EMPOWERMENT OF INDO-CANADIAN WOMEN THROUGH PRENATAL EDUCATION: A CASE STUDY

THESIS

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ABSTRACT

This thesis presents a qualitative study on the motivational needs and inhibiting barriers for participation in a prenatal education program. Three focus groups were planned, developed, and implemented in 1998. The focus groups consisted of 12 pregnant Indo-Canadian women who were involved in, or recently had participated in, a prenatal program; 1 husband and 5 health care providers in total. These pregnant Indo-Canadian women in my region of British Columbia were at-risk for delivering a low birth weight infant; however, many other similar at-risk women were not receiving prenatal education in the region. As the program coordinator of a prenatal program, I was aware that Indo-Canadian women in British Columbia's Lower Mainland have a higher rate of low birth weight than the Canadian norm. Also, the self-referral of Indo-Canadian women to the prenatal program where I worked was very low. As a recruitment study, the focus group questions explored methods to increase the participation of Indo-Canadian pregnant women in my prenatal education program. I sought to investigate ways adult educators can break through the cultural barriers faced by Indo-Canadian women, empower them to seek prenatal education, and increase their rate of self-referral. I believe my study has shed light on the problem facing the Indo-Canadian community in British Columbia's Lower Mainland. There are many deep-rooted internal and external factors impacting this group's participation and self-referral to prenatal education programs. My findings have interesting connections to the literature on oppression and women. Significant efforts need to be made in order to address this complex issue. Indo-Canadian women need to move from a state of disempowerment to empowerment. Prenatal education can be an opportunity to achieve this.

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CHAPTER 1

INTRODUCTION

The issues surrounding pregnancy and childbirth are universally recognized as being important to the health of a society. Women and health care providers all over the world view education for pregnant women as being vitally important (Institute of Medicine, 1985; M. A. Rose, 1993; Watters & Avard, 1992). Unfortunately, not all pregnant women benefit from prenatal education. Factors that may be intrinsic to the women themselves, or external factors, may hinder their participation in prenatal education programs. Understanding and addressing this issue presents a challenge for adult educators within the public health sector.

The fields of adult education and prenatal education are generally considered to operate in separate disciplines, but they have strong connections because both involve empowering individuals in gaining greater control over their future. Prenatal education has importance to the community, and the field of adult education has a long tradition of community-based education.

This thesis discusses a qualitative study in which I used focus groups to explore how adult education strategies could be used to overcome the barriers pregnant Indo-Canadian immigrant women face in attending prenatal education programs. Although this case study was with a small population, and I do not assume the findings are generalizable. However, the research process and outcomes should be of interest for those working in the area of prenatal education.

Background Information

Few problems are more pressing or more significant in Canadian health care than the issues surrounding low birth weight. According to Watters and Avard (1992), "prevention of low birth weight is one of the most pressing issues in perinatal care, not only in Canada, but worldwide" (p. 15). The health risks associated with low birth weight babies are well documented in the literature. Low birth weight babies face a higher risk of infant death. Low birth weight babies also face a higher risk of suffering from serious health problems and disabilities such as mental handicaps, cerebral palsy, vision and hearing impairment, or learning disabilities (British Columbia Ministry of Child and Families, 1997/98; M. A. Rose, 1993; Watters & Avard, 1992). The education of pregnant women plays a major role in preventing the conditions that lead to low birth weight infants.

Some women have difficulties accessing prenatal education because they face numerous barriers to participation. These typically include financial hardships or the cost of prenatal programs; lack of support, transportation, or childcare; and the social stigma that are sometimes attached to attending such programs. However, women of ethnic minority groups face additional barriers. In the case of Indo-Canadian women, for instance, they often have cultural and religious beliefs that discourage attendance at prenatal programs, language barriers in even knowing such programs exist, and lack of spoken and written English when prenatal education is only offered in English. By understanding the marginalization these women face, solutions can be explored and education can be used to reduce the barriers for them. Access to prenatal education can be a reality in many Canadian communities, if well designed adult education programming

takes place. Much of the literature (e.g., Acton, 1995; McAlpine, 1992;. Powell, 1997; The Volunteer Centre of Metropolitan Toronto, 1992), indicates that prenatal education programs that use culturally sensitive approaches to adult education and recruitment of participants can be highly effective.

I became interested in examining how adult educators can help facilitate the prevention of low birth weight babies while working in a prenatal program center in British Columbia's Lower Mainland. Some background information about this education program is helpful. This prenatal program is a provincially funded program targeting high-risk pregnant women for prenatal education. The prenatal program provides nutrition education as well as lifestyle counselling and support to high-risk pregnant women who do not typically access traditional health services. The provincial mandate provides criteria for determining who high-risk clients are. The high-risk factors included in the criteria are grouped into four areas: physical factors, substance abuse or misuse, psychosocial factors, and economic factors. A pregnant woman must have two risk factors from these categories to be eligible to join the prenatal program. Also, only women who are less than 28 weeks gestation at the time of referral are eligible to join the program.

The goals of this prenatal program are threefold: (a) to reduce the number of low birth weight babies born, (b) to reduce the incidence of fetal alcohol syndrome babies born, and (c) to reduce the incidence of neonatal abstinence syndrome (drug addicted babies) babies born in the community. The center is located in an area with a high East Indian population, and the program offers free prenatal education in both Punjabi and English. Both individual education sessions and group education are provided. Group

education sessions are specifically targeted for Indo-Canadian clients and are offered twice a month by a registered dietitian and/or a nurse.

The Problem

Pregnant Indo-Canadian women in the Lower Mainland region of British Columbia have a higher incidence of low birth weight babies than other women. According to Pastoree, Cocking, and Stilwell (1998) a study of a random sample of Indo-Canadian mothers who had given birth in December 1996 and January 1997 revealed that "10.9% of Indo-Canadian babies had low birth weight in contrast to 6.5% for 'other babies'" (p. 56). Having worked in this prenatal education program for 2 years, I determined that pregnant Indo-Canadian women who are at-risk for delivering a low birth weight infant are not receiving adequate prenatal education.

Also, I noted that the self-referral of Indo-Canadian women to the prenatal education program I worked at is very low. This program has made ethnic-specific recruitment efforts by marketing in both English and Punjabi. Recruitment efforts in 1998 included a mail out to local physicians with large Indo-Canadian clientele and public service announcements on local Punjabi radio stations and in Punjabi newspapers. Despite our recruitment efforts over a 2 year period, the number of pregnant Indo-Canadian women who self-referred was still low. During the 1997/1998 fiscal year, only 14% of Indo-Canadian women self-referred, where as 49% of Caucasian women self-referred. I began to wonder why. The question arose, how can adult educators overcome the cultural barriers Indo-Canadian women face in participating in prenatal education? This became the focus for my study.

Purpose of the Study

As an adult educator working in a prenatal education program in British Columbia's Lower Mainland, I wanted to explore methods of increasing the participation of pregnant Indo-Canadian women in prenatal education programs. I sought to investigate how adult educators could break through the cultural barriers faced by Indo-Canadian women (in this study), empower them to seek prenatal education, and increase their rate of self-referral. The hypothesis was that culturally appropriate recruitment and prenatal education would encourage more to participate in the program. This, in turn would help pregnant Indo-Canadian women in the region achieve improved health behaviors during pregnancy and aid in decreasing the rate of low birth weight infants in this population. Therefore, the purpose was to determine how the program might successfully recruit more expectant Indo-Canadian women to the center. As a secondary purpose, I hoped to shed light on the cultural barriers that face this group of women.

In order to pursue this purpose, I decided to hold focus group sessions with Indo-Canadian women who were participating or already had participated in my agency's prenatal education program. My intent was to obtain perspectives from participants about factors that both positively and negatively influenced them and others in the region, concerning their decision to join the prenatal education program. I also decided to hold a focus group with health care providers at the prenatal program in order to obtain insight into their perspectives about factors that they believed positively or negatively influenced Indo-Canadian women's participation in the prenatal education program.

Scope of the Study

This study is in the area of health and nutrition education. Its focus is on motivation and recruitment within the context of social-cultural factors of educational participation. The study deals specifically with Punjabi-speaking pregnant Indo-Canadian women living in the Lower Mainland of British Columbia. It only includes Punjabi-speaking women who have emigrated from India, meaning first-generation women. It does not include Punjabi-speaking women who have been born and raised in Canada. Also, it includes only those pregnant women who have been enrolled in my agency's prenatal education program. In order to be enrolled in this program, these women had to meet the provincially mandated risk criteria for joining the program, as discussed earlier. Therefore, this is not a study about South Asian women in general, nor about any other cultural groups.

The study was planned, developed and implemented during 1998. The focus groups for the study were held in June and July 1998. In total, 12 Indo-Canadian women participated in either of the two focus groups, and 5 health professionals participated in a third focus group. In the evaluation phase, I analyzed the data in search of similarities, differences, themes, and major ideas within each focus group and between all focus groups.

Limitations of the Study

One major limitation of this study is that the true magnitude of the problem of low birth weight affecting South Asian women, and Indo-Canadian women specifically, is not currently known. Unfortunately, statistical data regarding language, ethnic origin, and

immigration by municipality is not available in Canada. Therefore, it is difficult to specifically determine how large the Punjabi-speaking population of the geographic areas serviced by the prenatal program actually is. Also, in 1998 the number of Punjabi-speaking women who delivered at the local hospital was unknown, and the total number of high-risk Punjabi-speaking women (using the criteria given) who were living in BC's Lower Mainland at the time of this study is unknown. These data may have helped this study and this may be seen as a limitation as well.

Also, there are limitations attached to using focus groups as a method of studying the topic. Krueger (1988) notes that the researcher has less control in group interviews as compared with individual interviews, the data are more difficult to analyze, groups can vary considerably, it can be difficult to assemble the groups, and carefully trained interviewers are required. Nevertheless, I believe I and my colleagues overcame these methodological issues, as is seen in chapter 3. From a statistical viewpoint, the sample size of the focus groups was relatively small. This may be seen as a limitation. However, this study was qualitative in nature, and the findings as well as the research processes used are intended to be illustrative only.

Assumptions

I began with the basic assumption that the vast majority of women, regardless of age, race, or cultural background, desire to give birth to a thriving healthy baby. Also, I assumed that women want to avoid giving birth to a low birth weight baby. I assumed that the outcome of low birth weight could be influenced by behavioural changes made

by pregnant women and that using adult education techniques can bring about behavioural changes.

I also assumed that the responses given by the women involved in the focus groups were honest ones. I based this on the fact that their ideas and responses were their own, were not unduly influenced by the opinions of the facilitator, and the results were analyzed in an unbiased manner. Interestingly, their speculations on why others did not participate provided a sense of freedom in the group—freedom from personally criticizing the cultural restrictions they experienced daily in the Indo-Canadian community.

Definitions

There are several terms used in this thesis that have a specific or special meaning. These words include: low birth weight, South Asian, Indo-Canadian, oppression, empowerment, and non-formal education. To avoid confusion, these words are defined here.

Low birth weight. In the literature, low birth weight is defined as an infant birth weight of less than 2500 grams, or 5 pounds 8 ounces, or 5 ½ pounds (British Columbia Ministry of Child and Families, 1997/1998). This definition of low birth weight is well accepted in the literature (Dunn, 1984; M. A. Rose, 1993; Watters & Avard, 1992). For this thesis, I also use this definition.

South Asian and Indo-Canadian. Understanding the term South Asian is integral to understanding the specific population that this thesis refers to. Assanand, Dias, Richardson, and Waxler-Morrison (1990) define this term as follows:

> The term "South Asian" refers to people with cultural origins in the Indian subcontinent, which include Pakistan, India, Sri Lanka, Bangladesh, and Nepal . . . people of South Asian cultural heritage have also immigrated to Canada from other parts of the world including the South Pacific (Fiji) and East Africa. (p. 141)

The term Indo-Canadian is also used throughout this thesis. For this study, Indo-Canadian specifically refers to Punjabi-speaking women who have emigrated from India and are presently living in Canada.

Access. The Websters New Collegiate Dictionary (1959) defines the broad term of access, as: "Approach; admittance; admission; accessibility; as, to gain access; easy [sic] of access; also, an advance or approaching"(p. 5). Gulzar (1999) provides a definition of access specific to health care: "Access to health care is defined conceptually as the fit among personal, sociocultural, economic, and system-related factors that enable individuals, families, and communities to have timely, needed, necessary, continuous, and satisfactory health services"(p. 17). In this thesis, I use access to mean admittance and accessibility for prenatal education.

Oppressed and oppressor. Freire (1970) refers to the oppressed as being subservient to the oppressor. The oppressed are dehumanized by the power of the oppressor. The oppressed believe they are beneath the oppressor and are dependent on the oppressor. Freire describes the oppressor as having the need for ownership, which is usually at the expense of those who have nothing.

Empowerment. According to Jarvis (1990), the term empowerment generally refers to the outcome of the educational process. "Conservative adult educators use the term to refer to equipping and raising confidence of individuals so that they can be more successful in the world" (p. 114). However, more radical adult educators view

empowerment as the outcome of education as it relates to making changes in one's social structure for greater equality.

Non-formal education. Jarvis (1990) defines non-formal education as: "Educational activity which occurs outside of the established formal system and is organized to serve the identifiable learning needs of specific groups" (p. 244). This education is specifically designed to meet the specific needs of the individuals. Non-formal education is used extensively for children and adults in many Third World countries.

Plan of Presentation

The thesis is divided into four chapters. Following this chapter, chapter 2 provides a review of the literature relevant to this study. Topics of review include: the importance of prenatal education, access to prenatal care and education, oppression and empowerment, participation and non-participation in adult education, and culturally sensitive programming and recruitment approaches to adult education.

Chapter 3 describes the study that I planned, developed, and implemented at a prenatal program in British Columbia's Lower Mainland. The chapter includes details of the design phase and a description of the focus groups. Finally, the findings extracted from each of the focus groups are presented and summarized.

Chapter 4 combines what I have learned from my study at the prenatal program and from the existing literature. Six main themes are discussed. These include the general motivators and barriers to prenatal education faced by participants, factors of oppression and empowerment at play, implications for other prenatal programs, recruitment issues,

my personal learning and growth, and perceived learning of the participants in this study. Also, it provides conclusions and recommendations for practice and further research.

CHAPTER 2

LITERATURE REVIEW

This chapter provides a review of the existing literature that is relevant to the study I conducted. The literature review is divided into five major sections. The first section discusses the importance of prenatal education. I identify the relationship between prevention of low birth weight and adult education for pregnant women. The second section examines the issue of access to prenatal education; I look at access in general as well as individual barriers and access issues specific to South Asian women. The third section examines the concepts of oppression and empowerment. Here, I discuss the oppression of women, freedom from oppression, women's ways of knowing and non-formal education as a tool for the empowerment of women. The fourth section discusses participation and non-participation in adult education. The fifth and last section discusses education of ethnic minorities in North America, culturally sensitive approaches to adult education, and effective recruitment strategies for ethnic groups.

The Importance of Prenatal Education

In most Western countries, low birth weight is a major determinant in infant death (Dunn, 1984; Institute of Medicine, 1985; Silens et al. 1985). The Institute of Medicine (1985) notes that, for Canada, in addition to increased morbidity and mortality of infants, many health problems and disabilities are associated with low birth weight:

> The association of neurodevelopmental handicaps and congenital anomalies with low birthweight has been well established; low birthweight infants also may be susceptible to a wide range of other conditions, such as lower respiratory tract

> infections, learning disorders, behaviour problems, and complication of neonatal intensive care interventions. (p. 1)

Similarly, M. A. Rose (1993) states, "low birthweight babies are more likely to have health problems and disabilities, or to die soon after birth"(p. 13). Because low birth weight infants are at higher risk of health problems and disabilities, this has a major impact on the health and well-being of a society. Consequently, according to the British Columbia, Ministry for Children and Families (1997/1998), low birth weight has a significant impact on Canadian health care costs: "The cost of [health] care over the lifetime of one handicapped low birth weight child is over $1.5 million" (p. 1).

The Rationale for Declining Perinatal Mortality Rates

Thanks to improved medical technology, the rate of infant deaths in the Western world has been decreasing over the past two decades. Silins et al. (1985) indicate that approximately three quarters of infant deaths in Canada during 1978-1979 period were related to low birth weight or fetal immaturity. However, these rates are improving: "perinatal mortality rates are declining throughout the Western world, including Canada" (p. 1218).

More recently, Nault (1997) describes trends in infant deaths and incidence of low birth weight in Canada from 1975 to 1995. Nault states, "The drastic reduction in infant mortality—deaths of children younger than age one—in Canada and in other industrialized countries is a major achievement of this century" (p. 39). He notes there has been a significant decline in the annual number of infant deaths over the past 20 years, but that the rate of decline is slowing down. He differentiates between infant deaths less than 7 days of age, less than 28 days of age, and under 1 year of age; all of

these fall under the term infant mortality. He states that there was a marked drop in the overall infant mortality rate from 1975 to 1985, it fell from 13.6 infant deaths per 1,000 live births to 7.9. In 1995, there was a small drop to 6.1 infant deaths per 1,000 live births. He also notes an improvement in infant deaths less than 7 days of age. He attributes this improvement to medical advances. According to Nault (1997), the incidence of low birth weight fell from 6.64% to 5.53% from 1975 to 1985, but then increased to 5.77% in 1995. He presents the incidence of low birth weight by maternal characteristics, age and marital status of the mother, number of weeks of gestation, and birth order. Ethnicity of the mother is not one of the factors by which low birth weight is presented.

The declining mortality rates are reported to be due to improved medical technology rather than improvement in infant birth weights (M. A. Rose, 1993; Silens et al. 1985; Watters & Avard, 1992). The birth weight of a newborn is considered one of the best indicators of his or her chance of survival (Nault, 1997; M. A. Rose, 1993). Silens et al. (1985) recommend focusing on the prevention of low birth weight infants. This could be made possible by examining and reducing the risk factors of pregnancy. By examining these risk factors, an effort can be made to educate and to encourage pregnant women to reduce those factors and to strive for health behaviours that are considered ideal for a healthy birth weight infant.

M. A. Rose (1993) notes that, over the past 25 years, medical advances in rescuing small infants have been successful in reducing the rate of infant deaths. To continue to see further improvements in birth outcomes, Rose argues health care workers need to look beyond medical technological advances. She recommends reducing the

number of low birth weight infants being born by preventing the conditions that lead to such low birth weight incidents. Here is an obvious role for adult educators.

The Role of Prenatal Education in the Prevention of Low Birth Weight Infants, Risk Factors

The literature supports the importance of identifying risk factors in pregnancy that lead to low birth weight infants. Watters and Avard (1992) explain, "The role of prenatal care in the prevention of low birth weight has been highlighted in most of the literature" (p. 23). They state, "attention is now turning to the prevention of low birth weight by focusing on the modifiable risk behaviours" (p. 16). The Institute of Medicine (1985) has listed risk factors in the U.S.A. that increased chances of developing a low birth weight infant. These are grouped into demographic, medical prepregnancy, medical current pregnancy, behavioural, environmental, and health care categories:

> These factors include demographic characteristics, such as low socioeconomic status, low level of education, nonwhite race (particularly black), childbearing at extremes of the reproductive age span, and being unmarried; medical risks that can be identified before pregnancy, such as poor obstetric history, certain diseases and conditions, and poor nutritional status; problems that are detected during pregnancy, such as poor weight gain, bacteriuria, toxemia/preeclampsia, short interpregnancy interval, and multiple pregnancy; behavioural and environmental risks, such as smoking, alcohol and other substance abuse, and exposure to various toxic substances; and health care risks of absent or inadequate prenatal care and iatrogenic prematurity. (p. 2)

The risk factors of low birth weight infants that can be modified include smoking, poor nutrition, and the abuse of alcohol and other drugs. Other (societal) factors include poverty, stress, and lack of social support (M. A. Rose, 1993; Watters & Avard, 1992). These modifiable risk factors are essentially the same risk factors noted by the Institute of Medicine (1985). Watters and Avard (1992) claim that these factors do not act

independently: "Poverty and its consequences play a reoccurring role in the etiology of low birth weight. Factors such as low income, low education, low social support, high smoking, and low self-esteem are intertwined risks for poor childbearing women" (p. 63). Education for pregnant women about lifestyle issues becomes crucial in influencing these modifiable risk factors. As Watters and Avard (1992) state, "Low birth weight is a complex multifaceted problem--no single solution will work. A variety of approaches are needed" (p. 63).

Prenatal Education Programs

Low birth weight is a multifaceted issue with overlapping and interacting risk factors that are key to the prevention of infant death and serious health problems. To affect change, a variety of prenatal education approaches are needed.

Strychar, Griffith, Conry, and Sork (1990) view pregnancy and prenatal education as an important period of adult learning. During pregnancy, a woman goes through many physical, social, and psychological changes. Because women want to have a healthy pregnancy and baby, Strychar et al. state that these types of changes can be "powerful motivating factors for women to engage in learning about selected health issues" (p. 17). Various education programs have arisen in North America for the prevention of low birth weight. According to Watters and Avard (1992), "The presumed link between nutrition, both preconceptual and prenatal, and birth outcomes forms the basis of a number of large scale programmes which include improvement of birth weight as one of several goals" (p. 26). Watters and Avard further note that the best known program in the United States is the Women, Infants and Children (WIC) program that has been in operation since

1972. Some of the well established Canadian pregnancy nutrition programmes (sometimes called perinatal outreach programmes) include the Montreal Diet Dispensary and Healthiest Babies Possible in Toronto and Vancouver.

Recently, Fisk (1997) advocates that effective health education for pregnant women gives them the best chance of having a healthy infant: "Prenatal care and education—for all women, as well as targeted programs for women at-risk—help to prepare women and their families for childbirth and childrearing" (p. 79). The question for adult educators in the health field is how to bring this education about.

Access to Prenatal Care and Education

To explain access to health care, Gulzar (1999) looks at what prohibits and enhances access to health care. He states that, on one hand, "barriers result in the inability of people to access health care," (p. 17) while, on the other hand, "facilitators [can] enhance the use of health care services" (p. 17). He reports that each individual, family, and community may experience these barriers and facilitators differently. Access becomes a possibility once health care services are offered. However, people are often not able to use these services due of the enormity of the existing barriers. As Gulzar puts it, "Access is realized when health care is used resulting in user and provider satisfaction with services. Efficient and effective access enhances satisfaction with health services and increases continuous access" (p. 17).

Access to Prenatal Education and Individual Barriers

Little statistical information is available on the numbers of Canadian women who access prenatal health education. Watters and Avard (1992) explain,

> How much do we know about the extent to which prenatal care is accessed by Canadian women? Do all women seek prenatal care? When do they initiate care and how many visits do they receive over the course of their pregnancy? A survey of provincial and territorial health ministries by the Canadian Institute of Child Health in 1987, found that the answers to these questions were generally unavailable. (p. 24)

The unavailability of such data creates challenges for the provision of prenatal education to all Canadian pregnant women.

One of the challenges pregnant women face is access to prenatal care and education. M. A. Rose (1993) puts this succinctly: "Poor access to prenatal care is often cited as one of the barriers to reducing low birthweight rates in the United States" (p. 6). According to Watters and Avard (1992), pregnant Canadian women who have universally funded health care face fewer financial barriers to accessing prenatal care than pregnant women in United States. They find that cost is a major barrier to access in the United States. The assumption made here is that prenatal education in Canada is free. However, what American authors may not realize is that there is variation among provinces and regions with regards to the cost of prenatal education classes. For example, in the Peel Region of Ontario, prenatal classes are free. In the Hamilton-Wentworth Region and Halton Region of Ontario, the cost of prenatal classes is approximately $120-$170 for a series of 6-8 classes. Meanwhile in the South Fraser Health Region of British Columbia, prenatal classes cost $75-$120 per couple, depending on the length of classes chosen.

This region also offers financial subsidy to those who meet the eligibility criteria, such as a pregnant woman on social assistance.

However, offering prenatal education provides the *opportunity* for participation, but this does not necessarily result in participation. There may be many other reasons why women do not access prenatal education. As M. A. Rose (1993) argues: "In both countries [Canada and the U.S.] women who can access often do not. Other barriers to obtaining prenatal care must be explored" (p. 6).

Some barriers to access that pregnant women face include financial hardships, cost of the program, lack of spoken and written English when prenatal education is only offered in English, a lack of family support, and various cultural or religious reasons which discourage attendance. Watters and Avard (1992) add that "transportation, childcare, and provider attitude may act as barriers for groups such as adolescents, single parents, non-Canadians, and the poor" (p. 24).

Pregnant women of ethnic minorities may experience unique barriers to accessing prenatal education, thus, may be doubly disadvantaged. According to McFarlane and Fehir (1994), a Mexican-American woman is far less likely to participate in early prenatal education and suffers greater risk of receiving no prenatal care than an American white woman. McFarlane and Fehir initiated a program which aimed to decrease barriers and increase access to prenatal care. They began the program with

> the premise . . . that culturally relevant social support coupled with community resource information would enable pregnant women to successfully transcend barriers to early prenatal care and thereby open the door to health and social services for themselves, family, and neighbours. (p. 382)

The program was successful in empowering the women, enhancing the self-esteem of individual women, and in improving the community as a whole.

Socio-Cultural Access Barriers Facing South Asian and Punjabi-Speaking Women

South Asian women living in Canada may experience unique social and cultural barriers to accessing prenatal education. South Asians living in Canada have great social and cultural diversity and are not a homogenous group of people. According to Assanand, Dias, Richardson, and Waxler-Morrison (1990), there are approximately 300,000 South Asians--meaning, immigrants from the Indian subcontinent--living in Canada. Significantly for this study, "The Sikhs from northern India, particularly the Punjab, represent the largest group of migrants from India" (p. 143). The largest Sikh populations in Canada can be found in British Columbia's Lower Mainland, Edmonton, Calgary, Winnipeg, and Toronto.

Choudhry (1997) recognizes that women emigrating from India, like other immigrant women, bring beliefs, customs, and taboos about pregnancy, childbirth, and infant care. They have beliefs about what facilitates a good pregnancy and its outcome and what is not recommended during pregnancy. Many families new to Canada want to preserve some of their tradition and values from their homeland. Choudhry finds that health care systems in North America may present challenges for immigrant families from India because "the new options on one hand and tradition on the other may cause conflict and confusion" (p. 533). In India, pregnancy is viewed as a natural occurrence that does not require the aid of health care professionals. As Choudry (1997) explains: "During the entire childbearing period, the elder women of the family and/or community provide information, guidance, and assistance" (p. 534). Choudhry notes pregnant women in India often maintain a fatalistic view about pregnancy: "Most Indian women believe they have little or no control over their pregnancies or outcomes" (p. 534). This poses a

particular challenge for Western health care providers; namely, how to ensure participation of underrepresented groups in prenatal education. Choudry also discusses the role that family plays in the perinatal period. She states that: "In the United States and Canada, childbirth is viewed within the context of the nuclear family" (p. 536). However, in Indian culture, the role of the family involves not only the immediate family, but also the extended family, friends and neighbours. As Choudry explains: "These people provide emotional and social support, and excluding them would deprive the family of necessary backing during a time of need" (p. 536). Therefore, as Choudhry says, "Understanding beliefs about pregnancy and childbirth can help nurses and other health care professionals to accommodate women from India in the Canadian and U.S. health care systems" (p. 538).

Oppression and Empowerment

Many pregnant women who are at-risk for delivering a low birth weight baby may not access prenatal education. According to some theorists, an underlying factor for this poor participation is that some women belong to marginalized groups and face oppression; this is particularly the case with ethnic women, such as East Indians. Empowerment is needed to free them from oppression. Much can be achieved through education.

Oppression of Women

To understand oppression, one must understand the meaning and relationship of the oppressor and the oppressed. To examine oppression, many in the field of education and adult education look to the early works of Paulo Freire.

Freire (1970) refers to the oppressed as having had their humanity stolen by the oppressors who require this domination to feel more powerful. The oppressed believe they are beneath the oppressor and are emotionally dependent on the oppressor. As Freire argues: "The oppressed feel like 'things' owned by the oppressor" (p. 51). Freire describes the oppressor as having the need for ownership, which is usually at the expense of those who have nothing. The oppressor exploits others with his or her power, is incapable of recognizing others as people, and is often the initiator of violence. Freire describes the oppressor-oppressed relationship as one in which the oppressed only have choices that are dictated to them by the oppressors. Because of the nature of oppression, those who wish to overcome oppression become engaged in an inevitable struggle.

However, one area where Freire is silent is that of gender. A reading of his works makes it is obvious that he omits an analysis of women's struggles. He sets the context of socio-economic oppression but, for issues on gender, it is useful to look to the research of authors such as Bhasin (1996), Briskin and Coulter (1992), and Horsman (1999).

Bhasin (1996) has researched issues related to development, education, and gender in India. She addresses gender specific issues and emphasizes the daily struggles of women. She focuses on the issue of patriarchy; women living under the rule of men. Patriarchy affects women in many different ways but, as she explains, the basic struggles women face are common. She explains how oppressed women in countries such as India

find themselves supporting the rule of men. Women can face an internal struggle where they internalize their notion of powerlessness to men. Essentially, women co-operate with the idea of patriarchy. Bhasin encourages people to consider who creates the patriarchal system; it is the men, thus, "the problem is with the framework itself, and the framework is determined by men" (p. 55).

Briskin and Coulter (1992) examine the oppression of women as it relates to education in Canada. The major emphasis in women's education, they say, has historically been on access and entry to schools. However, "By the end of the nineteenth century, girls were able to attend secondary schools in most provinces" (p. 247). Women succeeded in their battle for equity and were allowed to attend schools but were treated differently than men. Some barriers women face in accessing education have been overcome, but many challenges still exist. As Briskin and Coulter state: "Access to education is elusive for women who live in poverty and cannot afford tuition fees, textbooks, or child care, and for women whose abusive partners forbid them to attend learning institutions" (p. 248).

Horsman (1999) discusses the violence and trauma faced by women. She finds that all levels of education are profoundly affected by violence and that most adults with limited literacy skills have experienced "the violence of oppression, of marginalization around the issues of poverty, class, race, ability and language" (p. 36). She identifies the invisible nature of the violence endured by women and what it means for literacy learning. She notes that stories of violence have not led to change in this field.

Horsman (1999) looks at the models used to describe literacy learning. A deficit model is often used, where the learner is cited as the problem. The learner has "a deficit

of skills" (p. 30) and the learners' strengths and knowledge are ignored. In the deficit model, it is only the learner that needs to change. This model does not serve literacy learners well. Horsman indicates that some researchers working in the field of literacy argue against the deficit model and argue that schools value only certain forms of literacy.

> Schools validate forms of literacy practiced and taught in white, middle-class families, and devalue and even obscure awareness of the diverse literacy practices and multitude of different ways of knowing practiced in other cultures and communities. This leads many students to learn through the school system that they are stupid and cannot learn, a legacy which haunts their adult learning attempts. (p. 30)

In the field of literacy, knowledge gained from life experience is often valued. This presents a challenge for literacy workers. Society often sees people who have limited English as ignorant, inferior, and inadequate. As Horsman says, "A society that values only one form of reading--the reading of print--discounts all other forms"(p. 31). Horsman asserts that many literacy workers try to educate literacy learners using methods that "recognize learners as knowledgable, and to help them build on their existing knowledge, to which they seek to add literacy skills"(p. 31). Horsman discusses the complexities of the impacts of violence/trauma. She identifies these impacts of trauma as being "the issues of presence, all or nothing, trust and boundaries, telling the pain and finding space for joy, creating safety in literacy programs" (p. 169). She contends that if these issues are not recognized, they can become barriers to learning. Horsman states that it is very challenging for women who have survived violence and trauma to set goals, and notes a strong link among control, meaning, and setting goals: "To set goals a woman has to believe she has some possibility of having control and connection at least to herself; she must believe her life can have meaning" (p. 164). According to Horsman,

those who are marginalized in society are more at risk of being controlled. Horsman suggests engaging the whole person in the learning process, referring to the body, mind, emotion, and spirit.

Throughout Horsman's (1999) research one finds the topic of immigrant women. She notes that immigrant women, in particular, have added deterrents against leaving violent situations. She says:

> They may fear being alone in a foreign land, the disapproval of their community, or have difficulty with language. Language barriers, unfamiliarity with the system, fear of the police, and racism, may make it harder, or impossible, for some immigrant women to access shelters or protections offered by the legal system. (pp. 68-69)

She also identifies the importance of recognizing cultural boundaries surrounding both individual therapies and self-help groups. Horsman says that people working with literacy learners need to be aware that they may be dealing will issues of trauma. To best support these learners, literacy programs should have a good knowledge of and links with the range of counseling services available in the community. As many of these learners may want to access counseling programs, it is important that these services are culturally appropriate. This allows the learners to deal with their issues of trauma while still continuing their learning.

Freedom from Oppression

Freire (1970) describes the internal struggle faced by oppressed peoples. On one hand, he argues that the oppressed desire their freedom, on the other, they fear freedom. Fear of freedom arises from the oppressed-oppressor relationship, a relationship that gives the oppressed a sense of security. Many living under the structure of domination

have become resigned to it. The idea of autonomy becomes frightening. According to Freire, often the oppressed have internalized their domination and believe that they are not capable or deserving of freedom. Fear of freedom also manifests itself in the possible consequences of challenging their existing way of life. Committed involvement from a large number of the oppressed is required to change their circumstances. Freedom from oppression "can be done only by means of the praxis: reflection and action upon the world in order to transform it" (p. 36). Freire uses the term *conscientization* to describe this process. In order for reflection to be possible, the oppressed must learn that oppression is a limiting circumstance that they can change. Freire views adult education as a vehicle for increasing one's awareness of oppression in society so that the oppressed might learn how to change society. To achieve freedom from oppression, he proposes that marginalized people look to adult education as a tool for empowerment.

Women's Ways of Knowing and Non-formal Education

Belenky, Clinchy, Goldberger, and Tarule (1986) were among the first to examine the ways in which women acquire knowledge and the ways women learn. Previously, research focused on how men learn. Women learn in ways different from those of men. They found that mothers usually named childbearing or child rearing as their most powerful learning experiences. Belenky et al. say, "We show how women's self-concepts and ways of knowing are intertwined. We describe how women struggle to claim power of their own mind" (p. 3).

Belenky et al. (1986) categorize women's ways of knowing into five categories which move from the simple to the complex. First there is the category of silence, where

women perceive themselves as "deaf and dumb" (p. 24). They obey authorities, accept feelings of powerlessness, and lack dialogue. Secondly, there is the category of received knowledge, where women learn by listening to the voices of friends, and authorities. Women "think of words as central to the knowing process" (p. 36). The third category is termed subjective knowledge. Women listen to their inner voice and begin the quest for self. They often deny external authority but are unable to express themselves in public. The fourth category is procedural knowledge, the voice of reason, which is presented as more objective than subjective knowledge. Procedural knowledge has two distinctive forms; separate knowing and connected knowing: "At the heart of separate knowing is critical thinking" (p. 104). In separate knowing, women have doubt, listen to reason, and exclude personal feelings and beliefs. In connected knowing, women believe that the most dependable knowledge comes from personal experience rather than authorities, "connected knowers seek to understand other people's ideas in the other people's terms rather than in their own terms" (pp. 123-124). Lastly, constructed knowledge is a category where women find their unique voice. Women integrate their own voices with the voices of others. Belenky et al. argue that adult educators can play a major role in aiding women to develop their own voices if they

> emphasize connection over separation, understanding and acceptance over assessment, and collaboration over debate; if they accord respect to and allow time for the knowledge that emerges from first hand experience; if instead of imposing their own expectations of arbitrary requirements, they encourage students to evolve their own patterns of work based on problems they are pursuing. (p. 229)

Belenky et al. conclude that "every woman, regardless of age, social class, ethnicity, and academic achievement, needs to know that she is capable of intelligent thought" (p. 193).

The literature shows that poor women and immigrant women have been marginalized. This impacts the education of women. Many women face the complex struggle of freedom from oppression. Education can be used to empower women and free them from oppression. With this background in mind, I first look at the general concept of using non-formal education for empowerment as discussed by Freire (1970). Then I discuss the literature that examines using non-formal education as a tool for empowering women in particular.

Freire (1970) offers two theories of education, one that is empowering and one that is not. Freire terms one concept, "the banking concept of education" (p. 58). In this method of education, the communication from teacher to student is unidirectional whereby students are encouraged to simply memorize and regurgitate information. This furthers oppression by teaching learners to be passive and to accept their existing conditions. The oppressors consciously or unconsciously use the banking concept to stifle creativity and free thinking among the oppressed. If the goal is freedom from oppression, Freire states that we must "reject the banking concept of education" (p. 66).

Freire (1970) recommends the concept of "problem-posing" education as a method of empowering the oppressed. In this method of education, the teacher uses communication and dialogue with the students to help them form opinions. Students are exposed to an education that presents problems within their world; as a result, they become more critical and more interested in seeking solutions. This method of education leads to a freeing of their mind, which helps them develop the commitment and attitude needed to change the reality of their oppression. As Freire says: "Problem-posing education does not and cannot serve the interests of the oppressor" (p. 74).

Non-formal education is one tool that can be used to empower women. According to Peters, Jarvis, and Associates (1991):

> Adults learn at home, in the community, and in the workplace much more often than they do in formal instructional settings. The social context of learning is increasingly recognized as an important element in determining the context of adult education. (p. 263)

Khawaja and Brennan (1990) have worked to determine whether non-formal education is a feasible solution for education in Pakistan. They find that, in Third World countries, formal education is often not an option for oppressed groups such as women. Thus, they say that formal "education has become another form of oppression" (p. 8). However, they also state:

> Non-formal education is conceptualised as a world-wide educational movement emerging as a result of the failure of the established educational system to fulfill the roles which had been prescribed for that system but an international movement which manifests itself in a different way in different nations because of cultural and historical factors. (p. 5)

Khawaja and Brennan show that non-formal education is an effective way to empower women in developing countries. They argue that non-formal education "has also become the way, particularly for developing nations, to respond to problems identified as being specially relevant to nations in the developmental phase" (p. 31).

Lephoto (1995), similarly studied the education of women for empowerment in Africa. Empowerment was viewed as having four dimensions: cognitive, psychological, economic, and political. Cognitive and psychological dimensions were concerned with the personal steps taken to change an oppressive situation. Lephoto views non-formal education as a tool to educate women about their rights and emphasizes the accessibility of non-formal education, adding: "Non-formal education is unique as an instrument for empowerment because it is accessible to all members of the population. Its programs are

not fixed but can be designed to address a particular felt need" (p. 6). The strength of non-formal education, Lephoto says, is that "It can be organized in the mode that suits the participants and accommodates their particular schedules. The participants themselves are involved in the planning of their learning experiences" (pp. 6-7).

Education helps women obtain information to make decisions that may lead to social transformation. Lephoto (1995) suggests five-steps in non-formal education that enhance empowerment. These consist of (a) awareness of the problem, (b) ownership of the problem, (c) information seeking from outside sources, (d) action at a personal level to promote change, and (d) collective action aimed at social change. Lephoto concludes that non-formal education is "the most appropriate mode of training that is compatible with the empowerment process and the life experience of adult women" (p. 11).

In the area of nutrition and health education, Travers (1997) analyzes how participatory research and community organization have empowered low-income urban women in Nova Scotia, Canada. The study is based on Freire's empowerment education principles for social change, and deals with nutrition inequities. Women attended regular group meetings at a Parent Center. In the early meetings the facilitator would ask questions and the women would respond. Women shared their experiences and listened to the experiences of others. Through the group sessions women found strength in their common struggles and oppression, and learned coping strategies from each other. The consciousness-raising was simply the first step. The women in the study then began brainstorming and talking about problem solving. Travers acted as a facilitator (not an expert) and assisted them in learning how to calculate unit cost of food. Upon completing these calculations, the women found that their inner city chain grocery stores were indeed

more expensive than other stores. The women brainstormed on how to deal with this. They were empowered to act on this information and wrote to the inner city chain grocery stores. The stores took action and the end result was lower prices. The women in the study initiated other changes such as lobbying and advocating to politicians. In this study, women were successfully empowered by participatory research for social change, economic development, and political development.

In the area of health and literacy, Comings, Smith, and Shrestha (1994) find that: "Adult educators have, rightly, seen literacy as a human right that has been denied to women" (p. 98). They examine the connection between non-formal literacy education for women, and health and family planning. Because literacy training can be attained through non-formal adult education, they seek to determine whether it is "the experience of schooling or the literacy skills acquired during schooling which impact health maintenance and family planning" (p. 93). They examine four mechanisms linking the education of women to health and family planning; these include time in school and work, school-acquired dispositions, literacy skills, and knowledge of health and family planning. They find that (a) time in school and work, and school-acquired dispositions are more likely to be acquired through their schooling as girls, but may also be acquired in adult literacy classes; (b) literacy skills can be equally acquired by schooling or non-formal adult literacy education; and (c) knowledge of health and family planning is more likely to impact women in non-formal adult education. They conclude, "nonformal education can have an impact similar to girls schooling" (p. 95). In essence, non-formal education is a powerful tool that can be used to empower women to change their oppressive circumstances.

Participation and Non-Participation in Adult Education

Selman and Dampier (1991) define participation in adult education as "the act of joining some form of adult learning activity" (p. 71). Similarly, Jarvis (1990) defines participation as "the attendance at adult education courses" (p. 259). He notes that there are many definitions of the term learning. The vast number of definitions is a "reflection of the on-going debate about the definition of this process" (p. 196). Mezirow (1991) states that "learning means using a meaning that we have already made to guide the way we think, act or feel about what we are currently experiencing. Meaning is making sense of or giving coherence to our experiences" (p. 11). In addition, Merriam and Caffarella (1991) propose that "adult learning does not occur in a vacuum" (p. 21). Rather, there are many characteristics that affect learning in adulthood. They identify three interacting factors that affect one's learning climate: people, structure, and culture. They note that many educators believe that these factors "can either facilitate or deter learning" (p. 30). The people factor refers to the individuals involved in the learning process. The structure factor involves the physical facilities and operating procedures of an organization. The culture factor represents the shared beliefs and values within an organizational or social context.

Participation in Adult Education

Peters, Jarvis, and Associates (1991) state, "since the 1960's, adult educators have shown strong interest in determining the motives (a psychological term) for adult participation (a sociological term) in adult education programs (an adult education term)" (p. 78). In this sense, models of adult participation are typically based on psychological,

social-psychological, and educational theory. Fundamentally, sociological theory is concerned with structural inequalities in society such as age, class, race, and gender. As Peters et al. (1991) say, "From the practitioner's point of view, these categories tend to converge in the issue of participation. Participation in adult education is, in fact, most readily grasped in terms of sociological rather than psychological categories" (p. 261). They urge adult educators to acknowledge social factors that create groups of people who are least likely to participate in adult education. They indicate that personal and situational factors affect an adult's decision to participate in adult education. These include the image of the agency, and price, place, and time of program.

By contrast, Merriam and Caffarella (1991) state that "the simplest way to find out why adults participate in education is to ask them" (p. 71). In an analysis of studies of participation, Merriam and Caffarella find that "people's decisions to participate have less to do with needs and motives than with their position in society and the social experiences that have shaped their lives" (p. 95). However, many do not participate in formal adult education programs.

Non-Participation in Adult Education

Jarvis (1990) states there has been much research conducted to discover why adults do not participate in adult education activities. He uses the term barriers to participation as a term "used to refer to the obstacles which appear to prevent adults from joining such [educational] activities" (p. 38). He notes that:

> there are three sets of barriers: situational, due to position within the social structure; institutional, which refers to the types of procedures and time-tabling of educational institutions that are less oriented to certain groups of people than they

> are to others; and dispositional factors, which refer to the negative *attitudes* of non-participants towards education. (p. 38)

Scanlan and Darkenwald (1984) also note: "If it is true that nearly all adults need and want to continue to learn, then the concept of deterrent is obviously crucial to understanding and predicting their involvement in education" (p. 156). They developed an instrument to measure the concept of deterrents in adult education. They called this the Deterrent to Participation Scale (DPS). They conducted a study with physical therapists, respiratory therapists, and medical technologists. Scanlan and Darkenwald acknowledged that the findings of this study "cannot be generalized to all health professionals or to professionals in general, much less to the general adult population" (p. 165). Then in 1985, Darkenwald and Valentine sought to identify factors that deter the *general* public from participating in organized adult education. They developed a generic form of the DPS and used a broad and heterogeneous study sample.

These two sets of studies (Scanlan and Darkenwald, 1984; Darkenwald and Valentine, 1985) found different deterrents at work. Darkenwald and Valentine "suggest that modified or specially developed DPS instruments are needed to measure deterrents for distinctive sub-populations" (p. 185). They conclude that it is the combined effect of many deterrents that results in the decision not to participate in adult education, and this finding is a widely accepted principle in the field today.

In Canada, Selman and Dampier (1991) add that it is more difficult to determine the barriers to participation than the motivators of participation. They say, "There is not a simple 'cause and effect' relationship between any one barrier and participation"(p. 90). They recognize that a vast number of barriers to participation exist.

The Impact of Language on Participation in Adult Education

Language has a significant impact on whether or not adults participate in adult education. Merriam and Caffarella (1991) note, "Minority adults, for example, are disproportionately represented among the unemployed, the low income stratum, and the less educated. These characteristics are correlated with low rates of participation in organized adult education" (p. 9). Ethnic minority groups face significant barriers to participation in adult education. One of these is language.

Pattanayak (1986) discusses the use of the mother tongue language in education. He finds that, "Language has been the object of intense passions, prejudice and patronage, but seldom has it been a concern for those working the area of development planning" (p. 5). He notes that language can provide or deny access to education, knowledge, and information. He finds that language is a major element in forming a hierarchy of elitism and alienation. Language can inhibit or enhance equality in social, political, and economic opportunity. Pattanayak notes that in Africa and Asia, some people consider mother tongues to be barriers against upward mobility, while others view the mother tongue as their key to equal opportunity. He describes the mother tongue as being the language through which a person perceives their surrounding world and their human identity. He encourages teaching reading and writing in the mother tongue language, before teaching literacy in a foreign language.

Cassara (1990) refers to linguistic minorities in the United States as a "very diverse group of people" (p. 47). Some immigrant groups learn English quickly and begin using English as their primary language. Others are slow to develop proficiency in English and primarily speak their mother language. This variability of proficiency in the

English language presents a challenge for adult educators and the types of programs offered to ethnic groups.

Cassara (1990) discusses factors that contribute to non-participation. One of these consists of social-psychological factors that make it difficult for new immigrants to learn the English language. Often it is assumed that these individuals are literate in their own language. However, this often is not the case. For example, Aggarwal (1989) indicates that "the Asia and Pacific region is the home of more than 650 million illiterates, the highest concentration of illiterates anywhere in the world" (p. 29). The Asia and Pacific region here refers to Vietnam, Korea, Philipines, China, India, Japan, Guam, and Samoa. Aggarwal indicates that approximately 60 percent of the illiterate population in Asia and Pacific region are women. Cassara notes that many English as a second language programs have overlooked programming for individuals "who are not only non-English-speaking, but who are not literate in their own language"(p. 52). As a solution, Cassara recommends teaching literacy in one's own language before teaching English.

Other factors contributing to lack of participation in adult education are the inappropriateness of the programs available, an institutional barrier; the fact that less educated adults tend not to participate, a dispositional barrier; the fact that non-participation may be furthered by cultural differences, and numerous situational barriers. In the final analysis, they may not see additional education as being beneficial in improving their life situation, which blends all 3 barrier categories.

Culturally Sensitive Programming and Recruitment Approaches to Adult Education

Oppressed women face significant challenges to participating in prenatal education. Women belonging to ethnic minority groups face even more barriers in this regard. Culturally sensitive approaches to adult education are essential for positive and successful outcomes. Crucial to participation in prenatal education is the issue of recruitment.

Education of Ethnic Minorities in North America

The cultural diversity of North America is continually increasing. Canada and the United States take different approaches to cultural groups in their nations. Selman and Dampier (1991) note that Canada is a country of immigrants that maintains the "Canadian mosaic" concept, where as the United States maintains the "melting pot" concept. According to Selman and Dampier, the education of Canada's immigrant population has been a priority throughout its history. Examples of adult education initiatives for immigrants include citizenship education, English as a second language, and adult basic education. However, the issue of the relevance of the content in some of those programs has been raised by others (e.g., Quigley, 1997).

The importance of incorporating ethnic groups into adult education has received much attention in recent years. Mitter (1992) notes that "concepts and tasks to be included in or associated with multicultural education have gained worldwide range and relevance...there are few countries in the world which are not confronted with this

phenomenon" (p. 31). How effective has the education of ethnic minorities in Canada and United States been?

The literature shows that many ethnic minorities have in fact been excluded from adult education. Merriam and Brockett (1997) contend that, to a large extent, various cultural groups such as African Americans, Native Americans, Hispanics, and women have been left out of the development and the professional practice of adult education. Through history, A. Rose (1992) indicates that multicultural education is essential, but it has not been clearly acknowledged or addressed by western society. Similarly, Hemphill (1992) notes that "a well-thought-out framework for understanding cultural diversity" (p. 8) has not been developed or provided by the literature. Hemphill finds that culture is an issue that is easy to overlook and simplify, but an issue that is difficult to examine and investigate. Cassara (1990) states "there are millions of adults in various ethnic groups in the United States who are not well served--if served at all--by educational institutions" (p. 2). According to Ross (1989), educators as a whole have not found easy solutions to providing education to a culturally diverse body of learners; however, the availability of books and journals on this topic has increased, and every indication is that these issues have been a growing concern since the early 1980s.

Researchers agree that educating a culturally diverse population is a difficult task, one that has not been accomplished effectively. However, an effort is being made, as seen in the next subsection.

Culturally Sensitive Approaches to Adult Education

Providing culturally sensitive approaches to adult education is a complex task. Recent literature explores components of cultural sensitivity in education, including: (a) being a culturally sensitive educator and program designer, (b) knowing one's own cultural identity, (c) using a cultural expert, (d) including the learner in program planning, (e) effective and appropriate communication, and (f) educators examining their present ways of teaching.

Powell (1997) describes being culturally sensitive as "being able to view the world from the stand point of a culture other than one's own" (p. 6). He contends that cultural sensitivity in education is crucial as "values are vastly different from culture to culture" (p. 11). Cultural sensitivity includes "awareness of the diversity of learners, but also an appreciation of this diversity" (p. 8). Lack of cultural sensitivity in program design or delivery can be problematic. He notes that a culturally sensitive educator or designer will explore cultural identity before attempting to understand a different culture. He states, "to accommodate for diversity in the education process, [we] must start with our own cultural sensitivity" (p. 13). He recommends that someone of the same culture is often the best trainer as it offers a role model for the learners.

Ambury (1995) agrees with Powell, saying, "the more one knows about their own cultural identities, the more likely they are to appreciate and understand the differences and similarities amongst diverse groups of people" (p. 1). Meanwhile, Acton (1995) challenges the field by adding: "adult education needs to continually find ways to include more voices and shared perspectives" (p. 3). Acton feels that missing from the work of Mezirow, Freire, and Brookfield is a "comprehensive understanding of how to begin

developing an increased awareness of one's own multilayered identity" (p. 3). She contends that adult educators need to have an understanding of their own assumptions, perceptions, and biases before trying to understand and appreciate the perspectives of diverse learners.

McAlpine (1992) acknowledges the importance of cultural appropriateness in designing education programs. She recommends using a cultural expert when the culture of the target learners is different from that of program designer:

> Input from the cultural expert can be crucial in affecting the impact of instruction when the designers of the instruction come from a culture different from that of the learners, particularly when the instructional content is not purely technical. This is especially the case when the culture of the developer is western and high status, while the culture of the learners is non-Western and low status. (p. 310)

She suggests using a cultural expert to design programs, develop materials, and provide feedback for evaluation and revisions. By using a cultural expert, one aims to "provide more useful, meaningful learning interventions when working with individuals from other cultures" (p. 314).

Finally, Knowles (1980) discusses the importance of including the learner--a basic principle of cultural sensitivity--in program planning. He says: "The very act of asking an individual to state his [sic] preferences involves him in the program-planning process, gives him a sense of influencing decisions that affect him, and makes him feel a part of a mutual undertaking" (p. 96). Such challenges may be directed to some adult education practitioners. For example, hooks (1994) urges teachers to examine their teaching styles and acknowledge that change may be needed to meet the needs of a diverse society. She states, "I saw for the first time that there can be, and usually is, some degree of pain involved in giving up old ways of thinking and knowing and learning new

approaches. I respect that pain" (p. 43). Clearly, culturally sensitive programming is a complicated task, one that is essential for effective adult education.

Recruitment Strategies for Ethnic Groups

Recruitment of new participants for adult education is critical to the success of a program. An effective recruitment campaign can include various promotion strategies. In order to recruit ethnic minority groups, recruitment efforts must be culturally sensitive and appropriate. To discuss this, I first look at research by Knowles (1980), the Volunteer Centre of Toronto (1992), and Hemphill, Ianiro, and Raffa (1995); I then turn to recruitment strategies for South Asian women for prenatal education.

According to Knowles (1980), "Many good programs have failed because of poor promotion--people just never heard about them or did not realize how good they were" (p. 189). He recommends one should develop a general promotional plan, then plan its distribution: "Good promotion goes deeper than merely describing a program. Adult education has to be 'sold'" (p. 190). Knowles suggests a variety of approaches to distributing a promotional plan and attracting new participants. Some of his examples include newspaper advertising, "a 'shotgun' medium--it reaches out to the public at large" (p. 197); radio and television announcements by commentators, as well as interviews with staff members, or participants, and presentations by staff members; direct mail and printed materials; the use of posters, displays, and exhibits in areas frequented by the public; personal contacts in the community; and enlisting the support of participants already in the program. As Knowles says, "A body of satisfied customers is a most effective instrument of promotion" (p. 208). Knowles reminds one to evaluate any

promotional campaign. Evaluation can help determine the most effective recruitment methods. However, Knowles does not delve into recruitment strategies for ethnic groups.

The Volunteer Centre of Metropolitan Toronto (1992) looks at the recruitment of volunteers from the perspective of reaching a broad range of ethnic groups. They state: "targeted recruitment to ethno-racial populations that utilize culturally and linguistically appropriate material and a wide range of distribution outlets can achieve the desired results" (p. 3). They list recruitment strategies similar to those presented by Knowles (1980). These are grouped into three broad categories: (a) people-to-people communication, which includes people talking to people, community organizations, and community leaders; (b) free communication, which includes public service announcements through the media, and local events; and (c) paid communication, which includes television and radio advertising, print advertising, and direct mail. They find that bilingual or multilingual materials can be most effective for their purpose. They conclude, "no matter what methods you choose, make sure your message and visuals are consistent and are culturally and linguistically appropriate for the target audience" (p. 7).

Hemphill et al. (1995) examine the impact of electronic media on literacy and language in immigrant and multicultural contexts. They find there is a high degree of uncritical acceptance and consumption of electronic media, such as television, video, and computers among this group. This is partly due to the social isolation felt by new immigrants. Participants used electronic media "to support and maintain cultural identity" (p. 157). Immigrants with very limited English relied more heavily on "native language television broadcast channels" (p. 157). Immigrants also employed "video and television extensively for second language development," (p. 158) and as a source of social

knowledge about the dominant culture. Noting the high consumption of media messages and products by new immigrants, electronic media may be an effective way to recruit ethnic groups for education.

Attracting pregnant women belonging to high-risk groups and ethnic groups to prenatal education programs is crucial for the field of health and of adult education. There is little research specific to the recruitment of South Asian women for prenatal education. However, there is one exemplary study by the Indo-Canadian Women's Organization (1995) which is noteworthy here. It conducted a pilot project (at two sites in British Columbia) to raise awareness of health and social issues facing pregnant Indo-Canadian women in relation to prenatal education. The recruitment efforts were conducted by physicians and community members. The recruitment methods they used included individual mailings to local physicians, phone calls to physicians' offices, information pamphlets dropped off at physicians' offices, and radio and television appearances on Indo-Canadian programs. Their effort to recruit participants was intensive and challenging. At one pilot site, few clients were recruited and participated; however, recruitment for the second pilot project was successful. Unfortunately, they do not give any possible explanations for the low levels of participation at one site. They conclude: "Indo-Canadian women will attend perinatal programs if sufficient resources are devoted to participant recruitment and if key professionals, especially physicians, are supportive of the women's participation" (p. 15). To be effective in recruiting Indo-Canadian women to prenatal education programs, recruitment strategies must be culturally sensitive and linguistically appropriate.

Summary of the Literature

Low birth weight babies have a higher chance of death and serious health problems than babies born heavier than 5 ½ pounds. Educating women about the factors that lead to low birth weight infants is key to the prevention of low birth weight. Through education, adult educators can assist pregnant women to achieve improved health behaviors during pregnancy. Prenatal education has significant importance to the community and the field of adult education.

Prenatal education programs are offered in many cities in Canada but are not always accessed. This is typically due to the multitude of barriers women face to accessing prenatal education programs. Indo-Canadian immigrant women face additional barriers. Such barriers must be reduced by adult education so women can access education programs.

Historically, women have been marginalized in Canada and around the world. This is one of the underlying reasons for poor access and participation in prenatal education. The oppression of women has had a significant impact on their learning and education. Many women, especially immigrant women, need to be empowered to change their situation. Education is a powerful tool that can be used for the empowerment of women, particularly non-formal education.

Research conducted on why adults participate in adult education or why they choose not to participate has resulted in the development of many theories of participation. A multitude of deterrents to participation has also been identified.

It is clear that cultural sensitivity in educating women is a complex task, yet one that is critical to the education of women. The components of cultural sensitivity should

be examined closely. The recruitment of participants to prenatal education is fundamental to the success of any program. Although a variety of recruitment strategies exist, only those that are culturally and linguistically appropriate for the target group are likely to be effective. Thus, prenatal education programs that take culturally sensitive approaches to adult education and recruitment of participants will be the most effective.

Although the field of adult education and prenatal education are two separate fields, it is evident that they are strongly connected and both are of great significance to the community. Adult education has an obvious and significant role for educating pregnant women. In the next chapter, I describe the study that I planned, developed, and implemented at a prenatal program in British Columbia's Lower Mainland. The chapter includes details of the design phase, an overview of the focus group implementation, and the findings extracted from each of the focus groups are presented and summarized.

CHAPTER 3

PLANNING AND IMPLEMENTING THE STUDY

This chapter describes the study that I planned, developed, and implemented at a prenatal program in British Columbia's Lower Mainland in 1998. The purpose of my study was to explore methods of increasing participation of pregnant Indo-Canadian women in prenatal education programs. This exploration involved convening three focus groups--one with current Indo-Canadian participants in the program, one with prior participants, and one with health care workers at the program. The focus groups discussed a fairly detailed set of questions about their reasons for participating, their perceptions of the value of prenatal education, their perspectives on why others in their community do not participate in prenatal programs, their perspective on how others in their community might be encouraged to participate in prenatal programs, and their perception of their role as a community member. The data were analyzed for themes and other relevant findings.

Design Phase

I chose to use focus groups to obtain the information that I was seeking because by using focus groups, I could have the opportunity to ask open-ended questions that allowed the participants opportunity to discuss their attitudes, opinions, and beliefs. Significantly, many Indo-Canadian women may find it difficult or uncomfortable to discuss these issues, because there is a sense of inherent risk in talking with a researcher in a new culture for these women. However, according to Krueger (1988), "the intent of

the focus group is to promote self-disclosure among participants" (p. 23). The group fosters and supports openness. Krueger lists other advantages of focus groups, including: a socially oriented research procedure, relatively low cost, a format that allows the moderator to probe, the ability to increase the sample size of qualitative studies, and the ability to provide fairly quick results. In designing the focus groups, activities I undertook included logistical organization, involvement of the program's staff, development of a set of focus group questions, and planning a basic procedure for facilitating the groups' process.

Organization of the Focus Groups

I organized three focus groups. Two focus groups included pregnant Indo-Canadian women and one included health care providers working with pregnant Indo-Canadian women.

My goal was to organize two focus groups of pregnant women; each comprising approximately 4 to 7 Punjabi-speaking Indo-Canadian women who had participated in the prenatal program and *completed* the program, meaning I wanted 4 to 7 who had stayed in the prenatal program until their baby was born, giving a minimum of five individual visits. The rationale for two different groups was to reflect representation of Indo-Canadian women who referred themselves to the program, and women who were referred by a third party. I wondered whether the women who self-referred may be immigrants from urbanized cities in India and may have higher levels of education. I thought perhaps the women who were referred by a third party may be rural immigrants or women with lower literacy requirements. The third focus group was comprised of

health care providers who worked with pregnant Indo-Canadian women in the community.

Involvement of Staff with the Focus Groups

Four staff from the prenatal program assisted with the actual running of the focus groups. They included an Indo-Canadian nurse, 2 Indo-Canadian staff members, and myself. My role at the prenatal program was as a program coordinator. I was one of the two facilitators for Focus Groups 1 and 2, and the only facilitator for Focus Group 3. Also, I was one of the two people writing participant responses. All of the staff involved were fluent in both Punjabi and English. Two additional Indo-Canadian program staff assisted in recruiting the participants by phone for Focus Group 2, but did not assist with the focus group itself. In addition, a summer student assisted with childcare and transportation for Focus Group 2. All involved were female.

Development of the Focus Group Questions

I developed a set of questions for the focus groups. Since my first language is English, I developed the questions in English and then translated them into Punjabi. If this were to be conducted in another study, the comfort level of the participants' language should be assessed. The questions should be developed in the language that the participants are most comfortable. If participants are most comfortable speaking Punjabi, the questions should be developed in Punjabi. This point is addressed in the recommendations section. In developing the first draft, I considered numerous factors. I needed to be sure that the questions were open-ended and required explanatory rather

than "forced choice" answers. They had to be easy to translate into Punjabi, use words and terms that women with English as their second language would understand, be of an appropriate literacy level, and be culturally sensitive to Indo-Canadian women in these groups.

I identified members of the community who could provide me with feedback on the draft questions for the focus groups. I recruited 6 professionals to review the questionnaire. These included: (a) a community nutritionist in the region who was familiar with the program and situation, (b) an Indo-Canadian staff member at the Lower Mainland prenatal program, (c) a nursing consultant from the local health unit, (d) an Indo-Canadian physician, (e) an Indo-Canadian dietitian in BC's Lower Mainland, and (f) an English as a second language teacher from BC's Lower Mainland. I also requested feedback from my thesis advisor. Feedback was used to revise the questionnaire 3 times using a Delphi type feedback and revision cycle.

In the final version, the first set of questions posed to the two groups of participants (Focus Groups 1 and 2) dealt with the participants' individual experience with the prenatal program. Participants were asked: (a) What were some of the reasons you came to the prenatal program? (b) What were some things that made it hard for you to join the prenatal program? (c) If you referred yourself to the prenatal program, why? (d) Did anyone encourage you to join the prenatal program? (e) Did anything happen in the past that made you want to join the prenatal program? (f) Was anyone against you joining the program? (g) If you did not refer yourself to the prenatal program, why not? (h) Who are some people who could support you to join the prenatal program? (i) Did anyone discourage you from joining the prenatal program? (j) What are some ways the

program could help some family members be supportive of your joining a prenatal program?

The second area of questions dealt with the participants' general perception of prenatal education. Participants were asked (a) Do you think it is important and /or helpful for pregnant Punjabi women to join a prenatal program? (b) Why? What are the good points about prenatal education? (c) What things do you think a pregnant women should learn? (d) Who did you ask when you had questions about your pregnancy? (e) Did you share with anyone that you joined the prenatal program? Why, or why not?

The third set of questions focused on their community perspective of prenatal education. They were asked: (a) Why do you think other Punjabi women in BC's Lower Mainland do not join prenatal programs? (b) How do you think we can lessen these problems so more women could join prenatal programs?

The fourth set of questions also dealt with their community perspective. They were asked: How do you think health professionals (like dietitians, nurses, doctors) can let more Punjabi-speaking women know that education for pregnant Punjabi women is important?

The final question focused on their perception of their role as a community member. They were asked: (a) How do you think you (as a member of the community) can help tell more Punjabi-speaking women that education for pregnancy is important? (b) If you do not think you can help, why? (c) Do you think the prenatal program can help you to help other pregnant Punjabi women understand why education for pregnant women is important? Lastly, participants' were asked (d) Do you want to say anything else?

Focus Group Procedures

A primary goal of the focus groups was to obtain reliable, accurate information. The following explains the procedures that were used to ensure accuracy, consistency, and reliability. I allotted 90 minutes for each focus group.

Focus Groups 1 and 2 were asked exactly the same set of questions, based on the standard questions developed for the focus groups. The questions were asked in English first and then translated into Punjabi. Two facilitators were used; one primary facilitator, and one who further assisted in explanation or translation. In light of the importance of language and translation, the same two individuals facilitated and translated in both groups. An Indo-Canadian staff member and I recorded participants' comments and responses by hand. To ensure accuracy and consistency, two recorders were used for Focus Groups 1 and 2. The same two individuals recorded for both focus groups. Participant responses were both in Punjabi and English, however the recorders documented the participant responses in English.

Slight adjustments were made to the focus questions for Focus Group 3 (the health care providers). Some questions were omitted, as they were only relevant to women who had participated in the prenatal program, and the health care providers had not attended the program as participants. Questions were asked in English as per the participant's preference. I was the facilitator for this focus group, and I also recorded participant responses.

In all three focus groups, participants were informed that they should respond in the language with which they were most comfortable, English or Punjabi. The majority of participants of Focus Groups 1 and 2 chose to speak in Punjabi. Occasionally,

participants used English words, and a couple of women chose to speak in English. Focus Group 3 participants spoke in English.

Incentives were offered to participants in Focus Group 1 and 2. Incentives included a $5.00 gift certificate for food items, transportation to and from the focus group, and childcare for their children. The incentives were not offered to Focus Group 3, as they were health care providers who participated in the focus group discussion during their working hours.

Overview of the Focus Group Implementation

First, a demographic description of each of the focus groups is given. This is followed by a general description of each of the focus groups.

Demographic Description of the Focus Group Participants

Demographic information was collected from each of the focus group participants. In total, there were 13 participants in Focus Groups 1 and 2. This includes 11 women who participated in the prenatal program between 1994 and 1998. In addition, a husband and one woman attended a focus group as a guest. Demographic information for the husband and the friend is not available as they were not past participants in our program; therefore, they have been excluded from the demographic information. Therefore, this demographic description reflects the 11 focus group participants who were enrolled in the prenatal program between 1994 and 1998.

The average age of the 11 participants was 27 years; the age range was 21 years to 32 years. All participants were married, spoke Punjabi, and were born in India.

The average time they had lived in Canada was 4.7 years; the range was less than 1 year to less than 10 years. Of these women, 64% had immigrated from urban settings and 36% had immigrated from rural settings.

All the women were educated in India. The level of education was variable: 45% had completed grades 9 to 11; 27% had completed grade 12; and 27% were university graduates. None of the participants reported having less than a grade 9 education. For 55% of the participants, this was their first pregnancy. Of the other 45% who had previous pregnancies, only one woman (9%) had previously attended prenatal education.

We inquired into how these women had been referred to our prenatal program for this pregnancy. Five of these women (45%) were referred by a third party; 6 women (55%) referred themselves to the program. In examining the source of third party referrals, it was found that 4 women (36%) were referred by the local hospital pre-registration program, 1 woman (9%) was referred by a community group, and no referrals came from local physicians. Of the 6 self-referring participants, 5 (83%) emigrated from an urban city in India. Also, all of the participants had family physicians of East Indian origin.

As for their present living situation, 73% considered themselves to have financial constraints. They were not on social assistance but they reported they had a low or inadequate income. Fifty-five percent of the focus group participants were employed during their pregnancy. Their occupations included cook, factory worker (sewing, assembly line), farm worker, and salesperson. The other 45% did not work outside the home, but were homemakers.

Among those who were referred by a third party, there was a range of reasons given for their referral. The provincial mandate for the prenatal program indicates that an individual must have at least two risk factors in order to be eligible to join the program. The average number of risk factors for each pregnant woman was 4.3. The most common risk factors listed, from most frequent to least frequent, included: (a) isolation: ethnic, or language isolation, social isolation, and/or geographic isolation; (b) financial constraints; (c) inadequate nutrition; (d) low self-esteem, low rate of weight gain, illness or condition during pregnancy, inability to cope or anxiety regarding pregnancy and birth interval. Other risk factors that were cited but were less frequent were a low pre-pregnancy weight or body mass index, previous pregnancy loss, multiple pregnancy, inadequate housing, and limited learning ability.

Focus Group 3 was comprised of health care providers, and only a limited amount of demographic information was collected. There were 5 participants in focus group 3. The average age of participants was 29 years; the age range was 22 to 39 years. Three of the participants were married and had children at home, while the other two participants were single and had no children. Four participants were fluent in Punjabi and English, whereas one did not speak Punjabi.

Looking at ethnic origins, 4 participants had emigrated from India, the other one was not of Indian origin and was born in Canada. Of the 4 who emigrated from India, the average number of years living in Canada was 11.9 years; the range was 6 to 24 years.

Description of Focus Group 1: The Large Group

Focus Group 1 was conducted on Tuesday, June 16th, 1998 from 1:00 p.m. to 2:15 p.m.. It was 75 minutes in length. This group consisted of a random group of pregnant Indo-Canadian women who were presently enrolled in, and were actively participating in the prenatal program. This was our usual bimonthly group education session with the prenatal program. Women enrolled in the prenatal program attend this group on a drop-in basis. Therefore, these women were not actually "selected" to participate in the focus group, but were informed that a focus group would be conducted rather than their usual education session. Therefore, it is a mixture of women who began the program as self-referred participants and those who were referred to the program by a third party. All voluntarily agreed to participate in this study during the regular group meeting.

Six pregnant women enrolled in the prenatal program attended Focus Group 1. In addition, one woman's husband attended and one woman brought a friend who is a young Punjabi-speaking mother who emigrated from India. The latter two were visitors that day and not regular participants, however, the two visitors did participate in the focus group discussion. This meant that Focus Group 1 had 8 participants, 7 women and 1 man.

Description of Focus Group 2: The Small Group

Focus Group 2 was conducted on Tuesday, July 8th, 1998 from 1:20 p.m. to 2:25 p.m.. It was 65 minutes in length. For this focus group, women who had referred themselves to the program and were previously or presently enrolled in the prenatal program were all invited to participate. A total of 5 women came.

For Focus Group 2, I did something a little different because I wanted a wider sample than I could get in the regular meetings. Therefore, I first identified all Indo-Canadian women who had referred themselves to the prenatal program since the 1995/1996 fiscal year. I then developed a standard explanation of the purpose of the focus group and the study for the group participants to ensure consistency and avoid confusion. The staff member who had worked with each client at the time of their enrollment was asked to contact clients by phone to explain the purpose of the focus group and invite them to attend. Due to staff turnover, this was not always possible. In this case, another staff member who was familiar with the client was asked to make the phone contact. A total of 17 women were identified, all self-referring clients, and they were all invited to Focus Group 2 (6 women from 1996/1997, 4 women from 1997/1998, and 7 women from 1998/1999). Of these women, 3 had phone numbers that were not in service, 4 were unreached by phone, 2 were unable to attend due to employment obligations, 1 had already attended Focus Group 1 as a random participant, and 7 said they wanted to participate and planned to attend. However, only four actually attended Focus Group 2. In addition, one woman brought her friend who had previously attended our group sessions in 1994/1995, but had not received a phone invitation due to her date of attendance. (As stated earlier, only women who had self-referred to the program since 1995/1996 were recruited for the focus group). The friend was a visitor and did participate in the session. Her demographic information was collected. This meant that Focus Group 2 had 5 participants.

Description of Focus Group 3: The Health Providers' Group

Focus Group 3 was conducted on Tuesday, July 14th, 1998 from 2:45 p.m. to 3:55 p.m.. It was 70 minutes in length. It consisted of health care providers at the prenatal program who worked with Indo-Canadian women.

Five staff members who worked with Indo-Canadian clients attended Focus Group 3. Four of these were individuals fluent in Punjabi and English. Two of these 5 had also assisted in the running of Focus Groups 1 and 2, in the capacity of interpreter. Therefore, they were familiar with the questions being asked, and with the responses being given by clients. The other 3 individuals were not familiar with the questions asked at previous focus groups, or client responses, but had been briefed about the focus group process. The focus group questions were adjusted slightly for Group 3. Questions pertaining to women who had participated in the prenatal program, were omitted as the health care providers had not attended the program as participants.

Findings from Focus Group 1: The Large Group

All of the participant information was translated from Punjabi into English, documented in English, and typed. The raw data from all three focus group discussions consisted of 16 pages of single spaced typed material.

The focus group discussions were designed to ask the participants their opinions about pregnancy, prenatal education and the prenatal program. They started from participants' personal experience and then moved on to their perceptions of the wider community. Participants' opinions were broken down into four categories: their personal experiences at the prenatal program, their general perception towards prenatal education,

their community perspective, and their perception of their role as a community member. Their additional comments appeared in the closing section of the discussion.

For Focus Group 1 the 7 women and 1 husband was mainly comprised of referred clients. These women were mainly from villages in India with lower levels of education.

Their Personal Experiences with the Prenatal Program

In looking at the participants' own experiences with the prenatal program, we examined the reasons they joined the prenatal program, the barriers they faced in joining the prenatal program, the reasons for self- referral or for not referring themselves, and suggestions or solutions for helping them to self-refer.

Participants joined the prenatal program primarily because they wanted more information about pregnancy and how to care for a baby. Some attributed their desire for more information to the lack of knowledge of their family members. One participant stated: "I wanted more knowledge to care for myself during pregnancy." Another reason for joining the program was due to illness during pregnancy. The general hope was that joining a prenatal program would help.

The primary barrier for not attending prenatal education programs that the women said affected them personally was a lack of transportation. This made it difficult for them to attend group education sessions. Even the bus system, which is very good in BC's Lower Mainland, was not helpful because they were reluctant to take the bus. They were not familiar with public transport. For some, their family or husband did not allow them to take the bus. Lack of proficiency in English was also cited as a major barrier, and a

lack of knowledge about the program was cited as a barrier as well. As one woman said: "it's hard to join [a prenatal program] if you don't know about the program."

Only one woman in the large focus group had self-referred. She noted pre-pregnancy maternal health problems as one of her reasons for joining the program. The remainder of the participants were referred to the prenatal program by a third party. The primary reason given for not self-referring was that they did not know such a program existed. Another reason stated was the lack of trust in a program that they knew very little about. As one said: "I saw the poster at the Sikh Gurdwara [temple], but I didn't know anything about the program and I didn't trust it. But once the nurse phoned [and told me about the program] I gained trust in it and joined."

Participants were then asked if anyone was against them joining the prenatal program. Participants had no response to this question. It was my opinion that, despite the trust level, this question probed too deeply into their personal circumstance. It is possible that some women did not understand the question, and it was too discomforting to continue with this line of discussion.

Participants who were referred by a third party were asked if they had any suggestions or solutions on what could have helped them to self-refer. Participants noted that family members (husbands and sister-in-laws) supported them to actually participate in the prenatal program. It was also noted that past participants could encourage other pregnant women to join the prenatal program. All participants felt that family doctors should tell pregnant Punjabi-speaking women about the prenatal program, especially because services are offered in their own language. Significantly, not one participant had been actively referred by a doctor. One client was told about the prenatal program by

their doctor. Interestingly, this was not a local physician, but instead a physician from Kamloops, BC, where she resided before moving to the Lower Mainland. It was also noted that the majority of the clients did not communicate with their doctor that they were participating in the prenatal program. They were asked why, and only one response was given. One said that she gets little time with her doctor. Other clients had no comment or were unwilling to comment. Clearly, the community they belonged to was a small one and they were afraid of the implications if they were critical of community members.

Their General Perception of Prenatal Education

All participants felt it was important and helpful for pregnant Punjabi-speaking women to join the prenatal program. The participants stated numerous reasons and benefits of the prenatal program. The primary reason stated was that one gets information about pregnancy, food and eating, and labour and delivery. Other benefits included home visits rather than office visits, and information was given in Punjabi rather than English. Participants said they appreciated receiving a $5.00 gift certificate for groceries, and free bus tickets for transportation at the prenatal group sessions. As one put it: "I am told everything in Punjabi so I understand. If I was told in English and not Punjabi, it would be a problem."

Participants were asked what they thought a pregnant woman should learn about. The most frequent response was related to food and eating. Other responses included: exercise during pregnancy, baby care, harmful substances, and getting ready for the hospital.

Participants were asked whom they went to for information when they had questions during their pregnancy. All clients who had been referred by a third party stated they first went to their family doctor with questions; however, it was not their doctors who referred them to the program. A small number indicated that they also had spoken with staff from the prenatal program, and their family members. Interestingly, none of these clients contacted the local health unit or a nurse for such information.

With respect to disclosure to others regarding attendance at the prenatal program, all of the participants told their family members they were participating in prenatal program. Two participants told their friends, and two participants told their family doctor.

The Community Perspective of Group 1

There was a lengthy discussion about the barriers that other pregnant Punjabi women face in joining prenatal education programs and the many reasons why others were not participating. Until this point in the discussion, participants had not indicated that their families actively discouraged attendance. Now this changed. I believe that the participants were now more open in discussing barriers, as they were deeper and deeper into discussion; and I also believe that these women felt much more comfortable discussing these barriers because the topic was "other" women rather than themselves.

The majority of the discussion was around the lack of family support or the family discouraging their attendance. This discouragement or lack of support had a strong cultural basis, with several explanations. Participants indicated that, in India, pregnancy is viewed as natural, something that the elders in the family have experienced and know all about. So the family feels that the prenatal program is not important or beneficial;

moreover, attending this Canadian-based education is an implicit insult to the family elders. Also, family members discourage attendance to pregnancy programs because they may be afraid that the prenatal program may not be teaching them what they consider proper information for a pregnant woman to learn. One participant stated that the family may be "afraid that joining the program may change the girls or teach them things that they don't want them to learn." Another participant stated that "elders [mothers-in-law] may say there is no need to join a [prenatal] program, and may be suspicious or fearful that their daughters-in-law may learn a lot, [become empowered] and no longer listen to them." Also, families may discourage participation because they think the East Indian community will not approve and may question where their daughter-in-laws are going.

There was also discussion about their family doctors. One woman noted that some Indo-Canadian women might be afraid that their doctor may not be supportive or may even disapprove of joining a prenatal program. This may be one reason that many Indo-Canadian women do not tell their family doctors that they have joined the prenatal program. Significantly, all of their family doctors were East Indian.

Other reasons reported for not participating, included the situational barriers of transportation, not knowing that the program exists, being afraid that the program will cost money or that they will get charged later, and thinking information will be given in English and they will not understand it.

There was discussion about the role that the prenatal program can play in helping to overcome the barriers that pregnant Punjabi-speaking women in the Lower Mainland of British Columbia face. Focus group participants suggested that the prenatal program should advertise the program on the Punjabi television shows and radio, emphasizing that

these are free programs that offer home visits for pregnant Punjabi women. They also suggested that, when a health professional tells them about the prenatal program, the first thing they should tell the pregnant woman is that it is free.

Focus group participants were asked to discuss the role that health professionals can play in educating Punjabi women on the importance of prenatal education. The most commonly noted response was to ask doctors to refer their pregnant clients directly to the prenatal program early in their pregnancy, and to put prenatal program posters and brochures in their offices and waiting rooms. One woman felt that hospital pre-registration was good because that is how she heard about the prenatal program, but it came too far into her pregnancy. She said it would have been better if she knew about the prenatal program earlier, and felt that this would be good for other women too.

They suggested that posters and brochures be placed at other places such as grocery stores, video stores, and at the Punjabi places of worship. Punjabi newspapers were also suggested as a place for promotion.

The General Perception of their Role as Community Members

In looking at the large focus group's participants' perception of their role as community members, we examined the role they could play in educating Punjabi women of the importance of prenatal education, the reasons that they may have if they think they have no role to play, and how the prenatal program can assist them to assist others.

Participants were asked what role they felt they could play in educating Punjabi women of the importance of education about pregnancy. The common response was to talk to other people about their positive experiences with the prenatal program and to

encourage others to join the program. Focus group participants gave no other suggestions. One participant stated, "we could tell them about the program, but it's their choice, they need to choose to join."

There was a brief discussion as to the reasons that participants may think they have no role to play in educating other pregnant Punjabi women of the importance of prenatal education programs. They gave only one reason for hesitation: "I may hesitate to tell women because they may laugh or make fun of me."

Focus group participants were asked how they felt the prenatal program could assist them to help other pregnant women to understand why education during pregnancy is important. This question was either not well received or not well understood by participants, even after translation and probing. This may mean that they feel powerless and incapable of helping others, or that they see no responsibility for themselves in helping others. Participants indicated that they could tell their family about the things they learned, but only after they learned it at the prenatal program. For example, "I will tell my family that milk is good for you, it is high in calcium."

Other Comments

Lastly, participants were asked if they had any other comments that they would like to add. Many of the participants' comments pertained to the issue of language and language barriers. One participant commented that the doctor gave them a book about pregnancy (*Baby's Best Chance: Parents' Handbook of Pregnancy and Baby Care*, 1994), but it is in English. "I can only understand about half of it, maybe less," she said. All participants agreed that this was a major problem and something that could be

improved upon. They suggested translating it into Punjabi. All participants in Group 1 had also received a copy of the educational resource entitled *Celebrating Pregnancy* (1995) and *Celebrating New Life* (1995). They explained that these were much better resources because they were easy to read and were written in Punjabi.

One woman who was concerned about the language barrier questioned whether there would be Punjabi-speaking nurses at the local hospital when she delivered. The focus group facilitator responded that, to the best of her knowledge, there was only one Punjabi-speaking nurse on staff at the maternity ward of the local hospital at this time. The pregnant woman then commented this would be very challenging for her. Many participants agreed this presented a challenge and hoped that this would somehow change. A few participants reported that this would not be an issue for them, but that it would be for other pregnant Punjabi women they knew.

Also, participants took this opportunity to ask the focus group staff questions. Their questions pertained to the availability of pre-pregnancy planning information in Punjabi, Punjabi-speaking nurses at the local hospital, and whether Punjabi-speaking staff from the prenatal program would visit their clients in hospital.

One woman stated that she hoped this focus group information would help make changes so that more services could be offered to Punjabi women. Others agreed. Another questioned whether it would make a difference at all. In her view, little would ever change.

Findings from Focus Group 2: The Small Group

As stated earlier, Focus Group 2 consisted of Indo-Canadian women who had self-referred to the prenatal program. I had originally wondered if self-referred participants came from urban centers in India with higher levels of education; looking at the demographic characteristics of these women, I found this to be true.

Their Personal Experiences with the Prenatal Program

In looking at participants' own experiences with the prenatal program, I found these participants joined the prenatal program primarily because they wanted more information about pregnancy and how to care for a baby; some attributed their desire for more information to the lack of knowledge of their family members. One participant stated: "it was my first pregnancy and I didn't know anything, I wanted knowledge of pregnancy." Like Group 1, they hoped that by joining a prenatal program, they would learn more.

The primary barrier for this group not attending prenatal education programs was a lack of transportation. Although they had overcome this situational barrier, it made it difficult for them to attend group education sessions. Again, even the bus system was not helpful because they were reluctant to take the bus. They were not familiar with public transport, or their family did not allow them to take the bus. Two clients noted no barriers to joining the prenatal program.

The reasons they gave for taking the initiative to join the prenatal program included recommendation by family or friends who had previously been in the prenatal program, or a recommendation by a health professional. One participant had past

experiences that influenced their decision to join the prenatal program. She said: "something happened to my sister's baby; I wanted to be sure that my baby would be healthy." Participants were asked if anyone was against them joining the prenatal program, all participants said "no."

Their General Perception of Prenatal Education

In looking at the participants' general perception towards pregnancy and prenatal education, I found that all participants felt it was important and helpful for pregnant Punjabi-speaking women to join the prenatal program. The benefits included home visits rather than office visits, there was group education and guest speakers (in Punjabi), ongoing group sessions with different topics every time, ongoing support, positive encouragement, and a $5.00 gift certificate for groceries and free bus tickets for transportation with every visit. One woman said: "I was given diet information in Punjabi rather than English, this was good. At the hospital I was given diet information in English, it was hard for me to understand."

Participants were asked what they thought a pregnant woman should learn about. The most frequent response was related to food and eating. Other responses included labor and delivery, exercise, diabetes, and ways to prevent a Cesarean section.

Participants were asked whom they went to for information when they had questions during their pregnancy. They asked staff from the prenatal program, family members, the local health unit, and the local nurse. Interestingly, none of the self-referring clients reported their family doctor as a place for getting answers to questions.

This was opposite to the response from group 1, where all participants went to their doctor with questions.

With respect to disclosure to others regarding attendance at the prenatal program, all of the participants told their family members they were participating in the prenatal program. One self-referring client stated:

> I told my family; they were hurt and felt bad that I went outside of the family to seek out knowledge because I did have elders in the home who were available to give me information. But they did not stop me from going to the prenatal program.

A few clients told friends and two clients told their family doctor after they joined the prenatal program.

The Community Perspective of Group 2

I found there was a lengthy and active discussion about the barriers that other pregnant Punjabi women face in joining prenatal education programs and the many perceived reasons why others were not participating. Again, until this point in the discussion, participants indicated that their own families had not been actively discouraging attendance. As with group 1, the participants were now more open in discussing barriers as they were deeper into discussion, and that the women felt more comfortable discussing barriers because they involved "other" women rather than themselves.

The majority of the discussion was around lack of family support or the family discouraging attendance. Again, this discouragement or lack of support had a clear cultural basis. One woman stated: "families who are from India have traditional beliefs, and feel that elders in the family have experience and know all about pregnancy. The

family feels that there is no need to join a prenatal program." Also, family members discourage attendance to a pregnancy program because they may be afraid that the prenatal program may not be teaching what they considers proper information for a pregnant woman to learn. Another woman stated: "[the] family may say it is not a program which is helpful."

There was also discussion about their family doctors. One participant stated "some [Indo-Canadian] people think if you have a doctor, you don't need anything else. You don't need the [prenatal] program."

Other reasons for not participating, already noted, included the problem of transportation; not knowing that the program exists; work commitments (especially in the summer because many Punjabi women often work on the local farms); and some Westernized Indian women take pregnancy classes at the hospital or in the health units.

There was discussion in Group 2 about the role that the prenatal program can play in helping overcome the barriers that pregnant Punjabi-speaking women in the Lower Mainland of BC face. Self-referring focus group participants provided a lengthy list of suggestions regarding the role of the prenatal program. These included: the prenatal program should not have the group sessions at the Punjabi place of worship as it may be viewed as inappropriate or suspicious to the family and community; it should advertise that a $5.00 food voucher is given to the pregnant woman on every visit; it should offer group sessions on evenings and weekends, promote social interaction, and provide a free lunch; and the prenatal program staff should ask doctors to put posters or brochures in Punjabi and English in their offices and waiting rooms. Finally, all doctors should refer pregnant Indo-Canadian women to the prenatal program, as needed.

The focus group participants in Group 2 were asked to discuss the role that health professionals can play in educating Punjabi women on the importance of prenatal education. The participants suggested that the prenatal program and other health professionals should ask doctors to refer their pregnant clients directly to the prenatal program early in their pregnancy, and put posters and brochures in their offices and waiting rooms. They also suggested having health professionals promote the pregnancy programs during an interview on the local Punjabi television shows and radio shows. Participants suggested that all advertising should reinforce that it is a free program.

The General Perception of their Role as Community Members

Participants were asked what role they felt they could play in educating Punjabi women of the importance of education about pregnancy. The common response was to talk to other people about their positive experiences with the prenatal program and to encourage others to join the program. Focus group participants gave no other suggestions. One participant stated, "we could tell people that you get a lot of one-on-one time, unlike at the doctors, and we could tell people it is a good program."

There was discussion as to the reasons that participants may think they have no role to play in educating other pregnant Punjabi women of the importance of prenatal education programs. This group of self-referring participants gave numerous reasons as to why they might hesitate to tell other pregnant Punjabi women about the importance of prenatal education. The primary reason for this was the uncertainty of the reactions that the Punjabi community may have and the social stigma attached to being enrolled in a pregnancy program. One participant stated, "people may think it's a program for low

income people, or for lower status people." Another agreed, stating, "for Indian women, there is low status attached to needing help during your pregnancy." Another woman stated, "she may want to keep it private [within the family], and other people [in the community] may not approve of letting their daughter or daughter-in-law go to classes."

The Group 2 participants were asked how they felt that the prenatal program could assist them to help other pregnant women understand why education during pregnancy is important. This question was either not clear, not well received or not well understood by participants, even after translation and probing. Participants had no response. This may mean that, in the face of the many socio-cultural constraints involved, they feel incapable of helping others, or they see no significant personal responsibility for helping others in a similar situation.

Other Comments

Lastly, participants were asked if they had any other comments that they would like to add. Many of the participant comments pertained to the issue of language and language barriers. As in Group 1, one participated suggested that the book called *Baby's Best Chance: Parents' Handbook of Pregnancy and Baby Care*, (1994), should be translated into Punjabi. All but one participant had also received a copy of the educational resource entitled *Celebrating Pregnancy* (1995), and *Celebrating New Life* (1995). They felt this was a much better resource because it was easy to read and it was written in Punjabi. Also, participants took this opportunity to ask focus group staff questions. Questions asked pertained mainly to breastfeeding myths, problems, and solutions.

Findings from Focus Group 3: The Health Provider Group

Focus Group 3 consisted of health care providers working with pregnant Indo-Canadian women. The interview section which looked at participants' own experiences with the prenatal program, was not applicable to health care providers. Therefore, this question was omitted, and the discussion began with the general perception of prenatal education.

Their General Perception of Prenatal Education

All of the healthcare providers from the prenatal program thought it was important and helpful for pregnant Punjabi-speaking women to join the prenatal program. An extensive list of benefits of the program was given, including: a Punjabi-speaking staff, educational material written in Punjabi, prenatal nutrition information, the ability to connect with the new immigrant women who suffer from isolation, confidential services, support throughout the pregnancy, food vouchers, free pre-natal vitamins, home visits for individual education sessions, group education sessions, and the opportunity for family involvement and support. One participant stated:

> Often it is easier to attain family support of visitation when it is in the home because the family can supervise the first visit if they wish. Usually I find the first visit is almost always supervised [by the family], but once trust is achieved, privacy is provided to the educator and the pregnant woman.

Providers were asked what they thought a pregnant woman should learn about. As expected, they provided a lengthy list. The most frequent response was related to food and nutrition. Other responses included contraception, breastfeeding, infant feeding, labour and delivery, relaxation, self-esteem, self-confidence, fetal development, child safety, expected changes during pregnancy, self-care during pregnancy, how to access

other community resources and services, the importance of asking one's doctor questions, postpartum depression, and exercise during pregnancy.

The Community Perspective of Group 3

In looking at the participants' community perspective towards pregnancy and prenatal education, the majority of the discussion was around cultural factors that served as barriers to participation. Cultural isolation of new immigrant women was one barrier noted where "they [pregnant Indo-Canadian women] may be afraid of new information and services and unaware of services available." One participant stated, "culturally, women [from India] are submissive and passive, so it would be inappropriate to seek assistance or support [outside the family], even if they desired to do so." There was also much discussion around the lack of family support, again an issue with a cultural basis. It was said that, in India, there is no concept of formalized prenatal education; instead, elders in the family are expected to tell the woman about pregnancy. Therefore, a family that has emigrated from India may not feel that prenatal education is necessary and may discourage attendance. Also, many Indian families feel that pregnancy is a private issue, not to be discussed with others outside of the family. The family may worry about how this may be perceived by others in the community.

Other perceived barriers to participation included a lack of transportation. Pregnant women may be reluctant to use the transport system, or family members may not permit them to use public transport. They may be afraid there is a cost associated with the program. They may believe there is a lack of doctor support, or be afraid of breach of

confidentiality in the local setting. The cultural stigma of participating in a free program was also raised.

Care providers offered many suggestions about the role that the prenatal program can play in reducing barriers that Indo-Canadian women face. Much of the discussion surrounded program marketing and community awareness. Participants suggested that the agency could focus promotion of the program within the Indo-Canadian community. For example, it should be advertised that the prenatal program is a free and confidential program offered in Punjabi. Marketing should be more extensive to reach family members and, possibly, it should include participants from the prenatal program. They also suggested that the prenatal program should increase program awareness with nurses at the local hospital so they can refer potential clients. There was much discussion around educating East Indian physicians and their secretaries about the prenatal program. One provider commented that many mailouts and other such attempts had been made in the past years, with little success. "Our prenatal program still gets few Indo-Canadian referrals from local physicians; the lack of support from physicians is frustrating," said one participant. Physicians seemed to be one of the biggest challenges in the many cultural issues raised.

Providers were asked to discuss the role that health professionals can play in educating Punjabi women of the importance of prenatal education. Emphasis was on educating the community as a whole--both community members and health care professionals--about the benefits of prenatal education. They reported this could be achieved by using culturally appropriate mass media techniques. Perhaps a documentary or video could be prepared and used in various venues such as on television, at local

hospitals, and in doctor's waiting rooms. The Punjabi newspapers were also suggested as a place for program promotion.

Participants recommended that posters and brochures be placed at doctors' offices, hospitals, Indian video stores, libraries, laundromats in Indian neighbourhoods, Indian sweet shops, Indian samosa shops, Indian banquet halls, at the Punjabi place of worship, and at Indian festivals.

The General Perception of their Role as Community Members

In looking at the focus group participants' perception of their role as a community member, providers were asked what role they felt they as individuals could play in educating Punjabi women of the importance of education about pregnancy. The common response was to talk to anyone who was willing to listen, family and friends.

There was discussion as to the reasons that providers may think they have no role to play in educating other pregnant Punjabi women of the importance of prenatal education programs. Responses included: nobody has ever asked me to do this before, many Indo-Canadian women keep their pregnancy a secret, and many women whom I know would not be considered high-risk and not eligible for the prenatal program.

Other Comments

Lastly, providers were asked for any other comments that they might add. The majority of the discussion was around the lack of prenatal education programs available in Punjabi. One person noted, "the prenatal program has a 6 to 8 week waiting list, and the prenatal program can't do it all . . . more prenatal education programs for Indo-

Canadian women are needed." Also, they suggested that the staff of nurses in local hospitals and health units should reflect the Indo-Canadian population in the region; this would definitely enhance services for the community. An increase in educational material written in Punjabi was suggested, along with the translation of the book, *Baby's Best Chance: Parents' Handbook of Pregnancy and Baby Care*, (1994). They also identified a lack of culturally sensitive parenting programs in BC's Lower Mainland. One women stated: "I am happy to see that this research is being done. I hope it helps in finding solutions, alleviating the problem, developing more programs for the community and, most importantly, it helps to build a healthier Indo-Canadian community."

Summary of Findings

The three focus groups provided insight into the factors that can serve to increase participation in prenatal educational programs for pregnant Indo-Canadian women. Insight into factors that can serve as inhibitors of participation were also provided, from the perspectives of those who have participated in the program and from the perspectives of the health care providers in the program.

Summary of Findings from Program Participants

The participants in Groups 1 and 2 provided perspectives with many similarities and a few differences. In demographics the main difference between the two groups was that Group 1 participants had mainly been referred to the prenatal program by a third party, whereas the Group 2 participants had mainly self- referred themselves into the prenatal program.

Most women expressed greater comfort discussing issues about community perspective than about discussing their personal experience. Nevertheless, their responses indicate that most women in both groups joined the prenatal program because they wanted more information about their pregnancy, and their families were either not knowledgeable or not experienced. The barriers that women noted as inhibitors to joining the prenatal program included lack of transportation, lack of proficiency in English, and lack of knowledge of the program. The primary factor that self-referring clients gave for joining the prenatal program was the recommendation given by family or health professionals.

All of the women felt it was important for pregnant women to join the prenatal program, identified benefits of having joined the prenatal program, and identified learning needs of other pregnant Indo-Canadian women. Interestingly, the majority of participants did not tell their family doctor regarding their participation in the prenatal program. Participants reported this was because they get little time with their family doctors, and they held a fear of disapproval or lack of support from the family doctor.

Participants had a lengthy open discussion about the barriers that they perceive other Indo-Canadian women face in participating in prenatal education programs. The main issue was lack of family support, where families actively discourage enrolling in prenatal education. A secondary issue regarded the lack of support or information--real or imagined--from their family doctors. Another issue revolved around the language in which information is given.

Participants thought the primary role of health professionals was that doctors should refer pregnant Indo-Canadian clients to prenatal programs. Participants suggested

mass media marketing about the program, and about the importance of prenatal education to the Indo-Canadian community.

Participants had only one opinion as to their role as a community member. They unanimously recommended they could talk to other people about their positive experiences with the prenatal program and encourage them to join. However, participants reported that they may hesitate to do so for cultural reasons, such as uncertainty about the reactions they may receive from others in the Punjabi community. All participants had difficulty understanding how the prenatal program could assist them in their word of mouth advertising. No suggestions were given on this point. It seems that the Indo-Canadian women in my study did not see themselves as active agents in changing the present situation that many pregnant Indo-Canadian women faced, although they would promote this program in ways they felt comfortable with.

There were some differences in the perspectives of the two groups. Some participants in Group 1 stated they did not self-refer mainly because they did not know about the program. Another difference was seen in the area of the sources used to seek out information. Referred participants in Group 1 primarily went to their family doctor with questions. In contrast, self-referring clients in Group 2 were able to seek answers from a wider range of sources, including staff from the prenatal program, family members, local health unit, and a nurse.

Summary of Findings from Health Care Providers

As expected, the prenatal program providers gave an extensive list of the benefits for women participating in the prenatal program, and the learning needs of pregnant Indo-

Canadian women. For barriers to participation, providers of the prenatal program mainly discussed cultural factors. These included: cultural isolation, cultural expectations of the women's behaviour, a cultural perception that prenatal education is not important, a lack of family support, and fear of a negative perception by the Indo-Canadian community.

Providers suggested extensive marketing of the program and increasing the Indo-Canadian community awareness of the program. Participants believed the role of health professionals, in general, was community education using a variety of mass media techniques and venues. They also expressed frustration about recruiting Indo-Canadian doctors to refer their pregnant clients to prenatal programs.

Providers of the prenatal program had only one opinion on their role as a community member: to talk to family and friends who were willing to listen. However, they cautioned that community members might hesitate because of cultural and organizational reasons. Culturally, Indo-Canadian women may be secretive about pregnancy. Organizationally, not all Indo-Canadian women meet the eligibility criteria for the prenatal program. In the next chapter I discuss these findings in comparison with the literature.

CHAPTER 4

DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

During my work in prenatal education, I have noted that prenatal education is a very important period of learning in a woman's life. As seen in chapter 2, the literature reveals that low birth weight is a multifaceted issue with interacting risk factors that are key to the prevention of infant death and serious health problems. To affect change, a variety of prenatal education approaches are needed. Adult educators can play an important role in assisting women achieve the ideal health behaviors associated with having a healthy baby. This has led to the rise of various education programs in North America for the prevention of low birth weight, such as the program in British Columbia's Lower Mainland that is the basis for this study on the participatory needs of Indo-Canadian women. In this chapter, I discuss the unique social and cultural barriers, and the general motivators and barriers contained in chapter 3. I organize this discussion into six topics: the general motivators and barriers to prenatal education faced by participants, factors of oppression and empowerment at play, implications for other prenatal programs, recruitment issues, my personal learning and growth, and perceived learning of the participants in this study. I discuss the interview data from Focus Groups 1 and 2 mainly and draw on the observations of the health providers group where relevant. This is because this study is primarily about the participants and their own needs and insights. I end with conclusions, recommendations for practice and for further research.

General Motivators and Barriers to Prenatal Education Faced by Participants

There is considerable research in the areas of prenatal education, oppression, empowerment education, and culturally sensitive programming. However, I notice that there is a limited amount of literature specific to pregnant South Asian women. Therefore, this study adds to the existing literature. Furthermore, in many ways, my findings are consistent with the existing literature on oppression, empowerment, and recruitment. In addition to the culturally specific factors, immigrant South Asian women face many factors similar to other women.

For example, pregnancy is an opportune, teachable moment for adult educators. The motivation to learn is great. According to Strychar, Griffith, Conry, and Sork (1990), a woman goes through many changes during pregnancy. Women want to have a healthy pregnancy and a healthy baby; thus, Strychar et al. state that these types of changes can be "powerful motivating factors for women to engage in learning about selected health issues" (p. 17). This is consistent with the findings from my study. The participants in my study indicated that they joined the prenatal program to gain more knowledge about pregnancy and to have a healthy baby.

I found the existing research on the area of access to prenatal education and the aspect of individual barriers women face, to be interesting. According to M. A. Rose (1993): "Poor access to prenatal care is often cited as one of the barriers to reducing low birthweight rates in the United States" (p. 6). Watters and Avard (1992) identified additional barriers to accessing prenatal education as transportation, childcare, and provider attitude. Interestingly, the participants in my focus groups identified lack of transportation and the perceived cost of the program as barriers to joining the prenatal

program. However, as the interviews progressed, it became obvious that the deeper issues arose from lack of approval from the elders in the families to attend, and fear of what might be involved in the program. My findings are consistent with the existing literature on the general situational barriers women face in attending prenatal education. The findings from my study indicate many additional barriers, such as the fact that these were immigrant women. Watters and Avard do mention immigrant women, but not by specific cultural background. However, I did note they discuss the need for special attention to Aboriginal women in Canada.

Socio-Cultural Facts of Oppression and Empowerment at Play

Choudry (1997) provides insight into maternal and childcare practices among women from India. My findings are consistent with Choudry's research as it pertains to the perceptions that women and families from India have in regards to the need for prenatal education. For example, both Choudry's and my findings indicated that many families from India view pregnancy as a natural occurrence that does not require the aid of health care professionals. Instead, pregnant women seek information from the family. Note that Choudry's literature is generalized to women from India; the findings from my study emphasize the nature and depth of the cultural barriers that Indo-Canadian women face in joining prenatal programs--a more specific issue.

The early work of Freire (1970) were very inspirational to me. I noted several adult educators who also claim Freire's work is inspirational, one such example being hooks (1994). Similarly, Vella (1994) cites Freire as a mentor. By examining Freire's theory on the area of oppression, I was able to draw connections to the research of other

adult educators. Freire (1970) views adult education as a vehicle for increasing one's awareness of oppression in societies so that people might learn how to change such oppression. Here I focus on the relationship between the oppressor and the oppressed, and connect this issue to the findings from my study. According to Freire, the oppressed believe they are beneath the oppressor and are emotionally dependent on the oppressor. The oppressor exploits others with his or her power, and is incapable or unwilling to recognize others as actual people. The oppressor-oppressed relationship is one in which the oppressed only have choices that are dictated to them by the oppressors. In a country where patriarchy is dominant, India being but one example, oppression exists for women. By definition of patriarchy, men play the role of the oppressors and women as the oppressed. This does not change by moving to a new country. It may, in fact, become more prevalent between women and the men or the families that find themselves threatened by the new culture. Looking at the findings from my study, participants reported that many Indo-Canadian women from traditional families are actively discouraged from attending prenatal education programs by their families. Neither husbands nor men in general were identified as discouraging attendance. In fact, mothers-in-law were identified as discouraging attendance. Families in general appear to be the oppressors. As one participant indicated, some families from India fear that the pregnant women will learn something new, have their own thoughts, and no longer listen to elders within the family. It appears that some traditional Indo-Canadian families wish to maintain this control over the younger pregnant women, making it very difficult for these younger women to attend prenatal education programs. Here it appears that oppression mainly arises out of a fear that there will be a loss of authority among the elders, and, in

turn, an erosion of the traditional family structure. According to Freire, the oppressed must learn that oppression is a limiting circumstance that they can change. Committed involvement from a large number of the oppressed is required to change their circumstances.

My study found that East Indian physicians did not refer pregnant Indo-Canadian women to prenatal education programs. One possible explanation is related to the concepts of oppression, as discussed above. Perhaps the East Indian physicians, who are perceived as individuals in power and authorities, do not want Indo-Canadian women to be empowered and educated. According to Freire (1970), individuals in power wish to maintain this power over the oppressed. According to Freire, educating and empowering these Indo-Canadian women could alter this power relationship. Assanand et al. (1990) describe the relationship between a physician and his or her South Asian patient as being very formal in which the patient takes a passive role. The South Asian patient may answer questions asked by the doctor, but not ask questions and may "expect the doctor to have all the answers and make all the decisions" (p. 163). It is worth noting here, that it was beyond the scope of my study to examine the gender of the East Indian physicians. It would be helpful in a future study to take gender differences of physicians into account. This point is addressed in the recommendations.

Freire (1970) discusses the banking concept of education versus the problem-posing method of education. As the women in my study were all educated in India, I wonder whether the education they received in India was based on the banking concept or the problem-posing method of education. The research by Khawaja and Brennan (1990) indicates that in Third World countries education is not available to everyone, especially

not to women. According to Bhasin (1996), women in India live under the rule of men (patriarchy). Together with my own experience as a person of East Indian descent, this leads me to assume that the participants' education in India was based on the banking concept. According to Freire, this method of education furthers oppression by teaching the oppressed to be passive and to accept their existing conditions. In contrast to the banking model of education where the communication from teacher to the student is unidirectional, the women in my focus groups were invited to engage in a problem-posing model of education. They were made aware of the problem of low rates of participation in prenatal education for pregnant Indo-Canadian women in our region. They were asked to participate in focus group discussions and to assist us in finding a solution. The women were able to propose solutions to the problem. Their proposed solutions were mainly to be accomplished by other health care professionals, such as prenatal program staff and physicians. Significantly, such people could be viewed as authorities, people in power. The women in my study were unable to establish their own role in addressing this problem. This leads me to believe that many pregnant Indo-Canadian women are disempowered and feel that they have no role in providing a solution to the problem at hand. Instead they hand over this role to those in power, the authorities. This, I suggest, is at least partially learned through the typical Indian public and private school system.

Lephoto (1995) suggests five-steps that can enhance the levels of empowerment of women: (a) awareness of the problem, (b) ownership of the problem, (c) information seeking from outside sources, (d) action at a personal level to promote change, and (d) collective action aimed at social change. It is interesting to apply Lephoto's five-steps of

empowerment to the women involved in my study. Some of the women appeared aware of the problem; however, it is questionable whether they take any ownership of the problem. The participants do seek information from outside sources, primarily their physician. Only few are prepared to take any action at a personal level to promote change. That is, only a few referred themselves to prenatal education and those willing to refer others would do so only in a "safe" word-of-mouth manner. Did any of the women take collective action aimed at social change? Perhaps. In the focus group discussions, one participant stated that she hoped this focus group information would help make changes so that more services could be offered to Punjabi women. However, another participant questioned whether it would make a difference at all. In her view, little would ever change. I conclude that most of the women in my study had low levels of empowerment and only a small number of them may have had higher levels of empowerment.

Implications for Other Prenatal Education Programs

Looking at prenatal education programs, there is a link between the literature and the findings of my study. To begin with, Horsman (1999) indicates that many literacy programs use the learner deficit model, where the learners are seen as the problem, their strengths are ignored, and it is the learner who is required to change. Horsman's work has a distinct application to prenatal education programs. For example, prenatal programs are available to the public at large; however, many of these are offered only in English and may not be best suited for ethnic women who speak English as a second language. This begs the question, what underlying model of learning do the existing prenatal education

programs use? Perhaps many prenatal programs use the deficit model. Further examination of the models of learning being used by prenatal education programs in Canada is necessary. Perhaps the underlying model that prenatal education programs use is what needs to be changed in order to achieve empowerment though prenatal education.

Educating a culturally diverse population is an essential yet a difficult task. Researchers such as Cassara (1990), Hemphill (1992), and A. Rose (1992) agree that an effort is being made to educate culturally diverse populations in Canada and the U.S.A., but it has not been accomplished effectively. Likewise, many prenatal education programs in BC's Lower Mainland are available, but often these are only available in English. This leads to the question whether or not they are targeting a culturally diverse population or new immigrant women. It needs to be recognized that immigrant women do not comprise a homogenous group of people. According to Assanand, Dias, Richardson, and Waxler-Morrison (1990), even South Asians living in Canada are not a homogenous group of people. A single prenatal program cannot be generalized to target all immigrant women. Rather, a specific cultural group needs to be targeted, and the prenatal program needs to be designed for that cultural group, as Scanlan and Darkenwald (1984) found when they examined deterrents to adult education. They acknowledged that the findings of their study "cannot be generalized to all health professionals or to professionals in general, much less to the general adult population" (p. 165). This is yet another factor that may strongly impact the participation of Indo-Canadian women in prenatal education. How many prenatal programs in BC's Lower Mainland--or Canada--have a model of program delivery best suited to the needs of Indo-Canadian women, or the cultural group(s) of their region?

Belenky, Clinchy, Goldberger, and Tarule (1986) emphasize that women learn in ways that are different from those of men. They categorize women's ways of knowing into five categories which move from simple to complex: silence, received knowledge, subjective knowledge, procedural knowledge, and constructed knowledge. It is interesting to apply these categories to the women involved in my study. Although it was beyond the scope of my study to investigate the application of the categories of Belenky et al., some general observations can be made. Based on the discussions in the focus groups, I place many of these women in the more simple categories of silence and received knowledge--particularly those Group 1 women who were referred to the prenatal program. The category of silence is where women obey authority, accept feelings of powerlessness, and do not engage in dialogue. The category of received knowledge is where women learn by listening to the voices of friends and authorities, which is consistent with the findings of my study. The women perceived distinct roles for physicians and health care providers--individuals whom they perceived as authorities.

Women in Group 2, who self-referred, may be categorized as having subjective knowledge or procedural knowledge. Subjective knowledge is where women listen to their inner voice and begin the quest for self. Procedural knowledge is more complex, where women see their knowledge as being more objective. They listen to reason, have doubts, and value knowledge gained from personal experience. Were any of the women who self-referred in the most complex category of constructed knowledge? Perhaps. While there is an interesting connection between the ways in which women acquire knowledge and the likelihood of Indo-Canadian women to participate in prenatal education, the complexity of the connection needs further research.

Recruitment Issues

In the area of recruitment, I noted relationships between my study findings and research by Knowles (1980), the Volunteer Centre of Metropolitan Toronto (1992), and the Indo-Canadian Women's Organization (1995).

Knowles (1980) indicates that many good programs are unsuccessful due to poor promotion, "people just never heard about them or did not realize how good they were" (p. 189). This parallels the findings of my study. Many of the women involved in my study indicated that they did not know the program existed and they identified this as one of the barriers to joining the program. It is evident that effective marketing of the prenatal program is needed so that Indo-Canadian women are aware of the prenatal programs available to them. Knowles suggested seven approaches to distributing a promotional plan and attracting new participants. Similarly, the participants in my study suggested ways to promote prenatal programs to Indo-Canadian women. These included television, radio, newspaper, posters, and brochures. Essentially, these are the same as those suggested by Knowles.

The Volunteer Centre of Metropolitan Toronto (1992) found that written materials should be linguistically and culturally appropriate for the proposed target group. My findings were consistent with this. Indo-Canadian women involved in my study identified language numerous times. For example, they stressed the importance of having prenatal education in their mother language, Punjabi. Also, they stressed that brochures and information should be translated into Punjabi, and marketing strategies aimed at recruiting new participants should be in Punjabi and English.

The Indo-Canadian Women's Organization (1995) concludes that recruitment to prenatal education would be effective if health professionals, especially physicians, were supportive of women's participation. The findings from my study are consistent with this research. It appears that the women in my study viewed physicians and health care professionals as authorities and valued their opinions. My participants advocated that physicians, in particular, should refer pregnant Indo-Canadian women to appropriate prenatal programs.

I found that Indo-Canadian women in my study who self-referred had higher levels of formal education, emigrated from urban centers in India, and had resided in Canada for a longer period of time, as compared to the referred group. This finding implies that these characteristics empowered self-referring participants to seek out prenatal education. I noted that the majority of participants who self-referred had a grade 12 education or a university degree. On the other hand, the majority of participants who were referred reported an education level of grades 9 to 11. No participants in the referred group reported receiving less than a grade 9 education. Based on the women in my study, Indo-Canadian immigrant women have varying levels of education. Although, it was not the case of the women in my study, some Indo-Canadian immigrant women may be illiterate in both English and Punjabi. This has implications for recruitment of Indo-Canadian women to prenatal education. Recruitment efforts must take into consideration varying levels of education of the target population.

My Personal Learning and Growth

I believe that adult learning occurred for me as well as for the participants involved. I learned a number of things from this study, particularly in areas of research study design, implementation, and evaluation. Previously, I was unaware of all the research and work that goes into the design and planning phases of focus groups. It was a great learning experience for me to design the standard questions for the focus groups. I had a number of people with different areas of expertise review the questions. All the individuals had different perspectives and provided considerable valuable feedback. As a result of the feedback, I revised the original draft of questions 3 times before it was finalized and ready for use with the focus group. This is consistent with the literature on focus groups by Krueger (1988). Krueger stresses the importance of focus group questions and recommends that significant thought be put into developing focus group questions. He states, "Quality answers are directly related to quality questions" (p. 59).

Lessons that I learned in the design phase of the study were: (a) the value of having well thought out questions for focus groups; (b) the value of community feedback and input; and (c) the value of putting more time and effort into the design phase so as to improve the outcomes of the study. These findings are consistent with the literature in this area. According to Merriam and Simpson (1984), adequate time and energy should be given to clearly stating the topic, defining and stating the research problem, defining terms and concepts, and developing research questions. Merriam and Simpson state that "the careful delineation of the problem to be studied saves time in the long run and results in a more satisfactory experience overall" (p. 13). Similarly, Krueger (1988) indicates that planning research may appear simple, but it is quite involved. The conceptualization

phase involves considering the purpose of the research, the users, the target audience, and developing a written plan. Krueger states, "Think of a plan as a small investment in time and energy that is intended to prevent costly mistakes" (p. 52).

By conducting a focus group that consisted of East Indian immigrant women, I gained much insight into the challenges of working with this population. I learned how significantly culture influences women's quest for prenatal health information. These women and their families need to be empowered to seek out prenatal health education. I learned the importance of establishing trust with groups of women so as to encourage them to speak openly. I believe that one of the factors in establishing this trust with these women is the cultural background of the focus group facilitators and recorders. For immigrant women, I believe that it is vitally important that communication in the focus group be in their native language and allow the women the option of speaking in English or their native language. This is consistent with the literature by Vella (1994). Vella believes that speaking a common language, even if poorly spoken, can help build a relationship between teacher and student. She states that in "every non-English-speaking country I have worked in, my very desire to learn the language created a relationship with the local people" (p. 127). Likewise, Powell (1997) discusses the importance of cultural sensitivity of the educator. Powell notes that a trainer or educator who is culturally sensitive to the needs of the target population, and has made efforts to gain knowledge about that groups culture, history, social, and economic dynamics, can be effective. Powell states, "the best trainer is often someone of the same culture--a role model for the trainees to emulate" (p. 12).

One area of concern I had was whether the East Indian women would discuss the issues surrounding barriers, access, and recruitment for prenatal education. I found that as we got further into the focus group discussions, and turned the discussion to the more abstract question of what others besides themselves might do or not do, the women began to speak more freely. I was quite impressed by the openness in discussion. The women were very insightful and had much to share, when they felt it was safe to do so by not discussing their own personal situation.

I learned that analysis and interpretation of qualitative data an essential part of research, yet it is one of the greatest challenges involved. It was challenging to decide how to group and document the results and how to find themes and commonalities. According to Merriam and Simpson (1984), many investigators underestimate the time and effort required to report their findings from a study. They state, "Transforming the information and insights gleaned from any array of notebooks, audio tapes, or computer printouts into written format that others can understand often becomes an insurmountable task" (p. 149). Similarly, Krueger (1988) states "Qualitative researchers have been known to be overwhelmed with the vast accumulation of data and find that they have a multitude of choices" (p. 107).

The pursuit of my master's degree in adult education has been an exciting journey, one filled with challenges, rewards, and successes. This master's degree was definitely the right program for me. It has helped me discover who I am on a personal and professional level. Most importantly, it has helped me discover the gift of learning. To describe how my learning has affected me, I look back at my own experiences with school and education. I acknowledge that, previously, my motivations for learning were

to get good grades, to make my parents happy, and to get a career. I only read those books that teachers asked us to read and only studied the information that we would be tested on. I did well in school, but I can honestly say that I did not ever enjoy learning. In reflection, I was not a self-directed learner. But, at the time I was not able to acknowledge that, nor was it important to me. Since I have started working on my master's degree, I have truly enjoyed learning simply for the sake of learning. For the first time in my life, I honestly believe I have become a self-directed learner. This statement comes from a true moment of open and honest critical reflection, one that I would not have had prior to beginning my master's degree in adult education. This outcome is consistent with Knowles' (1980) literature, where he discusses one's self-concept in the journey of learning. He states that children begin at a state of dependency and move in the direction of self-directed learning. Knowles notes that it is in adulthood that one values self-direction. He states, "Once an adult makes the discovery that he can take responsibility for his learning, as he does for other facets of his life, he experiences a sense of release and exhilaration" (p. 40). This is a rewarding outcome for both the learner and the teacher involved.

Personally, the idea of being a self-directed learner has had a very profound impact on me. I feel fortunate to have discovered the gift of self-directed learning. One of my goals with my daughter Kirpa is to try to teach her about the joys of learning and to be a self-directed learner; something I only recently discovered. This will prepare her for a lifetime of learning. I owe this to the Master in Adult Education program at St.F.X. I do believe that starting and persevering through this program was one of the best decisions of my life.

Professionally, I have discovered that my true area of interest and passion lies in working with various cultural groups within the area of nutrition and health education. Upon completion of this master's program, I plan to establish new short and long term goals that encompass nutrition, health, adult education, and fostering empowerment within ethnic communities. Working on the master's degree has helped me gain confidence in my abilities as an adult educator. I truly have discovered that I have a great passion for learning and teaching, and I look forward to sharing this with others. I believe that an adult educator who is passionate in his or her beliefs, can make a difference. I believe that I have become a passionate adult educator. This outcome for me is consistent with hook's (1994) advocacy that passionate commitment to a vision results in social transformation. Hooks introduces her personal experiences she encountered as a student in a segregated black school, as compared to that of an integrated school. Also she cites personal experiences as a teacher, and emphasizes the pleasure of teaching. She discusses the visions of freedom, justice for all, desegregation in formal schooling, and ending racism. She concludes that although a classroom has many limitations, it continues to be a place of opportunity for education to be a practice of freedom.

Perceived Learning of the Participants Involved in their Study

I believe that learning occurred for the women as a result of participating in the focus groups. For many of the pregnant women involved in the focus groups, this may have been the first time they were ever asked for their opinions and views on an educational level. The fact that the women were included and asked to talk about their personal experiences and opinions is empowering on its own. I believe that they felt

empowered by being asked to help the prenatal program staff, the authorities, find solutions to a community problem. It gives value and merit to their personal experiences, and opinions. The feedback received after this study was very positive. For example, the women who participated were very thankful in being asked to talk about this subject, they expressed hope their input would help, and one woman asked for a copy of the final written results. This finding parallels the research by Travers (1997) where she discusses the idea of consciousness-raising as cultural development. Low-income women attended group meetings in a Parent Center in Nova Scotia. In the early meetings the facilitator asked questions and the women responded. Women shared their experiences and listened to those experiences of others. By participating in the group meetings they learned that other women shared their experiences and oppression, and learned coping strategies from each other. Being involved in the group meetings gave merit and value to the participants' experiences. In this study, the consciousness-raising was simply the first step in their empowerment. The women progressed to small group development, community organization, coalition advocacy, and political action.

I think that the women who attended the focus groups saw that the process itself may be beneficial. Many of the comments from the focus groups lead me to believe that they saw the focus group discussion as hope for change. One woman stated that she hoped this focus group information would help make changes so that more services could be offered to Punjabi women through translation of books, marketing, to more Punjabi-speaking staff in the regional hospitals. Another woman stated that the development of more community programs for pregnant Indo-Canadian women will help to build a

healthier Indo-Canadian community. However, there was one woman who felt that nothing would ever change.

In reflection, I believe that the spoken language used in the focus groups may have been empowering, but it may have been disempowering too, to the women. In all focus groups, participants were asked to respond in the language with which they were most comfortable, English or Punjabi. The majority of participants of Focus Groups 1 and 2 chose to speak in Punjabi. However, occasionally participants used English words, and a couple of women chose to speak exclusively in English. For those women who are confident in their skills with English, speaking in English may have been empowering. On the other hand, for those women who chose to speak in Punjabi, this may have been disempowering because they may feel inadequate about their literacy skills in English. Or they may have felt that their comments in Punjabi may not be considered as valid as those speaking in English. In the literature about language, Pattanayak (1986) finds that language is a major element in forming a hierarchy of elitism and alienation, and can inhibit or enhance equal opportunity. He notes that in Asia, some people consider mother tongues to be barriers against upward mobility, while others view the mother tongue as their key to equal opportunity.

This discussion of the findings from my study as it relates to the literature should prove to be helpful for adult educators working in the area of prenatal education. Next I will discuss conclusions, recommendations for practice and for further research.

Conclusions

This study identified perceptions of pregnant Indo-Canadian women pertaining to the prenatal program in BC's Lower Mainland and prenatal education programs in general. It demonstrated that the Indo-Canadian women in my study are motivated to gain knowledge and education during pregnancy, with the goal of having a healthy baby. Pregnancy is a good opportunity for adult education to occur.

The study demonstrated that Indo-Canadian women (in my study) do face numerous barriers to participation in prenatal education. Some of these barriers are common to those that other women face in joining prenatal education programs, such as perceived cost and lack of transportation. However, the majority of the barriers these women face are culturally based.

An interesting finding from my study is that the pregnant Indo-Canadian women participants perceived a definite role for staff of prenatal programs, health care professionals, and physicians. However, they did not identify a significant role for themselves. This finding implies that the prenatal program did not assist them in identifying a role for themselves. This is an interesting finding that has connections to the literature on oppression. Many Indo-Canadian women face oppression on a daily basis. They appear to be oppressed by people they perceive to be authorities, such as physicians and some family members. This leads me to believe that many pregnant Indo-Canadian women are not only disempowered by their families and perceived authority figures. They feel they are incapable of educating others, and the prenatal program did not help them feel that they could help others. The program itself may be acting in an authority capacity and consequently as a continuer of oppressive perceptions.

My study found that Indo-Canadian physicians did not refer pregnant Indo-Canadian women to prenatal education programs. This may be due to the existing power relationship, where physicians are viewed as authorities and the oppressor. Perhaps they do not refer these women to prenatal education in an attempt to maintain their position of power.

By examining prenatal programs in general, a few interesting questions arise. I introduced a question pertaining to the type of learning model that prenatal programs use. If a deficit model of learning, as defined by Horsman (1999), is being used, this only furthers the disempowerment of the participants. Perhaps the underlying model that prenatal education programs use is what needs to be changed in order to enhance participation of ethnic minorities? Another question that arises is, what population of pregnant women are prenatal education programs in BC's Lower Mainland targeting? In order to enhance participation of Indo-Canadian women in prenatal education, the programs need to specifically target these women. It is unlikely that programs that target a broader range of women, such as South Asians, or immigrant women in general will be effective for any one of the ethnic groups in the region.

In looking at the demographic characteristics of the self-referring participants, I noticed many similarities with participants who were referred by a third party. For instance, all women emigrated from India, all women were educated in India, all women were married, and all spoke Punjabi. However, there were some interesting differences. Participants who self-referred had higher levels of formal education, emigrated from urban centers in India, and had resided in Canada for a longer period of time, as compared to the referred group. The majority of participants who self-referred had a

grade 12 education or a university degree. On the other hand, the majority of participants who were referred reported an education level of grade 9 to 11. It seems that these characteristics empowered self-referring participants to seek out prenatal education and to make more suggestions concerning our program and health care generally.

In looking at the literature about empowerment, I noted the method of education Freire (1970) refers to as the banking concept of education. I assume that the participants in my study received formal education in India using this method--one that tends to further oppression. I believe that this may have an impact on why Indo-Canadian women in this study did not see themselves as active agents in changing the present situation.

It is interesting to analyze the levels of empowerment of the women in my study. Using the five-steps of levels of empowerment of women by Lephoto (1995), I conclude that most of the women in my study had low levels of empowerment, but that a small number of them may have had higher levels of empowerment.

Looking at the five categories of women's ways of knowing by Belenky, Clinchy, Goldberger, and Tarule (1986). I noticed a link between the ways in which women acquire knowledge and their likelihood to participate in prenatal education. That is, women who are at the simpler ways of acquiring knowledge are less likely to self-refer. However, further exploration into this area is required.

In the area of recruitment, I noted that my findings are consistent with those of Knowles (1980), and the Volunteer Centre of Metropolitan Toronto (1992). It is evident that effective marketing of the prenatal program is needed so that more Indo-Canadian women are aware of the prenatal programs those are best suited to them. Culturally

appropriate recruitment strategies could impact the proportion of Indo-Canadian women who participate in prenatal education programs.

There were two major factors that participants felt influenced self-referral to prenatal education programs. Firstly, the level of support and information about the program from their family doctor. Secondly, the level of support from the family. On the first point, my study demonstrated that the staff from the prenatal program, health professionals, and East Indian physicians, have a significant role to play. The participants in my study stressed the primary role of the physician in referring potential clients to prenatal education programs. This is congruent with Indo-Canadian women's state of oppression and subsequent deferral to perceived authority figures. It is likely that, with the support of East Indian physicians and health professionals, the number of Indo-Canadian women participating in prenatal education programs would increase. However, if we rely on these perceived authority figures to simply refer Indo-Canadian women to prenatal education, does it not simply further their state of disempowerment? On the second point, unfortunately, many families from India believe that prenatal education is not necessary, and may even be harmful to the mother and the family structure. Enhanced support from the family may be one way to increase self-referral. However, it must be identified that, in some families, such support may be difficult to achieve. It may imbalance the existing oppressor-oppressed relationship. This difficult issue presents an obvious challenge for adult education.

Recommendations For Practice

1. Based on this study, it seems that pregnant Indo-Canadian women living in British Columbia's Lower Mainland who are at-risk for delivering a low birth weight infant typically seek out family doctors of East Indian origin. Pregnant Indo-Canadian women see referral to prenatal education programs as a primary role of their family doctor. Support from Indo-Canadian physicians is crucial in increasing the proportion of high-risk pregnant Indo-Canadian women who attend prenatal programs. They should be made aware of the culturally appropriate prenatal programs available. Physicians should encourage Indo-Canadian women to take ownership of their health and to refer themselves to prenatal education programs. This may serve to empower Indo-Canadian women. Avenues of reaching and educating these physicians need to be explored, and further research on why they rarely do refer might be most helpful.

2. It is evident that the Indo-Canadian women in my study attach great importance to recommendations given by health professionals. Therefore, I recommend targeting the prenatal program marketing to health professionals. This may serve to increase women's trust in prenatal programs. In order to empower these women, self-referral to the prenatal program should be promoted rather than third-party referral by the health professional.

3. The local hospital pre-registration program has been successful in identifying and referring high-risk Indo-Canadian women to the Lower Mainland prenatal program. I recommend that the prenatal program continue to work closely with this program.

4. Recruitment efforts must be culturally and linguistically appropriate for Indo-Canadians. In this study, a motivational support mentioned by pregnant Indo-Canadian women for themselves was their family, but a major barrier they identified for others (nonparticipants) was a lack of family support or discouragement they received from family members. Education aimed at the family may be one way to increase self-referral. Recommendations on this point are:

(a) Recruitment strategies need to target Indo-Canadian families. Recruitment efforts that aim to empower both the pregnant woman *and* the family members (particularly the elders in the household) will be most effective and should be considered in any recruitment strategies proposed.

(b) Community education is needed to educate the Indo-Canadian community on the issue of low birth weight, how low birth weight can impact their families, and the importance of prenatal education. A mass media community education effort could prove to be effective. Past prenatal program participants, their family members, and Punjabi-speaking health professionals should be considered and included in this community education effort. A variety of ethnic specific venues could be used; for example, Punjabi language television channels, radio, video, and newspapers could carry announcements on the importance of prenatal education as it relates to healthy birth outcomes.

(c) Pregnant Indo-Canadian women identified language as a key issue of concern. I recommend that all recruitment efforts should be in Punjabi as the first language of communication.

(d) All of the program promotion strategies emphasized points that focus group participants felt were important in marketing: including that it is a free program, it offers a $5.00 gift certificate, it is a program offered in Punjabi, and it is confidential. Therefore, I recommend that future program promotion strategies include cost, incentives to join, language of service delivery, and confidentiality.

5. Prenatal education programs must be culturally appropriate. To achieve this, the following recommendations are offered:

(a) Prenatal education programs aimed at the general population are not well suited for pregnant Indo-Canadian women. Program planning, development, and evaluation must be culturally appropriate and specifically targeted to this population. The barriers to participation that the Indo-Canadian women in my study noted in this report should be considered in recruitment strategies.

(b) Home visitation rather than office visits for individual prenatal education is one way to reduce the barriers that families place on the pregnant women. Therefore, I recommend that prenatal programs targeting Indo-Canadian women offer home visits for individual education.

6. Prenatal education programs should be based on a model of service delivery that empowers Indo-Canadian women. The following recommendations are offered.

(a) Prenatal programs should not be based on a deficit model of learning. Instead the prenatal education program should focus on the strengths of the pregnant women and value their knowledge gained from personal life experience.

(b) The method of education used within the program should be empowering. Communication between the pregnant woman and the educator should be one that promotes dialogue. This can help them form their own opinions and empower them to discover their own solutions.

7. Since women work closely together in villages across India to support and help each other, methods for peer support in the community should be considered for purposes of empowering pregnant Indo-Canadian women. Research on various peer support models would be very helpful.

8. As the Indo-Canadian women in my study indicated, I recommend that the book entitled Baby's Best Chance: Parents' Handbook of Pregnancy and Baby Care be translated into Punjabi.

Recommendations For Further Research

In reflecting on this study, I suggest the following areas for future research.

1. Ways of reaching and educating East Indian physicians working in British Columbia's Lower Mainland, and quite possibly, other areas in Canada need to be explored. Further research on why these physicians rarely do refer pregnant Indo-Canadian women to prenatal education could be most helpful. The issue of power between East Indian doctors and their patients appears to impact the referral of Indo-

Canadian women to prenatal education. Further examination into the power relationship between East Indian physicians and their Indo-Canadian patients is necessary.

2. Further examination and research into the models of learning being used by prenatal education programs is necessary. Perhaps the underlying model of learning that prenatal education programs use is what needs to be changed in order to enhance participation of ethnic minorities.

3. Further research into the connection between levels of empowerment and participation in prenatal education for Indo-Canadian women might be helpful. Similarly, an in-depth analysis of the best ways in which Indo-Canadian women learn in this new cultural context could be very helpful.

4. The Indo-Canadian immigrant women in my study had varying levels of education. This has an impact on both recruitment and the content of prenatal education programs. It might be helpful to determine levels of education of Indo-Canadian immigrant women, as some of these women may be illiterate in Punjabi. Different recruitment strategies may be required for individuals with different levels of education.

5. I found that as we got further into the focus group discussions, and turned the discussion to the more abstract question of what others besides themselves might do or not do, the Indo-Canadian women in my study began to speak more freely. I think this technique of speaking "in the abstract" about the community is a technique that might be explored in future work of this kind.

6. I noted that Indo-Canadian women who self-referred to the prenatal program had higher levels of education, emigrated from urban centers in India, and had resided in Canada for a longer period of time, as compared to participants who were referred. These

characteristics seem to have empowered these women to seek out prenatal education. Further examination into this area of demographic characteristics would be interesting.

7. For this study, I developed the focus group questions in English and then translated them into Punjabi. If this were to be conducted in another study, the comfort level of the participants' language should be assessed. I recommend that focus group questions be developed in the language that the participants are most comfortable. If participants are most comfortable speaking Punjabi, the questions should be developed in Punjabi.

The initial question for this study was to determine how our program might successfully recruit more Indo-Canadian women to our center. The secondary question was to identify the cultural barriers that this group of women face in participating in prenatal education. I believe my study has shed light on this problem facing the Indo-Canadian community in British Columbia's Lower Mainland. There are many deep-rooted factors impacting the proportion of Indo-Canadian women who participate and self-refer to prenatal education programs. Based on the findings of my study, I believe that Indo-Canadian women can be empowered to seek out prenatal education. However, it is not a simple solution. Significant efforts need to be made. Knowledge is power and, more importantly, it can be empowering. Few educated people are powerless; for example, Nelson Mandela may have been in prison for many years but was not powerless. Freire was seen as radical and threatening; he was jailed in Brazil in 1964, and lived in political exile for many years following. But, Freire was not powerless. His teaching method to effect

freedom from oppression was used widely in literacy campaigns in Brazil and Chile. The spirit of these adult education leaders is needed in Canada and I hope this thesis helps to encourage such efforts.

References

Acton, R. (1995). Refocusing the multicultural discourse in adult education. In C. Danis & M. Hrimech (Eds.). Proceedings of the 14th Annual Conference of Canadian Association for the study of Adult Education (pp 1-5). Montreal: Concordia University.

Aggarwal, J. C. (1989). Adult and social education in India: Global perspective. Delhi, India: Doaba House.

Ambury, G. (1993). Faith in people: A case of one organization's struggle with the poor of North India to empower and liberate them. In M. Taylor & R. Bedard (Eds.), Proceedings of the 12th Annual Conference of Canadian Association for the Study of Adult Education (pp 7-12). Ottawa, ON: Faculty of Education, University of Ottawa.

Assanand, S., Dias, M., Richardson, E., & Waxler-Morrison, N. (1990). The South Asians. In N. Waxler-Morrison, J. Anderson, & E. Richardson (Eds.), Cross-cultural caring: A handbook for health professionals in Western Canada (pp. 141-180). Vancouver, BC: University of British Columbia Press.

Baby's Best Chance: Parents' Handbook of Pregnancy and Baby Care, 4th edition (1994). Toronto, ON: Macmillan Canada.

Belenky, M. F., Clinchy, B. M., Goldberger, N. R., & Tarule, J. M. (1986). Women's ways of knowing: The development of self, voice and mind. New York: Basic Books.

Bhasin, K. (1996). What is patriarchy? Convergence, 29(3), 54-56.

Briskin, L., & Coulter, R. P. (1992). Feminist pedagogy: Challenging the normative. Canadian Journal of Education, 17(3), 247-263.

British Columbia Ministry for Children and Families. (1997/98). Pregnancy Outreach Program Handbook. Victoria, BC: British Columbia Ministry for Children and Families.

Cassara, B. B. (1990). Adult education in a multicultural society. London: Routledge.

Celebrating New Life (1995). Surrey, BC: Options: Services to Communities.

Celebrating Pregnancy (1995). Surrey, BC: Options: Services to Communities.

Choudhry, U. K. (1997). Traditional practices of women from India: Pregnancy, childbirth, and newborn care. Journal of Obstetrics, Gynecologic, and Neonatal Nursing, 26(5), 533-539.

Comings, J. P., Smith, C., & Shrestha, C. K. (1994). Women's literacy: The connection to health and family planning. Convergence, 27(2/3), 93-100.

Darkenwald, G. G., & Valentine, T. (1985). Factor structure of deterrents to public participation in adult education. Adult Education Quarterly, 35(4), 177-193.

Dunn, H. G. (1984). Social aspects of low birth weight. Canadian Medical Association Journal, 130, 1131-1139.

Fisk, R. (Ed.). (1997, July). Pregnancy Outcomes in British Columbia. B.C. Health and Disease Surveillance, 6(7), 69-93.

Freire, P. (1970). Pedagogy of the oppressed. New York: Herder and Herder.

Gulzar, L. (1999). Access to healthcare. Image: Journal of Nursing Scholarship, 31(1), 13-19.

Hemphill, D. F. (1992). Thinking hard about culture in adult education: Not a trivial pursuit. Adult Learning, 3(7), 9-12.

Hemphill, D. F., Ianiro, S. L., & Raffa, D. A. (1995). Media, technology and literacy in immigrant and multicultural contexts. Proceedings of the 36th Annual Adult Education Research Conference, (pp 152-163). Edmonton, AB: University of Alberta.

hooks, b. (1994). Teaching to transgress: Education as a practice of freedom. New York: Routledge.

Horsman, J. (1999). Too scared to learn: Women, violence, and education. Toronto: McGilligan Books.

Indo-Canadian Women's Organization, the. (1995, November). Creating a supportive perinatal environment: Summary report of a health promotion research project. Vancouver, BC: Author.

Institute of Medicine. (1985). Preventing low birthweight. Washington, DC: National Academy Press.

Jarvis, P. (1990). An International dictionary of adult and continuing education. New York: Routledge

Khawaja, S., & Brennan, B. (1990). Non-formal education: Myth or panacea for Pakistan. Islamabad, Pakistan: Mr. Books.

Knowles, M. (1980). The modern practice of adult education. New York: Cambridge.

Krueger, R. A. (1988). Focus groups: A practical guide for applied research. New Park, CA: Sage.

Lephoto, H. M. (1995). Educating women for empowerment in Lesotho. Convergence, 28(3), 5-12.

McAlpine, L. (1992). Cross-cultural instructional design: Using the cultural expert to formatively evaluate process and project. Educational and Training Technology, 29(4), 310-315.

McFarlane, J., & Fehir, J. (1994). De madres a madres: A community, primary health care program based on empowerment. Health Education Quarterly, 21(3), 381-394.

Merriam, S. B., & Brockett, R. G. (1997). The profession and practice of adult education, an introduction. San Francisco: Jossey-Bass.

Merriam, S. B., & Caffarella, R. S. (1991). Learning in adulthood: A comprehensive guide. San Francisco: Jossey-Bass.

Merriam, S. B., & Simpson, E. L. (1984). A guide to research for educators and trainers of adults. Malabar, FL: Robert E. Krieger Publishing.

Merriam-Websters New Collegiate Dictionary. (1959). Cambridge, MA: A. Houghton and Co.

Mezirow, J. (1991). Transformative dimensions of adult learning. San Francisco: Jossey-Bass.

Mitter, W. (1992). Multicultural education: Basic considerations in an interdisciplinary approach. Prospects, 22(1), 31-40.

Nault, F. (1997). Infant mortality and low birthweight, 1975 to 1995. Health Reports, 9(3), 39-46.

Pastoree, M. T., Cocking, J., & Stilwell, J. (1998, June). Infant feeding practices survey: Final report. Delta, BC: Boundary Health Unit South Fraser Health Region.

Pattanayak, D. P. (1986). Educational use of the mother tongue. In B. Spolsky (Ed.), Language and education in multilingual settings. (pp. 5-15). Clevedon, England: Multilingual Matters Ltd.

Peters, J. M., Jarvis, P., & Associates (1991). Adult education: Evolution and achievements in a developing field of study. San Francisco: Jossey-Bass.

Powell, G. C. (1997). On being a culturally sensitive instructional designer and educator. Educational Technology, 37(2), 6-14.

Quigley, B. A. (1997). Rethinking literacy education: The critical need for practice-based change. San Francisco: Jossey-Bass.

Rose, A. (1992). Is multicultural education a radical notion? Adult Learning, 3(7),6.

Rose, M. A. (Ed.). (1993). Prevention of low birthweight in Canada: Literature review and strategies. Ottawa, ON: The Canadian Institute of Child Health.

Ross, J. M. (1989), Reaching and involving culturally diverse groups. In B. A. Quigley, (Ed.), Fulfilling the promise of adult and continuing education (pp. 95-105). San-Francisco: Jossey-Bass.

Scanlan, C. S., & Darkenwald, G. G. (1984). Identifying deterrents to participation in continuing education. Adult Education Quarterly, 34(3), 155-166.

Selman, G., & Dampier, D. (1991). The foundations of adult education in Canada. Toronto: Thompson Educational Publishing.

Silins, J., Semenciw, R. W., Morrison, H. I., Lindsay, J., Sherman, G. J., Mao, Y., & Wigle, D. T. (1985). Risk factors for perinatal mortality in Canada. Canadian Medical Association Journal, 133, 1214-1219.

Strychar, I. M., Griffith, W. S., Conry, R. F., & Sork, T. J. (1990). How pregnant women learn about selected health issues: Learning transaction types. Adult Education Quarterly, 41(1), 17-28.

Travers, K. D. (1997). Reducing inequities through participatory research and community empowerment. Health Education & Behaviour, 24(3), 344-356.

Volunteer Centre of Metropolitan Toronto. (1992). Volunteers from the multicultural community: Programs that work. Toronto: Author.

Watters, N., & Avard, D. (1992). Prevention of low birth weight in Canada: Literature review and strategies. Ottawa, ON: The Canadian Institute of Child Health.