born women had the highest instrumental birth rate and highest caesarean section rate. Further, their babies had the lowest mean birth weights in spite the fact that the rates of smoking, teenage pregnancy and older age were low among Indian-born women.

5. Discussion

Current trends indicate that Australian midwives will care for increasing numbers of Indian women of childbearing age. The majority of Indians in Australia enter under the skilled migration scheme and are well educated. A midwife cannot predict the level of importance Indian migrant women might give to traditional practices, it is important for midwives to find out each individual's cultural beliefs without making assumptions. Women's cultural preferences should be accommodated unless obviously hazardous. Australian midwives working in a technocentric culture may find some traditional rituals of an ethnokinesis culture puzzling. It might be helpful to consider postnatal rituals as rites of passage for new mothers that promote physical recovery, emotional stability and spiritual protection.

Cultural sensitivity requires cultivating respectful relationships rather than mere theoretical learning, and cultural competence is an evolving process that depends on self-reflection, self-awareness and acceptance of difference. As Grewal points out, whether we are givers or receivers of health care, cultural considerations and examination of unequal power relations are essential if midwives are to provide culturally safe care.

Migrant women noted that when their care provider showed interest and respect, this alleviated their anxiety about coming into a health facility in a new country. Many Indian women in labour valued being cared for by known midwives and during the postnatal period they valued being supported by family members. While it is beneficial for any pregnant woman to be able to build a trusting relationship and good communications with her carer, it is especially important for those from a culturally diverse background.

Finally, it is important not to lose sight of the positive contributions that occur in multicultural situations. DeSouza pointed out that studies on migrant women often focused on problems and risks rather than strengths. From a strengths-based perspective, in working through the dual transition of migration and motherhood, Indian women develop strong skills of adaptation and resourcefulness that should be recognised. Indeed, women value the opportunity to talk about their birthing experiences and their stories about childbirth are an important source of insight and knowledge for midwives. Currently, however, there are no studies on Indian women's experiences of giving birth in Australia. This gap needs to be filled, ideally through research with a phenomenological or ethnographically designed method that places the experience of Indian women, as told by them, at its core.

6. Conclusion

Childbirth is not merely a biological event, nor is it an isolated, individual experience. Indian childbearing traditions reflect the beliefs and expectations held by people and their communities. The childbearing woman is expected to follow certain behavioural and dietary protocols. The woman expects extensive physical and emotional support from her family and others around her.

This integrative literature review explored the birthing experience of Indian women living in New Zealand, Singapore, Canada and the US. A significant gap in the literature and a limitation of this review was that no specific literature relating to Indian women's experience of birthing in Australia was found. However, by extension, Indian women who birth in Australia also experience a transition to motherhood in a new culture. While adjusting to their new role as mothers, Indian women giving birth in Australia are also negotiating between their old and new cultural identities. It is essential that Australian midwives reflect
on their own, often technocentric practices in an informed way if they are to provide culturally safe care to Indian women.

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